Physicians decide to modify or leave practice for a wide variety of reasons. Factors may include unexpected injury or illness, military service, the need to care for family members, or continuing education. Some physicians may decide to modify their practices, for example, by not practicing obstetrics, by practicing as a hospital-based obstetrician (laborist), or by eliminating surgery from their practices. Leaving medical practice may be emotionally charged and may potentially affect relationships with patients, practice partners, colleagues, and family members. There also may be financial implications connected to a modification of practice. Consequently, creating a plan in advance is recommended, particularly if the physician plans to re-enter practice at a future date. This document includes information for physicians who voluntarily modify or leave clinical practice and are in good standing in their practice setting at the time of modification or departure (Box 1).

Advance Considerations
Physicians planning to leave or significantly modify their practices should understand the complexities involved with re-entering practice. Because a physician who leaves a medical practice is in a significantly different position from a physician who continues to practice at a reduced schedule (1), the following should be considered:

• Practice Partners—Communicate future plans with colleagues with as much advance notice as possible, particularly those with whom call responsibilities are shared.
• Patients—Patients should be notified of plans to modify practice. State licensing boards may require patient notification of leaves of absence and transfers of patient care, including medical records.
• Licensing and Certification—Become familiar with requirements for change of practice activity because these vary among states. It is important to consider state requirements for maintenance of licensure and whether it is possible to place one’s license in an inactive status. Additionally, be aware that Maintenance of Certification (MOC) requirements by the American Board of Obstetrics and Gynecology are based on an annual cycle.
• Clinical Competence—Maintaining clinical competence is critical to the re-entry process. Staying knowledgeable about current practice guidelines and recommendations may be accomplished by networking with colleagues or identifying a mentor with whom to meet during the period of clinical inactivity (1). Attending continuing medical education (CME) programs, either in person or online, also should be considered. Whenever possible, physicians in active practice should cooperate with retraining efforts of returning peers and colleagues.
• Employment—if employed, discussions regarding leaves of absence should be held with the appropriate member of the human resources department to discuss issues such as defined benefits and potential requirements during a short or extended leave of practice. When a physician leaves practice because of physical illness or injury or to take care of a family member, provisions of the Family and Medical Leave Act may be applicable and may require advance notification.
• Financial—Contact the appropriate professional liability carrier if leaving practice. Consider whether extended reporting period endorsement (tail coverage) will be necessary and, if so, who will pay for this
coverage. Fees for licensure and professional association membership may still need to be paid during any absence. Physicians with academic careers should understand that an absence may affect future promotions or tenure.

**Alternative Practice Considerations**

During any period of clinical inactivity, physicians are likely to fall behind in incorporating new knowledge into clinical practice. New drugs, devices, and evidence-based changes in clinical decision making are continuously incorporated into clinical care. In addition, changes in electronic interfaces, information technology, and equipment will occur, potentially resulting in a knowledge gap upon return to practice. Consequently, physicians should consider participating in activities that keep them informed of changes in clinical care by volunteering, teaching, or shadowing a physician (1). Job sharing or locum tenens work is another option for maintaining at least some clinical practice during a period of inactivity. Thorough records should be maintained to document practice activities that will be needed for future practice or employment opportunities. These records also will be important for maintaining CME requirements for licensure and specialty board certification. Keeping up with current literature is also valuable even when CME credit is not available.

It also may be useful to network with colleagues during a period of reduced practice or inactivity. For example, attending local medical society meetings may provide opportunities to keep up with changes in local medical referral relationships and other local health system matters (1).

**Preparing for Re-entry**

Unless adequate advance preparations are made before leaving clinical practice, physicians may face a number of barriers upon re-entry. The following elements should be considered when returning to practice:

- **Current Licensure and Drug Enforcement Agency Registration and State-Specific Controlled Prescribing Licensure**—Difficulties may exist in meeting state licensing board requirements for re-entry. Most states recommend, and several require, that physicians who take a leave of absence for more than 24 months participate in a physician re-entry program (2). The amount of time needed or required for educational experiences to be able to re-enter practice may be quite extensive. Unless adequately prepared, a physician returning to practice may not have obtained sufficient CME credit to fulfill the respective state’s requirements for maintenance of licensure. Sufficient time should be allotted to ensure that the pertinent state licensing provisions have been met before re-entry.

- **Board Certification and Maintenance of Certification**—The American Board of Obstetrics and Gynecology has the option to designate a Diplomate as “not currently in practice.” These physicians would only need to complete Parts 1 through 3 of the MOC. When returning to practice, the Diplomate would simply notify the American Board of Obstetrics and Gynecology and the designation “not currently in practice” would be removed. However, Diplomates who have not kept up with MOC will need to pass a re-entry test.

- **Medical Liability Insurance**—Many organizations, insurers, or managed care organizations may be unwilling to provide coverage to physicians who have not recently been in practice. Consequently, it is important to contact the professional liability carrier well in advance of plans to return to practice.

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**Box 1. Considerations at Various Stages of the Re-entry Process**

<table>
<thead>
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<th>Before Leaving</th>
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<tbody>
<tr>
<td>• Communicate with practice partners regarding coverage</td>
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<tr>
<td>• Inform patients about intended plans</td>
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<tr>
<td>• Contact medical liability carrier</td>
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<tr>
<td>• Find out requirements for maintenance of licensure and certification</td>
</tr>
<tr>
<td>• Review medical staff bylaws provisions about return to practice after period of inactivity</td>
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<th>During Absence</th>
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<tr>
<td>• Participate in continuing medical education activities and catalog hours</td>
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<tr>
<td>• Consider volunteering, teaching, or shadowing a physician</td>
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<tr>
<td>• Maintain current licensure, which will be difficult to get back once it has expired*</td>
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<th>During Re-entry</th>
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<tr>
<td>• Ensure the following are in place*:</td>
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<tr>
<td>— Board certification</td>
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<td>— Licenses</td>
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<tr>
<td>— Medical liability insurance</td>
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<tr>
<td>— Drug Enforcement Administration registration, if applicable</td>
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<tr>
<td>— Credentialing: hospital (including proctor) and insurance carriers</td>
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<tr>
<td>• Investigate re-entry programs</td>
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At the present time, none are endorsed or sponsored by physicians who have taken time off from clinical practice. Few organizations have developed re-entry programs specifically to those costs.

Re-entry Programs

Re-entry programs differ in experience offered, time in retraining, and supervision. Programs vary with regard to cost, distance from home, and flexibility. At this time, no standardization or oversight across programs is offered. The programs also may struggle to provide documentation sufficient to adequately establish physician competency. Re-entering practice requires regaining the numerous skills inherent in the practice of medicine, a process that may take months to accomplish. Simulation training may play an important part in various components of retraining. The Joint Commission now requires a period of Focused Professional Practice Evaluation for every physician initially requesting privileges (3). However, it is the responsibility of the chair or chief of staff, and ultimately the governing board, to confirm that the physician has demonstrated current competence in order to grant privileges to admit and care for patients.

Physicians who are returning to practice after a period of inactivity will need to consider a variety of factors before applying for hospital privileges. Factors such as liability insurance, proctoring, and, most importantly, demonstrating current clinical competence, will be critical. If retraining is necessary, the cost must be determined and the responsible party(ies)—the physician, hospital, or medical staff—must have a mechanism for contributing specifically to those costs.

In general, there are two types of re-entry programs: 1) evaluation and assessment and 2) retraining.

Evaluation and assessment programs, which constitute the majority of programs currently available, do not involve retraining. They are short in duration and last several days at most. They focus on the cognitive component of practice. In contrast, retraining programs may last for weeks to months. They typically cover cognitive skills and fund of knowledge but often not the manual skills applied in surgery. Currently, there are no accrediting bodies that oversee and approve the content of these programs.

At the present time, no specialty society has endorsed standards for re-entry programs or suggested standards for hospitals to use when credentialing and privileging re-entering physicians. Procedural and technical certifications are the most challenging component and, at this time, are individualized. Considerations for the development of a re-entry program include competition with residents for cases, use of simulators for manual skills, and compensation of preceptors.

The National Board of Medical Examiners and the Federation of State Medical Boards have developed a collaborative relationship with a number of national assessment programs that have the capability to provide localized, performance-based assessments in conjunction with the standardized assessment tools through the Post Licensure Assessment System (4). Information from these organizations’ web sites may serve as a resource. In addition, a collaborative endeavor called the Physician Re-entry into the Workforce Project, which consists of organizations such as the American Medical Association, the American Academy of Family Physicians, and the American Academy of Pediatrics, examines practice re-entry and creates guidelines, recommendations, and strategies that will serve to assist and protect physicians (1) (see Resources).

Conclusion

There are times in a professional career where leaving practice is a necessity; in these situations, strong consideration should be given to the logistics involved in practice re-entry. These factors may be costly and time consuming. Consequently, when possible, it is important to carefully plan both practice departure and re-entry and allow sufficient time and resources for these processes. Using a departure checklist, which includes the following elements, could be useful:

- Suspend medical license, hospital privileges, insurer credentials, professional liability insurance, and board certification in such a way that they can be reactivated with minimal difficulty.
- Continue contact with the profession and colleagues through MOC, attending grand rounds, CME opportunities, and social networking.

When possible, physicians should strongly consider the option of limited clinical activity rather than none at all. Because there is no national standard for practice
departure and re-entry and because all credentialing and privileging is local, each physician and hospital will ultimately have to determine the process by which the hospital and professional liability carriers will credential and privilege physicians re-entering practice.

Resources


Physician Re-entry Programs (as of August 2011)*

The Center for Personalized Education for Physicians (CPEP)
7351 Lowry Boulevard, Suite 100
Denver, CO 80230
Tel: (303) 577-3232
Web: www.cpepdoc.org

Drexel Medicine® Physician Refresher/Re-Entry Course
Drexel University College of Medicine
Office of Continuing Medical Education
1427 Vine Street, Room 405
Philadelphia, PA 19102
Tel: (215) 762-2580
(215) 991-8535
Web: http://webcampus.drexelmed.edu/refresher/default.asp

Florida Competency Advancement Program
PO Box 100277
Gainesville, FL 32610
Tel: (352) 273-9063

KSTAR Program
Texas A & M Health Science Center
Health Professions Education Building
8447 State Highway 47
Bryan, Texas 77807
Tel: (979) 436-0390
Web: www.rchitexas.org/KStar/index.html

PACE Program
University of California, San Diego
1899 McKee Street, Suite 126
San Diego, CA 92110
Tel: (619) 543-6770
Web: www.paceprogram.ucsd.edu

Pennsylvania Medical Society
PMSICO Healthcare Consulting
777 East Park Drive
Harrisburg, PA 17111
Tel: (888) 294-4336
Web: www.consultpmsco.com

References


*Inclusion in this listing should not be construed as support or endorsement by the American College of Obstetricians and Gynecologists.