



Reentry Barriers

The Physician Reentry into the Workforce Project maintains that decisions to leave and then reenter the workforce should be regarded as part of a physician's career trajectory, and not as an unusual event. Physicians who are considering leaving clinical practice, as well as those who are planning to reenter, should understand and acknowledge that there can be barriers to this process. Not all physicians will encounter all or even most of these barriers on the following list, but it is wise to be prepared.

- Physician/Practitioner Factors:
 - Lack of confidence and/or psychological concerns;
 - Lack of knowledge and skills, both clinical and documentation skills (i.e. EMR experience);
 - Lack of experience and comfort with other technological advances (i.e. internet searches, PDA use, etc.);
 - Lack of knowledge of requirements, sometimes leading to decisions that cause difficulty in returning (such as allowing a license to lapse or become inactive);
 - Failure to maintain knowledge in their clinical specialty because they do not anticipate a return to medicine;
 - “Unconscious incompetence” – even though the practitioner may have tried to prepare, s/he may be unaware of or unable to anticipate all areas in which s/he needs to update; inability to self-assess educational needs relative to the needs of the prospective practice setting; personal feelings of adequacy or ability to practice medicine as needed;
 - Pride: difficulty admitting that one is in need of further training;
 - Lack of time to address the educational needs; and inability to plan for oneself how to address the needs;
 - Difficulty determining when the educational gap is sufficiently addressed.
- Licensure and Licensing Board Factors:
 - Failure to educate practitioners who allow their license to lapse of these requirements and potential consequences;
 - Requirements that may be vague, arbitrary, and may have changed over time (or may in the future);
 - Requirements that differ in vigor from state to state;
 - Limited options given by which to demonstrate competence for any given state;
 - Limited means available by which to demonstrate competence;

- Lack of understanding whether the options to demonstrate competence actually do so; lack of understanding of what can be used as a proxy for “competence”;
 - Often the criteria used is hands-on patient care in the US (and the only criteria accepted by boards);
 - If criteria exist (such as the “two year rules”) they often do not differentiate between specialties. For example, perhaps “hands-on” care is more relevant for maintaining “competence” in surgical and procedural-based specialties, and the critical time out period should be different for procedural and non-procedural specialties;
 - Licensing organizations do not usually risk-stratify practitioners in deciding how a physician should prove competency after a time away (based on factors such as whether the practitioner is/was ever board certified, or whether the physician has required to recertify periodically, and has done so).
- Hospital and Other Privileging Bodies:
 - Discomfort with and/or lack of willingness to allow privileges to a physician who has not been in recent clinical practice;
 - Significant variations in this comfort level between hospitals (even for the same specialty);
 - Varying ability to provide proctoring or work with physicians in a staged re-entry process (i.e. gradually lessening levels of supervision);
 - Hesitance of managed care organizations and medical insurance companies to accept a re-entering physician onto their provider panel.
- Liability Coverage Factors:
 - Discomfort with and/or lack of willingness to provide liability coverage to a physician who has not been in recent clinical practice;
 - Significant variations in this comfort level between insurers and from individual to individual.
- Prospective Employer Factors:
 - As with all the other levels, lack of understanding of how to judge competence of a clinician who does not have recent clinical experience;
 - Limited availability of flexible work options;
 - Lack of support from the institution and colleagues for those integrating back into the workplace.
- Re-Entry Program Factors:
 - Discomfort with and lack of practicality in providing a “certificate of competence”;
 - Variability in what each program can offer to the practitioner and offer to the prospective board/hospital/malpractice insurer, etc.
 - Limited availability of sites where re-entry programs can provide hands on clinical experiences for physicians because of the above factors;
 - Cost of and distance to established programs; need for convenient and affordable programs;
 - Need for flexible programs;
 - Lack of standardization of how these evaluations are done and/or reentry process is conducted.
- Home and family barriers: ongoing needs such as childcare and needs of other family/household members;

- Multi-level Factors:
 - Multiple different layers of regulating and certifying bodies with different criteria for demonstration of aptitude and proficiency (which may or may not equate to competence), all of which the practitioner must fulfill; for example, requirements to maintain specialty board certification are not considered adequate demonstration of competence by boards and licensing authorities;
 - Unclear who is/should be the decision-maker in such matters;
 - Need for counselling to provide direction regarding the kind of learning and training needed.

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For more information on The Physician Reentry into the Workforce Project visit
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