

Reentry Into Clinical Practice Challenges and Strategies

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CAREER REENTRY HAS BEEN defined as returning to professional activity following an extended time lag after one has been trained or certified. We report on several factors that may contribute to decisions to take leave from clinical practice and the challenges that individuals may face during the reentry process.

CLINICAL INACTIVITY AND REENTRY

At various points in their clinical careers, physicians may encounter circumstances that compel them to take an extended leave from their clinical careers or contribute to their decision to do so. Historically, women are more likely to experience clinical inactivity and reentry because of societal expectations that women temporarily or permanently cease clinical practice when starting families or when family members become ill.¹ However, clinical inactivity and reentry can no longer be viewed solely as women's issues. Shifts in societal attitudes toward shared domestic responsibilities for men and women, changes in the practice, management, and delivery of health care, and increasing numbers of health care practitioners in nonclinical careers make clinical inactivity and career reentry important career matters for all health care professionals. Because much of the current literature on clinical reentry has focused on the nursing profession, we also report these results when appropriate.

Women and men who reenter clinical practice after a period of clinical inactivity often face personal, professional, and institutional obstacles. Although many associations and academic medical institutions realize the critical importance of retaining and promoting highly qualified individuals, it is equally important for health care professionals to have the opportunity to return to a successful professional career following extended clinical inactivity. Here we provide a review of factors that may contribute to clinical inactivity, discuss challenges associated with the reentry process, describe current reentry efforts, and propose recommendations for future directions.

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Caretaking and Relationship Issues

The dual demands of balancing a clinical career and familial needs often lead to career interruptions among health care professionals. A survey of 69 reentering female nurses in south Australia found that 48% of them temporarily left their careers because of caretaking issues.² Similar trends have been noted in other areas of medicine. In a 1996 survey³ of 656 physicians, 90% of 307 women had made career changes to care for their children, whereas 50% of 349 men reported having made such changes. The most frequent career changes included work and practice type, a decrease in hours, and discontinuation of clinical careers.³ Another study⁴ has shown that female physicians are twice as likely to interrupt their careers to accommodate their partners' careers, especially in the case of dual-physician relationships.

Although these results indicate that women are more likely to experience career interruptions, recent research reveals that younger cohorts of male physicians also take on multiple roles and express intentions to adjust their careers accordingly. One study⁵ found that

younger male physicians are twice as likely as their older counterparts to arrange their careers to accommodate children or marriage. Additionally, the Family and Medical Leave Act allows employees of certain businesses to take up to 12 weeks of unpaid leave for personal or familial issues. Although data on Family and Medical Leave Act use are not tracked by profession, the act's benefits may encourage male and female physicians to temporarily interrupt their careers. In fact, 29% of surveyed US men and women report that it is very likely that they will need to take family leave during the next 10 years, and 51% say that it is somewhat likely.⁶

Personal Illness

In addition to caring for family members, male and female health care professionals may take extended leave because of personal illness. For instance, 16 of 69 reentering Australian nurses

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reported leaving their clinical practice because of health-related reasons.²

Substance abuse disorders, mental health ailments, and physical illness are among the conditions that may contribute to extended absences.^{7,8} A 2001 National Institute on Drug Abuse report⁹ states that surveys and research in the early 1990s indicated that health care practitioners probably experience substance abuse, including alcohol and other drug misuse, at a rate similar to rates in society as a whole (8%-12%). According to the American Nurses Association, approximately 1 in 12 nurses in the United States has alcohol- or other drug-related problems that are serious enough to impair practice.¹⁰

As in other groups, depression is prevalent among health care professionals. Rates of clinical depression among medical interns are reportedly between 27% and 30%.^{11,12} Among practicing physicians, a 1999 study¹³ found that 19.5% of 4501 US female physicians reported a history of depression.

Career Dissatisfaction

Recent changes in the health care system have affected the careers of male and female health care professionals. High degrees of stress, burnout, and career dissatisfaction have all been documented.¹⁴ Additionally, there are significant disparities in income and leadership representation between male and female physicians.^{1,15} For instance, although women will constitute more than 30% of the physician population by 2010, they remain underrepresented in the upper echelons of academic medicine.^{1,16} In 1999, women accounted for only 10.6% of full professors.¹⁷ Similarly, the 1997 net median unadjusted income of male and female nonfederal physicians showed that male physicians earned \$55 000 more annually than their female counterparts.¹⁸

Women health professionals are also more likely to encounter sexual harassment. A 1993 poll¹ conducted by the American Medical Association found that 42% of 2300 female physicians experienced sexual harassment in their medical practice. Other studies^{19,20} have

highlighted the greater prevalence of sexual harassment among female health care professionals compared with male health care professionals. A 1993 study¹⁹ of internal medicine residents showed that 73% of the female residents reported being sexually harassed at least once during medical training, whereas only 22% of male residents reported such incidents.

The disparities in leadership representation, income, and sexual harassment are of particular concern, since female nurses and physicians report career dissatisfaction caused by a lack of autonomy and a perceived lack of promotional opportunities at greater rates than their male counterparts.^{14,21} Hence, the so-called glass ceiling that is reflected by these figures not only highlights the sex bias that is prevalent in the health profession but also may function to discourage women from continuing their clinical careers.

Alternative Careers

Many health care professionals may discontinue their clinical careers or take an extended leave to pursue other professional interests. Approximately 41 243 of the 650 899 nonfederal physicians in 1999 reported that they were engaged in nonclinical professional activities.²² Common nonclinical activities include earning additional degrees, political work, volunteering, management, teaching, policy making, or entrepreneurial ventures.

CHALLENGES FACED IN THE PROCESS OF REENTRY

In the absence of a database that tracks the number of reentering clinicians, determining the actual number of clinicians returning to their careers following an extended absence is difficult. Nonetheless, several studies^{2,23,24} have provided insight into the needs of this group. Reentering nurses have reported high levels of anxiety and low self-esteem as they embark on the continuation of their careers.² Not only must reentering clinicians cope with stressors associated with reviewing and updating their knowledge content and

clinical skills, but also they must face a professional and institutional climate that often lacks the necessary support. Health care professionals are further challenged by the reentry process because of a dearth of information on reentry programs and a lack of mentors.²³ In addition, women who return to practice following childbearing may be stereotyped by colleagues as being less dedicated than men.¹ Men who have adjusted their clinical careers to accommodate family responsibilities face the risk of being judged similarly. Reentering health care clinicians whose licenses have been revoked for reasons such as demonstrated deficiencies in clinical practice, substance abuse disorders, or inappropriate or disruptive methods of relating to colleagues are often distrusted by their colleagues.^{9,25,26}

EXISTING REENTRY EFFORTS

Biomedical Research Reentry Programs

The Office of Research on Women's Health of the National Institutes of Health offers a program that is designed to facilitate a smooth reentry process for women and men who have taken extensive leave from their biomedical research careers. Components of this program include close mentoring relationships, an awards system, and mechanisms for program evaluation and improvement.²⁷ This initiative conducted needs assessments before and 3 years after the program's establishment. The assessments unveiled salient barriers, such as family responsibilities, lack of research funds, and absence of role models, shared by men and women across ethnicity, culture, and scientific discipline.²⁸ The results of the assessments also indicated the critical importance of expanding recruitment and advertising efforts to audiences who do not have strong ties or associations with the institution offering the reentry program.²⁷

Reentry Programs for Nurses

The American Association of Colleges of Nursing surveyed its member nursing schools in 2001 as a step toward ad-

addressing these challenges. Of the 294 responding schools (54%), 23% indicated that they offer refresher continuing education courses. An additional 13% stated that they were considering offering such courses (American Association of Colleges of Nursing, RN Refresher Courses: Survey of Member Schools, unpublished data, 2001). Although a number of nursing reentry programs have been established throughout the United States, Great Britain, and Australia,^{3,29-32} without a centralized directory of nursing reentry programs, providing the actual number of such initiatives is impossible.

Although much of the literature on nursing reentry describes reentry programs in terms of content rather than final outcomes, some studies³¹ have evaluated program outcomes in terms of successful return to nursing practice. Among the reentry courses that were evaluated during the 1990s, the percentage of respondents who reported resuming nursing practice on completion of reentry programs ranged from 70.2% to 97.4%.^{29-31,33} Employment settings included acute care, outpatient care, long-term care, community health agencies, schools, physician offices, and home health care.³¹

Important components, as described by participants and developers of nursing reentry initiatives, include individually preceptored clinical opportunities, close collaboration among nursing practice and nurse educators in planning and delivering the programs, opportunities for peer support and networking, resume writing and marketability skills development, instruction that combines theory with clinical practice, and continual assessment throughout the planning, delivery, and evaluation phases.^{2,29-31,33} A major limitation shared by several reentry programs includes a lack of effective, widespread strategies for the recruitment of program participants and dissemination of program information.³³

Reentry Programs for Physicians

Few reentry programs exist for returning physicians. However, several phy-

sician retraining initiatives were developed during the early to mid-1990s, when a physician workforce projection predicted a shortage of generalist physicians and a surplus of specialist physicians.³² Many managed care and academic medical institutions began to explore physician retraining as an option for addressing this projection.³⁴ Unlike reentry, retraining generally involves moving into a new clinical area or augmenting prior professional skills. Various task forces and working groups were formed to strategize the development of programs to retrain practicing internal medicine subspecialists in the competencies and delivery of primary care. A directory of established and prospective programs was published by the Pew Health Professions Commission³⁵ in 1994. A number of these retraining initiatives have since been discontinued or were never implemented. A recent effort to update this directory revealed that many of these retraining efforts were discontinued because of a lack of funding, a lack of interest in retraining among subspecialists, turnover among key staff, or a resulting physician workforce distribution that was inconsistent with prior projections, namely, a predicted surplus of subspecialists.³⁴

Most of the reentry programs for physicians target mainly impaired physicians who are at risk of losing practice privileges and use an individualized approach to facilitate the reentry of inactive physicians, which involves a diagnostic assessment of the educational and clinical needs of the returning physician and is followed by recommendations based on these initial evaluations. For example, the University of Florida Comprehensive Assessment and Remedial Education Center evaluates the medical knowledge and clinical decision-making skills of each physician and assembles the results into an "educational prescription."³⁶ Similarly, the Colorado Personalized Education for Physicians program provides a 2- to 3-day assessment of medical knowledge, clinical reasoning, conceptualization, and communication that is fol-

lowed by 6 to 12 months of focused education.³⁷ Other programs provide educational sessions, mentoring, and posteducational assessments in addition to diagnostic evaluations. Examples of such programs include the Physician Evaluation, Education, and Renewal Program of the Oregon Medical Association and the Physician Prescribed Educational Program at the State University of New York (Syracuse).³⁷

Although longitudinal data on these programs are unavailable, many physicians have been involved in these programs since their establishment. For example, the Colorado Personalized Education for Physicians and the Physician Evaluation, Education, and Renewal programs have served more than 330 and 42 physicians, respectively, since 1990, and the State University of New York has served approximately 42 physicians since 1994.³⁷

RECOMMENDATIONS FOR A NATIONAL CLINICAL PRACTICE REENTRY PROGRAM

To address the issue of career reentry among health care professionals, the Office on Women's Health convened the National Task Force on Reentry into Clinical Practice for Health Professionals in 2000. With representatives from federal agencies, academic medical institutions, and professional organizations, the task force has explored strategies for developing a national reentry program that will systematically address the personal, professional, and institutional obstacles that health care professionals encounter during reentry. Using findings from the existing literature, lessons learned from reentry initiatives, and outcomes from the first 2 task-force meetings, the National Task Force on Reentry into Clinical Practice for Health Professionals has proposed the following set of recommendations for a national clinical practice reentry program.

Conduct a National Needs Assessment

National data on the number of inactive health care professionals who in-

tend to reenter their clinical careers are unavailable. The collection of such data would allow for the scope and extent of clinical inactivity and reentry among health care professionals to be defined. Equally important is the need to collect information on salient issues faced by reentering health care clinicians, including those that differ by and are shared across ethnicity, culture, and specific discipline. Information unveiled by such an assessment would provide guidance in the development of a national initiative on reentry into clinical practice.

Develop an Institutional Database

Health professional institutions should explore methods for monitoring clinical inactivity and reentry within their clinical settings. Additionally, efforts should be made to track Family and Medical Leave Act use by profession and sex. Such data will enable reentry programs to further assess the scope and needs of reentering clinicians.

Create a National Directory of Reentry Programs

A centralized, regularly updated directory of reentry programs can serve as a useful source of information for clinicians who are interested in reentering their field but are unaware of available resources.

Explore How Lessons Learned From Nursing Reentry Programs May or May Not Apply to Physician Reentry Programs

The task force recognizes that although there are significant differences between the competencies of nurses and physicians, nursing reentry programs are much better established than those for physicians. Thus, they can provide valuable insight for the development of a national reentry initiative. Specifically, the task force believes that lessons learned from program development, recruitment strategies, and evaluation methods of nursing reentry initiatives may be applicable to those for physicians. The task force also recommends that the applicability of nursing reentry programs

to physician reentry programs be further examined.

Widely Advertise and Recruit for the Program

Broad-based recruitment methods should be identified and implemented and may include advertising reentry programs through television, radio, the Internet, and professional and lay publications. Informational letters may also be automatically sent to clinicians who do not renew their licenses, although many physicians do not renew their state licenses because they have either moved or retired. Such efforts will address the challenge of informing reentering health care professionals of available programs.

Conduct Program Evaluations

Evaluations of programmatic activities and outcomes can enable the continual improvement of effective program components and aspects that may require revision. A combination of formative and summative evaluation methods can be useful to evaluate program components and outcomes. Examples of program outcomes include program completion, employment on program completion, longevity of employment on graduation, and career satisfaction. Lessons learned should be disseminated to the broader health care professional community to promote information sharing among current and prospective reentry programs and increase awareness of issues surrounding clinical inactivity and reentry.

Explore How Reentry Programs Can Address Educational and Personal Needs

Because reentering clinicians are often faced with educational needs and personal challenges, reentry programs must address mentoring components, strategies to enhance self-esteem and assertiveness, and revoked licensure issues in addition to providing clinical and didactic components that can include completing computer and distance education, attending grand rounds, and establishing formal shadowing or preceptorships. Health plan

organizations must be consulted to ensure that reentry programs meet their established standards and credentialing requirements. Furthermore, mechanisms must be implemented to decrease the stigma and stereotypes that often persist among the health care professional community regarding clinical inactivity and reentry. To promote an institutional culture that is accepting of reentering health care professionals, false and negative perceptions unfairly associated with these individuals must be addressed and changed.

Make Reentry Programs Mandatory After a Certain Time Away From Practice

To maintain public confidence, ensure public safety, and maintain the competencies and confidence of reentering health care professionals, the task force recommends that reentry programs become mandatory for clinicians who have been away from clinical practice for an extended period. The specific time away from practice and the required competencies should be determined by the 24 member boards of the American Board of Medical Specialties and the American Nurses Credentialing Center, in conjunction with state licensing boards.

Address Health Disparities

As a step toward addressing the health care needs of the underserved in the United States and fulfilling the mission of the US Department of Health and Human Services, the task force recommends that graduates of a federally funded reentry program consider serving or be required to provide their services to an underserved community for at least 1 year after graduation. Similar "payback" programs are administered by the Health Resources and Services Administration of the Bureau of Health Professions. For instance, the National Health Services Corps and the Nurse Education Loan Repayment Program are federally funded programs that promote health professional development while ensuring clinical services to underserved communities.³⁸ These programs offer new graduates of health care

professions loan repayment in exchange for full-time service for at least 2 years in a medically underserved community or designated facility facing a nursing shortage.³⁸ There is government oversight of these programs, and the career pathways of the graduates are followed. Funding of these programs can be adversely affected if graduates do not fulfill their obligations. Thus, the programs are encouraged to work with their graduates to meet these requirements.

The Task Force on Reentry into Clinical Practice recognizes that many health care professionals may interrupt their clinical careers because of multiple roles and family reasons. Therefore, the task force recommends that reentry programs that have received federal support explore flexible options for delivering health care to underserved communities, such as not requiring full-time work or relocating to a new area. For instance, reentry programs may develop partnerships with local community-based organizations and clinics for reentry graduates to be able to provide services without enduring extreme hardships to their personal or professional lives.

FUNDING

Although the task force has not specifically addressed the funding of reentry programs, this issue is central to the development and sustainability of reentry initiatives. Several factors that function as barriers to adequate funding of reentry programs include limited public information about the outcomes of reentry programs, the resource-intensive nature of reentry programs (funds are needed for teaching, mentoring, supervision, administration, record keeping and tracking, and evaluation), and a lack of standardized curricula or an officially recognized national accreditation process for reentry programs. Many nursing and physician reentry programs are funded by the supporting institution or program participants who must finance their own costs, which may serve as a barrier for reentering clinicians who

lack the means necessary to finance reentry programs.^{29,37} Additionally, the lack of specific funding mechanisms inhibits the growth of training programs.³⁹ Federal funds are not designated for clinical practice reentry programs. It may take joint efforts of public and private agencies and organizations to advance the development and evaluation of reentry programs.

CASE COMPETENCIES

Today, public demand for the accountability of physician clinical performance has in part stimulated the American Board of Medical Specialties to call for all its 24-member boards to reexamine their recertification policies and procedures.⁴⁰ The American Board of Internal Medicine and the American Board of Pediatrics. Both boards are moving toward adopting recertification policies that will require physicians to demonstrate competencies in several areas, such as medical knowledge and clinical skills. Many hospitals and insurance plans require providers to be licensed on completion of residencies. However, no board requires reentering clinicians to complete a full residency after an extended period away from clinical practice. In many states, physicians can maintain a valid license without engaging in any clinical practice.

CONCLUSION

Reentry poses a challenge for women and men; thus, these initiatives are intended to "humanize, not feminize," the profession.⁴¹ Through such efforts, we hope that all reentering health care professionals will have the opportunity to continue to provide compassionate and quality health care while prospering in their clinical careers and personal lives.

Disclaimer: The opinions that are expressed in this article are those of the National Task Force on Reentry into Clinical Practice and do not necessarily reflect the views or official policies of the US Department of Health and Human Services.

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The mountains are fountains of men as well as of rivers, of glaciers, of fertile soil. The great poets, philosophers, prophets, able men whose thought and deeds have moved the world, have come down from the mountains—mountain-dwellers who have grown strong there with the forest trees in Nature's workshops.

—John Muir (1838-1914)