

**ACADEMY OF
MEDICAL ROYAL
COLLEGES** _____

RETURN TO PRACTICE BACKGROUND DOCUMENT

EVIDENCE ON RETURN TO PRACTICE

APRIL 2012

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SUMMARY OF EVIDENCE

- Return to practice (RTP) for doctors is likely to become even more significant in the future as more doctors take leave from work and at a later date wish to return, for example changing work patterns and maternity leave for the increasing numbers of women in the medical workforce
- Return to practice is closely linked to patient safety and equality issues. Patient safety is the main reason for taking RTP seriously. This is mentioned by a number of medical regulatory bodies worldwide
- Any person's skills and knowledge can be lost or reduced over time, and in particular for doctors with clinical skills and knowledge
- Evidence from the USA suggests that age the number of years out of practice are factors affecting the performance of doctors who wish to return to practice. However, there is no clarity as to what the specific length of time away from practice would be in order to diminish a doctor's performance to the extent of creating risks to patient safety
- There is currently no clear evidence relating to differences between specialties with regards to RTP.

This paper considers evidence and anecdotal information from a range of contributors (including Medical Royal Colleges, a UK medical Dean and international medical regulators) it also:

- Compares the diverse RTP policies of Royal Colleges in the UK
- Highlights RTP policies of UK regulators in professions inside and outside of medicine
- Compares RTP policies, practices and views of medical regulators and other bodies internationally
- Includes views from medical educators (such as American universities and UK Deaneries).

Facts and figures

Thirty eight of 70 member boards in the Federation of State Medical Boards of the USA have reported that they have a policy on 'physician re-entry' or were developing one. The Federation is now looking at this issue in more detail. The Medical Council of New Zealand also has a clear policy on this issue.

In the UK four regulators of professions (not including doctors) have Return to Practice processes, although the degree to which they are compulsory varies (nurses being arguably the strictest and the most supported)

The length of absence from practice after which the RTP process begins varies widely in different policies – from six months to five years out of practice. However, one to two years seems common.

INTRODUCTION

The Academy's Return to Practice working group was established to produce guidance, both in order to highlight the importance of a good procedure for doctors returning to practice and to provide practical advice. The recommended guidance is based on the considerable experience of the working group involved and a review of the limited evidence available.

The working group was chaired by Professor Hugo Mascie-Taylor, Medical Director of the NHS Confederation.

The work comprised of four stages:

1. A scoping meeting, to identify key topics and areas for discussion to inform the report. The working group considered five questions in the formation of the research:
 - a. What evidence exists about competence to practice and loss of competence, both for doctors and those in other professions? Is there evidence of differences between medical specialties?
 - b. What currently happens when doctors return to practice?
 - c. What period of absence triggers the RTP process? How important is length of absence in reducing skills?
 - d. What are the different kinds of absence and how might these affect the RTP process?
 - e. Who is involved in this process and what do they do? Whose responsibility is it to help?
2. Collating and drawing from existing literature and policy from local, national and international sources using electronic searches
3. A call for written submissions and anecdotal evidence from a variety of sources, which specifically asked for:
 - a. Evidence regarding regaining skills/competence on return to medical practice (and if available, any evidence relating to differences between specialties on restoring skills/competence after returning to medical practice). Looking for example at:
 - i. How long it might take for skills/competence to be lost or reduced during a career break
 - ii. How any loss or reduction in skills/competence could or should be assessed on return to practice
 - iii. How the necessary, appropriate and proportionate support to regain skills/competence should be given
 - iv. How doctors are assessed and confirmed as reskilled to the necessary level of skills/competence
 - b. Any anecdotal information on the areas outlined above
 - c. What currently happens in practice with the above topics in your organisation (i.e. current rules for doctors returning to practice, and is this what actually happens in practice)
 - d. Any additional evidence regarding reskilling (and loss of) general professional skills (not just medical skills) would also be helpful.

***A list of those contacted is located at the back of this document*
4. Evaluation of the evidence and drafting of the guidance by Professor Hugo Mascie-Taylor and Miss Kate Tansley, Academy Revalidation Project Manager. Consideration and approval of the documents by the working group.

LICENCES FOR DOCTORS RETURNING TO PRACTICE

Licensing Doctors Returning to Practice

The General Medical Council's (GMC) thinking on the licence to practice is that doctors who have decided to take a career break will be able to give up their licence and then pick this up again after a period with no licence. This means that there would be a period on returning to work before they are appraised and before they are revalidated.

Relevant advice from the GMC is given below

*'Your ability to revalidate should not be affected if you take a short career break ... You will be expected to revalidate at the usual point in your five year cycle on the basis of the supporting information you have collected and appraisals that you have attended ... It should be possible for you to collect sufficient supporting information for a Responsible Officer to make a recommendation to the GMC. If you have been unable to discuss sufficient supporting information at your appraisal, your Responsible Officer may recommend a deferment of your revalidation.'*¹

The GMC has also provided a paper which is quoted later in this document.

The Future of Return to Practice

Return to Practice is likely to become an even more key issue in the future. According to the Royal College of Physicians report *'Women in Medicine'*, by 2017 women are likely to make up the majority of doctors. The report also states that *'cohort surveys do indicate that, after the early post qualification years, at any single point of survey, women are more likely than men to be on career breaks, and that maternity leave and childcare are the most common reasons for this'*.²

In addition, the number of people in the population generally offering informal care to disabled and older people is likely to increase enormously with the ageing population (and in addition more lives of children and adults being saved yet left with health problems or disabilities). According to one report by Carers UK, women have at least a fifty fifty chance of becoming carers at least once by the age of 59 and men by the age of 74. Women are at least 25% more likely to become carers. *'This additional 3.2 million in 2037 (of people over 75) is bound to increase the likelihood that there will be more carers required in the future.'*³ Doctors are likely to be affected by this increasing trend.

Other groups may also be affected such as: doctors with disabilities or health problems and refugee doctors. It is worth noting that the London Deanery offers specific support to refugee doctors. The Practitioner Health Programme also offers specific support to doctors with health problems affecting their ability to work. Older doctors may also experience issues if they decide to retire early or experience health problems causing absence, and then wish to return to practice. Evidence suggests that it may well be more difficult for older doctors to successfully complete a Return to Practice programme (page 10).

From a review of the evidence available it appears that ensuring the correct support is in place for doctors returning to practice to enable them to do so confidently and safely is a way of addressing the issues referred to.

DOCTORS AFFECTED BY RETURN TO PRACTICE AND ISSUES AFFECTING THEM

British Medical Association's (BMA) longitudinal study of 1995 medical graduates

The BMA conducted a 10-year longitudinal study⁴ of the career paths of 545 doctors. The tenth annual report gives information on workforce participation, career choice and views about practicing medicine. It showed that approximately 90% of the cohort continued to work as a doctor within the UK, approximately 8% worked overseas (either as a doctor or other occupation), approximately 7% had taken a break from working for other reasons, almost 5% had travelled overseas (other than for annual leave), and 1% had left medicine as a career.

Revalidation Support Team (RST) Pathfinder Pilots Evaluation Technical Annex

'Amongst the returners to work, only those returning from maternity leave (46, 2%) and other returners (18, <1%) were in double figures'.⁵ The size of the maternity sample limited the conclusions that could be made. However, it did show that while the average length of the preparation for the appraisal was the same for both groups, respondents recalled that the preparation time for their previous appraisals was shorter.

'Responsible officers reviewed the appraisals of ten doctors returning from absence, and encountered no difficulties with them in their role as responsible officer. The primary issue that responsible officers encountered with doctors returning to practice was the time required to complete the process. Responsible officers suggested the following to address the issue:

- *Provide additional time*
- *Ensure they understand the process*
- *Consider alternative assessments of safety.'*

Women doctors: making a difference

The report by Deech⁶ makes important points concerning return to practice following maternity leave. Key points from the report include:

- The lengthy nature of medical training, and the relative age of female medical trainees, women doctors often may go on maternity leave towards the end of their medical training.
- Flexible working and maternity leave cover:
'There are good data showing that in clinical areas where junior doctors work long hours with periods of sleep deprivation and long periods of alertness there is an increased risk of complications during pregnancy ... these effects appear to be mitigated if maternity leave and training policies are flexible. There is therefore a strong case for ensuring that women have access to flexible work and maternity leave cover...'
- How revalidation would affect this situation:
'It is vital that, as the implementation of revalidation continues, there is clear and unambiguous guidance for doctors on how they can register as 'non-practising' and on the requirements, on a sliding scale dependent on the length of absence, to resume practising again ...'

Recommendations from this report included:

- *'Ensure that the arrangements for revalidation are clear and explicit. The General Medical Council (GMC) and the appropriate medical Royal Colleges should ensure that they have a clear set of ... standards and assessment processes in place for doctors who have taken time out of training or the profession to return to work.*
- *Responsible officers should coordinate refresher training for those who have taken time out of training to meet these standards. There should be funding for this within the NHS budget.*
- *Trusts should offer 'back-to-work' and 'taster' sessions where those who have taken a career break can shadow working doctors to re-familiarise the doctor with procedures and work patterns, so that they are confident on return.'*⁶

Maternity leave

*'As an employee you have the right to 26 weeks of Ordinary Maternity Leave and 26 weeks of Additional Maternity Leave making one year in total... During your leave it is often helpful to keep in touch with your employer. Your employer is entitled to make reasonable contact with you during Statutory Maternity Leave. This might be to update you on any significant changes in the workplace ... You can work up to ten days' during your Statutory Maternity Leave without losing your Statutory Maternity Pay, Maternity Allowance or ending your leave. These are called keeping in touch days - and may only be worked if both you and your employer agree.'*⁷

Paternity leave

*'As long as you meet certain conditions you can take either one or two weeks' Ordinary Paternity Leave. ... Ordinary Statutory Paternity Pay is paid for up to two consecutive weeks, depending on how long you choose to take Ordinary Paternity Leave for. ... If your baby is due on or after 3 April 2011 you may have the right to take up to 26 weeks' Additional Paternity Leave'*⁸.

Maternity and sick leave

The National Clinical Assessment Service (NCAS) in its *Back on Track Framework* calls *'the process of addressing gaps in knowledge, skills and/or behaviours which result from an extended period of absence (usually over 6 months) so that the practitioner has the opportunity to return to safe practice'*.⁹ NCAS also suggested that: *'Where a practitioner has been on maternity or long-term sick leave the employer will have a responsibility to provide some funding to support the return to work programme.'*

Doctors who have been working abroad

The Revalidation Support Team (RST) report looked at doctors working abroad, identifying that the *'key message from the doctors working abroad was the need for flexibility, additional support and understanding on the specific circumstances of their work. This understanding needed to acknowledge cultural dependencies and sensitivities required even at the basic level of showing 'good standing' in the country of work. Respondents felt a need to ensure they were revalidated as part of their accountability, reputation and self development even when working outside the UK.'*¹⁰

Doctors who have experienced health problems which prevented them working

The NHS Information Centre has sickness absence statistics for NHS staff. For the period April to June 2010 the statistics showed that *'ambulance Staff had the highest rate for this period (5.91%) followed by Healthcare Assistants (5.89%) and Nursing, Midwifery and Health Visiting Staff (4.76%). Medical and Dental Staff had the lowest rate (1.10%) followed by Nursing, Midwifery and Health Visiting Learners (1.20%).'*¹¹

The 2010 Practitioner Health Programme (PHP) external evaluation report¹² notes that the programme *'has been successful in supporting doctors and dentists to return to work: High numbers of health practitioners returning to work or training (46% of patients not working whilst at PHP have now returned to work). Return to work – For some the PHP is also seen to give the ability to return to work by helping service users with their career prospects by most audience groups, either by helping them to return to work by helping with their health concerns or supporting cases with regulatory bodies. With 65% service users in the quantitative survey stating that the programme has had a positive impact on this.'*

Department of Health (DH) on Return to work

In the DH report *Invisible Patients* it recommends that *'when a health professional returns to work after a period of sickness absence attention to the follow points will help support that individual and protect the safety of patients:*

- *Ensuring the individual has access to appropriate treatment, mentoring and receives follow up care for their condition*
- *Risk management – monitoring for signs of recurrent ill health*
- *Re-skilling of the health professional in his/her field of practice*
- *Rebuilding of the health professional's career – mentoring and support*
- *Reintegration into the workplace – phased return and modifications to prevent relapse*
- *Re-establishing continuing professional development (CPD) – to include recent developments or address identified deficiencies.'*¹³

Cost effectiveness of RTP – and workforce issues

Estimates of how much it costs to train a medical student to graduation stage are at around a quarter of a million pounds. It is difficult to estimate exactly how much it would cost to support and train already experienced doctors who have been out of practice for a time, in order to safely re-enter practice. However, it is arguable that re-training costs would be far less substantial in the majority of cases. It seems reasonable to assume that in many cases, if the period of absence was not extensive (e.g. more than two years) and there were no previous performance issues, that it would cost far less than to train a medical student. There is also a risk to patient safety (and therefore potential cost) of not offering the relevant support and training to doctors re-entering practice to ensure that they are safe and competent to do so. In addition, proactively offering return to practice support and training can be a way of ensuring that public finance already spent on training doctors is not lost if a doctor leaves medicine temporarily and is then unable to return without support or training.

Offering the right support and training can be the first step to encourage workforce retention or return to work. This appears to have been successful with nurses, where in a recent NHS policy document the issue of female 'returners' is addressed. It describes a recruitment drive to get those nurses no longer working in the profession to return. *'Surveys found that four out of five nurses no longer working as nurses would come back under the right circumstances. Top priorities for them were personal*

support and accessible refresher training. Extra money was provided for free “return to practice” courses. A majority of the attenders went on to take jobs in the trust, which provides family-friendly employment options.¹⁴

HOW AND WHEN DOCTORS' COMPETENCE IS LOST DURING ABSENCE FROM WORK

The working group was unable to find much existing direct evidence regarding how and when doctors' competence is lost during a period of absence from work. Although a key factor appears to be how well the skills and knowledge were learned and practiced before the career break. The most relevant research is listed first, and other useful evidence follows. Anecdotal experiences collated by the authors are also detailed here.

Published Information

Centre for Personalized Education for Physicians, '*Physicians reentering clinical practice: Characteristics and clinical abilities*'

This research¹⁵ (although limited in scope) has identified important issues regarding doctors returning to practice:

- Years out of practice and age affected their ability to re-learn skills
- The doctors entering this re-entry educational scheme did so mainly in order to regain their licences to practice (as they had been instructed to do so by the medical regulator)
- The majority of doctors using this scheme did have some educational needs.

Due to the relevance of this research, key extracts from the abstract for this paper are quoted below: *'Sixty-two physicians who left practice voluntarily and without discipline or sanction and who were returning to practice in the same discipline as their previous practice participated in the CPEP reentry program. Physicians completed an objective clinical skills assessment including clinical interviews by specialty-matched board-certified physicians, simulated patient encounters, a documentation exercise, and a cognitive function screen. Physicians were rated from 1 (no or limited educational needs) to 4 (global, pervasive deficits)...'*

Some of the key findings included:

- *'Most of the participants enrolled to comply with a board rule to demonstrate competence, and the immediate objective of these participants was to gain licensure or relicensure'*
The majority (67%) were found to have educational needs requiring moderate to considerable re-education or training'
- The performance ratings were categorised as follows: *'Those physicians who demonstrated readiness to return to independent practice were rated a 1; physicians with global educational deficits needing residency education were rated a 4. Physicians rated 2 and 3 demonstrated moderate to extensive educational needs; for these physicians, CPEP recommended completion of a structured educational process'*
- *For those who had been out of practice for 1-5 years, none at all were in category 4*
- *For those who had been out of practice for more than 16 years, none at all were in category 1*
- *For physicians aged from 30-59 years, none were in category 4*
- *For physicians aged from 60-69 years, 1 was in category 4*
- *For physicians aged from 70-79 years, 3 were in category 4*
- *However, 1 physician aged 70-79 was in category 1'*

Other research by the Centre for Personalized Education for Physicians

The results from another, slightly earlier piece of research¹⁶ from the same organisation showed that *‘fourteen candidates have been accepted into the program ... Based on retraining assessment and planned scope of practice, applicants and program directors designed individualized curricula. As trainees demonstrated clinical proficiency, their level of independence increased in a condensed version of the residency training model. Of the 14 accepted candidates, 13 successfully completed the program and are actively engaged in clinical practice. One trainee did not successfully complete the program.’*

Other research

From an article on whether advanced life support skills are affected by trauma volume the following was shown regarding the loss of skills: *‘We assessed the effect of trauma volume on skills attrition among physicians completing the advance trauma life support (ATLS) course. ... Immediate and progressive cognitive skill attrition and detailed clinical skill attrition were worse in the low volume group. Global skills (organized approach and adherence to priorities) were preserved similarly for at least 8 years in all groups. CONCLUSIONS: Our data suggest that trauma volume affects trauma skills attrition.’*¹⁷

Medical News Today reported that research carried out by Dr Tom Lendvay of the University of Washington regarding surgeons, gives useful information regarding skills and ‘warming up’ which may bear some relationship to the ways in which skills need to be refreshed following an absence. *‘Even experienced surgeons derived benefit from the warm-up and there was an error reduction in surgical skills.’ In that study, the researchers found that a warm up comprising 15 to 20 minutes of simple surgical exercises involving both psychomotor and cognitive skills before an operation raised surgeons’ alertness to a higher level for surgical procedures and also helped fatigued surgeons perform better.’*¹⁸

Anecdotal information

Professor David Sowden, Dean Director, East Midlands Healthcare Workforce Deanery

‘Many established craft specialists (predominantly those in surgical specialties) report a short but noticeable decline in confidence, maximal dexterity and fast and confident decision making after as little as two weeks holiday. Such a deficit is quickly made up but many compensate by ensuring their initial operating list on return from holiday contains relatively straightforward cases. I would add that my personal experience in GP was similar, after a two week holiday it took the first surgery to get back up to speed but a three week holiday usually meant the first day at least. Clearly such a decline in capability (which may incorporate confidence) will be more noticeable in those still training where skills are not so well embedded in practice. In postgraduate medical training (pgme) we generally view a gap of six months as definitely requiring re-training or at the very least formal assessment of current capability – sometimes though a break of a few weeks can impact significantly on recently acquired skills, knowledge and understanding. For example a trainee who has just learnt to do a cataract extraction will lose those recently acquired skills very rapidly if not practiced regularly. I believe that there is research at a school level that demonstrates that the long summer break causes significant performance regression amongst pupils.’

In terms of Post Graduate Medical Education we also take a pretty firm view that training at anything less than 50% work time equivalent means that the trainee is not capable of progression just marking time.

From my perspective an assessment on RTP after a 6 month or more gap requires very close personal supervision by a senior colleague, and probably should always be in a supernumerary capacity, even if only for a few days. In some circumstances performance in simulations can confirm retained competence but this shouldn't be seen to equate to probable and hence actual performance in the work place.

Such a period of supervision will identify areas for attention which can then be focused on with those aspects that are deemed satisfactory allowed to be practiced more independently providing they can be separated from other aspects warranting attention.

I think in general that providing the gap has not been prolonged (probably over two years) then I think confirmation of satisfactory performance commensurate with the pre absence level by more than one and preferably at least three supervisors (a faculty of peers or seniors) would be adequate. For gaps beyond two years or so I think you need to consider the use of assessment frameworks associated with the curriculum for training but expressly tailored to the work/job plan being undertaken i.e. few consultants practice the full breadth of a specialty as defined by the training curriculum.'

Mr Richard Smith FRCS FRCOphth, Chairman of Revalidation Subcommittee, The Royal College of Ophthalmologists

'We really only have anecdotes as evidence, because the numbers involved are not large and there have been few instances where there have been difficulties which have come to the attention of the College training or professional standards committees. Also, such information as there is has to be relayed with care in a small specialty where individuals could potentially be identified. Most ophthalmologists who take planned career breaks tend to do so during specialty training and the reintegration is usually handled at Deanery level. Unplanned career breaks tend to be due to health problems or conflict with regulatory systems.

There are a few lessons which can be drawn from the available evidence:

- 1. Cataract surgery is probably the skill in our specialty which is most vulnerable to attrition during a career break. It is also affected by the age of the individual even where there has been no career break, to the extent that it is quite common for ophthalmologists to stop cataract surgery before the age of 65.*
- 2. The level of experience prior to the career break seems to be important. A surgeon who has done small numbers of cataract operations before a career break takes longer to "pick up the threads" than a surgeon who was more experienced.*
- 3. The age at which the career break is taken also seems to be important to the rate at which skills suffer attrition and the length of time it takes to get back to speed. Senior trainees and young consultants seem to fare best.*
- 4. For breaks of less than about three months, most ophthalmologists seem to be able to resume cataract surgery reasonably easily at the level at which they were operating beforehand. Most would probably make a conscious choice to select straightforward cases initially.*
- 5. For longer breaks, age and experience prior to the break seem to become more important. We are aware of a number of instances of ophthalmologists who have had a break from work of 6 months or*

more in their early 60s and in these cases, attempts to resume cataract surgery have generally been unsuccessful. There have also been a number of instances where trainees have undertaken a sub-specialty fellowship of a year at the end of the training programme which has not included cataract surgery, where they have taken up a consultant post on their return which requires them to perform high-volume cataract surgery and where there have subsequently been considerable problems (to the extent that retraining has been required). On the other hand, I have supervised a senior trainee who had done no cataract surgery for two years while doing a PhD and managed to resume cataract surgery very quickly.

I would say that the key take-home message is that there may be very few problems, but there needs to be a good safety net of supervision and problems need to be recognised promptly rather than hoping it will get better and allowing the doctor to muddle on. Good appraisal is very important.'

Mrs Charnjit Dhillon, Director of Standards, the Royal College of Obstetricians and Gynaecologists.

'I can share our experience with you from the last decade. At the outset we realised that we had to separate "refresher training" from "re-skilling training".

The refresher training for those who have been away from clinical practice due to non-clinical reasons, e.g. maternity, sickness, sabbatical, etc. What this involves is set out in our published document which was revised earlier this year. Even one of our former presidents underwent this process after his three year term during which time he did not maintain his clinical practice. This group is easy to manage.

The re-skilling training is very different and difficult. Usually, these are people who have had years of training, followed by hands-on experience, and they still haven't grasped the skills. They also don't usually have employers and finding placements are almost impossible and they need longer to get up to speed. We are aware of cases where there were deficiencies in skills after a 12 month re-training programme.'

Dr Jamie Harrison MA FRCGP, Deputy Head of School, Northern Deanery

'The Northern Deanery operates a 'returner' scheme along the following lines - <http://mypimd.ncl.ac.uk/PIMDDev/pimd-home/general-practice/continuing-practice-support/returning-to-gp/the-northern-deanery-gp-induction-and-refresher-scheme>

This scheme adopts the national refresher guidance, with further detailed information on the London Deanery and COGPED websites. It is our view, based on experience supported by simulated surgery assessments, progress on returner schemes, and performers list review processes that generally:

- 1. Under 2 years' absence from medical general practice (unless for significant episodes of mental illness or cognitive impairment) does not require a re-entry to practice programme*
- 2. Between 2 and 3 years' out of UK NHS general practice may require either a formal refresher programme or a supportive returning context; issues such as length and type of GP post-CCT experience, nature of absence (e.g. parallel GP work in New Zealand) and the absence of previous performance concerns (with appropriate supportive references) are taken into account*
- 3. Between 3 and 5 years' out of UK NHS practice would require significantly extenuating circumstances to permit a limited return to work package, rather than a formal refresher scheme (e.g. GP work in a parallel context, maintaining close links with the UK system,*

demonstrating active learning and passing a deanery or national simulated surgery and knowledge test)

4. *Over 5 years out of practice, full refresher package.*

Returning packages that could be used include the GP Induction and Refresher Scheme (gold standard), the GP Retainer Scheme, mentoring within a training practice, support and mentoring within a non-training practice, or some form of targeted (re-)training advised and supported by a PCT or Deanery (and monitored via the Performers List Regulations). Monitoring can be via a trainer report, simulated surgery (national or local), MCQ or other knowledge test, log book, or a variety of the above.'

GENERAL LOSS OF PROFESSIONAL SKILLS

Published information

Cardio pulmonary resuscitation (CPR) and first aid training

The Resuscitation Council UK states that Clinical staff should update CPR skills annually.¹⁹

Investigation of Procedural Skills Degradation from Different Modalities

Some key points quoted from this paper:²⁰

'McKenna and Glendon (1985) studied skill retention of CPR. They had 120 occupational first responders as experimental subjects. They reported that less than a quarter of their trained personnel were skilful at performing the CPR task six months after training...procedural skills are not always well retained. The CPR task is a procedural task that includes several decision-making points as cognitive tasks... presumed that there may exist different relationships of forgetting between different types of knowledge and skills.'

'Hagman and Rose (1983) mentioned that the best predictor of forgetting is the number of steps required in the procedural tasks. ... However, it seems that we rarely forget how to ride a bicycle or how to swim after learning these skills. These are perceptual-motor control skills. This aphorism and their investigations suggest that procedural (discrete) skills might be forgotten much more rapidly than perceptual-motor (continuous) skills.'

Other research on the topic includes the importance of the length of time acquiring a skill before losing this, and how some skills are retained well over a long delay and others are not. *'2 groups differing in the amount of verbal guidance were given extended training on a highly complex tracking task. ... The most important factor in retention is the level of proficiency achieved during initial learning.'*²¹

*'All young people experience learning losses when they do not engage in educational activities during the summer. ...On average, students lose approximately 2.6 months of grade level equivalency in mathematical computation skills over the summer months. Studies reveal that the greatest areas of summer loss for all students, regardless of socioeconomic status, are in factual or procedural knowledge.'*²²

UK PRACTICES AND POLICIES ON RETURN TO PRACTICE MEDICINE

Published policies

Approved Practice Settings: GMC information

The GMC's Approved Practice Settings²³ document states that:

'We expect approved practice settings to be regulated or quality assured by an independent body or organisation; and to have in place systems for:

- *The effective management of doctors that include:*
 - *An annual appraisal or assessment process for individual doctors, based on the principles of Good Medical Practice*
 - *A system of clinical governance.'*

London Deanery GP Refresher and Induction Scheme – and similar Deanery schemes

*'The purpose of the GP Induction & Refresher Scheme is to help doctors return to NHS general practice who have been out of active practice for 2-3 years or to have an induction into the NHS. These doctors will not be on a PCT Performer's list...'*²⁴ There is a structured assessment process including an interview, multiple choice questionnaire, a simulated surgery, and if the doctor is not a native English speaker, then there may be a language paper. Doctors outside the London Deanery may be referred by their own Dean.

This scheme usually takes 6 months full time or 12 months part time. Suitable placements, usually training placements, are arranged. There is an Exit Assessment.

In addition similar schemes are run elsewhere under the COGPED guidance (quoted elsewhere in this paper), as Professor Nigel Sparrow of RCGP has commented: *'We have a returner scheme in General Practice run within the deaneries for GPs who have been out of clinical practice for 2 years or more. They work in a training practice for 6 months under the supervision of a trainer who provides a report of competence at the end of 6 months and a returner also has to pass the Applied Knowledge Test of the MRCGP.'*

Both doctors returning to practice after a voluntary absence and those requiring remediation study together in this programme.

The Deanery, on behalf of PCTs, undertakes learning needs assessments for all these GPs (whether qualified from UK or EU) in order for the PCT to make the decision as to whether the GP is fit to work as an independent general practitioner in London.

*'Inevitably, the needs of each GP will be different. Many will feel unsure about how competent they are to practice and the majority will require a period of refresher training. EU GPs require a period of adaptation to a different health care system. ... The length of a GP Induction and Refresher (UK/EU) induction programme is usually 6 months full time / 12 months part time. This may be varied after the individual learning needs assessment to a period of between 3-6 months as agreed between the Deanery and the GP.'*²⁴

GPs would not normally be offered refresher training if they had been working in a substantive NHS GP post during the previous 24 months. (There may be circumstances when refresher training is

appropriate following shorter periods.

There are several tasks to ensure a successful completion of the placement:

- Doctors need to return the structured NHS log book (completed by their clinical supervisor) at the end
- An “exit” simulated surgery is taken
- There is an applied knowledge test run by the Royal College of General Practitioners
- The doctor receives a certificate of successful completion of the placement.

Refugee doctors and the London Deanery

The London Deanery offers refugee doctors structured clinical attachments as well as paid but supernumerary positions and training in order to ready them for practice. Structured questionnaires are used to identify learning needs. They also use the same formative and summative assessments in the F2 project, as are used as for F1 and F2 trainee doctors in the rest of the UK.²⁵

Summary of different College/Faculty policies

Policies and guidance that are available are detailed below.

Royal College of Anaesthetists

Policy document

*Recommendations for supporting a successful return to work after a period of absence*²⁶
(A new policy which reflects the Academy’s guidance is expected to be published in 2012)

What period of absence triggers the RTP process?

Not defined

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

‘In summary, an individually tailored return to work programme should identify the following:

- *Time scale, i.e. anticipated duration of programme*
- *Whether working full-time or part-time*
- *Levels of supervision required – direct or indirect*
- *An agreed format for assessment and feedback on progress*
- *Any specific targeted training areas*
- *Agreed outcomes, to include the date when the ‘training clock’ would restart for the trainee*
- *Timing of progress reviews, including agreed milestones*
- *Structure of summative report at conclusion of the process for the individual anaesthetist’s portfolio*
- *A limited number of experienced colleagues to work closely with a consultant or career grade anaesthetist*
- *Returning to work, e.g. joint operating theatre sessions, shared ICU ward rounds, combined pain management clinics.*

In addition to their guidance, the RCoA supplied guidance from the Association of Anaesthetists of Great Britain and Ireland which is in their Welfare Resource Pack (2008) section 10, page 18 which

can be read at: <http://tiny.cc/zx566>.

Whose responsibility is it to conduct the RTP process?

- *'A named Educational Supervisor is essential for consultants, career grade anaesthetists and trainees*
- *For patient safety*
- *To co-ordinate management of return to work and feedback*
- *For a consultant or career grade anaesthetist, this should ideally be someone senior to the individual, with a clear understanding of their role and responsibility*
- *Identify a mentor – or confirm availability of previous mentor*
- *Trust induction – depends on length of time away and if new to Trust*
- *Supportive environment – reasons for leave may be confidential*
- *Trusts should all have access to either physician or nurse led Occupational Health services to confirm the anaesthetist is physically and mentally fit to return to work*
- *OH services have responsibility to advise Trust management, after assessment of the individual, on any additional support required in the workplace*
- *A limited number of senior staff in any department including Clinical Director should be fully informed of the return to work process being considered if there are any serious concerns including competency issues*
- *Any GMC involvement necessitates approval for a return to work from Medical Director and Chief Executive and regular formal written progress reports to be submitted to the GMC.'*

Faculty of Public Health

Policy document

Return to work policy²⁷

What period of absence triggers the RTP process?

The policy applies after a break for any reason, of nine months or more when the doctor needs exemption from CPD. After such a break, the 'RTP' assessment is required.

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

The assessment is to be conducted by a trained appraiser in public health and should include:

- A review of training/refresher needs
- An assessment of fitness to return to unrestricted practice/need for period of supervision
- Development of new Personal Development Plan
- Setting of timelines for achievement of objectives
- Date of the next review.

Level of support and refresher training required will in part be determined by the length of the break and will vary between individuals. The programme will be assessed as complete when all training objectives and the assessor is satisfied that unrestricted practice may be resumed. There is a certificate at the end.

Whose responsibility is it to conduct the RTP process?

Trained assessor in public health. It is not specified who employs this person. However presumably FPH may have either some input into their training or conduct the training entirely in-house.

Royal College of General Practitioners

Policy document

*Induction and Refresher Scheme*²⁸ (RCGP follows the COGPED guidance for GPs)

What period of absence triggers the RTP process?

The scheme normally applies only to those doctors who have been out of practice for two years or more (unless the scheme is meeting some remedial needs). The scheme is mandatory after five years' absence and for any overseas IMG or EU doctor who has not worked in UK general practice.

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

- Entry assessments including a structured application form and CV, and Interview using the Deanery Interview form, a Knowledge Test, a Validated Simulated Surgery including languages assessment if English is not the first language, and two structured references, Occupational Health and Enhanced Criminal Reference Board check.
- Regular formative assessments should be undertaken during the placement
- Exit assessments including an Applied Knowledge Test (pass/fail decision - responsibility of Deaneries but RCGP provide validated questions), the NHS Induction Logbook signed off by trainer and two clinical structured references from the placement.

Whose responsibility is it to conduct the RTP process?

COGPED, Deaneries and RCGP

College of Emergency Medicine

Policy document

*CPD Guidance*²⁹ (CPD policy with some relevance to RTP)

What period of absence triggers the RTP process?

For an absence of under a year, *'any CPD deficit should be made up over the 5 year cycle.'* For over a year then *'the doctor may require specific CPD as agreed with the appraiser and College.'*

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

(This policy only gives explanations about CPD)

'Sick-leave, Maternity Leave or other Career Breaks: Any deficit in CPD activity should be made up over the remainder of the five-year cycle. This may be achieved either prospectively (where possible) retrospectively after return to clinical work, or a combination. Where the absence is for more than 1 year, advice from the College or Faculty should be sought.'

'Doctors working in isolated environments outside the UK

In some circumstances the type of CPD activity available may not conform to the quality standards set by the College. The doctor should self-accredit as much CPD as appears justifiable in terms of the learning achieved. Any shortfall should be made up on return to the UK. Periods of absence of more than one year may require specific CPD as agreed with the doctor's appraiser and College.'

'Doctors who have fully retired from clinical practice: If a retired doctor wishes to retain a license to practise, then the CPD requirements of the College or Faculty should be met. As much

flexibility as possible should be provided, and a doctor experiencing difficulty should contact the relevant College or Faculty.'

Whose responsibility is it to conduct the RTP process?

Appraiser and College or Faculty

Royal College of Obstetricians and Gynaecologists

Policy document

*Advice on returning to clinical practice after a period of absence*³⁰

What period of absence triggers the RTP process?

No specified time limit

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

'Good Practice No 1

This document gives general advice whilst acknowledging that the circumstances pertaining before, during and after the period of absence will vary with each case.

Scope of this guidance

The advice given below applies to doctors who have been away for the reasons listed above, or similar reasons. It is not necessarily adequate for doctors returning to work after a period of exclusion and more formal arrangements should be considered. Other formal arrangements may also be required for doctors returning to work after a period in voluntary retirement.

Preparing for return to work

Prior to return to work, the doctor will meet formally with the medical director and/or clinical director to discuss their integration back into the department. The areas covered during this discussion will include:

- *Confirmation that the doctor is in a position to return to work (where applicable, Statement of Fitness for Work)*
- *The doctor's perception of their needs regarding surgical and decision-making skills*
- *Revalidation requirements/updating personal portfolio*
- *Changes in organisation of trainees*
- *Familiarisation with trainees' competencies*
- *Changes in service management and delivery*
- *Any competency assessments that may be required and how these would be performed*
- *Other relevant clinical governance issues*
- *Fulfilment of CPD requirements*
- *Appraisal/job plan*

The doctor will be given the opportunity to voice their anxieties and suggest a suitable programme for reintegration.

The returning doctor will be encouraged to accept help from a senior colleague or peer who will act as a mentor in clinical and managerial matters. This will not be the individual involved in undertaking any assessment prior to the returning doctor taking on a full workload.

Phased return to work

The first week back at work (and, if necessary a longer period) will be regarded as an induction period, during which time the doctor will ideally be supernumerary. During this period the doctor will:

- *Shadow colleagues with similar clinical workload to update and familiarise themselves with the routine of outpatients, emergency work, labour ward, etc.*
- *Not operate with a junior assistant but will either arrange to assist a colleague with their list or operate with the assistance of a consultant colleague*
- *Not be on-call out of hours.*

At the end of the first week, the clinical director and returning doctor will meet to discuss the timescale for resumption to full clinical workload and on-call commitments. ...

It would be appropriate for the medical director and/or clinical director to meet with the doctor after one month, by which time it would be expected that most would have resumed their full workload. A date for the next appraisal will be agreed to ensure planning of the consultant's future professional development.'

Whose responsibility is it to conduct the RTP process?

Senior colleague or peer as mentor, and the medical director

Intercollegiate Improving Working Lives Committee

Policy document

*Recommendations for supporting a successful return to work after a period of absence*³¹

What period of absence triggers the RTP process?

'There is no defined minimum time off work required to trigger entry into any form of structured re-introduction to the workplace. For those who have been away for less than 12 months (classically maternity leave) an immediate return to service is frequently expected and organisation of any directly supervised time may have to be doctor led.'

Description of processes and models used including: what kinds of absence are there and how might these affect the RTP process?

'A re-introduction into clinical practice can be of 1-2 week's duration or 6 months or more. In support of the individual and taking into account patient safety issues, it is strongly recommended that some form of summative assessment of the individual's core competencies and confidence levels is undertaken prior to them undertaking independent practice, even after a minimum of 6 months away from work. Out of hours work in the acute specialties should not be an integral part of a returning to work package.

A focussed or targeted training programme will be required for the doctor with any identified areas of serious concern. The doctor must play a major role in the development of the programme, so that specific needs can be met.'

Whose responsibility is it to conduct the RTP process?

'Resources that might need to be identified in support of an extended return to work package

- *For the trainee*
 - *Deanery involvement - should offer financial support for a short term (3-6 months) supernumerary placement for trainee but is at the discretion of each Deanery*
 - *Employing Trust may be willing to support a trainee for a limited supernumerary attachment if leading to a future service contribution*

- *The individual may have to offer to self-fund a supernumerary placement for between 1-12 months to enable retraining to commence*
- *For the consultant / NCCG / Specialty Grade doctor*
 - *Local funding dependent upon their employing Trust*
 - *Explore access to separate funding via SHA - no central alternative to the Flexible Careers Scheme has been proposed*
 - *Utilise 'keeping in touch' days, which are a contractual requirement of the Trusts, with an entitlement of a maximum of 10 days*
 - *The individual may have to offer to self-fund a supernumerary placement for between 1-12 months to enable retraining to commence*
- *Occupational Medicine / Health Services*
 - *Trusts should all have access to either physician or nurse led OH services to confirm the doctor is physically and mentally fit to return to work*
 - *OH have a responsibility to advise Trust management, after assessment of the individual, on any additional support required in the proposed workplace'.*

INTERNATIONAL RESPONSES TO RTP IN MEDICINE

The following are the responses to the working groups questionnaire that were received from medical bodies (for example medical regulators) in countries outside of the UK.

USA

Federation of State Medical Boards

'We have recently convened a special committee to address the issue of physician reentry into practice. We will attempt to answer your questions in order below; however, as you might expect, there is quite a bit of overlap in issues involved. We should precede our comments by noting that in the US physicians are regulated by individual licensing authorities or "state boards" within each state. The Federation of State Medical Boards (FSMB) serves as a membership organization for the 70 medical and osteopathic state boards in the US and its territories. The reason there are 70 state boards is that 14 states have separate boards for the licensure and regulation of medical and osteopathic physicians; in addition, our membership is made up of state boards for the US territories (e.g., Puerto Rico, Guam).

Currently, many state boards have requirements for physicians seeking to reenter practice after some time away, such as passage of an examination, demonstration of prescribed number of continuing medical education hours, and others. A chart summarizing these requirements was recently assembled by the American Medical Association (AMA) as part of a yearly publication it releases on state medical licensure requirements and statistics. We have attached a copy of this specific chart from the 2010 publication to this email. A copy of the chart is also available on the following website - <http://www.physicianreentry.org/>. This website has been set up as part of the Physician Reentry into the Workforce Project, which is spearheaded by the American Academy of Pediatrics (AAP). We would highly recommend the information on the website as an additional resource for you, as much of it addresses the very same issues you are researching.

Unfortunately, there is not much information related to the issue of physician reentry, as you have likely realized in your research. Fortunately, a number of organizations including the FSMB, AMA, AAP and others have recognized that this is an issue of significant, and growing, concern within the medical community and have been working for the last few years to address the issue and to develop recommendations and resources to assist physicians and state boards. For your specific questions, we have answered them below underneath each question.'

1. Evidence regarding regaining skills/competence on return to medical practice (and if available, any evidence relating to differences between specialties on restoring skills/competence after returning to medical practice). Looking for example at:

a) How long it might take for skills/competence to be lost or reduced during a career break.

'We are not aware of any empirical evidence or studies on this issue. During discussions the FSMB have been a part of, 2 years has been informally recognized as a "cut-off" point after which physicians should be required to demonstrate their competence prior to receiving their license to practice. While this timeframe has a lot of "face validity", there is no evidence to support 2 years (or any other timeframe) as the cut-off point after which competence begins to deteriorate.'

b) How any loss or reduction in skills/competence could or should be assessed on return to practice

'As indicated in the attached chart, state boards in the US use a variety of tools to evaluate the competence of physicians who are seeking return to practice after some time away. It is important to note, however, that additional information may be reviewed or considered as part of the licensure process, such as:

- How long the physician has been out of practice (again, there is no evidence to support any timeframe as cut-off period, but on a practical level most states would likely recognize that there is likely a difference between a physician who has been out of practice for 5 years and one who has been out of practice for 15 years)*
- What activities the physician has been engaged in during his/her time off (e.g., has the physician engaged in part-time practice, even on a minimal level; has the physician participated in regular continuing medical education courses)*
- The reasons for the physician's departure from practice – did the physician leave practice voluntarily (e.g., to raise a family, to pursue a career outside of medicine or outside of active clinical practice) or did the physician lose his/her license as part of a disciplinary process? If the latter, the state board would likely also consider the reasons for loss of license (e.g., was it due to clinical care concerns or violations?).'*

c) How the necessary, appropriate and proportionate support to regain skills/competence should be given

'This is one of the issues we are currently working to address through our Special Committee on Reentry to Practice, as well as through participation in efforts by the AMA and the AAP. Unfortunately, there is not a definitive answer at this point.'

d) How doctors are assessed and confirmed as reskilled to the necessary level of skills/competence

'This is also being addressed through our special committee, and through efforts by the AMA and AAP. Given the varying reasons for physicians' departure from practice, it is likely that physicians will need a variety of tools available to them to get "up to speed" to return to practice and that state boards will use a variety of resources to assist them in evaluating physicians' competence for the purpose of return to practice. physicians will still need to be evaluated, to some extent, on a case by case basis, the These resources will likely include a variety of tools such as examinations, specialty board certification, evaluation by programs that conduct evaluations of physicians' clinical competence, mentoring and practice monitors, continuing medical education, personal interview with the state board, completion of a reentry plan and others.'

2. Any anecdotal information on the areas outlined

'Through our discussions with our member boards, we understand that they have long struggled with the issue of how to evaluate physicians for purposes of reentry to practice. As evidenced in the attached AMA chart, while some states have specific requirements for reentry to practice, many do not have any formal requirements for reentry or deal with the issue on a case-by-case basis as it arises. Given the national (and worldwide) economic downturn, this is an increasing issue for our state boards, as many physicians are seeking reentry to practice for financial reasons.'

3. What currently happens in practice with the above topics in your organisation (i.e. current rules for doctors returning to practice, and is this what actually happens in practice)

'Again, here we would refer to you the chart developed by the AMA to see how the individual state boards address this issue, as well as the resources available on the Physician Reentry into Practice website.'

4. Any additional evidence regarding reskilling (and loss of) general professional skills (not just medical skills) would also be helpful.

'Again, there is a dearth of information about loss restoration or loss or general professional skills. The resources available on Physician Reentry into Practice website would probably be most helpful. We have touched on this subject to some extent through our work on "Maintenance of Licensure", a process that is comparable to the Revalidation system that has been proposed in the UK. We have attached to this email a background paper that we recently developed as part of our Maintenance of Licensure work that you might find helpful. This background paper, and other resources about our work in this area, is available on the FSMB website at <http://www.fsmb.org/mol.html>.'

Frances Cain, Director, Post-Licensure Services FSMB.

New Mexico Medical Board on RTP

'You are asking a very complex question, the answer to which contains words like "depends". Putting that aside, here are some thoughts for you.

Our fundamental trigger for action can be found in our Board Rules:

http://www.nmmb.state.nm.us/pdf/Files/Rules/NMAC16.10.02_LicensureRequirements.pdf

16.10.2.9 MEDICAL LICENSE BY EXAMINATION.

A. Prerequisites for licensure. Each applicant for a license to practice as a medical doctor in New Mexico must possess the following qualifications:

a qualified applicant who has not been actively and continuously in practice for more than 2 years prior to application may be required to successfully complete a special examination or evaluation such as, but not limited to, the SPEX (special purpose examination), the PLAS (post-licensure assessment system of the federation of state medical boards), or specialty re-certification.

The two items we are interested in (to fulfill our primary mission of protecting the public, and our secondary mission of licensing competent, safe practitioners) are knowledge base and the clinical application of that knowledge, plus skills.

The usual ways in which we test the Knowledge Base include: Board re-certification; completion of relevant CME material, such as MKSAP; completion of special courses; and, a special examination (such as the SPEX). Once we are satisfied that the Knowledge Base is sound, then we turn to an arrangement we have with the University of New Mexico's Graduate Medical Education Division of Continuing Medical Education, in the form of a "Mini-Sabbatical". There is a charge for this, determined by the University and the Faculty, but it is not excessive.

The Faculty and the practitioner (usually an MD) set up a program in the relevant medical or surgical department in which the practitioner works in appropriate settings, under supervision and observation (much as takes place with Residents and Fellows). The length of the program is determined by the performance of the practitioner, and concludes when the Faculty can say, "this individual is safe to practice".

The Medical Board then receives a letter from the Faculty Chief attesting to the success (or, rarely, failure) of the program. The Medical Board, which has granted a Training License for this program, then considers the outcome and either converts the Training License to a full, unrestricted license, or recommends that the practitioner withdraw their application without penalty and seek another method or path to licensure (a full residency or fellowship).

When real issues of competence or medical problems, or other issues are added to this mix, we may refer the practitioner to the CPEP program in Colorado, or the PACE program in California for a wider and deeper review and educational remedy. This is a more costly approach because of the complex issues that may be involved.'

1. Evidence regarding regaining skills/competence on return to medical practice (and if available, any evidence relating to differences between specialties on restoring skills/competence after returning to medical practice). Looking for example at: a) How long it might take for skills/competence to be lost or reduced during a career break.

a) How long it might take for skills/competence to be lost or reduced during a career break.
'We draw the line at two years, and the longer the "break" the more detailed the program for remediation becomes.'

b) How any loss or reduction in skills/competence could or should be assessed on return to practice.
'See comment above'

c) How the necessary, appropriate and proportionate support to regain skills/competence should be given.
'As noted above. And, occasionally, we will use a practice monitoring approach when the circumstances warrant it.'

d) How doctors are assessed and confirmed as reskilled to the necessary level of skills/competence.
'The objective measure of examinations and tests and CME all may attest to the strength of the relevant knowledge base. When it comes to skills—the practical application of the knowledge—we rely on the Faculty at the Medical School to be able to make this judgment; it is the sort of thing they do every day with the House Officers.'

2. Any anecdotal information on the areas outlined.
'We have, of course, a number of years of experience with this approach, and it has worked well for us. Rarely, there are practitioners who cannot pass muster, but I can think of only 4 in the past 10 years.'

3. What currently happens in practice with the above topics in your organisation (i.e. current rules for doctors returning to practice, and is this what actually happens in practice).
'Detailed above.'

4. Any additional evidence regarding reskilling (and loss of) general professional skills (not just medical skills) would also be helpful.
'Other than what has already been said, I would refer you also to the Federation of State Medical Boards (FSMB) in Euless, Texas--near Dallas. It is my understanding that they are working on this issue and looking at "the big picture". Their Internet site is <http://www.fsmb.org> and the topics that are relevant to this issue are Maintenance of Licensure and Maintenance of Certification. These two topics address the issue of how to evaluate ongoing knowledge and competence as prerequisites for renewal of medical licensure. The article cited on the page you open to is by the Federation's President, Humayun Chaudhry, D.O., et al, entitled, Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care. I am sure you are aware of the FSMB as the "umbrella" organization that consists of all 70 Medical and Osteopathic Licensing Boards in the U.S.A. Dr. Chaudhry's office could steer you to other individuals involved in the larger issue of Physician Re-entry, which is a special subset of the maintenance of competence.'

Grant La Farge, Medical Director, New Mexico Medical Board.

University of California (San Diego) PACE program

'This programme offers 'assessment and remediation services to medical professionals. These assessments can be performed on practicing physicians as well as those who are seeking to reenter practice or obtain initial licensure. We also offer physician monitoring services through our Physician Enhancement Program (or PEP) and a number of continuing professional development (also known as continuing medical education) courses.'

'The UCSD PACE Program does not offer re-entry education opportunities. The reason is that we believe re-entry programs should look like "entry" programs, that is they should look like residency education, and that would include hands-on clinical opportunities. The PACE Program offers many good remedial programs, but we cannot offer hands-on clinical experiences ...

- 1) No one knows how long it would take for competence to be lost, and of course, there would likely be some considerable individual variation, but the U.S. Navy uses the time period of two years, and that makes sense to me.*
- 2) Again, no one knows for sure how long it would take for competence to be restored, and again, there would likely be considerable individual variation, but here at PACE we will not re-assess a doctor who fails the assessment for a minimum of six months. I also personally recommend to each physician who fails that they should treat their remedial education just as if they were returning to medical school. I tell them to organize a specific study plan and spend a minimum of 3 to 4 hours each day on reading, study, course attendance, and the like. I think a bright, motivated physician can probably remediate their cognitive deficiencies in six months. The surgical and procedural specialties are more vexing because they require true "hands-on" experiences, and those are difficult to find in the United States.*
- 3) To my knowledge, there are only two true re-entry programs in the U.S. (that is, they provide hands-on clinical experiences similar if not identical to residency education): the University of Oregon and Texas A & M University. The ideal re-entry program would include 1) a clinical competence assessment at the beginning to evaluate the deficits and guide the educational program; 2) a re-entry program that was organized specifically to address the clinical deficiencies and overseen by a physician mentor; 3) an assessment at the end of training to assess for competence and "safety to practice;" and 4) a program of ongoing proctorship including chart review and some degree of direct observation that takes places for at least six months to twelve months after return to clinical practice. (I am not aware of this happening anywhere in the United States, though if it did, it would be through either the Oregon or Texas A & M programs.)*
- 4) A doctor would be recognized as having regained his/her competence when he/she had successfully completed a competence assessment at the end of re-entry training and been found to have satisfactory clinical performance over a minimum of six months of proctorship upon re-entering clinical practice.*
- 5) What usually happens in the U.S. is that physicians learn to never allow their medical licenses to lapse. If they pay their license fees it is unlikely that a state licensing board would ever know of their time away from practice. What I believe happens in most states is that physicians who require remedial education are asked to participate in a variety of CME courses and eventually are re-instated. In California, the Medical Board of California (also the Arizona Medical Board) refers such physicians to UCSD PACE for a competence assessment.*

If there are concerns we either recommend the Oregon or Texas A & M programs or help them design a program of study.

I am not aware of any significant literature in this field, at least literature that is substantive.'

Dr William Norcross, Director, PACE

Oregon Medical Board's administrative rule on RTP

'Please see below the Oregon Medical Board's administrative rule on the issue of re-entry, as we refer to it, with the most relevant section highlighted. The rule is consistent with our Board's decisions re: re-entry in practice/on the ground.'

'The applicant who has ceased the practice of medicine for more than 24 consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out-of-practice, the applicant may be required to obtain one or more of the following:

(a) Pass the SPEX/COMVEX examination;

(b) Practice for a specified period of time under a mentor/supervising physician who will provide periodic reports to the Board;

(c) Certification or re-certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS);

(d) Completion of a re-entry program as determined appropriate by the Board;

(e) Completion of one year of accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director.'

Jennifer Lannigan, Licensing Co-ordinator.

Virginia Board of Medicine regulations on RTP

'18VAC85-20-240. Reinstatement of an inactive or lapsed license.

A. A practitioner whose license has been lapsed for two successive years or more and who requests reinstatement of licensure shall:

1. File a completed application for reinstatement;

2. Pay the reinstatement fee prescribed in 18VAC85-20-22; and

3. Provide documentation of having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been lapsed.

B. An inactive licensee may reactivate his license upon submission of the required application, payment of the difference between the current renewal fee for inactive licensure and the current renewal fee for active licensure, and documentation of having completed continued competency hours

equal to the requirement for the number of years, not to exceed four years, in which the license has been inactive.

C. If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations. For the purpose of determining active practice, the practitioner shall provide evidence of at least 640 hours of clinical practice within the four years immediately preceding his application for reinstatement or reactivation.

1. The Special Purpose Examination (SPEX) given by the Federation of State Medical Boards.

2. The Comprehensive Osteopathic Medical Variable Purpose Examination—USA (COMVEX-USA) given by the National Board of Osteopathic Examiners.

3. The Special Purposes Examination for Chiropractic (SPEC) given by the National Board of Chiropractic Examiners.

4. A special purpose examination or other evidence of continuing competency to practice podiatric medicine as acceptable to the board.

D. The board reserves the right to deny a request for reinstatement or reactivation to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.³²

Medical Board of California response on RTP

'Physicians must meet the Board's standards for continuing medical education (CME) to renew their licenses. When renewing their license (every two years), they must certify they have completed an average of 50 hours of approved CME during the renewal cycle. If a physician wants to retain a license while not actively engaged in their profession, they may apply for an inactive license. A physician who holds an inactive license may not practice medicine and need not comply with CME requirements until he or she wishes to restore the license to active status. At that time, the physician must have completed 50 CME hours (the number of CME units required for a single license renewal), including any specific types of required units.'

Medical Board of California

Iowa Board of Medicine response on RTP

'Our rules state that if a physician has been out of active practice in the past three years in any jurisdiction of the United States or Canada, they will require an applicant to either

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board; or

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board.

Almost all of our competency evaluations are done by the Center for Personalized Education for Physicians (CPEP) in Colorado.'

Amy Van Maanen, Director of Licensure & Administration

Texas Medical Board's response

The Texas Medical Board Rule 163.11, describes the Board's definition of "active practice of medicine", and can be viewed at http://www.tmb.state.tx.us/rules/docs/Board_Rules_Effective_07_01_2010.pdf

Note: this is a lengthy definition of active practice but includes full time practice (at least 20 hours a week for at least 40 weeks duration) in either of the last two years. If then the doctor is counted as retired, a formal process would have to be instituted in order to re-enter practice which might include taking examinations.

Also please see: http://www.aap.org/reentry/PhysicianRe-EntryintoPractice_TMA08.pdf

New Zealand

Medical Council of New Zealand

'New Zealand has two policies on this: one for doctors who have been out of New Zealand practicing medicine in a similar field and post overseas, and another for those who have been out of medicine altogether for three years. The latter is more relevant to our work so I have put some important quotes from this below:

- The Registrar must promptly submit an application for an annual practising certificate to Council if the applicant has not lawfully practised medicine in the three years preceding the application, in accordance with section 27(1)(f) of the Health Practitioners Competence Assurance Act 2003 (HPCAA)*
- The APC will be issued subject to conditions, in order to protect the health and safety of the public and to ensure a safe and structured RTP for the applicant.'*

Procedures include:

- 1. 'A doctor who enquires about returning to practice after an absence of three years or more will be sent an application for an APC and a Practice Intentions Form (see Appendix 1) to complete*
- 2. If working in clinical practice, the doctor must submit a detailed induction plan including time to be spent as an observer (up to one week, changed at the discretion of the Registrar)*
- 3. Council staff will formulate conditions to be placed on the APC, specific to the doctor's practice intentions.*

REQUIRED CONDITIONS

- That the medical practitioner <name> must work under the supervision of a medical practitioner registered within a vocational scope of practice <name>.*
- That the medical practitioner <name> may work only as a <work role> (in the branch of <branch of medicine>) at <place of employment>.*

OPTIONAL CONDITIONS FOR MEDICAL PRACTITIONERS IN CLINICAL PRACTICE

- *That these conditions may be removed by the Registrar on receipt of satisfactory supervision reports at one, three, and six months (12 and 18 months if necessary).*
 - *That the doctor <name> completes a Level 7 New Zealand Resuscitation Council approved Advanced Cardiac Life Support course within 3 months of commencing practice.*
1. *The conditions placed on the APC will depend on what work the practitioner will be doing, how long the medical practitioner has been out of lawful medical practice, how many hours the medical practitioner will be working, and what CME the medical practitioner has been involved in since ceasing practice. The formula below will apply.*
 2. *Doctors returning to hospital work must complete a Level 7 ACLS course.*
 3. *The medical practitioner will be asked to agree in writing to the proposed conditions.*
 4. *Once a doctor has agreed in writing to the proposed conditions, their application may be approved by the Registrar.*
 5. *If a doctor does not agree to the conditions proposed by the Registrar, their application will be considered at the next full Council meeting.*
 6. *Any application for an APC for a medical practitioner who has not practised medicine for 10 years or more must be considered by Council at the next full meeting.'*

Formula for calculating conditions in New Zealand:

	TIME OUT OF PRACTICE	
	3-4 years	5-9 years
<ul style="list-style-type: none"> • <i>Same work as before; and</i> • <i>Full time; and</i> • <i>CME completed</i> 	<i>Reports at 1, 3 and 6 months</i>	<i>Reports at 1, 2, 3, 6, 9 and 12 months</i>
<ul style="list-style-type: none"> • <i>Different work; and/or</i> • <i>Part time; and/or</i> • <i>No CME completed</i> 	<i>Reports at 1, 3 6, and 12 months</i>	<i>Reports at 1, 2, 3, 6, 9, 12 and 18 months</i>

Medical Council New Zealand

Additional Publications

A Physician Reentry into the Workforce Inventory

This publication provides practical checklists and information designed to help physicians who are contemplating leaving clinical practice to employ strategies that will enable them to maintain their practice skills and to engage in the practice of lifelong learning. While these checklists were initially designed for physicians, much will be relevant for health care providers in other disciplines. The full publication can be read at:

http://www.physicianreentry.org/yahoo_site_admin/assets/docs/Nov2010APhysicianReentryInventory-PV.308141316.pdf

Issue Brief on Critical Elements of Reentry Education

This publication from the American Academy of Pediatrics gives ideas for the types of reflections that doctors returning to practice should have including assessing learning needs for planning the return.

The full publication can be read at:

http://www.physicianreentry.org/yahoo_site_admin/assets/docs/reentry_issuebrief6_final.88133626.pdf

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EXAMPLES OF RTP PROCESSES IN PROFESSIONS OTHER THAN MEDICINE IN THE UK

Name of profession and its regulator	What period of absence triggers the RTP process?	Short description of processes and models used plus kinds of absence and how these might affect the RTP process	Who is involved in this process?
<p>Nursing</p> <p>Regulated by the Nursing and Midwifery Council</p>	<p>Nurses must renew registration with the NMC every three years. If they cannot fulfil the Standards (next column) they will need to join a RTP programme (approved by the NMC).</p>	<p>To maintain registration with the NMC, nurses must declare they have completed: 450 hours of registered practice in the previous three years and 35 hours of learning activity (Continuing Professional Development) in the previous three years. If they cannot meet the standards, they have to complete an approved return to practice programme to refresh clinical skills</p>	<p>RTP programmes are usually jointly run by NHS Trusts and university schools of nursing. The NMC approves them.</p>
<p>Health professions</p> <p>Regulated by Health Professions Council.</p> <p>(This covers: Arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics,</p>	<p>In order to return to the Register, professionals must meet the following requirements, depending on how long they have been out of practice: 0-2 years – no requirements 2-5 years – 30 days of updating skills & knowledge 5 years or over – 60 days of updating skills & knowledge</p>	<p>Every time professionals registered with this body renew their registration they are asked to sign that they have continued to practise the profession or met any return to practice requirements that apply. Therefore they will need to have practised at some point in the previous two years of their registration cycle. If they have not practised in the last two years, they must complete an updating period unless they have been registered for less than two years. After completing their updating they must complete an RTP form describing the activities undertaken. This must be countersigned by a health professional from their part of the register to confirm that it is correct.</p>	<p>The professional, another person from their part of the register who will sign, and the Health Professions Council</p>

physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, and speech and language therapists)			
Social work Regulated by General Social Care Council (GSCC)	Not specified	The Children's Workforce Development Council (CWDC) is offering advice and training through refresher courses covering current social work theory and practice.	CWDC for the refresher courses. The GSCC is involved in the registration process (social workers who have been out of practice may need to re-register).
Teaching Regulated by the Teaching Agency* *This replaces the General Teaching Council from 31 March 2012	Not specified	There is a free Return to Teaching Programme.	The Teaching Agency, local authorities, schools, etc

FURTHER INFORMATION FROM DIFFERENT PROFESSIONS

Dentists' return to practice

The General Dental Council has information for dentists who wish to return to practice for example, courses exist for dentists, dental therapists and dental hygienists, who have been absent from clinical practice and need to prepare to return. The postgraduate dental dean should have a 'retaining and returning' adviser in post who can advise dentists who want to return to practice.³³

Guidance for the return of radiographers to practice

The Society & College of Radiographers offers a Returners' Support Group and information on radiographers returning to practice. The College of Radiographers *Return to Practice: A Guide for Managers* states that '*Service Managers report a range of experiences in managing return to practice. The majority report a successful result although the commitment and effort from both the returner and the supporting staff is considerable. Being welcoming but not overwhelming is the best approach to take. Bite-size pieces of information about the changes and reassurance that it is not overwhelming or impossible is important. Putting them in touch with other returners for building of confidence prior to a more formal and wide-ranging interview would be valuable. Occasionally, it becomes obvious that the necessary competencies will not be achieved and the Service Manager is then in the position of having to manage this outcome. Good procedures for return to practice and especially the use of mentors and a competency portfolio will facilitate this. Support is available from various organisations (see resource and helpful hints) and Service Managers are advised to use all possible sources.*'³⁴

The Society & College of Radiographers website also provides a flowchart illustrating radiographers patterns of return to practice.³⁵

KEEPING SKILLS UP TO DATE

Royal Colleges' methods for ensuring doctors can update their skills

RCGP's Essential Knowledge Update (EKU)

A dedicated College EKU team together with the Editorial Board and a pool of EKU writers produce two updates each year. The Update content summarises guidance (e.g. newly published NICE/SIGN, Gold Standards) in clinical areas of national significance where there is consensus about best clinical practice, and the latest information about changes to legislation or new ways of working. They are a series of online learning modules on topics which are divided into major items and briefings. The major items examine the source document in detail, giving practical applications in practice, further reading and a self test quiz. The briefings report the outcome of the source document. Each Update has an associated Essential Knowledge Challenge (EKC), an applied online knowledge test, which is issued six months after the relevant Update. This voluntary self-assessment process enables GPs to test their learning and download a certificate as part of evidence for revalidation. The Updates are divided into eight major items and around 20 minor topics. The written content of the major topics includes text, scenarios, self test MCQs, and practice based exercises. At the end of sections there are suggestions for audit, practical tips and links.

Royal College Of Anaesthetists Return to Work Simulator Course: Giving Anaesthetics Safely again

An example from April 7th 2011

'Summary:

- *A one day course at the UCLH education centre focussing on anaesthetists returning to the clinical workplace after a period of absence*
- *Aim to bring together a cohort with similar underlying anxieties about returning to practice in a non-threatening and confidence building environment*
- *Advertised nationally and open to permanent staff and trainees*
- *Pre-course information (algorithms and guidance) sent out in advance*
- *Pre-scenario briefs followed by scenarios and a debrief*
- *Simulation facilitators experienced in adult learning and reflective feedback*
- *Scenarios covered included paediatrics, airway, obstetrics, trauma , resuscitation and anaesthetic crises*
- *Encompassing key components around knowledge, practical skills and anaesthetic non-technical skills*
- *Opportunity to explore changes in practice introduced in the last 12-24 months e.g. WHO check list, resuscitation guidelines*
- *Numbers of candidates limited (8-10) to ensure optimal exposure to all scenarios'*

I attended as an observer in my role as RCoA LTFT (less than full time) advisor and having an interest in best practice around returning to the work environment after a period of absence.

The majority of attendees looking for return to work support are likely to be post-maternity leave trainees, as was demonstrated by the cohort at this UCL simulation day. They were all female and had been away from the workplace for between 9 months and 2 years. Only one candidate was not post-maternity leave and the majority had booked on this course in anticipation of a return to work in the next 1-3 weeks.

The feedback on the day was extremely positive. All declared that the day had been informative, educational and enhanced their confidence levels around going back to work. There was a cohesive and supportive approach evident throughout the day between the candidates, which promoted self analysis and active discussion within the group after each scenario. A course evaluation is being undertaken and the results from this will feed into future Return to Work simulation sessions.

It would appear that this form of practical educational day is particularly suited to anaesthetists prior to starting back at work, as many potentially stressful situations can be rehearsed in one concentrated session.

A further Return to Work simulation day is now being organised in Bradford, West Yorkshire for the autumn, targeting the Schools of Anaesthesia in Manchester, Leeds, Sheffield, Hull and Newcastle.'

Dr Carolyn S.Evans RCoA BJA LTFT

Keep in Touch days

Advice from the Government regarding Keep in Touch Days (during statutory maternity leave) says that *'during your leave it is often helpful to keep in touch with your employer. Your employer is entitled to make reasonable contact with you during Statutory Maternity Leave. This might be to update you on any significant changes in the workplace, including any opportunities for promotion or job vacancies. You can work up to ten days' during your Statutory Maternity Leave without losing your Statutory Maternity Pay, Maternity Allowance or ending your leave. These are called keeping in touch days - and may only be worked if both you and your employer agree. You cannot work during compulsory maternity leave which is the two weeks immediately after your child is born. Although particularly useful for things such as training or team events, keeping in touch days may be used for any form of work. They should make it easier for you to return to work after your leave. You will need to agree with your employer what work is to be done on keeping in touch days and how much pay you will receive.'*⁷

Information from the Royal College of Anaesthetists

*'Many consultants and career grade anaesthetists are not aware of 'keeping in touch' (KIT) days. These are a contractual requirement of the Trusts, with an entitlement of a maximum of ten days. This time is paid and helps an employee to keep in touch with working practice and can be arranged with their local department. Otherwise there are limited options for extended return to work programmes and no central alternative has been proposed to the Flexible Careers Scheme, from which funding was withdrawn.'*²⁷

Information from the Royal College of General Practitioners:

The RCGP says that Keep in Touch days are funded by GPs themselves and practices offer availability of these days at no cost.

ORGANISATIONS CONTACTED FOR INFORMATION

Medical Royal Colleges/Universities/Educational Centres

Postgraduate Medical Education, McGill University, California *

Royal College of Anaesthetists *

College of Emergency Medicine

Royal College of General Practitioners *

Royal College of Obstetricians and Gynaecologists *

Faculty of Occupational Medicine

Royal College of Ophthalmologists *

Royal College of Paediatricians and Child Health *

Royal College of Pathologists *

Faculty of Pharmaceutical Medicine *

Royal College of Physicians and Surgeons of Glasgow

Royal College of Physicians of Edinburgh

Royal College of Physicians of London *

Royal College of Psychiatrists

Faculty of Public Health

Royal College of Radiologists

Royal College of Surgeons of Edinburgh *

Royal College of Surgeons of England *

Academy of Medical Royal Colleges' Patient Liaison Group *

East Midlands Deanery *

Naval Medical Center, San Diego

North Western Deanery *

Oregon Health And Science University Physician Re-Entry Program *

University of California, San Diego School of Medicine, Pace Program *

Medical Organisations in the UK and overseas, Including Medical Regulators, Trade Unions, Professional Bodies and Departments of Health

Alabama Board of Medical Examiners *

Alaska State Medical Board

American Medical Association *

Australian Capital Territory Department of Health

Australian Medical Council *

Belgian Order of Physicians

Board of Healthcare Funders of South Africa *

Board of Registration In Medicine Massachusetts
Capital And Coast District Health Board, New Zealand
Colorado Medical Group Management Association
Connecticut Department of Public Health
Conseil National De L'ordre Des Medecins
Danish Medical Council *
Delaware Board of Medical Licensure And Discipline
Department of Community Health, Michigan
Department of Health England *
Department of Health, Hong Kong *
District of Columbia Department of Health
Federation of State Medical Boards, USA *
Florida Department of Health
General Council of Medical Colleges of Spain
General Medical Council (UK) *
Georgia Composite State Board of Medical Examiners
German Medical Council (Bundesärztekammer) *
Health Professional Licensing In Maryland *
Health Professions Council of South Africa *
Indiana Professional Licensing Agency
International Association of Medical Regulatory Societies *
Iowa Board of Medicine *
Kentucky Board of Medical Licensure *
Louisiana State Board of Medical Examiners
Maine Board of Licensure In Medicine
Medical Board of California *
Medical Council (Ireland)
Medical Council of Canada
Medical Council of New Zealand *
Medical Protection Society *
Medical Quality Assurance Commission, Washington State Department of Health *
Medical Women's Federation *
Minnesota Board of Medical Practice
Mississippi State Board of Medical Licensure
Missouri Board of Registration For The Healing Arts *
NHS Employers *
Nebraska Department of Health & Human Services
Nevada State Board of Medical Examiners
New Hampshire State Board of Medicine
New Jersey State Board of Medical Examiners
New Mexico Medical Board *
New York State Board For Medicine
North Carolina Medical Board

North Dakota State Board of Medical Examiners
North East Strategic Health Authority
Norwegian Medical Association
Osteopathic Medical Board of California
Pennsylvania State Board of Medicine
Physician Re-entry Website (USA)
Practitioner Health Programme
Professional And Vocational Licensing, Department of Commerce And Consumer Affairs, State of Hawaii *
Revalidation Support Team (England) *
Singapore Medical Council
South African Medical Association
South Carolina Board of Medical Examiners
South Dakota Board of Medical And Osteopathic Examiners
Standing Committee of European Doctors
State of Idaho Board of Medicine
State of Oklahoma Board of Medical Licensure & Supervision *
State of Oregon Medical Board *
Supreme Chamber of Physicians (Poland)
Swedish Medical Association
Tennessee Government Department of Health *
Texas Medical Board *
Vancouver Coastal Health *
Virginia Board of Medicine *
West Virginia Board of Medicine *
Wisconsin Department of Regulation And Licensing
World Medical Association
Wyoming Medical Board

Other Professions' Regulators, Trade Unions And Professional Bodies

Bar Standards Board
General Social Care Council *
General Teaching Council for England
National Union of Teachers
Nursing and Midwifery Council *

Note: Internet searches were also carried out regarding other professions

Hospitals And Health Care Providers

Cedars Sinai Hospital

Kaiser Permanente Hospital
Massachusetts General Hospital
Mayo Clinic
Memorial Sloan-Kettering Cancer Center
New York Queens Hospital
Royal Brisbane Hospital And Royal Women's Hospital *
San Francisco Hospital
South Eastern Sydney And Illawarra Area Health Service *
Sydney Hospital
Wellington Hospital (NZ)
Vancouver Hospital

Locum agencies

Ambition 24 Locums
Fresh Medical Recruitment
JCJ Locums
Medacs

* Provided responses to the research and/or were involved in the working group

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