

# RETURN TO PRACTICE GUIDANCE

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# PREFACE

Through its role in developing revalidation for doctors, the Academy of Medical Royal Colleges developed considerable concern and perceived a lack of guidance regarding doctors' return to practice after a period of absence. In light of this a working group was established to produce a report, 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.

**Patient safety is the guiding principle of this report and must be put first, above all other considerations.**

## Who is the guidance for?

- All doctors returning to the same area of clinical practice as previously practiced following an absence for any reason (including those returning to their usual practice after working in a different area of clinical practice). It is the duty of all doctors to ensure that they are safe to return to practice.
- All doctors who are absent for three months or longer and including in all cases where the licence to practice has been surrendered and is then restored by the GMC.

This guidance can be used in all circumstances as part of the process of return to practice. In cases where there are unresolved issues that need to be addressed separately, these should be dealt with via the normal processes. However, this guidance can still be used in addition to that process. Examples of three such situations are:

- Health issues (which should be addressed through occupational health processes)
- Conduct issues (which should be addressed through (HR) management processes)
- Capability issues (which should be addressed through remediation processes).

It should be noted that the guidance focuses on re-entry of doctors to practice. It is not designed as a guide to obtaining re-employment.

I would like to thank the members of the Return to Practice working group who gave their time and expertise to this work. I would also like to thank all those who provided evidence for our research. In particular, my thanks to Kate Tansley, whose energy and intelligence greatly facilitated the production of this report.



**Professor Hugo Mascie-Taylor**  
Chairman, AoMRC Return to Practice Working Group

# 1 WHO SHOULD USE THIS GUIDANCE?

## **Doctors**

It is the professional duty of the doctor to ensure that they are safe to return to practice. Doctors must identify and address issues arising from absence and help set in place the necessary processes to support them to update their skills and knowledge.

## **Designated bodies/those who employ or contract doctors (including GP partners)**

Organisations need to prepare for absences and returns, identify issues, agree the processes - and help put appropriate, targeted and proportionate support and training in place. Employers should facilitate return to work of employees. This might often be within the remit of the clinical manager.

**Regulators including the General Medical Council (GMC) and Responsible Officers** Regulators and Responsible Officers need to ensure that there is proper evaluation and support of doctors to ensure their safe return to the workplace – as part of clinical governance.

## **Doctors' appraisers**

Appraisers need to identify issues affecting the returning doctor and ensure that the correct process is being followed.

## **Locums, their employers and contracting agencies**

Employers and contracting agencies should clarify locums' employment records – these recommendations apply to doctors returning after an absence of three months or more from regular practice (or potentially less than three months if they have not been in regular practice).

## **Those holding performers' lists (currently Primary Care Trusts)**

These organisations may need to consider a mechanism to ensure that doctors absent from practice for three months or more can return to practice safely.

## **Deaneries and/or those delivering/designing training for doctors, and trainee doctors**

Deaneries should plan and ensure a safe and effective return to learning, and also to practice.

## **Organisations offering Continual Professional Development (CPD) and support to doctors, including Medical Royal Colleges**

These organisations may offer updates to clinical skills (Appendix 1).

## 2 HOW SHOULD THIS GUIDANCE BE USED?

Designated bodies and their Responsible Officers, doctors, employers, contractors and regulators all have responsibility to ensure an appropriate process is in place and is followed for a doctor's return to practice to ensure patient safety. The use of this guidance will facilitate this.

This guidance covers doctors who have been absent for three months or more. The checklists (Sections 6 & 7) should be used pre and post absence to conduct an individual evaluation of the doctor returning to practice. The guidance also gives recommendations for a return to practice action plan and organisational policy to ensure an effective return to practice in the interests of patient safety and suggests the need for an organisational policy. The checklists and action plan give an opportunity to identify issues, potential training and support required by the returning doctor. It does not assume that the returning doctor is not fit to practice. The doctor may need advice and guidance from colleagues and managers before answering these questions.

Each doctor will have different needs when returning to practice reflecting their experiences and circumstances, not simply time out of practice. Designated bodies and their Responsible Officers should use the checklists as part of the appraisal process when doctors are to return to practice. They will need to take account of the doctor's revalidation dates and their need to gather supporting information, participate in Continued Professional Development (CPD) etc.

The evidence gathered by the Return to Practice Working Group identified two key factors: time out of practice and increasing age (the evidence is available from the Academy). Taking this evidence into account, the longer the period out of practice, the more robust the process of return to practice should be. However, all return to practice assessments should be robust, appropriate and commensurate with the period of absence as well as other factors identified through the checklists.

- Shorter absences: An absence of less than three months, in the view of the Return to Practice working group, appears less likely to cause significant problems, but may still affect confidence and skills levels. The majority of doctors in these cases should be able to return to work safely and successfully, they may sometimes require support. Should further research evidence on length of absence emerge at a later date, this 'cut off' of three months may need to be reviewed.
- Longer absences: An absence of three months or more appears more likely to significantly affect skills and knowledge. Therefore an assessment is recommended and the approach should be commensurately robust the longer the period of absence to ensure patient safety.

It is important that doctors and employers prepare for any predictable absences from practice. Early notification of absence to the employer will be beneficial to both the doctor and employer, enabling better planning of any support needed. The notification of absence is the doctor's responsibility, but it is the responsibility of a good organisation to work with the doctor to identify issues or support needed. Those who do not have an organisation may be able to obtain help from one of the organisations listed Appendix 1. Where doctors do not have

employers, they still have a responsibility to manage their own return to practice and ensure that they have the necessary support.

The doctor should take an active part in setting up the action plan. This should be done either previous to return or immediately on return. Those carrying out the evaluation may need to judge what insight the doctor has into their needs in creating the plan.

Precisely who undertakes the evaluation is a matter for employers and regulators, but that individual needs to be well defined and appropriate to the organisation e.g. Medical Director, Responsible Officer, Clinical Director or Lead Clinician. Notes should be made and records should be kept. The doctor (and their employer, partner or contracting agency) should review the answers to the previous checklist (if available) to note any changes from expectations and progress during the period of absence.

If evidence arises at any point that patient safety is being compromised, the necessary processes must be put into place, the appropriate authorities must be informed and action taken. The name of whoever is empowered by the organisation to agree that any potential patient safety concerns have been met (and thus the doctor can return to independent practice) should be identified to the doctor.

The final decision regarding returning to practice rests with the relevant body (for example, the employer/designated body, the practice or the regulator). For trainee doctors, plans for a return to learning as well as return to practice, should be made. If an issue arises which creates difficulties in agreement between doctors and employers, normal methods of dispute resolution should be undertaken.

# 3 SUMMARY OF EVIDENCE ON RETURN TO PRACTICE

As part of this report, an extensive search for evidence was conducted. The collated evidence is available from the Academy. In summary, whilst there is little shortage of opinion in this area, there is little clear evidence. However, the best published evidence available is from United States<sup>1</sup> regarding a re-entry programme run for doctors who had been absent from practice for 18 months or more. It states that:

*'The majority (67%) were found to have educational needs requiring moderate to considerable re-education or training ... many re-entering physicians may not be ready to jump back into practice.'*

The re-entry programme study found two key factors affecting a doctor's performance when returning to practice:

- The more years the doctor was out of practice, the more likely they were to have poor performance ratings.
- Older physicians were more likely to have higher ratings of poorer performance.

## **Other information gathered includes:**

The Federation of State Medical Boards of the USA stated that *'currently many state boards have requirements for physicians seeking to re-enter practice after some time away, such as passage of an examination, demonstration of prescribed number of continuing medical education hours, and others. Thirty eight of seventy member boards in the either have a policy on 'physician re-entry' or they are developing one/plan to develop one.*

A number of other professions in the UK have return to practice processes, varying in the degree to which they are compulsory. For example nurses have university led, regulator approved return to practice courses.

A number of organisations in the UK and abroad offer retraining schemes e.g. The Committee of General Practice Education Directors (COGPED) or have retraining requirements (e.g. some USA state medical boards) for doctors who have been out of practice for two years or more. However, formal retraining schemes do not exist in many specialties in the UK and formal retraining may often not be appropriate for doctors returning to practice after a shorter period of absence, even though doctors should be evaluated after an absence of three months or more.

1. Elizabeth S. Grace MD, Elizabeth J. Korinek MPH, Lindsay B. Weitzel PhD, Dennis K. Wentz MD., Physicians reentering clinical practice: Characteristics and clinical abilities†, 22 SEP 2010



## 4 RETURN TO PRACTICE ACTION PLAN

### **In formulating a return to practice action plan, the following should be identified:**

- The doctor's learning needs based upon the answers to the checklists
- How the doctor has learned successfully in the past
- How and when it will be assessed whether the learning needs have been met
- Which new learning is necessary to help improve patient care
- How this learning will fit in to the doctor's job plan
- How to fund the learning.

### **Possible actions to assist the doctor in safely returning to practice:**

- The doctor should list any plans for education on return to practice or any CPD that can be undertaken whilst away, or immediately on return, such as specialty specific updates. The doctor should plan to keep a record of any work or CPD that is undertaken during an absence
- Ensuring that first patient list(s) is/are straightforward and that additional support is available. The longer the doctor has been absent, the longer this support may be necessary
- Ensuring that enough time is allowed when first returning to work for discussions with colleagues and managers to respond and assist where necessary. Again, more time would usually be needed for those doctors who have been absent longer.

### **Other important methods to consider using:**

- Arranging for periods of observation of the doctor (either by the doctor, the organisation/employer or both)
- Supernumerary arrangements for a period of time if needed
- Professional development (e.g. Essential Knowledge Update, or refresher courses where they exist)
- Setting up formal or informal mentoring arrangements
- Flexible hours or other flexible arrangements that may be necessary.

### **Arrangements for ensuring and clarifying the success of the return to practice process:**

- Those responsible (e.g. Medical Director, clinical manager, appraiser, Responsible Officer, etc) should be given updates of the plans for return to practice, and of their safe completion. The employer and the Responsible Officer should plan to review progress after a reasonably short period of time, e.g. six months, or more frequently if other causes for concern are identified
- A date for a formal appraisal should be arranged on or soon after absence, and when the appraisal takes place, evidence of completion of the return to practice action plan should be given. The appraisal should determine whether the questions raised in the checklists have been addressed

- Where doctors do not have employers, they still have the responsibility to manage their own return to practice and ensure that they have the necessary support, and that arrangements are made to support their safe return. They may need to inform their Responsible Officer. Organisations who can provide advice to doctors who are returning to practice are listed Appendix 1.

**In drawing up this plan, targets should be realistic and dates should be set for its review.**

# 5 SETTING UP AN ORGANISATIONAL POLICY ON RETURN TO PRACTICE

For the purpose of patient safety, a clear and supportive process for the return to practice of medicine should be in place in all organisations employing or contracting doctors. Doctors themselves also have a professional responsibility to ensure that they are safe to return to practice and follow the guidance set out in this report. All organisations and groups named within this report are responsible for ensuring that they are aware of and use this guidance.

## **An organisational policy for return to practice should include:**

- Preparation by doctors and those working with them before any absence from work (where possible) to ensure that there is a supportive plan for the doctor's return – using the checklists and recommendations given in this report.
- An initial evaluation of the individual doctor's needs just before or on return to work, using the suggested checklist and recommendations in this report.
- Following this evaluation, a proportionate response to the doctor's needs should be devised which would have different levels of formality depending on the level of the needs. Employers should consider how the process they agree with returning doctors fits with processes for other health professionals working for them.
- There should be timelines agreed for the completion of any support or training and the evaluations that are necessary.

## 6 PLANNING AN ABSENCE FROM PRACTICE – RECOMMENDED QUESTIONS AND ACTIONS

The following checklist of questions is recommended to be used pre-absence in order to help with identification of issues and facilitate support planning.

1. How long is the doctor expected to be absent? (Is there any likelihood of an extension to this?)
2. Are there any training programmes or installation of new equipment due to take place in the doctor's workplace in the period of absence? If so, how should the doctor become familiar with this on their return?
3. How long has the doctor been in their current role? Is this relevant in determining their needs?
4. Will the doctor be able to participate in any 'Keep in Touch' days or other means of keeping in touch with the workplace? If so, how will this be organised?
5. Does the doctor have any additional educational goals, during their absence?
6. What sort of CPD, training or support will be needed on the doctor's return to practice?
7. Are there any funding issues related to question 6 which need to be considered?
8. Will the doctor be able to retain their licence to practise and to fulfil the requirements for revalidation?
9. Are there any issues relating to the doctor's next appraisal which need to be considered? If so, the Responsible Officer/representative may need to be informed.
10. If the doctor is a trainee, how do they plan to return to learning?
<b>Signatures</b> <b>Doctor</b> _____ <b>Date</b> _____
<b>On behalf of the organisation</b> _____ <b>Date</b> _____

## 7 A DOCTORS RETURN TO PRACTICE – RECOMMENDED QUESTIONS AND ACTIONS

The following checklist of questions is recommended to be used post-absence in order to help with identification of issues and facilitate support planning.

1. Was a pre-departure checklist completed? (If so, this should be reviewed.)
2. How long has the doctor been away?
3. Has the absence extended beyond that which was originally expected? If so, what impact has this had? (If it was an unplanned absence, the reasons may be important.)
4. How long had the doctor been practising in the role they are returning to prior to their absence?
5. What responsibilities does the doctor have in the post to which they are returning? In particular are there any new responsibilities?
6. How does the doctor feel about their confidence and skills levels?
7. What support would the doctor find most useful in returning to practice?
8. Has the doctor had any relevant contact with work and/or practice, during absence e.g. 'keep in touch' days?
9. Have there been any changes since the doctor was last in post? For example: <ul style="list-style-type: none"><li>• The need for training such as for new equipment, medication, changes to infection control, health and safety, quality assurance, other new procedures, NICE guidance, or anything that the doctor needs to learn</li><li>• Changes to common conditions or current patient population information</li><li>• Significant developments or new practices within their specialty</li><li>• Changes in management or role expectations. What time will the doctor have for patient care?</li><li>• Are there any teaching, research, management or leadership roles required?</li><li>• Changes in the law that affect doctors' practice and developments in guidance on professional standards and ethics.</li></ul>

10. Has the absence had any impact on the doctor's licence to practise and revalidation?  
What help might they need to fulfil the requirements for revalidation?

11. Have any new issues (negative or positive) arisen for the doctor since the doctor was last in post which may affect the doctor's confidence or abilities?

12. Has the doctor been able to keep up to date with their continuing professional development whilst they have been away?

13. If the doctor is a trainee, what are the plans for a return to learning?

14. Is the doctor having a staged return to work on the advice of Occupational Health?

15. Are there any issues relating to the doctor's next appraisal and preparation for this, which need to be considered? Is the revalidation date affected? (If either/both applies, the Responsible Officer/ representative should be informed)

16. Are there other factors affecting the return to practice or does the doctor have issues to raise?

17. Is a period of observation of other doctors' practice is required and/or does the doctor need to be observed before beginning to practise independently again?

18. Will the doctor need training, special support or mentoring on return to practice? If so, are there any funding issues related to this which need to be considered?

**Signatures**

**Doctor** \_\_\_\_\_

**Date** \_\_\_\_\_

**On behalf of the organisation** \_\_\_\_\_

**Date** \_\_\_\_\_

# APPENDIX 1

## ORGANISATIONS WHO CAN ADVISE DOCTORS RETURNING TO PRACTICE

<b>British Medical Association</b>	<a href="http://www.bma.org.uk">www.bma.org.uk</a>
<b>General Medical Council</b>	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
<b>Royal College of Anaesthetists</b>	<a href="http://www.rcoa.ac.uk">www.rcoa.ac.uk</a>
<b>College of Emergency Medicine</b>	<a href="http://www.collemergencymed.ac.uk">www.collemergencymed.ac.uk</a>
<b>Royal College of General Practitioners</b>	<a href="http://www.rcgp.org.uk">www.rcgp.org.uk</a>
<b>Royal College of Obstetricians and Gynaecologists</b>	<a href="http://www.rcog.org.uk">www.rcog.org.uk</a>
<b>Faculty of Occupational Medicine</b>	<a href="http://www.fom.ac.uk">www.fom.ac.uk</a>
<b>Royal College of Ophthalmologists</b>	<a href="http://www.rcophth.ac.uk">www.rcophth.ac.uk</a>
<b>Royal College of Paediatrics and Child Health</b>	<a href="http://www.rcpch.ac.uk">www.rcpch.ac.uk</a>
<b>Royal College of Pathologists</b>	<a href="http://www.rcpath.org">www.rcpath.org</a>
<b>Faculty of Pharmaceutical Medicine</b>	<a href="http://www.fpm.org.uk">www.fpm.org.uk</a>
<b>Royal College of Physicians of Edinburgh</b>	<a href="http://www.rcpe.ac.uk">www.rcpe.ac.uk</a>
<b>Royal College of Physicians London</b>	<a href="http://www.rcplondon.ac.uk">www.rcplondon.ac.uk</a>
<b>Royal College of Physicians and Surgeons of Glasgow</b>	<a href="http://www.rcpsg.ac.uk">www.rcpsg.ac.uk</a>
<b>Royal College of Psychiatrists</b>	<a href="http://www.rcpsych.ac.uk">www.rcpsych.ac.uk</a>
<b>Faculty of Public Health</b>	<a href="http://www.fph.org.uk">www.fph.org.uk</a>
<b>Royal College of Radiologists</b>	<a href="http://www.rcr.ac.uk">www.rcr.ac.uk</a>
<b>Royal College of Surgeons of Edinburgh</b>	<a href="http://www.rcsed.ac.uk">www.rcsed.ac.uk</a>
<b>Royal College of Surgeons of England</b>	<a href="http://www.rcseng.ac.uk">www.rcseng.ac.uk</a>
<b>Local deaneries</b>	<a href="http://www.copmed.org.uk/contacts">www.copmed.org.uk/contacts</a>
<b>Medical Women's Federation</b>	<a href="http://www.medicalwomensfederation.org.uk">www.medicalwomensfederation.org.uk</a>
<b>National Clinical Assessment Service</b>	<a href="http://www.ncas.npsa.nhs.uk">www.ncas.npsa.nhs.uk</a>
<b>NHS Careers</b>	<a href="http://www.nhscareers.nhs.uk">www.nhscareers.nhs.uk</a>
<b>NHS Employers</b>	<a href="http://www.nhsemployers.org">www.nhsemployers.org</a>
<b>Association of Anaesthetists of Great Britain and Ireland</b>	<a href="http://www.aagbi.org">www.aagbi.org</a>
<b>Academy of Medical Royal Colleges</b>	<a href="http://www.aomrc.org.uk">www.aomrc.org.uk</a>
<b>NHS Confederation</b>	<a href="http://www.nhsconfed.org">www.nhsconfed.org</a>
<b>Physician Re-entry Website (USA)</b>	<a href="http://www.physicianreentry.org">www.physicianreentry.org</a>

# APPENDIX 2

## MEMBERSHIP OF THE RETURN TO PRACTICE WORKING GROUP

**Professor Hugo Mascie-Taylor, Chairman**  
Medical Director of the NHS Confederation

**Dr Iain Barclay**  
Medical Protection Society

**Ms Maree Bennett**  
Department of Health England

**Miss Su Anna Boddy**  
Royal College of Surgeons of England

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

**Dr Carolyn Evans**  
Flexible Training Adviser,  
Royal College of Anaesthetists

**Professor Peter Furness**  
President, Royal College of Pathologists

**Mr Steve Griffin**  
NHS Employers

**Professor Jacky Hayden**  
North Western Deanery

**Ms Una Lane**  
General Medical Council

**Miss Lorna Marson,**  
Transplant surgeon at Edinburgh Royal infirmary  
and Chairman of the Women in Surgery Advisory  
Board for the Royal College of Surgeons of Edinburgh

**Ms Claire McLaughlan**  
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**Mr Bill McMillan**  
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**Mr Sol Mead**  
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**Miss Susan Mollan**  
Royal College of Ophthalmologists  
**Professor Mike Pringle**  
Royal College of General Practitioners

**Dr Ian Starke**  
Revalidation Lead for the Royal College of Physicians  
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