RACGP

Royal Australian College *of* General Practitioners

A guide to re-entry to general practice

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A guide to re-entry to general practice

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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A guide to re-entry to general practice

Introduction

General practitioners (GPs) may take time away from practice for various reasons including personal and family issues, illness, injury, extended periods of travel, study leave, career change or disciplinary action by the Medical Board of Australia (the Board). The time away might be planned or unplanned and the length of absence can be highly variable. GPs re-entering practice may face challenges such as updating their knowledge and skills, becoming familiar with changes in practice (such as adopting new technologies, management guidelines and therapies), making adjustments with respect to any personal impairments that may have been sustained, and complying with any restrictions imposed by the Board. Depending on individual circumstances, there may also be a degree of apprehension about returning to work.

This guide outlines The Royal Australian College of General Practitioners' (RACGP's) recommendations for GPs who have been absent or are intending to be absent from general practice for a period of time and whose intent is to re-enter practice.

Background

Skill retention is of particular concern in the military and emergency services domains where training is frequently followed by a period of non-use of these skills. Consequently, there is a significant body of research and literature, in these domains, examining the various factors affecting the decline in knowledge and skills (this has been termed 'skill decay' or 'skill fade'). Skill decay is a complex problem. While skills do decline over time, the greatest decline occurs immediately after skill acquisition, with subsequent decline becoming more and more gradual.

There are also various factors that modulate the degree of skill decay:

- Learning context (factors which are modifiable to enhance learning)
  - instructional strategies
  - degree of overlearning (learning beyond the point of initial mastery)
  - retention interval (the interval between the learning and the use of the skill)
  - conditions of retrieval (the degree of similarity between the learning and performance contexts)
  - interventions for preventing decay of skills
- Task type (inherent characteristics of the task which are not modifiable by the trainer)
  - physical versus cognitive
  - closed-loop versus open-loop (closed-loop tasks involve discrete responses and have a defined beginning and end; open-loop tasks do not have a defined end, are dynamic and are likely to be complex)
  - natural versus artificial
  - speed-based versus accuracy

  - simple versus complex
  - individual versus team-based
- Task context
- Individual differences in the trainee
  - ability
  - personality (conscientiousness, openness to experience)
  - motivation
  - self-efficacy.

There is still a lot that is not known about the interplay of the above factors, particularly with respect to 'complex' skills, because most studies involve 'simple' tasks. Physical, closed-loop, natural, speed-based and complex tasks appear to be less susceptible to skill decay than cognitive, open-loop, artificial, accuracy and simple tasks.

Very little is known about the impact that a period of absence from practice has on a GP's competence, performance and skills. However, it would not be unreasonable to assume that what is known about skill decay can be applied to the medical context. With respect to performance and skills, there are two aspects that have to be considered: if the GP's skills have deteriorated, and what changes have occurred to practice during the period of absence.

For a GP re-entering practice, the two broad areas affecting the retention of skills are individual factors and the length of absence. Clearly, the longer a GP is absent from practice, the greater the likelihood that knowledge and skills will decline to a degree that is significant. Concurrently, changes to practice will occur and the amount of change that a GP will have to contend with will also be dependent on the length of absence. Individual factors include the age of the GP: the older a GP is, the more difficult it will be for them to re-enter practice.

Overseas experience, with respect to doctors, suggests that two or three years' absence from practice requires some form of assessment and retraining prior to full return. Currently, however, in Australia, there is no formal program to assist GPs re-entering practice. The responsibility rests with the individual GP to ensure that they are safe to return to practice and that they have the required knowledge and skills for the scope of practice to which they are returning. It is important for the GP to identify as early as practicable what issues might arise, or might have arisen, as a result of absence and to put the necessary processes into place for upskilling or reskilling as early as possible. For example, a GP planning to be absent from practice for a significant period of time should be concurrently identifying what measures will be required to facilitate a successful re-entry. Similarly, a GP who is already absent from practice should be thinking about a re-entry plan from the moment that there is intent to re-enter. At the same time, consideration should be given as to whether a mentor and/or supervisor might be required to assist with planning for re-entry, as well as with the transition back into practice.

Re-entering practice

Medical Board regulations

A GP re-entering practice in Australia must adhere to the Board's 'Recency of practice', 'Continuing professional development' (CPD) and 'Professional indemnity insurance' standards.

To meet the 'Recency of practice' standard, a GP must practise within their scope of practice for a minimum total of:

- four weeks full-time equivalent (152 hours) in one registration period; or
- 12 weeks full-time equivalent (456 hours) over three consecutive registration periods.

'Full-time equivalent' equates to 38 hours per week and is the maximum number of hours that may be counted in a week.

A GP who has been practising in a jurisdiction outside Australia will meet the 'Recency of practice' standard provided they:

- have not been absent from practice for a year or more
- are not intending to change their scope of practice.

With respect to the CPD standard, a GP with specialist registration must meet the RACGP's CPD requirements.

In addition, the GP must be able to demonstrate that they are a 'fit person for practice'; that is, that they do not have an impairment, a criminal history or a professional disciplinary history that may impact upon their practice or has relevance to their ability to practise. The GP must also have the necessary professional indemnity insurance in place for when they commence practice.

When a GP has been absent from practice and not registered, or registered as non-practising, for more than one year and is applying for registration, the Board will consider:

- registration and practice history
- when the practitioner last practised and the period of absence
- the number of years of experience prior to leaving practice
- activities related to the practice of medicine undertaken since they last practised (this includes CPD, education or professional contact)
- intended scope of practice, including the proposed role and position.

For a GP with two or more years of clinical experience and now returning to practice, the Board has additional requirements based on whether they have practised or not during the period of absence:

- If they have not practised for up to and including 12 months
  - no additional requirements before re-entering.
- If they have not practised for between 12 months and up to and including 36 months
  - at a minimum, the equivalent of one year's CPD activities relevant to the GP's intended scope of practice, before re-entering practice. These activities must have been with respect to maintaining and updating knowledge and clinical skills.

- If they have not practised for more than 36 months
  - a plan for professional development and re-entry to practice must be provided to the Board for consideration and approval. The GP will have to work under supervision for a designated period of time (as determined by the Board). Consequently, a supervisor (who has agreed to undertake the supervisory and support role and report to the Board) must be nominated.

A GP with less than two years of clinical experience now returning to practice is required to work under supervision in a training position approved by the Board.

Changing scope of practice

If a practitioner is changing their field or scope of practice, they may be required to undergo additional training to ensure they are competent in the new field or scope of practice. The Board's requirements differ depending on the type of change.

If the change is:

- to a subset of the GP's current practice (ie narrowing the scope of practice), there are no additional requirements
- an extension to the GP's practice that might reasonably be expected for a practitioner in that field, the GP is required to undertake any training that would be expected by their peers in that field, before taking up the new area of practice
- to a different field of practice, the GP is required to consult with the relevant specialist college and develop a professional development plan for entering the new field of practice for the consideration and approval by the Board.

Performance assessment

The Board may sometimes require the practitioner to undergo a performance assessment before re-entering practice. This will generally occur when the practitioner has previously been investigated with respect to their professional practice and/or there is concern for patient safety. Unsatisfactory performance is defined in part 1, section 5 of the *Health Practitioner Regulation National Law Act 2009* as follows:

> *Unsatisfactory professional performance, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.*

The aim of a performance assessment is to identify any deficits in a practitioner's performance, so that a plan can be developed to ensure that the practitioner meets the expected standards, as well as to protect the public. It is usually conducted by one or more GPs who are not Board members, and who have the necessary expertise to assess.

As a result of a performance assessment, the Board may decide to:

- take no further action
- investigate the practitioner further
- refer the matter to a performance and professional standards panel

- impose conditions on/accept an undertaking from the practitioner
- require the practitioner to undergo a health assessment
- caution the practitioner
- refer the matter to a tribunal
- refer the matter to another entity (such as a health complaints entity).

Role of the RACGP

The RACGP considers that the onus for determining the clinical competency of GPs re-entering clinical practice after an extended period of leave lies with the GP, their employer and the Board.

The RACGP may provide the following assistance to a GP who is planning to take leave of absence from practice or to re-enter practice:

- Guidance on the process to follow when contemplating a planned absence and re-entry.
- Advice with respect to CPD requirements at the time of re-entry.
- Assistance in the development of a learning plan for re-entry.
- Advice with respect to suitable educational activities.
- Assistance with finding a suitable mentor and/or supervisor.
- Support for the nominated mentor and/or supervisor.

The RACGP also recommends the following, based on the period of absence:

- Absence of less than 12 months
  - While there are no specific Board requirements, a mentor would be of support to any GP who is apprehensive or has any concerns about how they will cope.
- Absence of between 12 and 36 months
  - In addition to the Board requirement that a minimum of 12 months' equivalent of CPD must have been completed prior to re-entry, it would be helpful for the GP to engage a mentor (who could be a colleague within or outside of the practice) to provide ongoing support and to assist with the formulation of a learning plan (for the CPD that has to be completed prior to re-entry and going forward after that), and/or a supervisor (within the practice) to provide day-to-day support and assistance with any concerns, teaching, and formative assessment of clinical skills by direct observation.
- Absence of more than 36 months
  - The GP must meet the Board's specific requirements, including the preparation of a professional development or learning plan and working under supervision. Whether a mentor will be helpful, in addition to a supervisor, will depend on the re-entering GP's needs and the terms of engagement with the supervisor. For example, the supervisor may not be involved in the formulation of a learning plan and a mentor may assist instead. A mentor may also be able to provide ongoing support. While the supervisor will have certain reporting responsibilities to the Board, they are also ideally placed to provide in-practice support.
  - The following initiatives would be useful as part of the re-entry plan
    - Regular teaching time
    - Formative assessment of clinical skills by direct observation
    - Prescribing and medical records review.

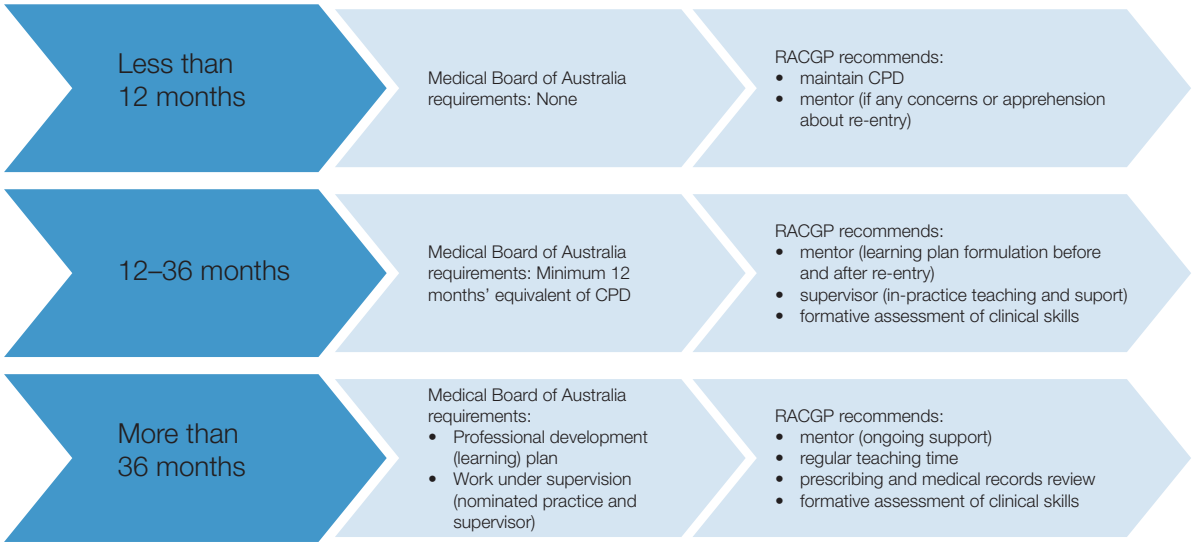

Figure 1. Requirements and recommendations for re-entry to practice

Preparing to re-enter practice

GPs are encouraged to commence planning as early as possible, ideally from the moment when a leave of absence from practice is being planned, but certainly when there is serious intent to re-enter. They should become familiar with the Board's regulations and how these regulations apply to their context because some processes can take time, particularly when the absence has been for more than 36 months.

It is each individual GP's responsibility to ensure their safety to practise as well as their personal wellbeing. A well-considered plan for re-entry will be guided by these two principles and will ensure a smoother transition into practice.

Rehabilitation

Chronic illness and disability is not a contraindication to clinical practice. Once again, patient safety is paramount. Allowances and adjustments can be made in the workplace so that the GP may function to the best of their ability, and advice and/or assistance in achieving this may be sought from:

- the GP's treating doctor(s)
- a rehabilitation physician
- an occupational physician
- an allied health professional, such as an occupational therapist or physiotherapist, who has knowledge of the GP's health issues and is in a position to advise.

While there is significant overlap between the roles of the rehabilitation physician and the occupational physician, the occupational physician is possibly better positioned to provide independent advice and support to not only the GP re-entering the workforce but also to the practice.

Organisational considerations

The practice that the GP is proposing to work in, may itself need an action plan. Apart from supporting the GP's re-entry, the practice should have considerations for

the functioning of the organisation and of those who will be working closely with the re-entering GP.

The following four elements should be considered as part of the practice's re-entry plan:

- Preparatory work before the GP commences
  - informing those in the practice of the GP's intention to re-enter practice and any accommodations that will have to be made to facilitate that re-entry
  - identifying support mechanisms, including the need for mediation should relationships become strained
  - working hours and rosters
  - with respect to a disability, making any necessary adjustments or modifications to the workplace.
- Formal induction and orientation to the practice
  - identifying how re-engagement with clinical activities will be managed (perhaps gradually phasing in to the clinical role)
  - explaining organisational structures and processes (including billing)
  - providing orientation to the medical software.
- Clear communication to reduce misunderstandings and to manage expectations within the practice, including
  - briefing the supervisor and other parties that are directly involved in the GP's re-entry program (information to those not directly involved should be on a 'need to know' basis)
  - communicating with patients where necessary
  - preparing for possible media inquiries or interested patient groups.
- Responding to the needs of individuals within the practice. Some individuals may feel uncomfortable or have reservations about the particular GP who will be working alongside them. Any issues should be discussed, preferably on a one-to-one basis, and the issues resolved (as far as possible) before the GP commences work.

Formulating a plan for re-entry

A plan for re-entry is more than a study or learning plan. It should encompass:

- a learning plan
- a schedule of activities
- orientation to the practice
- support
- provision for performance review in-practice
- ongoing evaluation of objectives and whether they are being achieved.

Each GP will have differing needs when re-entering practice that will reflect their experiences and circumstances, not simply the time out of practice. There are many factors that may have an impact on skills retention, the ability of the GP to update their knowledge and skills and be up to date with clinical guidelines and changes in practice. There may also be obstacles to overcome or restrictions to practice that will have to be adjusted to. Therefore, the following should be considered first when preparing a plan for re-entry:

- Reasons for the absence
  - personal reasons (illness, disability)
  - family reasons (parental leave)
  - restrictions imposed by the Board (restrictions, suspension, deregistration)
  - return from overseas (extended travel and/or study)
  - a career break or career change, including study leave.
- Length of time away. Shorter absences are less likely to cause significant problems; however, they still have the potential to affect confidence. The longer the period of absence, the more robust the approach should be in terms of problem definition, learning needs assessment and management.
- The GP's age. The older the GP, the more likely they will experience difficulties with re-entry and require a higher level of support.
- Any disabilities that may have been incurred as a result of illness and their potential impact on performance.
- The scope of practice to which the GP will be returning
  - if no change in scope, the GP will require refreshment and updating of skills
  - if modified or entirely new scope, the GP may require re-skilling, in addition to refreshment and updating of skills.
- The need for a mentor and/or supervisor.
- Undertakings to the Board that have to be met before and after re-entry.

The checklists in Appendix 1 ('Intended absence from practice') and Appendix 2 ('Re-entry to practice') will assist in identifying all the relevant issues. For every identified issue, it is important to consider, as fully as possible, the likely impact on clinical performance and the resulting implications for practice.

Having identified the issues that may affect re-entry, the next step is to complete a learning needs assessment. This will determine which areas of knowledge and skills require updating, and the activities that will be completed to address the identified needs.

A well-formulated learning plan will include the following:

- All factors impacting on clinical practice and how they will be addressed.
- Learning plan (a list of study activities for the period leading up to re-entry and the period of transition)
  - identified gaps in knowledge and skills
  - learning style
  - goals of learning
  - the activities and programs that will be undertaken
  - update of medico-legal obligations
  - funding of the learning plan.
- Realistic schedule (for the period leading up to re-entry and the transition period after re-entry)
  - clear time frames for the achievement of the objectives
  - anticipated completion date of the plan.

- Orientation to the proposed workplace (details of how it will be conducted and what will be covered).
- Support, psychological as well as day-to-day practice, because lack of confidence and/or lack of support can have significant impact on clinical performance
  - mentoring and level of supervision that may be required
  - terms of engagement with the mentor and/or supervisor
  - allocated time for regular formal feedback and/or performance reviews by the mentor/supervisor
  - ready availability of a colleague, who may be the supervisor, or the practice manager to answer questions and assist with any day-to-day concerns.
- Evaluation
  - ongoing review of learning needs. Most knowledge and clinical skills deficits will be identified in the course of consulting and provision should be made for addressing these needs
  - action that will be taken if the stated goals are not achieved in the stated time frames.

It is the individual GP's responsibility to ensure their safety to practise. Supervisors and mentors have a duty of care to the public and also to the re-entering GP. If, at any stage during the implementation of the re-entry plan, the safety of either is compromised, action should be taken. It may be that notification to the Australian Health Practitioner Regulation Agency (AHPRA) is mandated. In the first instance, however, the supervisor and/or mentor should speak to the re-entering GP and try to resolve any concerns. AHPRA should be consulted when it has been involved in the re-entry plan because it will be in a position to make a decision. The RACGP is unable to make decisions but may be able to advise.

Supervision

When a GP has been absent from work for more than 36 months, the Board's requirement is that they work under supervision. In some instances, the Board may also require a formal assessment of clinical skills prior to re-entry. Sometimes, the required level of supervision as well as its duration is stipulated by the Board. The Board will inform the GP, when applying for re-entry, about any such requirements for assessment and/or supervision.

Good supervision and feedback within a supportive environment enhances the improvement of clinical skills. It promotes the practitioner's strengths, elucidates the areas that need improvement and provides direction and strategies for improving performance. Even if the Board doesn't mandate it, supervision is advisable for any GP who has been away from practice for a substantial period of time, because it:

- provides evidence as to the practitioner's safety to practice and that the public is not at risk
- monitors and supports the practitioner throughout the duration of the re-entry plan to ensure that objectives are being met.

The need for supervision will be influenced by individual circumstances, including the:

- reasons for absence
- length of time away
- specific practice where the practitioner will be working (ie patient demographics and any associated risks)

- supports that will be in place (other than the supervisor)
- experience of the practitioner.

Supervision should be both formal and informal, tailored to the GP's needs:

- Formal supervision involves regular, scheduled time that enables in-depth discussion and reflection on clinical practice. It may include
  - review and feedback on performance, identifying strengths and weaknesses and performance issues
  - direct observation of consultations, including procedures
  - case discussion, including random case analysis
  - prescribing and medical record reviews
  - review of systems and practice procedures.
- Informal supervision may include
  - day-to-day observation, communication and interaction providing advice, guidance and support as required (many learning needs will arise during the course of consulting)
  - observing the supervisor's consulting.

The supervisor should be onsite when a re-entry GP is practising. When the supervisor is not onsite, they should be readily available by phone, or a secondary supervisor should be nominated to provide assistance.

Supervision should be directed towards self-management, starting with a higher level of supervision for an initial period and gradually reducing over a defined period. The level of supervision and its duration will be influenced by the re-entry GP's skill level, confidence and rate of progress.

Mentoring

The terms of engagement, with respect to supervision, will be fairly well defined. The mentoring relationship can vary considerably from informal and short term to formal and long term. The role of the mentor is both supportive and developmental. The mentor's role entails:

- assisting in the preparation of the learning plan
- providing ongoing advice, guidance and support (pre and/or post re-entry)
- periodically meeting formally and/or informally with the practitioner to discuss pertinent issues.

Permanently leaving practice

There are times when GPs do leave practice permanently and there are many reasons why this might occur. The decision to leave may be voluntary or it may be forced on the GP, for example, as a result of illness or deregistration. Regardless of the reason, leaving a practice permanently can impact significantly on self-worth and may also have implications with respect to finances and family responsibilities. Attention to self-care is paramount. Consulting with one's own GP and/or other treating doctors is advisable in the case of illness. Counselling from a psychologist would also assist with surmounting the difficulties of such a life-stage change. If the GP is still able to work and thinking of a career change, a careers advisor could assist with respect to the available options and decision making. The RACGP is also in a position, through providing the allocation of a mentor, to provide support and guidance to GPs in this situation.

Resources

AHPRA

- Performance assessment, www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Performance-assessment.aspx

Medical Board of Australia

- FAQs and fact sheets, www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ.aspx
- Registration standards ('Continuing professional development', 'Recency of practice', 'Professional indemnity insurance arrangements'), www.medicalboard.gov.au/Registration-Standards.aspx

The RACGP

- General Practice Education Framework, www.racgp.org.au/education/registrars/fellowship-pathways/general-practice-education-framework
- RACGP 2016 Curriculum, www.racgp.org.au/education/education-providers/curriculum/2016-curriculum
- Continuing Professional Development (CPD) Program, www.racgp.org.au/education/professional-development/qi-cpd
- *A guide to performance management and support for general practitioners*

Bibliography

- Academy of Medical Royal Colleges. Return to practice: Guidance. London: Academy of Medical Royal Colleges, 2012. Available at www.aomrc.org.uk/reports-guidance/revalidation-reports-and-guidance/return-practice-guidance [Accessed 6 February 2020].
- American Academy of Pediatrics. A physician reentry into the workforce inventory. Elk Grove Village, IL: AAP, 2010 (revised 2014). Available at http://physician-reentry.org/wp-content/uploads/AAPReentryInventory.pdf [Accessed 6 February 2020].
- Arthur W Jr, Day EA, Bennett W Jr, Portrey AM (eds). Individual and team skill decay: The science and implications for practice. New York: Routledge, 2013.
- Cox J, King J, Hutchinson A, et al (eds). Understanding doctors' performance. Oxford: Radcliffe Publishing, 2006.
- Evenson A. Your practice on hold: Planning for a leave of absence. Fam Pract Manag 2008;15(7):31–34.
- General Medical Council. Skills fade: A review of the evidence that clinical and professional skills fade during time out of practice and how skills fade may be measured or remediated. Executive summary. London: GMC, [date unknown]. Available at www.gmc-uk.org/-/media/gmc-site-images/about/skills-fade-executive-summary.pdf?la=en&hash=09D3F4BFB069F95F895DBF33632A0F071BAA2DAF [Accessed 6 February 2020].
- General Medical Council. Skills fade: A review of the evidence that clinical and professional skills fade during time out of practice and how skills fade may be measured or remediated. Full report. London: GMC, [date unknown]. Available at www.gmc-uk.org/-/media/gmc-site-images/about/skills-fade-literature-review-full-report.pdf?la=en&hash=8E0E20E07337E2344A5467F9B302C2D83CF2EBA5 [Accessed 6 February 2020].
- Gorman A. For doctors who take a break from practice, coming back can be tough. Kaiser Health News. 15 June 2015. Available at http://khn.org/news/for-doctors-who-take-a-break-from-practice-coming-back-can-be-tough [Accessed 6 February 2020].
- Henderson M, Brooks SK, del Busso L, et al. Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: A qualitative study. BMJ Open 2012. doi: 10.1136/bmjopen-2012-001776.
- Hill AB. Breaking the stigma: A physician's perspective on self-care and recovery. N Engl J Med 2017;376(12):1103–05. doi: 10.1056/NEJMp1615974
- Miller L. Doctors, their mental health and capacity for work. Occup Med 2009;59(1):53–55. doi: 10.1093/occmed/kqn111.
- National Association of Clinical Tutors. Supporting trainees: A guide for supervisors. Practical advice for educational and clinical supervisors. Bletchley, UK: NACT, 2018. Available at www.nact.org.uk/documents/national-documents [Accessed 6 February 2020].
- National Clinical Assessment Service. The Back on Track framework for further training: Restoring practitioners to safe and valued training. A good practice guide. London: NHS/NCAS, 2010. Available at https://resolution.nhs.uk/resources/back-on-track-a-good-practice-guide [Accessed 6 February 2020].
- Yancey JR, McKinnon HD Jr. Reaching out to an impaired physician. Fam Pract Manag 2010;17(1):27–31.

Appendix 1. Intended absence from practice – A checklist for the GP

The following is a checklist of questions to consider when intending to be absent from practice for longer than 12 months. For each question, consider the implications of being absent from work. What are the possible issues/concerns/needs that might arise with re-entry to practice? The answers to these questions will assist in the formulation of a learning plan in preparation for re-entry to practice.

Intended absence from practice checklist	
What are the reasons for the intended absence from work?	☐
What is the intended time away from practice? (Defined time frame/open-ended/planned/unplanned.)	☐
What is the plan for the transfer of care of your patients?	☐
How old are you? What is your past work experience?	☐
Will you be returning to the same place of practice? If so, how do you intend to stay in touch with the people at that practice? If you are a GP trainee, how do you plan to return to GP training? (In this instance it is important to speak with the remediation officer in your training organisation.)	☐
Will you be returning to the same/modified/entirely new scope of practice? Will reskilling be required? Will you be working full time or part time? Will a mentor and/or supervisor be advantageous/required?	☐
What will be the financial impact of the absence?	☐
On re-entry, will there be any issues with respect to illness that should be considered (eg disability, mental concentration, medication)? Will any adjustments or modifications be required in the workplace? Would advice from a treating doctor, occupational therapist or rehabilitation physician be helpful?	☐
What might be the personal/psychological impact of absence from work, particularly if it will be prolonged? (Assistance from a psychologist and/or treating physician may be helpful.)	☐
Medical Board of Australia requirements: Are there any undertakings that will have to be met? Will there be any restrictions to your practice?	☐
Professional memberships: Are these up-to-date (ie medical registration, medical indemnity, RACGP, others)? Can any membership be maintained?	☐

Appendix 2. Re-entry to practice – A checklist for the GP

The following is a checklist of questions to consider when absent from work for longer than 12 months and re-entry to practice is being contemplated. For each question, consider your present situation, what has occurred to date, and the possible issues/concerns/needs that might arise with re-entry. The answers to these questions will assist in the formulation of a learning plan in preparation for re-entry to practice.

Re-entry to practice checklist	
What were the reasons for the absence from work?	☐
What has been the period of time away from practice? When are you planning to return? Has a re-entry date been set?	☐
How old are you? What is your past work experience?	☐
Will you be returning to the same place of practice? Have there been any changes at that practice during the time that you have been absent? If you are a GP trainee, how do you plan to return to GP training? (In this instance it is important to speak with the remediation officer in your regional training organisation.)	☐
Will you be returning to the same/modified/entirely new scope of practice? Is reskilling required? Will you be working full time or part time? How will re-entry to practice be staged? Will a mentor and/or supervisor be advantageous/required? What orientation to the workplace will be conducted?	☐
Are there any financial concerns? (Current/anticipated)	☐
Are there any issues with respect to illness that should be considered (eg disability, mental concentration, medication)? Would advice from your treating doctor be helpful? Will any adjustments/modifications/supports be required in the workplace? Will assistance from an occupational therapist or rehabilitation physician be helpful?	☐
How confident do you feel about returning to work? Do you have any concerns? Would assistance from a psychologist be helpful?	☐
Medical Board requirements: Are there any undertakings that have to be met? Are there any restrictions to your practice? Does an assessment have to be conducted prior to re-entry?	☐
Professional memberships: Are these up-to-date (ie medical registration, medical indemnity, RACGP, others)? What needs to be re-applied for?	☐

Appendix 3. Formulating a learning or professional development plan

All factors having impact on clinical practice (as identified in completing one of the checklists in Appendix 1 or 2) should be considered when developing the learning plan. The mentor or supervisor will be able to assist in preparing the plan.

Preliminary considerations

Learning or professional development plan	
What gaps have been identified in knowledge and skills? Consider: • deterioration of knowledge and skills • the intended scope of practice • significant developments and any changes that have occurred to the intended scope of practice in the time of absence • undertakings that have to be met • findings of clinical assessments • other educational goals.	
What is your preferred learning style? Individual or group setting?	
What retraining or reskilling is required? Consider: • scope of practice • disabilities that may impact • adjustments, modifications and supports required.	
During your absence, what continuing professional development (CPD) activities have you engaged in?	

Formulating the plan

Learning needs	How will you address these learning needs?
Considering your answers to the above questions, what are your learning needs? What are the objectives of your learning? What specific programs will now be undertaken? List each learning need (along with its objectives) separately.	Consider a variety of learning opportunities: journal and other articles, learning modules (online and paper-based), workshops, clinical updates, tutorials, observation of clinicians in practice, case discussions, etc. For each learning need, list the activities that would better assist in attaining the identified objectives.

Additional considerations	
What will be the time frame for the execution of the learning plan?	
What orientation to the workplace will be conducted? Consider: • general administrative requirements • billing • medical software and note taking • protocols such as results checking, recalls, follow-up of outstanding requests and referrals, patient handover, emergency procedures and drugs, vaccines, near misses, OH&S, patient complaints.	
What will be your mentor's and/or supervisor's role in the execution of your learning plan? What will be the level of supervision? How will your performance be monitored? What other support will be available?	
What action will be taken if your learning objectives are not achieved satisfactorily within the stated time frame?	

Appendix 4. Re-entry to practice – A checklist for the practice

For the practice, there are essentially four stages to the re-entry process:

1. **Preparation**
2. **Terms of engagement** (devising and agreeing to a re-entry plan)
3. **Implementation** of the plan
4. **Completion** of the plan (**evaluation** of the outcomes and **decision making**)

The following is a checklist of the things that a practice needs to consider when preparing for and managing a GP's re-entry to practice.

Preparation

Has the GP worked at this practice before? ☐

If yes: What were the circumstances under which the GP left? What implications does this have with respect to their re-entry?

Review:

- any available documentation, such as information from any investigation, decisions that have been made, medical and other reports, and the learning plan.

Consider:

communication with colleagues regarding the GP's role in the practice

- the need for facilitation or mediation where relationships have been or might be strained
- adjustments that may need to be made to the workplace
- the GP's training and support needs
- the available options for resuming work
- the prospects for success/failure and the possible consequent action.

Can an agreement in principle be reached? If so, what is the proposed re-entry plan?

Organisational action plan

What is the GP's plan for re-entry (including learning needs)? What is the time frame? Is a formal agreement required? ☐

Is AHPRA involved?

Who are the individuals within the practice that will assist with re-entry? What are their respective roles? Is there a need for a supervisor, or an overseeing 'responsible officer'? Who will monitor progress?

How will re-engagement with clinical work be managed? Will a gradual return be beneficial? Is mentoring or supervision required?

Is any assistance required from outside the practice? A mentor? Expert advice?

Formal induction and orientation

What orientation will be conducted to the workplace? ☐

Consider:

- general administrative requirements
- billing
- medical software and note-taking
- protocols such as results checking, recalls, follow-up of outstanding requests and referrals, patient handover, emergency procedures and drugs, vaccines, near misses, OH&S, patient complaints.

Communication

Clarify the lines of communication between the GP, supervisor, mentor, practice manager, and any other involved parties. ☐

Brief the team that the GP will be working in but also, as required, the wider organisation.

Respond to the needs of individual colleagues.

Respond to patient needs and concerns, eg when certain restrictions have been placed on the GP's practice or questions are anticipated from patient groups or the media.

Completion

Who will evaluate the outcomes? How will they be evaluated? ☐

Who is responsible for decision making? Will the GP continue working in the practice? If so, what will be the new terms of engagement?

Who will sign off on completion? Who is responsible for reporting?

Appendix 5. Case studies

Case 1 – Dr GPT

Part 1: Dr GPT is pregnant and is planning to take maternity leave. She is not sure about how much time to take off.

Question

What options are available to Dr GPT and what implications will this have to her registration?

Part 2: Dr GPT had planned to only take 12 months' leave; however, unexpectedly, she fell pregnant again. She has been absent from practice for three years now, and she is planning to return to work as soon as she can. The practice that she was working at indicates that they are happy to have her back.

Questions

What should Dr GPT do to prepare for her return to work?

What should the practice do?

Case 2 – Dr GPU

Dr GPU had worked in general practice for a short period of time and then left to pursue a writing career. While that career has been very successful, he has decided that he would like to work in general practice again. He recognises that his skills are rusty and that many changes have occurred in clinical practice over the time that he has been away from it. It has been 20 years since he last worked as a GP.

Questions

How should Dr GPU prepare for his return to practice?

What would be an ideal time frame?

Why would anyone want to employ an ex-GP?

Case 3 – Dr GPV

Dr GPV returned to general practice after having recovered from a significant mental illness. The conditions imposed on her return by AHPRA are that she only work under supervision and that she undertakes a mentoring program to assist her with her clinical skills. The mentoring entails regular monthly sessions with direct observation of, and feedback on, her consulting, along with monitoring of her progress. Dr GPV has a supportive supervisor in the practice. She engages readily in the mentoring sessions which she says are very beneficial. After 12 months, however, the mentor determines there is very little improvement in her clinical skills. Dr GPV feels that this assessment is harsh. She takes a break from practice, then returns to work for a period of time, after which she decides to cease clinical practice altogether because she finds it very stressful.

Observations and questions

Health issues and clinical skills concerns often go hand in hand and do impact on each other. The supervision and mentoring assisted Dr GPV to return to practice and feel supported at the same time. It also provided a means for monitoring her safety to practise. Dr GPV lacked insight and had difficulty accepting her deficiencies whenever they were pointed out to her. With the assistance of her mentor she was eventually able to recognise and accept that she would never achieve the required standard of practice. She also came to the realisation that she couldn't afford to have a mental breakdown again. When Dr GPV took the short break from practice these things were already in her mind and she was starting to think about what she would do if she stopped practising.

Is this case a success story or a failure?

The supervisor's terms of engagement are to support and monitor Dr GPV's clinical capability and progress. If a serious critical incident occurs, is the supervisor vicariously liable?

If Dr GPV had not accepted the feedback that her performance was less than satisfactory, what can the practice do?

Case 4 – Dr GPW

Dr GPW is a recovering alcoholic and has a history of depression. He applies for a job at your practice. You are the prospective employer and Dr GPW presents for an interview with you. Consider the following two scenarios:

Scenario 1: Dr GPW is quite open about his past history. He speaks about his recovery and why he feels he is ready to start work.

Scenario 2: Dr GPW does not divulge any details of his past history. He says simply that he has had a 'health problem', has taken time off because of it, has now fully recovered and is ready to start work again. He points out that prior to leaving practice he was a very capable and respected GP.

Questions for each scenario

Do you have any concerns?

What questions do you have for Dr GPW?

You decide to give Dr GPW the job. What will be the terms of engagement? What supports will be provided for him in the workplace?

Case 5 – Dr GPX

Dr GPX is a young GP who has been diagnosed with multiple sclerosis (MS). To date, she has been managing at work although she has been taking a few days off here and there because she tires easily. Because her condition has been deteriorating, she now takes six months' leave from the practice for 'personal reasons'. The practice does not know that she has MS and that the time off is to undergo a new treatment. The six months extends to nine months. The treatment is not successful and Dr GPX now also has difficulty walking (weakness in one leg). Dr GPX would like to return to work but she is apprehensive.

Questions

What are the issues for Dr GPX?

What are the issues for the practice?

What is required for the return to work plan to be successful? Who can assist with this plan?

Case 6 – Dr GPY

Dr GPY's registration has been suspended for 12 months because of inappropriate narcotic prescribing. He was working as a solo GP in a country town but because that work was very stressful, he decided that he would be better off working in a group practice with more 'sensible' hours. His suspension is due to finish in two months' time and he applies for a job at your practice.

Questions (as the prospective employer)

What are your concerns?

What questions do you have for Dr GPY?

You decide to give Dr GPY the job. What will be the terms of engagement? What supports will be provided for him in the workplace?

Consider this alternative scenario: Dr GPY had been deregistered for professional misconduct and has been away from practice for eight years. He has recently applied for re-registration, and AHPRA has imposed high-level restrictions on his practice. He applies to work at your practice.

Questions (as the prospective employer)

What are your concerns?

What questions do you have for Dr GPY?

You decide to give Dr GPY the job. What will be the terms of engagement? What supports will be provided for him in the workplace?

Case 7 – Dr GPZ

Dr GPZ was recently assaulted in the waiting room of the clinic that she worked at by a patient high on drugs. The assault was unprovoked and random. Fortunately, she did not sustain any serious physical injuries; however, she was mentally traumatised. She takes a period of time off work and consults a psychologist.

Questions

If you were Dr GPZ, how would you be feeling?

Apart from the psychologist, what else would be helpful for Dr GPZ? How should she prepare for her return to work?

How should the practice manage her return to work?

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