

Re-entry residency training

Opportunities and obstacles

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ABSTRACT

OBJECTIVE To identify and quantify the reasons general practitioners and family physicians consider retraining and their reasons for not pursuing further training.

DESIGN Population-based mailed survey.

SETTING British Columbia.

PARTICIPANTS Family physicians and general practitioners identified by the College of Physicians and Surgeons of British Columbia.

MAIN OUTCOME MEASURES Practising physicians' level of awareness of the University of British Columbia's re-entry training program, the number and demographic characteristics of those who had considered retraining, their specialties of interest, and the barriers and possible inducements to retraining.

RESULTS Only half of the survey respondents were aware of the re-entry training program at the University of British Columbia. A small but substantial number of practising general practitioners and family physicians were interested in taking specialty training from the Royal College of Physicians and Surgeons of Canada. While several training programs were particularly popular (ie, anesthesia and psychiatry—18.5% of respondents for each), almost every specialty training program was mentioned. Physicians identified the length and hours of training, financial issues, family issues, and the need for relocation as obstacles to retraining. The availability of part-time training, regional training, and return-of-service financial assistance were all identified as potential inducements.

CONCLUSION To meet the needs of practising physicians, re-entry training programs will need to consider flexibility, where feasible, with regard to choice of specialty, intensity, and location of postgraduate training.

EDITOR'S KEY POINTS

- There is much speculation but little information about practising physicians' level of interest in returning to specialty training (re-entry).
- This study surveyed primary care physicians to assess their level of interest in retraining and to identify barriers to pursuing further residency education in British Columbia.
- Among the reasons for respondents' interest in retraining in specialties were burnout in current practice and a desire for more predictable working hours. Duration of the program was the most important reason physicians found returning to training difficult.
- This survey demonstrates that certain specialties are more appealing to physicians after a period of practice.

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Retour en résidence pour une formation

Possibilités et obstacles

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RÉSUMÉ

OBJECTIF Identifier et quantifier les raisons pour lesquelles les omnipraticiens et les médecins de famille envisagent de retourner en formation, et les raisons pour lesquelles ils abandonnent ce projet.

TYPE D'ÉTUDE Enquête postale de type démographique.

CONTEXTE La Colombie-Britannique.

PARTICIPANTS Médecins de famille et omnipraticiens identifiés par le Collège des médecins et chirurgiens de la Colombie-Britannique.

PRINCIPAUX PARAMÈTRES À L'ÉTUDE Niveau de connaissance des médecins en pratique sur le programme de retour en formation de l'Université de la Colombie-Britannique, nombre et caractéristiques démographiques de ceux qui avaient envisagé une nouvelle formation, leur spécialité d'intérêt, et les obstacles et éventuels incitatifs à ce projet.

RÉSULTATS Seulement la moitié des répondants connaissaient le programme de retour en formation de l'université de la Colombie-Britannique. Un nombre faible mais non négligeable d'omnipraticiens et de médecins de famille étaient intéressés à prendre une formation de spécialiste du Collège royal des médecins et chirurgiens du Canada. Alors que plusieurs des programmes de formation étaient particulièrement populaires (notamment l'anesthésie et la psychiatrie - 18,5% des répondants pour chacune), presque tous les programmes de formation étaient mentionnés. Selon les médecins, les obstacles au retour en formation étaient la durée et les heures de la formation, les questions financières ou familiales et la nécessité de déménager. La disponibilité d'une formation à temps partiel ou en région et un support financier en retour de service étaient considérés comme des incitatifs potentiels.

CONCLUSION Afin de répondre aux besoins des médecins en pratique, les programmes de retour en formation devront autant que possible être plus souples quant au choix de la spécialité, et à l'intensité et l'endroit de ce type de formation

POINTS DE REPÈRE DU RÉDACTEUR

- Il y a beaucoup de présomptions mais peu d'information concernant le niveau d'intérêt des médecins en pratique pour retourner se spécialiser (retour en formation).
- Au moyen d'une enquête, cette étude voulait évaluer le niveau d'intérêt des médecins de première ligne pour une nouvelle formation et identifier les facteurs qui les empêchent de compléter leur résidence en Colombie-Britannique.
- Les raisons pour lesquelles les répondants envisageaient une formation en spécialité comprenaient l'épuisement professionnel dans leur pratique actuelle et le désir d'avoir des heures de travail plus prévisibles. La principale raison pour laquelle les médecins trouvaient difficile de retourner en formation était la durée des programmes.
- Cette étude montre que certaines spécialités sont plus attrayantes pour le médecin après un certain temps de pratique.

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Before 1994, a common pattern for graduates of Canadian medical schools was to complete a 1-year rotating internship and receive a general licence. This licence allowed the physician to work in general practice, work as a locum, or continue on in specialty training. Over time, some general practitioners returned to postgraduate training and gained specialist qualification from the Royal College of Physicians and Surgeons of Canada (RCPSC). Several specialty programs, among them anesthesia, community medicine, and psychiatry, traditionally received many of their applicants from this mature pool of practising physicians.¹

In 1994 the rotating internship was eliminated as a single-year route to general licensure. Residents have an educational licence throughout their training and receive a full license, in the area of expertise, only upon certification in their field. Given the requirement to complete a full residency to be eligible for licensure, students are required to make a firm decision regarding their future careers in the final year of medical school, through the Canadian Residency Matching Service.

At the same time, the routine path of re-entry to training programs ended, largely because the overall number of postgraduate positions was filled by the number of graduating medical students, who now required a minimum of 2 years of training. Re-entry trainees as a percentage of the total exit cohort from RCPSC specialty programs decreased from 25% in 1992 to 1993² to 6% in 2004 to 2005.³

Students, medical school faculties, and practising physicians have expressed concern about the timing of career choice decisions, which now occurs during or before the final year of medical school. Another concern is the loss of flexibility for further training later in a physician's career.^{1,4-7}

There is much speculation but little specific information about practising physicians' level of interest in returning to specialty training (ie, re-entry). A survey of Saskatchewan physicians showed that 43% had changed their fields of training or practice at some time since graduation.⁸ A cohort study of Ontario physicians found that 8 to 10 years following Certification in family medicine, 8% of them had entered specialties and 12% had restricted their practices to such areas as sports medicine, emergency medicine, and geriatrics.⁹ The results of the 2004 National Physician Survey showed that approximately 4.2% of practising family physicians retrained in an area of specialized medical practice in the 2 years before the survey and a similar number of physicians planned to do so in the next 2 years.¹⁰

In 2001 the Faculty of Medicine at the University of British Columbia (UBC) in Vancouver created re-entry positions. There was anecdotal interest in these positions; however, applications and admissions to the program were limited.

The current survey of family physicians and general practitioners was used to assess the level of interest in re-training and to identify the barriers to continuing further education in British Columbia (BC). Our working model was that there is substantial interest within the medical community for re-entry residency education but that a number of obstacles exist, limiting pursuit of this interest.

METHODS

In 2003 a survey was conducted of all primary care physicians (ie, family physicians and general practitioners) in BC. The questionnaire was developed by the authors and reviewed by a sample of physicians in the target population before it was finalized. The overall study received approval from the UBC Behavioural Ethics Review Board.

Primary care physicians were identified by the College of Physicians and Surgeons of British Columbia as those with full registration, living in BC, and having either a Certification in Family Medicine from the College of Family Physicians of Canada or no RCPSC specialty designation. A postal questionnaire and a self-addressed return envelope were sent to each of the 4441 identified physicians. A reminder postcard and follow-up questionnaire were sent at 3 and 6 weeks, respectively.

All respondents completed demographic information and indicated previous knowledge of or interest in re-entry training. Those with current or past interest in retraining were asked additional questions regarding specialty interests and reasons for and against pursuing additional training. The questionnaire included a list of possible impediments and inducements to retraining, specifically related to those factors that could be directly changed by the postgraduate program. Open-ended responses, however, were encouraged.

Data were analyzed using SPSS versions 12 and 17. Multiple-response tables and descriptive statistics were generated. Likert scales were analyzed as continuous variables and compared using ANOVA (analysis of variance). Cross-tabulations (χ^2) were used to measure associations between categorical variables.

RESULTS

Response rate

There were 2450 responses (55%) received; 2278 of them were included in the analysis. Responses from physicians who were retired or currently in training or practising in RCPSC specialties were excluded. Respondents were similar to the total group of eligible physicians in BC in terms of age and place of undergraduate training (Table 1). Women were slightly overrepresented. Practice

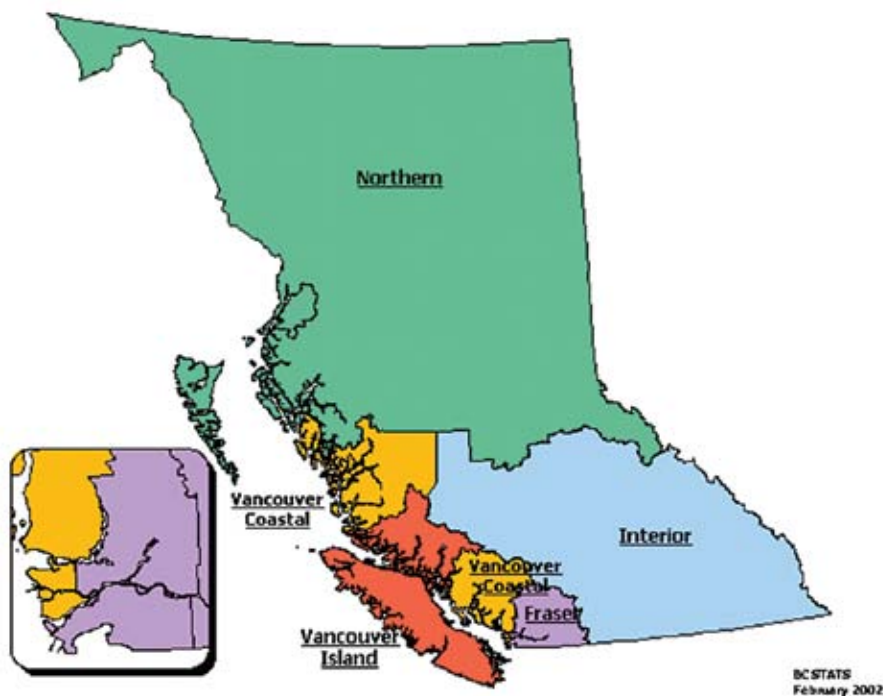
Table 1. Characteristics of respondents

CHARACTERISTICS	RESPONDENTS, % (N) N=2278	MAILING LIST, % (N) N=4441	99% CONFIDENCE INTERVAL
Sex			
• Male	63.9 (1455)	66.7 (2963)	61.3-66.5
• Female	35.4 (806)	33.3 (1478)	32.8-38.0
• Not stated	0.7 (17)	0	NA
Age, y*			
• <30	0.8 (18)	1.2 (54)	0.3-1.7
• 30-34	6.8 (155)	6.8 (304)	5.4-8.2
• 35-39	13.1 (299)	13.3 (590)	11.3-15.1
• 40-44	17.5 (398)	17.7 (788)	15.4-19.8
• 45-49	19.2 (438)	17.5 (775)	17.1-19.6
• 50-54	16.8 (382)	15.7 (699)	14.7-17.8
• ≥55	25.5 (581)	27.7 (1231)	23.1-30.1
• Not stated	0.3 (7)	0	NA
Location of undergraduate training			
• University of British Columbia	36.3 (826)	33.9 (1505)	33.6-36.6
• Canada	42.4 (966)	44.5 (1977)	39.7-47.2
• Outside Canada	21.1 (481)	21.6 (959)	18.4-24.3
• Not stated	0.2 (5)	0	NA
Practice location (by health authority)*			
• Vancouver Coastal	30.7 (699)	32.4 (1440)	28.1-35.0
• Fraser	19.9 (453)	25.4 (1129)	17.3-28.0
• Vancouver Island	21.4 (488)	21.0 (933)	18.9-23.6
• Northern	6.4 (146)	5.8 (258)	3.9-8.4
• Interior	17.3 (395)	15.2 (676)	14.8-17.8
• Not stated or other	4.3 (97)	0.1 (5)	NA

NA—not applicable.

*Responses in the Mailing List column of this category do not add to 100% owing to rounding.

Figure 1. British Columbia health authorities



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location (BC health authorities [Figure 1]) was similar to the whole group, although response rate was proportionately lower in the more urban Vancouver Coastal and Fraser health authorities and proportionately higher in the Northern and Interior health authorities.

Interest in retraining

Fewer than half of the respondents (n=1056, 46%) had previous knowledge of the re-entry training program at UBC. Those in the Northern and Interior health authorities were more likely to have heard of the program ($\chi^2_6 = 79.7, P \leq .001$). Almost 40% (n=891) had considered or were considering retraining. This increased to 62% for those younger than 40 years of age. Physicians who had completed residency programs in family medicine were more likely to have considered retraining (42% vs 38%; $\chi^2_1 = 4.45, P = .035$), but this difference disappeared when adjusted for age.

Table 2 shows the specialties most frequently identified by respondents as desired programs for retraining, and almost every specialty is mentioned. While those specialties provided on the list were selected most frequently, several specialties that were not listed (ie, emergency medicine, dermatology, and plastic surgery) were volunteered by respondents.

Table 2. Specialties identified by respondents as desired programs for retraining: Respondents were asked to identify specialties of interest from a list of general programs with space to indicate subspecialty interests.

SPECIALTY	TOTAL RESPONSES* (N = 1715)	% OF RESPONSES†	% OF RESPONDENTS (N = 965)
Anesthesia	179	10.4	18.5
Psychiatry	179	10.4	18.5
General internal medicine	144	8.4	14.9
Radiology	143	8.3	14.8
Public health and community medicine	131	7.6	13.6
Obstetrics and gynecology	121	7.1	12.5
General surgery	104	6.1	10.8
Emergency medicine‡	95	5.5	9.8
Ophthalmology	78	4.5	8.1
Orthopedics	75	4.4	7.8
Dermatology‡	74	4.3	7.7
Pathology	65	3.8	6.7
General pediatrics	52	3.0	5.4
Plastic surgery‡	42	2.4	4.4
All others	233	13.6	24.1

*Multiple responses allowed.

†Percentage of responses does not add to 100% owing to rounding.

‡Response was handwritten.

Aside from “interest in the topic,” the most common reasons given for retraining were burnout and boredom in current practice (28% and 29%, respectively), to increase earning power (22%), to fill a need in the community (22%), a “lifestyle” change (18%), or because the wrong career choice had been made initially (11%). The most common reasons to retrain were for “better” or “more regular” hours and decreased on-call commitments. A small number of respondents (around 3%) had specialty qualifications in other countries, but these qualifications were not recognized in Canada.

Likert scales (1 = did not influence my decision; 5 = very significant impact on my decision) were used to indicate the reasons for not pursuing additional training (Table 3). While the single most important reason respondents found returning to practice difficult was the duration of the program, the following respondent statements reflect how a combination of factors affected their decisions to retrain:

To move my family to the city and starve while I trained and then move them again—it just asked too much of them.

With young children I realized I could not consider retraining that would more than likely involve significantly longer hours.

Table 3. Respondents' reasons for not pursuing additional training: Respondents indicated to what extent they were influenced by each factor on a 5-point Likert scale (1 = did not influence my decision; 5 = very significant impact on my decision).

REASON	MEAN	95% CONFIDENCE INTERVAL
Duration of training	3.76	3.68-3.84
Family issues	3.64	3.55-3.73
Hours involved	3.59	3.51-3.67
Financial issues during residency	3.59	3.50-3.68
Need for relocation	3.08	2.98-3.18
Concern about being in a trainee position	2.78	2.69-2.87
Uncertainty about new practice opportunities	2.36	2.28-2.44

The same Likert scales were used to identify measures that would make the retraining program more attractive. Of the possible inducements listed in the survey, the availability of part-time training was the most attractive (Table 4). This was particularly so for women (mean 4.30, F = 12.9, P ≤ .001). Regional training was most attractive to respondents in the Vancouver Island and Interior health authorities.

Table 4. Factors that make a retraining program more attractive, as indicated by respondents: Respondents indicated to what extent each factor made a retraining program more attractive on a 5-point Likert scale (1 = did not influence my decision; 5 = very significant impact on my decision).

FACTORS	MEAN	95% CONFIDENCE INTERVAL
Availability of part-time training	4.04	3.96-4.12
Return-of-service financial package	3.71	3.62-3.80
Ability to train in regional centres	3.63	3.54-3.72

DISCUSSION

More than half of the target group of primary care physicians responded to this survey, with many providing additional comments and even letters and telephone calls to express their opinions. A number of these individuals who were directly affected by the changes to licensure and training that occurred in the early 1990s expressed frustration at having the “door closed” without warning. This might partially explain the increased interest in retraining expressed by physicians younger than 40 years of age. It is probable that this group of disenfranchised physicians is overrepresented in our sample despite the similar age group mix. Certainly those who were able to undertake re-entry training in an RCPSC specialty, in Canada or elsewhere, have been specifically excluded.

While many physicians report that they have been or currently are interested in retraining, the re-entry program offered by UBC since 2001 is not well known. Further, while most of the current re-entry positions at UBC have been designated for general surgery and internal medicine, together these specialties account for only 15% of the interest based on the responses. There has been consistent but modest interest in internal medicine but little uptake for re-entry training in general surgery. Other re-entry programs have identified a number of “preferred specialties” but do not limit applicants to these selections.

Practising physicians in our survey were interested in a wide variety of specialty programs. Respondents listed almost all of the approximately 60 possible RCPSC specialty programs, several of which are offered as specific enhanced skills or as a certificate of special competence through the College of Family Physicians of Canada. The RCPSC specialties of particular interest were similar to those identified by Ryten et al as those which have been “dependent on career choices made only after 1 or more years of post-MD training.”¹ Several of these specialty training programs such as anesthesia and diagnostic radiology are already largely filled by the current year graduating classes. However, other specialties highly

rated by practising physicians, such as psychiatry, community medicine, and the laboratory-based specialties, had more than 15% of their first-year resident positions vacant after the first iteration of the Canadian Residency Matching Service match in 2005.¹¹ The sole re-entry position in community medicine at UBC has been filled consistently each year. Professional associations in both laboratory medicine and psychiatry have suggested re-entry training as a potential solution to physician shortages in these specialties.¹²⁻¹⁴

Respondents had numerous reasons for wishing to retrain. In some cases, they indicated that their current scope of practice included or was limited to a specialty area and retraining would allow them to obtain proficiency and gain recognition for their expertise. Almost 30% of those who considered retraining in a specialty indicated that they were burned out in their current practice, and many respondents referred to a desire for more regular or predictable working hours. It is not surprising then that 4 of the top 5 specialty choices are among those designated as “controllable lifestyle” specialties by Schwartz et al.^{15,16} However, the anticipated long hours during residency training required to become qualified in one of these specialties is a limiting factor for some physicians. The availability of part-time training is particularly important to female physicians, which might be owing to family commitments.

Financial considerations presented both incentives and obstacles to training. Nearly a quarter of respondents identified financial considerations as an important incentive for retraining, while the loss of income during residency training posed some concern. Relocation to Vancouver for specialty training would pose financial and other family-related hardships. Return-of-service financial packages that augment the training salary seem attractive to some physicians but have the potential of creating 2 tiers of residents. Other forms of financial assistance such as relocation assistance or locum coverage for existing practices were also suggested.


Survey respondents expressed concerns that the current system forced early career decision making, explaining how this affected both the individuals and the health care system. Physicians with practice experience bring knowledge and insight that are a benefit to the residency program and to their future practices.

Although some physicians expressed concerns that re-entry training would further reduce the number of family physicians, others believed that if re-entry training were more commonplace, new medical graduates might not be averse to “trying” family medicine. Ten percent of those interested in retraining stated that they had made the wrong initial career choice. Our findings suggest that physicians who have completed residency programs in family medicine are at least as likely to consider retraining as those who have not completed such programs; this finding corroborates Woodward

and colleagues' conclusion: "Receiving certification in family medicine does not guarantee that physicians will remain in family practice 8 to 10 years later."⁹ Without opportunities to change career paths, these individuals and those who are either bored or burned out in their current practices might choose to leave the health care system altogether.

Since the initiation of our survey, the federal, provincial, and territorial governments, in association with the Canadian medical community, have been developing a comprehensive strategy to address physician human resources, recognizing a need for enhanced re-entry training capacity. The Task Force Two report suggests that the loss of re-entry positions might have limited the number of new graduates entering family practice and anticipates that increased flexibility in retraining will have a positive effect on the specialty mix in the medical work force by reducing enforced early career decision making.¹⁷

Conclusion

A small but substantial number of practising primary care physicians in BC would like opportunities to re-enter postgraduate training. Some physicians are unaware of the current re-entry programs and the opportunities for part-time training. Their interests are diverse; however, this survey supports the argument that certain specialties are more appealing to physicians after a period of practice. Re-entry positions might offer opportunities and flexibility to match the professional development needs of individual physicians with the physician resource needs of the province. This survey shows that the success of a re-entry program will depend on careful attention to many of the issues and concerns of primary care physicians who might be candidates for the program. 

Dr Jamieson is a Clinical Assistant Professor in the Department of Family Practice, **Dr Webber** is an Associate Professor in the Department of Surgery and Assistant Dean of Postgraduate Medical Education in the Faculty of Medicine, and **Dr Sivertz** is a Clinical Professor in the Department of Psychiatry and Executive Associate Dean of Education in the Faculty of Medicine, all at the University of British Columbia in Vancouver.

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Contributors

All authors participated in the research design and development of the survey instrument. **Dr Jamieson** directed data collection and statistical analysis and all authors participated actively in the data interpretation and manuscript preparation. All authors have approved the final manuscript for submission.

Competing interests

None declared

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