REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 10 - A-03

Subject: Maintenance of Certification - Ethical Dimensions

Presented by: Leonard J. Morse, MD, Chair

At the 2002 Annual Meeting, the House of Delegates adopted Council on Medical Education (CME) Report 7-A-02, "Internal Medicine Board Certification Report – Interim Report." This report responded to several resolutions addressing recertification. Among its recommendations, the report called for a study of the ethical implications of the Maintenance of Certification (MoC) program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. This directive to take action has been referred to the Council on Ethical and Judicial Affairs (CEJA).

BACKGROUND

As the CME report describes, the "Maintenance of Certification" (MoC) concept is supported by the American Board of Medical Specialties (ABMS) through its commitment to the assessment of continuing competencies of physicians. It includes four basic components: evidence of professional standing; evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process; evidence of cognitive expertise; and evidence of evaluation of performance in practice.

However, the CME report focused on the American Board of Internal Medicine (ABIM), which had taken a lead in developing comprehensive approaches to the evaluation of physician performance, as part of Continuous Professional Development (CPD). It is within this framework that patient and peer assessment was identified as an important modality to obtain feedback on non-technical aspects of competence, such as communication skills and humanistic or professional aptitudes. However, among reactions to the ABIM efforts to implement CPD, the CME report noted that concerns had been raised that patient and peer feedback could be perceived as intrusive and potentially inappropriate.

ETHICAL CONSIDERATIONS

Relevant ethical policies

In exploring the professional and ethical concerns that may arise from the innovative evaluation tools being developed in the context of MoC, it is worth turning to the *Principles of Medical Ethics* for guidance. Three principles, in particular, should be considered:

I. A physician shall be dedicated to providing competent medical care…

II. A physician shall uphold the standards of professionalism…

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V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education…

Together, these statements are a clear expression of physicians' commitment to competency and education (Principles I and V), but also recognize that these responsibilities are embodied through the medical profession as a whole (Principle II), and not solely through individual physicians.

Other than these broad statements, the *Code of Medical Ethics* considers education and professional development through several opinions. For example, Opinion E-9.011, "Continuing Medical Education" emphasizes the value of furthering one's education throughout one's career. Specifically, it states: "…for only by participating in continuing medical education (CME) can [physicians] continue to serve patients to the best of their abilities and live up to professional standards of excellence." The *Code*, however, does acknowledge that matters related to education can be distorted or undermined. In this regard, Opinion E-9.01, "Accreditation," warns that "Physicians who… certify the attainment of specialized professional competence have the ethical responsibility to apply standards that are relevant, fair, reasonable, and non-discriminatory."

Some form of peer assessment is also addressed in Opinion E-9.10, "Peer Review." This opinion recognizes that the oversight of professional conduct compromises professional freedom but that it serves to "balance a physician's right to exercise medical judgement freely with the obligation to do so wisely and temperately."

It also is worth noting that the role of patients in education was recently included in the *Code* in explicit terms. Opinion E-10.02, "Patient Responsibilities," was amended in December 2000 to include the following guideline: "Participation in medical education is to the mutual benefit of patients and the health care system. Patients are encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees."

Potential ethical concerns arising from peer and patient assessment

Peer assessment

Throughout medical education and training, students and trainees are most often evaluated by teachers and supervisors, rather than peers, although such evaluation methods do exist in some educational settings. Once a physician has fulfilled all the formal requirements of training, however, his or her practice may come under the review of peers more frequently. There are various established traditions of peer review, which the Council recently acknowledged constituted the basis of endeavors to improve care and the dissemination of knowledge.[1] The Council also noted that peer review has been used as a tool to evaluate the competence of individual doctors by examining the appropriateness of care. In this context, concerns have been raised that peer review can be misused. This has led to the establishment of explicit expectation that peer review be conducted fairly and in good faith, and that appropriate safeguards be in place to protect all parties involved from punishment or unjustified recriminations.

Interestingly, there is a long-standing informal practice of implicitly evaluating colleagues' performance by either referring patients to them or not.[2] In the words of one sociologist: "If a

practitioner is dissatisfied with another's work, and talking to him does not lead to desired changes in his behavior […] the tendency is not to try to change [the practioner's] performance so much as to avoid choosing him to work with, and keeping one's own patients away from him."

Because peer assessment in the context of CPD is part of a structured approach to evaluate performance, it is appropriate to consider it in relation to concerns that generally have been raised regarding formal peer review. Foremost, peer assessment should be fair. Yet, because many components of the questionnaire do not lend themselves to an objective evaluation (e.g. respect, integrity, compassion, etc), it is difficult to ensure the fairness of an evaluation that uses a point scale. As peer assessment evolves, it would be important to identify the characteristics of optimal performance for each components of an evaluation.

For the time being, when the assessment of a physician's conduct varies considerably among the assessors, reliability of the results may be problematic. Indeed, it will be difficult to determine whether assessors are reporting a physician whose performance varies in quality, or whether the variation represents differing perceptions. In the absence of objective measures, uniform assessments also could be problematic. For example, low or poor assessments could reflect an environment that is highly competitive or plagued by rivalry, whereas high assessments could reflect an environment that is collegial, supportive, and where criticism is limited.

Aside from the objectiveness and reliability of the assessment, it can be expected that physicians will be concerned about its confidentiality. Any entity that institutes a form of peer review must be able to anticipate which other parties may be interested in the results, which of them have the authority to demand the results, or with which it is appropriate to share results. Next, such information must be shared with the physicians who undergo the review or assessment prior to it taking place.

Finally, it must be recognized that through the assessment of physicians' competencies, poor performances will be identified. Therefore, before a program of assessment is undertaken, it must be clear how such results will be addressed. Assessments intended to be formative, whereby feedback is provided to a physician but no remedial action is required, differ significantly from assessments that are summative, whereby a physician's low performance would require remedial action or result in sanction (i.e. de-certification). Boards should recognize that if poor assessments do not lead to any intervention, it could be argued that they are failing to ensure the competencies of specialists, which in turn could undermine public trust.

Also, it will be important for boards to make clear that peer assessment, as part of CPD, is not a substitute for other mechanisms that exist to report physicians who are incompetent. (See Opinion E-9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues") Therefore, in anticipation that assessors may become aware of conduct that jeopardizes the health and welfare of patients at the time they conduct assessments, they should be informed of mechanisms that exist to bring such matters to appropriate authorities responsible for the protection of patients notified.

Patient assessment

Innovative evaluation methods that involve patients, such as evaluation of students' or trainees' professionalism, are being introduced in some educational settings. Specialty boards should rely

on knowledge that arises from this sphere to inform their efforts. However, until more research is completed to assess the impact of these innovations, boards should remain mindful that, whenever the patient-physician relationship is expanded beyond the therapeutic alliance, prudence must prevail. Also, patient assessment should not be a determining factor in the re-certification process until the reliability, reproducibility and validity of such information has been established.

Above all, there must be a clear understanding on the part of the patient that the request has no bearing on the therapeutic alliance. This entails that the patient must be capable of appreciating the nature of the request. However, the CME report and many other sources that describe the current health care environment point to a significant proportion of patients with limited literacy skills. Along the same vein, many patients have limited English skills, and may not understand the exact nature of the survey, or may not understand the specific questions. A similar concern related to the impact on the therapeutic relationship arises in the context of patients who are very ill, frail, or distraught.

Beyond concerns related to the potential impact on the therapeutic relationship, it is important to recognize that patients with limited access to health care may have only sporadic interaction with physicians and may not be asked to participate in assessments. Altogether, the sample of patient assessors is likely to represent a segment of the physician's patient population that is literate, fluent in English, insured, and relatively healthy. Other potential biases may surface, for example on the basis of cultural or ethnic differences, and should be the object of comprehensive study.

Having identified a patient who is capable to participate, it remains very important not to unduly influence a patient to participate. Ensuring voluntariness, however, may not be as simple as making a request. Indeed, without some additional explanation, patients may misunderstand the nature of the survey. It is possible that some patients may fear that a refusal to participate could have future repercussions on their care. Patients who would accept to participate under such circumstances would most likely rate their physicians more favorably than if they understood the true purpose of the assessment. To limit the possibility that a patient may feel "pressured" to participate, it would be preferable that the request to complete a survey not be made directly by the physician, but rather by a nurse, other office staff, or an independent third party. The requester should emphasize that participation is voluntary, and should clearly present the assessment as a tool intended to assist physicians to better understand how they are perceived by their patients, and possibly improve their performance.

As with peer assessment, the confidentiality of the patient assessment process must be protected. However, it too may not be absolute, and patients should be informed of possible disclosures, even though this may affect their evaluations.

Finally, if patients do not understand the educational nature of the assessment, but rather believe it may be used by disciplinary bodies, they may expect an intervention to take place if they rate a physician very poorly. Trust could be severely undermined if a returning patient who had expected an intervention finds the physician's manners unchanged. This risk adds to the importance of clearly explaining the nature of the assessment and differentiating it from other mechanisms that exist to report misconduct or perceived negligence.

CONCLUSION

Professionalism demands that physicians remain competent. In this context, the American Board of Internal Medicine's Continuous Professional Development initiative presents itself as an innovative attempt to evaluate all dimensions of a physician's practice. Moreover, the use of patient and physician assessment represents an evaluation method that may provide physicians with valuable information, although its impact has only begun to be studied. Therefore, it is important that specialty boards develop such tools carefully, in light of the potential ethical concerns they could raise.

In particular, it will be important to strive for objectivity and fairness. Before peer and patient assessments are used as determining factors for purposes of re-certification, their reliability, reproducibility and validity should be established. In particular, it will be important to identify specific characteristics that describe the expected or optimal performance for each component of an evaluation. Moreover, in the context of patient assessment, it will be important to study whether biases toward certain groups of patients (literate, proficient in English, insured, relatively healthy) affect the results.

With regards to results, specialty boards will need to specify explicitly and in advance how they will be used (e.g. whether remedial actions or sanctions may be imposed), and be prepared to address instances where an assessment reveals conduct that places patients at risk of harm. Although such outcomes should be rare, they are likely to raise the greatest ethical challenges, and underscore the importance of protecting the confidentiality of the assessment.

Finally, specialty boards should recognize that the role of patient as assessor could impact the therapeutic alliance. Research should be conducted early to evaluate whether patients understand the nature of the assessment and whether their participation is truly voluntary.

REFERENCES

[1] CEJA Report, Ethical Responsibility to Study and Prevent Error and Harm in the Provision of Health Care [verify final title of this report]
[2] Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge. 1970.

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