**HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed**.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-09)
Remediation Programs for Physicians
(Reference Committee C)

EXECUTIVE SUMMARY

This report will discuss processes to address identified gaps in post-license physician remediation with regard to knowledge and skills. Specifically, the report will: 1) discuss the need to enhance opportunities for physician remediation; 2) define remediation and related terms; 3) present relevant AMA policy; 4) discuss the process of physician regulation related to remediation; 5) discuss methods of evaluating gaps in physician knowledge and skill including remediation and assessment programs; 6) present ways to avoid remediation; 7) present areas for further consideration; and 8) offer recommendations.

The increased demand by the public for the medical profession to demonstrate that physicians are maintaining and advancing knowledge and skills and by extension, providing quality patient care, has drawn attention toward the verification process by which physicians are deemed competent. Reports such as the Institute of Medicine's 1999 report entitled *To Err is Human: Building a Safer Health System*, has placed issues such as patient safety, physician accountability and physician competence at the forefront of public concern. However, there are limited programs and processes to support remediation of physicians' knowledge and skill deficits, and a lack of standardization of existing programs. There also are many barriers to physicians attending remediation programs, including access, cost, and lack of information about the availability of programs.

This report recommends that our AMA: 1) support the efforts of the Federation of State Medical Boards to maintain an accessible national database on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level; 2) collaborate with other appropriate organizations, such as the Federation of State Medical Boards and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care; 3) support efforts to remove barriers to assessment programs including cost and accessibility to physicians; 4) partner with the Federation of State Medical Boards and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills; 5) ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would require medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that would lead to later knowledge and skill deficits in practicing physicians.

**HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed**.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-09

Subject: Remediation Programs for Physicians

Presented by: Claudette Dalton, MD, Chair

Referred to: Reference Committee C
(Rodney G. Hood, MD, Chair)

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INTRODUCTION

In 2005, the American Medical Association launched the Initiative to Transform Medical Education (ITME), which aims to: "Promote excellence in patient care by implementing reform in the medical education and training system across the continuum, from premedical preparation and medical school admission through continuing physician professional development."[1] In its first two phases, ITME identified existing strengths, gaps and opportunities for improvement in physician preparation (2005-2006) and developed recommendations for change in the system of medical education to address the gaps which were identified (2006-2007). Now in its third phase (2007-2010), focused strategies for change in selected priority areas are being developed. Based on the gaps identified in phase 2, ITME made 10 recommendations for change in the system of medical education. ITME's second recommendation states: "Consider creating alternatives to the current sequence of medical education continuum, including introducing options so that physicians can re-enter or modify their practice."[1]

As a means to plan for implementation of Recommendation 2, the Council on Medical Education (CME) convened a task force to further discuss physician reentry, remediation, and retraining. As a result, in 2008, CME Report 6-A-08 on physician reentry was adopted at the AMA House of Delegates (HOD). This report will discuss the issue of physician remediation, and a report on physician retraining and a follow-up report on physician reentry will follow for the 2009 Interim Meeting.

SCOPE OF THIS REPORT

This report will discuss processes to address identified gaps in post-license physician remediation with regard to knowledge and skills. The scope of the report has been conceptualized in this way for two reasons: 1) physicians who are disciplined due to knowledge and skill deficits have received less attention that those who are disciplined for reasons of impairment such as substance abuse and 2) issues related to gaps in physician knowledge and skills are most appropriately addressed through the system of medical education.

It is important to note that the Council on Medical Education acknowledges the public's concern for patient safety and reduced quality of care which result from physician impairment. Vigilance by regulatory bodies, such as state medical licensing boards or hospital disciplinary committees in disciplining physicians who are impaired due to drugs or alcohol, boundary issues, psychological or psychiatric issues, or disruptive behavior must be strong. There is a relatively long history of

"informal and formal efforts to deal with physician impairment exist[ing] as far back as 1958," however, including policy of the AMA.2 In 1973, the AMA Council on Mental Health issued a landmark report on this topic entitled, The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism, and Drug Dependence.[3]

For the purposes of this report, remediation is defined as: *The process whereby deficiencies in physician performance identified through an assessment system are corrected* (CME Report 6-A-08). (See Appendix 1 for a list of terms and definitions.) Specifically, the report will: 1) discuss the need to enhance opportunities for physician remediation; 2) define remediation and related terms; 3) present relevant AMA policy; 4) discuss the process of physician regulation related to remediation; 5) discuss methods of evaluating gaps in physician knowledge and skill including remediation and assessment programs; 6) present ways to avoid remediation; 7) present areas for further consideration; and 8) offer recommendations.

## SCOPE OF THE ISSUE

The increased demand by the public for the medical profession to demonstrate that physicians are maintaining and advancing knowledge and skills and by extension, providing quality patient care, has drawn attention toward the verification process by which physicians are deemed competent. Reports such as the Institute of Medicine's 1999 report entitled *To Err is Human: Building a Safer Health System*, has placed issues such as patient safety, physician accountability, and physician competence at the forefront of public concern.[4] As a result, there is growing support for improving the ways in which physicians are currently evaluated on their ability to provide quality patient care. A 2003 Gallup survey commissioned by the American Board of Internal Medicine illustrates this point.[5] The study findings show that 73 percent of the 1001 respondents were in favor of "physicians being re-evaluated on their qualifications every so many years."[5] Another study found that 87% of respondents were in favor of periodic reevaluation of physicians' qualifications.[5] It follows therefore, that identified deficits will need to be "remediated" and the process through which remediation occurs needs further attention.

There are many reasons a physician may need remediation related to knowledge and skills, including practicing in an isolated area, cognitive decline, solo practice, lack of access to continuing medical education (CME) resources, and system-level factors including lack of adequate monitoring. Estimating physicians in need of remediation is difficult for a variety of reasons including differences in the initial concept that is measured and how that concept is operationalized. One estimate of the level of physician "dyscompetence"--defined as: *A physician who has failed to maintain acceptable practice standards*--is between 6 and 12 percent.[6] Not all these individuals would have reached a level of performance that requires remediation.

## RELEVANT AMA POLICY

Regarding physician competence, the AMA favors continued efforts to improve voluntary continuing medical education programs and to maintain the peer review process within the profession (Policy H-275.996, AMA Policy Database). The AMA urges the members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent (Policy H-275.998).

## REGULATING PHYSICIAN PERFORMANCE

Professional regulation has three main functions: "to provide a system of professional accountability; to ensure that basic standards of care do not fall below acceptable standards; and to promote continuing improvements in quality of care."[7] Self-regulation by physicians has been the standard in the U.S. Poorly performing physicians are primarily identified through a peer-review system. Concerns over medicine's ability to consistently and effectively regulate itself, however, could result in shared responsibility for regulation.[7,8] Currently, physician regulation is under the purview of the state medical licensing boards.

### *State Medical Boards*

Most states have passed medical practice acts to control the costs associated with malpractice claims. These acts guide state medical boards in the process of regulating medicine. State medical boards have the authority and responsibility to remediate (in the form of education or rehabilitation) physicians and when necessary, to remove them from practice. Medical practice acts define conduct that can be sanctioned on a state by state basis. State medical boards have the authority to discipline physicians for a number of reasons including incompetence. There is a four-step process by which state medical boards discipline physicians.[9]

First, physicians with competency problems are brought to the attention of state medical boards through consumer complaints, complaints from family members or friends, complaints from colleagues, malpractice data, and complaints from government agencies and health care institutions. An initial inquiry is conducted and the complaint is either closed, which is the majority of cases, or assigned for further review.

Second, an expert board of investigators reviews the case. If there is enough evidence to support the complaint, then the investigation moves to the third stage.

Third, a formal licensing board or court hearing is conducted where the allegations against the physician must be supported and where the physician must be afforded due process.

Fourth, if the allegations are substantiated, sanctions are delivered. This report deals with sanctions directed at remediating deficits in knowledge and skills.

It is the opinion of the Council on Medical Education that remediation should be a supportive, on-going and proactive process that precludes the need for sanctions whenever possible. Physicians should be allowed to remain in practice as long as patient safety is not endangered. Quality improvement of practice is central, as it is for physicians who have not been sanctioned. Unsuccessful remediation efforts may necessitate limitations in or removal from clinical practice.

### *Malpractice Claims Analyses*

There are multiple ways for malpractice claim analyses to inform the need for remediation. Some state medical practice acts mandate an investigation of physicians with a set numbers of judgments or who have topped a specific amount of rewards. Most hospitals have a process for peer review of any staff member who has a pending or former malpractice claim. Automatic investigation of large awards by the Boards of Medicine are a third way for claims to trigger a review of competency.

*Hospital Peer Review and Credentialing Processes*

Hospitals are required in some states to report physicians with a certain number of identified knowledge or skill concerns. The trigger points for these reports are highly variable and the link between local credentialing and reporting of problems is weak or non-existent in many venues.

EVALUATION METHODS

Once physicians have been identified with knowledge or skill deficits, there are various methods in place to assist in determining the nature of the problem including 1) testing and 2) assessments.[6,10]

*Testing*

The Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) collaborate on the Post-Licensure Assessment System (PLAS). Available through PLAS are two initiatives: the Special Purpose Examination (SPEX) and assessment modalities.

SPEX is a general knowledge test that "provide[s] services for use by medical licensing authorities in assessing a licensed or previously licensed physician's competence to practice medicine." State medical boards can use the SPEX in conjunction with other evidence to determine competence of physicians who have been referred to them. Endorsement of licensure and reinstatement of a license are reasons why physicians may take the SPEX. Physicians seeking reactivation of a license due to time away from practice may also take the SPEX. Reasons for time away from practice are related to both remediation (i.e., disciplinary action) and reentry (e.g., illness). Additional information about SPEX can be accessed online at: http://www.fsmb.org/plas_spexoverview.html

PLAS has also implemented a program aimed at assessing physician competence and highlighted by three assessment modalities: Standardized Testing, Personalized Testing, and Modular Knowledge Tests. A description of the assessment modalities can be accessed at: http://www.fsmb.org/plas_MMCCARcontentdescription.html and http://www.nbme.org/programs-services/practicing-physicians/description.html.

A key aim of PLAS assessment modalities is standardization of physician competency assessments. The assessments cover five areas related to physician competence: 1) medical knowledge; 2) clinical judgment; 3) decision-making; 4) patient management skills; and 5) clinical and communications skills. The assessment protocols aim to meet the needs of health care organizations as well as individual physicians. For example, hospitals, state or territorial licensing boards and healthcare organizations can assess a physician for whom quality of patient care may be an issue. There are also options for physicians who are themselves interested in self-improvement. Reasons why physicians may want to be voluntarily assessed include:

- practicing in an isolated area apart from colleagues;
- reentry to clinical practice after time away from patients;
- retraining due to a career transition such as changing the scope or area of practice;
- concerns about cognitive decline based on aging; and/or
- desire to stay current with new information, diagnostic modalities and procedures.
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The PLAS assessment modalities are available at a number of assessment programs in the U.S.

*Formal Assessments: Physician Assessment Programs*

In general, the main goals of assessment programs are to: 1) identify deficit(s), 2) provide education and training to correct the deficit(s), and 3) assure that physicians are competent to provide safe, quality patient care. Programs offer many educational approaches to remediation including formal continuing medical education (CME). Traditional CME courses developed for the average physician also are often used as resource for physicians needing remediation. Depending on the stipulations set by a state medical licensing board, successful completion of an assessment program may mean that a physician who has been disciplined can return to active clinical practice. While no comprehensive data on assessment and remediation programs exists, the web sites below are offered as resources:

PLAS collaborates or is developing collaborations with seven physician assessment programs across the country. A list of these programs including contact information can be accessed on-line at: http://www.fsmb.org/plas_MMCCARcollaborators.html.

The Coalition for Physician Enhancement (CPE) the mission of which is "to support and develop expertise in assessment and enhancement when competence and performance are to be assessed" also collaborates with physician assessment programs nationwide. CPE is made up of seventeen assessment programs from the U.S. and Canada. A list of these programs including contact information can be accessed online at: http://www.physicianenhancement.org/programs.html.

Additionally, the FSMB has a Directory of physician assessment and remedial education programs which can be accessed online at: http://www.fsmb.org/pdf/RemEdProg.pdf.

Most assessment programs are not limited to assessing gaps in knowledge and skills. In addition, many programs collaborating with PLAS and CPE have (or are developing) reentry and/or retraining components.

Physician assessment programs are designed to be supportive of physicians. The underlying assumption of programs is that physicians can and will improve in their knowledge and skills and successfully return to clinical practice. There are barriers to successful program outcomes, however. Tension exists, between meeting the individualized needs of physicians and having standardization across programs. While efforts to create standardized assessment programs, such as PLAS exist, questions related to the validity and reliability of outcomes remain including:

- Are the measures used to assess gaps in knowledge and skills measuring the problems that brought physicians into the remediation process?
- Are the assessment methodologies used by programs comparable in terms of identifying gaps in knowledge and skills?
- Are the assessment methodologies used by programs comparable in terms of correcting gaps in knowledge and skills?
- Are the methods of recognizing successful completion of a program comparable across programs? For example, are certificates of completion comparable to CME credits?

There are many other barriers associated with assessment and remediation programs. These include: the high cost of programs; the dispersed location of programs, resulting in physicians being assessed outside the context of their practices; the lack of a comprehensive database to inform physicians about assessment and remediation programs, such as their structure,

requirements, costs and outcomes;, the lack of standardized curricula, and the lack of a sufficient monitoring process to assess program outcomes.

## STRATEGIES TO AVOID REMEDIATION

To avoid remediation, prevention is key. Prevention efforts should exist at the system (regulatory) level through policies and during early education and training assessments by medical schools. Ideally, students with learning-related problems would be identified and remediated (if necessary) in medical schools and residencies where appropriate resources are available. Prevention must also occur at the level of the individual. Every physician must take responsibility, both personally and professionally, for achieving and maintaining competence to provide high quality care to patients by addressing problems early on before they rise to the level of system intervention.

Examples of system-level strategies that can be employed to prevent physician remediation include:

- Further develop and utilize life-long learning strategies, including CME (see Council on Medical Education Report 10-A-09, "Promoting Physician Lifelong Learning");
- Employing methods for the early identification of physicians who are at risk for developing knowledge or skill deficits throughout the educational continuum;
- Regular follow-up for post-licensure physicians with a history of disciplinary actions requiring remediation to assure that they do not experience knowledge/skill deficits again; and
- Early recognition and treatment of physical and mental comorbidities that may impact physician performance.

Examples of strategies individual physicians use to prevent the need for remediation include:

- Engage in self-assessment and life-long learning through CME;
- Actively work toward identifying and improving gaps in practice performance; and
- Obtain early intervention for cognitive difficulty.

## DISCUSSION AND ADDITIONAL ISSUES FOR CONSIDERATION

Increasing concern by the public regarding public safety and quality of patient care has warranted a closer look at the remediation process. While much attention has been given to the "impaired physician," by comparison, less has been focused on gaps in knowledge and skills. There is very little information on the extent of this problem within medicine and more research is needed to clarify terms related to remediation as well as to identify how many physicians have gaps in knowledge and skills and are in need of assessment and educational methods of remediation. Tools of assessment and remediation need further investigation particularly with regard to their reliability and validity. Further clarification as to what defines successful program outcomes is also needed. These issues must be addressed as the medical profession moves forward in making improvements to the physician remediation process. In addition to the issues identified above the following issues must be considered as well.

- Many in medicine prefer to view the remediation process as supportive. As improvements are made, however, it may be advantageous to return to the premise of remediation and ask: Is remediation a supportive process to get the physician back to a standard level of performance or one that is punitive for performance that falls below a standard and puts

patients at risk? Should the focus be on a few "bad" doctors or on systematic quality improvement among all doctors? These questions are stimulated by data from the National Practitioner Data Bank that show that, of physicians with a reported action, 4% had more than 10 malpractice actions reported to the data bank.[8]

- Whether and what types of deficits can be corrected through the remediation process should be considered. A physician with cognitive impairment or a physician who is repeatedly disciplined may not benefit from current models of remediation.

- Due to the relatively small number of assessment programs nationwide, physicians are unlikely to be assessed within the context of their own practice. The effect of being tested out of one's practice environment on assessment results remains unclear. assessing physicians locally within their own practice environments may yield better outcomes. There is precedent for this in England, where the process is a local one which sets "a doctor's performance in the context of his or her working environment."[11]

- CME Report 6-A-08, "Physician Re-entry," discussed both the interrelatedness of and distinctions between the need for reentry, remediation and retraining. It is becoming more common for assessment and educational programs to be used to meet all three of these needs. Assessment and remediation are often viewed by physicians as punitive rather than supportive. Physicians seeking ways to reenter clinical practice and/or retrain for a new clinical area may have requirements that are unique from those who are in the process of being disciplined and/or assessed for poor performance. Regardless of the reason, however, physicians in all three groups may benefit from assessment or training. Physicians from all three groups also must interface with regulatory systems within medicine which will determine if they are competent to practice. It seems necessary, therefore, that coordination within and among programs be strengthened to meet these realities.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed.

1. That our American Medical Association support the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level. (Directive to Take Action)

2. That our AMA collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care. (Directive to Take Action)

3. That our AMA support efforts to remove barriers to assessment programs including cost and accessibility to physicians. (Directive to Take Action)

4. That our AMA partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills. (Directive to Take Action)

5. That our AMA ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would require medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that ~~would~~ could lead to later knowledge and skill deficits in practicing physicians. (Directive to Take Action)

Fiscal Note: $5000 for staff time to conduct the recommended study.

## APPENDIX 1: DEFINITION OF TERMS

The definitions for the terms listed below expand on Appendix 1 of CME Report 6-A-08. The definitions have been adapted from the American Academy of Pediatrics (AAP) Physician Reentry into the Workforce Project, the AMA, the FSMB draft report on Maintenance and Licensure and literature review.

### DEFINITION OF TERMS

In this and future reports, the following definitions will be used.

Dyscompetent Physician: A physician who has failed to maintain acceptable practice standards.

Impaired Physician: A physician who is unable to fulfill personal or professional responsibility because of psychiatric illness, alcoholism or drug dependency.

Physician Reentry: A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment.

Physician Reentry Program: Structured curriculum and clinical experience which prepares physicians to return to clinical practice following an extended period of clinical inactivity.

Physician Reentry Program System: Provides a way of organizing and planning physician reentry programs.

Physician Retraining: The process of updating one's skills or learning the necessary skills to move into a new clinical area.

Remediation: The process whereby deficiencies in physician performance identified through an assessment system are corrected.

Underperformance: A physician who exhibits a decline in performance or who performs at a level that is significantly below that of his or her peers.

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