REMEDIAL EDUCATION: CAN THIS DOCTOR BE SAVED?*

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INTRODUCTION

An adversarial encounter with the Board of Medicine can be a devastating experience for a physician (1). Professional reputation and self-esteem suffer. It can have a negative impact on the physician's patients when his/her license is suspended or limited, especially when the physician practices in an under-served area. Annually, approximately 350 physicians encounter a patient-care problem that leads to their being identified by the Florida Board of Medicine for review. A similar proportion is reported from other states (2). While this number is relatively small compared to the number of practicing physicians in the state and nation, it is important and significant in that both the standard of care and the access to health care for a large number of patients are affected. Encounters also tend to cast doubt on the physician's knowledge and skill in patient care. Until the recent inception of the UF Comprehensive Assessment and Remedial Education Services (C.A.R.E.S.) program, no facility for assessing the educational needs of individual physicians existed in the Southeast. Fines, penalties, license restrictions, and directives to achieve a certain number of hours of continuing education have been given on the basis of the best judgment of the physician and lay members of the Board but without the benefit of a structured assessment of the physician's knowledge and skills. It is clear that fines and penalties served to emphasize a specific patient problem to the physician. However, the important question remains of whether the negative outcome or incident is indicative of an underlying deficiency in knowledge or skill, or represents an isolated and unfortunate incident for a fully competent practitioner (3). This distinction had to be made by the Board based upon incomplete knowledge of the physician's skills and abilities. The C.A.R.E.S. assessment is individually designed to provide objective information needed in making this important decision.

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ASSESSMENT AND REMEDIAL EDUCATION

Assessment and remedial education for physicians, sometimes called "physician enhancement" has gained national attention recently (4). As a result of the consumer movement and other influences, more physicians are being scrutinized for questionable practices (5). Regional assessment centers were created or expanded in Oregon (northwest), San Diego (southwest), Colorado (west), Wisconsin (midwest), New York (northeast), North Carolina (eastern seaboard) (6). Since it is not practical for every state to create an assessment and remedial education center, the regional sites serve physicians from other states. Under the auspices of the American Medical Association, the Coalition for Physician Enhancement (CPE) was created to serve as a forum for the regional assessment centers to share experience and strategies. With launch of the Program in January 1998, C.A.R.E.S became the southeast regional site. In the approximately two years since its inception, C.A.R.E.S has served more than forty physicians from Florida, Georgia, Mississippi, Alabama, and Michigan.

PROGRAM DESCRIPTION

All of the regional centers listed above follow a similar template with variations to correspond to the physician's area of practice and identified problem area, if any. The following program description represents the University of Florida C.A.R.E.S program.

Acceptance into the Program: Only physicians who meet certain criteria can be accepted. Acceptance criteria include:

- Participants must be psychologically and cognitively stable. Physicians with active alcohol or drug dependence cannot be assessed.
- Every effort will be made to accommodate all physicians, as space is available. However, the C.A.R.E.S. Program is based upon the clinical judgment of peers and the standard of practice. It may be difficult or impossible to accommodate physicians of some sub-specialties.
- In the initial triage interview an effort is made to establish rapport with the physician and to build an atmosphere of respect and collegiality. A successful assessment requires that physicians are cooperative and willing to participate in the assessment procedures. Persons who are aggressive or hostile cannot be accepted into the program.
- Physicians must pay the assessment fees according to schedule. Special arrangements can be made in cases of demonstrated hardship.

Practice Profile: Participation in the program begins with an

application blank soliciting information on the physician's education and training, areas of practice, employment, certifications, and other information. In addition, the physician is asked to complete a "Practice Profile" with a chronological list of patients admitted to the hospital in a recent six-month period. The profile also asks for a list of the past 100 patients seen in the clinic or office. Lists include a patient identification number, age, gender, and presenting or major complaint. The medical director and consultants analyze the information provided on the Practice Profile and a personalized assessment is designed based upon the physician's practice. For example, assessments for physicians who do not treat pediatric patients include few pediatric questions or cases.

Assessors/Examiners: University faculty members are recruited by the Medical Director to serve as examiners. Physicians in private practice are also recruited to provide a broader representation of the medical community and to avoid an "ivory tower" perspective. As a rule, physicians of the same specialty as the physician being assessed serve as assessors. Primary care physicians serve as assessors for physicians who practice primary care medicine.

The assessments of sub-specialists presents a special problem. For example, an ophthalmologist specializing in retinal surgery was referred. Following a concerted effort to identify qualified assessors and to develop appropriate assessment, it was concluded that UF C.A.R.E.S was not able to accommodate him. Fortunately, the staff was able to identify an assessment center in Colorado with the needed resources.

Assessment:

A personalized assessment is designed for each physician accepted into the program (5). Assessment techniques vary considerably but often include the following.

1. **Chart-Simulated Recall Examination:** This assessment technique is used to examine the physician's diagnostic and patient management knowledge and skills. It also provides direct information on the physician's record keeping and chart maintenance skills. The Chart Simulated Recall Examination requires that a sample of approximately six charts be randomly selected from the physician's office or hospital-based patients. Two physician/assessors review the charts prior to meeting with the physician and develop a set of management questions to discuss with him/her during a structured

interview. On the basis of the structured interview, the examiner(s) complete a report related to the physician's diagnostic and management skills and identify significant errors or commissions, if any. The Medical Director integrates results into the final report.

2. **Examination-Simulated Assessment:** A multiple-choice examination of approximately 100 questions is prepared to cover a wide range of concepts and relationships in the physician's area of specialization. The physician takes the examination without books or notes, and the examination is scored. The examination is not graded in that there is no passing score identified. Rather, in a structured interview, the assessors(s) discuss the examination with the physician, paying special attention to items that he/she marked incorrectly. The examiners ask probing questions of the physician to determine his/her cognitive process in responding as he/she did. At the conclusion of the structured interview, the examiner(s) complete a report related to the physician's knowledge in the areas covered by the examination. It is worth noting that many of the physicians being assessed are not good test takers and often have not completed a multiple choice examination in a substantial period of time. For many incorrectly marked answers, the assessors determine that the physician possesses the knowledge sampled by the test item but misinterpreted the question or marked it incorrectly in error. The Medical Director integrates results of this assessment into the final report.
3. **Simulated Patient Examination:** Physicians with identified potential deficiencies in patient examination or communication skills examine three or more simulated patients in the Harrell Center Simulated Clinic. The patient/actors are trained to provide authentic simulations of patients with specific presenting complaints. Supporting charts, lab work-ups and other documentation are available. Simulated patient examinations are be videotaped and assessed to identify specific skills deficiencies, if any. Simulated patients also rate the physician on several aspects including appropriate draping, eye contact, listening to patient's questions, etc. The Medical Director integrates results into the final report.
4. **Computer-Based Testing:** The Harrell Center and the UF Teaching Labs provide a variety of simulations and computer-based tests that may be used to assess physician's knowledge of anatomy, physiology, and several clinical areas. The medical director integrates results of the tests into the final report.
5. **Psychiatric Assessment:** Participants in the program are given a psychiatric screening for drug and alcohol abuse, depression and anxiety and other psychopathologies.

6. **Drug Testing** is conducted using a hair sample. The hair sample provides a profile of all drug use in a previous six-month period. The hair sample test does not include cannabis or alcohol use.
7. **Cognitive Assessment:** When deemed necessary, physicians meet with a University of Florida neurologist or neuropsychologist for a cognitive assessment. In some cases brain imaging studies are conducted. The Medical Director integrates results into the final report.
8. **Ethics Assessment:** Faculty from the Bioethics Department assist physician assessors in the development and administration of an assessment of the physician's ethical perspective and judgment.

Assessment Report: Ratings, reports and other information of the various assessments are compiled and the Medical Director writes a report on the assessment. The report describes all of the assessments administered and a description of the results. Deficiencies in knowledge or skills, if any, are identified and a personalized continuing education program is prescribed. Personalized programs may include: home-study programs, attendance at CME conferences, self-study-assigned readings, preceptorship or visiting mini-fellowship programs, other educational activities (5). The report is provided to the participating physician and the referring authority. Generally, reports fall into the following categories:

1. *No Deficiencies*—Physicians in this category are determined to be within the standard of care on all measured dimensions. There are no remediation recommendations. However, the assessment is also a learning experience. It provides physicians with suggestions for improvement and skills enhancement.
2. *Minor Deficiencies*—These physicians are also judged to demonstrate medical skills that fall within the general standard of care. However, there may be minor deficits that should be corrected (e.g., incomplete documentation) through traditional continuing medical education. These deficits are judged to not represent significant patient-care issues.
3. *Moderate or Specific Deficiencies*—In this case the physicians' general medical practice is determined to fall within the standard of care. However, there is likely a specific practice area (e.g., use of certain medications or specific procedure) where the physician has a noted deficiency. In this case the physician may be competent to provide safe and competent patient care with the recommendation that he/she refrain from a specific procedure or area of patient care (i.e. inpatient care) until he/she can demonstrate competency in that area.

4. *Significant Deficiencies*—These physicians have demonstrated deficiencies across several domains of the evaluation or in areas that appear central to their practice of medicine (e.g., an obstetrician who fails to recognize signs of fetal distress). In these cases, recommendations include extensive prescribed continuing education and/or that the physician be allowed to practice only under supervision before being allowed to resume the independent practice of medicine.
5. *Global Deficiencies*—In this case the physician is determined to currently be practicing below the standard of care for his or her specialty. However, it is felt that the physician has the capacity to develop these skills (e.g., an obstetrician who fails to recognize signs of fetal distress). In this case it would be recommended that the physician refrain from practice until completing extensive remediation (e.g. repeat residency or limited fellowship) and demonstrating competency.
6. *Catastrophic Deficiencies*—In these situations the physician is determined to be practicing below the standard of care with little chance of improvement through remediation efforts (e.g., physician suffering from Alzheimer's Disease, mental health or character disorder, etc.). In this case it is recommended that the physician not practice medicine in any capacity.

Prescribed Continuing Education:

As part of the assessment, physicians are given a detailed description of their deficiencies as well as a detailed remedial education program. Remediation "prescriptions" include:

1. Specific Continuing Medical Education (CME) recommendations.
2. Recommendations for supervision of practice ranging from chart review to direct supervision.
3. Experiential learning consisting of mini-fellowships or residency training.
4. Psychiatric/psychological treatment for an identified mental illness such as depression/anxiety or substance abuse.

Program staffs offer assistance in identifying appropriate courses and other educational opportunities. Upon completion of the remediation, a follow-up focused evaluation is available. The focused evaluation assesses if the physician's knowledge or skills in the deficient area(s) have been adequately corrected.

CASE STUDIES

Dr. X, a 63-year-old Caucasian male general surgeon, was referred to the UF C.A.R.E.S program by the Board of Medicine following several questionable patient outcomes and culminating in his falling asleep at the operating table. It was determined that Dr. X suffered from Parkinson's disease, COPD, and maintained a heavy patient load. Self-prescribed benzodiazepine, illness with influenza and an extremely heavy schedule contributed to his falling asleep in the operating room. Initial cognitive and neurological screening were conducted and Dr. X was found to be physically and mentally capable. The knowledge and skills assessments indicated that Dr. X was not current in several areas of his practice and used techniques no longer considered optimal. In general, the assessors judged that Dr. X possessed medical knowledge and clinical skills below community-based standard. They recommended that Dr. X refrain from heart and vascular surgery. It was also recommended that surgical backup be available on the premises when Dr. X was operating. Additional prescriptions pertained to updating his knowledge of anticoagulation, prophylaxis, and other areas. Accordingly, Dr. X agreed to limit his practice, acquire identified knowledge and skills and collaborate with another surgeon.

Dr. Y, a 42-year-old African American woman internist, was identified as having major mental illness as well as significant deficiencies in knowledge and clinical decision-making skills. The assessors were unable to determine the extent to which mental illness interfered with the assessment of her knowledge and skill but identified numerous significant deficiencies in medical knowledge and clinical decision-making skills. It was recommended that the physician seek psychiatric treatment and accomplish complete retraining.

Dr. Z, a 50-year-old Hispanic general practitioner had not practiced medicine in the US for six years due to his inability/unwillingness to comply with previous Florida Board of Medicine orders. His educational prescription called for focused continuing education in several areas including cardiology, gastroenterology, and prescribing. The prescription also called for supervised practice for a period of two years, with a follow-up assessment. Unfortunately, Dr. Z was unable to find a supervised practice setting.

SUMMARY

In the first two years of the program 30 physicians have completed the program. A list of the distribution of specialties/practice areas

TABLE 1
UF C.A.R.E.S Participants 1998–1999

Practice Type	Number
Anesthesiology	1
Emergency Medicine	1
Endocrinology	1
Family Practice/General Practitioner	11
General Surgery	3
Hematology/Oncology	1
Internal Medicine	6
Obstetric/Gynecology	3
Otolaryngology	1
Osteopathy	1
Psychiatry	1
Total	30

served is provided in Table 1. The data reveal that the distribution of practice areas corresponds approximately to the distribution of physicians practicing in the state.

The UF C.A.R.E.S Program provides a great benefit to physicians and their patients. It provides an atmosphere of professional collaboration and encouragement to address specific educational needs and underscores a commitment to providing continuing medical education, meaningful doctor-to-doctor collaboration, better patient care, and reflects a medical model of diagnosis and treatment of specific problems.

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DISCUSSION

CAREY, Charlottesville: I would like to ask you about the trigger points initiating this process and how much self-referral you have experienced.

CERDA: We get referrals from all of the states in the Southeast since we are the only major referral center. There is one in Wisconsin and there is one in Colorado. I would envision that not every state is going to be able to afford this or have the kind of resources that we do, so I would envision that there will ultimately be one in the Northeast, one in the center of America, one in the Southeast, one in Colorado, and probably one in California or Washington. I think this is the way it is going to sort out and we are already discussing this with many many educational investigators.

GREENBERG, Houston: I have recently heard the Wisconsin and Colorado programs presented and one of the things that struck me was what you have sort of alluded to. It is that several of the problems could be pinpointed back much earlier in a career. Do you have the same experience? Was there, in fact, in several of your physicians real trouble even in medical school or in residency if you went back and looked for it?

CERDA: Absolutely. I think we all do a poor job at looking at potentially problem physicians and students. My own personal experience at the University of Florida and at the University of Pennsylvania is that we tend to kind of blow it away and cover it up and really not take care of it. Then we send the fellow out and he is the same one who gets into trouble. I think we have to do a better job in our education as well as in our residency programs.

ALLEN, Charleston: This story reminds me a lot of when we moved to Charleston and bought a historic house. I was a little bit dismayed by the antiquity of the house and what it took to keep it going. I had a good friend in the Department of Pathology who said, "Jim, there is really no problem. What you do is that you go home at night, have a stiff drink, and then go out on the piazza and throw money at it." I am skeptical that $5000 covers the cost of the type of evaluation you have presented. Therefore, I share some concerns about the general applicability of what is otherwise a very admirable program. My real question, however, has to do with the long-term outcome, as was pointed out by the previous questioner. As your response indicates, these problems are of long duration and I find it extremely difficult to believe that even a very expert diagnosis and treatment as you propose is going to have a continuing effect. The question is not really how many you have returned to practice, but how long their remediation will last?

CERDA: That is an excellent question and, of course, only time will tell as the Board of Medicine will continue and we will find out whether or not they are "frequent fliers". We will find out whether or not they come back before the Board. We have seen many of these people that the airlines call "frequent fliers" before the Board two or three times at least in my four-year tenure with the Board. We are gathering that data and the Board is very responsive about this. At least the Board, which is comprised primarily of private practitioners, is very enthusiastic over this concept that we might be able to help, but you are exactly right. I don't know what the outcome is going to be.

HENRICH, Baltimore: Just one technical question and that is related to the outcomes that have been alluded to by other questioners. Is the Board indemnified against any problem that occurs because of a doctor's mistake? For example, in the case of the surgeon you cited, if that surgeon now has another blackout, or if there is a horrible outcome with the patient, I was worrying about whether or not a plaintiff's attorney might have actionable cause against you or against your Board?

CERDA: We have thought about that and I don't have the answer for you yet. Our attorneys for the agency for Health Care Administration, since I'm not a chairman of the

Board of Medicine, are well aware of that possibility. It hasn't occurred yet and the program has gotten wide press throughout the whole state of Florida. I actually plan to present this before the Florida Board Association in a modified form over the next month.

STEMMLER, Virginia: Just a point of information, Jim. The Federation of State Medical Boards and the National Board of Medical Examiners have formed a new organization aimed specifically at an organized process to accomplish what you are doing. They have contracted with Colorado and I think, perhaps, with Wisconsin, though I am not certain, but at least what they are trying to do is to utilize some of the very sophisticated test mechanisms that the National Board can contribute in addition to some of the other methodologies that you are using. That is just a point of information. The other is in my previous role related to the National Board. I had chaired that Board and had come across what those of you who serve on state medical boards are confronted with. It is an onerous responsibility which I realize now, at the end of my career, that academic medicine is really not usually a participant in. I am just astonished at some of the things that physicians do in practice that sometimes involve very egregious behavior before they ever even come to the attention of the Medical Board. I wouldn't want to leave an impression here that those of you who are serving on Medical Boards are able to return all of those misbehaving doctors to practice. Thank goodness that you get them out of practice.

CERDA: We don't return them all. I can tell you one thing: sex with a patient, your license gets pulled right on the spot. Emergency suspension is usually at least for the year by the time the lawyers and everyone decides what to do. They get out of circulation. Fraud is the other thing that gets them out of circulation pretty quickly. The issues are standard to care issues when you have a missed diagnosis and so forth. This is where this program really works better than anything else.