

E-merging views from



Center for *Personalized* Education for Physicians

Welcome to E-merging Views

It was a pleasure to see so many of you at the FSMB's Annual Meeting earlier this month. We look forward to continuing our work with state medical boards. The fourth issue of our e-bulletin reports CPEP's research findings on physician assessment and education. Please talk back to your e-bulletin so that we can represent your thoughts and ideas.

You can visit our website at www.cpepdoc.org or contact us at (303) 750-7150 or cpep@cpepdoc.org

Does Structured Remediation Make A Difference?

Elizabeth Korinek, M.P.H.
Kristin Y. Hasley, M.H.P.E.

There's an old song that says "Love and marriage . . . go together like a horse and carriage . . . you can't have one without the other." Well, times have changed since these lyrics were written – but the question of whether there is added benefit from combining the strengths of two separate but related resources remains relevant. In the case of physician evaluation, is an educational intervention that includes accountability and ongoing evaluation a requirement for successful remediation?

Medical boards and hospitals have taken a variety of approaches to addressing the deficits identified through a competency assessment: some allow the physician to construct their own educational program and report compliance to the board; some require that the physician enroll in specific courses; and others require completion of a CPEP Educational Intervention. All of these approaches contain useful learning opportunities. What varies, however, is the likelihood of success, and the boards' and hospitals' confidence in the effectiveness of these approaches when making decisions about licensure or privilege status.

A cross-sectional study was conducted of board-referred physicians who completed a CPEP Assessment between January 1, 2000 and December 31, 2001 and who were recommended to participate in a structured Educational Intervention (n=49). [Note: participants with no educational deficits and those with global deficits requiring residency training were not included in this study.] The physicians were grouped into two categories: physicians who completed a CPEP Educational Intervention (n=16) and physicians who

did not enroll in or complete a CPEP Educational Intervention (n=33).

Changes in medical licensure status, defined as improved or declined, were compared between the two groups. Examples of improved licensure status included moving from a suspended to a probationary license or from a probationary to an unrestricted license. Examples of declined licensure status included moving from an active to a probationary license or from a probationary to a restricted or suspended license.

More than 65% of the physicians who participated in a structured CPEP Educational Intervention improved their licensure status compared to less than 20% of those who did not pursue the recommended education through CPEP. In addition, less than 15% of physicians in the CPEP program had additional restrictions on their license or had their license lapse compared to more than 40% of the non-CPEP group.

This study provides strong evidence that participation in a CPEP Educational Intervention has a significant, positive impact on the physician's licensure status. While it is difficult to identify a direct measurement of physician performance in an actual clinical setting, evaluating change in licensure status serves as a preliminary method in determining a physician's ability to practice with reasonable skill and safety.

More research needs to be completed to further evaluate the impact of individualized educational interventions on improving the quality of health care delivery of physicians. Evaluating the incidence of malpractice cases and evaluating hospital credentialing outcomes after the completion of an educational intervention may shed further light on the impact such an intervention has on patient care. These findings give further support to our contention that when it comes to Assessment and Educational Intervention, the best outcomes take place when you do have one WITH the other.

Reasons for Referral for Personalized Physician Education: A Report from CPEP

Joel Dickerman, D.O.
Clydette Stulp-DeGroot, Ph.D.

Traditionally, medical knowledge is viewed as the primary indicator for physician competence. In recent years, the Accreditation Council for Graduate Medical Education (ACGME) has recognized that the practice of medicine involves a complex interaction of skills. The ACGME has identified six core competencies, including communication, professionalism, and practice-based learning, that are essential for the optimal practice of medicine.

By examining the reasons for referral for individualized assessment, we gain a better understanding of what constitutes physician competency. Analysis of 100 CPEP Assessments identified eight primary issues prompting evaluation of clinical competence:

- Privileges/Licensure (renewing, restoring, or seeking privileges or license);
- Clinical competence (poor clinical competence, bad patient outcomes or substandard care);
- Records/Documentation issues (incomplete, disorganized or inaccurate records);
- Prescribing problems (over use of medications);
- Patient complaints (patient disagreed with medical care);
- Behavior/Personality issues (disruptive behavior);
- Personal illness/Injury (recovery from illness, psychiatric problems);
- Other (self-referral to assure up-to-date skills).

Questions in more than one of the above areas often prompted enrollment in the program. On average, the physicians had two reasons for referral. While the most common primary reason for referral was clinical competence (35%), the majority (65%) of physicians were referred for issues in other areas. Concerns about physician behavior or personality were secondary reasons for referral in one-third (33%) of the cases. These results were consistent for both primary care and specialty physicians.

The findings from this study have a number of clinical implications. First, early identification of a deficiency in one or more of these areas may allow for remediation before an undesirable event occurs. Second, an understanding of these issues in the competent practice of medicine can have a great impact on postgraduate and continuing medical education.

Finally, the findings seem to support the core competencies promoted by the ACGME.

These findings were presented at the North American Primary Care Research Group's 2002 Annual Conference. This study received the Best Poster Presentation Award for its content and contribution to the understanding of medical care delivery.

CPEP Calendar

The Patient Care Documentation Seminar

Tuesday, June 3, 2003
7:30 AM–4:00 PM
Copic Companies, Denver, Colorado

The Critical Role of Healthcare Communication... Physicians as Leaders

Monday, October 27, 2003
7:30 PM–3:00 PM
Copic Companies, Denver, Colorado

Sponsored by CPEP, Copic Companies, and the Colorado Foundation for Medical Care

The "Problem" Physician...A step-by-step approach to assessing and managing competency, impairment and behavior concerns

Wednesday, October 8, 2003,
Chicago, IL

Sponsored by CPEP, The Greeley Company, and Postgraduate Institute for Medicine

Podiatry Assessments/Education Now Available

The CPEP Board of Directors approved a protocol for competency assessments in the area of Podiatric Medicine. Podiatrists complete a two-day evaluation process. An Associate Medical Director, a licensed physician, oversees each Assessment with qualified Podiatrists conducting the clinical interviews. It is personalized to reflect the participant's practice and the expectations of knowledge, decision-making, patient communication, and documentation required for Podiatrists. Personalized Educational Interventions are developed based on the Assessment findings, providing structure and oversight as the podiatrist addresses areas of educational deficiency.