Problem Doctors: Is There a System-Level Solution?

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Physician performance failures are not rare and pose substantial threats to patient welfare and safety. Few hospitals respond to such failures promptly or effectively. Failure to ensure the quality and safety of the performance of colleagues is a breach of medicine's fiduciary responsibility to the public. A major reason for this deficiency is the hospitals' lack of formal systems to monitor physician performance and to identify and correct shortcomings. To develop and implement these systems, hospitals need better performance measures and substantial expansion of external programs for assessment and remediation. This is a task well beyond the capacities of individual hospitals; a national effort is required. The authors call on the Federation of State Medical Boards, the American Board of Medical Specialties, and the Joint Commission on Accreditation of Healthcare Organizations (organizations that already bear a fiduciary responsibility for ensuring safe, competent care) to collaborate on developing better methods for measuring performance and to expand programs for helping practitioners who are deficient.

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The recent upsurge of interest in improving patient safety has been driven by lessons from the fields of cognitive psychology and human factors engineering. Research in these areas has shown that the vast majority of mistakes and injuries are attributable to faulty systems that cause injuries or lead even competent, careful people to make errors. The safety agenda is to redesign these faulty systems, and great effort is now being devoted to identifying and implementing safer policies and practices.

Some injuries, however, result from individual performance failures. Such failures may be caused by short-term stressors (such as emotional upset or overwork) or may have serious underlying causes that are less transitory in nature (such as drug or alcohol addiction, mental or physical illness, or declining knowledge and skills). Physicians whose performance persistently falters pose a substantial threat to patient safety that is often unrecognized or unsatisfactorily addressed in hospitals and other health care organizations.

Definitions

To facilitate discussion of performance deficiencies that threaten patient safety, we must first define some key terms that are used to categorize professional behaviors. *Professional competence* has been defined as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (1). The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties have divided competence into defined sets of "competencies" in specific domains, including those that apply to all physicians and those that are unique to each specialty. A deficiency in any of these domains can be referred to as a "dyscompetency," which is a useful concept because no one is totally incompetent.

Mental and behavioral problems include depression, anxiety, substance abuse, personality disorders (for example, antisocial behavior), and disruptive behavior with colleagues, patients, and subordinates. At the extreme are physicians who have severe psychopathologic manifestations, such as psychosis or suicidal behavior, but such cases are rare.

The term *disruptive physician* has been applied to physicians who exhibit abusive behavior that "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care" (2). Examples of disruptive behavior are provided in **Table 1** (3).

Disruptive, intimidating, or abusive behavior may increase the likelihood of errors by leading nurses, residents, or colleagues to avoid the disruptive physician, to hesitate to ask for help or clarification of orders, and to hesitate to make suggestions about patient care (4, 5). Such behavior may also deflect the physician's attention from the patient, thereby impairing clinical judgment and performance. When patients witness disruptive behavior, it undermines their confidence in the physician and the institution, as well as their willingness to partner in their own care (6). Consequently, disruptive behavior by physicians not only threatens patient safety but has a corrosive effect on morale, making life miserable for the nurses and residents who work closely with these physicians.

The term *impaired* has been defined by the American Medical Association as disability resulting from psychiatric illness, alcoholism, or drug dependence. However, the term has sometimes been inappropriately applied to physicians who have returned to good health, are substance-free and in a monitoring program, or have successfully completed a knowledge or skill remediation course.

See also:

Web-Only
Conversion of tables into slides

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Table 1. **Examples of Disruptive Behavior***

Profane or disrespectful language
Demeaning behavior (for example, referring to hospital staff as "stupid")
Sexual comments or innuendo
Outbursts of anger
Throwing instruments or charts
Criticizing hospital staff in front of patients or other staff
Negative comments about another physician's care
Boundary violations with staff or patients
Inappropriate chart notes (for example, criticizing the treatment provided by other caregivers)
Unethical or dishonest behavior

* From reference 3.

We will use the term *performance problems* to refer to all types of deficiencies, regardless of cause.

Underlying Causes

Physician performance problems can be usefully thought of as *symptoms* of underlying disorders, not as diseases. Underlying causes include mental and behavioral problems, including substance abuse or dependence (drugs or alcohol); physical illness, including age-related and disease-related cognitive impairment; and failure to maintain or acquire knowledge and skills. Contributing stressors include overwork, family strife, a dysfunctional working environment, supervisor pressure, and anxiety. Categories frequently overlap. For example, declining surgical competence can be attributed to knowledge or skill deficits *and* to alcohol dependence, and both of these problems may reflect underlying mental illness, such as severe depression.

Contributing to these problems are fatigue, stress, isolation, and easy access to drugs. The "normal" stress of medical practice has been compounded in recent years by large educational debt loads for graduating physicians, increasing malpractice premiums, decreasing reimbursement, and the pressure to see more patients in a shorter amount of time. Stress can lead to isolation and cause physicians to acquire maladaptive coping strategies, including alcohol or drug abuse.

In our experience, the professional realm is usually the last area in one's life that is affected by substance abuse and mental and behavioral issues (7). By the time these disorders manifest in the workplace, the physician's relationships with significant others, nuclear family, extended family, friends, and community have usually been "impaired" for a long time.

Extent of the Problem

The media frequently cite the number of physicians disciplined by state medical boards as a measure of performance issues. In 2002, approximately 0.5% of practicing physicians in the United States were disciplined; 1739 physicians had their licenses revoked, and state boards imposed restrictions on an additional 1218 (8). It is difficult to know how to interpret these figures because physicians are disciplined for various reasons, some of which may be unrelated to performance (such as fraudulent activities involving third-party payers).

Concerning mental illness, a recent study found a 16% lifetime incidence of major depressive disorders in the general population (9). The rate in physicians may be even higher (10); for example, the rate of suicide is 40% higher in male physicians and more than 2-fold higher in female physicians than in the general population (11).

Estimates of alcohol dependence vary from 8% to 15% (12–16), the latter being similar to the 13.5% rate for the adult population (16–18). The American Medical Association's estimate for drug dependence is 1% to 2% (18). The Medical Board of California estimated that 18% of physicians in its state abuse alcohol or other drugs at some point during their career (19).

Sound data are lacking for the incidence of disruptive behavior. Surveys of nurses suggest that most have witnessed episodes caused by 4% to 5% of the physicians at their institutions, but these data are flawed by low response rates (5, 20). Surveys of physician executives indicate that the percentage of disruptive physicians ranges from 1% to 5% (21). Hickson and colleagues (6) found that 6% of physicians received 25 or more complaints from patients over a 6-year period. Our best estimate is that 3% to 5% of physicians present a problem of disruptive behavior.

We found no studies of the incidence of physical illness among practicing physicians, but a reasonable estimate is that at least 10% of physicians must restrict their practice for several months or more during their career because of a disabling physical illness (such as diabetes, heart disease, or surgical procedures). Like everyone else, physicians are subject to cognitive decline with aging (22–24), but the extent has not been quantified.

Similarly, there are no overall estimates of the extent of knowledge and skill dyscompetencies. Results from 1 measure, recertification examinations, show that first-time failure rates in 4 specialties ranged from 1.0% to 14.0% (**Table 2**). Failure rates tend to be higher on subsequent examinations. We estimate that as many as 10% of physicians will demonstrate significant deficiencies in knowledge or skills at some point in their career.

Table 2. **Failure Rates for Specialty Board Recertification Examinations**

Board	Year	Registered Candidates, *n*	Failure Rate, %
American Board of Surgery	2004	800	3.8
American Board of Pediatrics			
General pediatrics	2004	3400	1.0
Pediatric subspecialties	2004	1100	4.0
American Board of Internal Medicine	2004	3042	14.0
American Board of Family Medicine	2004	6606	11.0

When all conditions are considered, *at least one third of all physicians will experience, at some time in their career, a period during which they have a condition that impairs their ability to practice medicine safely*; for a hospital with a staff of 100 physicians, this translates to an average of 1 to 2 physicians per year. Referral rates to state physician health programs suggest that most practitioners get little help. On the basis of our experience, even serious problems are often handled poorly at the hospital or practice level. However, ensuring high standards of professional conduct is arguably the greatest responsibility of a professional and one that the public, lacking an alternative mechanism for oversight, has a right to expect. We believe that our profession's failure to ensure the quality and safety of our colleagues' performance is a breach of its fiduciary obligation to the public.

An Ineffective System

Neither physicians nor hospitals have adequately addressed performance problems (3). Few organizations systematically monitor physician performance or have formal programs to identify problem doctors (3). Annual physical examinations are not required of physicians, and only the Department of Veterans Affairs (25) performs random drug testing. State licensing boards have relied on continuing education attendance as evidence of maintenance of competence.

Once problems are identified, management is also frequently haphazard. In egregious cases, investigations have repeatedly revealed that institutions ignored numerous warning signs months or years before a serious incident occurred (26, 27). Many physicians are reluctant to confront behavioral or competence problems. Independence is so highly valued that physicians are loath to evaluate or confront a colleague whom they perceive as having a problem (28, 29). Doctors abhor making judgments about colleagues who may also be personal friends or practice partners. Department chairs often lack the training and skills needed for managing doctors who perform poorly. The hospital may need the physician's revenue stream (30).

As a result, managing these situations can be difficult and aggravating for all parties concerned. Offers of assistance may be spurned. If disciplinary action is needed because a physician's performance is unsafe, it can be met with countercharges or a lawsuit, even when evidence is clear and due process is followed. At best, management is often a messy business; at worst, it can be hazardous to everyone involved.

Hospitals receive little help from regulators. Although they are required to have credentialing and disciplinary processes, the details of implementing such processes are left to the hospitals. There are few national or state standards of conduct or competence, or measures for monitoring performance.

State medical boards discipline physicians after the fact when unsatisfactory performance is reported by hospitals or patients or when malpractice settlements are reviewed. However, the state boards typically do not define prevention of injury as part of their responsibility.

Health care's casual approach to monitoring physician performance contrasts markedly to that of other professions whose conduct affects the public welfare. Commercial pilots, for example, must pass both physical and performance examinations every year.

The challenge is clear: We need to identify problem doctors early and address the problems in a timely fashion. To do this, we require better measures for identifying physicians who need help and better programs for providing help to those who need it. Although performance problems are widespread, we suggest that the place to start is in hospitals, where a credentialing process is already in place.

Identifying Physicians Whose Performance May Endanger Patients

We propose that the current ad hoc, informal, reactive approach to physician performance problems be replaced with a routine, formal, proactive system of monitoring that uses validated measures to focus strictly on clinical and behavioral performance. The goal would be to identify problem doctors early, before they jeopardize patient safety.

This system would have 3 essential characteristics. First, it should be *objective*. A common criticism of current methods is that they are based on subjective judgments of personality, motivation, or character instead of performance. The solution is to base evaluations on data, such as evidence of compliance with performance standards.

Second, the system should be *fair*. To avoid being viewed as stigmatizing or punitive, all physicians should be evaluated on an annual basis according to the same measures. The evaluation process must be open and unbiased, and it must comply with labor regulations.

Third, the system should be *responsive*. When physicians with problems are identified, they must be treated promptly. For some physicians, feedback and internal counseling may be all that is necessary. Others may need further assessment and referral to a program to help them to correct their deficiencies and enable them to continue to practice medicine, if possible.

A Model System

How would such a system operate? We envision 4 stages to the process: adopting standards, requiring compliance, monitoring performance, and responding to deficiencies.

First, an institution should adopt explicit performance standards of behavior and competence. These standards need to be developed at the national level; specialty boards are currently at work on such standards for competence. The Federation of State Medical Boards could develop be-

Table 3. **State Assistance Programs for Physicians***

Program Name	Sponsor				Funding					
	State Medical Society	State Licensing Agency	Independent Corporation	Other	State Medical Society	State Licensing Agency	Malpractice Insurance Companies	Hospital and Private Contributions	Participant Fees	Other
Alabama Physician Health Program	●					●	●	●	●	
Alaska Physician Health Committee	●				●		●	●	●	
Arizona Monitored Aftercare Program			●			●			●	
Arkansas Physician Health Committee				●	●	●	●		●	
California Physician Diversion Program		●				●			●	
Colorado Physician Health Program			●		●	●	●	●	●	●
Connecticut Physician Health Program	●				●		●	●		●
Delaware Physicians' Health Committee	●				●					●
Florida Physicians Recovery Network	●				●	●	●	●		
Georgia Physicians Well-Being Program	●				●		●	●	●	
Hawaii Medical Association Committee on Physicians Health	●				●				●	
Idaho Physician Recovery Network	●	●			●	●	●	●	●	
Illinois Professionals Health Program				●		●	●		●	
Indiana State Medical Association	●				●			●	●	
Iowa Physician Recovery Program		●				●				
Kansas Medical Advocacy Program	●				●	●				
Kentucky Impaired Physicians Program				●		●	●			
Physician Health Foundation of Louisiana				●	●	●	●	●		
Maine Physician Health Program	●	●			●	●	●			
MedChi, Maryland State Medical Society	●				●	●				
Massachusetts Physician Health Services	●				●		●			●
Michigan Health Professionals Recovery Program			●							●
Minnesota Health Professionals Services Program		●				●				
Mississippi Recovering Physicians Program	●				●	●		●	●	
Missouri Physicians' Health Program	●				●		●	●	●	
Missouri Association of Osteopathic Physicians and Surgeons Physician Health Program	●				●			●	●	
Montana Professional Assistance Program			●			●			●	
Nevada Health Professionals Assistance Foundation			●					●	●	●
New Hampshire Physician Health Program	●				●	●	●	●		
New Jersey Physicians' Health Program	●				●		●			
New Mexico Monitored Treatment Program			●			●			●	
New York Committee for Physicians' Health	●					●	●			
North Carolina Physicians Health Program			●	●	●	●	●	●	●	●
North Dakota Commission on Physician Health	●				●					
Ohio Physician Effectiveness Program, Inc.			●		●		●	●	●	●
Oklahoma State Medical Association Physician Recovery Program	●				●		●			
Oregon Diversion Program for Health Professionals		●				●	●			
Pennsylvania Physicians' Health Program	●			●	●		●	●	●	
Rhode Island Physicians' Health Committee	●						●	●		
South Carolina Physicians Advocacy & Assistance Committee	●				●					●
South Dakota Physicians Help Committee	●				●					
Tennessee Physicians Health Program	●		●		●		●	●		●
Texas Committee on Physician Health & Rehabilitation	●				●					
Utah Physicians Health Program	●	●			●	●				
Vermont Practitioners Health Program	●				●	●			●	
Virginia Health Practitioners' Intervention Program			●			●				
Washington Physicians Health Program			●			●	●		●	
Washington, DC Physician Health Program	●				●		●			
Wisconsin Statewide Physician Health Program	●				●					
Wyoming Professionals Assistance Program, Inc.			●		●	●		●	●	

* Confirmed plan features at time of publication are denoted by filled circles (●).
† Length of contract variable according to participant's need.

Table 3.—Continued

Condition Monitored								Length of Contract, *y*	
Chemical Dependence	Mental Health	Behavioral Health Problems	Sexual Misconduct and Boundary Violations	Physical Illness	Malpractice Litigation	Stress Management	Other	Chemical Dependency	Mental Health
•	•	•	•	•		•		5	†
•	•		•					5	†
•								5	–
•								5	–
•	•							5	5
•	•	•	•	•	•	•	•	†	†
•	•	•	•	•				5	†
•	•	•	•	•	•	•	•	5†	†
•	•	•	•	•		•	•	5†	5†
•	•	•	•	•				5	5
•	•	•	•					5	†
•	•	•	•					5	†
•	•	•	•	•		•		5	5
•	•	•	•	•			•	5	2
•	•			•				5	†
•	•	•	•	•				5	†
•	•	•	•	•				5	†
•	•	•	•	•				5	5
•								5	–
•	•	•	•	•	•	•	•	5	≤5
•	•	•		•	•	•		3†	2†
•	•							3	≤3
•	•							3; 5	2†
•	•	•	•					5	2 or 3†
•	•	•	•			•		5	5
•	•	•	•	•	•	•	•	5	5
•	•	•	•			•	•	5	3†
•	•	•	•			•		5	2
•								5	–
•	•	•	•	•	•			†	†
•								5	–
•	•	•						5	2†
•	•	•	•	•				5	†
•	•				•	•		–	–
•	•	•	•	•		•		5	5
•	•	•	•					5	5
•								5	–
•	•	•		•	•	•	•	5	3
•	•	•	•	•				5	†
•		•	•					5	5
•	•	•	•					–	–
•	•	•	•	•	•	•	•	5	2
•	•	•	•	•		•		5	5
•	•							2	–
•								5	–
•	•	•		•				5	5
•	•	•		•		•		5	†
•	•	•	•	•				5	5
•	•	•	•	•		•		2	2†
•								5	–

Table 4. **National Assessment and Remediation Programs***

Program Name	Sponsor				Funding				Condition Monitored		
	State Medical Society	State Licensing Agency	Independent Corporation	Other	State Medical Society	State Licensing Agency	Participant Fees	Other	Behavioral Health Problems	Stress Management	Other
Alabama Physicians' Enrichment Workshop				●			●	●	●	●	●
California Physician Assessment and Clinical Education				●			●				●
Colorado Personalized Education for Physicians			●		●		●				●
Florida Competency Assessment, Remediation, and Education				●			●				●
Minnesota Corrective Action Program		●				●			●		●
New Jersey Ethics Group			●			●	●		●		●
New York Physician Prescribed Education Program				●			●	●	●	●	●
North Carolina Clinical Enhancement Program				●				●			●
Oregon Physician Evaluation, Education, & Renewal	●				●		●		●	●	●
Wisconsin Personalized Remedial Continuing Medical Education				●			●	●	●		●
Canada Practice Enhancement Program				●	●			●			●
Citizen Advocacy Center Practitioner Remediation and Enhancement Partnership				●				●			●

* Confirmed plan features at time of publication are denoted by filled circles (●).

havioral standards by using currently available material. The Joint Commission on Accreditation of Healthcare Organizations should coordinate with these groups. During the interim, hospitals can develop their own performance standards (as many already have). These should address all aspects of professional behavior. For example, 1 standard might be, "All patients and personnel will be treated with respect."

Second, all physicians should be required to acknowledge that they 1) have read and understand the standards, 2) have a responsibility to follow the standards, 3) know that adherence will be monitored, and 4) understand that persistent failure will lead to loss of privileges and dismissal. This acknowledgment should be given in writing as a condition of being granted clinical privileges.

Third, adherence to standards would be monitored annually by formal evaluations of all members of the staff using accepted and validated measures of competence and behavior. These should include confidential evaluations by colleagues and coworkers and analysis of complaints by patients or others (6, 31).

Fourth, results of the evaluations should be provided confidentially to each individual (with the identities of their colleagues concealed for protection). If significant deficiencies are identified, the department chairman should be responsible for ensuring a prompt, appropriate response. This response could involve evaluative testing, counseling, or referral for further assessment and treatment. In cases that threaten patient welfare, department chiefs and hospital leaders must take immediate action to limit practice during assessment and rehabilitation.

An essential element of this system is that everyone clearly understands his or her roles and responsibilities when a practitioner with performance issues has been identified; from the outset, all parties will know who is responsible for collecting data, who should receive reports, and what actions are required by whom at each level. Such a system would provide accountability at all levels: physician to department chair, chair to hospital medical staff, medical staff to hospital board, and hospital to state boards and the Joint Commission on Accreditation of Healthcare Organizations.

Finally, assessment and treatment programs must be available for management of all underlying causes of substandard performance: substance abuse, psychiatric problems, behavioral problems, and dyscompetencies. Programs should be personalized to enable the individual to use his or her strengths and knowledge in productive ways, ultimately resuming practice if possible. If a physician refuses to accept education, treatment, monitoring, or necessary restrictions of practice, or if these interventions fail, the physician must be promptly referred to the state medical board for disposition.

We conclude that an effective system for managing

physicians with performance issues is built on the ideas that 1) subpar performance can be objectively defined; 2) routine monitoring of all members of the medical staff is necessary to detect problems fairly and early; and 3) the responses to deficiencies should be prompt, constructive, and sustained. The long-term objective is to enable physicians to continue to practice effectively and safely—not to "weed them out." If the system works properly, that is, if physicians who perform poorly are identified before serious consequences arise, then one might expect referrals to the state medical board for disciplinary action to decrease.

Moving Ahead

Implementing such a system requires a national effort on several fronts. Three issues must be addressed: developing better measures for assessing performance, expanding the number of assessment programs for physicians with competence or behavioral problems, and developing and supervising remediation programs.

Measuring Performance

Some authorities have contended that performance assessment is not feasible (31). We disagree. However, the obstacles for setting assessment standards for behavioral problems differ from those for dyscompetencies.

For behavioral problems, several measures could be combined to provide earlier identification of physicians who need help. For example, Hickson and colleagues (6) found that analysis of patient complaints can identify doctors with interpersonal problems and predict the likelihood of malpractice litigation. Physicians with 4 or more complaints over a 6-year period were found to be 16 times more likely to have 2 or more risk management files opened than were physicians with no complaints.

The Physicians Achievement Review program, which is run by the College of Physicians and Surgeons of Alberta, assesses every physician in Alberta every 5 years (32). Patients, physician colleagues, and nonphysician coworkers complete confidential questionnaires regarding the individual's clinical knowledge and skills, communication skills, psychosocial management, office management, and collegiality. Physicians are provided with detailed aggregate responses for their own practice and a report comparing their personal results with the summary profile of all physicians with similar types of practices. Surveys may also be suitable for identifying physicians with alcohol or drug dependence, physical impairment, and mental illness (33). These measures need to be validated in the clinical setting.

Serious consideration should be given to implementing annual physical examinations and random drug testing for all physicians. More controversial, but clearly in need of investigation, is the feasibility of routine cognitive evaluations for older physicians.

Competence is a more difficult area to measure. Myriad instruments have been advanced over the years to measure competence, but most have proven too cumbersome or expensive to be implemented for all physicians on a regular basis. However, the Accreditation Council for Graduate Medical Education and the members of the American Board of Medical Specialties have advanced a massive national effort to define general and specialty-specific competencies. They have started to develop measures of these competencies to assess trainees for certification (34), and these same measures will be used to assess practicing physicians as part of maintenance of certification. These tools could also be used by hospitals. Several specialty organizations, particularly the American Board of Internal Medicine, have already made substantial progress in developing measures (35; Cassel C. Personal communication, 18 December 2005). These assessments might be financed through a combination of user fees and support from the national boards and specialty societies.

Expanding Assessment Programs

A second serious challenge is the need to greatly expand the number and capacity of assessment programs for physicians with competence or behavioral problems. All states except Nebraska have physician health programs for doctors with alcoholism or drug abuse, and 41 states offer assistance for physicians coping with mental health issues; however, few state programs address knowledge and skill deficits, clinical dyscompetencies, or disruptive behavior (**Table 3**).

Nationwide, only 10 programs are available for assessing physicians' skills or for education plans to correct deficiencies (**Table 4**). Five programs assess disruptive behavior. Others deal with relationship issues, communication skills, medical skills and knowledge, clinical reasoning, and patient care documentation.

The Federation of State Medical Boards administers a standardized examination of clinical knowledge, the Special Purpose Examination, to physicians referred by state medical boards or by themselves. If results are questionable, the physician may undergo an additional assessment by The Institute for Physician Evaluation, which is a joint initiative of the Federation and the National Board of Medical Examiners. The Institute's assessments include computer-based case simulations, structured interviews, multiple-choice examinations, cognitive function screening, and interactive judgment analysis. The evaluations were previously administered in Philadelphia, Pennsylvania, and Dallas, Texas, but are now offered exclusively in cooperation with physician enhancement services at 5 locations: the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego; the Clinical Competency and Assessment Training Program (CCAT) at Rush University Medical Center in Chicago, Illinois; the Upstate New York Clinical Competency Center at Albany Medical College in Albany, New York; the Florida Competency Advancement Program (CAP) at the University of Florida in Gainesville, Florida; and the Physician Assessment Program at the University of

Wisconsin School of Medicine and Public Health, Madison, Wisconsin (36). These collaborators use the Institute's tools to assess competence, then strive to remedy the identified deficiencies (37).

Developing Remediation Programs

The final challenge is to use the assessment results to construct successful remediation programs for those with skill deficits. The obstacles to progress in this area are substantial. The first obstacle is a lack of expertise to oversee such programs. Few national programs exist, and hospital-level programs are often poorly organized. A major national effort is needed to develop additional programs. A second barrier is inadequate financing. If physicians who will already be losing practice income are responsible for the full cost, they may be unwilling to participate. Other potential sources of support include specialty societies, licensing boards, federal or state governments, and liability insurers.

Yet another barrier is the reluctance of hospitals and physician colleagues to voluntarily guide, mentor, and supervise remediation activities. Department chairs rarely have formal supervisory training and often lack the experience needed to effectively manage physicians with performance problems. In addition to time, cost, and liability concerns, many institutions are uncomfortable asking patients to give informed consent for physicians with acknowledged deficits to care for them. Effective models need to be developed and tested.

Medical schools and their affiliated teaching hospitals should assume a leadership role in developing supervised clinical programs for physicians who have been found to have remediable knowledge and skill deficits. If developed and coordinated like traditional postgraduate training programs, these "mini-residencies" could effectively overcome the time, liability, and informed consent issues.

A Call to Action

The responsibility for monitoring and ensuring acceptable physician performance must occur at the local level. However, hospitals lack the resources to develop the systems and measures that are needed. We believe the time has come for a major national effort to develop these systems and measures. The organizations that are best positioned to take on this task are those that already bear a fiduciary responsibility for ensuring safe, competent care: the state medical boards (represented by the Federation of State Medical Boards), the medical specialty boards (represented by the American Board of Medical Specialties), and the Joint Commission on Accreditation of Healthcare Organizations.

We call on these national organizations to collaborate in an effort to accomplish 3 goals: Develop standards and measures for annual data-based assessment of physician performance and require that they be implemented by all hospitals, launch a major effort to develop better measures of competence and behavior, and develop more state and regional centers for assessment and remediation of physicians with performance deficiencies. The initial specifications should be based on currently available data and should then be improved as better data become available. Demonstration of an individual's compliance with these national standardized measures should be sufficient to satisfy state relicensing and certification requirements.

Performance failures of one type or another are not uncommon among physicians, posing substantial threats to patient welfare and safety. Few hospitals manage these situations promptly or well. It is time for a national effort to develop better methods for assessing performance and better programs for helping those who are deficient.

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