Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

QUALITY ASSURANCE ACTIVITIES OF MEDICAL LICENSURE AUTHORITIES IN THE UNITED STATES AND CANADA

Richard P. Kusserow
INSPECTOR GENERAL

OEI-01-89-00561

OFFICE OF INSPECTOR GENERAL

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This report is a follow-up to an April 1990 OIG draft report entitled "State Medical Boards and Medical Discipline." It aims to provide an overview of the extent and type of quality assurance activities being undertaken by medical licensure authorities in the United States and Canada. The report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General of Region I, Office of Evaluation and Inspections, and Martha B. Kvaal, Deputy Regional Inspector General. Participating in the preparation of the report were:

Boston Region

Carol J. Baker
Carol I. Barash
Barry C. McCoy

Headquarters

Alan S. Levine

EXECUTIVE SUMMARY

PURPOSE

The purpose of this study is to provide an overview of the extent and type of quality assurance activities being undertaken by medical licensure authorities in the United States and Canada.

BACKGROUND

This report is a follow-up to an April 1990 Office of Inspector General draft report entitled "State Medical Boards and Medical Discipline." It draws on the experiences of 20 State medical boards and 3 Canadian Colleges of Physicians and Surgeons, which are the Canadian counterparts to the State boards. Throughout the report, the term "quality assurance" is used in reference to preventive efforts directed to licensed physicians and intended to minimize the need for disciplinary action.

FINDINGS

In both the United States and Canada, medical licensure authorities are giving increased attention to quality assurance activities.

In the United States, State medical boards are involved with many different types of quality assurance activities. These include the dissemination of practice information, encouragement of remedial education, and conduct and oversight of peer review.

In Canada, some of the Colleges of Physicians and Surgeons are regularly carrying out quality assurance mechanisms that are not being used by their United States counterparts. Most notably, these include mortality reviews and random audits of physicians' practices.

RECOMMENDATIONS

- The Federation of State Medical Boards (FSMB) should conduct an inquiry into the quality assurance activities of the Canadian Royal Colleges of Physicians and Surgeons to determine their potential usefulness to State medical boards.

- The FSMB and the American Medical Association should develop a joint initiative to encourage State boards and State medical societies to collaborate on the development of remedial education programs for licensed physicians.

- The Public Health Service should provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures.

COMMENTS

Within the Department, we received comments on the draft report from the Public Health Service (PHS) and the Health Care Financing Administration (HCFA). The comments were generally supportive of our recommendations. However, there were some differences expressed concerning our recommendation that PHS provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance mechanisms.

Both PHS and HCFA expressed the view that it was premature to undertake such demonstrations, while FSMB and AARP supported such an effort. We have considered all these responses and continue to believe that the recommendation should be carried out.

In the comments section of the report and in appendix A, we provide further information on the comments and on our response to them.

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INTRODUCTION

This is the third in a series of reports we have prepared on State medical boards (hereafter referred to as the boards).

The first report, "Medical Licensure and Discipline: An Overview," was issued in 1986. It identified various limitations of the boards, in both the licensure and disciplinary spheres, and offered numerous recommendations on how the Federal Government, State governments, and private associations might contribute to improved board performance.

The second report, "State Medical Boards and Medical Discipline," was issued, in draft, in April 1990. In contrast to the earlier one, that report focused on the disciplinary responsibilities of the boards. It sought to assess how well boards were carrying out these responsibilities. It found that although boards were making progress in improving their disciplinary capacity, they still reflected serious shortcomings in their identification, review, and disposition of cases. The report offered many specific recommendations on how these shortcomings might be addressed.

This report is a follow-up to the one noted immediately above. We have prepared it because in the course of conducting our investigations on the disciplinary practices of boards, we found that many boards were giving increased attention to quality assurance activities. This awareness led us to examine this development more widely, both in the United States and in Canada. We extended our inquiry to Canada because we heard that the medical licensure authorities of some of the Canadian Provinces were moving in a similar direction.

Thus, our purpose in presenting this report is to provide a useful overview on the extent and type of quality assurance activities being undertaken by the medical licensure authorities in both countries. Because of the limitations of our inquiry and of the available information, our emphasis is much more descriptive than evaluative. However, we do present information on results in the few instances where it became available to us, and we do address follow-up actions that might be taken by the Department of Health and Human Services, the Federation of State Medical Boards (FSMB), and the American Medical Association (AMA).

The information that we draw on in this report is based on the experiences of 20 State medical boards and 3 Canadian Colleges of Physicians and Surgeons, which are the Canadian counterparts to the State boards. We selected the 20 State boards by starting with the 4 States which have the largest number of practicing physicians (California, New York, Pennsylvania, and Texas) and which served as case study sites for our broader inquiry on State board disciplinary practices. Through various reports, articles, and "word-of-mouth," we then identified 16 other State boards that are carrying out quality assurance activities. We held discussions, either by telephone or in person, with representatives of all 20 boards and reviewed numerous documents they sent to us.

We selected the three Canadian Colleges of Physicians—those in Saskatchewan, British Columbia, and Ontario—because through the Federation of Medical Licensing Authorities of Canada and through various State board officials in the United States, we heard that these licensure authorities had substantial quality assurance efforts underway. We talked with representatives of these authorities by telephone and reviewed various materials they sent to us.

Because most of the information we obtained is descriptive, we present it primarily in two appendices—one focusing on the United States and the other on Canada. In the body of the report, we provide a brief overview of the findings, addressed in some detail in the appendices, and of follow-up actions that we think are warranted.

In using the term "quality assurance," we recognize that in a basic sense all of the activities of the licensure authorities may be regarded as quality assurance activities. In determining whether physicians are properly qualified to receive a license to practice medicine and in disciplining those found to be in violation of established requirements and standards, the authorities are providing the public with some degree of quality assurance.

Throughout this report, however, we use the term in a more precise sense. In particular, we use it in reference to preventive efforts directed to licensed physicians and intended to minimize the need for disciplinary action. These preventive efforts may involve initiatives to identify physicians who have knowledge, skill, or practice deficiencies. They may also involve initiatives to offer educational opportunities to physicians in order to correct such deficiencies or to prevent their emergence.

FINDINGS

In both the United States and Canada, medical licensure authorities are giving increased attention to quality assurance activities.

There appear to be two major factors contributing to this development. One is a heightened concern for continued competency assessment. Congressman Pete Stark recently reflected such concern by noting: "Just because a physician was judged minimally competent ten or twenty years ago has little bearing on whether he or she has maintained an adequate level of knowledge and skills."[1] The Federation of State Medical Boards shares this concern and for years has held to the position that:

> *"...it is essential that the population of licensed physicians be systematically assessed at appropriate intervals to identify those whose qualifications and/or fitness for continued licensure are open to reasonable question."*[2]

A second factor is the increased awareness of the costs associated with a strictly punitive approach to addressing poor medical practice. The disciplinary process can be quite expensive and time consuming. Moreover, in itself it provides little assurance that a disciplined physician will emerge any more competent than when the process started. Through earlier detection of minor practice deficiencies and appropriate remedial interventions, many licensure authority officials feel it may often be possible to avert the need for any disciplinary action and thus provide better protection to the public.

In the United States, it seems that there is yet another factor contributing to the increased emphasis on preventive, nonpunitive approaches. As a result of mandatory reporting laws and other factors reported in our April 1990 draft report,[3] most State boards have been experiencing a considerable increase in the number of incoming referrals and complaints. Yet, in most cases, there has not been a parallel increase in the investigatory resources of the boards. Thus, for cases where there appears to be some cause for concern, but not enough to warrant the costs of investigation and disciplinary proceedings, a nonpunitive, educational intervention of some kind presents an increasingly attractive alternative.

In the United States, State medical boards are involved with many different types of quality assurance activities. These include the dissemination of practice information, encouragement of remedial education, and conduct and oversight of peer review.

In appendix B, we provide numerous examples of such quality assurance activities. They range from the inclusion of brief informational items in a board newsletter, to the preparation and distribution of pamphlets devoted exclusively to issues such as pain management and overprescribing, to the conduct of individual consultation and referral for physicians with possible practice deficiencies, to the dissemination of practice guidelines, to the detailed review of patient care assessment efforts in hospitals and other health care facilities.

The great majority of these efforts are relatively small-scale ones intended to provide useful practice-related information to all licensed physicians in the State. A smaller but increasing number of the efforts involve educational interventions directed to individual physicians. Those that do involve such interventions are directed in some cases to physicians who have already been disciplined;[4] in other instances to physicians whose practices present some basis for concern, but not enough to warrant disciplinary action.

Among the State boards, the Massachusetts board probably has the most far-reaching quality assurance agenda. On the basis of recently enacted legislation, it has considerable authority to work with hospitals and other health care entities to identify medical practice problems before they occur. Among other things, each entity must establish and gain board approval for the criteria they use to analyze the clinical performance of physicians. Moreover, the entities and even individual physicians in their own office settings are required to report to the board major incidents which might involve substandard care. Such incidents include unplanned fractures, postsurgical abscesses, or, in the case of an office-based physician, an unplanned transfer to a hospital precipitated by an invasive procedure performed in the office.

In Canada, some of the Colleges of Physicians and Surgeons are regularly carrying out quality assurance mechanisms that are not being used by their United States counterparts. Most notably, these include mortality reviews and random audits of physicians' practices.

In appendix C, we provide information on both of these approaches. The mortality reviews typically involve a review of the circumstances surrounding deaths associated with anaesthesia, surgery, pregnancy, and childbirth. In cases where the death was found in some way to be preventable, the College, depending on the particular facts of the case, will either offer suggestions to the physician or conduct a formal investigation, possibly leading to disciplinary action.

The random practice audits are focused on the office-based practices of physicians and are conducted without any grounds for expecting practice violations by particular physicians. In the few instances where State medical boards in the United States conduct practice audits, they are directed only to particular physicians who have already been disciplined or are being investigated for a possible violation.

Among the Canadian licensure authorities, the Ontario College of Physicians is making the most extensive use of random practice audits. Through its Peer Assessment Program, it now conducts annual reviews of the practices of about 400 physicians. Of this total, about three-quarters are randomly selected from the total universe of physician licensees, the rest from a target group involving physicians 70 years old or over. As indicated in appendix C, the College has found the effort to be quite effective in identifying and correcting practice deficiencies.

The Ontario College has also joined with the Province's medical schools and medical association to establish the Physician Enhancement Program (PEP), which is geared to physicians requiring more intensive evaluation and remedial education. The PEP consists of a

three-part process which involves (1) an assessment leading to an educational prescription, (2) an enhancement directed to the individual physician's needs, and (3) a reevaluation when the enhancement program is completed. Since the beginning of the program, 54 physicians have been evaluated by the PEP, with 18 of them being referred by the College.

RECOMMENDATIONS

In at least one very important sense, it may be said that State medical boards are at a crossroads. They can continue to focus almost completely on their traditional licensure and discipline activities, or, with the guidance and support of their State legislatures, they can complement these activities with a full array of preventive initiatives. If they choose the latter path, they will add to the complexity of their job, but could also make more significant contributions to the quality of medical care being provided in the United States.

In that regard, the experiences of some of the Canadian Colleges of Physicians and Surgeons, particularly in Ontario and British Columbia, are of much relevance. Our recommendations are offered in this context.

FEDERATION OF STATE MEDICAL BOARDS (FSMB)

➢ The FSMB should conduct an inquiry into the quality assurance activities of the Canadian Royal Colleges of Physicians and Surgeons to determine their potential usefulness to State medical boards.

In particular, the FSMB should examine the Canadian experiences in using random practice audits and mortality reviews as preventive tools. Both of these approaches can be quite consistent with the FSMB's stated position of basing any assessment of licensed physicians on indicators of questionable physician performance. Moreover, both can be influential in directing at-risk physicians to remedial education before they reach a point calling for disciplinary interventions.

FEDERATION OF STATE MEDICAL BOARDS AND THE AMERICAN MEDICAL ASSOCIATION (AMA)

➢ The FSMB and the AMA should develop a joint initiative to encourage State boards and State medical societies to collaborate on the development of remedial education programs for licensed physicians.

The State medical boards and State medical societies have worked together constructively in establishing rehabilitation programs for impaired physicians. It would appear that they could and should do the same for licensed physicians who must improve their practice skills. In this regard there are some already established efforts that in some way might serve as models. These include the program on misprescribing at the University of New Jersey School of Medicine, the remedial education program in the Division of Family Medicine at the University of Maryland, and the Physician Enhancement Program in Ontario, Canada. Each of these provides evaluative services aimed at identifying the particular remedial needs of a physician and an instructional program addressing those needs.

THE PUBLIC HEALTH SERVICE

➢ The Public Health Service should provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures.

The Canadian experiences with this approach appear to be positive enough to warrant serious consideration in the United States. Demonstration efforts involving a few State boards could address different approaches for targeting the physicians whose practices are to be reviewed as well as different approaches for following up on those physicians found to have some kind of deficiency. Each of the efforts should involve the careful collection and analysis of data on costs and effects.

COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services (HHS), we received comments from the Public Health Service (PHS) and the Health Care Financing Administration (HCFA). In addition, we received comments from the Federation of State Medical Boards (FSMB) and the American Association of Retired Persons (AARP).

In appendix A, we present the detailed comments offered by these parties. As indicated there, the responses to our recommendations were generally supportive. However, there were some important qualifications and reservations expressed.

Of particular note in this regard is our recommendation that PHS provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures. The FSMB and AARP supported this recommendation, but the PHS indicated that such action would be premature because of "a lack of medical review criteria that are generally accepted by the medical profession." Similarly, HCFA urged that no demonstration funding be provided "unless the FSMB evaluates the Canadian medical authorities' quality assurance activities and finds them effective."

Upon reviewing the responses, we still urge PHS to proceed in providing demonstration funding on random practice audits. Our decision is based on the following considerations: (1) The FSMB, which indicates its familiarity with the Canadian efforts, expresses strong support for the recommendation. (2) Practice audits, even with existing knowledge bases, can provide an important early warning mechanism for preventive measures that can be taken concerning physicians with questionable practice skills. (3) Practice audits are already being carried out by some medical boards on physicians who are already under investigation or who have already been disciplined. (4) Practice audits can be a particularly important form of oversight for physicians who are not on hospital staffs and are not certified by a specialty organization.

APPENDIX A

Detailed Comments on the Draft Report and OIG Response to the Comments

In this appendix we present the full comments of all the parties that responded to the draft report and our response to each set of comments. Our response supplements that offered in the final section of the text.

Within the Department of Health and Human Services, we received comments on the draft report from the Public Health Service (PHS) and the Health Care Financing Administration (HCFA). In addition, we received responses from the Federation of State Medical Boards (FSMB) and the American Association of Retired Persons (AARP).

DEPARTMENT OF HEALTH & HUMAN SERVICES · Public Health Service

Memorandum

Date SEP 24 1990

From Assistant Secretary for Health

Subject OIG Draft Report "Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada," OEI-01-89-00561

To Inspector General, OS

Attached are the comments of the Public Health Service (PHS) on the subject draft report. We concur with the intent of the recommendation directed to PHS, but believe that medical review criteria and medical outcomes measures must be developed before building the quality assurance capacities of State medical boards. Activities are currently underway or planned within PHS to develop these criteria and measures.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF INSPECTOR GENERAL DRAFT REPORT "QUALITY ASSURANCE ACTIVITIES OF MEDICAL LICENSURE AUTHORITIES IN THE UNITED STATES AND CANADA," OEI-01-89-00561, AUGUST 15, 1990

General Comments

The draft report contains brief descriptions of quality assurance mechanisms used by State medical boards and their Canadian equivalents in a sample of the States and Provinces. It notes particularly the use of random practice audits by licensing authorities in British Columbia and Ontario. However, while the report provides a brief overview of the practice audits, it does not describe the measurement standards used in these reviews.

OIG Recommendation

The Public Health Service (PHS) should provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures.

PHS Comment

We agree with the intent of this recommendation. However, we do not believe that it is currently feasible to implement the recommendation. In order for such demonstration projects to be initiated, the reviewers will need to have medical review criteria that are sound and scientifically based. At this time, most State medical boards would be seriously hampered in carrying out random practice audits because of a lack of medical review criteria that are generally accepted by the medical profession.

PHS' Agency for Health Care Policy and Research (AHCPR) is in the process of awarding a contract to the Federation of State Medical Boards to strengthen its ability to assess and improve its performance in the area of quality assurance. AHCPR is also developing medical practice guidelines, and plans to develop medical review criteria by the end of fiscal year 1992. As these developmental projects proceed, demonstrations could play an important part in building the quality assurance capacity of the boards. We believe that it may be premature to begin such projects without additional progress in the development of medical review criteria and medical outcomes measures.

In addition, we highlight the fact that the draft report also recommends that the Federation of State Medical Boards conduct an inquiry into the quality assurance activities of the

Canadian Royal Colleges of Physicians and Surgeons to determine their potential usefulness to State medical boards. Consequently, our deferral of outright support for the recommendation directed at PHS is in keeping with the report's other recommendation that the Canadian practices be reviewed before they are implemented in the United States.

Technical Comments

On pages 4 and B-1, the report mentions the use of mortality reviews by licensing authorities in Canada. The Health Resources and Services Administration is now establishing a national infant mortality review program in conjunction with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and State health departments. This review program will build on multiyear demonstration projects of the Special Projects of Regional and National Significance Program that have developed infant mortality review methods for use in local communities by health departments and private providers. Though this program is not directed at State medical boards, it is mentioned to underscore the importance of active participation by the medical profession in the development and implementation of quality assurance programs.

OIG RESPONSE TO PHS COMMENTS

We agree with PHS that its efforts supporting the development of medical practice guidelines and the FSMB's capacity to address quality assurance efforts are important ones that over time can contribute to the successful implementation of random practice audits. We especially agree that progress in developing medical review criteria and medical outcomes measures will provide a valuable underpinning to random practice audits.

Yet, we disagree that it would be premature to move simultaneously in demonstrating the use of random practice audits. Our major rationale for this position was stated in the comments section of the text. In addition, we offer two other considerations.

Random practice audits, we believe, can serve as a much more effective and less obtrusive quality assurance mechanism than another approach that is increasingly being suggested. That approach would call for periodic examinations which physicians would have to take to retain their medical license. A practice audit approach would involve only a small sample of licensed physicians each year and would focus more directly on practice skills.

Further, the practice audit approach can be limited largely or even entirely to target groups of physicians for whom such oversight is regarded as especially significant.

These might be physicians who are not on hospital staffs and/or are not certified by a specialty organization. They might also be physicians who are over a particular age.

On the basis of these considerations, we hope that PHS will agree to extend more near-term support to this approach to quality assurance. In this regard, we particularly urge that PHS give major attention to random practice audits at the national meeting it will convening on State medical boards. We called for such a meeting in our August 1990 report entitled "State Medical Boards and Medical Discipline." The PHS agreed with our recommendation "provided that it is clear that sponsorship of such a conference is not taken to signal a change in the current roles of the Federal Government and the States in professional licensure and discipline."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date OCT 5 1995

From Gail R. Wilensky, Ph.D.
Administrator

Subject OIG Draft Report - Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada, OEI-01-89-00561

To
The Inspector General
Office of the Secretary

Thank you for the opportunity to review and comment on the subject draft report. The report provides an overview of the extent and type of quality assurance activities being undertaken by medical licensure authorities in the United States and Canada.

Although the report contains no findings or recommendations for HCFA, we do have one comment on the recommendation directed to the Public Health Service (PHS). That recommendation states that PHS should provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures. We believe that no funding should be provided, nor demonstrations undertaken, unless the Federation of State Medical Boards (FSMBs) evaluates the Canadian medical licensure authorities' quality assurance activities and finds them effective.

Please advise us whether you agree with our position on the report's recommendation at your earliest convenience.

OIG RESPONSE TO HCFA COMMENTS

We agree with HCFA that further inquiry into the Canadian quality assurance activities is desirable and could provide information relevant to the conduct of random practice audits by State medical boards. However, as we noted in the comments section of the text and in our response to PHS, we believe that there is sufficient basis to take action now to conduct demonstrations on the use of random practice audits. The demonstrations could provide a valuable additional tool to add to our knowledge base in this area.

In view of HCFA's suggestion that no funding for demonstrations take place until the FSMB finds the Canadian efforts to be successful, we urge that it consider the FSMB's positive response to our recommendation.

THE FEDERATION OF
STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.

6000 WESTERN PLACE
SUITE 707
FORT WORTH, TEXAS
76107-4618

817 735-8445
FAX 817 738-6629

Richard P. Kusserow
Inspector General Health and
Human Services
330 Independence Ave., SW
Washington, DC 20201

RE: "Quality Assurance Activities of Medical Licensure Authorities in United States and Canada"

Dear Mr. Kusserow:

I have reviewed the draft report on Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada prepared by your office in July 1990. Needless to say, I am encouraged by the efforts being made by many state medical boards in this country to address the issue of quality assurance and to act prospectively to avert serious disciplinary problems. Focused educational efforts and significant support of a variety of peer review approaches represent a growing understanding of board responsibility and potential. Fortunately, the diversity of efforts being undertaken give us the opportunity to test a number of quality assurance mechanisms, including the enhanced cooperation among medical boards and PROs that has been advocated by the Federation in testimony before Congress in recent months. No doubt some mechanisms will be found to be more productive than others over the next years and will spread widely as experience demonstrates their worth. The Federation has been, is, and will be, a leading voice in encouraging this process and in focusing attention on the need for state legislators to support these efforts of the boards with strong statutes and adequate resources.

Certainly, the efforts being made in Canada are commendable. Our relationship with our colleagues in Canada is quite close and we are familiar with the programs referred to in the report. In fact, the PEP program has been discussed at our Annual Meetings on several occasions. You can be sure the Federation will, as the report suggests, keep its membership informed regarding any significant programs developed in Canada that may be applicable to the US setting.

The report also urges the Federation to join with the AMA to jointly encourage state boards and societies to collaborate in remedial education programs. Since late 1989, the Federation and the American Medical Association, in cooperation with other interested healthcare-related organizations (ACCME, AHMC, AAMC, AMPRA, etc.), have pursued efforts in this regard. As a result, the Personalized Continuing medical Education Network has been established and will be an ongoing project addressing the issue of focused/remedial continuing medical education.

I cannot encourage too strongly the third recommendation in the report,that being for the Public Health Service to provide demonstration funding to State medical boards on the use of random practice audits as quality assurance measures. However,I believe the any such funds, should they be forthcoming, should be channeled through the Federation so that appropriate direction and assistance can be provided to the boards selected for such a demonstration project.

Let me thank you for the opportunity to offer my comments on this report.

Sincerely,

/s/

James R. Winn, MD
Executive Vice President

OIG RESPONSE TO FSMB COMMENTS

We appreciate FSMB's generally positive comments on our recommendations. On the two recommendations that directly concern FSMB, we recognize that FSMB has already taken initiatives in these areas and will continue to be involved in engaging the issues. At the same time, we think that much could be gained from additional efforts concerning random practice audits and remedial education programs.

With respect to the random practice audits we believe that a concerted inquiry, under FSMB auspices, of the quality assurance approaches by the Canadian Colleges of Physicians and Surgeons could be instrumental to the potential adaptation of such approaches in the United States. The PHS and HCFA responses to our recommendation on random practice audits underscore the importance of FSMB leadership in this area.

With respect to remedial education programs, we believe that further efforts by FSMB to showcase innovative remedial education efforts involving State medical boards and State medical associations and to encourage such efforts could be of great value. If boards and other entities are to become increasingly active in preventive efforts, it is increasingly important that well-conceived, sophisticated remedial programs be in place to provide assistance to physicians.

September 13, 1990

Richard P. Kusserow
Inspector General
Department of Health and Human Services
330 Independence Ave., S.W.
Washington, DC 20201

Dear Inspector General Kusserow:

The American Association of Retired Persons is very pleased to submit these comments on your draft report entitled "Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada." *01-89-00561*

Before commenting on the recommendations of the report, let me put my remarks in context with two observations.

First, AARP recognizes the importance of medical licensing boards undertaking preventive efforts intended to minimize the need for disciplinary actions. It is far too one-dimensional to think of Licensing Boards solely as policemen whose only measure of good performance is the number of disciplinary actions they bring. Early identification of possible problem physicians and early educational/remedial programs can upgrade the quality of medical care benefiting both the medical profession and the public.

However, it would be a step backwards if licensing boards ever consider preventative interventions as an alternative to discipline. Rather, preventative programs need to supplement strong disciplinary programs. Should a licensing board for budgetary reasons find that it must cut back on its activities, it is the preventative interventions that should give way to the disciplinary program. Other existing institutions, such as medical associations and various peer review organizations, can and do offer preventative programs. However only licensing boards can conduct a full-scale disciplinary program.

The first and foremost responsibility of boards is to take action against licensed physicians whose competence is below minimum standards. The public needs to be assured that this function is being performed as well as possible. Boards who are on top of this prime responsibility should be encouraged to expand and experiment with a wide variety of preventative programs. But until a board

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Robert B. Maxwell *President* Horace B. Deets *Executive Director*

can assure the public that its disciplinary program is adequate, there is a real danger that its involvement in preventative programs will be at the expense of its prime mission -- to remove the worst practitioners from practice.

Second, educational, remedial and other quality assurance programs need not be the exclusive responsibility of medical boards and medical societies. Numerous other institutions are equipped to be part of collaborative programs to develop, administer, and monitor the effectiveness of quality assurance programs. Involving other institutions would not only enrich the quality of preventative programs, but also would enhance their credibility and ensure their wider availability. Among the other institutions that could be involved are the Clearinghouse for Licensure, Enforcement, and Regulation (CLEAR), academic institutions, Peer Review Organizations (PROs), specialty societies and other credentialing groups, consumer groups, associations of allied health professionals, and institutional providers of health care.

In the context of these general observations, let me comment on the specific recommendations in the report as follows:

1. The FSMB should conduct an inquiry into the quality assurance activities of the Canadian Royal Colleges of Physicians and Surgeons to determine their potential usefulness to State medical boards.

AARP supports this recommendation and would further recommend that the Federation and other institutions that collaborate in quality assurance programs examine what is being done in other countries as well, seeking models that would be useful in the U.S.

2. The FSMB and AMA should develop a joint initiative to encourage State boards and State medical societies to collaborate on the development of remedial education programs for licensed physicians.

AARP supports the concept of joint initiatives, but would expand the universe of potential collaborators as explained in our general observation above. Great care must be taken to be sure that remedial programs for licensed physicians are properly juxtaposed to a licensing board's disciplinary responsibility so that they do not become an inappropriate substitute for discipline.

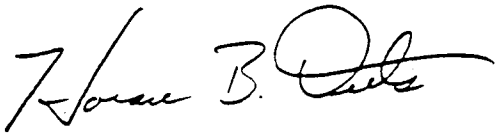
3. The Public Health Service should provide demonstration funding to State medical boards on the use of random practice audits as preventive, quality assurance measures

AARP supports this recommendation because it would expand the capacity of boards to identify potential problems while

there is still time for preventative action to avoid a situation that leads to a formal complaint and then disciplinary proceeding. Practice audits reach practitioners who do not practice in a hospital setting, thus providing a useful model for other professions.

Thank you for the opportunity to comment on your excellent report.

Sincerely,



Horace B. Deets

OIG RESPONSE TO AARP COMMENTS

We appreciate AARP's positive comments. We fully agree with its cautions that preventive actions should not become an alternative to discipline when the latter is the proper course of action and that many other entities should also be involved in carrying out quality assurance efforts directed to physicians.

APPENDIX B

Quality Assurance Activities Undertaken by Select State Medical Boards

In this section, we cite examples of three major types of quality assurance activities: (1) peer review, (2) remedial education, and (3) dissemination of practice information. In so doing, we recognize that we do not provide information on the effectiveness of these efforts and that there are many other examples we could cite. Our aim is to provide a glimpse of the kinds of quality assurance activities that are emerging.

In this context, we should note that there are other types of preventive efforts which many boards have been carrying out for some time. Most notably, these include the oversight of continuing education requirements applicable to licensed physicians in a State and the participation in impaired physician programs. Other examples include the administration of examinations to licensed physicians whose practice skills are questionable and the inclusion of various informational requests on license reregistration forms completed by physicians.

PEER REVIEW

The peer review efforts being conducted are of many different kinds. They include the oversight of peer review efforts conducted by other bodies and the actual conduct of peer review. The latter might focus on physicians who have already been disciplined, those who are being investigated for possible violations, and even those who are not being investigated.

The Virginia State Board of Medicine incorporated into its mandate authority to conduct practice audits on disciplined physicians for the purpose of ensuring practice improvements while physicians serve their penalties, and to identify physicians who are unable to correct their deficiencies. Audits are conducted on most disciplined physicians regardless of the reason for discipline, and usually occur within the first six months of a penalty. An audit consists of randomly selected patient charts reviewed for diagnosis, treatment, prescribing knowledge (including rationale for drug selection and knowledge of the chosen drug's side effects), and rationale for patient management.

The **Oregon Board of Medical Examiners** is mandated to conduct peer review for any health care institution upon request and, depending on how the institution wishes to act on findings, the board will develop a case for hearing. In addition, the Oregon Board of Medical Examiners, in conjunction with the Oregon Foundation for Medical Excellence, the University of Oregon Medical School, and the Oregon Association of Hospitals, is awaiting acceptance of a proposal to develop quality assurance criteria for hospital peer review. These criteria would aim to identify problem areas in education and training.

The **California State Board of Medicine** is participating in a commission which is examining how to conduct peer review in long term care facilities.

The **Colorado Board of Medical Examiners** recently established a subcommittee to act as a mini court of appeals for peer review decisions made by other bodies. Any appeal of a peer review outcome must go through this subcommittee. It is estimated that 40 to 60 percent of all peer review decisions will go through this process.

The **Minnesota Board of Medical Examiners** and the **Maryland Board of Physician Quality Assurance**, with the assistance of volunteers of the State medical associations, are empowered to conduct practice audits as part of an evaluation of competence during a disciplinary process. These audits are conducted by peers.

In **Maryland**, the **MEDCHI**, a group of volunteers from the State medical society, conducts practice reviews on all substandard care, gross professional misconduct, and willful overcharging cases being considered by the board. Two peers review randomly selected patient charts unless a more specific review is requested. In addition, reviewers evaluate the office's physical facilities and various other factors, such as policies regarding fee determination. The physician to be reviewed receives a letter informing him or her of an upcoming on-site review, along with a questionnaire to complete prior to the review. Two reviewers evaluate the same medical records, complete forms on each record, and submit their report to the society's peer review committee, whose members represent a broad spectrum of specialties. The committee functions as a stopgap, deciding whether more practice information is needed before a determination can be made and passed on to the board. The board's triage committee subsequently performs a similar evaluation of the findings, deciding whether to develop a case or request a more specific review.

The **Massachusetts Board of Registration in Medicine** was granted authority in 1986 to establish a qualified patient care assessment program (PCA). A major purpose of the program is to identify potential practice problems and to put in place preventive measures designed to minimize or eliminate substandard care. The program is intended to accomplish these goals by strengthening, formalizing, and integrating programs of credentialing, quality assurance, utilization review, risk management, and peer review.

A second purpose of this program is to accomplish a stabilization, if not a reduction, in the frequency and cost of malpractice claims against physicians and institutions. Every State licensee must participate in a PCA program established at his or her place of employment, covering all kinds of practice settings, including nursing homes and private offices.

Each facility must establish criteria with which to document and analyze clinical performance and must determine the mental and physical status of its physicians and assure that they meet continuing medical education requirements. Each facility establishes specific requirements for the practice of medicine, including regulation for medical records, prescribing practices, medical errors, and informed consent. Facilities conduct internal audits and peer review according to occurrence screening criteria. The PCA coordinator at each facility is charged to develop written recommendations for appropriate corrective actions. Major incidents are reported to the medical board.

Licensees who practice only in office settings must file incident reports in the event of unplanned transfers to a hospital or in the event of major or permanent impairment of a patient's bodily functions or unforeseen death. A licensee's office is subject to on-site audits by the board to assure compliance. Licensees performing invasive procedures in the office must also allow their insurer to conduct audits. The PCA committee, a subcommittee of the board, reviews all major incident reports to evaluate whether appropriate follow-up and corrective measures were undertaken and to determine whether the risk management quality assurance policy which existed was adequate or implemented correctly.

Though still in the initial phases of identifying risk patterns, the committee has observed the prevalence of two kinds of incidents which, it feels, may be eliminated by PCA-defined quality assurance policy and implementation. These are dual diagnosis and patient falls.

REMEDIAL EDUCATION

For physicians who need remedial training but have difficulty gaining admission to mini residencies and whose needs are not met by continuing medical education, some boards are taking steps to create educational programs tailored to the specific needs of these physicians. Moreover, some boards, in cooperation with other State entities, are developing programs equipped to provide individually tailored retraining. With increased awareness of this population, some boards are imposing remedial educational interventions as part of disciplinary orders or in their own right, unaccompanied by disciplinary actions.

The **California State Medical Board** conducts medical educational conferences with licensees who have been identified through the investigatory process as having practice deficiencies which, though not severe enough to warrant discipline, nevertheless do indicate the need for correction. During a conference, an investigator and medical consultant work with the physician to explain the nature of the deficiency, attempt to reeducate him or her, and allow the physician to implement recommendations in order to self-correct deficient practice patterns. About 300 of these conferences are conducted annually.

Oregon's Board of Medical Examiners, in conjunction with the Oregon Foundation for Medical Excellence, sponsors over 50 educational programs on various topics such as physician/patient communication, inappropriate prescribing, chemical substance dependence, and good medical records practices.

The **Illinois Department of Professional Regulation** may require remedial education as part of a disciplinary order, and in many cases the board has arranged the creation of a course designed to correct identified deficiencies. The University of Illinois College of Pharmacy, at the board's request, offers a course on the use of prescription drugs for disciplined physicians and other licensees. The board has also arranged for institutions to provide individually designed remedial training. The length of any such requirement varies, depending on the nature and extent of the deficiency. While all such courses end with the administration of an exam, the medical coordinator for the disciplinary board sets the passing score and decides whether the physician has been successfully retrained.

The **Minnesota Board of Medical Examiners** has begun imposing many more educational interventions both as part of disciplinary orders and as dispositions in their own right, unaccompanied by disciplinary actions. These interventions are tailored to identified deficiencies and are for the most part arranged by the board. The board will arrange for an institution either to sponsor a course, where none exists, or to provide remedial training with clinical supervision. In one instance the board arranged for a hospital to design a course on chemical dependence awareness and drug-seeking behavior by patients. Through these kinds of initiatives, many local resources are now available to physicians. For example, there now exist programs on chronic pain management and misprescribing. In addition, the board is currently negotiating a contract with a multi-hospital facility to provide remedial skill training. Under the contract the facility will accept disciplinary referrals.

For some time, the **Maryland Board of Physician Quality Assurance** has been able to refer physicians to a course in remedial recordkeeping offered at the Division of Family Medicine at the University of Maryland. In the past, the board has referred to the program physicians whose medical records are so poor that their competency cannot be evaluated or physicians whom the board suspects are incompetent. However, a more comprehensive remedial educational program, known as the Medical Education Project and developed by the peer review management committee of the State medical society, is now nearing institutionalization.

DISSEMINATION OF PRACTICE INFORMATION

While for some time boards have sent out newsletters informing licensees of available educational programs, of trends in the bases for disciplinary actions, and of changes in a State's Practice Act or other licensure requirements, some boards are now sending out specific practice information.

The **Massachusetts Board of Registration in Medicine** recently issued pamphlets on various health care/licensure topics, including AIDS treatment guidelines (such as providers' duty to care, anti-discrimination standards, privacy, confidentiality, and infection control procedures), guidelines for specialty standards, and information on prescribing registration requirements and other general prescribing information (such as treating drug-dependent patients and identifying the deceptive patient). Moreover, in addition to its previously described responsibilities, the PCA committee provides technical assistance in risk management. In this capacity it is developing a report on cardiac monitor failures which will be issued by the board. A second report containing guidelines for the use of new, more expensive contrast dyes is in development.

The **Maryland Board of Physician Quality Assurance** issues "letters of education," which contain standards of care. Letters have been sent on such topics as "Failure to notify a patient of a positive pap smear within a reasonable time," "Duty to warn patients of possible cross-allergy of penicillin and cephalosporin," "Medical justification for ordering a diagnostic test specifically as HTLV-III test," and "Duty to order blood tests to confirm or rule out a diagnosis of Hepatitis A." These letters inform physicians of what is expected of them and warn them that the board will take action in case of violations.

The **California State Board of Medicine** published pamphlets on guidelines for pain management and guidelines for AIDS treatment, for general practitioners.

The **Oregon Board of Medical Examiners**, in conjunction with the Oregon Foundation for Medical Excellence, sends out two to three pamphlets annually on overprescribing.

APPENDIX C

Quality Assurance Activities Undertaken by Select Canadian Provinces

The following discussion delineates quality assurance initiatives undertaken by select Canadian Colleges of Physicians and Surgeons. A College of Physicians and Surgeons exists within each Canadian Province. These Colleges, which are public entities and part of Provincial government, are the Provincial licensing and disciplining authorities and so, in essence, are the Canadian analogues to State medical boards. Like State medical boards, the Colleges function independently of the national government and each other, and operate on revenue generated from licensure fees. Also similar is the fact that the Colleges vary somewhat in structure from Province to Province and in the extent to which they pursue quality assurance.

The three Colleges that we reviewed reflect an enforcement philosophy that involves identifying and disciplining problem practitioners but also identifying practice deficiencies and correcting them before harm results. This requires providing physicians with the ability to identify their weaknesses and enhance their skills. The result is an emerging emphasis on skill evaluation as a basis for education and a complement to discipline, rather than as a basis for discipline.

These activities are proactive in the sense that they are intended as preventive strategies. For example, many of the Colleges in Canada have standing committees which conduct mortality reviews. These consist in reviewing all circumstances surrounding deaths associated with anaesthesia, surgery, pregnancy, and childbirth. The process concludes with the classification of cases as either nonpreventable, preventable, or ideally preventable. If factors of preventability are identified, recommendations are made to the responsible individual or institution in an effort to avert a similar incident in the future.

The Colleges have found such preventive activities to be effective and efficient strategies for identifying patient mismanagement or substandard medical practices, and for correcting poor-quality practices. In addition to the considerable expense, in both time and money, required to identify and discipline a physician, the societal cost is great. These strategies, in the views of the officials we interviewed, have proven to be more socially efficacious and considerably cheaper than the alternative, which is disciplinary proceedings and punishment. Early detection of minor deficiencies can encourage self-correction, thus promoting high-quality care and preventing minor deficiencies from becoming major deficiencies which may cause injury. Indeed, a large majority of physicians reviewed and found to be deficient, even if only minimally, had self-corrected their problems upon reassessment and offered positive comments about the educational value of the program. Moreover, these activities, which are funded by the Colleges, generate a considerable savings in both time and money. Officials in Ontario estimate that the Physician Enhancement Program alone is seven times cheaper than the cost of challenging licensure issues in court. The fact that no mechanism exists within the disciplinary system to ensure that disciplined physicians emerge at the end of

the disciplinary process any more competent than they were at the start of it is further impetus for these kinds of initiatives.

What follows is a description of quality assurance activities underway in three Canadian provinces: Saskatchewan, British Columbia, and Ontario. These descriptions are meant as illustrative of kinds of quality assurance initiatives which could be undertaken by State medical boards.

SASKATCHEWAN

The Department of Public Health in Saskatchewan, through its Medical Care Insurance Commission, conducts a peer review process which is focused almost exclusively on billing issues. The cases it reviews range from simple clerical errors to deliberate fraud or flagrant overservicing.

About 1,300 of Saskatchewan's 1,500-1,700 physicians are subject to a detailed billing audit conducted by the Saskatchewan Medical Care Insurance Commission. Physicians who have been identified for overbilling, incorrect billing, or other aberrant billing practices are referred by the Commission to a peer review committee. A case is presented as a summary of statistical information, including comparison to similar physician groups within Saskatchewan and samples of patient billing histories. The groups are defined by specialty, rural/urban residence, and clinic/solo practice affiliations. For those referred cases which are pursued, the committee asks the physicians for a written explanation of their practice patterns, as evident from their billing. If the committee is dissatisfied with any such explanation, the physician in question will be called to an interview with the committee. If the interview reveals practice deficiencies, the committee will make a recommendation to the Medical Care Insurance Commission which may include (1) reassessment of accounts, (2) referral of the case to the Provincial Department of Justice for investigation of fraud, and/or (3) referral to the College of Physicians and Surgeons for investigation of quality of care problems.

The Commission also interviews the physician and decides whether to proceed with or alter the peer review committee's decision. Historically, the Commission has altered only a very small number of cases. Very recent organizational changes have converted the committee from a subcommittee of the Commission to a decision-making body and have added the ability to impose a $50,000 fine in addition to any reassessment it may impose.

BRITISH COLUMBIA

The British Columbia College of Physicians and Surgeons is mandated to conduct practice audits of physician practices and is not required to demonstrate reasonable grounds for such audits. Its program for conducting peer assessment of physician office practices arose because of an increasing number of practitioners without hospital appointments. Unlike a decade ago, when all but a very few British Columbian physicians practiced in institutions with multiple oversight mechanisms, many physicians have recently elected to restrict their practice to private offices and so are not as subject to reviews of their medical practices.

The College's Committee on Office Medical Practice Assessment conducts about 150 random practice audits annually (which account for about 2 percent of all B.C. physicians) on the office medical practice of physicians. An audit consists of not only a random chart review but also an evaluation of an office's physical facilities. A report on each physician is submitted to the Committee, which assigns it to one of the following categories:

1 = No significant deficiency in medical records; no evidence of or minor deficiency in patient care.

2 = Minor deficiency in medical records; no evidence of or minor deficiency in patient care.

3 = Significant deficiency in medical records; no evidence of or minor deficiency in patient care.

4 = Medical records are so deficient that no judgment can be made regarding patient care.

Physicians in categories 2 and 3 receive a follow-up letter with recommendations. Physicians in category 3 receive a follow-up audit within one year to determine compliance with recommendations. Physicians in category 4 must appear before the committee with at least 30 charts to explain their practice.

Since the program began a year and a half ago, 92 percent of those audited have shown no significant deficiency, 6 percent have fallen into category 3, and 2 percent have fallen into category 4. The estimated cost of each audit to the College is $1,000.

There has been little professional resistance to the College's audits, with only one physician challenging findings. British Columbia is in the early planning phases of developing an enhancement program modeled after Ontario's Physician Enhancement Program.

ONTARIO

Ontario's College of Physicians and Surgeons also has statutory authority to conduct random audits without demonstrating reasonable grounds. In 1978 and 1979 Ontario's College of Physicians and Surgeons undertook two separate pilot programs, which demonstrated the need, feasibility, and likely acceptance of such a program. Subsequent reviews of a randomly selected sample of general/family practitioners and specialists in seven areas revealed serious deficiencies in 8 percent of the practices studied, with statistically significant differences demonstrated between family practitioners and specialists.

Further results from the past five years identified a pattern of risk and confirmed the previous finding that family practitioners constituted a high-risk group. Statistical analysis revealed that a higher number of problems occurred in physicians who were over 65, in solo practice, and not certificants of the College of Family Physicians of Canada. Specialists of the two national standard-setting bodies (Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada) posed no significant risks.

The Ontario College reports that through its Peer Assessment Program it is now reviewing about 400 physicians each year. Of this total, about three-quarters are randomly selected from the College's registration file. The rest are part of a target group involving family practitioners and specialists that are 70 years old or over. The College reports that at this time assessments have been conducted on every practicing family practitioner in the Province and, in 11 specialty areas, on every physician specialist over the age of 70. Overall, since the Peer Assessment Program began in 1981, the office practices of over 2,000 physicians have been assessed.

A representative of the College, in a January 1990 letter to us, commented as follows about the results of the assessment process:

> "The experience of the program continues to show that in excess of 50% of the physicians who have been previously identified as having deficiencies were found upon reassessment to have adequately addressed the concerns of the Committee. The Peer Assessment Committee has several options with regard to the remainder. Most frequently, a physician would be advised that he has failed to make appropriate improvements and is advised that he will be reassessed in the office. The physician might alternatively or in addition be requested to meet with the Committee once again in order to discuss the concerns.
>
> By far the majority of physicians who initially fail to address the problems will now take note of the concerns and take appropriate steps to correct the deficiencies. Since many of the physicians with the most significant deficiencies are in the more senior age groups, it has been our experience that a moderately large number of physicians will retire during the course of the process. There is then only a very small number of cases which are referred to the Executive Committee of the College for further consideration. Such physicians are interviewed by a member of the Executive Committee or the Registrar of the College in order to make certain that the physician is aware of the importance which the College places upon the program. During the whole of the process of course, the prime aim of the Committee is to provide educational contacts whereby a physician's deficiencies might by remediated.

Since the program commenced in 1981, only one physician has been referred to the Discipline Committee of the College and that was for the physician's continued refusal to participate in the program thus contravening Section 64A of the Health Disciplines Act."

Physician Enhancement Program (PEP):

For physicians requiring more intensive evaluation and further remedial education, the College has contributed to the development of a Physician Enhancement Program (PEP). Following is a brief summary of PEP prepared for us by the staff of the College:

"Ontario's Physician Enhancement Program (PEP) is an educational program designed to assist practicing physicians maintain their professional competence. The educational services are individualized, strictly confidential, and nonpunitive. Its structure, implementation, and management have been made possible by the joint efforts and interest of Ontario's five medical schools, the medical association, and the College of Physicians and Surgeons. The program has now been in existence for three years.

The PEP consists of three phases: I. Evaluation and educational diagnosis leading to an educational prescription; II. Enhancement tailored to the individual's needs; III. Re-evaluation upon completion of the enhancement program.

In phase I, physician participates in a 1.5-day assessment and is evaluated using 100 multiple choice questions, chart-stimulated recall, structured oral, OSCE and practice simulations with standardized patients.

Clinical and Societal competence is tested on the basis of knowledge (basic science and clinical science and ethics), clinical skills (history taking, physical examination, problem formulation, rational investigation, judgment/decision making, use of consultants, care management, therapeutics, follow-up plans, technical skills, and medical records), and psychosocial skills (attitude, self learning, communication, and interpersonal skills).

Through a one-way mirror, two assessors independently rate and score the physician's performance and complete a specific evaluation form for each activity. The assessors are blind as to the reason for physician's referral. The evaluation is videotaped.

Each evaluation is criteria based. The standards are defined mainly on performance obtained from the assessment of 30 rural and urban practitioners randomly selected from the communities.

Among the physicians assessed to date, the most common deficiencies found were problem formulation, knowledge, and interpersonal skills.

In phase II, the PEP coordinator, physician, and, if applicable, mentor/supervisor discuss the evaluation report. A set of evaluation objectives is developed, and based on the available resources an individualized enhancement program is developed.

Depending on the type of deficiencies, the enhancement program may consist of individual or group training. Group enhancement has been designed which consists of 24 two-hour sessions covering clinical problems, assigned reading, simulated cases, and a two-day workshop on communication and interpersonal skills.

If the physician is found to have minor deficiencies, a self-learning approach is advised. If the report indicates significant deficiencies, but physician is well motivated, he/she may be advised to work under supervision for a specific period. If the report indicates serious competency and learning/motivational deficiencies, a period of formal retraining may be advised.

In phase III, upon completion of the enhancement program, the physician is re-evaluated in those areas previously identified as deficient.

To date, 54 physicians have been evaluated, of whom 18 were College referrals, two hospital referrals, and 15 self-referrals.

Since the beginning of PEP, the College has been the sole provider for funding. The program operates on an annual fixed budget of $130,000 and variable cost of $1,850 for each evaluation. An enhancement program on interpersonal and communication skills has been developed at a cost of $1,700 to each physician. However, physicians are required to pay for the enhancement, which varies dramatically depending on individual requirements. All self-referrals pay for the program themselves (evaluation and enhancement).

The Physician Enhancement Program reflects the commitment of the medical profession to provide the best possible care to our patients."