Problem Doctors: Is There a System-Level Solution?

Deciding how to handle problem doctors can be extremely uncomfortable, but it must be done. Lucian Leape, MD, from the Harvard School of Public Health, Boston, Massachusetts, USA, described the issues surrounding this problem and made suggestions for implementing solutions. “When we say ‘problem doctors,’ we don’t mean bad doctors. We mean our friends and colleagues whose performance poses a potential threat to patient safety,” said Dr. Leape, a founder of the National Patient Safety Foundation. “Our failure to ensure that all of our colleagues are competent and safe is ethically indefensible, and we have to do something about it,” Dr. Leape continued. “We are the only ones capable of judging and taking action with our peers. No one wants someone else to judge these physicians or to get the court system involved. We have to take the responsibility.”

Common Problems
“Problem” doctors include those with substance abuse problems, mental or physical illnesses, and other impairments. Other physicians can show competency and behavioral issues; they are disruptive or abusive toward staff or patients (Leape et al. Ann Intern Med. 2006;144:107).

Questions in Supporting Recovering Doctors

- Who pays for assessment and remediation?
- How is his/her income maintained?
- Are we willing to make refresher positions available in all of our residency programs?
- Are we willing to mentor and supervise retrained doctors?
- Will we let them care for patients?

What Would an Effective Professional Accountability System Look Like?

- Performance standards would be adopted.
- Adherence would be a condition of appointment to staff.
- Everyone’s adherence would be monitored.
- Feedback on results and action would be provided.
- A broad repertoire of methods for remediation would exist.

Impaired Physicians. Approximately 8% to 13% of the U.S. population has a problem with substance and alcohol abuse. Reliable studies show that about 10% of Americans have an alcohol dependency problem and about 5% have a drug problem. Dr. Leape said the statistics are about the same within the physician population.

Mental Illness. A study published in The Journal of the American Medical Association estimated that 10% of Americans have a disabling bout of depression at some time in their lives (Kessler et al. JAMA. 2003;289:3095). During this time, they may be unable to work or function. The number may be higher for physicians because the incidence of suicide is higher in doctors than in non-physicians (Scherenhammer et al. Am J Psychiatry. 2004;161:2295).

Physical Illness. During physical illness, physicians may be unable to function in a safe and effective way for a projected period of time. Physicians develop cancer and heart disease and break bones just like the general public. Dr. Leape estimated that illness affects 10% of the current physician workforce.

Declining Competency. It is difficult to measure declining competency accurately. Dr. Leape analyzed one measure: failure rates on recertification examinations. He has some data about how well people do on their first recertification exam, which is typically 5 to 10 years after the original certification.” Dr. Leape explained. One measure looked at recertification examination failure rates in 2004 from the American Board of Surgery, the American Board of Pediatrics, the American Board of Internal Medicine and the American Board of Family Medicine. “What we see is not encouraging. About 5% to 10% of physicians flunk their first recertification exam,” he estimated.

Behavioral Problems. Studies that accurately measure physicians’ behavioral problems are lacking. While many surveys exist, few are done using rigorous methods and represent samples. Dr. Leape noted a 2004 survey of VHA hospitals worthy of consideration, as it involved a large number of nurses. Its results showed that about 95% of the nurses had witnessed or been the target of disruptive behavior from a physician. Nearly two-thirds had been abused verbally every two to three months. The study found that about 5% of doctors probably treat people this way (Rosenstein et al. Am J Nurs. 2005;105:54). This number is not too far off from survey results of hospital executives, who reported that between 1% and 5% of physicians engage in disruptive behavior, according to Dr. Leape.

Patient Abuse. Gerald Hickson, MD, and colleagues analyzed patient complaints to his hospital, Vanderbilt University, and linked the results with malpractice suits. Researchers estimated that about 6% of physicians are abusive. Abusive doctors were defined as those receiving more than two complaint letters a year. They found that most physicians at Vanderbilt (80%) receive no complaints from patients (Hickson et al. JAMA. 2002;287:2951). However, physicians who regularly receive complaints have a much greater chance of being sued for malpractice.

These common problems may overlay; a person with mental illness also may be an alcoholic with a competency issue. Dr. Leape estimated that about 30% to 40% of physicians will, at some time in their careers, be impaired in such a way that they cannot function safely. This large percentage, applied to the course of a professional career of 30 or 40 years, means that most healthcare workers probably are exposed to at least one of these physicians. At any given time, for every 100 physicians on staff, at least one is in trouble (Leape et al. Ann Intern Med. 2006;144:107).

It often is difficult for these troubled physicians to find and receive help. Many times, an incident or complaint triggers action even though warning signs can appear very early. Unfortunately, few institutions have good mechanisms to address these problems early. There also is resistance to bring problems or suspicions forward. “These physicians have to tough it out on their own until they get in trouble,” said Dr. Leape. “We tend to shy away from getting involved. These are, after all, our friends and colleagues. These physicians have a serious problem, and our first impulse is to make it someone else’s problem. There also is an incredible consequence of taking somebody off the staff - you’re in effect taking away their livelihood – and we are reluctant to do it.”

Implementing a Solution

A dismissed physician may fight back with a lawsuit, which creates an unpleasant and unappealing process. Dr. Leape called for a better system to address “problem” doctors. To put such a plan into action, three things are needed: standards, measures, and assessment remediation programs Early identification, proactive action and follow-up are vital in helping these physicians. The system should be fair and applied to everyone equally. “We need a peer-run system to identify people early,” commented Dr. Leape. “Our goal should not be to get rid of them. Our goal should be to make it possible for people to stay in practice.”

Multisource feedback is an important tool when trying to identify problems early. The College of Physicians and Surgeons in Alberta, Canada, developed a multisource, multiratification program called the Physician Achievement Review (PAR) (www .par-program.org. Accessed March 27, 2007). Physicians rank themselves, and nurses, patients, colleagues and others rank them as well. Confidential feedback shows each physician how he or she measures in each of the traits and compares the physician’s self-perception to others’ perceptions. Tracking patient complaints also is a fairly easy way to measure performance at the hospital level, according to Dr. Leape. “It would suggest that you think seriously about multisource feedback,” he said. “It is a very powerful instrument, and it can provide the
kind of information that is not available elsewhere.”

Subpar performance also can be identified early through routine monitoring. The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties have developed a written, clear definition of standards of competency. These standards act as requirements for residency programs and now are being adopted for maintenance of certification programs. “I’m particularly impressed with the work that the American Board of Internal Medicine has done,” Dr. Leape explained. “They now have a functioning program where physicians can have their competency assessed on a voluntary basis.”

Methods like these must be applied fairly; candidates likely to have problems cannot be singled out. Developing clear standards of performance that include standards for competency and behavior will create a system based on data rather than opinions. When physicians are hired, they should understand that the hospital is serious about this issue. Physicians should sign a document saying that they have read the standards, that they understand them, and that they know they are expected to follow them. They should know before joining the staff that if they do not follow these standards, they will be asked to leave. Behavioral standards should include language about showing respect for all workers and condemning abusive behavior. Adherence to standards should be a condition of appointment.

Other than what can be done on an individual basis, there is a definite gap in terms of what needs to be done once a problem is identified. “It is our responsibility to help the person straighten out,” said Dr. Leape, noting different levels of action. Sometimes one only needs to call attention to a problem; other times counseling, retraining or restriction of practice may be needed. Unfortunately, a large repertoire of methods for assessment and remediation is lacking. Only a handful of centers in the country can perform assessments and very few of those have much in the way of remediation programs. Dr. Leape suggested calling on bodies that can expand these programs at the national level: the American Board of Medical Specialties, the Federation of State Medical Boards, The Joint Commission, and the National Board of Medical Examiners. These groups should be asked to come together and establish resources.

Those identified as “problem” doctors should go to a center to receive retraining and be supervised after returning to work. “People may be skittish about having to monitor or mentor people who have had problems. However, we need take responsibility as people move back in. Retraining programs also may be considered for everyone in the profession. I think that one of the conditions for having a residency program in any specialty ought to be that you have one or two slots for retraining,” Dr. Leape said. “I’d like to see everyone go back every 5 or 10 years and spend a few months in residency to get updated.”

Testing physicians is a hot-button issue as hospitals develop systems to identify, monitor and treat “problem” doctors. “I remember a colleague of mine who practically passed out in the operating room one day,” Dr. Leape recalled. “We learned that he had diabetes that was not easy to control. He got absolutely no help because he didn’t ask for any help. In fact, he kept it a big, dark secret. That’s not fair to the patients.” Physicians are not required to take annual physical exams even though they may help identify these types of health problems. Dr. Leape also suggested exploring cognitive testing, citing data that show cognition declines with age (Powell. Profiles in Cognitive Aging. Cambridge: Harvard University Press;1994). As far as drug testing, only the Department of Veterans Affairs performs tests. “I think the time has come to say that the safety of patients is more important than the privacy concerns of individuals,” said Dr. Leape.

“We are talking about 30% or 40% of us, not just 5% or 10%,” Dr. Leape said. “This is a big challenge, a big agenda, and not an easy problem; however, it is something that we need to take on. I hope you’ll give it serious thought,” Dr. Leape concluded.

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**Continuing Education Self-Assessment**

**Problem Doctors: Is There a System-Level Solution?**

5. Which of the following is an effective strategy in dealing with “problem” doctors?
   a. Monitor only those who demonstrate signs of risky behavior in order to identify as many potential “problem” doctors as possible.
   b. Adherence to standards should be a condition for appointment.
   c. Staff may feel uncomfortable supervising a physician who recently has been retrained, so supervision should not be required.

6. What percentage of physicians will be impaired at some point in their careers such that they cannot function safely?
   a. 5% to 10%
   b. 15% to 20%
   c. 30% to 40%