Evolution of a Remedial CME Course in Professionalism: Addressing Learner Needs, Developing Content, and Evaluating Outcomes

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Introduction: *Scant information is available about the nature of the professional violations resulting in referral of physicians for remedial continuing medical education (CME). The CME program at Case Western Reserve University (CWRU) School of Medicine has developed the Intensive Course in Medical Ethics, Boundaries, and Professionalism (medical ethics course) for physician referrals due to ethical breaches. In this report, the authors present 7 years of data regarding the type of behavior that resulted in course referral as well as information regarding course and outcome evaluation development and participant demographics.*

Methods: *The medical ethics course has been designed in consultation with licensure agencies to address the learning needs of physicians with problems in the areas of boundary maintenance and ethics. Teaching methods and outcome evaluations include lectures, case discussions, multiple-choice question tests, skill practice sessions, and writing a reflective essay based on the participants' ethical lapse. Information is also gathered regarding participant demographics, training, and practice characteristics.*

Results: *Between September 2005 and February 2012, 358 learners participated in the course. The average age was 52 years and 73% were board certified. Of the 269 physicians who wrote a reflective essay, the reasons for referral included prescribing of controlled drugs, sexual boundary issues, providing services to family or friends, not maintaining proper medical records, and billing issues.*

Discussion: *This report outlines the strategies used by CWRU to develop remedial CME courses using the medical ethics course as an example for course and outcome evaluation development. This is the first report characterizing the type and frequency of the medical ethics violations that result in mandatory participation in remedial CME.*

Key Words: *remedial CME, medical ethics violations, professionalism, boundary maintenance, doctor-patient boundaries, physician problematic behavior*

Introduction

The role of the state medical boards is to ensure that physicians adhere to the standards of professional conduct set by the Code of Medical Ethics of the American Medical Association[1] and to determine whether any unacceptable behaviors warrant sanctions, which can range from mild to severe. Complaints to medical boards may come from a variety of sources, including other physicians, patients, families, malpractice data, health care institutions, and governmental agencies.

In 2009, disciplinary action was taken against 5 721 physicians in the United States, a figure that reflects the largest increase in several years, according to data from the Federation of State Medical Boards.[2] Over time, the increase in disciplinary actions has occurred predominantly in the category of mild sanctions. These sanctions typically result in reprimands, license modifications, or referral for remedial continuing medical education (CME). This increase

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in sanctions underscores the need for remedial CME offerings that are accessible, affordable, and effective. Remediation programs offer physicians an opportunity to learn, correct deficiencies, and avoid more severe sanctions. However, there is little evidence that remedial education actually changes physician behavior,[3,4] and very little has been published about the specific types of professional violations that have resulted in sanctions.[5–7] As the need for remedial resources continues to grow, data regarding violations and outcomes will be increasingly important to successful program design.[4,8,9]

The Case Western Reserve University (CWRU) program in CME has been at the forefront of remedial CME educational offerings for over 20 years and has developed a series of courses designed to meet the needs of health care providers in need of remediation. These courses have focused on areas of prescribing, record keeping, communication, and ethics. Begun in 1990, the goal of the program was to develop intensive, skill-based, longitudinal, practice-oriented courses that culminated in outcomes assessments. This intensive course series initially responded to requests from the Ohio, Indiana, and Illinois state medical boards but within 5 years was receiving referrals from boards from across the United States and Canada.

This article describes the process of developing one of these courses, the "Intensive Course in Medical Ethics, Boundaries, and Professionalism," which we will refer to as the medical ethics course. We will also present information regarding participant demographics and course outcome measures. Finally, we provide data on the nature and frequency of problematic physician behavior resulting in referral to the medical ethics course over the past 7 years.

Methods

The medical ethics course is offered twice a year on the CWRU campus and is designed for physicians who have an acute need for study in this area. Learners are referred by medical and pharmacy boards, medical societies, managed care organizations, credentialing committees, physician review organizations, and medical staff offices. Less than 5% of participants are self-referred.

Content Development

The CWRU CME program assesses the clinical practice gaps and learning needs of potential medical ethics course participants using aggregated data gathered from licensure agencies, risk management professionals, medical malpractice sources, and faculty-physician focus groups. In addition, as part of the initial development process, a survey was sent out to the executive directors of all state medical boards and state medical societies to obtain feedback about proposed course content and duration and to solicit recommendations about course topics. These responses identified specific practice gaps and learning needs focusing on professionalism in relationships including sexual boundaries, boundary issues regarding self-care and treating family and friends, prescribing controlled drugs, and fiduciary relationships.[6,10,11] Feedback provided was used to develop the course content and outline. The full agenda is available as supplemental material (APPENDIX S1) in the online version of this article.

Teaching Methods

Traditional CME has been primarily didactic; however, studies have shown that learners are more receptive to learning in smaller, interactive settings.[12,13] Enrollment in the medical ethics course is therefore limited to 25 to 35 participants per course offering. The teaching methods used include lectures, case discussions, frequent question-and-answer sessions, and skill practice sessions. Participants are also given an extensive syllabus, a pre-/post–targeted ethics multiple-choice question (MCQ) test focusing specifically on course content, a general medical ethics MCQ test, and a pre/post/follow-up reflective essay assignment with faculty feedback. This balance of educational strategies is designed to accommodate different participant learning styles, and emphasizes learning in knowledge, attitudes, and skills domains.

Evaluation Design

Several participant assessments have been developed over the past 5 years, primarily as self-evaluations that allow participants to assess their own skills. Assessments to determine whether course participants are adequately prepared to practice medicine, from an ethics and professional boundary perspective, are beyond the scope of the program in CME. The overall design of the evaluation is a single group with pre/post measures except as noted below. Participant assessment strategies include a general medical ethics MCQ test, a targeted pre/post MCQ test focused on specific course content, skill practice sessions, and a pre/post/follow-up reflective essay assignment (Moore assessment levels 3–5).[13]

General Ethics MCQ Test

The course begins with administration of the general medical ethics MCQ test to evaluate course participants' basic knowledge in ethics and professionalism. This test was assembled using several publicly available sources of ethics "shelf-examination" questions used by medical students and residents to prepare for licensure and specialty examinations.[9] On the second day of the course, participants

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are given their scores in specific ethical content areas, and the most commonly missed questions are then discussed in a large-group format.

Pre- and Post-Targeted Ethics Test

In 2010, the faculty developed a pre-/posttest with 3 to 4 multiple-choice items written specifically for each of the 10 course presentations, for a total of 35 questions and 52 points. Participants complete the same test at the beginning and at the conclusion of the course. The learners' pre- and posttest scores are tallied and shared with each participant. Results of the general ethics MCQ test and this pre-/post–targeted ethics test are available to referring agencies upon request. Agencies that refer physicians or other health care providers for remediation have shown more interest in this "content-specific" pre-/posttest than the general medical ethics testing, as it is a more targeted reflection of the content presented during the conference.

Skill Practice Sessions

Boundary maintenance skills require practice. Therefore, each participant practices from both the physician and patient perspective the clinical skill of "Getting to 'no.'" The specific scenario that is focused on in this skill practice exercise involves practicing saying "no" when asked to prescribe controlled drugs. Participants are observed by their partners using a skill checklist, given feedback, and given the continued opportunity to practice their ability to set boundaries until they complete the task.

Reflective Essay Assignment

Studies of medical practice show that reflection and reflective practice exercises provide physicians an opportunity to consider their strengths and weaknesses and help them to successfully integrate new learning into existing knowledge.[14] This reflective assignment consists of 2 main parts. Part 1 is an invitation to

> Briefly describe the clinical case or professional situation that prompted your interest in the upcoming ethics course. Please provide sufficient detail so that a course faculty member can read this case description and understand the essential issues that are presented." Part 2 takes place at the end of the course and requests participants to "write about your clinical case from three different perspectives: What were the ethical/boundary issues involved in your case or scenario? How do these issues relate to your original behaviors? Having completed this course, what are different possible actions/responses that you might use if faced with a similar situation in the future?

The revised essay is reviewed by the faculty, who provide individualized written feedback to each participant. This reflective essay is the only information routinely gathered relating to the reasons that caused the participants to be referred to the course. Referral agencies are not questioned about the veracity of the participants' self-report in an effort to establish and maintain an open and collegial course atmosphere that emphasizes participation in many learning activities.

Twelve weeks after course completion, participants are questioned about how they have applied their new skills in the clinical setting and are invited to revisit their reflective essay (the follow-up reflection). This provides them with an opportunity well after the end of the course to reflect on the process of integration of course learning into clinical practice. These follow-up course reflections are intended only for course participant self-learning. Although read by the course director, further feedback is not provided to participants. For the purposes of this report, each reflective essay was read by the course director and categorized in terms of the primary ethical, boundary, or professionalism issue that prompted conference attendance.

Results

Between September 2005 and February 2012, 358 learners participated in the medical ethics course. The majority of learners (95%) were mandated to participate in the conference by a referral agency (state medical board, hospital, or professional organization). Licensure data from the State Medical Board of Ohio indicated that the vast majority of CWRU course participants (85.2%) were in "Active" or "Active in Renewal" licensure status at the time of their participation. The average age of participants was 52 years and the majority (73%) had board certification, primarily in family practice or internal medicine. Most participants practiced in an urban setting and were in a single specialty group or solo practice. TABLE 1 demonstrates how participants in the CWRU course compare to the demographics of the general US physician population. It shows that physicians mandated to participate in this remedial ethics course are more likely to be male and more likely to be osteopathic physicians than the rest of the physicians in the United States. In addition, they are just as likely to be board certified and US medical graduates as the rest of the nation's physicians.

Pre- and post–ethics questionnaire results are available for 118 participants to date since the pre-/posttest was developed in the 2010 academic cycle. TABLE 2 describes the average improvement in posttest scores for each of the 5 groups to whom the test has been administered. Overall, course participants demonstrated an improvement in their MCQ test scores. One course participant scored 32 points higher on the posttest; however, 2 of the 118 participants scored 22 and 26 points lower on the posttest (out of a total possible score

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TABLE 1. Demographic Characteristics of 358 Intensive Course Participants Compared to General Population of Physicians in the United States, 2010

	CWRU data*	National data
Gender		
Male	87.0%	66.9%
Female	13.0%	29.0%
Board certified		
Yes	73.0%	74.5%
No	27.0%	25.5
Degree type		
Doctor of Medicine (MD)	80.2%	92.9%
Doctor of Osteopathic Medicine (DO)	13.1%	6.9%
Medical school type		
United States and Canada Medical Graduates	77.4%	75.5%
International Medical Graduates	22.6%	22.2%

*Case Western Reserve University.

of 52) for reasons that are unclear. The average increase in test scores is statistically significant, but significance was lower for the courses with the previously mentioned low posttest scores.

Between March 2006 and February 2012, 269 physicians participated in the pre/post/follow-up reflective essay assignment. TABLE 3 contains a summary of the primary ethical and professional boundary issues identified by reflective essay review. Data from these essays suggest that participants were mandated to attend for reasons that fall into 5 main categories: prescribing of controlled drugs, sexual boundary issues involving patients or staff, providing services to family or friends, not maintaining proper records to document medical care provided, and billing issues. Other issues included physician impairment, clinical or business practice disputes and related unprofessional behavior, nonsexual patient abuse, failure to maintain licensure or withholding information on professional applications, and disruptive communication behavior.

TABLE 2. Change in Pre- and Posttest Scores for the Targeted Ethics Test

Course date	Number of participants	Average change in score	Range of change in pre-/post score	p value
September 2010	25	3.56	−3 to +15	$p < .001$
February 2011	25	2.88	−22 to +10	$p = .030$
September 2011	21	4.00	+1 to +8	$p < .001$
February 2012	16	4.19	−4 to +11	$p < .001$
September 2012	31	4.29	−26 to +32	$p = .004$

TABLE 3. Breakdown of Issues Among Participants Who Participated in the Reflective Essay

Problem	Number of participants	Percentage
Controlled drug prescribing	75	27.8
Sexual boundary violation or accusation	63	23.4
Treating family and/or friends	53	19.7
Problematic medical record keeping	47	17.4
Billing issues/fraud	42	15.6
Physician physical or mental illness	17	6.3
Practice dispute with another physician or clinic/hospital	15	5.6
Patient nonsexual abuse/intimidation	13	4.8
Non-maintenance of licensure/misleading information on applications	12	4.5
Disruptive/verbal communication problem	11	4.1
Total	269	100

State Medical Board of Ohio data from 2003 through 2012 corroborate our reflective essay results, with most issues involving sexual boundaries and prescribing controlled drugs, followed by health care fraud, medical record keeping, physician impairment, and misrepresentation on licensure application. This provides indirect evidence that the reasons physician attendees reported for their participation in the course are similar to the reasons for licensure actions reported by the medical board.

Discussion

This is the first report characterizing the type and frequency of the professionalism and boundary issues that result in physicians being remanded to an ethics and boundaries remedial CME course. Our data identify boundary maintenance as a major learner problem and illustrate the importance of timely and focused physician education in this essential area of professionalism and health communications. The inability to maintain professional boundaries leads to problems with overprescribing of controlled drugs, doctor-patient sexual

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relations, and medical treatment of friends and family.[6,10,11] Medical student, resident, and physician education often emphasizes being "patient-centered" and the importance of a primary ethical commitment to the patient. As such, health communications and medical ethics have become part of the core competencies for both undergraduate and graduate medical education.[9] A recent review of ethics education in medical schools, however, found that while discussions of medical ethics are a key part of the curriculum, they may not be taught in a way that is clinically applicable to students or one that fosters critical thinking along with patient-centered care.[15,16] Our data indicate that specific skill practice in saying no to inappropriate requests and boundary maintenance skills should be a part of communications training in medical school and residency.

Interestingly, the reflective essay data collected during the medical ethics course stand in stark contrast to the participants' scores on the general medical ethics and course-specific MCQ testing. These scores indicate that physicians participating in this remedial course do recognize ethical principles and the importance of boundary maintenance in clinical practice. Their problems seem to stem from an inability to apply these principles in the clinical practice setting. Recognition of this gap between knowledge of ethical principles and application in clinical practice has been the reason for development of this medical ethics course. We hope that the reflective essay, with the built-in opportunity to revisit their own ethical challenge at the end of the course and 12 weeks postcourse, provides a chance to consider alternative future behaviors.

Limitations

This report is a single group pre/post design of 358 physicians who have participated in a specific remedial CME course and may therefore contain sources of bias. Data are dependent on which participant referral agencies refer to this course as opposed to other remedial offerings, so caution must be used when generalizing reasons for referral to remedial CME programs. In addition, the nature of ethical infractions that are referred for remedial education versus those that are dealt with either by warnings, more severe license interventions, or criminal justice investigation is unclear. The results are dependent on self-reporting by the course participants with no corroboration from referral agencies and may not be truly reflective of the full spectrum and frequency of physician ethical issues. Finally, although we found changes in pre-/posttest scores on an MCQ test written specifically for the content covered in this course, it is a measure only of knowledge and does not address change in clinical behavior.[13] In addition, the pre-/post–MCQ test questions have not been reviewed by school of medicine testing faculty and have not been vetted or edited by anyone other than the submitting faculty member. Even though the average increase in test scores is statistically significant, the clinical significance of this change is questionable. Education alone may be insufficient to change the behavior patterns of some ethically errant professionals, even those who appear by post-course measures to have increased their knowledge.[13]

Challenges to Providing Effective Remedial Education

There are many challenges to providing remedial medical education to practicing physicians. First, learners in these programs typically have strong emotions—fear, anger, humiliation, or resentment. Thus, establishing and maintaining a collegial learning environment while still addressing the specific educational needs of learners is a major challenge. For this reason, our course emphasizes participant self-disclosure of reasons for interest in the course and does not query referral agencies for their report. Second, because they usually involve a relatively small number of participants with acute learning needs, remedial courses require extensive faculty resources to teach, review materials, and provide meaningful feedback. Third, the nature of the topics addressed in remedial CME programs make outcomes assessments difficult, yet there is continual pressure from referral sources to refine and improve these measures. These last 2 points are particularly true for programs such as the medical ethics course where reflective learning practice (ie, the reflective essay) is used as a teaching tool. This method of teaching and evaluating learners requires a substantial commitment in terms of time and resources and yet is ideally suited for

Lessons for Practice

- Physicians must be alert for professional boundary and ethics lapses in specific areas: controlled drug prescribing, family relationships, sexual boundaries with patients and staff, and billing issues.
- Timely and focused education in the area of effective boundary maintenance is needed to provide physicians with the tools needed to avoid medical ethics violations. Early intervention—that is, in the training of medical students and residents—is recommended.
- Practicing the skill of saying "no" yet not escalating the doctor-patient encounter is an important aspect of preclinical, clinical, and continuing medical education.

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this type of learning environment. Fourth, remedial CME courses present specific ethical and boundary challenges to the CME provider. Providers are under pressure to provide high-quality yet "cost-effective" educational interventions and learners are under tremendous pressure to participate in the courses regardless of cost in an effort to avoid further disciplinary action. This situation increases the risk that remedial CME providers will take financial advantage of the desperation of course participants. Finally, there is substantial pressure from referral agencies for the course provider to assure the fitness of participants to practice medicine. However, courses such as the medical ethics course are designed to be a remedial educational process and not a fitness-for-duty evaluation or a forensic clinical assessment. It is essential for remedial CME providers to maintain clarity about the limits of what they can deliver and maintain a primary focus on their primary constituent—the physician course participant.

Future Directions

There are several areas of future study and education suggested by this article. One important area is the continued improvement of this remedial course. Based on overwhelmingly positive feedback from course participants regarding the use of the objectively structured clinical examination (OSCE) in other CWRU intensive courses, an 8-station OSCE was piloted in February 2013 in the medical ethics course. The stations addressed ethical and boundary challenges such as friends or family asking for prescriptions, patient invitations for dinner or questions about home life, and dealing with business propositions that could create a conflict of interest. The participants were given standardized patient and peer feedback based on a skills checklist at each station. This "Ethics and Professional Boundaries OSCE" was very well received by participants in the medical ethics course and will continue to be incorporated.

Based on information gathered during this course, an important follow-up study could involve contacting referral agencies and retrospectively comparing their reasons for physician referral to the remedial course with the participants' reflective essays. Eliciting this information from agencies prior to the course could provide insight for the course faculty that would add value to the reflective essay written feedback given to the participants.

Supporting Information

Additional supporting information may be found in the online version of this article:

APPENDIX S1: Medical Ethics, Boundaries and Professionalism

As a service to our authors and readers, this journal provides supporting information supplied by the authors. Such materials are peer reviewed and may be reorganized for online delivery, but are not copy edited or typeset. Technical support issues arising from supporting information (other than missing files) should be addressed to the authors.

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References

1. American Medical Association. Code of medical ethics. 2001; http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page. Accessed April 16, 2013.
2. Carlson J. Disciplinary actions up 6.4%. Federation of State Medical Boards study finds 5,721 instances last year. *Mod Healthc.* Apr 5, 2010;40(14):18.
3. Goulet F, Gagnon R, Gingras ME. Influence of remedial professional development programs for poorly performing physicians. *J Contin Educ Health Prof.* Winter 2007;27(1):42–48.
4. Humphrey C. Assessment and remediation for physicians with suspected performance problems: an international survey. *J Contin Educ Health Prof.* Winter 2010;30(1):26–36.
5. Williams BW. The prevalence and special educational requirements of dyscompetent physicians. *J Contin Educ Health Prof.* Summer 2006;26(3):173–191.
6. Khaliq AA, Dimassi H, Huang CY, Narine L, Smego RA Jr. Disciplinary action against physicians: who is likely to get disciplined? *Am J Med.* Jul 2005;118(7):773–777.
7. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Acad Med.* Mar 2004;79(3):244–249.
8. Leape LL, Fromson JA. Problem doctors: is there a system-level solution? *Ann Intern Med.* Jan 17, 2006;144(2):107–115.
9. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* Feb 5, 2002;136(3):243–246.
10. Morrison J, Wickersham P. Physicians disciplined by a state medical board. *JAMA.* Jun 17, 1998;279(23):1889–1893.
11. Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA.* Jun 17, 1998;279(23):1883–1888.
12. Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *JAMA.* Sep 1, 1999;282(9):867–874.
13. Moore DE Jr., Green JS, Gallis HA. Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. *J Contin Educ Health Prof.* Winter 2009;29(1):1–15.
14. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv Health Sci Educ Theory Pract.* Oct 2009;14(4):595–621.
15. Doukas DJ, McCullough LB, Wear S. Perspective: medical education in medical ethics and humanities as the foundation for developing medical professionalism. *Acad Med.* Mar 2012;87(3):334–341.
16. Doukas DJ, McCullough LB, Wear S. Reforming medical education in ethics and humanities by finding common ground with Abraham Flexner. *Acad Med.* Feb 2010;85(2):318–323.

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