

Recertification and peer review in the United States

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I AM delighted to respond to the Honorary Editor's invitation to write for the *Journal of the Royal College of General Practitioners* about some of the major issues in American medicine. They are physician-centred issues, but they have arisen from concerns expressed by the public and the government. They are: the evaluation of the necessity and the quality of medical care, and the evaluation of the knowledge and competence of the practising physician.

As medical editor of *American Family Physician* (its title was *GP* until three years ago), the official publication of the American Academy of Family Physicians (AAFP), I have long been actively concerned with the continuing education of general practitioners. I enjoy greatly helping to further the objectives of the American Association of Family Physicians which has, since its foundation in 1947, led American medicine in requiring continuing educational efforts as a condition of membership.

Recertification

The American Academy of Family Physicians is not the equivalent of the Royal College of General Practitioners. Royal Colleges are examining and certifying bodies. The American equivalents of the Royal Colleges are the American Boards. Here again, the general practitioners have led the way—this time in recertification. The American Board of Family Practice is the only one of the 21 American Boards that has a mandatory recertification examination.

Many other Boards have adopted voluntary recertification examinations. For example, in October 1974, the American Board of Internal Medicine will hold its first voluntary recertification examination for internists who are diplomates of the Board and who were certified before 1968. In preparation for this event, the American College of Physicians has been conducting for several years a programme of self-assessment of medical knowledge of voluntary self-study and tests for fellows and members of the College.

In addition to the recertification of specialists, relicensure of physicians has been under lively discussion. Licences to practise medicine are granted by the states through 50 different application procedures. There have never been requirements for periodic evaluation and relicensing. Relicensure has now started in Oregon, Maryland, and other states.

These developments represent the articulation of society's desire for certainty about the continuing competence of practising physicians. While this trend is deplored by some physicians, it is applauded by many. The task of keeping up with medicine is overwhelming. The expanding body of medical knowledge is intimidating. All but the least knowing among us have feelings of insecurity about the adequacy of our medical knowledge and our ability to 'keep up.'

Government participation

A major difference between British and American medicine is the degree of participation

by the government. The trend in the United States is not towards a National Health Service, where physicians are employees of the government, but rather towards comprehensive national health insurance. At present, several national health insurance bills are in preparation in Congress.

In recent years, we have operated under the Medicare and Medicaid programmes, which extend government health insurance to certain defined population groups, and which have become increasingly expensive. It has been estimated that Medicare, if not replaced by another system, would overrun its original projected costs by about \$240 (£100) billion in 25 years. Some people believe that this increase can be attributed to an excessive number of services rendered, as well as higher costs per service. Real or imagined increased costs have been paramount in bringing about the legislation known as the PSRO law—Professional Standards Review Organisations. This law embodies “peer review” by doctors.

Peer review

Professional Standards Review Organisations became federal law at the end of 1972. It is a programme organised, administered, and controlled by local physicians to evaluate the necessity and the quality of medical care delivered in their region under the federal Medicare and Medicaid programmes. The PSRO programme requires that a physician's services to these groups of patients in institutions be subject to review by his peers in the local PSRO. If a physician's peers in the PSRO disapprove of a proposed procedure or service, or an extension of length of hospital stay, the government would not pay for those services.

The law required that, by January 1974, the U.S. Department of Health, Education, and Welfare (HEW) designate the PSRO geographical areas throughout the country. Now, having done this, HEW must enter into an agreement with a qualified organisation in each of 203 regions to be the PSRO.

Surely, the noisy opposition to this law is audible on the other side of the Atlantic. Anecdotes abound. Physicians have “retired” from the practice of medicine rather than suffer the indignities of “government interference” with the practice of medicine. The law has been called “unconstitutional.” The fact is, peer review has been practised in American medicine for a long time, and the PSRO law is imperfect, albeit amendable.

When Medicare first became law just a few years ago, hospitals were required to set up ‘utilisation review committees’ composed of physicians to monitor the use of facilities for this group of patients. In the U.S., most physicians, including the general practitioners, or family physicians (who are proportionally fewer in our physician population than in Great Britain) have hospital privileges and care for their patients there under the eyes of their colleagues and in accordance with a variety of time-honoured and usually effective peer review mechanisms. (Daily trips to the hospital provide more continuing educational opportunities.)

Amendments to the PSRO law sought by the American Medical Association would enforce the notion that PSRO guidelines are not to be substituted for individual professional judgment, would ensure the confidentiality of medical records, and would selectively change other provisions. Some state medical associations are strongly opposed to the Department of Health, Education and Welfare's PSRO area designations; many had hoped for a single state PSRO area. It is not possible to provide here a detailed analysis of the complicated subject of PSRO. It is now law, and soon will be implemented. Much more will be heard of it.

Clearly, the impending adoption of a national health insurance programme will mean extension of the PSRO concept to the care of all patients, whether in institutions or private offices or clinics. It is essential that American physicians be fully informed of

these developments so that they can participate constructively with the administration of the law.

Research grants

Incidentally, there is another kind of "peer review" in American medicine. It must not be confused with the unrelated PSRO issue. The competitive applications for research grants from our National Institutes of Health, the equivalent of your Medical Research Council, are reviewed by committees of scientists working actively in the fields covered by the applications. Appointments to these review committees and councils are non-political. The American medical and scientific communities support this peer review system. It occasionally comes under hot political fire and must be staunchly defended from time to time.

Discussion

Many physicians wholeheartedly subscribe to the general principles embodied in the concepts of recertification, relicensure, and peer review. When properly implemented, they will help to maintain high professional and ethical standards of physicians, and they will improve public health and welfare. These elements must be tied together. Peer review without mechanisms guaranteeing the continuing education and competence of physicians is like tying the boat to a rotting pier ("or peer"!).

Senator Wallace Bennett of Utah, author of the PSRO legislation, has said that "the thrust of PSRO activities is educational and not punitive." There are legitimate fears on the part of conscientious practising physicians that this "thrust" can turn the other way, leading to mediocre, "defensive" medical practice. It has been said that "the brightest view that can reasonably be taken is that PSROs will improve some of the worst practitioners and institutions, and that the taxpayer will save some money." We shall see.

British and American physicians have much to learn from each other. We have different relationships with our governments, but not with our patients. The quality of the care we give our patients is based on warm and compassionate relationships, and the currency of our medical scientific knowledge. Medicine remains a learned profession so long as physicians are dedicated to a lifetime of learning.

The Royal College of General Practitioners is a potent force in this field—will it try recertification examinations?

DOES CONTINUING MEDICAL EDUCATION BY PEER REVIEW REALLY WORK ?

A peer review of breast operation statistics was conducted. Standards for the proportion of biopsies positive for cancer, and for length of postoperative stay after operation for benign and malignant conditions were developed and each surgeon was informed of his performance and how it compared with that of his colleagues. The same parameters of care were reviewed one year later to study changes in performance. Low volume of clinical material, failure of two surgeons to change, and a steady general improvement in all parameters in the years prior to the presentation of the peer review, confused the demonstration of improvement in the year after the educational effort.

There was a statistically significant improvement in the proportion of biopsies positive for cancer, reflecting a reduction in unnecessary biopsies, but the pre-existing annual improvement in reducing postoperative stays was not accelerated. Does continuing education by peer review really work? Probably.

REFERENCE

Devitt, J. E. (1973). *Canadian Medical Association Journal*, **108**, 1279–1281 (Author's summary).