If a position is to be taken by the College on these possibilities, my recommendation would be that it approve multiple pathways to recertification, that strong support be given to outcome evaluation, and that any attempt to require examinations as a sole method for recertification be opposed

Quality care, quasi-care, and quackery

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A presidential address furnishes a vehicle whereby an individual may expound his philosophical vagaries, illumine history, criticize the present, or propose a glimpse of the future. The last choice is intriguing but dangerous, for, to some degree at least, it places the recipient society at risk to consider the implementation of a new program. Yet it is precisely this choice that is necessary today.

Urgent demands placed upon the surgical profession and upon our College make this analysis imperative. It is doubly important to you 1,675 Initiates, who will practice in an environment that is now being molded, not alone by surgeons, but by other physicians and by the public. No longer is a presidential address, "Surgery, the Queen of the Arts", apropos as it was three decades ago; self-adulation must be replaced by vigorous adjustments to changing times.

The thesis of this presentation can be summarized in a few words. It is, in brief, that patient care will continue to be available to the public at several levels in the future just as it is today, but that the optimum care of the present time can be improved even more by yet untested mechanisms. Recertification and relicensure furnish important methods that must be considered in detail.

Three levels of care may be described. The best care—that of high quality—will, for purposes of brevity, be called quality care. The lowest, entirely non-scientific, will be called quackery. The intermediate type that will vary from good to poor will be termed, for the purposes of alliteration, quasi-care.

A thesis that proposes important changes in the present system involves persuasion based upon documentation. Parenthetically, I might state that a plausible presentation was made, at least to my own satisfaction, in the fourth draft of this address. With some pride I read it to my wife, my severest critic. After she had fallen asleep four times during the forty-minute harangue, she woke up briefly and announced, "You have written a legal brief, not a speech. It's as dry as the Sahara. Either change it, or serve a pitcher of water to each person in the audience". Logistics declared that much of the documentation then be slashed, resounding

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In brief . . .

Within the next decade a physician will be required to be relicensed to practice medicine and to be recertified as a specialist, Dr. Welch predicts, pointing out that this is his own opinion, and not that of the College.

Dr. Welch, in his presidential address delivered Thursday evening, October 18, in Chicago, points out several ways recertification could be accomplished, including a simple reexamination by computer, individual participation in a variety of educational activities, or a peer review system in which a surgeon's record would be considered as the basis for recertification.

rhetoric expunged, and only the bones be left, on which you may pick at your leisure.

First, then, let us consider quality care. This is the reason for which the College was founded and why it still exists. We may, by our own actions, without interference from others, analyze our weaknesses and improve what now exists. On the other hand, the public has defined what it means by this term in no uncertain words—it wants capable, skillful surgeons who have had excellent education and training, who possess knowledge of all that is new in medicine, who are ethical, restrained in their financial relationships, and who are available when and where they are required. Surgeons likewise approve these Utopian ideals but stress the fact that some of these demands, pushed to an extreme, are self-defeating and that attainment of a proper balance is not unilateral but will depend upon the public as well as the profession.

Two preliminary questions should be asked: "Is high-quality care provided only by high-quality surgeons?" and "Do high-quality surgeons ever deliver mediocre care?" Clearly poor surgeons can give good care, and good surgeons who are too anxious to wield the scalpel deliver poor care. However, as a practical matter it must be assumed that the quality of the surgeon and the patient care he delivers will be on the same level; high-quality care is poorly supported by ignorance.

The College has, on its own part, defined the credentials of a surgical specialist. For those educated in the United States, we have stated that qualification is based upon either board certification or board eligibility, or upon fulfillment of College training requirements. While such a definition satisfies legal essentials it is clear that it emphasizes past events without any necessary relevance to the present or the future.

At this point in time, should we take cognizance that the surgeon is faced with even greater demands that require contemporary and continuing scholarship and skills, both in the present and in the future? Those surgeons who have taken SESAP have indicated their approval of this concept and the 12,000 participants in the 1973 Clinical Congress have demonstrated their enthusiasm for voluntary participation in continuing education.

The emphasis placed upon voluntary continuing education in this context opens a discussion of required certification and relicensure —a topic that daily is increasing in importance. In the vernacular it is a new ball game. It is one on which the College has taken no official stand, so that the remarks that follow bear no official endorsement. I believe it is imperative that the College immediately investigate the entire subject of recertification and relicensure; thereafter if the College declares itself in favor of these procedures it must plan for the tactics of its involvement. These discussions must be held at all levels—Regents, Governors, Advisory Councils, and Chapters, for such a dramatic change in policy will require wide cooperation and commitment. Though the College ultimately may disagree, I believe that recertification and relicensure will be required within the next decade.

"Though the College ultimately may disagree, I believe that recertification and relicensure will be required within the next decade"

To buttress this point of view, it will be necessary to adduce arguments. Certainly such a statement is not pleasing to the practicing surgeon, who visualizes another noose around his neck and further depletion of his rare hours of leisure. It is not a pleasant prospect for the young physician whose admission to medical school essentially guaranteed graduation, often without marks or examinations. Nor is it complimentary to the medical profession to receive this essentially unique criticism. But there is overwhelming evidence that this will occur.

A plethora of historical details could be cited to show the rising wave of interest in requalification. First is the appreciation by the public that medical knowledge doubles within a decade; senescence occurs more quickly in medical practice than in any other profession. Official pronouncements about the processes involved have all been made within the last decade. In 1967 the National Advisory Commission on Health Manpower recommended the exploration of periodic relicensure based upon continuing education or examination. In 1967 the American College of Physicians introduced voluntary self-assessment examinations; they were followed by others, including the spectacularly successful SESAP I of the ACS, with over 13,000 participants. In 1969 the AMA established a "Physician's Recognition Award" based upon a variety of postgraduate educational activities. At present, six state medical societies require evidence of continuing postgraduate education for continuation of

membership, while 13 others have recommended voluntary participation.

Perhaps even more important is the attitude of the American Specialty Boards (hereafter known as "the boards"). They constitute the American Board of Medical Specialties—an organization that rapidly is expanding its influence—and which in March 1973 urged voluntary, periodic recertification of medical specialists. The American Board of Surgery has approved this principle. The National Board of Medical Examiners has declared itself ready to develop appropriate examinations.

It could be said that, on the part of the ABMS, this is mainly a congratulatory pat on the back for the societies such as the ACS, who have carried out what might be phase I—voluntary participation in continuing examinations—but it does more, for it urges recertification on that basis. The real teeth will be inserted in its recommendations if the words "voluntary" and "certification" are replaced by "involuntary" and "licensure". At the present time, recertification can be regarded as a merit badge—a nice decoration to wear, but of no economic significance; in the future, if relicensure is based upon recertification it could become a matter of economic life or death.

Such is the situation at present. However, it is necessary to plan for the future. It could be argued that the furor about recertification has about run its course. If so, all the College will need to do will be to perpetuate our SESAP activities and give appropriate evidence to the participant, in the form of a certificate, recognition in the ACS Yearbook, or by other means.

It is far more likely that the demands for recertification and relicensure will increase rather than diminish. Further comments on some of the problems that are involved therefore are in order. First let us consider the relatively simple package of certification and recertification.

"Certification" is defined as "the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or institution". Insofar as the members of the ACS are concerned, this would mean certification by an appropriate surgical board, Fellowship in the ACS, and, in a high proportion, membership in an allied qualified surgical specialty society; thus some members will have one, most will have two, and many will have three organizations by which they have been "certified".

"Recertification" likewise appropriately may be applied by any of these organizations. However, it must be recognized that the current tendency is to assume that recertification is a function of the boards alone. This certainly is not true now but could be in the future if the Coordinating Council on Medical Education or its constituent liaison committees on Graduate and Continuing Medical Education should impose that mechanism.

It probably is of less moment to consider the professional organization that will carry out recertification than it is to consider the means by which it will be accomplished, for these methods will be of great significance for the College.

"At the present time, recertification can be regarded as a merit badge—a nice decoration to wear, but of no economic significance"

Several methods may be suggested. The first, and by far the easiest, would be by the simple process of reexamination. At intervals of perhaps five to ten years surgeons would be required to take a computerized examination. Computerized results would follow, and a predetermined percentage of candidates would fail. Unless the examinations were farces (and they certainly should not be) it might be expected that there would be a 10 to 20 percent failure rate. The penalties exacted from these unhappy individuals could vary from mild to severe, and range from a warning to required attendance at postgraduate courses, or even to exclusion from practice until a further examination is passed. It is obvious that this method could be cruel to the individual, and catastrophic to the community in which he practices. Nevertheless this method, because of its facility, is the most likely to be chosen.

A second method is by individual participation in a variety of educational activities, such as attendance at Clinical Congresses, other specialty society meetings, or participation in various academic pursuits. Such activities have been detailed in the AMA Physician's Recognition Award. This would demand a great expansion of postgraduate specialty teaching programs by the College.

A third method would consider a surgeon's record as a basis for recertification, much as our credentials committees examine an applicant's operative records. The cumulative results in a 5-year period could be examined rigorously by

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a peer-review committee. This procedure may be identified as "outcome evaluation". Undoubtedly deficiencies in practice would be found. Some surgeons will have changed to become general practitioners, with insufficient surgical experience to maintain their skills. A few may be entangled in problems of ethics. In general, it is likely that few black sheep would be found among our Fellows.

Of the three methods, the third ultimately should prove to be the best. It affirms that "nothing succeeds like success". It avoids the valid criticism that a good mark on an examination does not equate with surgical ability. It is one, moreover, which only the College and its allied surgical specialty societies can develop. The manpower required for these extensive peer-review processes will be great, even if computer techniques are used to reduce the number of necessary person-to-person encounters.

If a position is to be taken by the College on these possibilities, my recommendation would be that it approve multiple pathways to recertification, that strong support be given to outcome evaluation, and that any attempt to require examinations as a sole method for recertification be opposed.

"It probably is of less moment to consider the professional organization that will carry out recertification than it is to consider the means by which it will be accomplished"

It is clear that the method that finally is selected will have a great effect on the College. If the written examination route is chosen to the exclusion of other pathways, the ABMS and the National Board of Medical Examiners will be ascendant, while the College will be employed only peripherally in the education of those who flunk examinations. It would be quite possible that the lively intellectual fare of the Clinical Congress could become more spartan since many academicians might pass the examination and feel that other activities such as attendance at the Congresses would be superfluous.

On the other hand, the College could be faced with greatly increased responsibilities if other methods were selected. An increase in postgraduate programs, if they become necessary, will tax our present resources, for great expansion will be necessary. If peer review of end results is accepted, the entire membership, including local organizations such as college chapters, will have to shoulder increased responsibilities.

In this context it should be noted that nearly all students of continuing medical education have recommended centralization of these activities in the universities rather than in a consortium of professional societies. The Coggeshall, Millis, and Carnegie Foundation reports support this conclusion. On the other hand, medical schools, with a few exceptions, have been too busy with their undergraduate problems and the need for financial survival to consider significant participation in this field. The College and other specialty societies will need to fill this vacuum for the indefinite future.

Now let us turn to the more involved and thorny problems of licensure and relicensure. Licensure is defined as "the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation". This relationship is relatively modern. For example, in the early days of the last century, in my own state licenses to practice medicine were granted by the Massachusetts Medical Society and later in conjunction with Harvard University. It was only after the Civil War that this power was assumed generally by the states. In England there is a basic license for all medical graduates, but the FRCS is, in effect, the license to practice surgery. It is conceivable, therefore, that our present system will not be immutable. However, it does prevent the formation of monopolies, and in these days when interaction between many diverse societal groups becomes ever more frequent, some such measures of governmental control is almost inevitable.

Theoretically, licensure could be effected at any of several levels. However, in this country it is now the custom to grant a license after reception of the MD degree. The recipient thereby gains the right to practice medicine and surgery according to the strictures of the medical practice acts in his state without fear of litigation for practicing without a license. Surgical privileges must be granted thereafter by each hospital, based on its own criteria.

This method actually allows full licensure at the midpoint of most dictors' formal education. Granting the fact that at least 80 percent of physicians will become board-certified it would not be illogical to grant licensure in a specialty after a residency. This would still entitle a specialist to the right to engage in other types of medical practice, but he would be considered as a specialist in only one.

These possibilities, and others that could be suggested, raise complex questions that are compounded by jealousies and petty quarrels between the various states and the federal government, and between groups of health providers. On the other hand, they must be identified and solved, for the specialties have grown enormously in power and, uncontrolled, could reintroduce guilds to our modern society. Again, the problem is compounded by the concurrent introduction of relicensure, which should only be considered after recertification by the appropriate board or specialty society.

Without outlining several alternatives, a possible solution may be suggested. The state already has difficult decisions to make when it defines various health professionals; let it continue to focus on this level, and describe the differences, for example, between a physician, a dentist, a nurse, or a podiatrist, and concentrate there. At the higher level, licensure of specialists should not be done unilaterally by the state. That this has been tried before is brought out by Rosemary Stevens in her absorbing account of the rise of medical specialties; that it failed is certainly no surprise, for boundaries between specialties are hard to define even in the hands of specialists, let alone in legal statutes.

Licensure at the specialty level then would require a partnership that would include the professional accrediting institution (whatever it may eventually be, but clearly one that combines the facilities of the boards and the specialty societies) and the state. The state would accept the candidates proposed by this accrediting body, reserving the right to eliminate those few who ran counter to other civil laws.

Now that this long and involved discussion of recertification and relicensure is finished, let us return to some practical results that would be expected if such a program were adopted. The public would obtain the well-trained specialists, who continuously renew their medical knowledge, that it demands. Specialists would not be required to restrict their practice to their specialty, for such a specification would place all medical care in a straightjacket in which every patient would necessarily be partitioned between proliferating specialists. Specialists could continue to function as primary physicians as the Millis Report has suggested, but only in his specialty would a surgeon be expected to offer care of the highest quality.

And so we return from care of the highest quality—quality care—to the next step down the ladder—quasi-care. Unfortunately, there is no way in which this large segment of care, mediocre though it is in some instances, can be completely eliminated. For example, there are not enough specialists to take care of every need of every patient in every hamlet of the United States. Even if surgeons were spotted everywhere many would lose their skills rapidly, and quasi-care would follow.

Nevertheless the outposts must be manned. Emergency surgery in isolated communities will remain a fact of life for the indefinite future. Elective surgery, even in the hands of relatively untrained men, will persist: it will be abetted by adoring patients who prefer their own community and their own doctor to the imagined perils of a regional center. The right of patients to select their own physician and surgeon cannot be eliminated in a free society; any attempt by better trained surgeons to deny this right would be opposed by the antitrust laws for it would introduce a monopoly. So mediocre care will persist. Whether it is given by a nurse, physician's assistant, general practitioner, or specialist practicing outside his specialty, it will not be the quality care described above.

"Even if surgeons were spotted everywhere many would lose their skills rapidly, and quasi-care would follow. Nevertheless the outposts must be manned"

This practical assessment does not imply that the College is complacent about the current situation or the practice of mediocre or poor surgery. Quite the opposite—it must continue to vigorously upgrade the level of care in every community.

There are several ways by which this can be promoted. It is most important that each surgeon improve himself; an even greater incentive occurs if he is given certain emoluments that will urge him to do so. For example, the Massachusetts Chapter of the ACS has considered the factors that improve the performance of a surgeon; the chapter suggests that these "modifying factors" be applied to add to the basic fee paid for a given service. Thus a general practitioner would be paid the basic fee for a surgical service. Additional increments would be allowed for each of these considerations: (1) if the surgeon were board-certified, (2) if he were a member of the ACS, (3) if he had at least five years' experience as a practicing surgeon, and

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(4) if he provided evidence of continuing education in surgery.

Furthermore transportation should be devised to bring patients to proper facilities. A nation that can send a man around the earth in an hour certainly should be able to devise some means to solve this delivery problem. Then, for example, general surgeons could be encouraged to practice in pairs in communities of 15,000, and other surgical specialists in larger centers.

Finally, improved care can result from a redistribution of specialists. The ACS soon will receive recommendations from the Study on Surgical Services for the United States reports, suggesting means by which this situation can be improved.

"We may deplore quackery, we can refuse to support it, but we cannot legislate it out of existence"

And so as time goes on all communities will receive more quality care, and less of the mediocre. Does the public in turn have any responsibilities? Here are surgeons, already harassed by day and night emergencies, asked to spend a fair proportion of their leisure time to keep abreast of medical knowledge. Certainly those specialists who are certified, licensed, and relicensed should be recognized by a premium payment for their services. This has been done for many years by the Veterans Administration and some other agencies. It should become the pattern for all third-party payers. The MD who has never aspired to certification, or the person who has failed recertification and relicensure as a specialist, would not lose his rights and privileges accorded to a doctor of medicine by the laws of the state, but all of this group would be paid only a basic fee. This attitude on the part of the public that would recognize and pay for the exceptional services of specialists in itself could improve patient care in a significant fashion.

A word on the final unit of the triad—quackery. Despite their protestations many segments of the public have remained utterly indifferent to the efforts of the medical profession that are designed to maintain services of high quality. Hallmarks of the age appear to be violence, strengthened by anti-intellectualism. What is called science may be nothing more than a blend of mysticism and optimism. The precipitate haste with which the American public has embraced acupuncture has outpaced any scientific approval. Chiropractic flourishes. Soothsayers and astrologers have been accepted throughout recorded history.

Actually, a sane, mature individual has an innate right to accept any of these teachings unless he harms others in the process. We may deplore quackery, we can refuse to support it, but we cannot legislate it out of existence. There is, on the other hand, absolutely no reason that any public funds should be used to support any of these non-scientific cults.

As Initiates, many of you already have observed the great gaps that exist between the desires of the public and the ability of the medical profession to respond. It has been impossible to describe all of them, but several significant methods that will serve to close these gaps either have been suggested or will follow shortly in the SOSSUS reports. In all of them the College can play a dominant role, while you, as individuals, must respond as well. To those of you who have little contact with the College let me attest that no more devoted and selfless group exists than the College staff, the Regents and the Governors. To work closely with them for the last twelve years has been an overwhelming privilege and a rare honor. May I wish for each of you the same friendship and rewards that accompany Fellowship, and accrue from devotion to the prime purpose of the College—optimal care for the surgical patient.

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