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## RECERTIFICATION: WILL WE RETREAT?

ONLY a few years ago, the notion of recertification of specialists seemed to enjoy wide support. All 22 of the specialty boards had committed themselves to at least voluntary recertification, although to date only five have actually started such programs. To its great credit, the newly established American Board of Family Practice was the first to make recertification mandatory. More recently, the American Board of Surgery has done the same thing, but it has placed the obligation only on diplomates certified after 1975 (a decision that a contributor to this week's correspondence section claims is discriminatory and unfair).

Now there are signs that the boards and many of the specialty societies are beginning to have second thoughts about the whole idea of recertification. At a meeting last March of the American Board of Medical Specialties, delegates had such misgivings that they could not agree on whether a specialist's recertification status should even be mentioned in the *Directory of Medical Specialists*.<sup>\*</sup> The Council of Medical Specialty Societies reports that at least four of its constituent societies (representing dermatology, neurologic surgery, orthopedic surgery and radiology) now oppose the idea of recertification, and other societies are said to have "sizable blocs of members with serious reservations."<sup>\*</sup> At the recent meeting of the AMA's House of Delegates in Chicago, a resolution was taken under consideration that recommends that all specialty boards except Family Practice call a moratorium on recertification. The intent of the resolution is to put emphasis on mandatory continuing medical education (CME) as a preferred alternative to any kind of recertification program.

It is still too early to know whether these developments portend a decisive change in organized medicine's attitude toward recertification, but what seems clear is that the recertification process no longer commands widespread confidence, if it ever did. A mood of skepticism and suspicion about the use of objective tests of professional competence seems to be emerging. Many physicians are apparently unconvinced that the formal examinations required for recertification can reliably evaluate the clinical skills needed in the practice of medicine. They are worried that many perfectly competent and conscientious practitioners might be unable to pass recertifying examinations that emphasize arcane facts and the latest literature rather than the practical management of patients. Many doctors also suspect that even voluntary programs would inevitably become compulsory and that the whole recertification process would soon come under government scrutiny and ultimately government control. Reimbursement schedules and hospital staff appointments might then be determined by recertification status; in consequence, specialists unable to meet arbitrarily imposed examination stan-

<sup>\*</sup>Recertification plans meet resistance. *American Medical News*, March 30, 1979

dards might find their professional standing and their livelihood in jeopardy. At least this is the frightening scenario that is being projected by those arguing against any further reliance on recertification. It's hardly surprising, therefore, to find CME being advocated as the best means of assuring the maintenance of professional competence. Mandatory CME, more palatable and less threatening than even voluntary recertification, seems to be gaining support in almost direct proportion to the decline in popularity of recertification.

These concerns are understandable; I share many of them. Yet it is illogical to abandon the idea of recertification entirely unless we are also willing to reject certification itself, and that we clearly cannot do. We can't have it both ways. We cannot defend the use of objective tests to determine which physicians are qualified as specialists while criticizing the use of tests to measure continuing competence. Even if we grant that the examinations appropriate for young physicians just completing their specialty training may not be suitable for specialists who have been in practice for many years, it does not follow that we should reject any kind of recertification examination.

Those who believe that mandatory CME is a better way to assure the maintenance of clinical skills need to recognize why it hasn't been used as the criterion for initial specialty certification. The reason is, of course, that CME alone, without some kind of test, cannot possibly assure competence. Mere attendance at lectures or conferences does not guarantee that the attendee is the wiser for it, any more than completion of specialty fellowship training automatically assures that the fellow is qualified to practice as a specialist (hence, the important difference between board "eligibility" and board certification). Mandatory CME may be better than nothing as a system for encouraging the maintenance of clinical competence, but it clearly cannot substitute for objective tests of ability. Many state licensing bodies have now adopted mandatory CME, but what may be used to satisfy the minimum requirements for relicensure should not be considered adequate for determining the higher qualifications of a specialist.

If there is legitimate concern about the relevance of the tests used for recertification, then it should be up to the specialty boards to see that the examinations are suitable. If there is reason to believe that the testing procedures are arbitrary, unnecessarily stressful, or unfairly administered, then ways must be found to remedy these defects. For example, instead of written examinations some specialty boards might prefer to rely on oral examinations or on peer review of records or clinical results. Others might wish to use written examinations only for screening purposes. Candidates who had difficulty with a written examination might then be tested orally, or be required to take remedial courses before reexamination. There must be many ways by which a specialist's clinical competence can be equitably yet objectively assessed by his

peers. The boards should feel challenged to explore the possibilities and experiment with various methods before deciding which they will adopt; during this trial period recertification programs probably should be on a voluntary basis.

The development of an acceptable method of recertification ought to be an achievable goal for any specialty board that commits itself to the task; it is simply a question of will. The boards need to be pragmatic and flexible in their approach to this problem, but for a profession that takes such pride in its self-imposed discipline, total abandonment of the recertification idea would be a mistake. A retreat on this issue would not be well received by a public that has already begun to wonder whether medicine is more interested in defending its privileges than in maintaining its standards.

ARNOLD S. RELMAN, M.D.

## THE QUINIDINE-DIGOXIN INTERACTION

### What Do We Know about It?

In 1978, three groups independently described a drug interaction between quinidine and digoxin: When quinidine is given to patients taking digoxin, the serum digoxin concentration increases.<sup>1-3</sup> These reports have raised many interesting and important questions and a flurry of investigation. Two recent articles in the *Journal* provide some insight into the mechanism of this interaction.<sup>4,5</sup> The purpose of this editorial is to review the information currently available on the digoxin-quinidine interaction and to discuss its clinical implications.

What is the prevalence of the interaction? Although the number of patients studied is still less than 100, we can be reasonably certain that about 90 per cent of patients taking digoxin who are also given therapeutic doses of quinidine will have some increase in serum digoxin concentration. Doering<sup>5</sup> and Leahey et al.<sup>1,6</sup> have studied a total of 87 patients both on and off quinidine and 83 (95 per cent) showed an increase in serum digoxin concentration when taking quinidine. The magnitude of the increase is quite variable but, on average, a twofold increase occurs. According to Doering,<sup>5</sup> the magnitude of the increase in serum digoxin concentration is dependent on the dosage of quinidine.

What is the time course of the interaction? This aspect of the interaction has been little studied. Doering's work<sup>5</sup> and that of Leahey et al.<sup>7</sup> suggest that the serum digoxin concentration starts to rise on the first day of treatment with quinidine and continues to rise until a new steady state is reached at about five days. The serum digoxin concentration remains elevated as long as quinidine is given.

Information on the mechanism of the interaction is sparse. Leahey et al. suggested that quinidine displaces digoxin from binding sites in tissue. They