Recertification:
A Look at the Issues

Formulated by the
GAP Task Force on Recertification

Group for the Advancement of Psychiatry

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This is the sixth in a series of publications comprising Volume IX. For a list of other GAP publications on current topics of interest, please see last page of book herein.

STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

RECERTIFICATION: A LOOK AT THE ISSUES was formulated by the GAP Task Force on Recertification. The members of this committee, as well as other committees and the officers of GAP, are listed below.

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FOREWORD

Medicine has traditionally been concerned with maintaining its professional standards through a variety of self-regulating and self-policing procedures, and it is not surprising in a period of intensified social unrest to find ourselves once again engaging in active self-scrutiny. Within this larger context, GAP's newly published Report on Recertification reflects Psychiatry's introspection into the problems peculiar to it as one of the medical disciplines.

The history, variety and consequences of Psychiatry's self-regulating mechanisms are reviewed with admirable clarity and succinctness in the few pages of this Report. One may not agree with all of the recommendations with which it concludes, but the issues its authors raise and the solutions they suggest will force each and every one of us to undertake a healthy reflection on one of the most serious questions confronting us today: What are the standards of knowledge and skill to which the psychiatrist must conform, and how are they to be measured and maintained in the individual clinician's care of his patients? On the answers we give depends our autonomy as a profession.

John C. Nemiah, M.D., President
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INTRODUCTION

In recent years the medical profession has been confronted with a rapid evolution of scientific, economic, political and attitudinal changes in our society. These changes have had and will continue to have major effects upon all physicians. For psychiatrists, one result is the increasing awareness that one-time certification by the American Board of Psychiatry and Neurology (ABPN) will not be accepted by the public, as well as by accrediting and governmental agencies, in evidence that the psychiatrist will continue to learn and apply new knowledge and skills. Increasingly, periodic recertification is being viewed as one way of helping to assure continued excellence of delivery of psychiatric services.

The purposes of this report are:

1. To examine recertification from a historical perspective,
2. To identify some of the sources that now advocate recertification and to consider realistic as well as idealistic needs which recertification is proposed to fill,
3. To examine the potential legal implications of recertification,
4. To describe major technical and theoretical problems of developing recertification procedures,
5. To discuss possible models for recertification,
6. To examine ongoing approaches to recertification and the purposes recertification can serve,
7. To put forth some recommendations aimed at facilitating the development of a recertification process that is both credible and feasible.

HISTORICAL BACKGROUND OF CERTIFICATION

In reviewing the problems associated with recertification, it is essential to understand the origins and nature of the certification process. The certifying body for psychiatrists and neurologists has been the American Board of Psychiatry and Neurology, Inc. (ABPN), which was founded in 1934. Originally developed in conjunction with the American Psychiatric Association (APA), the American Neurological Association (ANA), and the American Medical Association (AMA), the ABPN was founded on the principle that, as the accrediting body, it would have representation from these professional organizations but would function separately and autonomously.

The chief functions of the ABPN with regard to certification, as stated in “Information for Applicant,” issued by the ABPN in 1972, are:

(A) To determine the competence of specialists in Psychiatry and Neurology
(B) To arrange, control and conduct investigations and examinations to test the qualifications of candidates for certificates issued by the Board
(C) To grant and issue certificates or other recognition of special competence in the fields of Psychiatry and Neurology to successful applicants
(D) To serve the public, physicians, hospitals, and medical schools by preparing lists of practitioners who shall have been certified by the Board
(E) To consider and advise as to any course of study and technical training, and to disseminate any information calculated to promote and insure the fitness of persons desirous of qualifying for a certificate.

(F) To assist in the evaluation of training programs in hospitals, clinics, and medical centers for the purpose of determining their adequacy as training centers in Psychiatry and/or Neurology.

Thus, certification by the ABPN is a method of visibly documenting the fact that the psychiatrist who has completed psychiatric training has mastered a body of knowledge and skills from formal training and clinical experience. By recognizing through the certification process those psychiatrists who have mastered such training, the ABPN provides a valuable service to the public, to the profession, and to the psychiatrist.

How many psychiatrists have taken advantage of this service? Compared with other recognized specialties (those recognized by the consortium of specialty boards, the American Board of Medical Specialties), significantly fewer psychiatrists apply for board certification and significantly fewer psychiatrists achieve certification. In one sample of physicians who were graduated from medical school in 1960, only 34 percent of those who chose psychiatry had become certified by 1972. According to 1976 data from the APA Manpower Division, only 47.1 percent of its 22,205 members have achieved some kind of board certification in psychiatry. These figures are in sharp contrast to figures for other specialties, in which 61 to 91 percent of the 1960 sample had become board certified. Similarly, in comparison with other specialists, a significantly lower percentage of individuals who obtained psychiatric training actually applied for board certification.

The reasons for such seeming disinterest by psychiatrists in certification are complex, but are probably based on the following considerations, among others. To begin with, the practice of most psychiatrists is conducted primarily in private offices, an arrangement which shields the psychiatrist from the credentialing requirements often imposed by a hospital on its physician staff members. For most other specialists, hospital affiliation is necessary if they are to conduct their practice. In surgery, for example, 89 percent of the 1960 sample who became surgeons had obtained specialty certification in surgery. Similarly, in pathology, approximately 91 percent of those who entered training in this specialty became certified.

Another contributing factor may be the situation at state mental hospitals. A number of physicians serving at these facilities—many of them foreign medical school graduates—consider themselves psychiatrists, yet they have not completed sufficient psychiatric residency training for board eligibility and hence cannot be certified.

A number of psychiatrists have expressed disapproval of the content of the ABPN examinations. They claim that the emphasis on neurology and basic behavioral sciences is not relevant to the usual clinical practice. These psychiatrists regard their clinical skills as psychotherapists the major component of their professional competence and understandably feel that the existing board certification program is poorly designed to assess those skills.

Despite the apparent long-standing disinterest in certification on the part of psychiatrists, registration for the written examinations has increased from 1,600 in 1974 to some 3,200 in 1975. The increased number of those taking the examination has posed special logistical problems and has resulted in an increase in the number of oral examinations.

* In view of the fact that this study did not include foreign medical graduates, the actual percent certified among all physicians who identify themselves as psychiatrists is probably somewhat less than 34 percent.
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offered from two per year in 1974 to three per year in 1975. Moreover, informal and subjective observation suggests that there is an increase in the mean age of the candidates, with many psychiatrists taking the board examination for the first time after several years’ delay.

A number of factors may account for this recent upswing. The value of becoming certified in psychiatry may have increased as a result of expectations that third-party payers may in the future provide more favorable remuneration to those specialists who hold board certification. Moreover, with growing talk of the relicensing of physicians, many psychiatrists may speculate that certification and recertification in psychiatry might somehow forestall the need to be examined in internal medicine, pediatrics, surgery, and the other clinical disciplines as was required for initial licensure. Finally, board certification plays a significant role in the decisions of many interdisciplinary academic promotions committees. These committees are often more accustomed to requiring certification of faculty members than are psychiatrists themselves of each other.

SOURCES ADVOCATING RECERTIFICATION

The term recertification is used here in a way that parallels the meaning of the term certification. Recertification refers to a process whereby a nongovernmental agency (e.g., the ABPN) gives recognition to a previously certified physician who has met certain predetermined qualifications reflecting the maintenance of an updated body of knowledge and skills.

Professional stimuli for recertification

The interest of psychiatrists in maintaining individual programs in continuing education reflects a feeling that is widespread among members of the health professions and represents a natural result of the awareness by physicians of the enormous growth in medical knowledge. Until the past two or three decades, a psychiatrist might have rationalized, and justly so, that the growth of precise, clearly defined, clinically useful knowledge was so slow as to require very little personal effort to stay up to date. Fortunately, this is no longer the case. Today there is a rapid accumulation of literature in the basic sciences of neurophysiology and molecular biology which is highly pertinent to a more thorough understanding of the nervous system, the emotions, and mental illness. Similarly, the fields of psychopharmacology and genetics are growing and our understanding of psychiatric diagnoses and psychophysiological states is expanding.

Most psychiatrists feel that keeping up with new develop-
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ments in psychiatry is an ethical responsibility. Traditionally, many psychiatrists have used psychiatric meetings and professional publications like the journals to keep up with the advances in psychiatry. Some psychiatrists have focused most of their efforts in continuing education within the activities of psychoanalytic institutes.

In recent years the number of continuing education opportunities for psychiatrists has been on the increase. However, the experience of continuing education program directors suggests that, until recently, relatively few practicing psychiatrists actually registered and attended regional offerings. Moreover, those who have attended them have frequently done so as part of preparation for the ABPN certifying examinations.

There are, of course, reasons for the apparent indifference of psychiatrists toward the need for continuing education. Psychiatrists in private practice feel bound to their offices because of an ethical commitment to their patients and also because of their own financial needs. In addition, many psychiatrists question the relationship of continuing education programs, as well as certification, to the services they render patients.

In an intriguing 1973 survey of the post residency educational needs of psychiatrists in the Southwestern United States, Naftulin found that fewer than 2 percent of the 1,062 respondent psychiatrists reported that they had ever been called upon to engage in a professional activity for which they felt ill prepared. This puzzling high degree of satisfaction with one's own professional abilities may represent another factor which accounts for the lack of interest shown by psychiatrists in continuing education programs.

Organized psychiatry deserves credit for developing one of the earliest nationwide self-assessment programs, first sponsored by the APA in 1969. Many psychiatrists took part in this 1969 program and again in 1972, when a second edition was offered. More than twenty medical specialty groups now have self-assessment programs.

In 1974 the APA membership approved a constitutional amendment requiring 150 hours of continuing education every three years for maintenance of membership. Although this requirement has not yet been implemented, it is in accord with requirements of at least three other specialty groups—the American Academy of Family Physicians, the American College of Radiology, and the American College of Emergency Physicians. Moreover, the enactment of this amendment may have been partly responsible for the increased enrollment in continuing education offerings at the May 1975 annual APA meeting. Perhaps with this stimulus, more psychiatrists will continue to take advantage of such learning experiences at national meetings.

Many physicians feel that voluntary continuing education efforts will adequately meet the need for updating their knowledge and skills. Others feel that without some form of required evaluation to demonstrate that learning has actually taken place, any program of continuing education will be ineffective. The latter stance was evident in the action taken by the membership of the American Board of Medical Specialties (ABMS) which endorsed the following action at its March 1973 Annual Meeting:

... that the ABMS adopt in principle, and urge concurrence of its member boards the policy that voluntary periodic recertification of medical specialists become an integral part of all national medical specialty certification programs and, further, that ABMS establish a reasonable deadline when voluntary, periodic certification of medical specialists will have become a standard policy of all member boards.

In the interim between then and now all 22 member boards, including the ABPN, have endorsed this policy.
In all likelihood, some of the pressures coming from within the profession for required continuing education and/or recertification are generated in response to the pressures exerted by the public, either directly or through their legislative representatives, as noted in the following. The extent to which the psychiatric profession takes responsibility for assuring the maintenance of competence of psychiatrists will help determine the response of government to the public and legislative-political pressures currently being exerted toward further governmental regulation.

**Public stimuli for recertification**

The medical profession has been joined by consumers in expressing the doubt that advances in knowledge will necessarily be followed by improvement in the delivery of patient services. Increasing public sophistication and knowledge about medical problems, disease processes, and treatments not only strengthen the demand for good health care, but idealistically emphasize the "right to feel good." As these expectations have risen, so has the need for accountability on the part of the physicians. Widespread patient dissatisfaction with the quality and quantity of services provided by the health care system has probably accentuated the demands for more clearly demonstrated competence on the part of practitioners. Psychiatry, as a branch of medicine, is beginning to respond to these demands.

The concerns of consumers have been reflected in the reports of several commissions and organized consumer groups. As early as 1967 the President's National Advisory Commission on Health Manpower noted that in the past: "... reliance on quality controls in formal education and licensure have been the primary means of assuring that physicians use the best techniques and information available. But with the increasing pace of medical advances, these 'one-time' controls are not enough; the physician's education must be continued as long as he practices."

and that

"... professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification or acceptable performance in continuing education programs, or upon the basis of challenge examinations in the practitioner's own specialty."

In describing procedures for selecting a personal physician, a Consumers Union publication reported that "of all the mechanisms now available to enhance the quality of the medical professional, none is more likely to culminate in the incompetence than periodic, mandatory examinations."13

A most potent influence for accountability of services rendered by all physicians, including psychiatrists, has been that of the health insurance organizations such as Blue Cross/Blue Shield, CHAMPUS, Medicaid, Medicare, and commercial insurance companies. Should such organizations come to provide more favorable remuneration to board-certified specialists than to their noncertified counterparts, demonstrated evidence of continued competence in any given specialty might eventually be required. A recent step in this direction was taken by the Veterans Administration, which offers its physicians $500 per year of additional pay contingent upon receipt of the American Medical Association Physician’s Recognition Award.

**Legislative-political stimuli for recertification**

The Federal Government in recent years has demonstrated increasing interest in the problem of physicians maintaining professional competence. For example, the DHEW Report
of the Secretary's Commission on Medical Malpractice (1973) recommended "that the states revise their licensure laws, as appropriate, to enable their licensing Boards to require periodic reregistration of physicians...based upon proof of participation in approved continuing medical education courses."¹⁴

Legislative action, manifested by amendments to the Social Security law establishing area Professional Standards Review Organizations (PSROs) implies that continuing education will be required to meet PSRO standards. In Section 1160 the law states that services of practitioners "will be of a quality which meets professionally recognized standards."¹⁵ Earlier legal decisions and existing medical ethics require practitioners to keep abreast of new developments in their specialty.¹⁶ Through PSROs, specialists also may be required to keep up in the general field of medicine as it applies to their specialty.

Most of the major federal bills proposing national health insurance have contained continuing education requirements for physicians. Prominent among these proposals was the Kennedy Bill, which contains the requirement that physicians be relicensed every six years, and which states that they must meet national standards:

> Not later than two years after the effective date of health benefits, the Board shall by regulation establish for physicians, dentists, optometrists, and podiatrists such requirements of continuing education (taking into consideration standards approved by appropriate professional organizations) as it finds reasonable to maintain and enhance the quality of professional services furnished under this Act.¹⁷

There has been legislative activity at the state level, also. At least six states (Iowa, Kansas, Kentucky, Maryland, New Mexico, and Vermont) have taken steps to make continuing education mandatory for licensure and relicensure. Other states will probably take similar action. Ohio has made continuing education mandatory for participation in the State of Ohio malpractice pool.

These state and federal laws focus primarily upon mandatory continuing education. This suggests that voluntary continuing education alone has not been seen as a sufficiently strong approach to improving standards of patient care. On the other hand, there is no reason to think that mandatory continuing education alone will be sufficient, either. Only by providing more adequate methods of assessing psychiatric knowledge and skills as they apply to the delivery of services can the psychiatric profession assure an acceptable level of competence among its members. The recertification process may be an important step toward realization of this goal.

As the various specialty boards develop meaningful recertification procedures, legislative bodies may well decide to accept certification and recertification as evidence of professional competence. Nonetheless, serious legal opposition to mandatory continuing education or recertification can be anticipated. Only some of the legal issues can be mentioned within the confines of this brief report.
There are a number of legal issues relating to periodic recertification. Medical licensure by the states, which was established at the end of the 19th and the beginning of the 20th century, was based on state police power. Under the 10th Amendment, the state may establish regulations which reasonably protect the health, safety and welfare of the community. State licensure laws have remained essentially unchanged since passage of that Amendment. The state licensing agency has jurisdiction over all practitioners in the state. Usually, the license has been issued for life, with automatic periodic renewals. Historically, licensure has not been granted on the basis of specialty board certification.

Whereas the power to regulate is the prerogative of the state, the individual’s rights to pursue his or her profession are protected by the due process aspect of the 14th Amendment. The grounds for revocation or suspension of license are vague (e.g., “gross incompetence”) and, in fact, have usually been based on criminal offenses. So far, educational obsolescence has not been used as a reason for revocation of a license to practice medicine. By tying mandatory continuing education and recertification to licensure, however, the licensing board could then enforce the physician’s duty to keep up.

The action of those states which make participation in continuing education programs mandatory for licensure and relicensure will probably be tested in the courts. Indeed, this
is a new area as far as the courts are concerned and there are few cases from which predictions can be made regarding future court decisions. Rather, by looking at the law in analogous situations, inferences can be made about the types of questions and problems that might result from mandatory periodic recertification.

A number of cases have argued the due process issue as it applies in other professions. For example, the question of whether university faculty members can legally be denied renewal of their contracts by the university board of regents has been adjudicated in several cases. The courts have reasoned in these cases that an individual shall not be deprived of an occupation on which he has relied for economic survival without having recourse to due process of law. Due process requires specificity, rationality and fairness. Precise standards and guidelines which are both reasonable and predictive of quality practice must be established. The standards must be equitable and not arbitrary. A potential licensee should be able to anticipate whether or not he/she will qualify and must know and understand the prevailing interpretation of the rules. These same considerations of due process would be expected to apply to periodic medical relicensure.

Medical specialty boards have been under increasing pressure to justify the standards which they set as certifying bodies. They must provide a fair hearing and must be open to judicial review. For recertification, the guidelines will have to be correlated with effective practice. The demand for a certain number of hours of postgraduate education must relate, for example, to being a more effective diagnostician or therapist. Standards which fail this test may be stricken as merely restrictive and anticompetitive. It is argued that lengthy residence requirements for medical licensure of many states are merely an attempt to limit the market; hence they are held to violate the Constitution. To carry the requirements of due process one step further, a practitioner who was licensed and certified at a time when recertification was nonexistent could argue that he invested his time, energy and money in establishing a professional practice based on the standards prevailing at the time. Thus, certified psychiatrists may claim that to deprive them of their livelihood on the basis of a new standard would violate their protection under the 14th Amendment.

The Social Security Amendments of 1972 which established PSROs contained a civil immunity clause protecting from civil liability those physicians who practice according to the PSRO norms of professional care. The law makes the PSRO the arbiter of the standard of care in questions involving negligence. The question also arises, would noncompliance with the PSRO standard be prima facie (i.e., acceptable) evidence of negligence? Conceivably, failure to become recertified could be considered evidence of incompetence for malpractice purposes, since one may argue that it serves as proof of a failure to meet the community standard of care. The same reasoning may be applied to the continuing education requirements of state medical societies and specialty societies, including the APA. These are all exceedingly complex issues which will require further juridical study.

There are few legal sanctions for noncompliance with such continuing education requirements. Nonetheless, the loss of membership in a state medical or specialty society would have serious implications for the professional status of the nonpsychiatrist-physician and of those psychiatrists who work closely with these physicians. Furthermore, malpractice insurance contracts may force hospitals to demand their staff members meet continuing education standards. These sanctions would apply to psychiatrists working in psychiatric hospitals and in general hospitals, but may not apply so directly to the office-based psychiatrist.
To date, there has been no effective legal challenge to the right of medical societies and specialty societies to make continuing education a requirement for membership. Similarly, there has been no legal challenge to the right of specialty boards to require periodic recertification. Neither of these requirements implies legal sanction to prevent the practice of medicine. Nonetheless, the whole recertification process, including continuing education, must be carefully designed to avoid being viewed legally as merely restrictive and anticompetitive. Thus, it will be necessary to demonstrate a clear relationship between the recertification process and the effective practice of psychiatry. To do so, it will be necessary to consider the strengths and weaknesses of current methods of evaluating competence.

EVALUATION TECHNOLOGY

An effective program of recertification will require a system that will evaluate the knowledge and skills considered essential for quality psychiatric care in economical fashion. An important initial step in devising such a system is to develop a detailed definition of the professional competence which must be maintained by psychiatrists responsible for patient care. Such a definition of professional competence would call for (1) a base of knowledge and theory in the field of psychiatry; (2) interviewing skills; (3) psychotherapeutic skills; and (4) evidence of the ability to apply all these skills in day-to-day practice.

Defining professional competence

During the past twenty years a number of role-defining techniques have been proved useful in defining professional competence. These techniques include three different approaches:

The field-specific approach attempts to identify the knowledge and skills generally required of all individuals taking part in that particular discipline, that is, general psychiatry, child psychiatry, etc.

The physician-specific approach refers to the knowledge and skills deemed especially important for an individual practitioner, usually judged on the basis of the kinds of patients and medical problems for which the practitioner provides care.
The disease-specific approach attempts to define specific requirements for the management of specific kinds of medical problems—for example, the diagnosis and management of psychotic depression.

Field-specific approaches. Methods of defining professional competence which are field-specific have been used by several specialty boards such as the American Board of Orthopaedic Surgery and the American Board of Pediatrics. Varied techniques have been used by these groups. One field-specific approach is the critical incident technique in which practitioners and educators are asked to document a series of most effective and least effective examples of performance by a practitioner. After accumulating a large number of examples, these lists of behaviors are organized into a more meaningful definition of professional competence. This was the approach used by the American Board of Orthopaedic Surgery. The Committee on Certification in Child Psychiatry of the ABPN has sponsored an extensive study using the critical incident technique as one way of identifying factors necessary to the competent practice of child psychiatry. The outcome of this study will be of interest to general psychiatrists.

A somewhat similar approach involves the use of a series of expert committees, each one charged with defining in more precise terms a major component of professional competence. This approach was used by the American Board of Pediatrics in defining the components of competence for the general pediatrician. A third very similar approach involves the enumeration of all the tasks required of an individual within a particular profession, the so-called task analysis approach. A somewhat related technique for defining the field involves direct observation including time and motion studies—a method used widely in industrial psychology.

Thus far, these field-specific techniques have been used sporadically and there have been no comparative studies of their relative utility. We may find over the years to come that there is some merit in combining data derived from several different techniques before coming up with the most useful definition of professional competence.

Physician-specific approaches. Although field-specific techniques for defining professional competence may well be appropriate for most individuals about to enter independent practice within a particular discipline, an argument can be made for attempting to define the needs of an individual psychiatrist based on the type of practice he has developed. This is deemed especially important by practitioners who have developed a highly specialized practice. Various techniques for enabling a physician to provide a self-reported profile of his practice have been used. Both the American Board of Family Practice and the Philadelphia College of Physicians have undertaken studies focusing on this approach. The American Board of Family Practice has been developing a recertification program based on the needs of individual practitioners as evidenced by self-reported profiles of practice. At the time of this writing, however, it seems unlikely that this will be possible during the ABFP's first recertification program in 1976. The Philadelphia College of Physicians has attempted to develop individually reported profiles of practice, to administer examinations based on these practice profiles, and to design instructional programs based on the results of the examination performance in these specific areas.

There are problems in relying too heavily on self-reported profiles of practice needs. Because of individual interests or deficits in training, an individual practitioner may fail to identify important areas to which he should have been attending. For example, a psychiatrist whose interests have developed mainly in the area of psychotherapy of per-
sonality disorders may fail to identify the presence of depression. A more detailed analysis of this individual's practice might reveal the fact that several patients have made serious suicidal attempts, with perhaps one or more deaths. There is some evidence that an individual might be unaware of his own blindspots and might fail to report these as educational needs in the profile of his practice. While there are serious technical and financial difficulties associated with profile-dependent assessment procedures, further work may yield practical solutions to the problems posed by this approach.

**Disease-specific approaches.** Another approach to defining the knowledge and skills required of an individual practitioner has to do with identifying specific clinical problems and enumerating the steps which the physician must take in order to maximize the likelihood of favorable health care outcome. This approach, which might also be characterized as the Brown-Fleisher-Williamson approach to continuing education, is being widely adopted by groups such as the Joint Commission on Accreditation of Hospitals and other organizations of physicians concerned with developing PSRO review mechanisms. In this approach the knowledge and skills required of the practitioner are defined by listing those clinical problems within the community that have a high incidence and a high morbidity, and for which there are effective preventive or therapeutic interventions.

For inpatient psychiatry, a disease-specific approach might be used in developing standards of care for a variety of clinical disorders—for example, psychotic depression or acute undifferentiated schizophrenia. Using this approach, one would attempt to define the criteria for diagnosis, that is, elements of the clinical history, the physical examination (including the mental status examination), laboratory studies, and psychological testing. Both acceptable and unacceptable forms of intervention would be specified. Among acceptable forms specified might be tricyclic antidepressants, MAO inhibitors, and electroconvulsive therapy. Unacceptable forms of intervention might specify the following: exclusive use of psychotherapy or total reliance on such medications as phenothiazines or chlordiazepoxide, or exclusive reliance on general supportive milieu therapy.

**Assessment of knowledge**

Every definition of professional competence contains as an important element the individual's knowledge of his field. This view is accepted by most psychiatrists. To provide effective health care the individual psychiatrist must understand diagnoses, psychopathology, growth and development, various forms of intervention, including psychotherapy and the appropriate use of psychopharmacological agents, and community organization—not only the organization of communities in general, but of his/her own community and its resources. Most health professionals believe that a period of formal training is a requisite for acquiring the knowledge and skills necessary to the practice of their profession.

In all likelihood, the multiple-choice test is the most effective way to assess the individual knowledge of a large group of practitioners, but there are criticisms of multiple-choice testing, of two different kinds. One kind is based on the contention that the sort of information and knowledge required to pass standardized licensure and specialty board tests correlates very poorly with the individual's ability to provide effective care. This contention is probably based on frequently heard statements that there are knowledgeable practitioners who fail to provide effective care and likewise other practitioners who, though less knowledgeable in the field, provide effective care by their frequent use of such resources as consultants and printed materials like texts and journals.

A second criticism of multiple-choice testing (and, in fact, of all professional knowledge assessment) has to do with the
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Assessment of interviewing skills

A second major area in need of assessment concerns an individual psychiatrist’s interviewing skills. Some contend that the knowledge and skills required to interview patients are similar to those needed to ride a bicycle, in that, once learned, they are retained over a long period of time. If this were true, it might well be deemed uneconomical to incorporate interviewing into any recertification or relicensing procedure for psychiatrists. On the other hand, it remains to be determined whether or not diagnostic interviewing skills fall off with increasing years of experience.

A number of groups have devoted major research efforts toward developing more reliable and valid ways to assess interviewing skills. Traditionally, interviewing skills have been assessed by observing the psychiatrist interview a patient. In order to standardize the testing procedure, a number of studies have focused on the use of persons, as simulated patients, who are trained to take on a particular patient’s illness, lifestyle, etc. In addition, a variety of new rating procedures are being explored to alleviate the problem of achieving satisfactory agreement among different raters. One of these rating techniques is known as interaction analysis and consists of recording the nature of the physician-patient interaction every few seconds. Other approaches, making use of data checklists, permit the rater to determine whether the information which the simulated patient was trained to reveal on questioning actually was elicited by the interviewer.

Additional studies will be needed to determine the extent to which simulated patients can provide a reasonably valid portrayal of the verbal and nonverbal behavior of an actual patient. Considering all the problems involved in reliably assessing interviewing skills, simulated patients seem to provide a most valuable adjunct to the reliable assessment of interviewing skills.

A number of investigators have explored the usefulness of computer simulations to assess skills in interviewing and other aspects of data gathering. Such procedures have been explored by Harless, Starkweather, Pepyne, and others.
These investigators have programmed the computer to produce in written form the verbal responses of a particular patient to questions posed by the examiner. The examiner, who assumes the role of the physician, interviews a computer-patient by entering his questions into the console typewriter. Within moments after the completion of each typewritten question the patient’s response appears either on a written page or on a cathode ray tube display. Although it has been useful for instructional purposes, computerized simulation techniques have not yet been adapted for nationwide testing purposes.

**Assessment of psychotherapeutic skills**

The assessment of psychotherapeutic skills constitutes another major area for a recertification program. Efforts to assess these skills will not only elicit some of the same problems attendant upon the assessment of interviewing skills, but other problems as well.

One technique which has been used widely in evaluating psychotherapeutic skills is the retrospective reporting of psychotherapeutic transactions to an instructor, usually hours or days after the actual interaction has taken place. Other techniques include scrutiny by an observer (either in the same room, or watching through a one-way mirror) and post hoc reviews of videotape interview recordings. The difficulty of obtaining agreement among two or more raters about the demonstrated skills and abilities of the psychotherapist is common to all these approaches. There is the further objection that problems of patient confidentiality, which occasionally arise at a training center, may be insurmountable in the private practice setting.

At this time, the GAP Task Force on Recertification is unaware of any method that provides a reliable and valid assessment of the array of psychotherapeutic skills used within the private practice setting. This deficiency represents one of the major needs that must be considered in planning a recertification program for psychiatry.

**Assessment of delivery of care**

Each of the assessment procedures discussed up to this point focuses primarily on a one-time assessment of an individual’s capacity for applying certain knowledge and skills in professional contacts with patients. Another high priority in the design of a valid recertification procedure is to find some method of assessing the day-to-day application of the psychiatrist’s knowledge and skills. In many other fields of medicine, promising advances have been made in utilizing audits of the medical record as a means of monitoring the physician’s ability to provide good care on a day-to-day basis.

In developing assessment procedures from the medical record audit, several steps should be taken: (1) establishing criteria for specific kinds of diagnostic problems; (2) devising instructions by which nonphysician abstractors can determine whether the information deemed important is contained in the medical record; (3) designing computerized data-processing procedures to tabulate and summarize the data drawn from large numbers of record abstracts; and (4) arriving at some means of reporting feedback to the individual physicians, so that every examinee knows the extent to which he/she has complied with the criteria established by an expert peer group.

Application of the medical record audit to an assessment of the quality of care provided by the individual psychiatrist seems to be more practical in an inpatient setting than in outpatient settings. In fact, the implementation of PSRO and Joint Commission on Accreditation of Hospitals requirements may be expected to bring about increasing use of the medical record audit in hospital settings.

Will the medical record audit be useful in monitoring the quality of care received by patients in the psychiatrist’s pri-
vate office? The usefulness of the medical audit depends primarily on its ability to document the data gathered. Such data include elements of the medical and psychosocial history, physical examination findings, laboratory studies, and certain discrete forms of action taken—for example, the use of pharmacological agents. However, it will be much more difficult to make use of the explicit diagnosis-specific audit criteria in private practice settings which have proved so useful in the hospital setting.

The medical record audit appears ill suited for monitoring of the complexities of the psychiatrist-patient interaction as this evolves during the course of conventional psychotherapy or behavior therapy. The use of the medical audit, therefore, is another major area for research and development if we are to improve psychiatric services and maintain accountability to the public.

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WHAT WILL BE THE NATURE OF RECERTIFICATION?

Existing recertification programs run a gamut, clustering around four main levels of motivation:

1. Totally voluntary participation in a recommended number of hours of self-selected continuing medical education programs
2. Participation in continuing education programs as a requisite for professional society membership
3. Mandatory participation in continuing education programs and/or examinations as a requisite for continued practice
4. Mandatory reexamination and/or audit of hospital and office records

1. Voluntary continuing education

Thirty-three state medical societies and 19 specialty societies have established a recommended number of continuing education hours, and a few provide a means of keeping attendance records at approved programs. Except where tied to membership, these arrangements are voluntary and provide necessary flexibility permitting each specialist to focus on areas which he feels need additional study. This type of program is illustrated by the AMA Physician's Recognition Award.

Many private practitioners and academicians in psychiatry favor voluntary continuing education because they feel that
this approach will update the knowledge of the individual psychiatrist, will keep him in contact with colleagues, and will result in his delivery of better patient care. In this view, continuing education throughout a lifetime is considered to be a valuable way of life. Most psychiatrists prefer to identify their own educational needs. Some of the limitations to this approach have already been discussed in the preceding chapter.

In reviewing reports which reflect the judgment of professional, public, and legislative-political groups advocating recertification of physicians, it seems unlikely that voluntary approaches will be accepted as sufficient evidence of continued professional competence (see Chapter 2). These groups are giving increasing emphasis to the concept of professional responsibility to document visibly the fact that educational experiences actually enhance knowledge and improve the quality of services provided.

2. Continuing education for professional society membership

The APA requirement of 150 hours of continuing medical education every three years to maintain membership typifies this second approach. Although loss of membership could have a major impact on a psychiatrist's practice, it would not result in loss of his medical license or in the imposition of other legal sanctions against continuing practice.

Twelve state medical associations have made continuing education a requirement for membership. The Oregon Medical Association established this policy in 1973, thereby becoming the first state association to implement this approach. During 1974, Oregon physicians demonstrated progressively increasing willingness to comply with this requirement. By 1975, society officials reported that they expected to have to drop very few individuals from their membership because of failure to meet this new requirement.30

It is likely that most members of the APA will accept continuing education requirements, particularly if the local district branches can provide interesting, well-designed, and clinically relevant educational experiences at a reasonable fee. Here again, the question remains, whether participation in continuing education programs will insure improved patient care and provide adequate accountability to the public.

3. Mandatory participation in continuing education programs

Mandatory continuing education requirements are found in the medical practice acts of six states (Chapter 2). The New Mexico state licensing board was the first state to institute such a program, enacting its legislation in 1972. Although there was some strenuous vocal objection to the requirements as the deadline approached for meeting them, more and more physicians demonstrated their willingness to complete the necessary course work. In February 1975, as the first deadline approached, the New Mexico state licensing board anticipated that only a few practitioners would be dropped, for noncompliance, from its roster of licensed physicians.31

4. Mandatory reexamination

Since its formation in 1969, the American Board of Family Practice (ABFP) announced publicly that its certificates would be good for a period of only six years and that all ABFP diplomates would be required to obtain recertification after six years. The first recertification program is scheduled for October 1976 and will consist of four components. Each candidate for recertification will take a written examination. In addition, he/she will be required to demonstrate the completion of certain continuing education requirements similar to those of the AMA Physician's Recognition Award. There will also be an audit of office records focusing on patients
with any one of a given list of diagnoses; and a statement that there are no disciplinary actions by the state licensing boards pending against the examinee.

Although the ABFP represents the only group that so far has required reexamination, there are other programs which may inadvertently take on similar mandatory overtones. For example, the recent joint program sponsored by the American Board of Internal Medicine (ABIM) and the American College of Physicians was designated as strictly voluntary. Indeed, as the ABIM's current policy stands, no internist will be deprived of certification for failing to register and pass the recertification examination. However, those internists who passed the recertification examination were given a special designation in the official directory of the American Board of Medical Specialties. With that information available to the public, a third-party payer can easily reverse the voluntary nature of a recertification program by instituting a policy of differential fee payment in favor of those physicians who have completed the voluntary recertification program.

Other Approaches to Recertification

All 22 of the recognized specialty boards, including the ABPN, have supported the American Board of Medical Specialties policy for recertification. In fact, a number of these specialty boards have taken steps to initiate some type of recertification program. Although there has been little or no public challenge of the authority of specialty boards in taking on this responsibility, it is still somewhat unclear what role will be played by the corresponding specialty society. In a few instances, there has been evidence of a close collaboration between the specialty board and its corresponding society as described in the outline of the recertification program for internal medicine.

In 1969 and 1970 the American Board of Internal Medicine (ABIM) and the American College of Physicians (ACP) both adopted a resolution favoring recertification for its diplomates and members, respectively. Subsequently, the two groups began a very fruitful collaborative venture which, in October 1974, resulted in 3,356 diplomates of the ABIM voluntarily taking a one-day written Recertification Examination. As part of this program, the ACP Medical Knowledge Self-Assessment Program Committee had developed a syllabus of important advances made in general internal medicine within the preceding few years. The ACP syllabus and its references were made available to participants as a guide to studying for the recertification examination. Six months later, participants received, answered and returned a self-assessment examination consisting of 720 multiple-
choice questions pertaining to the syllabus and its references. Meanwhile, the ABIM Committee on Recertification had developed a Recertification Examination consisting of 274 multiple-choice questions. Of these questions, 64 percent were based on the ACP syllabus. Three months after the self-assessment examination, the ABIM Recertification Examination was given. The pass rate was subsequently set so that only 4.3 percent of those taking the examination failed to pass. Failure to pass did not entail loss of original certification. In order to provide an educational feedback, the ACP returned the self-assessment examinations, along with the correct answers to the participants.

This collaborative approach between specialty boards and its corresponding specialty society serves to encourage continuing education and also to provide visible documentation that a satisfactory amount of knowledge has been learned. The GAP Task Force on Recertification believes that this sort of collaboration between two such organizations has great potential for the implementation of recertification programs.

Of special interest to psychiatrists is the ongoing work of the Committee on Certification in Child Psychiatry, which operates under the auspices of the ABPN. As mentioned in Chapter 4, this committee has identified, through the use of critical incidents reported by consumers and through surveys of educators and trainees, many of the skills and much of the knowledge necessary to conduct a practice in child psychiatry. This study will form the basis for revision of the ABPN certification in child psychiatry and also, in all likelihood, the basis for development of a recertification program in child psychiatry.

In developing a recertification program for psychiatry, the GAP Task Force on Recertification believes that the following steps should be undertaken: (1) A determination should be made—partly based on consumer inputs—of the body of knowledge and skills deemed necessary before a practitioner can provide competent psychiatric services; (2) a determination should also be made of common deficiencies found among psychiatrists in the acquisition and maintenance of needed knowledge and skills; (3) carefully planned continuing education programs should be provided that are aimed at correcting these deficiencies; (4) multiple-choice examinations should be designed that will adequately assess the examinee's knowledge; (5) a variety of methods should be employed in assessing other skills such as interviewing, differential diagnosis, and psychotherapy and other psycho-social approaches; (6) the day-to-day application of these skills should be monitored by medical record audits or some other as-yet-to-be-discovered technique; and (7) ongoing research and development should be undertaken that will more closely correlate the methods and content of the recertifying examinations with the realities of psychiatric practice. Each of these procedures may be the focus of further research, which in turn will help to improve the overall recertification procedure. Properly planned and carried through over a period of years, such research would make for a more reliable (i.e., duplicable) and valid (i.e., assess important aspects of professional competence) recertification process.

It is important to realize that some time will be required before the knowledge, manpower, and financial resources necessary to launch an effective recertification program can be assembled. Moreover, the initial efforts of recertification may not be as comprehensive or as sophisticated as they might become after additional years of experience and further research and development. Nevertheless, we believe it feasible and desirable to develop by 1978 a voluntary recertification examination which visibly documents the fact that a previously certified psychiatrist has kept up to date with the advances in psychiatry. The most economical approach to this objective would be a multiple-choice examination.
At this time there are insufficient data to indicate how frequently an individual should be recertified. At the present time, a minimum of five years after graduation from medical school is required to obtain the original certification. The Carnegie Commission Report on Higher Education notes that the half-life of new scientific knowledge is five to ten years. Perhaps recertification might be undertaken by an individual every five to ten years. The procedures themselves should probably be available to be taken on a year-by-year basis. In any event, the logistics of administering such an examination to thousands of certified psychiatrists will require careful planning.

It should be recognized that a multiple-choice examination does not directly assess the examinee's ability to use psychiatric knowledge during the course of day-to-day delivery of services. Existing methods of assessing the quality of such services have some deficiencies, and further research will be required for their improvement.

In the view of the GAP Task Force, a well-designed recertification program would offer a number of benefits:

1. It would demonstrate visibly to professional, public and legislative-political groups that the psychiatric profession is doing everything reasonable to assure competent delivery of services.
2. It would head off governmental imposition of mandatory recertification standards which might be designed with minimal input from those physicians most familiar with criteria of quality patient care.
3. It would provide psychiatrists with clear guidelines for the maintenance of professional competence.
4. It would provide psychiatrists with appropriate recognition for having maintained their knowledge and skills.

5. It would encourage noncertified psychiatrists to become certified by providing clear indications of what is expected of them to demonstrate the maintenance of professional competence.
RECOMMENDATIONS

This report has discussed a variety of considerations regarding recertification, among them pressures from within the profession, from third-party payers, and from the public at large; problems concerning the large number of uncertified psychiatrists; questions about the relevance of existing certification procedures to the care of psychiatric patients; and the problems attendant upon an insufficiently developed evaluation technology. Despite this challenging array, the GAP Task Force believes that the psychiatric profession has at the present time the knowledge, the experience, and the determination to improve the continuing education of psychiatrists and to develop professionally relevant and publicly accountable means of documenting the attainment and maintenance by them of professional competence.

The recommendations which follow are based on the recognition that although residency training provides a setting in which professional skills are acquired, certification and recertification procedures play a significant role in assuring that these professional skills will be acquired and maintained. On the basis of these considerations, the GAP Task Force on Recertification in Psychiatry recommends:

1. That our psychiatric professional organizations collaborate in the development of new mechanisms through which to encourage all practicing psychiatrists who have not obtained certification by the ABPN to obtain this certification.
2. That the ABPN design a long-range research and development plan to be conducted in consultation with other interested psychiatric professional organizations to make substantial improvements in the certification process.

3. That our professional organizations explore the possibility of requiring psychiatric residents to become certified by the ABPN prior to entering independent practice.

4. That mechanisms be developed to provide the opportunity for all certified psychiatrists to become recertified by the ABPN.

5. That if states choose to require relicensing of all physicians, then the states should be encouraged to accept recertification in psychiatry as evidence of the maintenance of a psychiatrist's professional competence.

1. **Certification of uncertified practicing psychiatrists**

   In order to facilitate certification of the large number of uncertified psychiatrists, many of whom have been out of training for substantial periods of time, an active collaboration between the ABPN and the APA must be established. This collaboration will assure that (1) reasonable standards representative of the broadest scope of contemporary psychiatric practice and thought are reflected in the certification procedure; (2) the scope of knowledge and skills covered by the certification procedure is made known to candidates for certification; (3) educational opportunities, materials and references which encompass the scope of knowledge and skills required are made available to candidates; and that (4) a reasonable time frame will be established to permit practitioners to meet eligibility requirements and to become certified.

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It is further recommended that if at all possible, certification of psychiatrists who have been in practice for ten or more years beyond the completion of residency training should be based on assessment procedures that take into account the particular practitioner's area of subspecialization. The certification of all psychiatrists would be one way of documenting an acceptable level of professional competence for each psychiatrist. It would also provide consumers, hospitals, other health professionals, legislative bodies, accrediting agencies, and third-party payers with a more rational means for assessing on a nationwide basis the professional qualifications of individual psychiatrists.

2. **Improvement of the certification process**

   In order to develop a certification process which will be viewed favorably by the profession, major improvement in our existing techniques will be required. This calls for substantial planning and research. Efforts should focus on the creation of a more detailed definition of the components of professional competence and on improvement of the methods for assessing the various components of competence.

3. **Certification of psychiatric residents before entering independent practice**

   For ABPN and/or state licensing bodies to require that psychiatric residents obtain specialty certification prior to entering independent practice would require reorganization of the examination process. One solution might be to offer the written examination (Part I of the ABPN Certification Examination) immediately before beginning the final year of psychiatric residency. This would make it possible for the resident to identify and correct deficiencies of knowledge and skills while still in training. A major responsibility for
insuring that the resident successfully completes Part I would rest with the training program director. Moreover, this arrangement would assist residency training program directors in assessing the achievement level of individual residents. The oral examination (Part II) could be offered immediately before completion of the last year of training so that the resident might become board certified before entering unsupervised practice.

Implementation of this recommendation will require that residency training programs and chairmen of departments of psychiatry assume increased responsibility for insuring that residents achieve a standard base of knowledge and clinical skills necessary to obtain certification. In order to facilitate the attainment of this goal, we recommend that the ABPN consider reconstituting its membership to include representatives of the American Association of Directors of Psychiatric Residency Training Programs, the Association of Chairmen of Departments of Psychiatry, the APA, the American Academy of Child Psychiatry, and other appropriate organizations. This increased representation would enhance the ABPN's ability to develop and implement the procedures and standards of certification.

4. Voluntary periodic recertification

The psychiatric profession should take the initiative to develop reliable and valid procedures to encourage voluntary recertification of all practicing psychiatrists. This would help to insure that professional psychiatric skills are maintained on a nationwide basis. An important research priority will be the development of methods for assessing the quality of care provided by individual psychiatrists in various ambulatory settings.

Much will be required to meet effectively the challenge of these research needs. The work will not be achieved in a few months or a year. We therefore recommend that initial planning to develop a recertification process begin as soon as possible and that it employ multiple approaches for assessing knowledge and skills, utilizing some combination of the following:

1) an approach consistent with the continuing education requirement adopted by the APA which is currently based on the AMA Physician's Recognition Award
2) a written examination which focuses both on well-established knowledge and on new developments in diagnosis and patient care
3) methods of assessing interviewing and psychotherapeutic skills by the use of pretested films or videotapes of patient interviews or other innovative techniques
4) mechanisms yet to be developed that will utilize the medical record audit in assessing the quality of psychiatric practice

The recertification procedures should be based on data relevant to the professional activities and responsibilities required of a practicing psychiatrist. This Task Force further recommends the development of mechanisms to identify such subspecialty practice patterns as child psychiatry, upon which individualized assessment might be designed.

5. Relicensure and recertification

The activities of the legislative bodies in New Mexico, Maryland, and elsewhere suggest that an increasing number of states will require relicensing of all physicians. With the expectation that relicensure will eventually be mandated by state law throughout the United States, we recommend that all state laws be written to accept recertification in psychiatry as a basis for relicensure.

In 1974, a group which had been asked by the National
Board of Medical Examiners to review carefully the goals and priorities of this organization, recommended that state licensing procedures be reconstituted into the following two phases: (1) a limited license to practice under supervision would be granted at the end of medical school and prior to entry into post-M.D. training; (2) a full license to practice independently would be granted upon completion of graduate specialty training. At the time of this report, none of the various states have moved in this direction, but perhaps it is too early to tell whether this recommendation will be eventually adopted by the states. If the states do adopt this recommendation, then the GAP Task Force would recommend that they institute a two-stage licensing system which would permit recognition of certification by the ABPN as a means of obtaining a full license to practice without direct supervision.

Conclusion

The issue of recertification in psychiatry—as we have attempted to show in this report—is a profoundly complex one that touches upon many fundamental social and technical questions. Given this complexity, it seems unwise to expect or attempt to create immediately a recertification program aimed at solving all the social and technical questions involved. Therefore, this Task Force recommends a gradual and planned approach of doing the best that can be done now and improving recertification through further planning, research, and experience. This kind of approach is appropriate to our rapidly changing times. Decisions made in the next five years are likely to have repercussions on decades of psychiatric practice.

Implicit and important in these recommendations is the assumption that planned action is preferable to doing nothing. The latter course would invite imposition of standards from outside the profession.

The recommendations made in this report are based on the knowledge and skills presently available within psychiatry. With prompt organizational planning, recertification could and should begin within two years. With continued planning and solid research, the experience of actually carrying out the recertification process would provide data and information essential to the development of assessment methods and criteria of practice which are more directly related to quality patient care.

What this Task Force is proposing here offers a flexible approach which will meet the current realistic needs of consumers and legislative-political bodies for documented evidence of continued competence in the delivery of psychiatric care. Further, it could anticipate and meet new needs emerging from unforeseeable social changes. Equally important, it would permit psychiatrists to practice with competence and with dignity.
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