

(3) “Is it a valid measure of the way we approach problems in clinical practice?” It is not especially valid for that measurement target, nor is it intended to be. The examination is about what one knows about family medicine, rather than how one would behave at work with multiple demands on time simultaneously pulling in several directions. The certification examination is not a “cognitive exam” in the sense of psychological measurement, in which the quality of cognitions, handling of stress, and mental status may all be measurement targets. These issues are crucial to patient care at the moment of service delivery. The point of confluence of “circumstance, temperament, and emotional reserve” can be assessed by professional observation, in the context of a nationwide training apparatus over the course of years, just as in residency.

(4) “If clinical performance is the real target, why not examine it instead of our skill in taking a cognitive exam?” Clinical performance is not currently the real target, simply because it does not exist as a single, coherent measurement construct. In contrast, medical knowledge is well defined and measured by the ABFM exam. It is incorrect to suppose that the certification exam can stand as a global measure of physician quality. It should instead be viewed as a measure of knowledge, which is one universally agreed upon and absolutely essential characteristic of a highly competent physician.

Dr Loxterkamp questions the utility of the ABFM examination of family medicine knowledge in its present state. However, the null hypothesis, that there is no relationship between knowing medicine and effective medical practice, is simply not tenable. This is why there is relatively little literature on the topic. Medical education consists largely of imparting a tremendous amount of information

into the heads of physicians-to-be. Medical education takes for granted that knowing this information is important to effective practice.

Many of the points Dr Loxterkamp brings up clearly bear upon the quality of care provided. They are system-level problems, not individual-level problems. Certification of a physician does not guarantee one works in a well-organized, well-managed environment in which they can employ their knowledge effectively. Instead, Board certification follows the individual physician and offers strong testimony about the qualifications of that individual.

Dr Loxterkamp comments, “I know the argument: ‘Even though it’s a bad test, it’s all we’ve got.’” We object. The exam is quite good at separating those who carry around and can quickly access important and relevant medical information from those who cannot. It is not a measure of test-taking ability. We have tested this hypothesis. Excellent test takers cannot outperform any one of the 70,000 certified family physicians, and they do not even come remotely close. Extensive data has shown that knowledge, training, study, and practice experience elevate test scores. Movement away from family medicine practice lowers test scores. This is irrefutable evidence that the exam measures medical knowledge, as intended.

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Author’s Reply:

I am grateful to Drs Manahan, Puffer, Rinaldo, and O’Neill for thoughtfully reading and responding to my essay. The dialogue is not for us alone but for all those who have dedicated themselves to quality care and the survival of family medicine.

(1) The Maintenance of Certification (MOC) cognitive exam is a costly, time-consuming, and highly

visible stamp of approval for family physicians. It should be held to high standards. The American Board of Family Medicine and I share that conviction.

(2) Measurement is never neutral. It draws attention to certain things and ignores others, and it changes the very thing being measured (see the Heisenberg Uncertainty Principle). Thus, we must be willing to examine both the tools and their impact and set them aside when they no longer serve our purposes.

(3) I disagree with Rinaldo and O’Neill that “medical education consists largely of imparting a tremendous amount of information into the heads of physicians-to-be.” How students frame questions, access and apply knowledge, evaluate outcomes, and engage their patients are far more important, though less easily measured, qualities.

(4) I also disagree that “based on their entry into it, at least 85% of family physicians appear to find this voluntary process useful.” Physicians maintain board certification because it is expected and/or required of them. Patients are largely unaware of our status. They are more concerned about how they are treated when they’re sick. And increasingly, they are treated by physician assistants, nurse practitioners, and specialists because so few American medical graduates are going into family medicine. The “other” purpose of board certification (besides reassuring the public) was to prove the legitimacy of family medicine to a specialty-dominated medical system. This goal has not been realized.

(5) The purpose of medical education is to produce good doctors, not by our own standards but according to the public need. If we have forgotten the Hippocratic Oath to “enter every house only for the good of our patients,” we are often reminded that our license to practice is state-issued. The patient’s needs—discerned through careful listening—should direct every as-

pect of our training. Tolstoy's short story, "The Death of Ivan Ilych," where a patient consults the doctor because he is worried about dying, is instructive:

But the doctor ignored that inappropriate question. From his point of view it was not the one under consideration. The real question was to decide between a floating kidney, chronic catarrh, or appendicitis. It was not a question of Ivan Ilych's life or death, but one between floating kidney and appendicitis. And that question the doctor solved brilliantly, as it seemed to Ivan Ilych, in favor of the appendix.

Here I agree with Dr Manahan: "Physicians need better listening skills. We need more empathy and compassion. We need more time to spend with patients. . . . We need better skills in working with teams of all types of providers. And, primarily, we need to learn how to do a much better job of taking care of ourselves."

(6) It is possible to reject standardized testing, no matter how perfect the tool. Because it is machine-tooled, not hand-crafted. Because medical facts are produced by and for human beings. Because, as Anais Ninn once said, "We don't see things as they are, we see things as we are."

More than 815 4-year colleges in America no longer require the SAT or ACT to admit bachelor degree applicants, including schools like Bates, Bowdoin, Middlebury, and Mount Holyoke. The MCAT, which the average medical school applicant takes twice and pays for its preparation, may help predict who will complete medical school (under the current curricula) but not how competent or what kind of doctor he/she will become.

(7) It is possible to choose other methods of evaluation, such as direct observation or one that has a more direct impact on the future of primary care: certification as a Patient-centered Medical Home. This imperfect process does not depend on specialty brand but looks at the relationship between members of a team (physicians, PAs, NPs, nurses, assistants, educators) and their effectiveness in providing accessible, affordable, appropriate, and compassionate care.

(8) I disagree with Dr Puffer that allowing test-takers to access the Internet—just as practitioners do in their offices—would create "significant logistical and security problems that cannot be solved with our present day technologies." Lack of know-how did not, for example, create our reliance on foreign oil or gas-guzzling cars. There is inertia to overcome, and lack of political will, and the opposition of those

who have a vested interest in the status quo.

Making the exam competency based would require a consensus on the selected competencies and allow physicians to study to the test. This, too, may require a divorce from the American Board of Medical Specialties. Really, does anyone see how that relationship has benefited family medicine or the American health care system? Changing the test may weaken it for the purposes of grading, but it might better prepare us for the care of our patients.

The larger question is "What is the purpose of family medicine?" We have not had sufficient debate on that issue, despite the good efforts of Keystone and the Future of Family Medicine project. Who are we training for the future? What future are we training for? The ABFM, in its cognitive exam, has its lead foot stuck in the past; it must, at very least, shift its weight. If there ever was a baby in the bathwater—to punish another metaphor—it grew up and left home. The future lies elsewhere. Do we have the courage to walk toward it—alone, if need be, among the medical specialties?

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