COMMENTARY

The American Board of Family Medicine Certification Examination:

A Proxy for Quality

James Puffer, MD

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In this issue of *Family Medicine*, Terry and Hill present evidence from a recently conducted survey that suggests that osteopathic family medicine residents in training programs whose positions have been accredited by both the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA), so called "dual accreditation," are more likely to be certified by the AOA and less likely to seek certification by the American Board of Family Medicine (ABFM).[1] While studies of this nature are always limited by their inherent selection and recall biases, the conclusions reached by the authors nevertheless raise issues that merit careful consideration and further discussion.

Given the significant increase in the number of these dually accredited programs,[2] in 2009 the ABFM sought to gain further insight into the performance of osteopathic and allopathic residents on our certification examination.[3] The results of the 2007 and 2008 certification examinations were analyzed with a subanalysis of the 584 residents from dually accredited programs who took the examination in 2007 (496 allopaths and 88 osteopaths) and the 518 residents from dually accredited programs who took the examination in 2008 (453 allopaths and 65 osteopaths). Overall, allopathically educated residents performed significantly better than their osteopathic counterparts when mean scaled scores were compared; this data is consistent with historical performance on our examination by these two groups. However, no significant difference in mean scaled scores existed for the osteopathically educated and allopathically educated physicians that had trained in dually accredited programs in either 2007 or 2008. Using our Residency Training Management (RTM) data, we determined that approximately one fewer resident, on average, from each of the 85 dually accredited programs that were studied took the examination than would be expected.

Unlike our study, Terry and Hill report that many more osteopathic graduates from dually accredited programs are not opting to apply for certification by both certifying organizations. Sixty-six percent of the authors' respondents reported that 50% or less of their program's osteopathic graduates are electing to be certified by both boards. Since 90% of osteopathic residents are required to take the AOA examination in order for the program to maintain AOA accreditation, the authors imply that the majority of these residents are opting not to take the ABFM examination. Their methodology limits our ability to determine if in fact this is the case. However, if their assumption is true, their findings signal an important departure from the expectations that the ACGME has of its residency programs.

When the ACGME was established in 1981, it maintained the close relationship that had existed between its forerunner, the Liaison Committee for Graduate Medical Education, and the American Board of Medical Specialties

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(ABMS). Each ABMS member board, of which ABFM is one, establishes the standards for training within its specialty. These standards are used by ACGME Review Committees to develop the program requirements for their respective specialties. Substantial compliance with these requirements is necessary for accreditation of residency training programs within the specialty, and only residents successfully completing ACGME-accredited training may apply for certification by an ABMS member board. Therefore, the longstanding expectation for trainees within ACGME accredited programs is that they will subsequently become certified by an ABMS member board. Moreover, the ACGME uses residents' performance on ABMS member board's certification examinations as one of its measures for monitoring substantial compliance with specialty specific program requirements.

When the ACGME Outcomes Project began more than 10 years ago, it attempted to drive programs toward competency-based assessment. Unfortunately, at the outset of the project, insufficient tools existed to assist residency directors and their faculty with accurately assessing the six general competencies that had been created and agreed upon by both the ACGME and the American Board of Medical Specialties in 1999. Over time, the number of instruments in the competency-based assessment tool box has expanded. However, faculty are still not entirely comfortable using these tools, and the fact of the matter is that the ABFM certification examination still is the only objective measure that can be reliably used to measure family medicine resident performance directly and program quality indirectly. The examination is developed, administered and scored using widely accepted industry standards.[4] It is highly reliable (Cronbach alpha >0.90), has strong face validity (as determined by practicing family physicians), and has an absolute passing standard that is established by peer family physicians using the well-established modified Angoff[5] procedure.

Therefore, if a significant decline in the number of residents in ACGME-accredited positions taking the ABFM certification examination within specific training programs exists as suggested by Terry's and Hill's data, this would almost certainly limit the ability of the Family Medicine Review Committee to accurately assess those programs. To a large degree, this potential problem will be resolved when the new Family Medicine Program Requirements, which will be released for public comment this month, are approved. While I am not able to comment on specific elements of the new requirements, it has been public knowledge for almost a year that the new requirements will specify the percentage of residents that will be expected to take and pass the ABFM certification examination.

Increasing evidence is demonstrating the important relationship between knowledge and the quality of care delivered by practicing clinicians.[6] At the present time, evidence would also suggest that the only tool that can consistently measure this knowledge in residency program graduates is the certification examination developed by ABMS specialty boards.[7,8] The proposed changes in the Family Medicine Program Requirements are to be applauded. They will guarantee that a time-proven assessment methodology, the ABFM certification examination, will be used in a consistent fashion to measure the performance of graduates of ACGME family medicine residency training programs.

CORRESPONDENCE: Address correspondence to Dr Puffer, American Board of Family Medicine, 1648 McGrathiana Parkway, Lexington, KY 40511-1247. 859-269-5626. jpuffer@theabfm.org.

References

1. Terry R, Hill F. Analysis of AOA/ACGME accredited family medicine residency programs. Fam Med 2011; 43(6):387-91.
2. Freeman E, Lischka TA. Osteopathic graduate medical education [AOA communication]. JAOA 2009;109(3):135-52.
3. O'Neill T, Royal KD, Schulte BM, Leigh T. Comparing the performance of allopathically and osteopathically trained physicians on the American Board of Family Medicine's certification examination. July 2009. Education Resources Information Center (ERIC) ED506669. www.eric.ed.gov/ERICWebPortal/contentdelivery/servlet/ERICServlet?accno=ED506669. Accessed May 2, 2011.
4. American Educational Research Association, American Psychological Association, National Council on Measurement in Education. Standards for educational and psychological testing. Washington, DC: American Psychological Association, 1999.
5. Educational measurement, fourth edition. Westport, CT: Praeger Publishers, 2006.
6. Holmboe ES, Lipner R, Greiner A. Assessing quality of care: knowledge matters. JAMA 2008;299:338-40.
7. Sharp LK, Bashook PG, Lipsky MS, Horowitz SD, Miller SH. Specialty board certification and clinical outcomes: the missing link. Acad Med 2002;77(6):534-42.
8. Brennan TA, Horwitz RI, Duffy FD, Cassel CK, Goode LD, Lipner RS. The role of physician specialty board certification status in the quality movement. JAMA 2004;292(9):1038-43.