Family Medicine at 40 Years of Age: The Journey to Transformation Continues

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Forty years ago, the then-American Board of Family Practice (ABFP) was approved and recognized as the 20th medical specialty in the United States by the American Board of Medical Specialties (ABMS). At the time of its creation, several important milestones were established; the ABFP became the first medical specialty board to issue time-limited certificates and to mandate recertification every 7 years. Certification was attainable only by examination, and physicians' certifications could not be "grandfathered." Recertification was dependent on the completion of a required amount of continuing medical education; a full, valid, and unrestricted license; and the completion of an audit of office records. These requirements raised the bar for specialty certification in the United States and established the ABFP as a leader and innovator among ABMS member boards. Many of these innovations became the forerunners of the maintenance of certification (MOC) process that is now embraced by all ABMS specialty boards.

During the 40 years since its founding, the ABFP has enjoyed several additional "firsts" in its pursuit of advancement of the public's interests. These have included the first use of psychometric standard setting procedures rather than the more commonly used normative techniques to create the passing standards for its examinations; the creation of a scholarly journal that would nurture and showcase the research and creation of knowledge within the new specialty; the investment of millions of dollars to develop simulation technology to assess its physician diplomates; and a name change to the American Board of Family Medicine (ABFM) to more accurately reflect the specialty's role in contemporary American medicine.

Most notable, however, has been the ABFM's continued leadership since, in 2002, the ABMS endorsed and approved MOC programs for every specialty board. The ABFM was the first board to mandate participation in its MOC program—MOC for Family Physicians (MC-FP)—beginning in 2003; after the completion of this year's December examination cycle, the 7-year transition to MC-FP will be complete. ABFM will be the first board to mandate that every one of its diplomates participate in this new, more robust recertification paradigm. Along the way, ABFM became the first and only board to become a Center for Medicare and Medicaid Services-approved registry for the Physicians Quality Reporting Initiative. This important achievement allowed ABFM diplomates to qualify for the annual Physicians Quality Reporting Initiative bonus from the Center for Medicare and Medicaid Services while also achieving MC-FP Part IV credit if they chose to do so, uniting MC-FP with national efforts to enhance the quality of health care.

Since its inception the ABFM has changed and adapted to meet the challenges of the health care landscape and, although gradual, its evolution into the organization that it has become would not surprise its founders. As the above chronology highlights, the ABFM has transformed itself from an organization that simply examined family physicians every 7 years to an enterprise that is now squarely committed to serving public interests by assisting family physicians in delivering the highest quality care to their patients. However, this transformation is not complete, and indeed dynamic interplay among physicians, patients, payors, purchasers, and the government will continue to shape the ABFM's trajectory as it continues this ongoing transformative process.

Our founders would have expected nothing less, so it was in that spirit that the ABFM commissioned 3 articles and reactions to them by thought

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leaders from within and outside the specialty to help us inform and shape the direction in which family medicine and the ABFM should move during another period of broad and sweeping change now underway in the United States. With the addition of an opening historical perspective and an ending capstone, 11 presentations stimulated an informative and interactive symposium held in Lexington, Kentucky, in conjunction with the ABFM's 40th Anniversary Celebration. This symposium was a multigenerational, multidisciplinary dialogue attended by current and former members of the ABFM's Board of Directors and their guests as well as almost 40 current and past Pisacano Scholars. Participants ranged from medical students to a 95-year-old former director, and many participants were experts in fields other than family medicine. Some attendees characterized the day as "a circle of life event," and others cast it as "a family reunion with the kids, parents, and grandparents." In this supplemental issue of the *Journal of the American Board of Family Medicine* we are pleased to present the articles and reactions to them that were prepared for this anniversary event.

In the first of these articles, Gayle Stephens, introduced at the symposium as the "poet laureate of family medicine," frames the history and progress of family medicine within the social context that influenced its creation.[1] He argues effectively that the forces that influenced the eventual establishment of the ABFM were intimately tied to the expectations that the public had for the physicians who provided their care. To a large degree these expectations were not being met, and the answer to this dilemma was a new specialty that would train family physicians to become the personal physicians of a wanting public. Most telling is Stephens' insistence that while implementing the Willard[2]and Millis Reports[3] we should have paid more attention to the Folsom Report,[4] which emphasized the community as the natural habitat for family physicians. We would suggest that this advice rings true and that the specialty ignores this admonishment at the peril of both family medicine's and the public's interests.

In her compelling article, Karen Davis argues that a new model of care is necessary if we are going to rescue our dysfunctional health care system.[5] She provides convincing evidence that this model should rest on a foundation of primary care and should be based on the patient-centered medical home model that represents advanced primary care and that has repeatedly been shown to improve outcomes, relieve inequity and disparities, and contain or reduce costs. Although Davis argues effectively that reorganization of our primary care practice structure must be wed to payment reform, the implications for the redesign of our specialty and the opportunities that it represents for its renaissance are not lost in her thesis.

In response to Davis' article, both Kurt Stange[6] and Erika Bliss[7] provide complementary observations. Stange agrees with Gayle Stephens that the forces that were in play at the founding of our specialty remain operational today. He argues that, because we do not clearly understand what matters about what we do each day as family physicians, now is not a time to choose a single strategy as we redesign our practices. Along the way we need to explore and better understand where family medicine resides in a holarchy of health and health care and how meaning is created using the generalist approach. Bliss, echoing Stephens' admonishment, reminds us that good family physicians do what their community needs them to do. She posits that current quality measures measure responses to a system not well designed to meet the public's needs in the first place; therefore, the perverse financing arrangements that place distracting interests between patients and their family doctors need to be replaced. Creating a reimbursement system that places the patient in a position of power to influence where, when, and from whom they receive care is essential to patient-centered care.

During a robust question-and-answer period, symposium attendees expressed fear that the patient-centered medical home will become another commodity instead of a relationship, and they suggested that the primary issue is establishing and sustaining a patient-physician relationship founded on trust. Others hoped the country can move the "have nots" into the world of the "haves." There were cogent reminders that hospitals also are transforming.

Perry Pugno[8] provides a compelling argument for expanding our training model to a 4-year paradigm. He clearly believes that our continued insistence on a one-size-fits-all strategy fits no one and that more of the same is not what is needed at the present time. Instead, a focus on personal doctoring, evidence of what services need to be provided by the family physician of the future, and the

specific needs of the communities in which family physicians will practice should guide the creation of flexible models of training. Rigorous testing and evaluation of these models should guide their dynamic evolution over time.

In their reactions, Nikitas Zervanos[9] and Marguerite Duane[10] offer differing opinions. Zervanos believes that 3 years of training is sufficient for family physicians if organized properly in settings with necessary resources. Furthermore, he believes that extending training for an additional year would only exacerbate an already inadequate family physician workforce. Duane, on the other hand, believes that it is time for family medicine training programs to break from their traditional hospital-centric model and move toward a model that focuses on patients within the context of community. She argues that the length of these programs could be either 3 or 4 years, depending on the specific skill set required of a trainee who desires to practice in a specific setting.

Attendees asserted that the residency design wanted is hard to do, has not been done previously, and could be impaired or precluded by current economic arrangements and a lack of faculty prepared to teach and model redesigned practice. Some pleaded for a financial fix for residencies plagued by current innovation-limiting revenue schemes. Others wondered how the ABFM could certify graduates if there is intentional variation for each residency graduate. A medical student painfully reminded everyone that there are still academic health centers that communicate active disregard for family medicine.

In his article, Kevin Weiss[11] provides a glimpse into the future of certification and how that process will necessarily need to adapt to the external landscape. He nicely contrasts the roles that professionalism and physician accountability will play in the delivery of quality care and suggests that the interplay between these will shape a new era of "shared regulation." However, in his words, "the stakes are high and time is short," and therefore the ABMS board enterprise must accelerate its implementation of MOC.

In response, Janet Corrigan[12] and Paul Miles[13] echo Weiss' message. Corrigan believes that the ABMS boards are at a crossroads and either must respond to external challenges or risk becoming irrelevant, forfeiting the opportunity to contribute meaningfully to increasing quality and controlling costs. She argues that to date ABMS and specialty boards like the ABFM have at best played a minor role in the quality space. Miles confirms that a public role for ABMS boards is not merely an option but is a necessity. Although a focus on inspection is not bad, he advises that the ABFM and all ABMS boards should focus on improvement, thereby moving the entire specialty toward higher quality. In addition, he notes that family medicine can contribute greatly by studying and reporting the effects that MOC has on both care and costs.

Attendees wondered if ABMS and ABFM will be relevant when the ABFM turns 50. Some made suggestions, such as launching a speaker's bureau to teach about health care as it is and as it could be. Others asked probing questions, such as "How can we reduce undesired variability while assuring desired variation to personalize care in the context of particular communities?" and "How can ABFM garner valid public input to guide its further development?" Although ready solutions were not forthcoming, it was agreed that these are important areas to explore as ABFM evolves MC-FP.

In the final article in this collection, Bob Graham nicely summarizes[14] the specialty's past and its future. He notes that the introduction of time-limited certificates by the ABFM in 1969 was the disruptive technology that foreshadowed the gradual evolution of the specialty board movement from lifetime certificates to mandatory recertification and eventually MOC. Similarly, he sees the patient-centered medical home as an equally disruptive technology that will force the adoption of a new health care infrastructure that rewards the provision of comprehensive, personalized care provided by well-managed teams rather than piecemeal. In his conclusion he muses that family medicine may be positioned to refute the claim that you never have an opportunity to make a second first impression.

As we view these excellent contributions as a whole we are struck by a common theme that runs through each of them: that although much has been accomplished by family medicine during the past 40 years, it is sobering how much further the discipline needs to go. Engulfed in an environment that is demanding quality, cost-effectiveness, and patient-centeredness, Family medicine is positioned to influence positively the way in which health care will be delivered in the United States. By continuing to shape its training, practice set-

tings, and certification processes to respond to these environmental challenges, family medicine may actually accomplish what it set out to do 40 years ago.

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