communicating symptoms of dizziness to their physicians. This finding warns us that in addition to the danger of defining a vague condition too broadly for the purposes of guidelines, there is also the danger of a definition being too focused. In such a case, the guideline might well apply to the care of only a small proportion of the affected population and might also be directly supported by only a small body of scientific evidence.

Patient Outcomes

An even more important barrier to the development of a guideline on dizziness is the lack of information to date on the clinical outcomes that are either desirable to patients with the condition or are to be avoided. Sloane and colleagues have confirmed the observation of others[8,9] that dizziness is rarely a life-threatening illness. As the authors point out, however, a low mortality rate does not exclude the presence of interval morbidity. We need to define other outcomes potentially important to patients — such as duration or number of episodes of dizziness and resultant mobility impairment or reduction of normal activities — as well as patient expectations of treatment received. Given the heterogeneity of the condition, however, we might well expect to find a wide spectrum of preferred outcomes for patients with dizziness.

Provided that measurable outcomes (either benefits or risks) can be ascertained and prioritized, the effect of each physician intervention on each outcome needs to be assessed under defined conditions to determine the appropriate (or inappropriate) uses of the intervention. Only then can the risk-benefit ratio of specific management strategies for vague patient complaints be assessed and observed variations in physician practices (such as those noted by Sloane and colleagues) be adequately evaluated as justified or unjustified. This information will first help us answer the question of whether practice guidelines for symptoms such as dizziness are necessary and are likely to improve patient outcomes. It will also be the evidence upon which specific recommendations for the management of vague, nonspecific complaints in the primary care setting need to be based.

David C. Lanier, MD
Rockville, MD

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Board News

Paul R. Young, M.D.

Specialty Recertification in Modern Practice

The concept and practice of recertification in medical specialties were slowly and painfully developed in an era when competition among medical providers was largely based on individual qualifications. In those circumstances, patients and their families could rely on the certification process to assure that physicians had

undergone an evaluation by their medical peers and, if certified, possessed the training and cognitive knowledge that set them apart as having special qualifications in a given field.

In the specialty of family practice, mandatory recertification was initiated because it was realized that in a broad-based specialty, content and practice changed relatively rapidly. Thus, a physician who was examined at a given point in time might not necessarily maintain a high level of current knowledge in that specialty. This would lead to an increasing number of physicians who would possess a certificate but who no longer met minimum standards for practicing that specialty.

The recertification process was designed to assess whether the physician was maintaining knowledge and skills in the specialty. The process requires that the physician demonstrate the maintenance of a valid and unrestricted license, which means that the physician has met the standards required to practice in that jurisdiction. Further, recertification requires that the physician have a minimum amount of continuing medical education. In family practice, this means that he or she meets the same standards that are required for active membership in the American Academy of Family Physicians.

In an attempt to extend the evaluation to the specific practice of the physician, the office record review was developed. This requires that the candidate assess the quality of his or her records and measure them against peer-established standards. While it would be much more effective to actually visit the physician in the practice setting, the cost of such a process would be prohibitive.

Finally, there is the cognitive examination designed to reassess the physician's understanding of basic principles as well as knowledge of new information. The morning session samples general knowledge, and the afternoon session allows candidates to express knowledge in areas of special interest within the specialty by selecting three of six categories. This allows some degree of tailoring the examination to accommodate a variety of practice patterns.

Because the tests are designed to sample the content of a specialty that is very broad in scope, some of the questions can appear less relevant than others. The examination taken as a whole, however, is based upon validation studies that include the scope of practices throughout the country. Careful assessment of the examination shows that it meets all current standards of validity and reliability for certification examinations.[1] In addition, questions that do not conform to standards of validity and reliability are studied after the examination, and inappropriate questions result in adjustment of scores.

Questions are written by family physicians from a variety of professional settings. Selection of questions for the examination is done by family physicians. The score for pass-fail is established by family physicians. Extensive measures are taken to assure that the test is valid, reliable, and fair.

Currently the practice of medicine is facing challenges by society to change. The system of health care delivery is being scrutinized with the obvious intent to reduce costs and at the same time to extend health services to all the citizens of the United States. We are seeing managed care systems develop competitive marketing and reliance on competition to reduce costs. In order to compete with each other, these systems are requiring individual providers to meet higher standards, i.e., certification, in order to participate. Thus certification standards are being used for purposes for which they were never intended and are not designed to accomplish. Thus, some physicians appear to be limited in their practice options simply because they have chosen, for whatever reasons, not to be certified by the ABFP.

The ABFP is being asked to modify its standards by allowing alternate routes to certification or by modifying its recertification process to accommodate a different standard for recertification. In other words, should the standard for recertification be driven by the economics of health care, or should it remain based on standards of excellence?

This is a difficult and very substantial question. To every complex question there is an answer that is simple, direct, and *wrong*. The ABFP will do its best to avoid such simplistic responses.

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