International Perspectives

Evaluation and Examination in Family Medicine in Israel

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In Israel, general practice has been recognized as a separate medical specialty since 1964, with a curriculum which originally consisted of two years' rotating hospital residencies. Organized training programs, however, were not available, and the content of the specialty was undefined. Its status was inferior to that of the traditional specialties, and it remained a "paper tiger" which failed to attract local graduates who streamed in alarming numbers to the hospital based specialties with scarcely a second glance at their older colleagues in the community clinics. The resulting shortage of competent, younger, motivated general practitioners was further compounded by blatant deficiencies and fragmentation in the organization of the health services, inadequate remuneration, and lack of professional satisfaction among the physicians working in primary care, whose varied proficiency and competence reflected the wide spectrum of the medical schools in prewar and postwar Europe.

Nevertheless, as in many other countries, the winds of change are blowing with refreshing candor over the field of primary care, and the past few years have witnessed a quiet revolution which, in some respects, has even surpassed the modest expectations of those who may have contributed to these changes. Some of the reasons for these changes must be sought in the spiraling costs of subspecialized fragmented hospital care, while others reflect an ideological whiplash away from chrome and plastic technology, and a return to whole person comprehensive health care. A major impetus was provided in 1969, by the establishment of the first independent undergraduate department of family medicine at the Sackler School of Medicine in Tel Aviv, followed in later years by each of the three remaining medical schools. In the same year, the curriculum for specialization was completely revised and now extends over four years, based on rotating internships in selected hospital wards and family medicine clinics, and a compulsory day-release course in the "basic sciences" of family medicine.

While it is premature to assume that family medicine has now taken firm root as a specialty of equal status to all others, medical graduates are being attracted in increasing numbers by the challenge of this new and revitalized specialty. With the introduction of mandatory examinations for all specialties in Israel in 1975, the first Board of Examiners in Family Medicine was appointed. The almost insurmountable problems of assessing clinical competence by examination have been extensively discussed in numerous publications and academic forums. Within the limitations of these problems, our Board has instituted an examination which attempts to assess competence in five broad areas of family practice:

1. Clinical knowledge and skills
2. The patient as a unique individual
3. The role of the family
4. Practice management
5. Research methods

In relation to these objectives, a two-tier examination has been instituted: (1) The Primary Examination, consisting of 150 multiple choice questions which test mainly factual recall, interpretation, and integration of a wide range of clinical conditions relevant to the work of a family physician in our country; and (2) The Final Examination, which is an oral assessment of clinical competence and problem solving in relation to the comprehen-

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sive management of patients in the community. This examination consists of four sections. Firstly, the candidate is required to describe and discuss a family under his care, so as to demonstrate his ability to recognize the specific interpersonal, behavioral, and cultural factors which are relevant to the health care of its members. Next, he is placed in a clinical setting with a patient for interview and examination. The candidate is expected to elicit an appropriate clinical history, perform a relevant medical examination, and discuss the possible diagnosis and management of this patient. Additional and laboratory findings are provided on request. In the third section, the examiners present him with several short clinical situations commonly seen in family practice. His task is to assess and interpret the limited information available at this stage and to adopt a reasonable problem solving approach in the investigation and management of these situations. In the fourth section, the candidate must discuss the priorities of medical care in his practice in relation to health promotion, illness prevention, and early detection and follow-up of long-term illnesses. He should also demonstrate his understanding of the basic methods involved in planning a clinical study relevant to the health needs of the population under his care or to evaluating the quality of the medical care which he provides.

Although our experience with these examinations in their present form is rather limited, there is a general feeling that they could be developed as a reasonable basis for assessing the competence of our candidates in relation to the defined objectives. Nevertheless, it is painfully obvious that any such assessment requires a far more precise definition of the knowledge, skills, and attitudes which they attempt to assess, of the standard of performance required, and of the conditions under which they are to be assessed. There is, therefore, an urgent need to develop and improve measures which are valid, reliable, objective, and efficient means of assessing the quality of clinical competence in relation to vocational training.

If we accept, and surely we must, that the medical needs of a developed society have created the need for comprehensive family practice, then this specialty should also ensure its own standards on a level which is no less rigorous than those of other recognized specialties. The achievement of these objectives in relation to the quality of vocational training programs would appear to represent a major challenge to the future development of family medicine in Israel.