Five Easy Answers: Where the ABFM Cognitive Exam Has Gone Wrong

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The American Board of Family Medicine Maintenance of Certification (MOC) Exam of Cognitive Expertise is a rite of passage for the board-certified family physician. This year is the author’s turn, and he looks at what the test includes, omits, and says about our professional posture. He questions the reader for five easy answers to the quagmires of everyday practice.

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There is something deeply satisfying about answering the practice test questions for the American Board of Family Medicine Maintenance of Certification (MOC) Exam of Cognitive Expertise. They are a comfort food for the frenzied physician. Perhaps this is why we don’t complain about them no matter how spotty, overly simplistic, and anachronistic they seem.

Such exams recall a time when the goal of education was to build a fund of knowledge through the reading of textbooks and the attendance of lectures, when the knowledge that mattered was the knowledge we memorized. Doctors still want to believe that medicine is a file folder of neatly ordered categories, where smart clinicians encounter discrete diseases, offer best practices, and achieve predictable outcomes. We want our fund of knowledge to be a well that no drought will dry.

This year is my turn to take the MOC. In wading through the American Academy of Family Physicians online practice exams and a trove of self-selected review articles, I began to ask questions of my own: Is there evidence that taking a Board exam makes us better clinicians? Does the rank and file find it useful? Is it a valid measure of the way we approach problems in clinical practice? Would the public be better served by systematic changes in the health care system than by efforts to measure their doctor’s knowledge base?

For a process that captures 85% of licensed American physicians¹ and is not cheap ($1,150 for family medicine’s cognitive exam, excluding late fees), there is scant evidence that board certification improves clinical outcomes. A review in the British Medical Journal² could find only 15 articles in the past 4 decades that link board certification with the provision of higher-quality health care or lower rates of disciplinary action. Tamblyn et al² showed that Canadian family physicians who score higher on certification and licensing exams produce higher rates of mammography screening and fewer prescribing errors. Holmboe et al³ reported that internists scoring in the highest quartile of the maintenance of certification exam were more likely to meet benchmarks for diabetic testing benchmarks and mammography screening, but not for lipid screening, than those in the lowest quartile. But all of these are cohort/observational studies, and there is no evidence that the intervention (studying for or taking or passing a standardized exam) was responsible for the measured result. They beg the essential question: If clinical performance is the real target, why not examine it instead of our skill in taking a cognitive exam? Shouldn’t we be choosing the most effective educational and motivational strategies (eg, continuing education or payment for performance) to achieve the desired outcome?

The development and validation of certification exams is a sophisticated science, and even a cursory overview is beyond the scope of this commentary. But suffice it to say that test items must be readable, accurate, unbiased, and reliable—that is, they must reliably discriminate between high performers and low. Moreover, we might hope that content would be relevant to the job at hand and that taking the test would reflect the job’s cognitive demands. Process is absolutely central to the
practice of family medicine, where we treat individuals in the context of financial, temporal, relational, and cultural constraints.

Here are my own submissions for next year’s cognitive exam. The items are a Whitman’s Sampler from a week in private practice:

1. A patient returns with a nondescript rash that is not getting better. He says, “Doc, I did everything you told me.” Now what would you do?:
   A. Refer him to a specialist.
   B. Switch creams: antifungal to an antibiotic or steroid, or vice versa.
   C. Do a punch biopsy, which will buy time as the rash resolves.
   D. Schedule a follow-up visit in 6 weeks or more.

2. A patient is pratling on and on through a list of complaints, and you are 30 minutes behind schedule. How will you escape?
   A. Arrange for the nurse to knock on the door after 15 minutes.
   B. Write a prescription, draw blood, or order an imaging study.
   C. Hang on the doorknob until the patient gets the hint.
   D. Both agree on the one problem you can address today.

3. It is Friday afternoon, and you were expected home for a dinner party 30 minutes ago. You realize that you have several calls to return before you leave. Which can wait?
   A. Your friend’s rising PSA of 5.6.
   B. Cough and fever in a smoker who always calls at the last minute.
   C. The new patient you saw yesterday who is unhappy about his bill.
   D. The patient in Question 3 who would like to ask “one more question.”

4. Your partner prescribed Vicodin for a new patient’s chronic back pain. The patient returns to see you for refills because your partner is on vacation. What is your logical next step?
   A. Check the Prescription Monitoring Program for his narcotic history.
   B. Sign a narcotics agreement and obtain a witnessed urine drug screen.
   C. Refer him back to your partner with a week’s worth of Vicodin.
   D. Take a thorough history and physical and get to know him as a person.

5. A consultant calls on a busy Monday afternoon to grouse about a partner of yours. How would you respond?
   A. Agree with him because it gets him off your back.
   B. Defend your partner because everyone knows “the guy is a jerk.”
   C. Listen to both sides—his and your partner’s—in noble pursuit of the truth.
   D. Agree to talk later in an effort to improve communications.

We are not so unalike, are we, that you haven’t experienced these scenarios or solved them differently at different times? It all comes down to context, the moment at hand, that unpredictable confluence of experience, circumstance, temperament, and emotional reserve. It’s not that you and I don’t know the right answer or couldn’t locate it, but we are angry at the patient, afraid to disappoint him/her, preoccupied with our own frustrations, or running hopelessly behind. We may not have chosen the best answers this week, but we are learning, examining ourselves, and improving over the long haul with the help of a supportive and self-critical team. And really, who cares if we know the right answer but fail to deliver it and fail again to ask ourselves why not?

Let me suggest five more easy answers for improving the Maintenance of Certification cognitive exam for family physicians:

1. Make it an open book (Internet accessible) but time-limited test. This is how we live and practice in the real world.
2. Teach to the test. If the questions are important enough to be asked, they should be important enough to study. Why not create an exam of “Core Knowledge in Family Medicine” where the “Five Hundred Most Relevant Facts” could be debated, published, and studied at home.
3. Validate the test by asking practicing clinicians if the test items seem relevant to their everyday practice.
4. Realize that our mistakes rarely arise out of ignorance but issue from a lack of time, focus, tools, feedback, and reward for doing the right thing in every instance. Ultimately, changing the system is the only way we will change the quality of care, and this must be our overarching concern.
5. Give 50 bonus points for essays on how each candidate has changed personally since the last exam. Change, and our ability to accept, adjust, and transform ourselves through change, is the most powerful magic we offer our patients. The mystic and civil rights activist Howard Thurman got it right when he said, “Don’t ask what the world needs. Ask what makes you come alive and go do it. Because what the world needs are people who have come alive.” Changing with the changing world is how we come and stay alive.

I’m not Pollyannaish about the prospects for changing the MOC cognitive exam. I know the argument: “Even though it’s a bad test, it’s all we’ve got.” Like the prostate-specific antigen test for prostate cancer, people would rather have an ambiguous or misleading result than none at all. Like the lipid panel or glycated hemoglobin level, it creates a number that can be easily measured, compared, and “treated.” We have created an industry around it. It keeps us in the
game, even though it’s a game we can never win.

The American Board of Family Medicine (ABFM) takes pride in being a leader in board recertification. From its inception in 1969, the ABFM was the first specialty board to issue time-limited certificates and require mandatory recertification every 7 years. Perhaps it could innovate again and differentiate itself from the other specialties. Yes, it must conform to the guidelines of the American Board of Medical Specialties, but it can still do so boldly and imaginatively on behalf of the real needs of physicians and their patients.

Intended or not, the MOC exam says a lot about who we are and what we think our patients need. Do they come to us for instantaneous answers, or does something lie behind their aches and complaints? When we offer a treatment plan, do we recognize what we are giving them beyond the prescription, lab test, or imaging study? Our patients need doctors who will wade beside them through the abyss, understand the particulars of their lives, and show their feelings, even feelings of fear or doubt or deep affection. It is our humanity that we offer our patients and our humanity that connects us to them, which is the one true thing we all need.

Perhaps it is not possible to formulate a test with nuanced questions (the more delicate and disturbing the better) and real-world ambiguities or one that measures our engagement in life-giving relationships. But it should not diminish our pride or self-confidence in the unmeasured purposes of primary care or allow us to forget that life is a process of self-discovery, not a cattle run prodded by our good advice or fenced in by five (hundred) easy answers.

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References