



Should an examination that doesn't represent our work be the basis of our professional certification?

The problem(s) with board exams

Medical board examinations profoundly impact our professional lives without necessarily adding discernable value.

Every occupational physician, like me, is tested on the facts that vanadium exposure can lead to a green tongue and that OSHA was (surprisingly) signed into law by President Richard Nixon. The former is exceedingly rare (I don't know anyone who has ever seen it) and the latter has no clinical application. Do these "pearls" of wisdom demonstrate acumen in my field?

Early in our careers, the USMLE Step 1 examination, which is not clinically relevant or correlative to clinical expertise, is used as the primary factor in selecting applicants for residency programs. Then come the specialty board certification examinations, which often do not reflect the complexities or commonalities of clinical practice.

These examinations require weeks upon weeks of study and thousands of dollars—and are unavoidable for licensure and if you want to demonstrate your expertise in specific clinical areas.

I'm not alone in having concerns over their value; there is a class-action lawsuit of more than 100,000 physicians against the management and control of certification from the American Board of Internal Medicine. (Full disclosure: I am not one of the physicians in the lawsuit.)

Both the format and content of these examinations seem inappropriate for measuring what matters. A multiple-choice question format, the most common form of medical certification testing, stifles the true spirit of clinical medicine, in which differential diagnoses are considered and a multifaceted plan is often implemented in order to narrow possible diagnoses to the most likely, based on actual findings.

Certification exam questions frequently fail to reflect the breadth of knowledge of clinical expertise or are too deep, present-

ing uncommon clinical conditions (the so-called "zebras") rarely encountered in clinical practice. Should an examination that doesn't represent our work be the basis of our professional certification?

Clinicians also dispute the high costs of these examinations. Large hospital system practices often include continuing medical education (CME) time as a benefit of employment, but this CME time is often limited and frequently used mostly or entirely to attend professional conferences, not for study, travel or sitting for examinations. Budgeted CME funding is also limited, except in those instances where an employer independently pays for certification examinations. The time spent and costs are amplified for physicians with multiple board certifications, who may already be paying for several professional memberships and conferences.

How do we fix this? First, we must work to increase the return-on-investment of certification examinations or to decrease the burden on individual clinicians. Personalized feedback from board examinations would create real value; currently, feedback is vague to avoid "giving away" proprietary test content.

Ultimately, clinicians must collectively decide how best to measure and communicate medical student or specialty competency and then advocate for certifying bodies that are serving their best interests.

Although I'm still a few years away from recertifying for my specialties, I'll continue entertaining at parties with my stories about the interesting history of OSHA. And the only green tongues I've seen so far are from candy ... but I'll keep looking. **MM**

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