



Recertification for Internists — One “Grandfather’s” Experience

Troyen A. Brennan, M.D., J.D., M.P.H.

Practicing internal medicine can be isolating: lacking the clear-cut outcomes of one-time interventions like surgery, internists work from day to day essentially without signposts indicating success

or failure. Without performance data, not only do I, as an internist, have little sense of where I stand, but the clinical leader of my practice group knows little about my fund of knowledge. She has some key evidence with regard to the group’s younger doctors, for they are being recertified. If they fail their board examination, it probably indicates some deficiency. But most members of our practice, having become certified before 1990, are grandfathered into the old system of lifetime certification. Now, in

the face of public demand for greater transparency, many are pushing for greater accountability through universal recertification — a worthy goal, as my recent experience with voluntary recertification convinced me.

I took many standardized tests in my day. Starting with an entry exam for parochial school at 10 years of age, I sat for them all. Unsure what I wanted to do, I added to the usual SATs, MCATs, and NBME exams the LSAT, several GREs, and the GMAT. Not being a natural test taker, I didn’t

do very well on most of them. But there were new things to do, and the exam was the gate to the next level. I thought I had long ago taken my last test: I had nowhere else to go. This is, in fact, the problem with taking the boards as a grandfathered internist: since there is no new plateau to reach, the only side seems to be the downside — you could fail. Moreover, as the brain ages, memory weakens. Why ask for trouble?

So I wouldn’t have attempted recertification were it not for a nagging sense of hypocrisy and my unease with some relevant clinical issues. I saw a lack of integrity in belonging to a profession that forced younger physicians to become recertified while I de-

clined to do so myself. My discomfort was compounded by a letter someone wrote to the American Board of Internal Medicine (ABIM) complaining about the recertifying exam and pointing out that I, the ABIM chairman at the time, had never been recertified.

Then, a cardiologist friend told me that he had signed up late for his recertification exam and would have to take it without studying — but, he said, “I practice it every day; I’d better be able to pass.” I realized that I did not have his confidence — indeed, I had begun to feel out of date. For example, though I had cared for patients with HIV infection since the mid-1980s, I had grown increasingly reliant on infectious-disease consultations as I became less comfortable with new anti-retroviral drugs. I was not just letting myself down: I had patients to consider.

I gave myself two years to complete recertification. First, I would have to work through some knowledge modules (the ABIM self-evaluation program or the Medical Knowledge Self-Assessment Program [MKSAP] of the American College of Physicians) and demonstrate my practice effectiveness, which currently entails completing the Peer and Patient Feedback or the Practice Improvement Modules, both ABIM products. Finally, I would have to pass a proctored, secure examination.

I used the ABIM products for the initial stages. The peer and patient assessment was a matter of asking some of my peers and patients what they thought of me — useful silence breaking, even if I didn’t get many take-home

messages from it. And it took only a few hours.

The Practice Improvement Modules required me to gather data on 20 of my patients with diabetes and send them a survey. Collecting the data showed me how inadequate our electronic medical record was: to find my study sample, I had to print out the names of all my patients and remember who had diabetes. The data were submitted to the board,

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and the results were none too rosy. I — like most other internists, apparently — was not doing so well. At least part of my problem was that I hadn’t thoroughly reviewed diabetes treatment since residency and was not up on the latest expert guidelines.

Which leads me to the big hurdle: the exam. Physicians complain that it is high-stakes (those with time-limited certificates don’t want to lose them), irrelevant (it doesn’t test knowledge that internists need), not useful (one isn’t a better doctor for having taken it), and time-consuming. On the basis of my experience, I believe that none of these complaints are valid. Moreover, given the relatively low failure rates, taking the exam appears to be less risky than many physicians fear (see table).

Having committed myself to finishing by the summer of 2005,

I signed up to take the exam in May. I had already done several self-evaluation program modules through the ABIM and had found them difficult, even after reviewing the literature or online textbooks. Clearly, I needed a thorough review.

So from March through May, I spent a good deal of time with the MKSAP, reviewing various specialties and answering the accompanying questions. I was disturbed by my inability to reply to more than 30 or 40 percent of them without having to look up answers — and even then, I was wrong more frequently than seemed reasonable.

But the material hardly seemed irrelevant. True, I’ve seen no patients with membranous glomerulopathy since I began practicing. However, that condition did not seem any more irrelevant in a recertification review than it was when I first learned about it. It does seem appropriate for an internist to have some working knowledge of intrinsic renal disease. And true, reviewing can be a grind, especially since the MKSAP seems to presume that you are the only internist for a 700-bed hospital. But I realized that I was becoming the sort of internist who treated hypertension and upper respiratory tract infections but otherwise simply consulted experts without trying seriously to think through differential diagnoses. Relevance was not an issue.

Nor was usefulness. My review improved my hunches about common medical problems and made me comfortable in areas that used to be somewhat murky. I have caught up on the literature on

Pass Rates for First-Time Takers of Selected ABIM Maintenance-of-Certification Examinations.*								
Examination	2001		2002		2003		2004	
	No. Taking Exam	Pass Rate (%)	No. Taking Exam	Pass Rate (%)	No. Taking Exam	Pass Rate (%)	No. Taking Exam	Pass Rate (%)
Internal Medicine	2374	92	2702	91	3050	85	3042	86
Cardiovascular Disease	1066	92	350	89	738	86	326	83
Critical Care Medicine	495	85	244	91	250	91	206	90
Gastroenterology	681	93	277	87	625	91	203	89
Infectious Disease	110	97	313	95	126	85	251	90
Medical Oncology	356	95	157	96	287	92	129	93

* Data are from the American Board of Internal Medicine.

such bread-and-butter conditions as severe congestive heart failure, uncontrolled diabetes, ischemic heart disease, and severe chronic obstructive pulmonary disease, and I understand the research questions currently being explored. I believe I will serve my patients better.

So it was definitely worth the time. Of course, I may have been more sorely out of date than other internists, and I may have more time than most for studying, since only a small percentage of my time is spent in patient care. I sympathize with overworked physicians for whom all this might seem excessively burdensome.

But consider the big picture. Surveys show that patients expect us to engage in frequent review and testing.¹ External regulators are challenging us to prove that we provide high-quality care. If we are to retain the prerogative of self-regulation, we must demonstrate that such regulation is thorough and exacting. So yes, a recertification examination is high-stakes and demanding: it has to be.

The day of the exam arrived. I really needed more review, but I knew much more internal medicine than I had known two months earlier. Taking the exam gave me a slight feeling of what Durkheim referred to as anomie.² I recalled the national board and original certification exams as convivial experiences: I knew a lot of people in the room, and we shared our thoughts and concerns. This time, I took the test at a nondescript office building just outside Worcester, Massachusetts — computer-based testing can take place at relatively small sites. It can also begin whenever the applicant arrives and completes a computer-based tutorial, so individual exams start at different times, as do breaks. It's possible that several of my fellow test takers were internists, but since other exams are given at the site, they could have been prospective accountants or bus drivers.

The test was exhausting: three 60-question sections, each lasting two hours. Not much that I do today requires such prolonged

concentration. And there was the disquiet that came from not being sure which answer was correct, even if I could narrow down the alternatives.

But the test seemed fair, and the questions appropriate and relevant: I felt that I should know this material. Some argue that physicians can always look up technical information online — a thought that occurred to me more than once during the exam. But there are a lot of basics that internists should know, and the more one knows, the more in-depth and accurate one's review of electronic sources can be.

Now I wait for my score. Given the electronic format, it was probably available the afternoon of the test, but I wasn't in any hurry. I knew that eventually it would be posted on the Web — a prospect I did not entirely welcome. And yet I couldn't help thinking that if there were more public awareness and discussion of the examination process, I would feel different. Indeed, perhaps universal recertification would help us to be honest about

the quality of care that we provide — and to find new ways to improve it.

Editor’s note: Dr. Brennan reports that he did in fact pass the recertification examination in May.

Dr. Brennan is a professor of medicine at Brigham and Women’s Hospital and Harvard Medical School, Boston.

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Personal Metrics for Practice — How’m I Doing?

Richard J. Baron, M.D.

Part of the challenge of being happy in medical practice arises from the difficulty of ascertaining whether we are truly succeeding as doctors. In primary care, we take on complex problems and often feel as if we’re failing. So we take whatever encouragement we can get. I was flattered recently when the husband of a dying patient thanked me for my care and said, “You’re one of those people who really *should* be a doctor.” The good feeling didn’t last, however — I soon ran into a man who had changed doctors after I had counseled caution on screening with prostate-specific antigen, and then the laboratory panel required by his insurance company revealed an abnormal result that led to a diagnosis of prostate cancer. He glared at me angrily as we passed on the street.

Doctors in academic and corporate settings have ranks, promotions, publications, titles, and corner offices. How do we practicing physicians know where we stand — according to meaningful measures of quality, independent of random instances of praise and blame?

One might say that the most readily available metrics for practitioners are financial. To assess

the financial performance of our four-physician practice, I use aggregated measures that are tracked and trended over time. With a standardized accounting framework and resources from national organizations, I can determine that the practice has done 8 percent better than last year, for instance, or that my income is 10 percent lower than the incomes of my colleagues. I can reorganize our office’s staffing and scheduling patterns or switch to a cheaper supplier of paper towels and see whether the bottom line improves. Yet financial success has almost no connection to my reasons for going into medicine. Gaining a sense of success that is congruent with my core medical goals requires a different set of measures altogether.

This past spring, in an effort to get a more stable, aggregated view of the quality of care I provide, I completed a diabetes practice-improvement module, part of the maintenance of certification process of the American Board of Internal Medicine (ABIM). Although my certification is not time-limited, I went through voluntary recertification in 1998 and have remained in the program to assure myself and my

patients that I still know what I am doing — and, more recently, to assess whether I am actually doing it. To complete the new module, I mailed a structured patient survey to a random sample of 21 of our patients with diabetes and audited their charts. The board compiled the results and sent them to me. There was some good news and some bad news, some expected findings and some surprises.

In our practice, we have worried a lot about having reliable office procedures to respond promptly and safely to patients’ telephone calls and requests for prescription refills or referrals. So it was gratifying to learn that 100 percent of the surveyed patients said it wasn’t a problem to reach us with a question or concern or to get a referral, and 90 percent said it wasn’t a problem to get prescriptions refilled. Current LDL cholesterol test results were available for 19 of the 21 patients; of these levels, 12 were less than 100 mg per deciliter and 3 were more than 130 mg per deciliter. All 21 patients had current glycosylated hemoglobin measurements, but only 15 of 21 had urinary microalbumin results available. It was painful to learn that only 60 percent of these pa-