

Preparing for Part II of Boards

Disclaimer: Deadlines need confirmed from ABOS

Preparing for boards, particularly Part II, is always a nerve wracking experience. It is particularly harrowing for trauma surgeons who may not have control of their patient population and cases they do. However, this obstacle may be overcome with careful preparation. Following are some hints to help you in your preparation. Begin applying these principles on the very first day at your new job; it is very important that you start by September 1 if you want to take your boards two years later.

Begin by looking at the American Academy of Orthopaedic Surgeons web site (AAOS.org) Use the link for member services on the left side of the page. This brings up a variety of choices, including ABOS (American Board of Orthopaedic Surgeons).

Here you will find information on the Part II examination.

Applicants who have passed Part I of the examination must be continuously and actively engaged in the practice of orthopaedic surgery for 22 months immediately prior to the examination. Of the 22 months, 12 consecutive months must be in one location. Time spent in fellowship is not counted.

Once you have determined that you meet these qualifications proceed to the link that gives information on the examination schedule. Application forms are available in June preceding the year in which you will take the examination. Applications are due by October 31 of that year with a \$950 application and credentialing fee. If you miss this deadline you have until November 30th of the year preceding the year you want to take your boards to pay both your \$950 application fee and an additional late fee of \$250.

Your printed case list forms are due by October 31 of the year you are taking boards. In April of that year you will receive notification of your admission to the exam, and an additional \$925 examination fee is then due.

In April of the exam year you will receive your list of 12 selected cases. You select 10 of these 12 cases for presentation and testing.

The examination is given in July, recently at the Palmer House Hilton in Chicago.

The Application

The application form requires a lot of names, phone numbers and e-mail addresses of everyone in the hospital, including anesthesia, nurses, and the chief of staff of the hospital, radiologists and general surgeons. You must have information for all the hospitals you practice at, including the names, addresses,

and contact information. It might be easier to gather the essential information before you begin filling in the form.

This is required for every facility where you have privileges.

Look also at the case log and how it works.

When you first begin to establish your log the system provides you with a user name and password. It asks if you want the computer to remember the password. I suggest that you do so as you will be going to this site frequently. (This, of course, assumes that you are the only one with access to your computer.)

Logging in Cases

Cases require an ICD-9 code and CPT code. You use patient initials and the medical records number to identify the patient. For each case you must provide the diagnosis and procedure code, patient data including their age, and a brief description of procedures performed on this patient. You will also be asked for any complications, and for follow-up. . It is important to remember that everyone has some complications. You will need to keep this information updated and current. It is also important for the 10 cases that you choose that you have every effort documented to contact the patient if they were lost to follow-up.

Complications and follow-up may not be available initially, and may become apparently only as the case progresses. You will also be asked to assess the patient results as excellent, good, fair or poor. While making up this list remember that in trauma surgery you often have patients who have such complications such as infections and compartment syndromes. These patients may not have been your patients early in their care, and you may be dealing with late developing complications. Sometimes, on call, you may be doing infected joint washouts etc. I indicated :”Patient of partner” when performing these procedures.

From your first day of practice form the habit of collecting all operative reports. If you place ICD-9 and CPT codes on them as they come in it will make things easier down the road. Check all dictations carefully for any errors – yours or the transcriptionist – and be certain that the report is correct before you sign it. This practice should become a habit you will carry throughout your professional career – not just while you are preparing for boards.

You should keep copies of all clinic notes and communications with the patient. These will be valuable should this case be selected. A good assistant is invaluable in this process and should be rewarded appropriately for their help during this time.

Radiographs

Some hospitals have systems which track radiographs and prevent loss. In other hospitals, the old-fashioned x-rays and CT scans must be collected by hand. In large cases or cases involving complications it might be wise to keep their x-rays

available your office in case they are selected. The system used by your hospital determines how much you have to worry about obtaining the x-rays in advance. In my hospital it is essential that I keep track of x-rays, and I maintain an x-ray box to store x-rays of any of my big pelvic acetabular and spine trauma cases, multitrauma cases (especially multitrauma cases who died), and/or patients who have complications. I keep their x-rays available, and when they come back to clinic add them to that file.

By mid-- to late September you should have the majority of your cases entered, along with their follow-up. Print them out and review the printout to see how everything looks and which details are missing and must be added. Your case collection period is the time period from April 1 to September 30 of the year preceding your boards. . However, in reading the fine print, you must remember that for every week day that you are absent during your 6-month collection period, you have to go back 1 day. You can breathe a sigh of relief once January 31 arrives and everything is entered. It is paramount to remember that you have to obtain a notarized copy of your surgical cases from the medical records department for each facility that you do cases at to send in with your case log. If you haven't done any cases at a facility during your collection period, you have to obtain a notarized letter from the medical records department stating this.

Comment [F1]: I'm not sure what day this is now.

Notification of your cases and how to organize for the board exam

Once you receive your 12 cases in mid April it is time to gather all the data. You need to choose the 10 that you are going to present. Although you don't have to present all of the data for the other two cases, you need to be prepared to be able to discuss the cases. Hopefully your earlier organization before will make this easier. You need to assemble all the x-rays, CT scans and/or MRIs which may be pertinent, and the patient charts. Most trauma patients have multiple volumes of films. Note the Board is only interested in the pertinent films, as their instructions are to bring "The pertinent pre-operative, intra-or immediate post-operative, and most recent follow-up x-rays for each case selected by the candidate for presentation".

At my hospital I was required to get the signature of the hospital CEO to request my 12 patient charts without an IRB approval. Apparently they thought I was conducting research without an IRB approval.

You should obtain video or photo prints of any arthroscopic cases you have done. Collect all operative reports. This is where careful review of operative reports really pays off.

The next step is to organize all of the information appropriately. For example, you could have the preoperative x-rays, the post-operative x-rays, then the latest follow-up x-rays in order (the number of follow-up films is determined by the individual case). During the examination it is very important to look organized –

hanging x-rays backward or upside down does not make you look knowledgeable. I used a colored sticky dot that at the top left of every x-ray. I could tell quickly how to hang it, without any fumbling. I used one color for all preoperative x-rays, a second color for operative films and postoperative films, and a third color for the latest follow-up x-rays. Pertinent CT scans or MRIs were marked in the same manner. I also marked the key images which demonstrated the diagnosis, and supported the treatment rationale. The trauma x-ray jacket may contain several x-rays, particularly in a patient with a prolonged course. You are responsible only for the x-rays relating to the orthopaedic injuries, so those were the only x-rays I took to my board exam.

If you have a digital radiology system, you have two options. You can either print off hard copies of your radiographs, CT's, MRI's, etc. to bring, or you can create a binder with the pertinent images printed on photo paper. The photo binder is accepted by the ABOS. You should bring one for you and one for the examiners. This is a lot more efficient than having to put the films on the light box and reorganize the individual films after each case presentation. It is recommended that you bring printed hardcopies of CT scans and MRI's in case they want to see cuts that you didn't print on photo paper.

Charts

It is important to copy the H&P from the chart. Many times, especially for trauma, the patient may not be on your service. Therefore, it is important -- not only for your board exam --but in terms of practice management, to write a note in the chart, although you may not be the patient's primary physician. I made it a practice to examine all patients in the preoperative area and to carefully document this. Even in patients brought to the operating room emergently I wrote a separate note from my operative note to indicate what I was called to the operating room for, the condition the patient was in, and any information I might have gathered from the EMT and/or trauma team. In addition I always documented my own operative reports and follow-up rounds in the chart. I copied the H&P whether or not it was mine, and indicated whether the patient was on my service, or the trauma team's, my examination of the patient, the operative report, and the entire hospital chart notes from all services during the patient's stay (Please note, many patients may have huge volumes of in-patient notes. One recent test-taker copied only the ortho in-patient and out-patient notes and initial consult from other services. It worked fine.)I did not include the vital sign sheets, x-ray orders, and order sheets. In preparation for the exam I highlighted important points. You will also need the operative notes and the clinic notes. You will also need the operative notes, discharge summary, and the clinic notes. You may also want to include other initial consultant notes (i.e. neurosurgery, etc.), pertinent lab values and radiology reports, and some examiners have asked to see the consent form or ISS for polytrauma patients.

You must take to the exam a notebook for each of the two examiners and one for yourself. I suggest making an extra notebook, which is left in your office, in the event that something happens to the others during your travels to the examination.

The information you receive from the examiners tells you how to organize your notebooks. You list your cases and indicate the cases that you did not choose. Next come the list of cases you did select, your complication list, and then the individual cases. For each of my patients I had the hospital chart, the hospital discharge summary, then in a separate section I had operative notes, then clinic notes, giving me four sections for each patient. This helped to keep it organized as provided for easy access during the examination. I label each of the 4 sections using their initials (For patient AB, for example, AB Hospital, AB discharge summary, AB operative note, AB clinic notes) I preceded each case with a one page concise summary for the examiners. The case summary is highly recommended. It allows the examiners to focus on the important points.

Studying for the Boards

Because the majority of my practice is in trauma I chose to test in that area. My board examiners were all in trauma. However, it is important not to forget the basics. I recommend reviewing the chapter in ***Skeletal Trauma*** for each case. As I read the chapter I made notes and then condensed these notes as I completed pertinent literature searches, etc. Literature searches are important and should include not only classic articles, but also current treatments and rationale to support what you did. Other sources of support include the OTA web site, where you might find program abstracts, which deal with your topic. The question everyone asks is whether or not you should provide the key articles for the examiners. It is generally not recommended as it gives them more information they could quiz you on. I kept the key articles – a summary of them – in my notebook as I was studying, and made index cards for the key articles for each case.

Don't forget the basics!

Even though this is part II of boards and you think you will just be asked treatment rationale, options and fracture classifications, it is important not to forget the basics such as radiographic lines, for example, for the AP pelvis film for classification of acetabular fractures, basic anatomy such as compartments of the leg, innervation for muscles, etc. If you have any spine cases all of the basic reflex testing, the nerve roots, etc. It is important that you can state basic information clearly and succinctly.

Another question, which often comes up, is whether one should draw the lines on the radiograph or provide more information. For example, you might draw the tip apex distance if you did a DHS. As a general rule it is not necessary to draw lines, and is not recommended as that provides more for them to quiz you on.

However, you should be very familiar with the angle and know the pertinent value. Another example is roof arc angles – it is not necessary to draw them, but you should know what the roof arc angles are and what the values mean. If you had preoperative planning and templating you may include that with your x-rays, however, it is something you don't volunteer. The more information you volunteer the more they have to ask you about.

Practice

Practice, practice, practice. It is important to review your cases with other orthopaedic surgeons in your specialty area. I found that the most helpful person for me was someone who was in the city who I did not know and who did not know me. They were the most objective. Many of the people you work with know your style and have confidence in you, therefore they do not ask you questions in the same manner as someone who does not work with you on a regular basis. Schedule these practice sessions in advance, as summer is a busy time for many orthopaedic surgeons, with their practice, their family, and vacations. I reviewed my upper extremity cases with an upper extremity surgeon, my spine cases with a spine surgeon, and pediatric cases with a pediatric orthopaedic surgeon. They each gave me the best insight into current trends and current literature in their field.

Don't forget in this very rushed time period to make your reservations for the Palmer House Hilton Chicago and your plane reservations. Do not go out on the last flight the night before your exam. Midway Airport is closest to downtown Chicago, although the airport does not always have flights available from all cities. I strongly urge that you carry your binders in your carry on bag, and do not let them out of your control. It would be much easier to replace your clothes than your binders if your luggage should be lost. Dress as you would for a job interview. . It's recommended that you arrive a day or two early to allow yourself time to do your final preparation and review. You are away from family, work distractions, etc. All you need to focus on is your exam.

Checking in at the Palmer House

My room at the Palmer House was right next to the pool, and I heard everyone playing in the indoor pool. It was quite loud and noisy. The rooms are also small and don't have the best lighting. If important, see your room before check-in to be sure it is not in an undesirable or noisy location if you plan to study. The pool is open and full of kids until at least 10 p.m.

Examine very carefully any information booklets sent with your

examination information. I received a little blue book explaining the criteria and grading system for the exam. Many of the candidates when I took my examination indicated that they had not looked at the information very closely and therefore they did not understand how the exam was. You are evaluated on your data gathering and interpretative skills, diagnosis, treatment, technical skills, outcomes and applied knowledge. ***In addition, one other thing you might***

consider is advice about dictating your own op notes even if you have residents/PA, and including in the op note that informed consent was obtained, a time out was held, antibiotics were given, the correct limb was identified in the holding area with the patient awake, and the plan for DVT prophylaxis. These are all questions that are were on last years questionnaire for each patient so I just dictated them into my op note to make it easy on the examiners to find the information (and to make sure I was always thinking about it). It was a good habit to get into as I still do it.

Hints During the Examination

The examination consists of a 35 minute session with each of three sets of examiners. There are two examiners in each set. If the examiner asks you if you want to select the first case by all means do so. Choose a case that you feel most confident of, which will give you confidence and help you establish good rapport with the examiners. Two of my three sets of examiners did offer me that opportunity. During the examination answer the questions that are asked, but do not offer additional information to show how much you know. This only invites further questioning, which may get you in areas that the examiners obviously know more about than you. Do not badmouth your colleagues. Do not put blame on your residents or on people who handled cases before you, and do not be confrontational with your examiners. . Be sure to review the reports that the ABOS give you regarding complications, percentage of cases, etc. This is fair game.

Last minute organizers should know that there is a business center in the Palmer Hilton and a Kinko's nearby.