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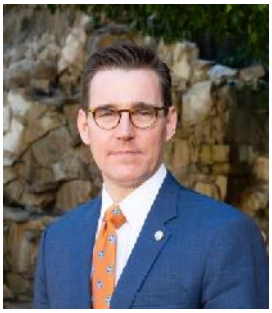
Chair Report



"A Recent History of the Oral Examination"

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For me, serving on The American Board of Plastic Surgery, Inc. (2012-2019) has been the highlight of my academic career. Most meaningful to me has been working on the Oral Examination Committee (OEC) and serving as the Oral Examination (OE) Chair from 2015-2017. The OE has evolved over time into what I believe is a far more valid examination - one that is digitally employed, reliable, consistent, and standardized, with a predetermined analytic pass-point - independent of candidate performance, allowing all those who take the OE to demonstrate competence and successfully pass.

What follows in this article is an abridged recent history of the OE under each of its most recent Chairs (see below figure) and ending with some philosophical discussions about the examination in general.

Nicholas B. Vedder, M.D. (OE Chair 2007-2008)

Dr. Vedder became Oral Examination Chair when medical photography was evolving from Kodachromes to digital images. The 12 Theory and Practice (T+P) Cases at that time were chosen from a bank of "interesting" cases that oral examiners would send in to the Board throughout the year. Also, at that time the Board was trialing analytic scoring of the examination, moving from a holistic "pass-fail" scoring system that was marred by huge variability in examiner severity. After Dr. Vedder became Chair of the OE in 2007; and, following a couple years trial of dual-system (holistic and analytic) scoring systems, the Board fully implemented the analytic scoring system. Dr. Vedder recently stated that he believes this was the single most important improvement in making the OE fair and equitable, finally correcting for inter-examiner variability in scoring severity. Dr. Vedder also introduced the famous atomic clocks that improved the synchronization of the 50-plus examination teams. The concept of an "online" OE was discussed during this time, but it was thought that the logistical difficulties precluded this idea.

Michael L. Bentz, M.D. (OE Chair 2009-2011)

Under Dr. Bentz's leadership, ethics questions were instituted within the T+P cases; and, these questions were developed with the assistance of the public members of the Board. At that time, one of the public members was an academic professor of social ethics. Ethics questions

remain on the examination today. Importantly during this period, as the pool of qualified examiners increased, an examiner rotation policy was instituted by Dr. Bentz and the OE Committee; and, this was not very popular. However, with time, this rotation policy allowed examiners the freedom to offer to be rotated; and, it eliminated the "urban legend" that declining an invitation to give the boards would hurt your prospects of being invited back. The Board currently has a robust pool of examiners. A Training Course is held annually and, each year, the examiner pool grows by 10-12%. The ABPS Oral Examiners volunteer their time and expertise and the Board greatly appreciates their dedication. Dr. Bentz also began to "soften" the candidate briefing to stress the collegial nature of the examiner-examinee relationship that is continued today.

William M. Kuzon, Jr., M.D. (OE Chair 2012-2014)

Dr. Kuzon became OE Chair a few years after the analytic scoring system was in place. He spent time learning exam theory and distribution free statistics (Rausch analysis) which is the basis of the OE analytic method. Dr. Kuzon worked closely with the Board's psychometrician leading up to the important OEC conference call where the critical pass/fail cut-off was determined. It became clear, during this period of time, that a Standard Setting Exercise was important to establish, prior to the administration of the examination, what the minimally competent candidate should score to pass the exam. Initially, the Standard Setting Exercise was completed with just the OEC alone; and, over-time evolved to include the entire Board of Directors. The first time this methodology was employed, the OE fail rate dropped from the historical approximate rate of 20% to around 10%. This resulted in some concern over and consideration of the new passing rate; however, objective minds prevailed because of the objective methodology and the psychometrically sound statistical analysis, there was no ethical justification to ignore the results. As well, Dr. Kuzon inherited the new rotation policy and during his time, applied this uniformly and consistently. Dr. Kuzon eliminated the "evaluator for life" role and limited this role to those actively on the Board or to those who recently completed their term as Director. This group is well aware of the current mechanics of the examination resulting in a more thorough evaluation of the exam teams.

Joseph E. Losee, M.D. (OE Chair 2015-2017)

During this time, the OEC moved away from choosing T+P cases based on the accumulated pool of submitted pictures from examiners, and instead used the ACGME-ABPS Milestones to choose topics for each years 12 T+P cases. After reviewing the T+P cases from prior years, and making sure that all topics are covered overtime, the OEC selects the 12 T+P cases. After the cases are chosen, then pictures were requested from Directors of the Board. During this period, greater emphasis was placed on assuring that every candidate received the exact same "scripted" examination, identical in type and complexity; because, this reliability, standardization, and consistency is the only way for the examination to be valid. For example, while "probing" is encouraged, remaining "on script" is mandated. Another change during this period was the elimination of the required anatomy and category classifications on the submitted Case List.

Candidates at this time were required to perform a broad range of specific cases (anatomic and category) during the Case Collection period to be allowed to submit their Case List. Eliminating this requirement allowed for the early specialization that occurs for many; for example, allowing someone to have a dedicated hand practice right from the beginning. The Board felt this was an acceptable decision, because the T+P portion of the examination, representing two-thirds of the examination, tested the full scope of plastic surgery. The big change during this period of time was bringing the OE digital or "on-line". This process began with utilizing tablets for presenting the T+P cases. This allowed the OEC to use additional images, such as post-resection images, or images of complications, additional pictures facilitated a more realistic clinical scenario. Next came the electronic upload of the candidates Case Reports and the retirement of the "Blue Books". This allowed for examination teams to review the candidates Case Reports over a period of time at the examiner's leisure, work with their examination partner, construct the examination questions, request additional information, and "clear" the Case Reports well in advance of leaving for the examination. This greatly diminished the infamous "long Thursday night" work-load for examiners, eliminated the possibly to send a candidate home for inadequate Case Reports, and facilitated a greater in-depth assessment of the candidate with a more robust examination. Finally, this past year, under the leadership of David H. Song, M.D. the current OE Chair, the final component of the digital OE scoring transition took place – the successful implementation of electronic scoring, making the OE an entirely paperless process.

Future of the Oral Examination

When I came on the Board, the out-going Chair, W. P. Andrew Lee, M.D. told me that if I wanted to make a meaningful contribution to the Board and the OE, I should find a successful way to truly assess a candidate's ethics and professionalism. To date, we were relying essentially on controversial CPT coding as a surrogate, along with the "forced" ethical questions scattered throughout the T+P cases that suffer from the problem that many ethical dilemmas do, the reality that, not everyone entirely agrees with the stated "experts" conclusion and answer. The OEC worked on this challenge for years, and I believe that the future of the OE is bright under Dr. Song's leadership. Plans to address this critically important, however elusive goal, will begin this year. The Board will be rolling out a plan to perform an assessment of ethics and professionalism, during the Case Collection period, with a process similar to the assessment of professionalism that occurred with the Board's old MOC program and fashioned after a successful similar program that the American Board of Orthopaedic Surgery currently employs. In addition to submitting all advertisement material at the time of Case List submission, peer evaluations will be sent to the Chief of Surgery or Plastic Surgery, Chief of Staff, Chief of Anesthesiology, O.R. Nursing Supervisor, Former Fellowship Director (if applicable), one ABPS Board Certified Plastic Surgeon of the candidate's choosing, and one ABPS Board Certified Plastic Surgeon of the Board's choosing from the candidate's region. Should this assessment reveal significant concerns, the Board's Credentials and Requirements Committee will conduct an investigation that could include an in-person site visit of the candidate's practice. Should the Board take the next potential step and complete the 360-degree assessment, by including the candidate's patients in the process?

Has the OE become too easy to obtain a Passing Score?

The Board has been accused by some of getting "soft" as the OE pass rates have risen and remain high. My personal answer to this accusation is "no", with an argument that goes something like this: the OEC has gotten better at producing and implementing a more reliable, consistent, and standardized Oral Examination, complete with a predetermined analytic pass-point that is independent of candidate performance, and arrived at through a Standard Setting Exercise, allowing all those who take the OE to demonstrate competence and successfully pass. Philosophically, the OE is a certifying examination - certifying what our residency training programs have produced, what their Clinical Competency Committees have recommended, and what their Program Directors have attested to: that the candidate admitted to the certifying examination is competent to independently practice plastic surgery. The OE is essentially one of the "quality control" mechanisms – another attempt to confirm that the candidate is safe and ethical to practice the broad scope of plastic surgery and, by doing so, protect the public. Another way of looking at this is to ask ourselves, "If the pass rate was 82%, are we comfortable concluding that 18% of the time our training programs have failed in the product that was produced, recommended, and attested to?" Again, I would answer "no". Today with a more scientific, analytic, reproducible, standardized and increasingly valid examination, I am comfortable that we are confirming or certifying what our training programs are producing.

***ABPS Oral Exam Chairs, from left**: Michael L. Bentz, M.D., Joseph E. Losee, M.D., William M. Kuzon, Jr., M.D., David H. Song, M.D., Nicholas B. Vedder, M.D.*