PASS YOUR ORAL OB/GYN BOARD EXAM!

Fifth Edition

• How to Prepare for it • How to Take it • How to Pass It!

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Chapter 1

The Oral Versus the Written Exam: How They Differ

The most common test format throughout medical school and residency is a written exam. Years of experience with the written format make taking your primary written exam straightforward and predictable. Preparing for and taking an oral exam, however, are quite different. Experimentation with the oral exam format should not be reserved for your first encounter with the oral boards.

The oral boards differ from the written boards in several ways. The first of which is timing. You cannot sit for the oral exam until you have successfully completed the written exam. Most graduates have transitioned into clinical practice, which is just enough time to fall out of the mandatory rigors of the academic environment of residency. No more morning report, morbidity and mortality conference, or grand rounds—just enough time to have succumbed to "the good life," just enough time to "get out of shape" for intense academic discipline. This academic apathy results in a rude awakening when you face the intensity of effort that will be required to prepare adequately for the oral exam.

Isolation from the medical center mecca not only predisposes to academic laxity, but also strips away the advantage of "misery loves company" that helps to motivate studying. Typically, residents prepare collectively for upcoming tests, such as CREOG (Council on Resident Education in Obstetrics and Gynecology) in-service exams and the written board exam.

2 Chapter

The Application Process

Applying for the Exam: Fast Track vs. Traditional

The *Bulletin* published by the American Board of Obstetrics and Gynecology, Inc. is a guideline for the application process. This resource is invaluable and you will refer to it repeatedly throughout the entire process. You may download a copy from their website at **www.abog.org**.

Since 2002, candidates can apply for the accelerated oral exam process. Historically, you had to wait two years between successful completion of the written exam and the oral exam. In 2002, however, this was shortened to a one year wait between the two tests.

There are pros and cons for each track. The advantage of the fast track is you get it over with sooner. Why put off until tomorrow what you can do today? You also can ride on the academic momentum of your written exam preparation, rather than letting it slide away for another year.

The advantage of the traditional track is that it's logistically easier. You get a whole year to get settled into your new practice, community, lifestyle, etc. In the fast track, you have to begin collecting cases within a week after completing the written exam. Furthermore, the exponential growth in your clinical skills the first couple of years in practice will really help you on the exam. For these reasons, I recommend the traditional track.

I recommend the fast track only if you are immediately starting into a practice limited to just obstetrics or gynecology or you are planning to pursue subspecialty fellowship training. Since you are examined in both topics, you won't forget as much in one year. However, you will need to use

3 Chapter

Scope of the Exam

The purpose of the exam is to evaluate your knowledge and skills in solving clinical problems in obstetrics, gynecology and women's health. Most importantly, you are expected to demonstrate a level of competence that allows you to serve as a consultant to non-obstetrician-gynecologists in your community.

There is no better DNA of a practitioner's mode of practice than his case list. This is the one component of the exam that has remained constant for many years. Thus, half of your test is devoted to defending your case list. You must demonstrate the following abilities when questioned from your case list:

1. to develop a diagnosis, including the necessary clinical, laboratory and diagnostic procedures
2. to select and apply proper treatment under elective and emergency conditions
3. to prevent, recognize and manage complications
4. to plan and direct follow-up and continuing care

The *Bulletin* clearly states the case list is an essential component of the test. For years defending the case list has comprised half of your test. The other half has varied through the years. However, since 2007 the other half has been exclusively the structured cases.

This vague, yet all-encompassing subject matter makes studying rather challenging. In 2015, ABOG published a list of test topics in addition to the case list categories. Additionally, ABOG does not disclose their grading scale.

4 Chapter

Getting Started

Priority of Study Topics

The oral exam can cover any topic related to Obstetrics, Gynecology and Women's Health. However, it is obviously impossible to review every topic. Perhaps the most common and costly mistake is failure to prioritize and focus your studying.

To prioritize, you must identify your personal strengths and weaknesses in specific topics. It is neither helpful nor realistic (yet typical of most compulsive physicians) to underestimate your strengths. Most candidates assume that they are weak, or at least in need of a review of all topics. The task of identifying and then prioritizing your knowledge base entails two critical steps.

The first step—and the most important while prioritizing—is to identify which topics are most likely to appear on the exam. Your case list is essentially an open book test. Take advantage of this and prepare for every topic on your list. You are accountable for every case list category, even if you didn't chose it for your case list. How to extrapolate which of these topics is most likely to appear on your exam is covered in Chapter 5 (The Case List). Effective in 2015, ABOG publishes a list of exam topics in the *ABOG Bulletin*. This list is similar to the case list categories, but with a bit more detail. Obviously you need to embrace each of these topics.

The second step is to identify your individual strengths and weaknesses in topics not yet covered above. Although there are as many different ways to tackle this problem as there are candidates, two techniques are popular.

5 Chapter

The Case List

Significance of the Exam

The ABOG *Bulletin* states that half of your exam is defending your case list. The case list is a far more accurate assessment of your mode of practice than a mere three hours of testing. It is the culmination of applying book knowledge to clinical practice for a full year. Thus, in my opinion, the most important variable of all exam components is the case list.

The examiners receive your case list at least the day before your exam. Certainly the degree of scrutiny varies with each examiner and the number of case lists he receives. Nevertheless, the examiner meets your case list before he meets you. Undoubtedly, he will form a first impression of you based exclusively on your case list.

I have reviewed many case lists. Outright failures, although rare, are obvious. On the other hand, there are no guaranteed passes based on the case list alone. The other test components (e.g. structured cases) and especially your finesse with the oral exam format, greatly influence the outcome. However, as long as you do not outright flunk the other exam components, you will surely pass the exam if you have satisfactorily defended your case list.

Thus, sound performance on the oral exam and a solid case list defense are a sure bet for passing. An unsound case list, regardless of a stellar performance on the exam, will most likely result in failure. An unsound case list and a weak performance on the exam are guaranteed to result in failure.

6 Chapter

Kodachromes

The Kodachrome section was ELIMINATED in 2003. For those of the digital generation, Kodachromes are 35-mm slides that are projected images. A few isolated ones have surfaced since 2003 and they are now projected onto the laptop screen. They may represent any Ob/Gyn topic, but their role on the exam has shifted. Initially, the emphasis was on correct identification of the slide. Later, they were used as a starting point for discussion of a particular topic and comprised no more than 25% of the exam.

Historically, there were six to nine slides: two or three each for obstetrics, gynecology, and office practice. The set of slides changed daily. Typically, the slides were labeled with the diagnosis; although usually at least one diagnosis was unknown.

Obviously, the labeled slides stated the diagnosis up front. Although correct identification of the unknown slide scored points, you did not lose points if you did not identify the slide correctly.

The examiners recognized that the unlabeled slides were subject to interpretation.

Thus, there may have been more than one correct answer for each slide. The emphasis was not on your correct identification of the Kodachrome, but on the justification for your interpretation. Variable interpretations were a springboard for a variety of topics. The examiner had less control of the agenda and you then had the opportunity for expression of individual, creative thinking and spontaneous discussion of various topics. On the other hand, a labeled slide set a defined agenda and allowed standardization among candidates.

If you can picture a topic, it can easily be projected. The ACOG on line CREOG QUIZ is a good reference since the questions always start with a picture. The difference is that they are followed by written questions, so all you need to do is turn them into an oral discussion. You can also turn many of the structured cases into a kodachrome or image.

7 Chapter

Case of the Day

"Case of the Day" is my term for what the board refers to as Structured and/or Simulated Cases. The case of the day was introduced in 1994 when they replaced the pathology microscopic slides interpretation; half of the exam entailed the kodachromes and the other half was the case of the day. This change signaled the board's attempt to standardize the exam and introduce more objectivity to an inherently subjective format.

The purpose of the structured cases, per the ABOG *Bulletin,* is to interpret a candidate's response to specific clinical situations. Typically, each case starts with a written patient management scenario that is projected onto a screen and serves as a springboard for a specific topic. Standardized follow up questions ensue. Unlike the questions during the case list section of the exam, ABOG (not the examiner) predetermines most of these questions.

All candidates being examined on the same day have the same structured cases; hence, my nickname "case of the day". There is a different set of cases every day. In 2003, when the kodachromes were deleted, the exam was limited to defending your case list and the case of the day. Therefore, half of your test, or 30 minutes, is devoted to the case of the day.

Like other exam components, the case of the day has also evolved. Over the years, the number of cases fluctuated from a minimum of three to as many as seven. Like Goldilocks, ABOG decided the "just right" number was five. Each section starts with the case of the day, and then switches to defending your case list for the last half.

8 Chapter

Studying for the Exam

The focus of this book until now has been the individualized study strategy applied to specific phases of preparation for the oral exam. This chapter summarizes the process of studying in general.

You must first prioritize your study topics. Ideally, this is accomplished about six months before the exam, when you attend your first review course. Your objective in prioritizing is to identify and rank your personal strengths and weaknesses across the range of study topics that are covered during the review course.

Compare this list with topics that you know will be on the exam; namely, those exam topics that are published in the *Bulletin* and those on your case list. Finally, identify those topics that have been high yield during morning report throughout your residency, M&M conferences, and CREOG in-service training exams. Predictably, certain topics rise to the top. Those topics that I feel are the highest yield are called "Know Cold" topics in Table 1. Those topics that are important to know, but of lesser importance, I refer to as "Hot Topics" in Table 2. Each topic is followed by a line of questioning to answer during your review. The intent is not to be all-inclusive, but rather to stimulate you to ask even more probing questions.

Combine the above lists and draft an updated priority list. Stash it away for later reference. Next, funnel all your energy into compiling the case list. After the case list is cast in stone, identify the study topics that it generates. Cross-reference this study list with the earlier list generated above. Once again, compare the two lists and prioritize an updated list.

9 Chapter

Image Enhancement

You can't judge a book by its cover—or can you? Image enhancement is a facet of testmanship that is traditionally ignored. It entails the strategy of optimizing not what you say, but how you say it. In other words, it is how to influence positively, or manipulate, the examiner's first impression.

Stereotypically, physicians ignore society's emphasis on the physical impression, whereas in other professions (such as business or law), one's image can make or break a deal or case. A well-known study concluded that the first impression is based predominantly (55%) on appearance. Second, the quality of one's voice, such as tone, pitch and speech pattern, has a 38% influence. A mere 7% is based on what you say. Furthermore, the first impression is made within only five seconds.

Some of you may argue that you don't have to, that you don't want to, and ultimately that you refuse to play the game. But given all the effort that has gone into preparing for this exam, can you really afford not to? Why not approach this issue as stacking the deck? Not bucking the system, but beating the system. Besides, if you don't like it, change it when you're the examiner. Remember, "You can't change the system if you're not in the system."

Testmanship is the art of knowing not only what is on the exam, but who the examiner is.

An examiner's academic profile influences the type of questions that he or she asks. Similarly, understanding the examiner's physical image will give you yet another insight into his or her makeup. The more you know about the examiners, the better armed you are to battle with them.

10 Chapter

The Oral Exam

Until 2000, all of the exams were conducted over the course of one week at the Westin Hotel in Chicago, and typically held in early November. Since 2000, the exams have been administered in Dallas and are spread out over three months. The candidates are divided into three groups and each group is examined over one week in each of three months: November, December and January. The reason for this change is not clear. It certainly makes exam security a lot tougher, and major holidays —Thanksgiving, Christmas/Hanukkah and New Years—are definitely ruined. Perhaps the board intends to use the same pool of examiners for all three months to promote standardization and consistency of exam conduct and thus, afford truer assessment of pass/fail.

In the past, it was rumored that a minimum percentage of candidates were designated for failure. This change refutes that rumor because the results of the exams are announced within one week. Obviously the November results cannot be delayed until the January exams. Whatever the reasons for the change, it does not change your timeline for preparation. Once you know the date of your exam, back-plot the timeline for studying as recommended in Table 1 of Chapter 4, "Getting Started". Given that the December and January dates coincide with the holidays, don't dillydally in making your airline reservations to Dallas.

11 Chapter

Test Results

Historically, departing remarks were a clue to whether or not you passed the exam. "Have a nice flight" or "Enjoy the holidays" implied that you had passed. There is no more guarantee in these remarks than there is in predicting the sex of a fetus by its heart rate. ABOG dispels this claim in the 45-minute introductory slide show. The specific criteria for passing still remain a well-guarded secret. The *Bulletin* cites the following generic criteria for evaluation:

1. Develop a diagnosis, including the appropriate clinical, laboratory and diagnostic procedures.
2. Select and apply proper treatment under elective and emergency conditions.
3. Prevent, recognize and manage complications.
4. Plan and direct follow-up and continuing care.

The examination is designed to evaluate your qualifications as a specialist or consultant to non- obstetrician-gynecologist colleagues. The goal of the test is also to evaluate your behavior in independent practice. The emphasis is on patient management knowledge and skills.

The best benchmark or standard to emulate is the ACOG standards. As long as your management is consistent with the ACOG guidelines in the Compendium, you will meet the passing criteria.

12 Chapter

A Candidate's Journey

I have been mentoring candidate's preparing for their board exams for nearly twenty five years. Yet it seems like only yesterday when I went through that miserable process myself. Although the blood, sweat, and tears have long dried, I wanted to capture those emotions to help others know what to expect, as forewarned is forearmed.

Everyone's journey is unique, yet we share that same quest to put FACOG behind our beloved MD. I met KJ at our April review course. She was preparing for her oral exams the following fall. I am always impressed with those who have the foresight to be so proactive, as most will delay attending the review course until the fall of the exam. Coincidentally, KJ and I ran into each other at the airport after the course. I knew she was from my state, but discovered she actually practiced only about an hour from me, thus we were on the same flight. Naturally we began to chat.

I applauded her for being ahead in the game. She confessed that actually she was not preparing for the oral exam at all, rather for the written boards *again*. She had failed her written exam and was devastated. "I had *never* failed anything in my life. I was crushed, humiliated, and demoralized. You are actually only the second person I've told. Only my husband knows. I couldn't even tell the rest of my family, friends, nor even my partner".

We physicians are so darn tough on ourselves. But it's true, we don't accept defeat well. Heck, we're devastated if we get a B, but to *fail*? I truly believe that there is no way anyone can make it through four years of college, four years of medical school, and four years of residency if he weren't smart.

13 Chapter

Lessons Learned

After the exam is over and the dust has settled (or perhaps more appropriately, after the blood, sweat, and tears have dried), I have asked candidates, "If you had to do it all over again, what would you do differently?" Below are the most frequent responses.

1. **Start collecting my case list earlier and updating it more frequently (regularly).**

   Recommendation: Start collecting cases on July 1 and enter them after every surgery and delivery.

   Start collecting cases on July 1. Begin collecting and entering your gynecologic cases after every surgery, and your obstetric cases after every delivery. Put some blank case list forms in your locker in Labor and Delivery and Surgery, in your office and in your briefcase. Better yet, put a form in the patient's office chart when you head over to surgery and fill it out in the operating room after you dictate the procedure. Match these rough drafts with the accompanying history and physical, operative or delivery notes and discharge summary.

   If you cannot update after every surgery or delivery, do so *at least weekly*. If you procrastinate more than two weeks, you will have lost recall of precious details. In the long term, you will waste more time, and experience more frustration in trying to capture lost dates and details.

   For the office case list collection, I recommend you keep a list of the categories on your desk starting in August. Over the next few months, simply jot down the patient's name and diagnosis when they fit a particular category. Once you have four names in a category, cease further collection.

A

Appendix

ABOG Acceptable Case List Abbreviations

Check the ABOG Bulletin for the most up-to-date list of approved abbreviations, but don't feel like you have to limit yourself to only these abbreviations. I am not aware of any case list being rejected for using a few that are not on this list—just use conventional abbreviations. The columns are narrow and your case list gets cluttered with tedious long words that are conventionally abbreviated. For example, I would use DMPA rather than spelling out Depo Medroxyprogesterone Acetate. Avoid regional colloquialisms such as IOL, Induction of Labor. An easy check to make sure your abbreviation is conventional and not regional, is to take your case list to the review course and get a couple of opinions from a few folks who are not geographically close. If everyone instantly recognizes and uses the same abbreviation, then I would use that abbreviation.

Do not amend the ABOG abbreviations. For example, I would suggest not using NSVD, normal spontaneous vaginal delivery, in lieu of the ABOG recommended abbreviation of SVD, spontaneous vaginal delivery. Admittedly, some of their abbreviations are atypical: for example, CD for cesarean delivery rather than C/S for cesarean section. However, when in Rome, do as the Romans.

A&P repair	Anterior and posterior colporrhaphy
AB	Abortion
AIDS	Acquired immune deficiency syndrome
ASCUS	Atypical cells of undetermined significance
BSO	Bilateral salpingo-oophorectomy
BTL	Bilateral tubal ligation
CBC	Complete blood count
CD	Cesarean delivery
CIN	Cervical intraepithelial neoplasia
cm	Centimeter
CT	Computerized tomography
D&C	Dilatation and curettage
D&E	Dilatation and evacuation
DEXA	Dual-energy x-ray absorptiometry
DHEAS	Dehydroepiandrosterone sulfate

B

Appendix

Acronyms and Abbreviations

ABC	America's OB/GYN Board Review Course
A&P	Anterior and posterior colporrhaphy
ABOG	American Board of Obstetrics and Gynecology, Inc.
ACOG	American College of Obstetricians and Gynecologists
AUB	Abnormal uterine bleeding
BHCG	Beta human chorionic gonadotropin
BSO	Bilateral salpingo-oophorectomy
CD	Cesarean delivery
CIN	Cervical intraepithelial neoplasia
CMS	Center for Medicare and Medicaid Services
c/o	Complains of
CREOG	Council on Resident Education in Obstetrics and Gynecology
CS	Cesarean section
CT	Computerized tomography
D&C	Dilatation and curettage
DIC	Disseminated intravascular coagulation
DMPA	Depo Medroxyprogesterone acetate
EGA	Estimated gestational age
EKG	Electrocardiogram
FACOG	Fellow of the American College of Obstetrians and Gynecologists
FPM/FPMRS	Female Pelvic Medicine & Reconstructive Surgery
G	Gravida
GDM	Gestational Diabetes Mellitus
GnRH	Gonadotropin Releasing Hormone Agonists
GYN	Gynecology
HCG	Human chorionic gonadotropin
HIPAA	Health Insurance Portability and Accounting Act of 1996
HMB	Heavy menstrual bleeding
HMOs	Health maintenance organizations
HPV	Human papilloma virus
HRT	Hormone replacement therapy
HSV	Herpes Simplex Virus
HTN	Hypertension
IC	Interstitial Cystitis

C

Appendix

Addresses

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http://www.acog.org

For publications: ACOG Distribution Center, 1-800-762-2264 or http://www.acog.org

D

Appendix

Custom Case List

The most influential factor for passing your test is your case list. Henceforth, it is imperative that you strategically construct it to put your best foot forward. Remember, your examiner sees your case list before he even shakes your hand; therefore, his first impression of you is based entirely on your case list.

Your priority is to construct the best case list possible. It is absolutely imperative that you select the case list software that will best help you meet your goals. You have two options: you can either purchase pre-existing case list software or you can create your own. Let's review the pros and cons of each.

ABOG Software

ABOG has software that you may obtain by simply ordering online at abog.org. Candidates erroneously assume that it is mandatory to use the ABOG software. This is simply NOT true. You may use ANY format, as long as it exactly duplicates the ABOG case list forms.

In my opinion, the ABOG software is the least preferable option. ACOG was the first to author the software in the early 1990s and then relinquished it over to ABOG in the early 2000s. As with any project, each revision improves on the last; however, it still continues to have many limitations.

The ABOG program is not very user friendly. You have little control of the order of cases and editing within each case. The ABOG software will not let you easily make logical word breaks in columns or pages, nor can you align your flow of thought from one column to the next. Finally, the ABOG software doesn't track statistics accurately for your summary sheets.

E

Appendix

Recommendations for Subspecialty Fellows

The pressing issue on most subspecialty fellows' minds is *when* to take their general boards exam. One thing for certain, you cannot sit for your subspecialty oral boards until you pass your general oral board exam. You will be horrified to acknowledge how much you have forgotten about your non-subspecialty areas. For this reason, I recommend you take your general board exam as soon as possible.

Effective in 2013, you can sit for your exam anytime during your fellowship. Of course, not all fellowship directors are in open support of this and some may discourage you from taking it until your third research year. You will forget so quickly those off-specialty topics. The longer you wait, the worse the recall. If you're no longer practicing general OB/GYN, you peaked in your chief residency year. Back then, it was inconceivable that you could ever forget how to deliver a baby or perform a hysterectomy, since you could practically do it in your sleep. However, it's true - if you don't use it, you'll lose it. You need to persuade your fellowship director that it's to the program's advantage for you to take the exam as soon as possible, in order to enhance your chances of passing and also to assure your program's excellent reputation.

I strongly recommend you apply for your basic oral exam the first year of your fellowship. Specifically, you took your primary written board exam at the end of June of your chief residency year and you started your fellowship on July 1. You won't even get your written exam results until September 1, so you will need to apply for the accelerated or fast track.

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Appendix

Recommendations for Military Personnel

The primary reason for seeking board certification is probably the same for civilian and military physicians. Some incentives, however, are unique to the military.

If you are board-certified, you receive a monthly bonus stipend. Furthermore, board certification influences your assignment of duty position and station. You are more likely to be assigned to a sought-after teaching facility if you are board-certified. Certainly board certification makes you marketable if you decide to leave the military.

Historically, military personnel enjoy an excellent track record. Statistically as a group, you have a nearly 100% pass rate. Are you better trained? I doubt it, since most of you were trained in civilian residencies. The explanation probably lies in the unique differences and challenges of practicing Ob/Gyn in the military.

It usually becomes obvious when you are defending your case list that you lack the support of both Ob/Gyn and other colleagues because of the omnipresent physician shortage in the military. Ancillary resources are restricted because of geographical limitations and shortages. Your patient population is different. Deployments, missions, and nontraditional job duties often influence timing and urgency for evaluation, management, and follow-up. Thus, you must be more creative, broad-based, resourceful, and independent than your civilian colleagues. Examiners love it!

G

Appendix

Case List Review

We have discussed throughout the book, the importance of having your case list reviewed. Of course, it is the most helpful BEFORE you turn it in on August 1. Your reviewers will pick up on not just the obvious, but equally important the subtleties that can really add up. Ideally you should have you case list reviewed in May and then in early-July after your first re-write.

The more reviews, the better. I recommend your referring MFM review the Obstetrics case list, your GYN Oncologist or FPM your Gynecology case list, and your Reproductive Endocrinologist your Office Practice. The specialists represent those of your examiners and are especially important to help you recapture the specialist, rather than the generalist perspective.

Given however, this is your *general* boards, I recommend you have some generalists look at any of the three sections. Furthermore, you want to have a stranger who is unfamiliar with your mode of practice, to give you a true unbiased picture. Finally, a non-medical person can pick up on typos and spelling errors.

Absolutely ALL of your reviewers should be clinicians. The practice of medicine is so dynamic, that even one who only recently stopped practicing will already be out of date. This exam most definitely will hold you to the latest standards. Furthermore, your reviewer must also be performing the same surgeries and procedures as you in order to provide the most contemporary and comprehensive suggestions. You can sure bet your examiner is the expert for those as well.