AMERICAN OSTEOPATHIC
BOARD OF **ORTHOPEDIC SURGERY**

# AOBOS
# Clinical Exam
# Handbook

# American Osteopathic Board of Orthopedic Surgery

## Board Members



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# FOR CANDIDATES

## INTRODUCTION

The information in the enclosed booklet will assist you in proceeding with the Clinical Examination. Board certification in Orthopedic Surgery is administered by the American Osteopathic Board of Orthopedic Surgery for the American Osteopathic Association (AOA). It requires the successful completion of a written examination and a clinical review with an oral defense. The clinical review with oral defense consists of a chart review and oral defense of cases.

### Objective of the Clinical Examination

The objective of the Clinical Examination is to evaluate a candidate's surgical practice by review of their medical records and oral defense of a subset of cases. To accomplish this goal, two board-certified orthopedic surgeons will review the medical record with particular emphasis on presurgical evaluation and preparation, postoperative management, surgical judgment, and overall patient care. Twelve cases will be reviewed in detail, and five of the twelve cases will be chosen for case defense. Please review the scoring rubrics found at the end of the handbook for a detailed scoring breakdown.

It is imperative that the medical record reflects the candidate's active management of the case. Documents including, but not limited to, the history and physical exam, daily progress notes, consults, operative reports, pre-op/post-op orders, and discharge summaries MUST reflect the candidate's personal involvement. ***Notes authored by house officers, residents, fellows, physician assistants, nurse practitioners, etc., that are countersigned ONLY, do not satisfy this requirement.***

If H&Ps are done by other physicians, the candidate must duplicate that process to show thier involvement in the case and management of decisions. The candidate physician must have personal documentation that they have done a pre-op evaluation and documented the rationale for surgery. If necessary, the candidate physician can attach an addendum to the chart explaining his/her pre-op evaluation, diagnosis, and indications outlining the patient treatment plan.

### Board Eligibility

Board Eligibility is necessary to participate in the AOBOS certification process. The only exception is the Written Exam which can be taken in the fourth or fifth year of residency. Fourth-year residents must provide an approval letter from the Program Director.

Board Eligibility is automatic. Board Eligibility begins after the successful completion of your Orthopedic Residency and confirmation of 'Training Complete' status by the Residency Program Director.

You will be considered board eligible for six (6) years after the completion of your residency until 12/31 of the sixth year. Board eligibility begins upon residency completion, a fellowship year would occur during your board eligibility period. For example, if the date you completed your residency was 6/30/2021, your board eligibility would expire 12/31/2027.

For those candidates who were or became board eligible during 2020 an extra year of eligibility has been added due to the pandemic.

Board eligibility policy is set by the Bureau of Osteopathic Specialists (BOS) the governing body for all osteopathic certifying boards. To see the board eligibility policy and options upon the expiration of board eligibility please see the BOS Handbook; Article VI. Board Eligibility.

# EXAM PROTOCOL

## Snapshot of the Overall Clinical Examination Process

1) Application

   *a)* Surgical log must be submitted with the application. Log includes ALL major cases in 6 consecutive months. The minimum number of cases is 100. Collection may continue up to 18 months if 100 cases is not achieved in 6.
   *The Surgical Log serves as a representative snapshot of your practice. It will provide the pool from which your senior examiner will select cases for you to prepare for the Clinical Examination. The materials for all of the cases in your log MUST be available to you to gather for your exam.*

   b) Mortality report must also be included for any mortality within 30 days of surgery.

   c) **PLEASE NOTE:** The application can be closed at any time due to reaching maximum testing capacity. Examiners are limited requiring us to cap the number of candidates per cycle. Apply early to secure your spot.

2) Application review and log approval.

   a) AOBOS staff confirms the application is complete and does initial review of the surgical log.

   b) A member of the AOBOS Board reviews the surgical log and mortality report (if applicable).

   c) Candidate is notified if log or mortality report revisions are required or if the log is approved.

3) Examiners are assigned.

4) Contact information for the candidate and both examiners is emailed to all parties. Examiners are sent their candidate's surgical log and mortality report (if applicable). A schedule with due dates is distributed to all parties.

5) Senior examiner selects cases from the surgical log to prepare for the examination.

   The selection will span the log collection period, be representative of the breadth of practice, and include cases that vary in complexity.

6) Examiners and candidates follow the cycle schedule for each portion of the exam.

   a) Examiner case selection and communication to candidate. (~ 12 Days)

   b) Candidate case material preparation and upload to secure file share. (~ 35 Days)

   c) Examiner review of case material, scheduling and execution of case defense Zoom meeting. (~ 55 Days)

   d) Examiner evaluation submission to the Board.

   e) Grades are posted within 12 weeks of the Final Examiner Grading Submission Deadline.

# THE CLINICAL EXAMINATION STEP BY STEP

## Step 1 - Application and Surgical Log Submission

Candidates may complete the application and pay the examination fee to hold a spot in a clinical exam cohort. You must add your required documents before the published first deadline date to complete your application.

You must have been in practice post-residency (and fellowship if applicable) for a minimum of one year at the time of surgical log submission.

ALL major surgeries where you are the primary surgeon during the collection period must be included in the surgical log. The collection period must cover 6 consecutive months and include a minimum of 100 cases. ALL major cases in the 6 months must be included, collection does not end when 100 cases are reached. If you do not reach 100 cases in the 6 months, collection may continue for up to 18 months. The oldest eligible cases for inclusion are those occurring up to one year before the exam application opening date. The most recent eligible cases for inclusion are those occurring on the day of the first application deadline.

*The Surgical Log serves as a representative snapshot of your practice. It will provide the pool from which your senior examiner will select cases for you to prepare for the Clinical Examination. The materials for all of the cases in your log MUST be available to you to gather for your exam.*

Mortalities apply to deaths that occur within 30 days of the surgical procedure. Mortalities are to be listed both in the category of primary treatment and under Category I (Mortalities**).** All mortalities require a summary report to be personally authored by the candidate and submitted as part of the documentation necessary for the Clinical Exam application. A Mortality Report Template can be found on the AOBOS website.

All surgical logs are subject to audit. If a candidate's surgical log is selected for audit, the AOBOS will require the hospital(s) surgical record for the candidate's recording period before their surgical log will be approved.

### Major VS. Minor Cases

The AOBOS uses the criteria established in the RBRVS, ***Resource Based Relative Value Scale*** (the physician payment schedule for Medicare) for what constitutes major vs. minor cases. Use the RBRVS (***Resource Based Relative Value Scale***) to look up the code in question. If it has a 90 day follow-up, the case is considered major. If it has a 0-10 day follow-up, the case is considered minor.

If you do not have access to the RBRVS code book, you can access the Medicare website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to use the Physician Fee Schedule Look-Up Tool.

## Cases vs. Procedures

The log is intended to report "cases", not procedures. A "case" is a patient contact or encounter, for which multiple surgeries or procedures may have been performed. You must choose the primary procedure you want to include in your log and submit it in the appropriate category. The other procedures from that "case" can be optionally listed with the primary procedure, to indicate other work was done, but only the primary procedure is tallied in the category.

For example, you might have repaired flexor tendons and digital nerves in the surgical visit, accounting for multiple "procedures". However, you must choose which procedure you want to log, i.e. either flexor tendon repair or digital nerve repair, and not list them as separate "cases".

The medical record number should be recorded in the **Case #** field of the Surgical Log.

## Complications and Outcome

The Complications and Outcome column on the Surgical Log template should be used to record surgical complications and the outcome of those complications.

If no complications occurred leave this field **BLANK**.

Listed below are examples of complications that may occur after surgery. Complications may include but are not limited to this list.

- Infection
- DVT
- Neurovascular compromise
- Wound dehiscence
- Malunion/non-union
- Morbidity
- Mortality
- Indication of related cases

The complications and outcome column should also be used to make note of related cases. If there are multiple cases on different dates for the same patient that are related this should be noted under Complications and Outcome. This will ensure that your examiner does not select two related cases for you to prepare for examination with the impression that they are independent cases.

## Clinic Cases

If you are practicing in a Residency Training Program where you supervise the clinic run by the residents who perform the procedures and manage care of patients from that clinic, you have the option of excluding these cases from your log. If you choose to include them, you will be held to the same standard

of participation as expected in the rest of your cases including evidence that you clearly have supervised the management of these cases.

## Mortalities

**Mortalities apply to deaths that occur within 30 days of the surgical procedure.** All mortalities require a summary report to be personally authored by the candidate. A Mortality Report template is available within the clinical application and on the AOBOS website.

This summary should explain in as much detail as necessary:

1. The Orthopedic surgery performed
2. The pre and post-operative course
3. The cause of death
4. How the surgery affected the mortality
5. Any pertinent lab or x-ray findings
6. The general hospital course

It is up to the Senior Examiner whether or not a mortality case is chosen as one of the twelve (12) cases for the Individual Chart Survey.

## Surgical Log Template

Surgical Logs must be compiled using the Excel template found both on the AOBOS website (www.aobos.org ) and within the application portal.

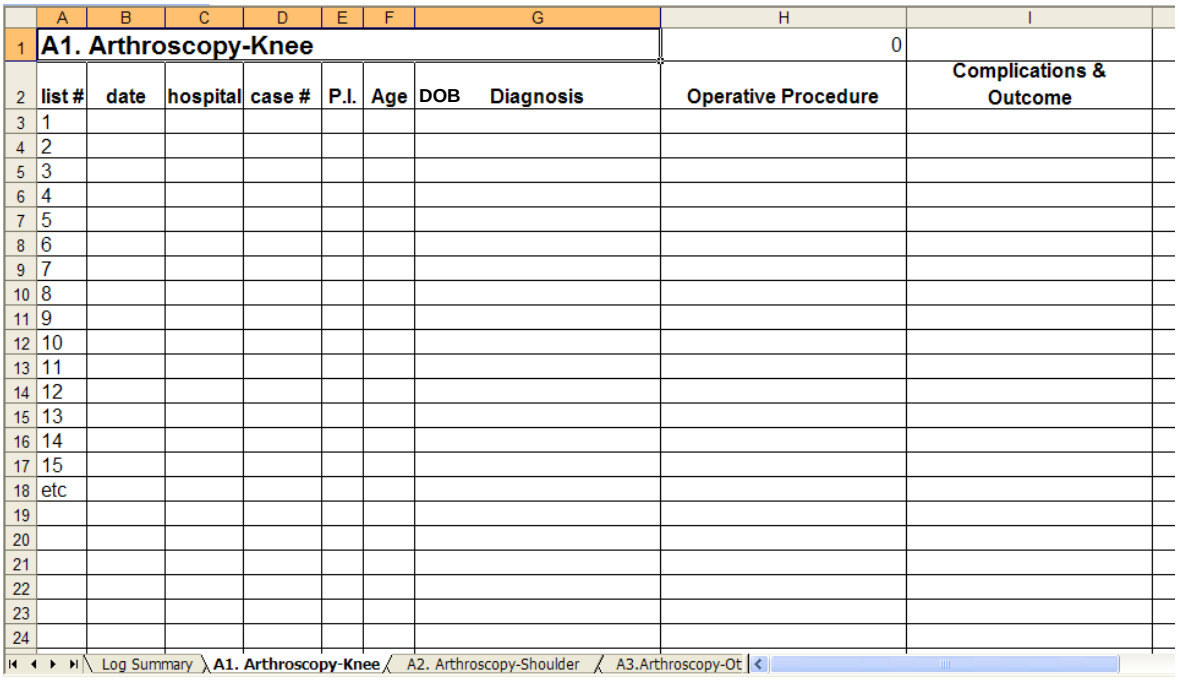
*The Surgical Log serves as a representative snapshot of your practice. It will provide the pool from which your senior examiner will select cases for you to prepare for the Clinical Examination. The materials for all of the cases in your log MUST be available to you to gather for your exam.*

This is the required format for the submission of surgical cases. No independent format may be substituted. No alternate categories may be used. The first worksheet visible in the Excel file is the Log Summary Sheet, as displayed below.

Enter your name in cell B3 on this form and the beginning and ending dates for your surgical log entry in cell B5. When finished entering your surgical log data in the appropriate categories, enter the number of cases for each category in column B on this worksheet.

## Surgical Log Template Cont'd

A sample of the ***A1. Arthroscopy – Knee*** log is displayed below.



| | A | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| 1 | A1. Arthroscopy-Knee | | | | | | | 0 | |
| 2 | list # | date | hospital | case # | P.I. | Age | DOB Diagnosis | Operative Procedure | Complications & Outcome |
| 3 | 1 | | | | | | | | |
| 4 | 2 | | | | | | | | |
| 5 | 3 | | | | | | | | |
| 6 | 4 | | | | | | | | |
| 7 | 5 | | | | | | | | |
| 8 | 6 | | | | | | | | |
| 9 | 7 | | | | | | | | |
| 10 | 8 | | | | | | | | |
| 11 | 9 | | | | | | | | |
| 12 | 10 | | | | | | | | |
| 13 | 11 | | | | | | | | |
| 14 | 12 | | | | | | | | |
| 15 | 13 | | | | | | | | |
| 16 | 14 | | | | | | | | |
| 17 | 15 | | | | | | | | |
| 18 | etc | | | | | | | | |
| 19 | | | | | | | | | |
| 20 | | | | | | | | | |
| 21 | | | | | | | | | |
| 22 | | | | | | | | | |
| 23 | | | | | | | | | |
| 24 | | | | | | | | | |

Log Summary | A1. Arthroscopy-Knee | A2. Arthroscopy-Shoulder | A3.Arthroscopy-Ot

Within each category, you must:

1. List the cases chronologically.
2. Number your cases 1 to X separately for EACH category.

A sample log for the category, A1. Arthroscopy – Knee, is listed on the following page.

Medical Record Number

P.I. = Patient Initials

Laterality should be indicated. No CPT codes.

## A1. Arthroscopy-Knee

Candidate Name

| list # | date | hospital | case # | P.I. | Age | Diagnosis | Operative Procedure | Complications & Outcome |
|---|---|---|---|---|---|---|---|---|
| 1 | 1/12/2014 | LSC | 12367890 | DKM | 22 | Tear medial meniscus Left knee | Scope medial menisectomy left knee | |
| 2 | 1/15/2014 | LSC | 12389012 | SWQ | 27 | Tear medial meniscus Left knee | Scope medial menisectomy left knee | |
| 3 | 1/17/2014 | LSC | 12390123 | HTF | 31 | Tear lateral & medial meniscus Rt knee | Scope medial and lateral menisectomy rt knee | |
| 4 | 1/17/2014 | LSC | 12391123 | JKU | 26 | Tear medial meniscus and ACL left knee | Scope medial menisectomy left knee, ACL reconstruction B-T0B allograft | |
| 5 | 1/19/2014 | LSC | 12400121 | TAM | 16 | Chronic lateral tracking rt patella | Scope lateral retinacular release rt knee | |
| 6 | 1/30/2014 | LSC | 12400245 | EWS | 18 | Tear meidal meniscus Left knee | Scope medial menisectomy left knee | |
| 7 | 2/2/2014 | LSC | 12400345 | HGT | 27 | Tear right ACL | Scope hamstring tendon ACL reconstruction rt knee | |
| 8 | 2/26/2014 | LSC | 12431189 | FTR | 65 | Tear medial meniscus Left knee; djd MFC | Scope medial menisectomy left knee, chondroplasty medial femoral condyle | Post op DVT. Admitted for heparinization. Discharge in 3 days. Recovered uneventfully. |
| 9 | 3/1/2014 | LSC | 12481190 | DGJ | 21 | Bucket handle tear medial meniscus rt knee | Scope medial menisectomy rt knee | |
| 10 | 3/4/2014 | LSC | 12500121 | GBI | 65 | Tear medial and lateral meniscus rt knee | Scope medial/lateral menisectomy rt knee | |
| 11 | 4/1/2014 | ACH | 290-090 | ITD | 67 | Septic Arthritis left knee | Scope irrigation, synovectomy, insertion of inflow outflow drains left knee | |
| 12 | 4/4/2014 | ACH | 290-290 | ITD | 67 | Septic Arthritis left knee | Scope, synovectomy left knee | |



Example of a complication and outcome notation

If there are no complications, this field should be blank.

The Complications & Outcome column should also be used to note related cases. i.e. If related procedures were performed on the same patient on different dates.

## Step 2 - Examiners are Assigned

Two examiners are assigned to each candidate, a senior and a junior examiner. You will be notified with the names and contact information of your two examiners after examiner positions are filled. All examiners are Board Certified and have been trained in the Clinical Examination process. Every attempt is made to ensure at least one examiner practices the same subspecialty as you.

If you have a conflict with either examiner, contact the AOBOS office immediately so that a replacement can be found.

## Step 3 - Senior Examiner Chooses Charts

The senior examiner is sent the candidate's surgical log, hospital location sheet, and mortality report (if applicable). From these documents, twelve (12) cases that represent the candidate's practice with varying degrees of complexity are selected and the list is sent to the candidate. (Note: any candidates remaining in the Historical Exam format will have 20 cases selected and will not have the Case Defense aspect of the exam.)

## Step 4 – Candidate Examination

Once examiners have been assigned a detailed schedule for the cycle will be distributed to candidates and examiners with deadlines for each portion of the process. Candidates will be given no less than 30 days to prepare the case materials for the selected cases.

Twelve (12) cases are reviewed in great detail by the Senior and Junior examiners. 5 of the 12 are chosen for case defense interview.

(Note: any candidates remaining in the Historical Exam format will have 20 cases selected and will not have the Case Defense aspect of the exam.)

For the Case Defense segment, the senior examiner will confer with the junior to find several available dates and times for the Zoom meeting and present them to the candidate. You will work together to find a meeting time that works for all parties. You will not know before the interview meeting which 5 cases were chosen and should be ready to discuss any of the 12 cases you have prepared for the examination. Each case will be discussed for approximately 15 to 20 minutes. This is an opportunity for the examiners to determine medical decision making and thought processes that may not be readily evident from the chart review alone.

The Case Defense Zoom will be scheduled for 2 hours to provide a buffer but should be closer to 1.5 hours in duration.

### Chart Preparation General Guidelines

It is the policy of the AOBOS that there must be clear evidence and written documentation that the surgeon has evaluated the patient pre-operatively. If the information was gathered as an outpatient or during an office visit, it is advisable to attach the appropriate office records to the hospital (or outpatient

surgery center) chart. We are interested in your preoperative management and your reasoning for choosing surgical treatment. You make the decision whether office records are necessary for the examiners to understand your surgical indications and workup.

Remember you are also being graded on follow-up care, so the examiners will also need to review office radiographs and office charts. Generally, the most recent radiographic studies should be available. However, if there were any complications or other significant events in the course of treatment, interim images may be necessary. Use your best judgment in this regard.

You are responsible for documenting the disposition of the case. This includes circumstances such as transfer out of the geographic area, transfer to a nursing home or extended care facility or simply a no show in the office. (In the event of a no show, you must state what action was taken.) This documentation can be either in the hospital discharge summary or in your office records.

The chart must clearly document the active role the surgeon plays in patient evaluation and treatment. House officer notes, only countersigned by the surgeon, are NOT sufficient

1. A complete chart must include the following:
2. Entire pre-operative office notes denoting the pre-operative workup
3. H&P or pre-operative documentation of the treatment plan authored by the candidate

   Following Medicare guidelines an H&P must be performed no more than 30 days prior to admission and updated the day before or day of surgery. Office medical records that substantiate the hospitalization or procedure should be part of the inpatient record. Medicare requires that the hospital medical record justify the admission and treatment
4. Evidence of informed consent
5. Operative procedure note authored by the candidate
6. Official operative record denoting operative time and blood loss
7. All post-operative orders
8. If outpatient surgery, prescription documentation and discharge instructions to patient
9. Entire post-operative hospital record, which should include labs, orders, radiographic studies, post-operative notes and all progress notes.
10. Discharge summary or comprehensive discharge note
11. Post-operative office chart depicting aftercare until discharge from care

A complete radiographic chart must include the following:

1. Pre-operative or injury films and all appropriate ancillary studies (CT, MRI, Bone scan etc.)
2. Intra-operative or immediate post-operative radiographs
3. If arthroscopic procedure, pre and post correction pictures

4. Representative post-operative radiographs to depict follow up AND final radiographs demonstrating condition at time of discharge from care

ALL pertinent pre-op, intra-op and post-operative radiographic studies should be placed into a Power Point format that is labeled and dated. Images should appear as they would in a PACS (they should not be distorted).

## Clinic Cases

If you are practicing in a Residency Training Program where you supervise the clinic run by the residents who perform the procedures and manage care of patients from that clinic, you have the option of excluding these cases from your log. If you choose to include them, you will be held to the same standard of participation as expected in the rest of your cases including evidence that you clearly have supervised the management of these cases.

## Redaction

All identifying patient information must be redacted from the case materials. Redaction can be accomplished in any manner that works for the candidate as all medical records systems and office notes are stored differently. Options are: search & replace, Adobe redaction feature, or simply blacking the information out or covering it before scanning paper files.

## Chart Review Grading (Please see the rubric for greater detail)

1. Pre-Operative Care & Evaluation
2. Chart Mechanics:
    a. H&P/Consults/Progress Notes
    b. Operative Consent
    c. Operative Report/Discharge Summary/Orthopedic Post-Op Instructions.
3. Indications for Surgery
4. Performance of Surgical Procedure
5. Quality of Follow-Up Care
6. Holistic Impression

## Case Defense

For New Format candidates the senior examiner will contact you with several possible dates/times that work for the senior and junior examiner to find a date/time that works for you. The senior examiner will communicate the final decided upon date/time to AOBOS who will schedule the Zoom meeting and send invitations to all parties. The case defense meeting will be scheduled for 2-hours to provide cushion for any delays but should last for approximately 90 minutes.

The 5 cases to be discussed will be relayed to you at the start of the meeting. You should be prepared to discuss any of the 12 cases that you prepared.

The meeting will begin with you giving a brief summary of the case followed by questions from the examiners. You should be connected to your fileshare site or have downloaded your cases to your local drive and be prepared to share your screen to review chart materials particularly imaging to illustrate the diagnosis, treatment, and outcome.

### Case Defense Grading (Please see the rubric for greater detail)

1. Patient Presentation, Relevant History
2. Interpretation of Studies - *Only studies submitted with case materials for chart review can be considered during the Case Defense interview. New studies may not be introduced during the Oral Case Defense interview.
3. Medical Knowledge
4. Medical Decision Making
5. Post-Op Protocol / Outcomes

## Step 5 – Scores are Determined

Following the exam, the examiners will submit their evaluations. They will not be able to tell you if have or have not passed the exam. The evaluations will then undergo a statistical analysis by a psychometrician. The scaled scores will be submitted to the Board for review.

Examination results are reported on a scale of 200 to 800. A scaled score of 500 or greater is required to pass.

Grades will be posted for candidates within 12 weeks of the examiner grade submission deadline. AOBOS staff will email all candidates with login instructions when grades are available.

# FOR EXAMINERS

## INTRODUCTION

The AOBOS utilizes a scoring method for the Clinical Exam where examiners score candidates in multiple predetermined areas.

The scoring will be derived from an in-depth review of 12 charts from the candidate's surgical log and a case defense interview for 5 of those 12 charts. (Note: there are a small number of candidates who are grandfathered into the Historical Clinical Exam format, this is a review of 20 charts with no case defense interview. The Historical Format will retire as of 12/31/2024) The format of the exam is noted with the candidate information.

## EXAM PROTOCOL

These are the basic steps in the Clinical Exam Process:

### Step 1 - Application Process (Candidate)

Candidate submits Application, Payment, Surgical Log, and Mortality Report, if applicable.

### Step 2 - Log Approval (Board)

AOBOS staff reviews application and Surgical Log for completeness. AOBOS Board reviews the Surgical Log and Mortality Report, if applicable, and makes approval determination.

### Step 3 - Examiners Assignments (AOBOS Staff and Examiner Volunteers)

The AOBOS staff will solicit trained examiner volunteers to perform exams. After Senior and Junior examiner assignments are completed, candidates and examiners will be sent notifications, materials, and a detailed timeline for the exam cycle.

### Step 4 - Chart Selection and Communication to Candidate (Senior Examiner)

The senior examiner will review the candidate's surgical log and mortality review report (if applicable) and select the cases for the candidate to prepare for examination. 20 for Historical Format candidates and 12 for New Format candidates. The senior examiner may consult with the junior examiner in selecting cases for review. See the section on selection charts for review for specific guidelines.

Time allotted is approximately 12 days.

### Step 5 - Chart Preparation and upload (Candidate)

Candidates compile all materials for each selected case into the required template provided to them and upload materials into the secure fileshare which will be shared with examiners.

Time allotted is approximately 30-35 days.

### Step 6 - Examiner Chart Review, Case Defense or Exit Interview Zoom Meeting (Sr. and Jr. Examiners plus Candidate for Meeting)

a. Examiners are sent access to the secure fileshare where candidate materials are stored.

b. Examiners review each case and enter scores in the online scoring form.

c. The Senior examiner coordinates a date/time with the junior and candidate for the Case Defense interview (New Format) or the Exit Interview (Historical Format).

d. The senior examiner relates the selected date/time to AOBOS staff and staff creates the Zoom and sends invitations to all parties.

e. Examiners and candidates participate in Zoom meetings.

f. Examiners enter Case Defense scoring for New Format exams in the online scoring form.

g. Examiners submit final scoring by the designated due date.

Time allotted is approximately 55 days.

### Step 7 - Scores are Determined (AOBOS)

At the end of the clinical examination cycle, all scores for each exam conducted are compiled and sent to the psychometrician for evaluation. The psychometric report, examiner letters and evaluation forms are reviewed by the Board. Candidate result letters and score reports are posted within 12 weeks of the examiner grade submission deadline.

## RESPONSIBILITIES

### Senior Examiner

1. The senior examiner plays a crucial role in the exam process by performing the following:

2. Volunteer for the exam. Ensure the absence of any personal or professional conflicts with the candidate. This includes a prior relationship, (such as previous partner, or student/resident) or practice conflicts (too close geographically, litigation etc.).

3. Review logs and mortality review report sent via email by AOBOS staff.

4. Selects cases for the exam. The senior examiner may consult with the junior examiner in selecting the cases for review.

5. Schedule and conduct the Zoom meeting, by coordinating with the junior examiner and candidate.
   Collaborate with the junior examiner to select the 5 cases for review during the Oral Case Defense Zoom interview.

6. Utilize the online grade entry to enter grades.

### Junior Examiner

1. Volunteer for the exam. Ensure the absence of any personal or professional conflicts with the candidate. This includes a prior relationship, (such as previous partner, or student/resident) or practice conflicts (too close geographically, litigation etc.).

2. Communicate directly with the senior examiner regarding the examination.

3. Consult with the senior examiner about case selection if requested.

4. Work with the senior to find a time for the Zoom Case Defense (New Format) or Exit Interview (Historical Format) and participate in the meeting.
   Collaborate with the senior examiner to select the 5 cases for review during the Oral Case Defense Zoom interview.

5. Utilize the online grade entry to enter grades.

## GUIDELINES FOR SELECTING CASES FOR CHART REVIEW

1. Select cases that represent a broad inspection of the candidate's scope of practice. There will be 20 cases selected for Historical Format exams which are chart review only and 12 cases selected for New Format exams which are chart review and case defense.

2. The selected cases should be of sufficient scope to include fracture management, trauma, arthroscopy, joint replacement, adult diseases. Subspecialty exams should select cases across a spectrum of pathology.

3. When selecting cases of similar type, such as ankle fractures, it is recommended to select cases from varying times over the course of the log. For example, selecting three ankle fractures, one from the early log, one from mid log and one from the end of the log provides examiners a longitudinal look at the candidate's work.

4. Some complicated cases should be reviewed to evaluate the candidate's management of complex cases. However, it is inappropriate to select all complicated cases.

5. Be cognizant of related cases. Two cases for procedures performed on the same patient that are related should not be selected as independent cases for review due to the overlap in pre-operative workup and follow up.

6. Both examiners review the same cases and score them independently.

7. Cases should be selected at communicated to the candidate by to stated deadline to allow the candidate the same preparation period as all other candidates in the testing cohort.

## SUBSPECIALTY ORTHOPEDIC SURGEONS

If the candidate's practice is predominantly in a subspecialty, e.g. spine, hand, pediatrics, etc., you must keep in mind you are still certifying him/her as an Orthopedic Surgeon.

Whatever the subspecialty may be, the Board will make every attempt possible to arrange one of the examiners to have a similar subspecialty, provided the candidate informed the Board of their subspecialty.

## CHART REVIEW

**The candidate must show they are managing the case, not necessarily authoring and dictating all notes. Candidates must clearly document their active role in patient evaluation and treatment.**

Following Medicare guidelines:
An H&P must be performed no more than 30 days prior to admission and updated the day before or day of surgery. Office medical records that substantiate the hospitalization or procedure should be part of the inpatient record. Medicare requires that the hospital medical record justify the admission and treatment.

Discharge summaries should be dictated as soon as possible after discharge. If unable to dictate on the day of discharge, write a final summarizing progress note to include:

1. Principal diagnosis, secondary diagnoses and principal procedure.
2. Brief description of the hospitalization, disposition of the case, and follow-up care.
3. Results of diagnostic testing that confirm the principal diagnosis.

### Chart Review Grading

The individual charts are to be reviewed in detail. In evaluating each of the components follow the Chart Review Scoring Rubric.

Most of this is self explanatory, but the following instructions are provided to give a better explanation of each area.

In the grading form there is a comment section provided for each grading point. Please utilize this section particularly when assigning a marginal or unsatisfactory rating.

### Pre Operative Care & Evaluation

This includes documentation of conservative care, proper work-up including appropriate diagnostic studies, consultations when necessary, and clear evidence the candidate is personally managing the case.

### Chart Mechanics

To be acceptable, each area must:

- Be present
- Contain the appropriate information
- Provide documentation authored by the candidate clearly documenting the active role the candidate plays in patient evaluation and treatment

The history and physical and/or pre-operative evaluation may be part of the outpatient record.

Progress notes are not required daily if the candidate's practice situation has coverage by other orthopedic surgeons. Other provider notes, which are countersigned ONLY, are still not acceptable. However, if any untoward event occurs or change in normal post-operative management is required, the candidate ***must*** document this fact on the record.

Operative reports must be added by the candidates.

Discharge summaries should be added by the candidate; however, a written discharge note that outlines the post discharge plan is acceptable. A check form signed by the candidate is not acceptable.

### Indications for Surgery

In your judgment, was the surgery, as performed, indicated? Was the appropriate surgery chosen?

### Performance of Surgical Procedure

Was the surgery performed competently? This may include operative time, blood loss, complications, and especially, review of the post-operative images.

### Quality of Follow-Up Care

We ask you to review the entire patient course, including the post operative follow-up care.

Therefore, it is necessary for you to review the candidate's office records and follow-up images. The most recent films should be reviewed, along with any interim films as necessary.
The scoring is based on appropriate follow up care. Some areas to consider include:

- Was the patient seen back in a timely manner?
- Were all post-operative complications acknowledged and treated appropriately?
- Was rehab provided when needed?
- Was the final result as expected?

The candidate is responsible for documenting the disposition of the case. This includes circumstances such as transfer out of the geographic area, transfer to a nursing home or extended care facility or simply a no show in the office. This documentation can be either in the hospital discharge summary or in the candidate's office records.

### Holistic Impression

Your overall professional evaluation of the candidate's performance of the case reviewed. You will provide a Holistic Impression for each case in the chart review portion of the exam.

### Post Observation Letter to the Board

Please use this area to explain deficiencies or problematic areas.

It is critical the Board have this information, especially in the case of an exam failure.

It is also useful to report extremely high performing candidates that are potential future examiners.

## Chart Review – Mortality Review

***All*** mortalities ***must*** be reported in the candidate's surgical log. In addition to indicating the mortality in the log candidates must provide a mortality report. **Mortalities apply to deaths that occur within 30 days of the surgical procedure.**

The Mortality Report should explain in as much detail as necessary:

1. The orthopedic surgery performed
2. The pre and post operative course
3. The cause of death
4. How the surgery affected the mortality
5. Any pertinent lab or x-ray findings
6. The general hospital course

It is up to the Senior Examiner whether or not a mortality case is chosen as one of the cases for review.

# CASE DEFENSE

For new format examinations a case defense interview will be conducted to discuss in more depth a subset of the cases selected for chart review. The case defense will occur after both examiners have fully reviewed the chart materials for all 12 cases. The senior and junior examiner should discuss which 5 cases should be selected for case defense. **The candidate should be prepared to discuss any of the 12 cases. The 5 cases for defense should be relayed to the candidate ONLY at the start of the Zoom case defense meeting.**

The case defense meeting should begin with informing the candidate which 5 cases were selected. The candidate should be given the opportunity to present a summary of the case followed by questions from the examiners.

The Case Defense Zoom will be scheduled for 2 hours to provide a buffer but should be closer to 1.5 hours in duration.

## Case Defense Grading

The case defense focuses on 5 components. See the Clinical Case Defense Scoring Rubric for a detailed scoring breakdown.

In the grading form there is a comment section provided for each grading point. Please utilize this section particularly when assigning a marginal or unsatisfactory rating.

### Patient Presentation, Relevant History

Evaluation of the candidate's explanation of the patient presentation, complaint, diagnosis, and relevant history.

### Interpretation of Studies

*Only studies submitted with case materials for review can be considered during the Case Defense interview.

Evaluation of the candidate's description of the studies performed.

### Medical Knowledge

Evaluation of the candidates understanding of the classification systems and natural history of the disease.

### Medical Decision Making

Evaluation of the candidate's description of the surgical plan including awareness of complications, treatment options, and efficiency.

### Post-Op Protocol / Outcomes

Evaluation of candidate's description of post-operative follow up, patient recovery.

# RUBRICS

## AOBOS Clinical Chart Review Scoring Rubric

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Pre-operative Care & Evaluation** | Inadequate or no work-up to establish a diagnosis. Studies ordered do not support the diagnosis. Poor documentation of history and physical exam findings. Limited or no attempt at conservative care, when indicated | Incomplete work-up. Limited documentation of history and physical exam findings such that the diagnosis is unclear. Conservative care documented when indicated, but of insufficient duration or type. | Documentation supports the diagnosis and treatment plan. Proper ancillary studies available and interpretations documented. Appropriate type and duration of conservative care. | Documentation supports the diagnosis and treatment plan and considers differential diagnosis. Correct ancillary studies available with complete documentation of findings and significance. Proper conservative care documented with consideration of alternatives. |

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Chart Mechanics: H&P/Consults/ Progress Notes** | Inadequate or no documentation to establish diagnosis. Studies ordered do not support the diagnosis. Poor documentation of history and physical exam findings. Very limited or no objective finding. Indicated consults not done or not documented. Notes not done by the surgeon. Complications not discussed or documented. | Limited documentation of history and physical exam findings such that the diagnosis is unclear. Limited documentation by the surgeon (i.e. most documentation is authored by ancillary staff). Insufficient consultation documentation. Incomplete progress notes. Incomplete documentation of complications. | Documentation supports the diagnosis and treatment plan. Proper ancillary studies available and interpretations are documented. Notes authored by the surgeon that are appropriate and complete with objective findings. Complications and plans of treatment are clearly documented. | Documentation supports the diagnosis and treatment plan and considers differential diagnosis. Correct ancillary studies available with complete documentation of findings and significance. Complications are identified and documented by surgeon with treatment plan. |
| **Chart Mechanics: Operative Consent** | Office notes do not document pre-operative discussion of the planned procedure, risks and benefits of the procedure. Surgical permit incomplete or inadequate description of planned procedure. | Office notes document incomplete pre-operative discussion of the planned procedure, risks and benefits of the procedure. Surgical permit meets minimum required description of treatment plan. | Office notes document complete pre-operative discussion of the planned procedure, risks and benefits of the procedure. Surgical permit clearly describes treatment plan and risks. | Office notes document complete pre-operative discussion of the planned procedure, risks and benefits of the procedure, and alternative treatments with rationale for decision making. Surgical permit clearly describes treatment plan and risks. |

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Chart Mechanics: Operative Report/Discharge Summary/Post-Op Instructions** | Documents incomplete or not present. Documents do not contain required information. Insufficient description of procedure. Inaccurate description of procedure. (i.e. – x-ray findings do not match operative report) | Documents minimum requirements only. Incomplete description of procedure. | Clearly and accurately documents complete procedure. Discharge instructions complete and appropriate for procedure and diagnosis. | Clearly and accurately documents complete procedure. Documents include indications for procedure, operative findings, and all pertinent facts. Discharge instructions are complete and appropriate for procedure and diagnosis including restrictions, therapy, and follow-up plan. |
| **Indications for Surgery** | No documentation of indications for the procedure. Clear documentation of contraindications for the planned procedure. Planned procedure inappropriate for the clinical situation. | Indications for the procedure are questionable. More information needed to justify surgical plan. Procedure may be indicated, but documentation does not clearly support the plan. | Surgical procedure is appropriate for the clinical situation and documentation supports the diagnosis and surgical plan. | Modification of the surgical plan reflects high level of knowledge and experience in avoiding complications while simplifying the treatment approach. Mature judgement is reflected in the plan. |

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Performance of Surgical Procedure** | Technical mistakes compromise the outcome of the case. Dangerous practice observed that is likely to lead to complications. Failure to recognize and treat pathology. Clearly failing candidate. | Technical errors observed. Completes case but struggles with technique. Borderline failing candidate. | Completes case appropriately with minimal error. Errors that occur are recognized and addressed appropriately. Proceeds with reasonable efficiency. Passing candidate. | No technical errors occur. Very time efficient. Proceeds with confidence and great skill. Clearly excellent surgeon. |
| **Quality of Follow-Up Care** | No, or incomplete, follow-up. Lost to follow-up with no documentation of attempts to contact the patient. Failure to recognize and/or treat a complication. Patient discharged from care at inappropriate time. | Follow-up incomplete or not clearly documented. Failure to completely recognize and/or treat a complication. Errors in post-surgical management. | Appropriate follow-up and management. Recognizes and treats problems in a timely manner. Follows patients for reasonable time post-operatively. Unsuccessful attempts to reach the patient are acceptable if documented. | Excellent documentation of follow-up. Appropriate decision making. Recognizes problems early and adjusts treatment as indicated. Clearly excellent management. |

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Holistic Impression**<br>*Your overall professional evaluation of the candidate's performance for the chart reviewed, including the candidate's logic, fundamental understanding and professional judgment.* | Poor insight; fails to formulate correct diagnosis; misinterprets data; incorrectly evaluates and manages problems; frequent incomplete or missing documentation; poor decision making. | Limited insight; questionable decision making; minimum knowledge; management and technique falls below reasonable standards; incomplete documentation to support medical decision making. | Sufficient knowledge; moderately capable; acceptable assessment capabilities; room for improvement. Makes reasonable management and treatment decisions; accurate and complete critical documentation; reasonable technical execution of treatment plan. | Clear and concise comprehension; correct decision making without any errors; can work through entire case management with no issues at all; demonstrates advanced knowledge; excellent complete documentation of medical decision making; excellent technical execution of treatment plan. |

# AOBOS Clinical Case Defense Scoring Rubric

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Patient Presentation, Relevant History** | Candidates' summary describing the patient presentation, complaint, diagnosis, and relevant history is insufficient. | Candidates' summary describing the patient presentation, complaint, diagnosis, and relevant history lacks detail. | Candidates' summary describes the patient presentation, complaint, diagnosis, and relevant history in satisfactory detail. | Candidates' summary describes the patient presentation, complaint, diagnosis, and relevant history in great detail. |
| **Interpretation of Studies**<br>*Only studies submitted with case materials for review can be considered during the Case Defense interview. | Candidate describes studies performed. Studies are inaccurate or have not been submitted. Candidate's understanding of the workup is unacceptable. | Candidate describes studies performed. Studies are insufficient but not inaccurate. Candidate displays limited understanding of the workup. | Candidate describes studies performed adequately. Studies are appropriate. Candidate displays reasonable understanding of the workup and has included the gold standard test. | Candidate describes studies performed completely. Studies are appropriate. Candidate displays full understanding of the workup and has included the gold standard test. |
| **Medical Knowledge** | Candidate's understanding of classification systems and natural history of disease is insufficient. | Candidate's understanding of classification systems and natural history of disease is marginal. | Candidate's understanding of classification systems and natural history of disease is satisfactory. | Candidate's shows complete understanding of classification systems and natural history of disease. |
| **Medical Decision Making** | Description of surgical plan that is inappropriate for the clinical situation. Technical mistakes compromise the outcome of the case and could lead to complications. | Description of surgical plan is inadequate. Shows insufficient awareness of complications. Errors occur that are not addressed with the appropriate technique. | Description of the surgical plan is appropriate for the clinical situation. Shows satisfactory awareness of complications. Minimal errors that are recognized and addressed appropriately. Reasonable efficiency. Candidate has awareness of different treatment options. | Description of the surgical plan reflects high level of knowledge and experience in avoiding complications while simplifying the treatment approach. No technical errors occur. Very time efficient. Candidate has full awareness of different treatment options. |

| | Unsatisfactory<br>1 | Marginal<br>2 | Satisfactory<br>3 | Superior<br>4 |
|---|---|---|---|---|
| **Post-Op Protocol / Outcomes** | Candidate describes incomplete or no post-operative management. Patient is lost to follow-up with no attempts to contact Failure to recognize and/or treat a complication. Patient discharged from care at inappropriate time. | Candidate describes sub-optimal objective measures of patient recovery at follow-up. Fails to completely treat a complication. Errors in post-surgical management. Follows patient for insufficient period. | Candidate describes generally appropriate objective measures of patient recovery at follow-up. Recognizes and treats problems in a timely manner. Follows patients for reasonable period. | Candidate describes appropriate objective measures of patient recovery at follow-up. Recognizes problems early and adjusts treatment as indicated. Follows patient for the appropriate period. |