

The oral boards – How to handle them

By Eric Katz

The oral boards are a mandatory part of becoming “Board Certified” in Emergency Medicine. They are a little controversial in that there is little published about them and few people seem to have a good sense of what they actually test. It is clear that the test is not about medical knowledge, since the written boards test that already. The oral boards probably test patient care and interpersonal skills more than anything else... so it's not what you know, it's how you apply it. So how do you prepare for the test?

One word: **Organization**

If you have an organized and stepwise approach to the oral boards, you will do great. If you don't approach it in an organized manner, you'd better really be thorough, but you'll be in trouble regardless. So here are some helpful factoids and hints...

1. The makeup of the test:

The oral boards consist of 7 oral case sessions. 5 are single-incident cases, while 2 are multiple (3) incident cases. The single incident cases are 20 minutes each, while the multiples are 40 minutes each. Two of the 7 don't count towards your score – they are being tested for future exams. You don't know which ones. That's why you aren't allowed to discuss the cases.

A. Single case

Time: 20 minutes (15 for mock orals)

Format: you are working on a single patient, and usually there is one underlying disease they are testing for – although comorbidities play a role (for example, how much beta-agonists for a COPD patient with severe CAD?). These cases may be diagnostically challenging or very routine. There is nothing that is not possible, but usually, the cases are straightforward. They are usually testing your organization and not testing your intellect. Stay organized and reassess frequently. Cover your bases, but don't “over think.” It'll only get you in trouble.

B. Multiple Cases

Time: 40 minutes (30 for mock orals)

Format: This is testing multitasking. You will have three cases to work through and information will be presented to you sequentially at set points. Any information they hand you for each patient is color coded for you to help keep patients straight, but labs on patient #1 may not come back until patient #2 is stable. Patient number 3 may not show up until you've done something on patient #1. The proctor will keep the case moving if it is obvious you've missed

something, but remember, when there is a long pause in the play of the case, there is something you should be doing.

Keeping you on time is the responsibility of the examiner, but they will let you waste time if it appears you don't know how to take the test. If you don't finish a case, you will likely do really poorly on it. Organization will keep you on track. We'll talk about how to do that in a little bit.

2. Grading

The areas you are graded on are: data acquisition, problem solving, patient management, resource utilization, health care provided (outcome), interpersonal relations, comprehension of pathophysiology, clinical competence (overall). There is a list of "critical actions" to each case that you must hit. For example, on an uncomplicated acute MI case, the critical actions might be:

1. recognizing the acute MI on the EKG
2. think about transfers to a cath lab within/outside the hospital you are at
3. assessing indications and contraindications for lytics, then using them appropriately
4. calling the cardiologist and getting the patient admitted to a CCU.
5. Administering ASA, Beta blockers, heparin, plavix, and morphine

You are required to get **all** of these or at least prove you have considered them.

There is also a list of "dangerous actions" for each case, any one of which is enough to fail you. These are not always laid out in advance as it is hard to predict what kind of ideas people will come up with. For example, one resident saw a patient with unequal pupils and immediately intubated him. Turns out the patient had acute angle closure glaucoma and an artificial eye on the other side. You'd probably fail the case for that... A list of "dangerous actions" for the AMI case might include:

1. Not doing a rectal exam
2. Forgetting to evaluate for signs of heart failure
3. Forgetting to recheck an EKG if the patients symptoms change.
4. Not assessing for an aortic dissection
5. prophylactic lidocaine
6. OTHER

2. What is expected of you

Be professional, stay calm and practice like an EM specialist. Recognize what you know and don't know. Don't "reach" for diagnoses or treatments unless you think they will work. They aren't testing for weird diagnoses. Also, like the written boards, they are not testing the latest controversies and medical practice. The boards may be 2-3 years behind current literature, but you won't be penalized for being up to date.

Dress code is suit and tie or equivalent (*for the mock orals, shirt and tie or equivalent is expected*).

You aren't allowed to bring anything into the room with you other than a pencil. They'll provide you with a piece of paper that has an outline of a body and plenty of room for notes (for the triple it has 3 bodies). Calculators, PDA's, phones, etc. aren't allowed.

I've said a couple of times so far that they aren't testing medical knowledge, but there are a few things you really do need to know. ACLS, ATLS, PALS (and especially the drug doses included for them). Sedation meds. Pick one thrombolytic and learn it (I recommend reteplase (r-TPA) since it isn't weight or age based. Just remember it is two doses. So say "I'd like to give reteplase 10 units now and 10 units in 30 minutes.") If you don't know a dose, don't guess incorrectly, but say "I'd look it up in _____." Common medication doses you'll know anyway but if you are looking up the dose of Tylenol, you will look dumb.

3. When your examiner meets you at the door, the case has started. Be professional. Expect no humor, good-natured discussion or other interaction. The examiner role plays every person you interact with, but does not have much leeway in the information they give you (so the cases are standardized among testers). They will NOT deceive you, try to hide information or attempt to trip you up. However, they also will NOT volunteer information unless directed to do so. This includes things you would normally notice in the course of events (i.e. a family member is standing with the patient, the patient is blue, the monitor has gone to asystole).

IMPORTANT TIP: One of the board's favorite things to do is not tell you what would normally be obvious, so when you walk in the room, it is a very good idea to start every case with "As I walk into the room, what do I see, hear and smell?"

4. When the case begins, you will be handed a sheet with selected basic information such as name, vitals, mode of arrival, chief complaint, etc. If there is info you'd like that isn't on the sheet, you must ask for it.

IMPORTANT TIP: If the triage sheet has anything remotely resembling acute illness, use the phrase "I'd like to order a large bore IV (or 2), O2, Monitor, and pulse ox and please show me a rhythm strip when it is available and let me know if the pulse ox changes."

IMPORTANT TIP: If the triage sheet doesn't have all 5 vital signs on it, ask for it immediately. It is usually very important.

5. The role-playing portion of the exam is very artificial, but crucial. "Interpersonal relations" is a category you are judged on. To speak with someone, you simply say, "I'd like to speak with the mother." To speak with their physician, you ask to have them paged. You can try to call consultants, family, PCP's, etc. They may not always be available, but you

can try. To admit patients, ask the appropriate MD to admit them. Do NOT have fights with anyone.

IMPORTANT TIP: If a consultant doesn't agree with you, restate your request. Usually, when you repeat your request, every consultant caves in unless there's something obvious you are missing.

IMPORTANT TIP: If a patient comes by ambulance, when you go into the room say "I'd like to ask the EMS crew to stand by in case I have questions." Otherwise EMS leaves.

6. Don't think out loud. If you are wrong, it counts against you and if you are right, it'll show in how you manage the case. Don't give them a reading of the EKG or CXR unless they ask for it. When they hand you the EKG, just say thank you. If reading it is a critical action, you'll be asked for the reading by the examiner with something like, "the nurse is asking what the EKG showed." Usually you'll need to let the patient's physician know the result later on anyway.

7. Keeping yourself organized during the case

There are lots of ways to organize your data acquisition and care plans during the oral boards. I'm going to outline the way I learned, but if you find or create others, please share them.

How you do this is up to you. There are many different formats to use. I'll show you the one that works for me, but you'll need to figure out what works for you.

In the room, you'll receive a sheet of paper with a stick figure on the left (takes up 1/3 of the paper). The rest is blank. I don't use the stick figure unless there is a trauma case, in which case it's helpful to mark the injuries as a reminder (traumas can be complicated). I use a 2 X 3 table.

<p>History</p> <p>PMH ROS FHx Soc Meds All</p>	<p>Physical exam</p>
<p>Orders</p> <p><i>I keep orders and results next to each other and draw a line for things I need to check for. For example:</i></p> <p>BMP \longrightarrow</p> <p>monitor \longrightarrow</p>	<p>Results/Reaction</p> <p>(what did it show)</p> <p>(here I'd put in the rhythm)</p>
<p>DDx/Disposition</p>	<p>Reassessment/Discussed with</p>

IMPORTANT TIP: Whatever skeleton you use to organize yourself, go into the room, take your paper and draw the skeleton. Check off the boxes on each one so you know you've done it. *Never consider the case done unless EVERY box is checked.* (can't stress that last line enough)

8. Random Thoughts

- A. If you have time left over and the proctor hasn't finished the case, there's a reason. Think what you are missing.
- B. If you are running out of time, think of what's most important and get it done.
- C. Remember that nothing is given to you unless you ask. If you hook a patient up to the monitor but don't look at it, you won't know what it shows. This is very artificial, but they are testing how well you play the game.
- D. The overall failure rate for this is 5-8%. This is slightly lower than the written boards. But these test an entirely different subject. Organization and multitasking are key. Knowledge is pretty easy on most of these.
- E. Deterioration and death are bad things. Always react to it.
 - 1. The sole exception is that if they come in dead and are in rigor mortis, have dependent echymosis, etc. check a temperature and pronounce them. This may be in a multiple incident case. Talk to the family and move on.
- F. Go through your motions and check every box unless the patient is unstable. If the patient is unstable, stabilize, but then GO BACK and fill in your notes.
- G. PUT THE ONUS ON THE EXAMINER – “tell me when the _____ is back.”
- H. Be conservative in management. No bonuses for sending people home.
- I. When a crisis develops, check your own pulse first.

So these are my thoughts. It's hard to articulate this stuff in writing so I've probably missed a bunch of stuff. As much as you can, relax, practice and stay organized. Be the good EP that you know you are and you will do fine.

Happy boarding!