Examinee's Guide to the Written and Oral Exams

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INTRODUCTION

This guide is intended to provide comprehensive information about the examination process of the American Board of Facial Plastic and Reconstructive Surgery lnc.® The guide is organized to provide readers with: (1) a historical background of the examination, (2) an orientation to the purposes of the examination, (3) the format used in the examination, (4) the content specifications for the written and oral parts of the examination, (5) how the examination is prepared, (6) how the examination is administered, (7) how the examination is scored and reported, and (8) how the examinee can best prepare for the written and oral parts of the examination. Sample written and oral items are provided.

HISTORICAL BACKGROUND

The ABFPRS was organized in 1986 to improve the quality of medical and surgical treatment available to the public by examining for professional expertise in facial plastic and reconstructive surgery.

The ABFPRS examination tests three groups of surgeons, applicants for certification by the American Board of Facial Plastic and Reconstructive Surgery®, fellows of the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery, and applicants for certification by a member society of the International Federation of Facial Plastic Surgery Societies. The examination is funded in part by the Facial Plastic Surgery Fellowship Examination Corporation, a non-profit educational organization established to assist in testing graduate fellows completing training programs in facial plastic and reconstructive surgery.

To become certified by the ABFPRS, a surgeon not only must pass the ABFPRS examination, but also must meet established standards of training and clinical experience.

The Board offered its first examination in 1988 and offered two exams each year through 1991. It now offers an examination program once a year for surgeons already certified by the American Board of Otolaryngology or the American Board of Plastic Surgery, fellows completing the AAFPRS Foundation training program, and IFFPSS candidates.

PURPOSE OF THE EXAMINATION

The examination is one phase of the two-phase process whereby surgeons may become certified in the medical specialty of facial plastic and reconstructive surgery. Its specific purposes are to promote scholarship and to test examinees' familiarity with the generally accepted body of knowledge in the specialty and their ability to apply problem-solving skills to complex medical cases.
The examination does not test actual facial plastic and reconstructive surgical skills, which only may be seen in the operating room. However, the complete certification process, during which surgeons must verify surgical experience, credentials, and training, is designed to identify examinees with sufficient evidence of both knowledge and skill in facial plastic and reconstructive surgery to justify the award of Diplomate status by the Board.

The certification process ultimately aims to improve the level of competence of practice in facial plastic and reconstructive surgery available to the public.

To safeguard the public and promote competent facial plastic surgery, the examination is annually reviewed and administered in accordance with *Standards for Education and Psychological Testing,* prepared jointly by the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. The Board has maintained high standards in test development and administration for its certification process so as to provide the highest quality examination program possible.

FORMAT OF THE EXAMINATION

Because facial plastic and reconstructive surgery is a highly complex field, the Board has determined that two examination formats are necessary to test an examinee's knowledge. The first part involves a written examination in multiple-choice format; the second part involves the use of an oral examination.

The written part is the most effective way to test for knowledge of facts, concepts, principles, and procedures; the interpretation of this knowledge; and the use of this knowledge to solve a patient's problems. The oral examination provides a meaningful complement in terms of testing for extended problem-solving ability.

The written test consists of 300 three- or four-option, multiple-choice test items. Of this total of 300 items, 50 are always new items that are undergoing field testing. These 50 items are not counted in an examinee's score, but the information collected about these items helps the Board decide if the items can be included in future examinations. This strategy of adding 50 new items each year ensures that the multiple-choice test will consist of high quality items and that the construction of the test will be consistent with current test construction practices.

The oral examination consists of three 50-minute sessions. Each session is spent with an oral examiner who presents four patient problems and, generally, a battery of eight to 12 related questions per problem. The examinee's answers to these questions determine the score he or she receives on each problem. In the three sessions, a total of 12 patient problems are administered, and 12 ratings of performance are made by the oral examiners.

EXAMINATION CONTENT

Generally, examination content is derived from published literature and from the curriculum of the AAFPRS Foundation fellowship program. Reading lists may be obtained from the ABFPRS office at (703) 549-3223 and the AAFPRS at (703) 299-9291.

The Written Examination

Guidelines for the allocation of items to the written examination are as follows:

ABFPRS WRITTEN TEST SPECIFICATIONS

Percentage	*Category*
15%	I. Basic Sciences
10%	II. Diseases and Disorders
(2%)	A. Congenital
(8%)	B. Acquired
75%	III. Management of Diseases and Disorders
(10%)	A. Medical Management
(25%)	B. Reconstructive Surgery
(40%)	C. Cosmetic Surgery

As noted in these guidelines, 15 percent of the written examination involves items dealing with basic sciences, 10 percent with diseases and disorders, and 75 percent with management of diseases and disorders. In addition to these topical classifications for items, each item also is classified into three categories representing various types of thinking.

- **Recall** involves the retrieval of information from memory.
- **Interpretation** involves the use of information, often requiring the examinee to draw conclusions based on photographs, line drawings, laboratory information, x-rays, CT scans, and the like.
- **Problem solving** also involves the use of information (usually about a patient) to draw a conclusion; however, the level of complexity of problem solving is considerably higher than the two previous types of thinking. Problem solving is distinguished from interpretation by its complexity; problem solving usually requires other mental activities, such as recall and interpretation.

Each year, the written test is carefully constructed using previously used items that have been field tested, approved, and classified according to the item classification guide (see Appendix A). These items are selected by the ABFPRS Examination Committee to conform to the test specifications. Candidates for certification can be assured that the content of the test will remain consistent with these specifications.

The Oral Examination

The oral examination consists of a total of 12 oral protocols (problem-solving exercises) consisting of a patient problem, laboratory information, photographs, and other information pertinent to the treatment of the patient. The questions in each protocol are intended to test the examinee's ability to treat the patient in a safe and effective manner. The questions are designed to probe into the various aspects of the problem-solving process that are part of normal practice in facial plastic and reconstructive surgery. The sum of the performance on each problem is represented by a rating, to be described in a subsequent section of this guide.

Generally, 60 percent of the oral problems deal with cosmetic aspects of facial plastic surgery, 33 percent deal with reconstructive surgery, and 7 percent deal with medical management.

Patient problems dealt with in the oral examination are not rare in nature, but rather are ones considered typical of the practice of facial plastic and reconstructive surgery. Therefore, examinees should not encounter problems with which they are totally unfamiliar.

HOW THE EXAMINATION IS PREPARED

The Written Examination

Each year the ABFPRS Resource Development Committee identifies topics for the development of items for the written examination. Committee members and selected facial plastic surgeons are commissioned to write new items. Then, the ABFPRS Examination Committee selects items for the written examination. As noted in the previous section, these selections are based on the content specifications. All items are prepared by highly knowledgeable facial plastic and reconstructive surgeons, edited by professional editors, and reviewed by senior level facial plastic and reconstructive surgeons. Further, these items are field tested in prior examinations before actually being used to compute an examinee's score. Items being field tested are used in the test but not counted in computing a total score.

Once items are chosen for the written examination, the items are assembled into a draft test, which is reviewed by the ABFPRS Examination Committee. A key is prepared that describes the content specifications of each item as well as the correct response. This information is used to ensure that the test is properly scored and that it meets the content specifications described earlier in this guide.

The difficulty of the test also is controlled relevant to the passing score so that it is constant and equal for examinees regardless of the year the test is taken.

The Oral Examination

Each year, the ABFPRS Resource Development Committee identifies the topics of the oral examination for the next year. Committee members and senior facial plastic and reconstructive surgeons are commissioned to write the oral protocols. Each is based on an actual patient. These protocols are reviewed by the chair and other members of the committee. Each protocol also is edited by a professional medical test editor. The ABFPRS Examination Committee selects the protocols to be used at each session of the oral examination.

HOW THE EXAMINATION IS ADMINISTERED

The examination is scheduled once each year in Washington, D.C., in June. Specific dates for current and future year examinations may be obtained by calling the ABFPRS office at (703) 549-3223.

The written and oral examination is administered over one weekend. Examinees must travel to Washington, D.C., and it is strongly advised that they stay in the hotel where the examination is scheduled. Many elect to arrive Friday evening so as to get settled and prepare for the long and arduous weekend ahead. The first mandatory events are registration and orientation, beginning at 8:00 a.m. Saturday. During the registration session examinees will receive their individual examination schedules. Any examinee who fails to attend registration and orientation may forfeit his or her place at the examination.

The Written Examination

The written examination takes five hours to administer, and is divided into two equal parts, each lasting two and one-half hours. As described in an earlier section, the entire written examination consists of 300 multiple-choice test items, with each part containing 150 items.

The written examination is given in a room with comfortable and private seating. Examinees are NOT permitted to bring any articles with them to the examination room. Personal items must be left in the sequester room or, better, not even brought to the examination site.

The written examination proctor will seat examinees and instruct examinees about the proper completion of the answer sheets and other matters of test administration.

Restroom breaks are permitted only upon permission of a proctor. Only one person is permitted to leave the room at a time. Telephone calls may NOT be made or received during the examination.

Examinees are NEVER to discuss the test with other examinees or with proctors unless there is an irregularity. Irregularities should be brought to the proctor's attention immediately. Proctors are instructed NOT to discuss the meaning of test items or the issues or problems represented by the items.
Pencils are provided. No calculators or other materials are needed nor should they be brought to the examination room.

The proctor will announce, on the hour, the time remaining for each part of the examination. When 30 minutes remain in the examination period, the proctor will make the appropriate announcement. When 10 minutes remain, the proctor again will make an appropriate announcement. The proctor will make a final announcement two minutes before the examination's conclusion.

As examinees finish each part of the examination, they will submit their materials to a proctor and remain quietly until all materials have been checked. When the test supervisor is satisfied that all materials are collected, examinees will be dismissed. In some circumstances, the group of examinees will be ushered to a room for sequestration. No one will be permitted to leave during the last 15 minutes of the examination.

The Oral Examination

The oral examination takes three hours to administer. It consists of three 50-minute sessions, each session containing four patient problems. Generally, each problem contains eight to 12 related questions. After the last oral examination session, examinees are usually debriefed by an oral examiner before being dismissed or sequestered. This debriefing is important and informative, and also provides a chance for examinees to give feedback about the examination process.

As with the written examination, examinees are advised not to bring materials to the examination. All materials relevant to the examination will be provided by the oral examiner.

Examination Weekend Schedule

All examinees are randomly divided into examination cohorts, depending upon the number of examinees sitting the examination and the number of oral examiners available. The cohorts will stay together each day of the examination weekend, receiving each part of the written examination at one time and the oral protocols at another. Each cohort may vary in the sequence and schedule of examinations. There are two cohorts, which proceed through the weekend as follows: Examinees will be sequestered each day as necessary to ensure the security and integrity of the examination process. Lunch will be provided for cohorts with scheduled breaks.

		Cohort 1	Cohort 2
Saturday	9am-12pm	Written A	Written A
Saturday	1pm-4pm	Written B	Written B
Sunday	9am-12pm	Orals 1, 2, & 3	Free Time
Sunday	1pm-4pm	Dismissed	Orals 1, 2, & 3

HOW THE EXAMINATION IS SCORED AND REPORTED

The scoring and reporting of the examination comprise a highly complex process, which is why several weeks pass before examinees receive the examination result. Since the score is an important aspect of the examination process, great care is taken to ensure that tests are properly scored and that the score report provides a complete and accurate description of the results.

This section describes how the score is computed and evaluated to make a pass/fail decision.

The examination contains a total of 750 points, with 375 points represented in the written examination and 375 points represented in the oral examination.

Examinees must achieve a score of 250 points or higher on EACH the written and the oral examinations, for a total minimum passing score of 500 points. Examinees who do not receive passing scores on one or both parts of the examination may sit again for the examination at any offering within five years from their first examination date without submitting a new application. Examinees may retake only that part of the examination (written or oral) that they failed. If passing scores are not received on both written and oral examinations after sitting three times for the examination, the ABFPRS Board of Directors may require examinees to complete additional training before being eligible to reapply for the examination.

The Written Examination

When the written examination is completed, examinees will return their test booklets and answer sheets to the test proctor, who, in turn, will return all materials to the test supervisor for counting and processing. The written examination answer sheets are electronically scanned and computer scored using the key. A computerized item analysis is used to determine if any item failed to perform adequately. The ABFPRS Examination Committee reviews any poorly performing items to determine key changes, elimination of the item, or other revisions. Such procedures assure the reliability of the examination. Once the key is verified, the test answer sheets are re-scored electronically. For examinees whose scores are very close to the passing standard of 4.0, the answer sheets are hand-scored. When the set of scores is verified, the scores are algebraically converted to standard scores, and the passing score of 250 is used to determine who passes and fails the written examination.

The Oral Examination

In each session, the oral examiner completes a rating form (see Appendix B) where the performance for each of the four oral protocols receives a rating from 1.0 to 7.0. The examinee receives a total of 12 ratings, one for each oral protocol. The average of these ratings constitutes the score. An average score of 4.0 or higher is required to pass. After scores are averaged, they are algebraically converted to standard scores, and the passing score of 250 is used to determine who passes and fails the oral examination.

Oral examiners' ratings are carefully studied for potential biases to assure that the performance of oral examiners is consistently of high quality. During debriefings after the oral examination, examinees will have an opportunity to express concerns about any irregularities in the oral examination.

Right to Review

In accordance with the *Standards for Educational and Psychological Testing,* the Board provides an appeal process to any examinee who wishes his or her examination scores reviewed. An administrative fee of $300 is charged for the review. This fee covers rescoring the written examination and providing the examinee with a detailed analysis of test performance according to content areas of the examination. A complete review of the oral examination also is conducted, and the total examination score is re-computed. The review does not include access to written test booklet, answer keys, or other secure test materials.

Requests for review must be made within six months following the examination. The review process will be completed no later than three months prior to the next examination. The Board reserves the right to make appropriate rulings, interpretations, decisions, and departures from the *Standards,* and its decisions are not subject to further appeal. The review process is the exclusive remedy for a dissatisfied examinee.

■ PREPARING FOR THE WRITTEN EXAMINATION

This section is devoted to helping examinees prepare for the written examination. The advice contained here is mainly in the category of test-taking strategies. However, all examinees should realize that the best preparation for an examination of this type consists of high quality training, regular self-study, and relevant experience in facial plastic and reconstructive surgery. This section merely provides advice on how to take written tests, particularly a test that features highly technical information and patient problems requiring higher level thinking.

Test-taking skills are important not only to the examinee's success, but also to the examination's success. Uniform test-taking skills among all examinees for certification help to eliminate the bias that comes from a lack of these test-taking skills. Examinees may fail to perform up to their level of capability because of a lack of these test-taking skills. Having test-taking skills thus eliminates one handicap to scoring up to one's capability.

This section is divided into five categories of behavior.

Test Anxiety

Test anxiety is the tendency to perform below capability due to psycho-physical reactions that are normally beyond the control of the examinee. Some researchers have estimated that one of every four persons is negatively affected by test anxiety. The stress and pressure of test-taking, particularly in a Board examination, are likely to induce test anxiety.

Serious forms of test anxiety should be treated by a qualified professional. They are treatable and correctable. Less serious forms of test anxiety can be overcome by acquiring test-taking skills and by having a sound educational preparation for the test. The higher the level of knowledge, the less chance there is for eliciting test anxiety. A good study program prior to the examination should diminish the role of test anxiety. The mastery of the skills described here also should improve the chances for eliminating anxiety.

Time-use Strategy

The Board's written test takes five hours to complete. This is an average of one minute per item, 300 items for 300 minutes. Most examinees finish before the time limit; however, the use of time is critical to maximizing performance.

Based on the true level of knowledge and individual educational experiences, some items will be very easy and some items will be very difficult. With this knowledge, there are several steps that may be taken:

- Set up a schedule for how to complete the test. Don't forget to monitor progress throughout the test. Allow enough time at the end of the test for a review of selected, difficult items. Keep time with a wristwatch, and pace responses to test items accordingly.

- Work rapidly, answering the items that are easy. For items that are hard, omit a response and mark the item in the test booklet. Review these items later. Also make notations in the test booklet next to these hard items if relevant information may help later in decision-making.

- Review those difficult items later. If the correct option cannot be confidently identified, make an "educated" guess. This is perfectly legitimate, because partial knowledge of the content represented by the item will help increase the probability of selecting the right answer. Collectively over the entire test, this partial knowledge is realized by a high degree of successful guessing and a higher score.

Error-avoidance Strategy
This section is devoted to avoiding errors that will cost precious test score points.

- Read directions carefully. Understand that the pencil marks on the answer sheet are the official record. These must be made clearly and correctly. There should be only one mark per item. Multiple marks will result in the item being scored as incorrectly answered.

- Read each item carefully to understand what is being asked or expected in the answer.

- Check the answers on the answer sheet at the end of the test period. Make certain that all items are answered. Make sure that the fifth position (E) is NOT marked because this is a three- and four-option test (ABCD).

Guessing Strategy
There is no penalty for guessing. Therefore, all examinees are encouraged to make "educated" guesses on any items for which the answer is not known. This strategy is perfectly ethical and ensures that all examinees have the same benefits during the test. Therefore, no items should be unanswered.

Deductive Reasoning Strategy
Contrary to popular folklore, the first choice that comes to mind is NOT always the best choice. In fact, there is substantial literature that shows that continued study of an item will improve the overall score. Answers may be revised after pondering a problem or thinking through a test item. Of course, doing this takes time, and time is limited. Make sure the schedule allows this time for deductive reasoning.

There are some very specific things to help with deductive reasoning for each item:

- Eliminate implausible options. These are options that are clearly wrong. Sometimes three implausible options can be eliminated, leaving only the right answer. With the elimination of implausible options, chances for an "educated" guess improve, as does the total test score.

- Sometimes other items may provide information about the problem presented in an item. Although such cluing is unintended, long tests often provide opportunities for such clues.

Item Faults
Some multiple-choice tests contain items with a host of flaws that give away the obvious right answer. Longest options are often right. The right answer is usually in the third position. Wrong answers all look alike.

There is no point in learning these specific test-taking skills, because the Board's written examination item bank has been rigorously reviewed to eliminate such item-writing faults. A multitude of checks and balances has been employed to ensure that the Board's multiple-choice items are relatively free of such flaws.

Sample Items
Appendix C provides several sample items of the kind used on the Board's written test.

■ PREPARING FOR THE ORAL EXAMINATION

The oral examination consists of three intense 50-minute sessions. In one 50-minute session, four patient problems are presented, and the examinee is asked eight to 12 questions about each problem. The oral examiner is permitted to probe more deeply into a response to determine the specific understanding required of a qualified facial plastic and reconstructive surgeon.

There are definite test-taking skills for oral examinations. Seldom do examinees have opportunities for practice in this area. The advice below is intended to assist in presenting the truest level of competence, without handicaps due to poor test-taking skills.

As with the written test, the best preparation for the oral examination is sound training, experience, and a strong commitment to learning, manifested in an extensive program of scholarship through professional training and development. In other words, there are no shortcuts.

DOs and DON'Ts about the Oral Examination

1. The examination calls for a maximum effort. Examinees should be physically and mentally well prepared.

2. Avoid any reference to the examiners: for example, their preferred name, reputation, where they live, and what they do. All of this is irrelevant to the examination and its purpose. Avoid any personal discussion. Examiners are instructed also to avoid personal conversations.

3. Answer questions directly and briefly. Since only 50 minutes is allotted for up to 48 questions and answers, responses must be kept to the point. If you do not know an answer, be honest and report so. The tendency to "bluff" through a response may result in low performance ratings.

4. There is a host of verbal behavior patterns to be avoided in making an oral response to a question. Such habits are detrimental to good performance. Some of these are briefly reviewed here:

    - *Unnecessary references to the literature to impress the oral examiner.* The use of references is important in justifying a response. However, this can be overdone or misused, particularly if the intent is to impress the examiner with the high level of scholarship.

    - *Flattery.* Oral examiners are well schooled not to be influenced by such superficial tactics to win high ratings.

    - *Lengthy answer.* Given that most professionals are highly able and talented individuals who are reasonably compulsive, there is a tendency to give long answers. As pointed out previously, answers should be brief and to the point. Lengthy answers are often interpreted as a ploy to overwhelm the oral examiner with irrelevant information. Therefore to reiterate earlier advice, answers should be complete but brief.

    - *Rapid, aggressive talking.* A natural tendency under the pressure of an oral examination is to talk rapidly and overconfidently. This prevents the oral examiner from probing or moving on to the next question. While the strategy may seem to work, it has an overall negative effect on ratings and should be avoided.

    - *Excessive vocabulary.* The proper use of terms is critical in making a favorable impression. However, this can be carried to extremes with vocabulary that is excessive. Principles of effective oral communication apply, and with that goes the use of appropriate vocabulary.

    - *Right answers to other questions.* Another tactic to create a good impression is to answer another, unasked question when the answer to the question that is asked is not known. This action implies that maybe the examiner can be impressed with knowledge of something else. This tactic may seem to work but also has negative effects on ratings.

Sample Protocol

Appendix D contains a sample protocol, one that contains the oral examiner's line of questioning and a model answer. This is intended to provide an accurate glimpse into the nature of the oral examination and to assist in preparing how to respond in the oral examination.

Summary

To summarize, the oral examination is a stressful event. The presentation of 12 patient problems and the related lines of questioning are difficult for examinees at any level of competence. To maximize performance, sound training, relevant experience, and broad scholarship will help overcome handicaps that may negatively affect oral examinees.

APPENDIX A: WRITEN ITEM CLASSIFICATION GUIDE

I. Basic Sciences

A. Gross Anatomy
1. Auricle
2. Cheek
3. Chin/Zygoma/Maxilla/Sinus
4. Esophagus
5. Eyebrow
6. Eyelid
7. Forehead/Temple
8. Larynx/Trachea
9. Lips
10. Mouth/Oral Cavity/Dental/Salivary Glands
11. Neck
12. Nerves
13. Nose
14. Orbit/Lacrimal/Eye/Globe
15. Pharynx
16. Scalp/Skull
17. Other

B. Biochemistry

C. Embryology

D. Genetics

II. Diseases and Disorders

A. Congenital
1. Genetic
2. Non-genetic (Familial)

B. Acquired
1. Degenerative
2. Developmental
3. latrogenic/Complications
4. Idiopathic
5. Infectious
6. Inflammatory
7. Metabolic/Endocrine
8. Neoplastic Benign
9. Neoplastic Malignant
10. Psychogenic
11. Traumatic
12. Vascular
13. Other

III. Management of Diseases and Disorders

A. Medical Management
1. Complications
2. Diagnosis/Assessment (Hematology, Radiology, Special Tests)
3. Disease Prevention
4. Emergencies
5. Medico-legal
6. Office/Ambulatory
7. Psychology/Psychiatry
8. Rehabilitation
9. Treatment-Preoperative
10. Treatment-Intraoperative
11. Treatment-Postoperative
12. Treatment-Nonoperative
13. Other

B. Reconstructive Surgery
1. Complications
2. Congenital Defects
3. Emergencies
4. Laser
5. Neoplasia/Ablation
6. Orthognathic/Dental
7. Scar Revision
8. Septal/Sinus Surgery
9. Skeletal/Maxillofacial/Craniofacial
10. Soft Tissue - 1°, 2°, Mohs
11. Soft Tissue - Grafts
12. Soft Tissue - Flaps
13. Soft Tissue - Techniques
14. Trauma - Soft Tissue
15. Trauma - Skeletal
16. Other

C. Cosmetic Surgery
1. Blepharoplasty
2. Chemical Peel/Skin Exfoliation
3. Complications
4. Dermabration
5. Direct Brow Lift
6. Emergencies
7. Forehead Lift
8. Filling Agents/Implants
9. Hair Replacement
10. Laser
11. Liposuction/Lipoaugmentation
12. Malar/Submalar Augmentation
13. Otoplasty
14. Rhinoplasty
15. Rhytidectomy
16. Skeletal Augmentation
17. Other

APPENDIX B: RATING FORM FOR ORAL EXAMINATION

Instructions: Circle or fill in the blank for each section.

1. Examinee Identification Number: _____

2. Oral Examiner: _____

3. Session:

ORAL 1	ORAL 2	ORAL 3
Sunday 9:00 a.m. - 10:00 a.m.	Sunday 10:00 a.m. - 11:00 a.m.	Sunday 11:00 a.m. - 12:00 p.m.
Sunday 1:00 p.m. - 2:00 p.m.	Sunday 2:00 p.m. - 3:00 p.m.	Sunday 3:00 p.m. - 4:00 p.m.

4. Oral Protocol #: **Score:**

1	1	2	3	4	5	6	7
2	1	2	3	4	5	6	7
3	1	2	3	4	5	6	7
4	1	2	3	4	5	6	7
5	1	2	3	4	5	6	7
6	1	2	3	4	5	6	7
7	1	2	3	4	5	6	7
8	1	2	3	4	5	6	7
9	1	2	3	4	5	6	7
10	1	2	3	4	5	6	7
11	1	2	3	4	5	6	7
12	1	2	3	4	5	6	7

NOTE: Protocols are to be graded separately, not as a group. Circle the appropriate rating you ascribe for each protocol given, according to the following rating scale:

7 = OUTSTANDING PERFORMANCE - Response to protocol was what might be expected from an **outstanding** facial plastic surgeon.

6 = VERY GOOD PERFORMANCE - Response to protocol was what typically might be expected from a **highly competent** facial plastic surgeon.

5 = GOOD PERFORMANCE - Response to protocol was what typically might be expected from a **competent** facial plastic surgeon.

4 = MARGINAL PERFORMANCE - Response to protocol was what typically might be expected from a **barely competent** facial plastic surgeon.

3 = FAILING PERFORMANCE - Response to protocol indicates **incompetent** professional practice.

2 = FAILING PERFORMANCE - Response to protocol indicates **incompetent** and **unsafe** professional practice.

1 = FAILING PERFORMANCE - Response to protocol indicates **incompetent** and **unsafe** professional practice, and **no clinical comprehension** of the problem.

5. Comments: Please note any examination irregularities or observations about the examinee.

_____

APPENDIX C: EXAMPLES OF MULTIPLE-CHOICE ITEMS

1. Nasal avulsion most commonly involves the:
A. bony dorsum.
B. cartilaginous dorsum.
C. tip.
D. ala.

2. A melanoma on the cheek of a 66-year-old man is 1 x 0.5 cm in surface area and 0.5 mm deep, extending into the papillary dermis. According to Clark, the melanoma would be classified as Level:
A. II.
B. Il-A.
C. III.
D. Ill-A.

3. An apparently nonviable 2 x 3 cm area is noted in the non-hair-bearing postauricular region of a patient who underwent a rhytidectomy six days ago. Recommended management consists of:
A. immediate excision, with skin grafting if necessary.
B. prompt excision and repair with a rotation flap.
C. prompt excision and primary closure after lateral undermining.
D. serial debridement and healing by secondary intention.

Items 4 and 5 Refer to Figure 1.

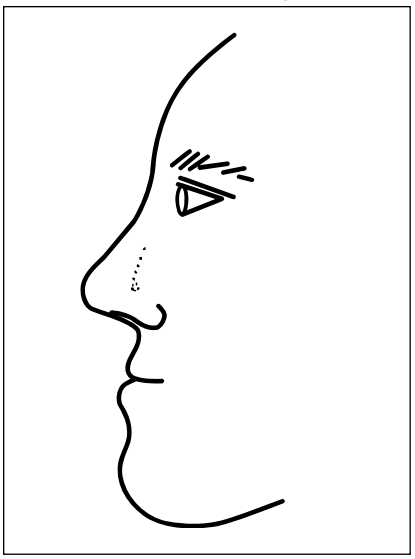


Figure 1

4. Figure 1 depicts what nasal deformity?
A. Polly beak deformity
B. Nasal tip ptosis
C. Columellar retraction
D. Alar flaring

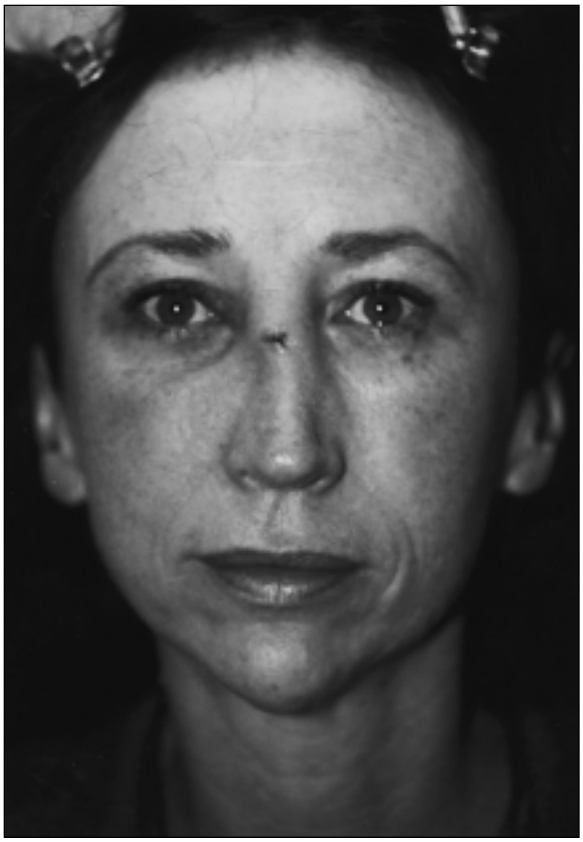
5. The most appropriate correction of the deformity in Figure 1 consists of:
A. shortening the nasal septum.
B. placement of a columella strut of plumping graft.
C. cephalic trimming of the lower lateral cartilages.
D. conservative trimming of the alar nasal sils.

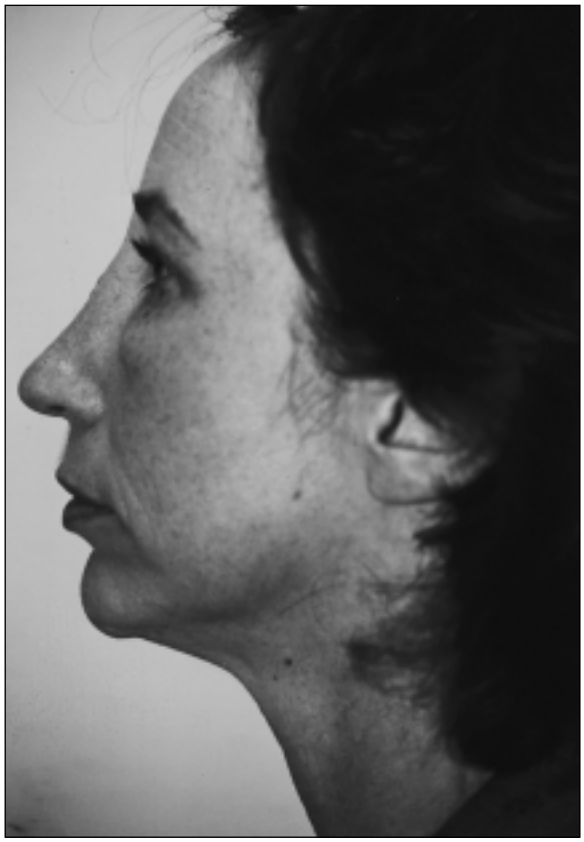
Answers: 1-D 2-A 3-D 4-C 5-B

APPENDIX D: SAMPLE ORAL PROTOCOL

EXAMINER INFORMATION
Oral Protocol XYZ

Examinee Information
A 43-year-old white woman who underwent a septorhinoplasty three years ago has bilateral obstruction of the nasal airways. Examination reveals an S-shaped septal deformity anteriorly and posteriorly. The left septum deviates off the maxillary crest.





Proposed Line of Questioning

1. **How would you describe the defects shown in these preoperative photographs?**
   The bony cartilaginous pyramids are separated and the cartilaginous pyramid is displaced to the left. The nasal tip is pinched, and there is alar collapse on the left side. The dorsum has been overresected. There is obvious asymmetry and ptosis of the nasal tip.

2. **When this patient undergoes rhinoplasty, what would be the advantages of an external approach?**
   An external approach allows increased exposure, an opportunity to correct the problems already discussed, and an opportunity to diagnose any further problems. It also allows more precise suturing of grafts.

3. **Exposure of the airways reveals that both lower level cartilages have been unevenly resected, and that both are over-resected. The left lower lateral cartilage has a fracture deformity. How would you correct these deformities?**
   The remaining lateral portions of the lower lateral cartilages should be augmented or resected to provide symmetry and support, and should be divided at the dome, so that the knuckle of the left cartilaginous fracture site is repositioned. The domes should then by appropriately sutured.

4. **The media crura, caudal septum, and membranous septum have been over-resected, resulting in nasal tip ptosis and loss of tip support. How would you correct these deformities?**
   Tip support should be provided by an autogenous cartilaginous strut. The crural caudal septum should be sutured, with shield grafting of the nasal tip.

5. **How would you correct the over-resection of the nasal dorsum?**
   The dorsum should be augmented with an autogenous cartilage graft taken from the septum or ear, or with a bone graft using the hip or cranium, or an alloplastic graft material.

6. **During surgery, you discover an open roof defect of the nasal dorsum. How would you correct it?**
   Medial and lateral osteotomies are the treatment of choice. Multiple osteotomies may be appropriate. If necessary, a dorsal augmentation graft should be used.

7. **You discover a great deal of scarring in the supratip area. How would you manage this?**
   The appropriate amount of scar tissue should be resected and the patient should be followed postoperatively.

8. **Several months after surgery, there is a return of the supratip fullness and of the polly beak deformity. What should you do?**
   When these deformities are noted, injections of a steroid should be begun.