Hotel Room #1438

Meredith Barrett, MD

I did not pass boards on my first attempt when I took it in a hotel room. When I took the exam this year, I was in in my hospital, in the town I live, in my office. I cannot fully express how this change in location benefited my psyche. To clarify, I did not experience any mistreatment while testing in person, nor do I suspect that the delivery of the questions was any different for me than it was for my male colleagues. In fact, I am sure that the hotel room format had its discomforts for them as well. Further, I am not blaming my failure on the environment in which I was tested, but I can assure you it did not help. Oral exams are innately flawed in their inability to recreate the clinical scenario for which you are being tested—but I know we can do better than a hotel suite with a bed within eyeshot. Since the certifying exam was first administered, the world of surgery and the education of its trainees has vastly changed. The demographics of the doctors taking this exam have become much more diverse; however, the examination process has failed to reflect this modernization or appropriately welcome the broadening of our field. Additionally, recent data suggests that certain races, ethnicities, and genders may be disadvantaged with this certification format. The COVID-19 pandemic has illustrated that we can utilize technology to keep our patients safe at home and optimize their interactions virtually. I suggest we treat our newest and most vulnerable surgical colleagues with the same respect.

Consider this a call to action. Any high-stakes exam in any medical subspecialty should be rigorously assessed. Examination boards should evaluate whether any step of their process disadvantages a potential examinee. For example, asking applicants to travel long distances for certification can add unnecessary financial, psychological, and family stress. Equally important, environments such as hotel rooms invite unnecessary psychological tension and intensify the discomfort of power differentials. We must optimize environments for examinees as well. A virtual examination format without the burden of travel may allow for a broader examinee population, which will further enrich and validate the process.

Let us make a seemingly small change that could result in enhanced equity and over due positive outcomes. Let us work to build psychological safety within our assessment structures and look to eliminate disadvantages that exist for individuals before they step foot into the exam room. Let us be innovative in our assessments rather than defaulting to the way we have always tested. The argument that every other board-certified surgeon has gone through this process before does not suffice. This exam should be a test of ability, not a rite of passage. We cannot continue to do the same thing just because it has been that way for decades. Surgical innovation is retained for tradition rather than function. COVID-19 has pushed us to imagine alternative processes: telehealth expansion, virtual Grand Rounds and society conferences, education via Zoom. The American Board of Surgery certifying exam process is another example. In the setting of the COVID-19 pandemic, for the safety of all participants, the board rerouted the exam from hotel rooms in Philadelphia to a virtual environment. A change that was long overdue. Why should we, as a profession striving to achieve equity, ask candidates to prove their knowledge within an antiquated and gender biased format? I would not allow my best friend to enter a hotel room with 2 males she did not know—should the future of my surgical career be decided there? Oral examinations have been disputed for decades. Proponents praise their ability to assess problem solving and reasoning while fostering a personal connection to the examinee, while opponents have questioned the validity and fairness of these innately subjective exams. To achieve their objective of assessing surgeon competence, oral examinations must be valid, reliable, and fair. The board has worked hard to train and proctor examiners on proper questioning as well as limiting either negative or positive feedback to examinees. Further, providing examinees a structured curriculum and examination process allows for increasing validity and reliability of the test. But I disagree that it is possible for an examination delivered in a hotel room to achieve the third tenant of fairness.

Keywords: certification, education, equity, gender


“Wait outside the door. You will be allowed to enter when the examiners are ready.”

These are the instructions that repeat in my head as I stand in the seemingly endless hallway of an upscale Philadelphia hotel room. I am surrounded by other examinees; we stand in a collect nervous silence. No one says a word. In these pivotal moments, it’s hard not to reflect on the journey that brought me here. I had spent the last seven years of my life working arduous hours—reading about different pathologies, honing my technical skills, and taking care of patients. I had sacrificed time with family and friends to reach this day. As a woman in surgery, parts of my training were statistically and anecdotally harder. I stare at the placard on the hotel room door; #1438. It suddenly swings open and invites me in. Two senior male surgeons greet me.

Let me emphasize that: in order to be a certified general surgeon, I had to be allowed into a hotel room with 2 men that I did not know.

The COVID-19 pandemic has brought more bad than good, more suffering than joy, more loss than gain. But one thing we must take from this pandemic is the opportunity to identify structures retained for tradition rather than function. COVID-19 has pushed us to imagine alternative processes: telehealth expansion, virtual Grand Rounds and society conferences, education via Zoom. The American Board of Surgery certifying exam process is another example. In the setting of the COVID-19 pandemic, for the safety of all participants, the board rerouted the exam from hotel rooms in Philadelphia to a virtual environment. A change that was long overdue. Why should we, as a profession striving to achieve equity, ask candidates to prove their knowledge within an antiquated and gender biased format? I would not allow my best friend to enter a hotel room with 2 males she did not know—should the future of my surgical career be decided there?

Oral examinations have been disputed for decades. Proponents praise their ability to assess problem solving and reasoning while fostering a personal connection to the examinee, while opponents have questioned the validity and fairness of these innately subjective exams. To achieve their objective of assessing surgeon competence, oral examinations must be valid, reliable, and fair. The board has worked hard to train and proctor examiners on proper questioning as well as limiting either negative or positive feedback to examinees. Further, providing examinees a structured curriculum and examination process allows for increasing validity and reliability of the test. But I disagree that it is possible for an examination delivered in a hotel room to achieve the third tenant of fairness.

From the University of Michigan, Ann Arbor, MI. mebarret@med.umich.edu. The authors report no conflicts of interest.

Copyright © 2021 Wolters Kluwer Health, Inc. All rights reserved.
ISSN: 0003-4932/21/27402-0229 DOI: 10.1097/SLA.0000000000004889

Hotel Room #1438

Meredith Barrett, MD

I did not pass boards on my first attempt when I took it in a hotel room. When I took the exam this year, I was in in my hospital, in the town I live, in my office. I cannot fully express how this change in location benefited my psyche. To clarify, I did not experience any mistreatment while testing in person, nor do I suspect that the delivery of the questions was any different for me than it was for my male colleagues. In fact, I am sure that the hotel room format had its discomforts for them as well. Further, I am not blaming my failure on the environment in which I was tested, but I can assure you it did not help. Oral exams are innately flawed in their inability to recreate the clinical scenario for which you are being tested—but I know we can do better than a hotel suite with a bed within eyeshot. Since the certifying exam was first administered, the world of surgery and the education of its trainees has vastly changed. The demographics of the doctors taking this exam have become much more diverse; however, the examination process has failed to reflect this modernization or appropriately welcome the broadening of our field. Additionally, recent data suggests that certain races, ethnicities, and genders may be disadvantaged with this certification format. The COVID-19 pandemic has illustrated that we can utilize technology to keep our patients safe at home and optimize their interactions virtually. I suggest we treat our newest and most vulnerable surgical colleagues with the same respect.

Consider this a call to action. Any high-stakes exam in any medical subspecialty should be rigorously assessed. Examination boards should evaluate whether any step of their process disadvantage a potential examinee. For example, asking applicants to travel long distances for certification can add unnecessary financial, psychological, and family stress. Equally important, environments such as hotel rooms invite unnecessary psychological tension and intensify the discomfort of power differentials. We must optimize environments for examinees as well. A virtual examination format without the burden of travel may allow for a broader examinee population, which will further enrich and validate the process.

Let us make a seemingly small change that could result in enhanced equity and over due positive outcomes. Let us work to build psychological safety within our assessment structures and look to eliminate disadvantages that exist for individuals before they step foot into the exam room. Let us be innovative in our assessments rather than defaulting to the way we have always tested. The argument that every other board-certified surgeon has gone through this process before does not suffice. This exam should be a test of ability, not a rite of passage. We cannot continue to do the same thing just because it has been that way for decades. Surgical innovation is retained for tradition rather than function. COVID-19 has pushed us to imagine alternative processes: telehealth expansion, virtual Grand Rounds and society conferences, education via Zoom. The American Board of Surgery certifying exam process is another example. In the setting of the COVID-19 pandemic, for the safety of all participants, the board rerouted the exam from hotel rooms in Philadelphia to a virtual environment. A change that was long overdue. Why should we, as a profession striving to achieve equity, ask candidates to prove their knowledge within an antiquated and gender biased format? I would not allow my best friend to enter a hotel room with 2 males she did not know—should the future of my surgical career be decided there?

Oral examinations have been disputed for decades. Proponents praise their ability to assess problem solving and reasoning while fostering a personal connection to the examinee, while opponents have questioned the validity and fairness of these innately subjective exams. To achieve their objective of assessing surgeon competence, oral examinations must be valid, reliable, and fair. The board has worked hard to train and proctor examiners on proper questioning as well as limiting either negative or positive feedback to examinees. Further, providing examinees a structured curriculum and examination process allows for increasing validity and reliability of the test. But I disagree that it is possible for an examination delivered in a hotel room to achieve the third tenant of fairness.

From the University of Michigan, Ann Arbor, MI. mebarret@med.umich.edu. The authors report no conflicts of interest.

Copyright © 2021 Wolters Kluwer Health, Inc. All rights reserved.
ISSN: 0003-4932/21/27402-0229 DOI: 10.1097/SLA.0000000000004889
I will conclude with this statement:

The validity of one’s medical training cannot be decided in a hotel room.

This perspective describes my experience taking the American Board of Surgery Oral Boards examination. My objective in writing this perspective was to share my story firsthand, not to speak for all examinees or women. It is in no way meant to be reflective of all new graduates, in particular women—although my opinions on the topic are not novel or unique. Further, I acknowledge and appreciate the work that the American Board of Surgery has recently undertaken to mitigate biases in its examination processes. I am proud to be a board-certified surgeon and to serve alongside a community that holds itself to the highest and fairest standards. This includes the expectation that we can, and must, speak up regarding policies, cultures, and practices that can be further improved. Thank you to Annals of Surgery for providing the platform to share my voice.

ACKNOWLEDGMENT

Thank you to Alexandra Highet, MS; Seth Waits, MD; and Gurjit Sandhu, PhD for their thoughtful reviews of this manuscript as well as their support and allyship.

REFERENCES