

Operative Case Summaries

The American Board of Otolaryngology (ABO) requires a complete summary of each resident's cumulative operative experience throughout his or her residency as a condition for acceptance into the examination process for Board Certification. In other words, *you cannot become Board-Certified as an Otolaryngologist unless this list is satisfactorily completed.* Our department takes this summary very seriously, and each resident is responsible for keeping meticulous records tabulating his/her surgical experience. (Your experience during your General Surgery year(s) is not counted in this process.)

On a monthly basis, and at the completion of each rotation, and again annually, each resident will submit to the Program Director a list of his/her surgical cases documented in the ABO format. This format will be provided to every resident by the ABO via electronic mail.

As a practical matter, the best means of keeping track of your cases is to maintain a logbook of every patient you operate on. This log should contain the patient's name, diagnosis, hospital number (so you can retrieve records if necessary), and list of procedures performed. (Most hospital operating rooms supply an adhesive sticker or patient stamp that gives most of this information, which you may want to simply paste into your logbook and supplement with notes.) Although the ABO does not ask for all of this information, you will find that it is instructive for you to maintain it this way, and it greatly simplifies the ABO reporting process. Your book should be updated frequently, at least weekly, so that no omissions occur. Remember that if you do not have sufficient cases recorded, you may be rejected as a candidate for Board Certification.

All surgical procedures performed by a resident should be recorded in the case summary, including those managed in the emergency rooms, "minor surgery" suites, and clinic procedure rooms. Residents are advised to develop the habit of dictating all surgical procedures, regardless of the location in the hospital where the treatment was rendered, so that documentation is complete, and because when you dictate, you automatically receive a copy of the dictation for your records.