Orthopaedic Surgery
and Rehabilitation

# Resident / Fellow Handbook

## 2020 - 2021

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DEPARTMENT OF ORTHOPEDIC SURGERY AND REHABILITATION
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

# Purpose, Philosophy and Objectives

The Department of Orthopaedic Surgery and Rehabilitation maintains a three-fold purpose:

1. Exercise excellent patient care
2. Teach graduate and postgraduate students
3. Conduct clinical and laboratory research

The goal of the patient care program is to carry out the highest quality patient care that is concerned with the person's wellbeing and not limited to just the specific disease condition or symptoms that are manifest. This includes a high level of technical competence and skills, a concern for the whole person's physical and mental wellbeing and an integration of these two aspects so that the patient can return to full function. While maintaining high quality patient care, the Department continues to pursue excellence in the treatment of the whole patient through the example of compassionate care.

The objective of the teaching program is to conduct an outstanding program that will produce medical students who have the cognitive knowledge, practical skills, and attitudes that are appropriate for their level of education.

The goal of the residency program is to develop the physician's skill in the diagnosis of all musculoskeletal injuries, diseases, and afflictions while learning and performing the appropriate surgical and nonsurgical interventions, follow-up care, and rehabilitation with supervised training. The adequacy and appropriateness of this goal continue to be measured by the passing Board scores that are earned.

The goal of the research program is to conduct clinical and laboratory research that supports the patient care and teaching programs in advancing knowledge of the discipline. The potential for a solid research base is present.

# Hospital Procedures

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street
JACKSON, MISSISSIPPI 39216-4505

Department of Orthopedic Surgery
and Rehabilitation

Area Code 601
984-6525

**DEPARTMENT OF ORTHOPEDIC SURGERY AND REHABILITATION**
**CALL COVERAGE**

**Primary Orthopaedic Call During the Day: (6:30am to 5:00 pm)**

-Call the First call orthopaedic Pager (929-6223)

**Primary Othopaedic Call During the Night: (5:00pm to 6:30am)**

- Call the First call orthopaedic Pager (929-6223)

**Hand Call**

-During the Day (6:30am to 5:00pm)----First determine if orthopaedics or plastic surgery is on Hand Call, then if orthopaedics is on call, call the Hand Resident who's pager is listed on the call sheet

-During the night (5:00pm to 6:30am)----First, still determine if orthopedics or plastic surgery is on Hand Call, then if orthopaedics is on call, call the First call orthopaedic pager (929-6223)

**Pediatric Orthopaedics:**

-During the Day (6:30am to 5:00pm): Call the pager of the 3rd year resident on the pediatric orthopaedic surgery service, which is listed on the call sheet and changes every 3 months. The next person to call is the Chief resident on the pediatric orthopaedic surgery service, which is also listed on the call sheet

-During the Night (5:00pm to 6:30am): Call the first call orthopaedic pager: (929-6223)

ON CALL RESPONSIBILITIES

1. Prompt, courteous response to all calls is expected and mandatory.
2. All first call personnel are to notify the Chief Resident on call if there are any problems, backups or surgeries.
3. All first call personnel will remain in the hospital overnight.
4. First call personnel should never be away from the hospital.
5. The staff physician on call is to be notified of all patients going to surgery or admitted to the hospital.
6. Pager batteries are kept in the Administrative Office.

CALL SCHEDULE PREPARATION

The Chief Administrative Resident prepares the chief call schedule.

The 3rd year resident on B Service(Sports/F&A) prepares the back-up or second call schedule with a 3rd year covering first call on Fridays.

First Call is covered by the Trauma Float resident Sunday - Thursday with 2nd years covering 1st call on Saturdays.

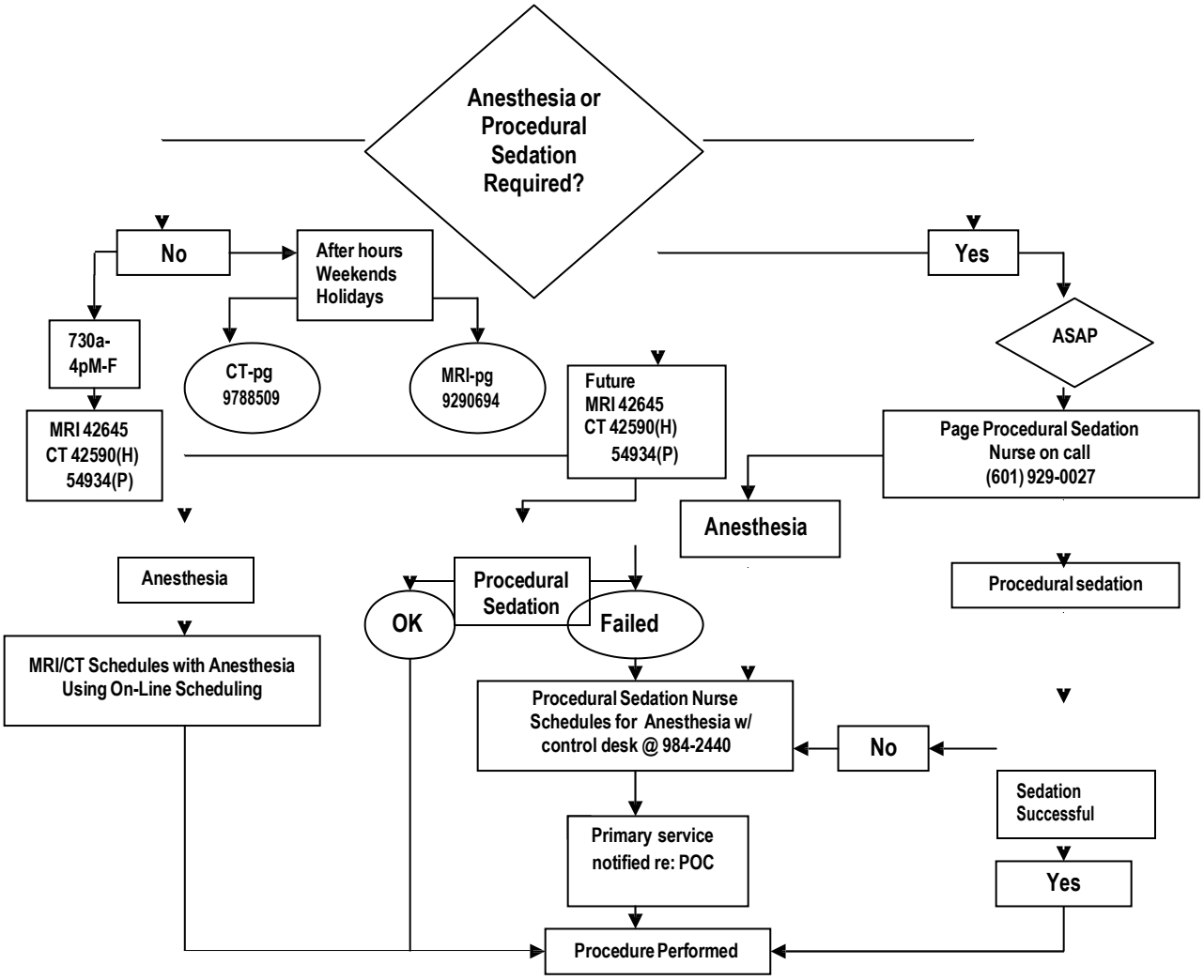
**All lists are due on Donna Reyer's desk (MT705) by the 10th of the preceding month !**

**You can email the list if you want – dreyer@umc.edu**
**Donna's phone number is 984-5146 – her fax is 984-5151.**

June 2013

# *CT/MRI Process*

## *Outpatients and Inpatients*




*H=Hospital P=Pavilion*

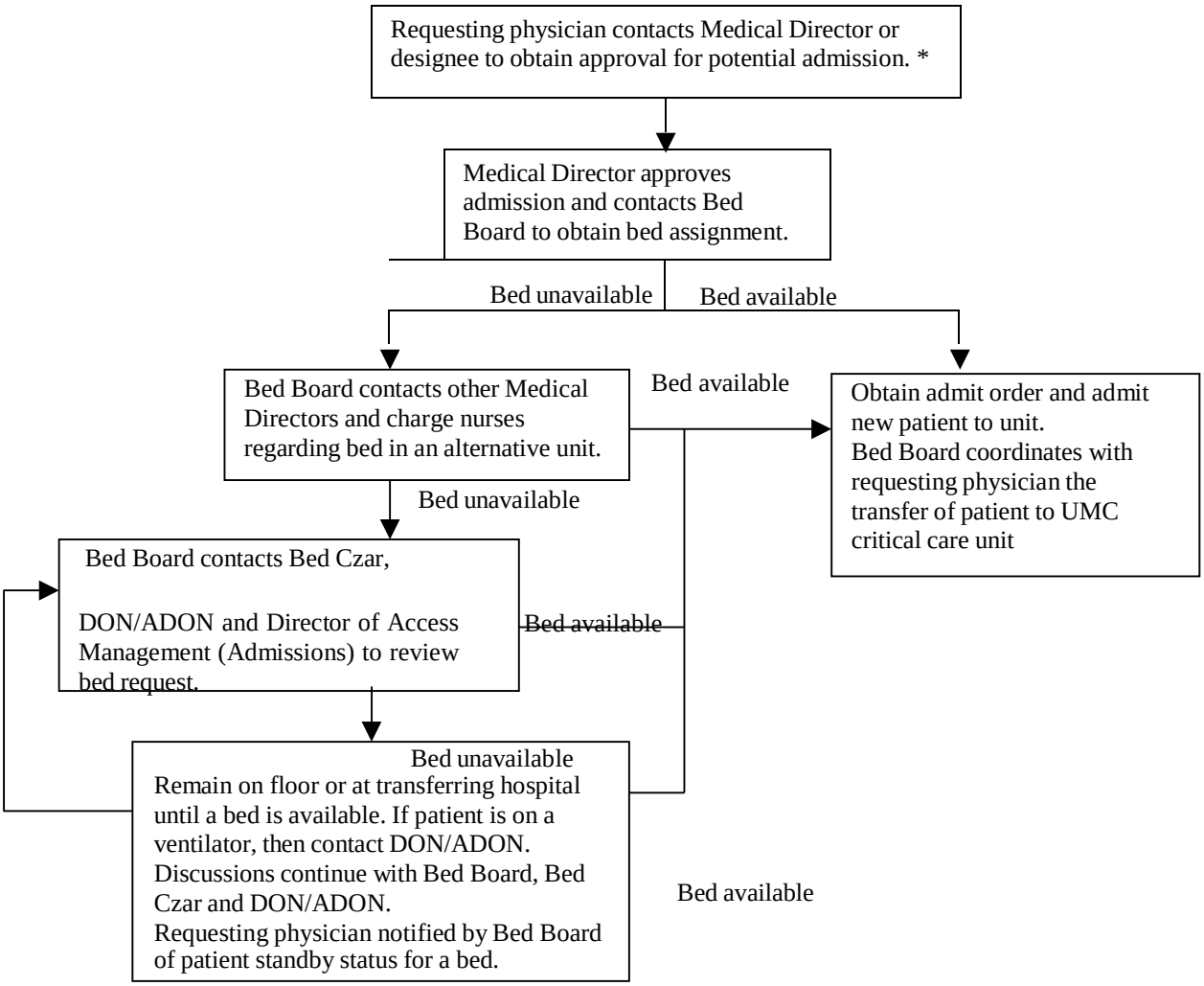
**CPT Codes**

**70551 – MRI Brain without Contrast**
**70552 – MRI Brain with Contrast**
**70553 – MRI Brain without and with contrast**
**72141 - MRI C-Spine without contrast**
**72156 - MRI C-Spine without and with contrast**
**72146- MRI T-Spine without contrast**
**72157- MRI T-Spine without and with contrast**
**72146- MRI L-Spine without contrast**
**72157- MRI L-Spine without and with contrast**
**71550 – MRI Chest without contrast**
**71552– MRI Chest without and with contrast**
**74181 - MRI Abdomen without contrast**
**74183– MRI Abdomen without and with contrast**
**72195 – MRI Pelvis without contrast**
**72197 – MRI Pelvis without and with contrast**

**71555 Angiography of Chest without and with contrast**
**74185 Angiography of Abdomen without and with contrast**
**72198 Angiography of Pelvis without and with contrast**
**73725 Angiography of L. Lwr Extremity with and without contrast**
**73725 Angiography of R. Lwr Extremity with and without contrast**

**MRI/CT Schedules for Anesthesia w/control desk 984-2440**

Algorithm for admission of a patient to any UMC Adult Critical Care Unit from any source




*** Information needed from requesting physician to be obtained by Medical Director:**

1. Patient's name
2. Facility transferring from name and number
3. Transferring physician name and number
4. Receiving physician name and number
5. Diagnosis
6. Financial class
7. Medical Record number

# UMC ORTHOPAEDIC ADMISSION PROTOCOL

1. Routine admissions from the Jackson Medical Mall Orthopaedic Clinic are scheduled by calling extension 42140. All admissions are to go through the Admissions Office.

2. Emergency admissions are handled as follows:

   A. 8:00 a.m. to 5:00 p.m., call 42140 and schedule.

*** B. If no beds are available, call admissions and find out which service has beds available. Contact the resident on that service and attempt to borrow a bed. If this is unsuccessful, Admissions and the Hospital Administrator on call must be notified by the resident in order to secure a bed. If any difficulties occur at this point, the Orthopaedic Chief Resident on call should be contacted.

   C. Night emergency admission are handled as in A & B.

3. Pavilion patients are to be handled through the appropriate Orthopaedic Department nurse by calling extension 46525.

4. Jackson Medical Mall Orthopaedic Clinic elective postings are to be handled through the appropriate Orthopaedic Department nurse by calling extension 46525.

5. AM admissions for surgery are scheduled by calling 42140 for admissions.

## HISTORY AND PHYSICAL EXAM

1. Each patient admitted to the Orthopaedic Service must have a history and physical. This can be dictated - one H & P per patient, per admission.
2. Student H & P's must be co-signed by a physician.
3. The format for the history and physical must include the following:

    Chief complaint in patient's own words
    History of present illness
    Past medical history
    Past surgical history
    Medicines
    Allergies
    Social history
    Family history
    Review of systems
    Physical exam of all systems - with emphasis on ROM of joints, description of wounds, muscle strength (0/5 - 5/5) and **neuro exam**.
    Laboratory results at admission excluding EKG
    X-rays - within normal limits or if abnormal, a description of findings of all x-rays including CT scans, MRI's, tomograms, etc.
    Diagnosis
    Suggested plan of treatment

    **Work Status - please clarify with distinct answers**
    **(if work status is not documented – you will be contacted at a later date to respond.**

# POSTING FOR SURGERY

1. All elective surgery should be posted the day before the surgery with the appropriate Orthopaedic Department nurse at extension 46525. Sequence of cases will be accomplished between the Adult and Trauma services through the Chief Administrative Resident the day before surgery.

2. Emergency surgeries are to be posted with the Operating Room, ext. 45924. The Resident or the OR Desk will call Anesthesia for work up.

3. All open fractures and compartment syndromes are to be considered emergencies.

   If there is a prolonged delay, for any reason, in getting to and accomplishing surgery,

   the attending physician on call is to be notified.

   The attending physician on call is to be notified when anyone is taken to surgery.

4. Ambulatory surgery procedures are to be scheduled by calling the appropriate Orthopaedic Department nurse at extension 46525. The nurse will schedule the case for you. If the patient is to be admitted post-operatively, call admissions to schedule that admission. Packets for outpatient surgery and AM admissions are to be filled out, and the patient sent to outpatient surgery for the Anesthesia workup. Lab work is valid for 14 days, and operative consent is valid for one month.

OPERATIVE REPORTS (allowed 24 hours to complete verbal)

1. Each surgery is to be documented immediately after the occasion of surgery.

2. The resident in charge of each case is responsible for the documentation.

3. Each op report must include the following:

   Staff name
   Date of Surgery ** VERY IMPORTANT ** not always the date dictated
   State whether in-house patient or outpatient ** VERY IMPORTANT **
   Surgeon and assistant
   Anesthesia method (general, regional, etc.)
   Anesthesia staff name
   Pre and post op diagnosis
   Operation and CPT code ** VERY IMPORTANT **
   Short summary before procedure outlining the history and indications.
   Work-related injury or non-work related injury.
   Documentation of definitive procedure to include amount of blood loss, hardware used, etc.
   No abbreviations may be used.
   **State whether this case is a Worker's Compensation case or not !!**

4. Please understand that documentation is a requirement for our department by the hospital. This is monitored by the department and the hospital for delinquencies. Should this documentation not be done as required, the hospital could loose accreditation.

5. **Never document "opinion" in medical record - only the facts!**

# ER AND FLOOR CONSULTS

Consult must include the following information

1. Date and time
2. Chief complaint
3. HPI - pertinent to reason consulted, referring physician
4. PE - pertinent to reason consulted
5. X-RAYS - description of each taken
6. Pertinent lab work
7. Diagnosis
8. Procedure with CPT CODE (do not forget post splinting/casting x-rays)
9. Instruments and follow-up (be sure to have x-rays done at follow-up)
10. At top of green sheet write in the following information and then put a circle around it:

    * Staff on call
    * Diagnosis
    * Treatment
    * Follow-up
    * CPT code

## Discharge of Patient

1. Preplan discharge by consulting the appropriate Orthopaedic Department nurse and the social worker if necessary.
2. Write the discharge order including re-appointment date and whether the appointment is for Jackson Medical Mall Ortho Clinic or Pavilion clinic. Submit discharge prescriptions. (Don't forget x-rays at follow-up.)
3. In the progress notes write a F.P.N. (Final Progress Note) to include:
   * Diagnosis - * Operation (if any) - * Disposition
4. Fill out entirely the Patient Discharge Summary. **No abbreviations are allowed. No space can be left out**. If nothing is applicable to the patient, write none. Write out diet and activity under discharge instructions. (You may use abbreviation for disposition only - - example: "See FPN" or "See Discharge Orders".)

## Discharge Summary

A discharge summary will be dictated on all patients at the time of discharge. It should include the following elements with variation as needed.

1. Patient name
2. Medical record number
3. Bill Number
4. Date of Admission
5. Date of Discharge
6. Physician of record (may not be admitting physician)
7. List of active admission and discharge diagnoses\
8. Summary of history and physical exam and clinical course in hospital
   This does not need to be exhaustive. Include the main diagnoses, surgeries with their dates, allergies, complications, treating consulting physicians with whom further consultation will be needed. For minor or unrelated issues may refer back to admission H + P. Medication may be listed only once as those at discharge. Include advanced directive status if indicated. If from nursing home indicate name of nursing home and name and phone number of family member responsible for informed consent
9. Discharge instructions - To include list of all medication (duration of medications if timed such as antibiotics), clinic follow-up appointments (physician name and date), important instructions (to include weight bearing status, need for x-rays on return) need for home health (name of agency if available). Discharge to home or other facility.
10. If transfer to another facility give name of facility and accepting physician.
11. Copy to referring phycian if known
12. Copy to physician for follow up if different from physician of record.

## Expiration Summary

Expiration summary paradigm:

The expiration summary is a special kind of discharge summary. It will be reviewed internally and often externally by state officials (coroner, DA's office, etc.) When a death occurs in the hospital it may be the only record read by a coroner to determine if an official inquiry is needed.

Items needed on the expiration summary

1. Patient Name
2. Medical record number
3. Billing number
4. Date of admission
5. Date of expiration
6. Physician of record (may not be admitting physician)
7. Admission diagnoses
8. Diagnosis as cause of death
   This should match the death certificate attestation as to cause of death. In some circumstances this may be vague but refer to a pending autopsy report. Cardio-respiratory arrest is not the diagnosis but the terminal event common to all.
9. Summary of history and physical exam and clinical course in hospital.
   Important to include advanced directive status and issues which would indicate that patient's demise may have been imminent (DNR order, hospice care, etc.) An objective record of the events leading to the hospitalization should be recorded (homicide, MVA, etc.) as the details may trigger a coroner's review. Status at time of admission to the hospital is recorded. If patient is a nursing home transfer, need name of facility and family member contact. As for discharge summary, a concise summary of the history and physical exam and the clinical course in the hospital is given. Dates of surgeries and complications are included. If death was expected as due to the culmination of a chronic disease, state this should be obvious. If the demise was unexpected, the result of traumatic injury or otherwise accidental, this should also be clear. The resuscitative efforts surrounding the terminal event are already recorded on the chart and may be summarized as needed.
10. Date and time that death was declared. Name of attending physician involved and name of the attesting physician.
11. Notification of family members
12. Autopsy status (declined, accepted, coroner's case) and disposition of the body
13. Copy to family / referring physician as known.

**As of May 2020 all resident clinics have been moved from the MedMall and are now continuity clinics in conjunction with rotations / services.**

## CONFERENCE ATTENDANCE

Per accreditation guidelines, all residents are required to attend Tuesday, Wednesday, and Thursday morning conferences. The only exception to this is if you are on elective outside the Jackson area, on vacation, or at a meeting out of town. Interns on rotations other than Orthopaedics should request permission from the service to attend conference. If there is a problem with the service allowing you this time, notify the Program Administrator.

## USMLE Step III / DEA

Please be aware you are responsible for contacting USMLE to register and take Step III in order to be fully licensed and be able to apply for your DEA certificate. You should begin this process upon the start of residency, due to the fact this takes many months to complete. Should you have any questions, please contact Amy or check out USMLE's website shown below. Residents are required to Pass Step III during their PG1 Year.

http://www.usmle.org/

## COMPLICATIONS

Complication reporting sheets are provided to residents to report needed information regarding complications / mortality with our patients. These sheets are to be turned in to Amy during the fourth Wednesday's conference /grand rounds Morbidity and Mortality presentation of the cases by residents.

We are currently working on a new process for presentation and review.

Front of Form

UMMC ORTHOPEDIC MORTALITY & MORBIDITY
AND
PERFORMANCE IMPROVEMENT
DATE _____

| Initials | Age | Staff | Diagnosis | Procedure | Complications | Codes | Comments | Type | 1 yr F/U | Quality Concern Score |
|---|---|---|---|---|---|---|---|---|---|---|
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**Quality Review document. Not subject to discovery. Not to be distributed.**

# ORTHOPEDIC SURGERY
## PERFORMANCE IMPROVEMENT
## COMPLICATION CODES AND TYPES

**COMPLICATION CODES**

**1. Missed Diagnosis**
- **1.1 Fracture**
- **1.2 Joint dislocation**
- **1.3 Intra-articular Loose Body**
- **1.4 Nerve Injury**
- **1.5 Arterial Injury**
- **1.6 Compartment Syndrome**
- **1.7 Suboptimal w/u of Med Problem**

**2. Late Peripheral Nerve or Vessel Injury**
- **2.1 During Closed Manipulation**
- **2.2 During Surgical Procedure**
- **2.3 From Intra-Op Position**

**3. Prog of Neuro Deficit in SCI**

**4. Skin breakdown**
- **4.1 Intra-Operative Injury**
- **4.1 Cast Ulcer**
- **4.2 Pressure Sore**
  - **4.31 Sacral**
  - **4.32 Heel**

**5. Wound Problems**
- **4.3 Cellulitis**
- **4.4 Acute Wound Infection**
- **4.5 Hematoma**
- **4.6 Skin Sough**
- **4.7 Wound Dehiscence**
- **4.8 Late Abscess or Infection (>30 days)**
- **5.7 Bone Graft Donor Site Inf**

**6. Osteomyelitis**
- **6.1 Of Closed Fracture**
- **6.2 Of Open Fracture**
- **6.3 Of Osteotomy or Arthrodesis**

**7. Union with Unacceptable Angulation**

**8. Unexpected Nonunion**
- **8.1 Nonunion of a Fracture**
- **8.2 Nonunion of Arthrodesis**
- **8.3 Nonunion of Osteotomy**

**9. Failure of Closed Treatment**

**10. Complication of Traction**

**11. Complication of Halo or Tongs**

**12. Unexpected Re-operation**

**13. Complication of External**
- **13.1 Loss of Fixation**
- **13.2 Pin Site Infection**

**14. Failure of Operative Fixation**
- **14.1 Missed Screw Placement**
- **14.2 Screw too Long or too Short**
- **14.3 Intra-Op Fracture/Comminution**
- **14.4 Suboptimal Choice of Implant**
- **14.5 Failure to Achieve Reduction**
- **14.6 Implant Failure**
- **14.7 Fracture Displacement around**
- **14.8 Unexpected Loss of Motion**

**15. Fracture Above/Below Implant**

**16. Complication of Arthroplasty**
- **16.1 Intra-Op Fracture**
- **16.2 Infection**
- **16.3 Suboptimal Position**
- **16.4 Loosening**
- **16.5 Dislocation**
- **16.6 Required Joint Manipulation**

**17. Complication of Microsurgery**
- **17.1 Donor Site Problem**
- **17.2 Flap/Replant Re-operation**
- **17.3 Flap/Replant Failure**

**18. Complication of Arthroscopy**

**19. Non-Orthopaedic Complications**
- **19.1 DVT**
- **19.2 PE**
- **19.3 Urologic**
- **19.4 Respiratory**
- **19.5 Hematologic**
- **19.6 GI**
- **19.7 Cardiac**
- **19.8 EtOH Withdrawal**

**20. Death**

**TYPE OF COMPLICATION**

ED ERROR IN DIAGNOSIS
- **EJ Error in Judgement**
- **EM Error in Management**
- **ET Error in Technique**
- **PD Patient Disease (Expected Risk)**
- **NC Patient Non-compliance**
- **AC Anesthetic Complication**

**QUALITY OF CARE SCORING SYSTEM**

0. AFTER REVIEW OF THE MEDICAL RECORD, NO QUALITY OF CARE CONCERNS EVIDENT
1. **Quality concern which did not affect the patient's well being and is unlikely to have had an adverse effect of the patient's condition.**
2. **Quality concern which did not affect the patient's well being, but had the potential to have an adverse effect on the patient's condition.**
3. **Quality concern which had an adverse effect on the patient's well being, but not life threatening (eg., unnecessary or invasive procedure or postoperative or other complication).**
4. **Quality concern which resulted in patient loss of a major physical function or potentially life threatening situation.**
5. **Quality concern which demonstrated a life threatening situation or resulted in death.**

# Administrative Procedures and Policies

# PROFESSIONAL DEMEANOR AND APPEARANCE

It is expected that the demeanor and personal appearance of the resident will reflect quality professionalism and pride in all the roles in which the resident finds himself or herself. In addition to the resident's clinical skills and technical abilities, the way we "present" to other people is the crucial element in earning the confidence and respect that is so important to successful patient and professional relationships.

The following practices should be observed:

## Dress

1. A coat and tie must be worn at all times, including weekend with the exception of night call. Bloody athletic shoes are not considered acceptable attire.

2. O.R. dress code will be strictly adhered to.

## Conduct

1. Attendance is expected at all scheduled conferences and clinics unless specifically excused by the Chief Resident or Staff.

2. Hospital rules for smoking will be observed. In addition, simple courtesies such as no gum chewing or eating during patient contact or while presenting are observed.

3. Everyone with whom the resident comes in contact is to be treated courteously. Do not respond to irritating behavior with an angry response; nothing positive is accomplished. Rather, submit the problem areas to the Chief resident or Staff as appropriate.

4. Do not take up **personal** vendetta with any office, position or person. Be honest and candid and use sound judgment and discretion. When we fail in our interpersonal contacts, the best remedy is to seek forgiveness. It is professional and reflects mature character to say "I'm sorry".

5. **Be especially courteous to nurses and ancillary personnel.**

## Pagers

Upon your entrance to our residency program, you are furnished with a specifically assigned pager. The pager service is provided through Teletouch and is assigned to you for your entire residency period. These pagers provide basic paging capability along with internet messages, email forwarding, etc. Should you loose or misplace the pager, you will be responsible for its cost ($ 50.00). If you have difficulties with the pager (not working, etc.) you are to take it to the Telecommunications Office for repair.

## Radiation Badges / Lead Apron / Thyroids Shields

Radiation badges are exchanged every month. Please be sure to wear. Details regarding enlisting in this program are covered during resident orientation. Lead Aprons and Thyroid shields are provided by the department and are available in the operating room and radiology.

## Salary

Residents are paid twice a month. The Resident's pay schedule will follow the UMMC biweekly payroll schedule. You must have your check deposited directly to your account. Call the Payroll Office at extension 1050 with any questions. During orientation, you will provide bank information so your check can be automatically deposited to your bank account.
The following is the 2019 – 2020 Salary Listing:

| | |
|---|---|
| PGY - 1 | $ 50,038 |
| PGY – 2 | $ 51,797 |
| PGY - 3 | $ 53,470 |
| PGY- 4 | $ 55,391 |
| PGY- 5 | $ 57,564 |
| PGY- 6 | $ 59,337 |

## Meal Cards

The University Hospital provides On-Call Meal Cards to house officers who stay in-house for call. These meal cards cover the cost of meals after 5:00 pm and before 8:00 am and up to $6.00 in cost. Meal cards are distributed to those persons scheduled for in-house call - at the beginning of the residency period by the education administrator / coordinator for each department.

# SAMPLE CONTRACT

## This is not an executable agreement.

**HOUSE OFFICER CONTRACT**

**This contract made and entered into by and between THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER ($UMMC#), and First Name Last Name , Title ($Physician#);**

**WITNESSETH:**

**I. UMMC does hereby contract with and accept Physician as a postgraduate House Staff Officer at UMMC, Jackson, Mississippi (and/or at departmental facilities, clinics, hospitals thereunder) for the period beginning July 1, 20XX and ending June 30, 2 0 X X at an annual rate of $ Salary , payable in pro-rated monthly installments at the close of the months of July through June, inclusive; provided, however, if and when during the period specified above, Physician serves at another hospital or institution with the specified concurrence and approval of UMMC, then, said other hospital or institution may be responsible for the direct payment to Physician for the services rendered and the time served and a pro-rata deduction may be made by UMMC from the amount to be paid as specified above; provided also, that if Physician is appointed and serves as Chief Administrative Resident by UMMC, then Physician s pay shall be increased for the period so served in accordance with rates established for such service; and provided finally, that if Physician commences employment after the first of a calendar month, the first and last months salary shall be pro-rated to reflect the actual number of days of work. Promotions occurring during the academic year will be recognized.**

**II. UMMC agrees further that:**

**1. It will provide an educational program for postgraduate training in keeping with established standards; reference to the UMMC House Staff Manual is hereby made for UMMC s obligations as to responsibilities of Physician, conditions under which living quarters and meals are provided, leave, and duty hours.**

**2. It will administer Physician s training program in accordance with the policies, rules and regulations of the Board of Trustees of Institutions of Higher Learning and the University of Mississippi.**

**3. At the time of termination of Physician's participation in an academic training program, UMMC will issue an appropriate record for all time satisfactorily completed.**

**4. Physician shall not be required to perform duties other than those related to the residency program.**

**5. Physician shall have all benefits of University employees and be protected from sexual harassment, as designated in the Handbook for Employees.**

**6. Disciplinary matters and grievances are primarily handled with the individual residency programs. Physician shall have the right of appeal as stated in the Handbook for Employees for matters related to employment, and general conduct; and shall have the right of appeal to the Graduate Medical Education Committee for all academic and medical matters.**

**7. Physician is covered for professional liability pursuant to the Mississippi Tort Claims Act for all duties related to official program rotations within the State of Mississippi`.**

**8. Physician shall have access to appropriate and confidential counseling, medical and psychological services.**

**9. Physician will be provided the following: (a) an educational program regarding physician impairment, including substance abuse; (b) white coats and scrub suits (laundry is provided at the discretion of the departments); (c) employee discounts in the hospital dining room; and (d) support space for on-call activities, execution of patient care, educational endeavors and research efforts.**

**III. Physician agrees further that:**

**1. Physician will serve during the entire period stated above, will fulfill the educational requirements for the program, and accepts the obligation to use best efforts to provide safe and effective patient care.**

**2. Physician will comply with laws, regulations, and requirements of the State of Mississippi, as to the practice of medicine and all laws, regulations and policies governing said UMMC, including UMMC Hospital Medical Staff bylaws, including, but not limited to, application for and maintenance of the appropriate license for the practice of medicine from the Mississippi State Board of Medical Licensure. Physician understands that regardless of the commencement date of this contract, Physician will not be permitted to commence employment until such time as Physician has been granted the appropriate medical license aforesaid.**

**3. Physician will consider the stated stipend and the experience and instructions received as sole compensation from University Hospital or affiliated institutions for all training program related activities and will not personally accept fees in any form for patients treated or seen as part of the prescribed training program.**

**4. Physician acknowledges that in Mississippi, it is illegal for residents with temporary or limited institutional medical licenses to engage in moonlighting for which unrestricted medical license is required. Further, Physician accepts and acknowledges that UMMC discourages moonlighting because such activity tends to interfere with the educational process and health of the physician-in-training.**

**IV. Both parties further agree that:**

**1. In accordance with the Mississippi Constitution (Article B, Section 213-A), UMMC is empowered to terminate this contract at any time for malfeasance, inefficiency or contumacious conduct by Physician.**

**2. Physician hereby accepts the employment herein above specified upon the terms and conditions herein stated.**

**3. Special clause for early contracts in advance of legislative appropriations and approval by the Board of Trustees, Institutions of Higher Learning: Contracts for house staff positions signed in advance of usual budgetary and approval processes are contingent upon subsequent legislative appropriations and Board of Trustees approval. These advance contracts reflect stipend rates which will be adjusted if and when new rates become effective.**

**4. UMMC reserves the right to terminate this contract and/or decrease the salary specified at any time by giving one month's notice to Physician in the event a state of financial exigency is declared by the Board of Trustees. Physician, when resigning voluntarily, shall give one month s notice in writing to UMMC.**

**5. Reappointment for additional years of training shall be based upon evaluation of the Physician s performance and availability of positions. If Physician does not commence the training program upon the first day of the regular academic year of UMMC, viz., July 1, and Physician does not exhibit sufficient competency to advance to the following year of residency, then UMMC may terminate this contract at the end of the academic year of the training program even if this contract states a later termination date. UMMC shall give Physician at least four (4) months written notice of an intent not to reappoint Physician to the next year of training, unless the event or events giving rise to such non-reappointment occur during the last four months of the academic year, in which case UMMC shall give Physician as much notice of non-reappointment as is reasonably allowable.**

**WITNESS our signatures, this the_____day of_____, 20XX.**

**UMMC:**

**UNIVERSITY OF MISSISSIPPI MEDICAL CENTER**

**By:XXXXXXXXXXX_____**
**Vice Chancellor for Health Affairs**
**for the Board of Trustees, Institutions of Higher Learning**

**By:XXXXXXXXXXX_____**
**Associate Dean for Graduate Medical Education**

**Physician:**

**XXXXXXXXXXX_____**
**Name**

**Department of Orthopedic Surgery and Rehabilitation**

**Leave Policy**

One week of personal leave is allowed per rotation. Leave requests will be submitted through email at the beginning of each rotation. As of 7/01/05 Adm Leave is granted for scheduled fellowship interviews up to 6 days.

| | |
|---|---|
| Length of personal leave: | PGY-1 2 weeks |
| | PGY-2 4 weeks |
| | PGY-3 4 weeks |
| | PGY-4 4 weeks |
| | PGY-5 4 weeks |
| | PGY-6 2 weeks |

OITE (Orthopaedic In-Training Examination) which is the second Saturday in November.

1. When requesting vacation, request a Monday through Friday. The weekend should not be requested but worked out amongst your class to have off. Vacation should not be split into two separate weeks or a few days at a time. This will only be approved under special circumstances deemed appropriate by staff and chief residents. If you must split your vacation into separate weeks, please list the reasoning with your request. This will help eliminate some of the confusion about coverage that we had this year.

2. Vacation requests should be emailed to admin chief (chief on F&A/Sports), Amy, Khristina, chief on your service, and attendings on your service, 4 weeks in advance. Vacation days should be discussed with co-residents on the service and approved through them before submitting official requests. Vacation should also be worked out amongst your class so there aren't multiple residents taking off at the same time and interfering with call schedule.

3. There should be no trauma or float vacation during June and July. There is no intern on the service during this time

4. The PGY-2 on trauma/float should not take two weeks of day vacation or night vacation during a 3 month block. For instance, one person should take a week of night vacation and the other person a week of day vacation during a 3 month block then switch the next 3 month block.

5. An intern should not take vacation during an orthopedic rotation. If you are scheduled for Friday night buddy call during your vacation week, you need to switch calls with one of your classmates who is not on trauma so everyone takes the same amount of call.

6. Please don't be inconsiderate with your vacation requests. If your attending is out on a service for an extended period of time, please take vacation during this time. That way another resident is not having to cover for you when your attending comes back and is doing double duty. Just be considerate and think about your fellow classmates.

7. No vacation during first week of new rotation or during holiday weeks except under special circumstances deemed appropriate by chief residents and staff.

The intern schedule will be set in terms of buddy call and weekend call. Notice will be sent detailing the interns' call schedule and responsibilities.

June 2020

## Department of Orthopedic Surgery and Rehabilitation
## Leave of Absence Policy
## Policy on Effect of Leave for Satisfying Completion of Program

The American Board of Orthopaedic Surgery Rules and Procedures state the following:

1. Five years (60 months) of accredited post-doctoral residency are required.

2. Each program may provide individual sick leave and vacation times for the resident in accordance with overall institutional policy**. However, one year of credit must include at least 46 weeks in full-time orthopaedic** education. Vacation or leave time may not be accumulated to reduce the five-year requirement.

3. Program directors may retain a resident for as long as needed beyond the minimum required time to ensure the necessary degree of competence in orthopaedic surgery.

Should a UMC orthopaedic resident take a leave of absence, the Department would require the resident to extend the training period at the end of the normal training period by an equal number of weeks and/or months of training missed. This would be necessary to assure the resident of ABOS eligibility.

## University of Mississippi Medical Center
## GMEC Policy on Leave

Leave will be accrued in accordance with UMC policy, and as permitted by the VA. Leave must be reported and may be granted in accordance with the requirements of the individual residency programs, and in addition, in accordance with the requirements of the VA for those residents assigned to the VA.

A resident must not take leave without first obtaining approval from the program director.

House officers should refer to the House Officer Manual for further details.
https://www.umc.edu/uploadedFiles/UMCedu/Content/Education/Schools/Medicine/Graduate_Medical_Education/Resident_Information/HouseStaffManual.pdf

Approved GMEC 5/22/2003

Reviewed PAAC 8/17/2016

House officers Leave

Graduate Medical Education
University of Mississippi Medical Center

House officers enrolled in graduate medical education programs at the University of Mississippi Medical Center are unique in their dual roles as both student and employee. Each UMMC house officer is enrolled in an American Board of Medical Specialties and Accreditation Council of Graduate Medical Education (ACGME/ABMS) defined, time-limited, training program. Advancement in the program and annual contract renewal are performance dependent. Benefits including medical insurance and medical leave are prescribed by the national accrediting agencies. To maintain compliance with accreditation regulations, insure consistency and fairness across individual programs and the institution, and meet state and federal regulatory requirements, the following guidelines are provided for administering Medical Leave:

- House officers will accumulate leave at the same rates as any state employee.
- House officers will accumulate 12 days medical leave annually in the first three years of training.
- House officers will accumulate 18 days personal leave annually in the first three years of training.
- The first day of any leave taken for medical reasons will be subtracted from personal leave time
- Extended medical leave requires documentation from a treating physician
- Paid leave for medical purposes, in any year of GME training, may not exceed the anticipated 30 days (6 weeks) to be accumulated in the current active 12 month employee contract PLUS any time accumulated and not yet used from previous years of UMC employment MINUS any personal or medical leave time already used in the current year of training.
- Medical leave beyond 6 weeks in duration in the first year of training at UMMC will be taken as unpaid leave
- Up to 12 weeks leave may be taken in accordance with FMLA guidelines; leave time beyond the anticipated annual 30 days and previously accumulated medical and personal leave time will be unpaid.
- Any house officer failing to complete their twelve month contracted training and employment time, will repay to UMMC any unearned medical or personal leave they have received.

University of Mississippi Medical Center
Graduate Medical Education

Evaluation Policy and Grievance Algorithm

All trainees at the University of Mississippi Medical Center will receive both formative and summative evaluation on a periodic basis. Attending physicians are expected to provide feedback and constructive criticism on all aspects of the trainee's performance, including but not limited to, clinical judgment, medical knowledge base, data gathering skills (history taking, physical exam, old record review, lab follow-up), procedural skills, humanistic attributes, professionalism, over-all patient care skills as well as all behaviors defined within the six ACGME descriptive areas of competency. *Trainees should expect direct constructive criticism and suggestions for improvement.* The Training Program Director or his/her designee will meet individually at least semiannually to review each house officer's overall performance and progress in the training program.

The details of the process of resident evaluation and grievance will vary appropriate to the requirements of the RRC or other accrediting agency for the resident's specialty or subspecialty. The process will typically include the elements described below.

ATTENDING PHYSICIAN:

If the trainee is performing at a low satisfactory or unsatisfactory level, the substandard performance should be brought to the trainee's attention as soon as possible. Performance problems should be documented with clear suggestions regarding appropriate conduct for such situations in the future. In addition to discussing the problem directly with the trainee, the attending physician should notify the program director (preferably in writing) of the nature of the problem as soon as possible. In some cases, changes in routine supervision on patient care services may be warranted. If a trainee is unhappy with an evaluation or feels it is unfair, he/she is encouraged to discuss the evaluation in detail with the attending physician. It is advisable that the resident initial and date all documentation to signify his/her awareness of the opinions and actions recorded.

PROGRAM DIRECTOR:

If after additional discussion, the trainee feels the evaluation is unjustified, he is asked to put his complaint in writing and discuss the evaluation in detail with the program director, who will serve as a mediator. In most cases, after seeking input from all involved parties and reviewing the situation in detail with both the attending physician and the trainee, the program director will dictate a report to be included in the trainee's file along with the original evaluation and the trainee's rebuttal and explanation. In some cases, the attending physician may wish to file an amended evaluation. In all cases, the trainee is asked to define specific ways in which the behavior can be changed or improved. In the setting of continued marginal or unsatisfactory performance, a house officer may have clinical privileges revoked by the program director, and be asked to

function in a remedial role in which all aspects of patient care must be immediately supervised by another physician including countersignature of all patient orders and notes. In general, a remedial program will be established which includes reading assignments and didactic conference attendance, (and in some cases language classes) in an effort to improve performance. A specific probationary period will be defined.

DEPARTMENT CHAIRMAN:
Unsatisfactory trainee performance may result in the dismissal from the program of the House Officer. This decision will be made by the Program Director in consultation with the Chairman of the Department. If a House Officer wishes to contest the Program Director's decision for termination from the training program, appeal for review can be addressed to a constituted Departmental Grievance Committee composed of selected peers and faculty.

APPEAL FROM DEPARTMENTAL CHAIR:

House Officers may appeal grievable matters by petitioning in writing to the Vice Chancellor for Health Affairs within fourteen calendar days of notice of termination from the program director or chairman exclusive of University of Mississippi Medical Center holidays. Upon receipt of a formal written request from a resident for review of a Department Chair's / *Program Director's* action, the Vice-Chancellor will select a faculty member of the Graduate Medical Education Committee to chair an appeals committee. The appeals committee chair will appoint an appeals committee of four (4) additional GMEC *or RRSC* members, including at least 1 (one) member of the House Staff. The appeals committee chair will promptly convene the committee to hear the appeal, generally within ten (10) business days of the Vice-Chancellor's appointment of the appeals committee chair. The decision of the appeals committee will be submitted to the Vice Chancellor. The decision of the Vice Chancellor shall be final in accordance with the by-laws and policies of the Board of Trustees of State Institutions of Higher Learning.

Per the University of Mississippi Medical Center*, the following issues are considered "grievable":

- Complaints against faculty;
- Disciplinary actions, including dismissals, demotions and suspensions;
- Application of personnel policies, procedures, rules and regulations, ordinances and statues;
- Acts of reprisal against employees using the grievance procedure;
- Complaints of discrimination on the basis of race, color, creed, political affiliation, religion; age, disability, national origin, sex, marital status, veteran status; or
- Any matter of concern or dissatisfaction to an employee if the matter is subject to the control of institutional management.

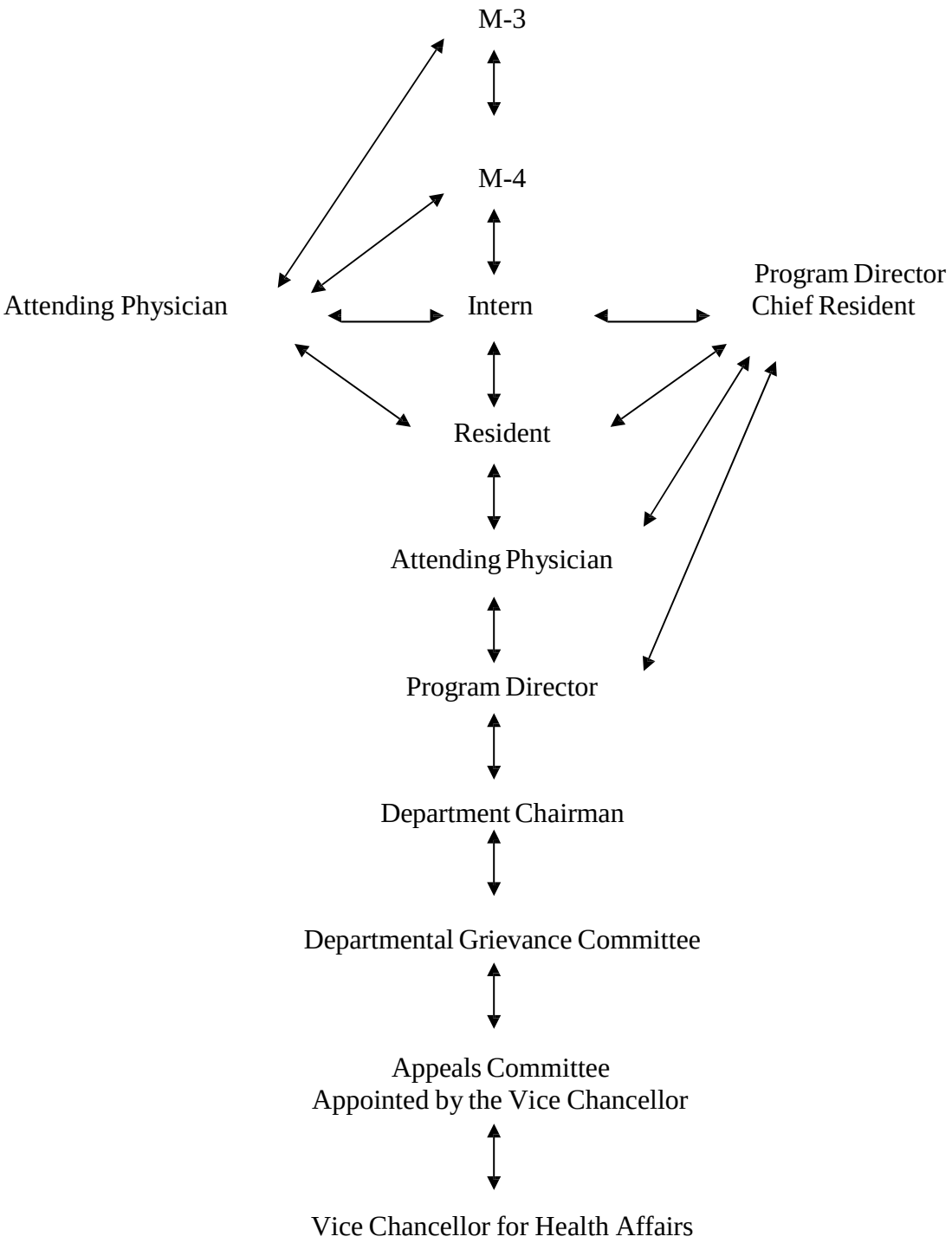
Likewise, the following issues are considered "nongrievable":

- Scheduling and staffing requirements;
- Issues which are pending or have been concluded by direct appeal through an administrative or judicial procedure;
- Temporary work assignments which do not exceed 90 calendar days;
- Budget and organizational structure, including the number of assignment of employees or positions in any organizational unit;
- The measurement and assessment of work through performance appraisal, except where the employee can show that the evaluation was discriminatory, capricious, or not job related;
- The selection of an individual by a department head or designee to fill a position through promotion, transfer, demotion, or appointment unless it is a violation of UMC or Board of Trustees policy;
- Internal security practices established by the institution, department head or designee;
- Termination or layoff from duties because of lack of work, reduction of the work force, or job elimination;
- Voluntary resignation by an employee bars action under the grievance procedures;
- Any matter not within jurisdiction or control of the institution;
- Content of published UMC polices or procedures;
- An action by the institution pursuant to federal or state law or directions from the Board of Trustees of State Institutions of Higher Learning; or
- Establishment and revision of wages and salaries, position classification and general benefits.

*(Employee Handbook, The University of Mississippi Medical Center)

Revised GMEC 4/21/05

TRAINEE GRIEVANCE ALGORHITHM



# INVOLUNTARY TERMINATION

The rules and regulations section of the UMC Employee Handbook, which outlines grounds for dismissal also, applies to the Orthopaedic Resident.

Among those grounds for dismissal, the resident should make particular note of the following:

1. Neglect of duties
2. Incompetency
3. Insubordination
4. Unprofessional conduct
5. Frequent tardiness or absenteeism
6. Discourtesy
7. Disregard for established organization and Department procedures
8. Neglect of personal appearance, dress or hygiene.
9. Inappropriate use of the internet and/or electronic mail.
10. Unauthorized use of authorized computer password to invade patient, employee or student privacy by examining records or information for which there has been no request for review.

In the event that a resident shows disregard for UMC or Department rules, the Chairman of the Department will schedule a disciplinary conference with the resident and place a written record of the infraction in the Department's files. The Chairman may place the resident on probation if he determines the situation warrants such action. When dismissal is considered, a committee will address the issue and render the final decision.

**Approved by GMEC 7/24/2000**

## University of Mississippi Medical Center

## GMEC Policy on Work Environment

The graduate medical education work environment of the University of Mississippi Medical Center and University of Mississippi Health Care fosters achievement of educational goals of the learner and the specific GME program while serving to promote high quality patient care. UMMC is committed to resolving any and all issues which might compromise the learning environment for any trainee.

The general employment policies and procedures are described in detail in the House Staff Manual and in the Faculty and Staff Handbook.

Several mechanisms exist for residents to raise issues of concern about the work environment.

- Residents are encouraged to discuss problems as needed with their chief residents and program director. Recognizing that residents do not always feel comfortable with their direct leaders, a variety of other mechanisms are in place to allow residents opportunities to have all issues addressed and resolved.
- The Resident Council exists for the purpose of discussing issues related to the work and academic learning environment. The council is composed of peer-elected resident representatives and meets quarterly with institutional GME leadership.
- Residents may also raise issues through resident or faculty representatives on the GMEC and RRSC.
- The Chief Residents' Council meets monthly with GME leadership and key hospital administrators, which provides a venue to specifically address issues in the hospital setting which impact resident satisfaction or patient care.
- The Resident Suggestions page on the GME website is a secure, anonymous on-line resource that allows residents to report issues they prefer not to discuss in person directly to the GME Office.
- The DIO is readily available to discuss any issue at the request of residents or faculty and works regularly with hospital administration, human resources, legal, and compliance to resolve problem issues as needed.

Revised by the GMEC 6/16/2011

PAAC Reviewed /revised 11/03/2016

University of Mississippi Medical Center
Graduate Medical Education
Harassment Policy as outlined by the UMMC Handbook

It is the policy of the Medical Center to foster an environment of respect for the dignity and worth of all members of the UMC community. The Medical Center is committed to maintaining a work and/or learning environment free from any type of harassment. UMC will not tolerate offensive or inappropriate sexual behavior and requires that all persons avoid any action or conduct which could be viewed as sexual harassment.

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

1) submission to such conduct is made either explicitly or implicitly as a term or condition of an individual's employment or academic standing; or

2) submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting such individual; or

3) such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive work or learning environment severe or pervasive enough to alter the terms or conditions of an individual's employment or academic endeavors and create an abusive work or learning environment.

Examples of prohibited conduct include, but are not limited to: lewd or sexually-suggestive comments; off-color language or jokes of a sexual nature; slurs and other verbal, graphic or physical conduct relating to an individual's gender; or display of sexually explicit pictures, greeting cards, articles, books, magazines, photos or cartoons.

**It is your responsibility to report any incident believed to be sexual harassment immediately.** Even if you believe the act of harassment to be isolated or infrequent, you must report it so the Medical Center will have the opportunity to investigate, and, if appropriate, take action to ensure that the conduct does not continue or rise to the level of sexual harassment. Do not wait to determine whether the conduct will continue. Follow the procedure below, and report the conduct immediately.

It is important for you to understand that no division/department head, dean, manager, faculty member or supervisor has the authority to condition the terms and conditions of your employment (pay raises, promotions, demotions, undesirable assignments, disciplinary action or termination, etc.) or academic standing (grade assignments, progress, performance, etc.) on the receipt of sexual favors. If any person has in any way suggested that you or anyone else should provide sexual favors in exchange for a job or academic benefit, or to avoid an unfavorable employment or academic action, you must report this immediately. Do not wait to determine whether a favorable or unfavorable act actually occurs before reporting the conduct. Follow the procedure below and report the conduct immediately.

**The Medical Center must have everyone's cooperation to implement its sexual harassment policy.** UMC cannot address employee concerns regarding sexual harassment if they are not brought to the attention of appropriate Medical Center management. To report conduct which may be in violation of this policy, you should contact your immediate supervisor, department head, or dean immediately. If you are uncomfortable discussing this matter with your supervisor or department head, or dean, or do not feel that your complaints have been or will be adequately addressed, contact the director for equal employment opportunity at 601-815-5150. UMC will promptly investigate your complaint and will take whatever corrective action is necessary and appropriate. The Medical Center strictly prohibits any retaliatory action against persons reporting conduct they believe to be in violation of this policy.

**POLYGRAPH EXAMINATION**

In consideration of employment sought, and as may be required as a condition of continued employment, employees consent and agree to submit themselves upon request for a polygraph examination. Employees who refuse to take a polygraph examination should be told their refusal may result in termination of employment.

Excerpted from UMMC Faculty and Staff Handbook and Personnel Procedures
PAAC reviewed / updated 08/12/2016

https://intranet.umc.edu/sites/Administration/business_services/hr/Organizational_Development/Pages/Harassment.aspx

## Department of Orthopedic Surgery and Rehabilitation
## Policy on Resident Evaluation, Promotion and Dismissal

Residents are evaluated at the end of each rotation by multiple individuals using Milestones. The program director reviews evaluations with the resident twice a year at which time the resident is asked to initial each form. A Resident portfolio requirement was added in January 2005 to this semi-annual evaluation time. This portfolio consists of an outline of their research, a current CV, publications, and courses taken, along with their personal learning plan – goals & objectives. The Clinical Competency Committee reviews milestones and makes recommendations to the PD.

A resident is promoted at the beginning of each fiscal year, July 1st, on the basis of evidence of satisfactory progressive scholarship and professional growth. Graduation of a resident requires successful completion of the program as well as a demonstration of a capacity for independent specialty practice. A lack of progressive scholarship and professional growth would constitute a review of the resident's performance by the program director and the Clinical Competency Committee. Dismissal of a resident would occur only after a thorough review of the resident's difficulties. All documentation is maintained in the Administrative Offices. June 2016

## University of Mississippi Medical Center
## Policy on Evaluation and Promotion and Dismissal of Residents

All residency programs are required to provide regular evaluations to the residents. Programs will provide formal written evaluations from the program director, program residency committee, department chair, or designee at least two times per year or more often if required by the accrediting body for that program. Residents whose performance is below an acceptable standard must be notified of deficiencies in their performance.

Each program must establish criteria for promotion for each level of training and completion of the program. Unsatisfactory trainee performance may result in the dismissal from the program of the House Officer. This decision will be made by the Program Director in consultation with Chairman of the Department. If a House Officer wishes to contest the Program Director's decision for termination from the training program, appeal for review can be addressed to a constituted Departmental Grievance Committee composed of selected peers and faculty.

Reappointment for additional years of training shall be based upon evaluation of the resident physician's performance and availability of positions. If the resident physician does not commence the training program upon the first day of the regular academic year of UMMC, viz., July 1, and the resident physician does not exhibit sufficient competency to advance to the following year of residency, then UMMC may terminate this contract at the end of the academic year of the training program even if this contract states a later termination date. UMMC shall give the resident physician at least four (4) months written notice of an intent not to reappoint the resident physician to the next year of training, unless the event or events giving rise to such non-reappointment occur during the last four months of the academic year, in which case UMMC shall give the resident physician as much notice of non-reappointment as is reasonably allowable.

GMEC 12/16/04

GMEC Reviewed & Re-Approved 6/17/2010

PAAC Reviewed 10/19/2016

## Department of Orthopedic Surgery & Rehabilitation
## Policy on Duty Hours

The Department of Orthopaedic Surgery and Rehabilitation supports the Institutional Policy on Resident Duty Hours as approved by the Graduate Medical Education Committee. This policy meets guidelines set for by ACGME. Orthopedic surgery rotations are closely monitored as to meet these guidelines. The department monitors duty hours through the MedHub resident / fellow self-entry system. This system has electronic rules set up that help the PD and Education Administrators monitor for violation. The duty hour entry reports are run by month and reviewed at the quarterly Program Evaluation Committee meeting. This committee reviews resident hours and makes recommendations to the PD, should any changes need to be made. Minutes of these meetings are available as well as duty hour reports.

**University of Mississippi Medical Center**
**GME PARKING POLICY FOR RESIDENTS**

In order to simplify access for residents and fellows to convenient parking when coming to the hospital for short term event, Lower Level B will be accessible to all residents and fellows.

**Please continue to park in C for long term parking or shift work.**

Both parking garages are badge access and will be monitored for use.

## University of Mississippi Medical Center
## Policy on Resident Duty Hours

**PROFESSIONAL ISSUES**
**DUTY HOURS POLICY**

The University of Mississippi Medical Center and its affiliated hospitals are committed to providing excellent patient care and outstanding education for physicians in training. Compliance with all Accreditation Council for Graduate Medical Education policies is expected. Effective July 1, 2011, the work hours of resident physicians enrolled in programs not granted a work-hours extension are as follows:

### Duty Hours

- Duty hours are defined as all scheduled clinical and academic activities related to the residency program, *i.e.,* patient care (both inpatient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, time spent in- house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- Scheduled duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- Residents are to be provided with one day in seven free from responsibilities to the program, averaged over a f our-week period, inclusive of call and free from all clinical, educational, and administrative activities. One day is defined as one calendar day.
- Residents should have 10 hours free of duty, and must have 8 hours off between Scheduled Duty Periods.

### On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. I n-house call is defined as those duty hour s beyond the normal work day when residents are required to be immediately available in the assigned institution.

- Interns (PGY-1's) are limited to a maximum of 16 hours of continuous duty in hospital.
- PGY-2 residents and above must be scheduled for In-house call no more frequently than every third night (when averaged over a four-week period).
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. PGY-2's must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single

patient. justifications for extensions of duty hours is limited to reasons of required continuity for severely ill or unstable patients and must be documented as defined in section VI.G.4.b of Specialty and Subspecialty Program Requirements.

- All trainees are limited to no more than 28 hours continuous duty in the hospital (24 hours in house call, plus 4 hours to complete post call patient care responsibilities).
- No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- At-home call (pager call) is defined as call taken from outside the assigned institution.
    - Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven completely free from all educational and clinical responsibilities of duty, when averaged over four weeks. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
    - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    - Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".
    - The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

**Moonlighting**

- The Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- External Moonlighting must be monitored and tracked in addition to In-House Moonlighting and must be counted toward the 80-hour Maximum Weekly Hour Limit (as defined in the ACGME Glossary of Terms).
- In Mississippi, it is illegal and /or grounds for loss of temporary or limited medical licensure for any resident or fellow in training to engage in moonlighting unless in possession of an unrestricted license to practice medicine in the State. Residents are not required to engage in moonlighting; further, the University of Mississippi Medical Center (UMMC) discourages moonlighting or professional activity by residents or fellows apart from full-time UMMC-sponsored or ACGME-sanctioned postgraduate educational programs because these activities tend to interfere with the educational process and health of the physician-in-training. The program director must acknowledge in writing that a resident or fellow is moonlighting, and the information made a part of the resident's folder. The effects of moonlighting on performance in the residency pro-gram will be monitored and adverse effects may lead to withdrawal of permission to engage in moonlighting activities.

  The University of Mississippi Medical Center Professional Liability Program for residents only applies to those professional activities within the course and scope of their employment while at UMMC and/or on official rotation at other hospitals or clinics. It does not apply to outside professional activities such as moonlighting.

  The UMMC institutional DEA number must not be used while moonlighting.

Oversight

- Each residency program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of scheduled duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
- To monitor compliance with applicable institutional and specialty/ subspecialty duty hours policies and requirements, the GMEC will assess each UMMC residency program at least annually. The extent and frequency of monitoring for each program will be determined by the GMEC based upon the program's duty hour history, data collected by the GMEC from the program and its residents, and other data sources identified by the GMEC. Duty hours assessment will also be a standard component of each G MEC-RRSC internal program review and report.

Work Hours Extension

The work hours of resident physicians enrolled in programs which have been granted an extension are limited to the amount in that extension up to a maximum of 88 hours per week. Except for an extension of total work hours all other aspects discussed in section 1 a-d of this policy apply to those programs receiving the extension.

The UMMC considers the participation in program or institutional work hours monitoring processes to be a part of the resident physician's professional responsibilities.

Effective 7/01/2011 Per GMEC

# Duty Hours Survey
## University of Mississippi Medical Center

The University Hospitals and Clinics wishes to provide the best possible care for patients, outstanding education for physicians in training, and maintain compliance with all ACGME requirements regarding resident work hours. Please take a moment to answer these questions about your recent experiences and duty hours compliance.

Resident PGY Level(circle): 1 2 3 4 5 6 7 8 Date:_____

Department / Training Program :_____

Rotation Type: In-patient/ Medical Surgical ICU

(please circle most recent) Emergency Dept Outpatient Clinic Labor/ Delivery

Other: _____

1. Do you feel your department is committed to duty hour compliance? Yes No

2. Do you feel your education has been compromised by duty hours policy? Yes No

3. Do you feel peer pressure to work beyond your assigned duty hours? Yes No

4. Do you feel faculty pressure to work beyond your assigned duty hours? Yes No

5. Can you identify specific rotations or duty assignments in your training program you feel violate duty hour guidelines? Yes No If yes, please list:_____

_____

| *On my most recent rotation(s):* | *Never* | *Some-times* | *Usually* | *Always* |
|---|---|---|---|---|
| I was assigned call more frequently than every third night, averaged over four weeks. | | | | |
| I received fewer than 4 days off when averaged over four weeks. | | | | |
| I was required to work more than 80 hours per week when averaged over four weeks. | | | | |
| I was assigned new patients after 24 hours of continuous duty. | | | | |
| I was routinely required to work more than 6 additional hours after my 24 hour call assignment ended. | | | | |
| I had fewer than 10 hours rest or personal time between assigned daily duty periods. | | | | |
| Call taken from home was excessive and precluded reasonable personal time | | | | |
| I participated in moon-lighting my program director is unaware of. | | | | |

Please write any additional comments or suggestions on the back of this sheet. Your answers are confidential and your department will not see your specific answers.

# The University of Mississippi Medical Center House Officer Attestation of Professional Commitment

Preparation for a career in medicine requires the acquisition of a large base of knowledge and skills. It also demands the virtues that form the basis of the doctor-patient relationship and sustain the profession of medicine as a moral enterprise. This attestation serves as both a commitment and a reminder to house officers that their conduct in fulfilling their professional obligations is the key to becoming a fully competent physician.

## House Officer Commitment (Signed at Orientation)

I pledge my utmost effort to acquire the knowledge, skills, attitudes, and behaviors required to fulfill all educational objectives established by the faculty as part of my training curriculum. I pledge that I will cherish the professional virtues of honesty, compassion, integrity, fidelity, and dependability. I pledge that I will embrace the highest standards of the medical profession and conduct myself accordingly in all of my interactions with patients, colleagues, and staff. I will respect all individuals without regard to gender, race, national origin, religion, age or sexual orientation.

I recognize the importance of personal health and well-being as a physician. I pledge to follow the duty hours limits as established by the Accreditation Council on Graduate Medical Education, the University of Mississippi Medical Center, and my Department.

In conjunction with my program director, I agree to monitor myself for signs of excessive fatigue. I agree to report excessive fatigue or violations of duty hours policies to my program director and / or the Office of Graduate Medical Education. I understand that any such reports may be made anonymously through the GME web-site if desired.

_____ _____

(signature) (department)

_____ _____

(print name) (date)

Department of Orthopaedic Surgery and
Rehabilitation Procedures for
Logging of Duty Hours

The Department uses Med Hub self-reporting system. The department uses the information input by residents to generate reports to monitor the duty hours. This information is reviewed during the department's regularly scheduled Program Evaluation Committee (PEC) Meetings.

All residents (PGY-1 to PGY-5 or 6) are to enter time on a weekly basis- including call and educational leave.

# COUNSELING AND PSYCHOLOGICAL SUPPORT

**I. Purpose:**

**To establish policies and procedures for counseling and psychological support that is available and applies to employees, including medical house staff, of the University of Mississippi Medical Center. These policies are intended to promote psychological health, and offer guidance and assistance in referral when needed.**

**II. Policy**

**Medical Support:**

**Refer to the Administrative Policy and Procedure Manual, Code H-1, for policies and procedures relating to provision of medical services. Currently, a twenty percent discount on hospital services is allowed for University Hospital employees and their dependents when covered by the state insurance plan. Routine physician discounts or waiving fees for any third party payer, courtesy write-offs, or not charging for services are not allowed in accordance with the Health Insurance Portability and Accountability Act, a federal statute. All UMMC employees are eligible for medical services through the Quick Care Clinic, University Hospital Emergency Department, Outpatient Clinics, and Inpatient Services, as needed.**

**Psychological Support and Counseling:**

**All UMMC employees are eligible for psychological services through the Department of Psychiatry and Human Behavior, or may choose care through the private practice sector if so desired. Additional services related to counseling and advice are available through the office of the Hospital Chaplain, limited to the customary and usual service provided by that office. In addition, Life Synch, UMMC's employee assistance program (EAP) provider, offers a confidential short-term counseling program and a work-life program which provides assistance for everyday issues free of charge to all Medical Center employees.**

**III. Procedures:**

A. **It is to be understood that all communication regarding counseling and psychological support be held in strict attention to confidentiality, and involve only those persons having unavoidable or essential knowledge of the reasons for and content of such counseling or psychological/psychiatric services. This is necessary to encourage the individual to seek the care they need, with confidence.**

**B. The individual in need of care or advice has several options as to which initial contact person or entity is utilized:**

- **Student/Employee Health Department**
- **The individual's supervisor**
- **The Hospital Chaplain**
- **The individual's personal physician**
- **Other trusted confidant of the individual**

**C. The most direct procedure, especially when utilizing the services of UMMC is for the individual to present initially to, or be advised to present to, Student/Employee Health Department. At that time an initial discussion can be held with the physician on duty to determine the type of problem and the most advisable next step.**

**If the resident wishes to contact Life Synch (EAP provider), he/she may call Life Synch 24/7 at 1-866-219-1232 or visit its website at lifesynch.com/eap (username "UMMC"; password "ummc"). The scope of the EAP/Work-Life program includes the following issues:**

**Three (3) free counseling sessions per issue with a licensed counselor or psychologist**

**Life/ stress, addiction and recovery, depression, anxiety, relationships, grief and loss**

**Legal/estate planning, legal forms, wills, power of attorney, final arrangements (free initial legal consultation, 25 percent discount from standard legal fees for subsequent services)**

**Family/childcare resources, emergency and backup care, summer school/vacation camp, parenting, adoption, child development, college planning, caring for older adults**

**Work/Co-worker relationships, change and transition, balancing work and personal life, relocation, business travel, job stress, and communication**

**Money/budgeting, debt management, home buying and refinancing, retirement planning, insurance, tax planning, identify theft**

**D. Information as to what extent the state insurance plan covers such services can be obtained from the departments of Human Resources or Student/Employee Health, or from the policy description given to each employee.**

**E. A list of providers under the various options of the state insurance plan is available through the department of Human Resources Benefits Division.**

**F. A list of providers under the various options of the state insurance plan is available through the department of Human Resources Benefits Division.**

**IV. Employee Health Clinic Hours and Location:**

**A. All UMMC students are eligible for services. Hours of clinic operation are from 7:00 a.m. to 4:00 p.m., Monday through Friday (except holidays). During other hours, care is provided in the Emergency Department.**

**B. Employee Health is located in N136, at extension 4-1185.**

**GMEC Approved: 4/6/00**
**GMEC Reviewed and Re-approved: 6/17/10**
**PAAC Reviewed 10/19/16, revisions approved**

**UNIVERSITY OF MISSISSIPPI MEDICAL CENTER**

Substance Abuse Policy

Excerpted from *UMMC Faculty and Staff Handbook – Drug Awareness Program*

The Medical Center is required, as mandated by the Anti-Drug Abuse Act of 1988, to maintain a drug-free workplace. It directs contractors receiving federal funding to establish and communicate policies on drug awareness to all employees, as well as to report workers convicted of workplace-related drug activities to the respective procuring federal agency within 10 days after an employee's conviction or within 10 days after they have actual knowledge of such conviction. Employees are required to notify the Medical Center in writing of any conviction of drug violation in the workplace within 5 days after the conviction.

Any employee engaged in work under a federal contract or grant shall furnish the written notification to the principal investigator or project director for the project, or if unavailable to the department chair. The recipient of the written notification will then provide the relevant information immediately to the Office of Research and Human Resources so the required notifications can be provided to the funding agency. The law also requires individuals who win government contracts to certify they will not engage in illegal drug activities while performing the contracted work.

Employees are the Medical Center's most valuable resource and for that reason, their health and safety are of paramount concern. The Medical Center is committed to maintaining a safe, healthful and efficient environment which enhances the welfare of our employees, patients and visitors. It is the policy of the Medical Center to maintain an environment which is free of impairment related to substance abuse by any of its employees.

Our patients, their families, our students and the Medical Center expect employees to arrive for work in a condition free of the influence of alcohol and drugs while they are on the job and to refrain from their use, possession or sale on UMMC property.

**Policy.** The following rules represent the University of Mississippi Medical Center's policy concerning substance abuse. They are enforced uniformly with respect to all employees, as indicated:

- All employees are prohibited from being under the influence of alcohol or illegal drugs during working hours, including while on-call.
- The sale, possession, transfer or purchase of illegal drugs on Medical Center property or while performing Medical Center business is strictly prohibited. Such action will be reported to law enforcement officials and licensing and credentialing agencies when appropriate. Such referrals will be done only after consultation with the director of human resources.

- The use, sale or possession of an illegal drug or controlled substance while on duty is cause for immediate termination.
- Any employee who commits an unlawful act on or off Medical Center premises or whose conduct discredits the Medical Center in any way, will be subject to disciplinary action, up to and including termination.
- No alcoholic beverage will be brought onto or consumed on Medical Center premises.
- Prescription drugs may be brought onto Medical Center premises. Such drugs will be used only in the manner, combination and quantity prescribed, as long as they do not impair the employee's ability to perform job functions.
- Any employee whose off-duty abuse of alcohol or illegal or prescription drugs results in excessive absenteeism or tardiness or is the cause of accidents or poor work performance will be referred to Employee/Student Health Services for evaluation or will face termination depending upon the circumstances.
- For purposes of this rule, an **alcoholic beverage** is any beverage, including beer, which may be legally sold and consumed and has an alcoholic content in excess of **three percent by volume**.
- Drug means any substance other than alcohol capable of altering an individual's mood, perception, pain level or judgement. A **prescribed drug** is any substance prescribed for individual consumption by a licensed medical practitioner. An **illegal drug** is any drug or controlled substance of which the sale or consumption is illegal.

**Purpose.** The purposes of the policy set forth above are:

- To establish and maintain a safe, healthy working environment for all employees;
- To ensure the reputation of the Medical Center and its employees within the community and industry at large;
- To reduce the number of accidental injuries to persons or property;
- To reduce absenteeism and tardiness and improve productivity; and
- To provide rehabilitation assistance for any employee who may seek such help.

The Medical Center regrets any inconvenience or problems that the policy may cause but believes that the overall benefit to the institution and its employees makes it both necessary and helpful.

**Rehabilitation.** Any full-time regular employee who feels that he/she has developed an addiction or dependence on alcohol or drugs is encouraged to seek assistance. Requests for assistance will be confidential. Requests for assistance may be directed to the individual's department head, supervisor, director of Human Resources or the director of employee/ student health services. Rehabilitation itself is the responsibility of the employee. A full-time regular employee seeking medical attention for alcohol or drug addiction is entitled to benefits under the Medical Center's group medical insurance plan. Any regular full-time employee who has successfully completed the initial employment

period may be granted a temporary disability leave for a reasonable time. Normally, the leave will not extend beyond a six-month period to accompany the combined accrued major medical and personal leave. It is the intention of this policy and its entitlements to provide leave for rehabilitation that will encompass a reasonably predictable period of time. The Medical Center reserves the right to require certified medical statements in support of the University's need to determine that employees be permitted to work. Failure to provide the requested necessary documentation may result in a "nonpay" status for the period of time in question, and/or dismissal (although accrued personal leave and major medical leave exist).

Employees who are under treatment at approved rehabilitation programs may protect their employment status at the University of Mississippi Medical Center as follows:

1. The Medical Center has a temporary disability leave policy whereby, among other things, an employee, by his/her own volition, may request a temporary disability leave (TDL) to confidentially correct a drug/alcohol abuse problem before job performance is affected and noticed by management. Employees may keep their substance abuse problem and treatment confidential from the Medical Center if they wish to pursue this option. Because of the confidential nature of the ESAP, administered by Employee Health Services, the ESAP may still be used by the employee.
2. Employees who have been determined by the Medical Center to have a substance abuse problem and desire to go through a drug and/or alcohol rehabilitation program will be reinstated to their job or an equivalent job provided they:
    a. Take a temporary disability leave to correct their problem;
    b. Successfully complete an approved substance abuse rehabilitation program and maintain the preventive course of conduct prescribed by the employee's drug or alcohol program. Employees will be required to supply ongoing documentation to their respective department heads which indicates they are remaining substance free; and
    c. The leave that the employee is required to take under this option, shall commence on his/her last day of actual work. An employee may be paid if the individual has accrued leave time.
3. Any physician found to be impaired will be dealt with as specified in the Medical Staff Bylaws, Rules and Regulations of the University Hospital, University of Mississippi Medical Center.

Upon returning from temporary disability leave, the employee must process through Human Resources and Employee/Student Health Services when notified by Human Resources. Employees will continue to accrue personal and major medical leave while on a paid leave status. Should the employee have a period of leave without pay, no leave time will accrue and insurance benefits can only be continued if payments are made by the employee through the Payroll office.

**Procedures to be Followed Before Request for Drug and Alcohol Screening**

1. The supervisor who observes or to whom it is reported that an employee is under the influence of a drug and/or alcohol, must confirm the observations or report by establishing that there is reasonable cause for action which is manifest in the employee's behavior and job performance.
2. Prior to initiating questioning on use or possession, the supervisor is to first consult with Human Resources personnel, if they are available. The supervisor is to have another supervisor present and limit questioning to that which will determine the employee's general condition.
3. The supervisor is to follow the procedures outlined in the observation checklist which may be obtained from Student and Employee Health Department.

   If the employee refuses to be tested after the supervisor has determined the need by the process outlined in No. 3 above, the employee should be suspended and told that, after further investigation, appropriate disciplinary action may be taken, up to and including termination.

4. Pending return of any test results, the employee should be suspended and told that appropriate disciplinary action may be taken once the test results are available, up to and including termination.
5. At the point that the employee has been suspended to await the results of the tests or because the employee has refused testing, the director of human resources will assume responsibility for the further direction of the incident.
6. Management and supervisors are to restrict conversations concerning possible violations of this policy to those persons who are participating in any questioning, evaluation, investigation or disciplinary action and who have a need to know about the details of the drug/alcohol investigation. This restriction includes not mentioning the name of the employee or employees suspected of violating this policy. **Management, supervisors and investigators are to instruct other employees, except as stated above, not to talk about such possible violations**.

**Employee Assistance Program.** Effective July 1, 2007, employee assistance services are available free of charge to all UMMC employees through a contractual agreement with LifeSync. This benefit entitles employees to obtain guidance regarding life, relationships, work, money, legal, family and everyday issues. These services can be accessed by calling (866) 219-1232 and setting up an appointment.

**Involvement of Law Enforcement Agencies/Licensing Agencies.** The use, sale, purchase, transfer, theft or possession of an illegal drug is a violation of the law. The Medical Center will refer such illegal drug activities to law enforcement, licensing and credentialing agencies when appropriate.

**Responsibility.** The administration of this policy is the responsibility of each department head and supervisor working in conjunction with the director of the Department of Human Resources.

Excerpted from *UMMC Faculty and Staff Handbook – Employee Alcohol and Controlled Substance Testing Rules*

The University of Mississippi Medical Center is required, as mandated by the Omnibus Transportation Employee Testing Act of 1991, by the Department of Transportation, to require each employee or applicant for employment who is required to possess a commercial drivers' license (CDL) to be tested for drugs, alcohol, or controlled substances.

On February 15, 1994, the Department of Transportation (DOT) published final rules implementing the Omnibus Transportation Employee Testing Act of 1991. Every college and university will be required to conduct pre-employment/pre-duty, reasonable suspicion, random, and post-accident alcohol and controlled substances testing of each applicant for employment or employee who is required to obtain a commercial drivers' license. An employee covered by the rules will be prohibited from refusing to take a required test.

Colleges and universities also are required to impose penalties on covered employees whose test results confirm prohibited alcohol concentration levels or the presence of a controlled substance; comply with extensive new reporting and record keeping requirements; adopt an employee alcohol and controlled substances misuse program; and provide for alcohol and controlled substances misuse information for employees, supervisor training, and referral of employees to employee assistance programs.
The following rules represent the Medical Center's policy concerning each employee or applicant for employment at UMMC who is required to possess a commercial drivers' license (CDL) to be tested for drugs, alcohol, or controlled substances. This policy is enforced uniformly with respect to all employees, as indicated.

- **Employee Alcohol Testing**
  **Program Requirements.** The rules prohibit alcohol misuse that could affect performance of a safety related function. This prohibition extends to 1) use of alcohol on the job; 2) use of alcohol during the four hours (in most cases) before performance of a safety-sensitive function; 3) having prohibited concentrations of alcohol in the system while performing safety-sensitive functions; 4) exhibiting behavior and/or appearance characteristic of alcohol misuse or an adverse effect on the employee's ability to perform due to alcohol misuse while performing safety-sensitive functions, and 5) use of alcohol following an accident.

  Following a determination that a covered employee has engaged in misuse of alcohol, UMMC will follow the Medical Center's Drug Awareness Program Policy. Pre-employment, random, post-accident, reasonable suspicion,

rehabilitation and follow-up controlled substance testing will be performed by the Department of Employee/Student Health or emergency room.

- **Employee Controlled Substance Testing Requirements**
  **Program Requirements.** A covered employee may not report for duty or remain on duty requiring the performance of a sensitivity-safety function when the individual uses any controlled substance. An exception to this rule applies in the case of an employee whose use of a controlled substance is pursuant to the instructions of a physician who has advised the employee that the substance will not adversely affect his or her ability to safely operate a commercial motor vehicle. UMMC may require covered employees to notify the Department of Employee/Student Health of any therapeutic drug use.

  Following a determination that a covered employee had engaged in prohibited use of a controlled substance, UMMC will follow the University of Mississippi Medical Center Drug Awareness Program Policy. Pre-employment, random, post-accident, reasonable suspicion, rehabilitation and follow-up controlled substance testing will be performed by the Department of Employee/Student Health or emergency room.

Excerpted PAAC for posting to GME website: August 2016

## University of Mississippi Medical Center
## Process for Initiating New Residency Programs

The formal process for initiating a residency program begins with a discussion between the appropriate department chairman or designee and the Vice Chancellor for Health Affairs. If the Vice Chancellor supports the establishment of the program, a proposal is submitted to the GMEC for review and approval. The proposal will include the naming of a program director and a description of the educational program, program resources and program policies and procedures. New programs must be approved by the GMEC and Vice Chancellor before residents may be enrolled.

## University of Mississippi Medical Center
## GMEC Policy on Quality of Education

Residency and fellowship training programs sponsored by the UMMC are required to maintain educational programs which meet or exceed the standards of the external accrediting bodies. The programs will establish educational goals consistent with these standards. Programs in emerging fields for which accrediting bodies do not exist are required to develop and maintain educational programs consistent with the goals of the program.

The educational experiences will include formal instruction and clinical experiences with appropriate supervision to ensure that the educational objectives are achieved. The program and its faculty are required to provide residents with formal evaluations of their progress in the program. Programs must provide residents with a mechanism to evaluate faculty and the educational program. In addition to the specific educational requirements of each program, all programs are required to provide a curriculum and evaluation system ensuring achievement of the following general competencies: patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems based practice.

The programs will receive periodic formal internal reviews at approximately mid-cycle between accreditation visits. Additional full or ad-hoc reviews may be conducted if significant problems are identified either through the review process or other mechanisms or if requested by programs.

# Resident Eligibility and Selection Policy

The Graduate Medical Education office monitors the compliance of **Section III.A. Resident Appointments** in the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements.

## Resident Eligibility

The University of Mississippi Medical Center participates in the National Resident Matching Program (NRMP) and adheres to this section of the Institutional Requirements.

The Graduate Medical Education office also reviews the applications of international medical graduates who have been accepted to transfer into and/or enter residency educational programs to assure their eligibility complies with both the Institution and ACGME requirements.

## Selection

To assure the methods of selection meet the standards of the University of Mississippi Medical Center and ACGME, the UMMC Graduate Medical Education Committee (GMEC) solicits written copies of the methods in effect in each program on an annual basis and these are reviewed at a meeting of the GMEC. Copies are maintained in a file in the Graduate Medical Education office.

To be reviewed by GMEC 6/17/10
PAAC reviewed/revised 11/3/16

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Department of Orthopaedic Surgery and Rehabilitation
Hand Fellow Recruitment and Appointment

1. Applicants interested in the hand fellowship position either call-in or mail their request - application requirements and materials available on our website.

2. Upon receipt of the request for information the following information is emailed to the applicant: information about the program, the city, and the state.

3. The applicant is instructed to complete and submit the Universal Hand Surgery Fellowship Application along with supporting documentation.

4. Once the application and required information from the applicant is received, the program director reviews the application and decides whether or not to invite the applicant for an interview.

5. Interviews are conducted at a mutually agreed upon time, and the match list is submitted on the day designated by the NRMP.

6. Match results are announced in May.

7. The Office of Medical Education mails the matched applicant a contract and other pertinent information regarding employment at UMMC.

8. Orientations are conducted on or prior to the August 1st start date.

9. Should the program not match with an applicant, applications are accepted by mail, outside the NRMP. Applicants are interviewed and offered the position.

Department of Orthopedic Surgery and Rehabilitation
Resident Recruitment and Resident Appointment

1. Applicants interested in a residency position either call-in or email their interest in the program.

2. Upon receipt of the request for information the following is provided via email: program information, UMC web page directions, and information about the city and state.

3. The applicant is instructed to apply through the NRMP via ERAS.

4. The application and information from the applicant is received via ERAS. Some applicants also mail information although they are advised to apply only through ERAS per AAMC and NRMP.

5. The Resident Selection Committee screens all completed applications and approximately 40 applicants are invited to interview.

6. Interviews are conducted on 2-4 days during the month of December & January, and the match list is submitted prior to the designated deadline in February.

7. Match results are announced in mid-March.

8. The Office of Medical Education mails the matched applicant pertinent information regarding employment at UMMC.

9. Orientations are conducted on or prior to the July 1st start date.

10. Should the program not match with an applicant, applications are accepted by mail, outside the NRMP. Applicants are interviewed and offered the position.

University of Mississippi Medical Center
Policy on Recruitment and Appointment of Residents

The University of Mississippi Medical Center's education, research and service programs and facilities are open to every qualified person. Equal employment opportunity is announced, provided and insured for all persons; and affirmative action is taken to guarantee that individuals are hired, trained, promoted and in all ways treated equally without regard to race, color, religion, sex, national origin, marital status, veteran status, age or disability as defined by law.

I. **Purpose**: This policy outlines the methods by which the University of Mississippi Medical Center selects physicians to participate in its residency educational programs. It applies to all applicants for residency slots in ACGME approved residency programs.

II. **Definition**: An applicant for a residency educational program will be a physician eligible for full medical licensure or limited medical licensure under the regulations of the Mississippi State Board of Medical Licensure and pertinent state and federal statutes.

III. **Policy**: The procedures for selection of residents at this institution will comply with the guidelines outlined by the Accreditation Council for Graduate Medical Education (Institutional Requirements. II. Residents A. Resident Eligibility and Selection).

IV. **Procedures**: The University of Mississippi Medical Center residency educational programs participate in the National Resident Matching Program. Individual programs are responsible for the selection from among qualified applicants both through the NRMP and above the PGY-1 level.

To assure the methods meet standards of the University of Mississippi Medical Center and ACGME, the UMMC Graduate Medical Education Committee solicits written copies of the methods in effect in each department on an annual basis and these are reviewed at a meeting of the GMEC.

The Graduate Medical Education office reviews information submitted by each international medical graduate who is accepted by a residency educational program to assure the candidate meets the criteria established by ACGME and that the candidate is eligible for a medical license through the Mississippi State Board of Medical Licensure.

GMEC Approved May 13.1999

GMEC Reviewed & Re-approved June 17, 2010

PAAC reviewed & Re-approved August 2016

## University of Mississippi Medical Center
## Residency Reduction/Closure Policy

The University of Mississippi Medical Center requires Educational Program Directors to provide written notice of any proposed changes in the status of their training program to the Associate Dean for Graduate Medical Education for inclusion on the agenda of the GME Committee.

If the Institution intends to reduce the size of an educational program or to close a program, each resident/fellow is to be informed in writing as soon as possible. Copies of the notification letter should be provided to the GME office.

Residents in good standing must be allowed to complete the program if the institution is in a position to provide adequate faculty and staff to meet the ACGME requirements of the program. The institution will assist them in enrolling in an ACGME accredited program in which they can continue their education if it is unable to maintain the program.

PAAC Reviewed August 2016

## University of Mississippi Medical Center
## Policy on Resident Transfers and Re-hiring

The University Medical Center understands that residents, for various reasons, may choose to change their career choice during residency training, giving rise to transfer between academic departments within the University, or re-hiring into the University after resignation or dismissal. This policy does not apply to outside applicants or to transfers or changes in position within a department such as transition into a fellowship within the same department. In addition, for residents in good standing in preliminary programs who are matched through the NRMP to another specialty, transfer into the subsequent program is an expected step in their training. In such cases, the program director of the preliminary year program should forward a letter to the accepting program director, but approval of this type of transfer is not necessary.

The University of Mississippi Medical Center understands that:

- Residents have a right to choose a program and a field of medicine in which they will be happy.
- Programs have a right to choose the best applicants for their positions.
- The overall goal is to train good physicians and protect the integrity of the programs and the institution.

In accordance with ACGME Document II.C on Resident Appointment and Transfers, the program director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation, including an estimate of competence, of the transferring resident prior to acceptance into the program. A program director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

- The initial contact with a department should be, ideally, resident initiated.
- Following resident contact, the contacted department may interview the resident confidentially and discuss available positions/options, but NO assurance of employment or formal offer can be made until the transferring department is made aware of the contact and a residency director's letter is received from the resident's current or formal department. Residents may seek transfer only into open slots. The residency director's letter must contain information on the resident's academic performance/problems, interpersonal and administrative skills, professional demeanor and conduct and any disciplinary warnings or actions taken. Finally, a list of rotations successfully completed and verification of training must be included. (see attached example letter).
- The resident may obtain letters of recommendation from other UMC faculty with whom they have worked in addition to the program director, but a letter from the PD is required.
- A release of information is not necessary for programs to access resident information in UMC files.
- All residents seeking transfer or re-hire will be made aware by the accepting program that their employee file in Human Resources at UMC is open for the program's review.
- All programs involved in resident transfers and re-hiring will advise Human Resources of the resident seeking transfer or re-hire. HR will make available information kept in the resident's HR file for review by the program director and/or Chairman. In addition, HR may assist with additional legal information kept in separate files.
- All residents seeking transfer or re-hire will be made aware by the accepting program that their resident file, and information contained therein, from the previous program may be made available to the receiving department. The receiving program may request any additional material deemed pertinent to making a decision regarding acceptance of the resident.
- While there is no breech of contract clause in resident contracts, residents will be informed that professional standards dictate a minimum of 30 days notice be given to their present residency program.
- All offers of transfer or re-hire must be approved by the Associate Dean for Graduate Medical Education and, ultimately, the Vice Chancellor. The Chairman or residency director will request approval prior to any offer being made to the resident.

Attachments (2): Example Program Director Letter, Approval form

PAAC reviewed August 2016

## EXAMPLE PROGRAM DIRECTOR'S LETTER

To: *Receiving Residency Director*
Re: *Residents name*
*Performance Summary*

Dr. *name* entered the *residency program* on *begin date,* having received his medical degree from *name of medical school*. *If the resident had previous residency, military or private practice experience, a comment regarding this should be made.* Throughout residency, his progress and performance has been *entirely regular and without administrative or academic problems or identify any problems. If the reside nt's course included probation, warnings, disciplinary actions, administrative problems, professional/conduct/ethical problems or required remediation, a statement to that effect, including successful resolution, should be included.* Dr. *name* is currently a PGY *(level)* resident and is expected to successfully complete all requirements on *end date*.

Dr. *name* has successfully completed the following rotations in our residency program: *(list)*

Based on his performance in our program, Dr. *name* received *describe performance (such as consistently above average ratings) in the areas of medical knowledge, clinical competency, diagnostic ability and interpersonal skills. Additionally, his attendance, interest, and rapport with staff and colleagues were deemed satisfactory or unsatisfactory. (Add specifics as appropriate here.)* Strengths include: *specific comments and " quotes" from rotation evaluations*. Areas for improvement include: *specific comments and " quotes" from rotation supervisor evaluations*.

Additional achievements during residency include *awards, research, presentations, offices (chief/assistant chief), and student teaching involvement.*

Give summary statement and recommendation of resident. Include a statement concerning approval to release or not release the resident from his contract should a position in the other department be offered.

If you have further questions, please give me a call at: *phone number*.

Sincerely,

*residency director's name and signature*
Residency Director

University of Mississippi Medical Center

# Approval for Resident Transfer or Re-Hire

Resident seeking transfer/re-hire: _____

Previous Training at University of MS Medical Center:
Department(s): _____

Dates of Attendance: _____

Reason(s) for resident seeking transfer or re-hire:

I, (residency director/Chairman) of the Department of (accepting department), verify that I have followed the procedure outlined in the UMC-GMEC Policy for Resident Transfers and Re-hiring, and have extended an offer for a (PGY level) position to (resident name) beginning (anticipated start date). The resident and I understand that this position is pending the final approval of the Associate Dean for Graduate Medical Education or the Vice Chancellor.

Comments by accepting department:

Respectfully submitted:

_____ _____
Chairman/Residency Director Accepting Department Date

Approved:

_____ _____
Vice Chancellor/Associate Dean for GMEC Date

## Department of Orthopedic Surgery and Rehabilitation
## RESIDENT WORK OUTSIDE OF UMMC - Moonlighting

Any plans for working outside of the The University of Mississippi Medical Center (moonlighting) must be discussed with the Department of Orthopedic Surgery and Rehabilitation Chairman.

## University of Mississippi Medical Center
## Moonlighting Policy

In Mississippi, it is illegal and/or grounds for loss of temporary or limited medical licensure for any resident or fellow in training to engage in moonlighting unless in possession of an unrestricted license to practice medicine in the State. Residents are not required to engage in moonlighting; further, the University of Mississippi Medical Center (UMMC) discourages moonlighting or professional activity by residents or fellows apart from full-time UMMC-sponsored or ACGME-sanctioned postgraduate educational programs because these activities tend to interfere with the educational process and health of the physician-in-training. The program director must acknowledge in writing that a resident or fellow is moonlighting, and the information made a part of the resident's folder. The effects of moonlighting on performance in the residency program will be monitored and adverse effects may lead to withdrawal of permission to engage in moonlighting activities.

The University of Mississippi Medical Center professional liability program for residents only applies to those professional activities within the course and scope of their employment while at UMMC and/or on official rotation at other hospitals or clinics. It does not apply to outside professional activities such as moonlighting.

The UMMC institutional DEA number must not be used while moonlighting.

**GMEC Approval - 4/3/2003**

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

**HOUSE OFFICER MOONLIGHTING POLICY:**

# EXPLANATION AND ACKNOWLEDGEMENT FORM

(This form should be signed by the resident and program director. It should be kept in the resident's file/residency education office).

The official medical center policy on Moonlighting for house officers is attached. Please review in detail. Key points are highlighted below:

- In Mississippi, it is illegal and/or grounds for loss of temporary or limited medical licensure for any resident or fellow in training to engage in moonlighting unless in possession of an unrestricted license to practice medicine in the State. PGY-1's may not moonlight.
- Residents are not required to engage in moonlighting;
- The University of Mississippi Medical Center (UMMC) discourages moonlighting or professional activity by residents or fellows apart from full-time UMMC-sponsored or ACGME-sanctioned postgraduate educational programs because these activities may interfere with the educational process and health of the physician-in-training.
- The effects of moonlighting on performance in the residency program will be monitored and adverse effects may lead to withdrawal of permission to engage in moonlighting activities.
- The University of Mississippi Medical Center professional liability program for residents only applies to those professional activities within the course and scope of their employment while at UMMC and/or on official rotation at other Mississippi hospitals or clinics. It does not apply to outside professional activities such as moonlighting.
- The UMMC institutional DEA number must not be used while moonlighting.
- Program directors must be informed if a resident is engaged in moonlighting activities. Failure to do so, may result in disciplinary action up to and including dismissal.
- General UMMC employee policy requires that any full-time employee seeking to be engaged in outside employment must complete the Conflict of Interest Disclosure section of the Human Resources Compliance web-site https://apps.umc.edu/conflictofinterest/start.

Please indicate by signing on the appropriate line below whether you are engaged in outside professional moonlighting activities. This form must be updated ANNUALLY. If you indicate that you are engaged in moonlighting you must fill out the "Application for Permission to Engage in Outside Employment or Practice of Profession" form and submit it to the Program Director for approval.

I am_____ am **NOT**_____engaged in professional moonlighting activities.

Resident's signature _____Date

Program Director's signature_____Date _____

**GMEC Approval - 4/3/2003**

Revised 3/27/17

## Vendor Interactions Policy

## Graduate Medical Education

## University of Mississippi Medical Center

This policy addresses resident/fellow behavior and relationships with vendors in educational contexts, which may include clinical training sites. The purpose of this policy is to ensure that graduate medical education activities at the University of Mississippi Medical Center (UMMC) and affiliated training are not compromised through vendor influence, collectively or through individual interactions. The goal of this policy is to further the professional accountability in trainees to their patients and colleagues. UMMC and the primary clinical training sites support policies governing vendor practices and conflicts of interest, and all residents and fellows are expected to observe local policies. Because residents train in many different venues within and outside of UMMC, it is possible they will encounter conflicting policy statements on various aspects of vendor interactions. It is the overarching policy of UMMC that the stricter policy will apply to any given situation of this type.

### Pharmaceutical Samples

Acceptance of pharmaceutical samples for self-use is strictly prohibited for all residents and fellows. Acceptance of pharmaceutical samples for delivery to patients by residents or fellows is not allowed except through approved institutional mechanisms.

### Vendor Gifts

The term gifts refers to items of value given without explicit expectation of something in return. Gifts may also include meals and beverages, outside meals at restaurants, promotional items, services such as transportation, invitations to participate in social events, and business courtesies. UMMC residents and fellows may not accept gifts, regardless of value, for themselves or on behalf of UMMC, individually or as a group, from any vendor of a healthcare product.

### Vendor Sponsorship at Educational Activities

Vendor sponsorship of GME educational activities should take place under the unrestricted grants and gifts only. An unrestricted grant or gift is one that is given to a UMMC department or program in which the donor(s) have specifically identified their intent to support certain activities (such as education for residents.) In instances where the grant is for GMD educational use, the donor may not specify content, topic, or speaker.

### Participation in Industry-Sponsored Programs

Residents and fellows may not participate as paid presenters or speakers in industry-sponsored programs such as lectures and panels without the express permission of the program director. Residents or fellows participating in such activity must report for duty hour purposes the actual time spent in this activity, and must disclose to the program director the amount of any compensation offered, including non-monetary items.

**Program Monitoring of Resident-Vendor Representative Interactions**

Programs should provide training to residents and fellows on vendor relations and conflicts of interest, including reference to this policy and other relevant institutional policies. Program leadership should be aware of and discuss with residents any interaction with representatives from vendors to ensure that any contacts are within the scope and spirit of this policy. Interactions that appear to place the resident in a position of obligation to or influence by, the vendor, should be explicitly discouraged.

Approved by GMEC: June 17, 2010

PAAC reviewed 11/03/2016

# Disaster Response Policy

# Graduate Medical

# Education

# University of Mississippi Medical Center

In the event of a disaster impacting the graduate medical education programs of the University of Mississippi Medical Center(UMMC), the DIO in collaboration with the GMEC has established this policy to protect the well-being, safety, and educational experiences of residents involved in our training programs.

**Disaster Declaration**

The ACGME published policies defining a disaster will be used for purposes of determining the declaration of a disaster at this institution. Once a disaster has been declared, the DIO and GMEC will work with other sponsoring institutional leadership to restructure or reconstitute all education experiences as soon as is reasonable. The DIO and GMEC will make the determination if transfer to another program is necessary.
This determination will be made as soon as possible to maximize the likelihood that residents would be able to complete program requirements within the standard time for certification of that specialty.

**Resident Transfer**

Once the DIO and GMEC determine that (UMMC) can no longer provide an adequate educational experience for its residents, the institution will arrange for the temporary transfer of the residents to programs at other sponsoring institutions until such time as UMMC is able to resume providing the experiences. Residents who transfer to other programs on a temporary basis will be informed by the Program Directors the estimated length of time that relocation will be required. If an extension is needed, the resident should expect notice of that extension from the UMMC Program Director. If the disaster prevents the institution from re-establishing an adequate educational experience within a reasonable period of time following the disaster, then permanent transfers will be arranged.

Institutions offering to accept temporary or permanent transfers from programs affected by a disaster must complete a form found on the ACGME website. Upon request, ACGME will give information from the form to affected programs and residents, and post the information on its website, upon authorization.

**Communication**

The DIO and Program Director(s) will communicate with the RRC(s) and ACGME regarding the impact of the disaster. Within ten days after the declaration of a disaster at UMMC, the DIO or designated representative will contact ACGME to discuss due dates for the programs to submit program reconfigurations and inform each program's residents of resident transfer decisions.

The DIO in conjunction with the GMEC will monitor progress of both healthcare delivery and functional status of GME programs for their educational mission during and following a disaster. Information and decision communications will be maintained with Program Directors and house staff, as appropriate to circumstances of the individual disaster event.

**PATIENT CARE LEVELS OF RESPONSIBILITY**
**University of Mississippi Medical Center**

## I. INPATIENT CARE RESPONSIBILITIES

### A. Attending physician:

1) A single attending physician is designated for each in-patient at both the University Hospital and the Veterans Affairs Medical Center.

2) The attending physician has ultimate medical-legal responsibility for all patients admitted to his service.

3) The attending physician has overall responsibility for both teaching rounds and management rounds on his/her ward patients.

4) An attending physician will round regularly with the residents and provides supervision for all medical care provided by the house staff.

5) The attending physician will review the admission history and physical exams performed by the resident and intern on the service and will make a note of this review in each patient's chart. In addition, the attending physician will supplement the residents' history and physical when necessary and will complete a full history and physical in the event that the history and physical documentation was done by a medical student.

6) The attending physician will review on a regular basis progress notes entered into patient's charts by medical students, interns, and residents and will indicate support of the patient care plan in the patient's chart.

7) The attending physician is responsible for reviewing all evaluation and management plans designed by the house staff and will revise and re-direct these plans when appropriate.

8) Attending physicians are responsible for teaching not only practical points of patient management, but enhancing the house officer and medical student's understanding of the pathophysiology of diseases as well as the cost benefit and financial implications of any path of medical management.

9) Each attending physician will be responsible for providing feedback directly to house officers and medical students during their attending experiences and will provide written evaluations for resident and student files as requested

10) The attending physician will be responsible for "signing-off" or certifying procedural skills in the procedure log of house officers working under their supervision at the end of each month or rotation as requested.

11) The attending physician should serve as a role model in ethical and professional behavior, including interdisciplinary management and patient safety and quality.

12) It is imperative that the attending physician recognize house officers do have conference commitments many days each week. As such, attending ward rounds should be completed in time for house staff to arrive at required conferences in a timely fashion. Effective and efficient time utilization is a responsibility of the attending physician.

13) The attending physician will be cognizant of the ACGME duty hours requirements and will complete teaching rounds at an appropriate time to allow house staff suitable time for patient hand-offs and medical follow-up while remaining compliant with duty hours guidelines.

14) The attending physician will oversee all admissions performed by house officers in the capacity of either "direct supervision," "indirect supervision with direct supervision immediately available" or "indirect supervision with direct supervision available."

15) The attending physician will be serve as "direct supervision" for any procedure for which the upper level resident has not met competency requirements.

16) The attending physician is responsible for recognizing signs of sleep deprivation in the house staff under his supervision, reporting these signs to residency program leadership and offering assistance to mitigate the effects.

**B. Resident (Junior and Senior level; PGY 2-5)**:

1) The resident is responsible for directing and managing the care of each individual patient.

2) The resident is the leader of each patient care team and responsible for the day-to-day management of each patient on his service.

3) The Senior resident supervises Interns and Junior house officers as well as students on the service.

4) The senior and junior residents have teaching responsibilities to the interns and medical students. The resident will act as "direct supervision" in any procedures performed by an intern who has not yet met competency requirements for that procedure. If the intern has met the requirements, the resident may serve as "indirect supervision with direct supervision immediately available."

5) The resident is responsible for guiding the intern in development of plans for patient care evaluation and therapy.

6) Senior level residents will be expected to carry greater responsibility for total care of the patient. However, attending physicians must be available at all times in the capacity of “indirect supervision with direct supervision available”. This is especially important in the setting of severely ill patients or when controversial management decisions must be made.

7) The senior level resident is responsible for teaching day-to-day management skills to his team and assisting students and younger house officers in developing confidence in their physical examination and history taking skills, in developing time management skills, and in recognizing and appropriately dealing with signs of sleep deprivation.

**C. Intern (PGY-1):**

1) The intern is responsible for implementing the plan of evaluation and care for each patient on his service.

2) The intern is expected to perform a history and physical examination and develop an extensive problem list for each patient under his direct care.

3) The intern is expected to develop a plan for diagnosis, treatment, etc. Although the intern is expected to have active input into the decision making process, the resident and attending physician have ultimate supervisory responsibility for every PGY-1 house officer.

4) The intern is expected to develop during his PGY-1 year increasing expertise in dealing with day-to-day patient problems, and increasing confidence in evaluation and management skills.

**D. Fellow (PGY-4 through PGY-8)**

*******Fellow participation in subspecialty services is variable. Not all services will include participation of fellow trainees. When participating in the team:

1. The fellow will supervise residents on the subspecialty service in the evaluation and therapy of patients.

2. The fellow is expected to enhance the learning experience on the service and participate actively in the teaching of other house officers and students on elective rotations.

3. The fellow will assist house officers in developing skills in the fine points of physical examination and procedures as specifically relate to their subspecialty training area.

4. The fellow will be responsible for providing “direct supervision” or “indirect supervision, with direct supervision immediately available” on all procedures that are specific to his/her subspecialty, that are performed on patients.

5. The fellow is responsible for directly managing the care of patients if the number of patients on the subspecialty service exceeds the appropriate number of patients that house officers may manage.

## II. AMBULATORY PATIENT CARE RESPONSIBILITIES

### A. Attending Physician

1. An attending physician will be present in each ambulatory care clinic to supervise all resident patient care activities.

2. The attending physician has ultimate medical-legal responsibility for all patients seen in continuity care clinics under his/her supervision.

3. The attending physician is responsible for review of history and physical examination and problem lists for each patient.

4. The degree of attending physician involvement in each patient's care will depend upon the education and competency level of the resident involved. Interns will review all patients seen with the attending physician or upper level resident in detail. Upper level residents will review all new patients in detail with the attending physician and will review the specific problems of return clinic patients when needed.

5. The attending physician will be responsible for encouraging preventive health maintenance and reviewing patient problem lists and medication lists as required by JCAHO in each ambulatory care chart or in the electronic medical record.

6. The attending physician will be responsible for evaluating each resident under his supervision as requested by the program director..

### B. House Officer

1. The house officer is responsible for assessment and management of each individual patient designated to his/her care.

2. The resident must maintain problem lists and medication lists as required by the hospital for compliance with JCAHO regulations.

3. Senior level residents will be expected to carry greater responsibility and see increasing numbers of patients in clinic, including both new patients and return patients.

4. The resident is expected to address social, economic, preventive, occupational, and psychiatric aspects of disease in the ambulatory patient setting as indicated.

**revised 6/16/11**

UMMC POLICY ON RESIDENT FATIGUE

The University of Mississippi Medical Center and University of Mississippi Health Care is committed to the management of potential negative effects of fatigue on patient care and learning. Adequate sleep facilities are available to residents. In addition, safe transportation options for residents who may be too fatigued to safely return home will be provided as follows in the order indicated:

1. Sixth Floor Call Rooms - 6E
2. Residency program (call education administrator)
3. Graduate Medical Education (984-1113)
4. Taxi Vouchers
5. UMMC security (601-984-1360)

7/1/2017

**University of Mississippi Medical Center**
**Graduate Medical Education**
**Hand-Off Policy**

**I. PURPOSE**:
The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care responsibility from one physician to another. In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face to face, that occurs when transitions in the care of the patient are occurring. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a "hand-off" is to provide complete and accurate information about a patient's clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

**II. SCOPE**:

These procedures apply to all UMHC physicians who are teachers or learners in a clinical environment and have responsibility for patient care in that environment.

**III. POLICY**:

- Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
- A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A "hand-off" or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
- A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A "hand-off" or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:

a) Move to a new unit
b) Transport to or from a different area of the hospital for care (e.g. diagnostic/treatment area)
c) Assignment to a different physician temporarily (e.g. overnight/weekend coverage) or longer (e.g. rotation change)
d) Discharge to another institution or facility

- Each of the situations above requires a structured hand-off with appropriate communication.

## IV. CHARACTERISTICS OF A HIGH QUALITY HAND-OFF:

- Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
- Hand-offs include up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.
- Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.
- Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

## V. HAND-OFF PROCEDURES:

- Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:

  a) Shift changes
  b) Meal breaks
  c) Rest breaks
  d) Changes in on-call status
  e) When contacting another physician when there is a change in the patient's condition
  f) Transfer of patient from one care setting to another

- Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.
- Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
- Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
- Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.
- Each hand-off process must include at minimum a senior Resident or Attending physician.
- A Resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior Resident that is coming onto the service. Telephonic hand-off is not acceptable.

## VI. STRUCTURED HAND-OFF:

- Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.
- Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):

    a) Patient name, location, age/date of birth
    b) Patient diagnosis/problems, impression
    c) Important prior medical history
    d) DNR status and advance directives
    e) Identified allergies
    f) Medications, fluids, diet
    g) Important current labs, vitals, cultures
    h) Past and planned significant procedures
    i) Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
    j) Plan for the next 24+ hours
    k) Pending tests and studies which require follow up
    l) Important items planned between now and discharge

- A receiving physician shall:

    a) Thoroughly review a written hand-off form or receive a verbal hand-off and take notes
    b) Resolve any unclear issues with the transferring physician prior to acceptance of a patient

- In addition, the SBAR can be used to deliver or receive the information:

    a) **Situation**: What is the problem?
    b) **Background**: Pertinent information to problem at hand
    c) **Assessment**: Clinical staff's assessment
    d) **Recommendation**: What do you want done and/or think needs to be done?

November 20, 2014

**A SAMPLE FORMAT**

| | |
|---|---|
| I Illness Severity | Stable, "Watcher", Unstable |
| P Patient Summary | Summary Statement<br>Events leading up to admission<br>Hospital Course<br>Ongoing assessment<br>Plan |
| A Action List<br>. | To do list<br>Timeline and ownership |
| S Situation Awareness & Contingency Planning | Know what's going on<br>Plan for what might happen |
| S Synthesis by Receiver | Receiver summerizes what was heard<br>Asks questions<br>Restates key action/to do items |

Rev 11/20/14

University of Mississippi Medical Center
Department of Orthopaedic Surgery and Rehabilitation
Transition of Care / Hand-Off Policy

**Transition of Care / Hand-Off**

Please note the department's official hand-off or transition of care policy.

Weekdays, Monday through Friday, two hand-offs/transitions occur on a daily basis:

1. 6:30 am morning x-ray conference- new admissions and consults from the call night are discussed, radiographs and initial management are presented, and the patients are transferred to the appropriate service based on further needs. There is a list of all patients admitted on call kept on the computer in Philips iSite (the hospital's digital radiology database). It is listed under PUBLIC FOLDERS/ORTHO ON CALL/YEAR/MONTH/DATE. It can be easily accessed by anyone with a username and password.

2. 5:00 pm.- the first call pager is passed from the junior on the ortho trauma team to the on-call resident. Potential problem patients are reviewed and plans discussed.

Saturday, Sunday, and Holidays

1. One handoff/transition occurs at 8 a.m. New admissions and consults from the call night are discussed, radiographs and initial management are presented, and the patients are transferred to the appropriate service based on further needs. There is a list of all patients admitted on call kept on the computer in Philips iSite (the hospital's digital radiology database). It is listed under
PUBLIC FOLDERS/ORTHO ON ALL/YEAR/MONTH/DATE.
It can be easily accessed by anyone with a username and password.

Revised May 2015

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
SCHOOL OF MEDICINE
INSTITUTIONAL POLICY ON RESIDENT SUPERVISION

*Preamble:*
*The University of Mississippi Medical Center is dedicated to medical education. To fulfill this mission, it is recognized that trainees must participate in rendering services to patients. Trainees will be supervised as they perform diagnostic and therapeutic procedures to gain the skills and experience necessary to become qualified practitioners in their chosen field. The purpose of this mandatory educational method is to assure that all trainees demonstrate a progressive increase in proficiency to enable them to ultimately become a licensed independent practitioner. However, it must be emphasized that under no circumstances will a trainee ever perform an invasive procedure for any purpose other than for the benefit of the patient or to achieve a diagnosis. This policy extends to include patients who are near death or have expired. [Post mortem examination or the securing of organs/tissue for transplantation/research purposes will require an additional (separate) consent form secured prior to those respective procedures.] This document outlines the policy whereby the attending staff or other senior individuals will provide supervision of residents in the various clinical settings of this institution.*

Definitions:

Supervision will consist of two specific levels: Direct Supervision and Indirect Supervision.

Direct Supervision is defined as the supervising physician being physically present with the resident and the patient during the encounter or procedure.

Indirect Supervision is subdivided into three levels of intensity:

Indirect Supervision with Direct Supervision immediately available- the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision if needed.

Indirect Supervision with Direct Supervision available- the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Indirect Supervision with Oversight- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

General Policy:

The program director of the resident and the chairman of the department to whom the resident is assigned are ultimately responsible for assuring faculty supervision of each resident. Responsibility for the supervision will usually be assigned by these leaders to an attending faculty member supervising the resident on various specific academic and clinical rotations or experiences. These assignments are reflected in monthly rotation and call schedules which clearly delineate the assigned attending faculty member, and also upper level houseofficers who will be assigned to provide supervision as appropriate to junior level residents. All resident clinical activities are supervised 24 hours per day, 7days per week, 365 days per year.

Residents are members of the medical staff as defined in the hospital by-laws. They will provide assistance in the care of patients of physicians on the service to which they are assigned. All patients receiving care at this institution are assigned to a member of the medical staff. The staff member responsible for the care of the patient will provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment demonstrated by the resident(s) being supervised. As part of the training program, residents should be given progressive responsibility for the care of patients and to act in a teaching capacity and provide supervision to less experienced residents and students. It is the decision of the staff member, with advice from the program director, as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient. It is expected that faculty supervision assignments should be of sufficient duration to adequately assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Documentation of supervision will be by progress note or signature by the attending physician or reflected within the resident's progress notes at a frequency appropriate to the patient's condition, or as dictated by hospital policies.

Inpatient Areas: In general, patients admitted to the hospital who are in stable condition will receive indirect supervision with direct supervision available. The resident should notify the attending physician in a timely fashion of each admission, at the discretion of the attending or per program guidelines (e.g. for every patient admitted or for selected patients). The attending physician will be expected to personally see the patient and review the management plan within 24 hours of admission. Each program will utilize a specific set of guidelines to define circumstances and events in which residents must communicate immediately with appropriate supervising faculty member.

Outpatient Clinic: Residents seeing patients in an outpatient clinic will generally receive either direct supervision or indirect supervision with direct supervision immediately available. Management plans for new patients or revision of existing management plans will be reviewed during the clinic.

Emergency Room: Residents assigned to the emergency room service will receive direct or indirect supervision with direct supervision immediately available, depending on the severity of

the problem and experience of the resident. Residents providing consultation or care to patients followed by their respective services receive indirect supervision with direct supervision available by the staff of their service, in most cases. Dispositions of these patients may be discussed by phone with the appropriate staff member and/or reviewed on return to an outpatient facility. If the patient is admitted, the treatment plan will be reviewed by the attending faculty within 24 hours.

Operating Room or Special Procedure Facility: Residents performing diagnostic procedures that require a high level of expertise in performance or interpretation will receive direct supervision by a faculty member depending on the experience and proficiency previously demonstrated by the resident.

Emergency Care: In an emergency, defined as a situation where immediate care is necessary to preserve life or prevent serious impairment of health, residents are permitted to perform any and all necessary actions possible to save a patient from serious harm pending arrival of more qualified staff. The appropriate faculty practitioner will be notified as soon as possible of all emergency situations.

Fee for Teaching Physician Services: In those instances in which the attending physician submits a bill for services as the teaching physician, supervision must be provided in keeping with CMS Final Rule and its subsequent revisions.

*Violation of compliance with this policy by any trainee could result in (immediate) dismissal from the program.*

PAAC reviewed August 2016

University of Mississippi Medical Center
Department of Orthopaedic Surgery &
Rehabilitation House Officer Supervision Policy

Purpose:

Define the duties that individual residents may perform and what types of supervision they require.

Training Level Definitions:

Intern: PG-1 training level

Junior Resident: PG-2 and PG-3 training level

Senior Resident: PG-4 and PG-5 training level

Fellow: PG-6 training level

Supervision Definitions:

Supervision will consist of two specific levels: Direct Supervision and Indirect Supervision.

Direct Supervision is defined as the supervising physician being physically present with the resident and the patient during the encounter or procedure.

Indirect Supervision is subdivided into three levels of intensity:

Indirect Supervision with Direct Supervision immediately available- the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision if needed.

Indirect Supervision with Direct Supervision available- the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Indirect Supervision with Oversight- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Emergency: Medical or orthopedic situation in which death or irreversible medical and /or significant orthopedic sequellae may result from lack of immediate care.

Resident Communication with Faculty

Residents must communicate with their attending faculty regarding significant patient events including: patient hospital admissions, patient ICU transfers, and surgical decisions. We teach the SUPERB/SAFETY model concerning faculty/resident communication.

Intern

During the first year of training the intern will rotate through a variety of different medical and surgical subspecialties. Applicable supervision policy will change with each rotation to reflect that medical specialty's policy. When interns carry the orthopedic pager on shifts during RRC required orthopaedic rotations, the orthopedic surgery supervision policy guidelines will apply to orthopedic interns.

In general, significant procedural patient care performed by the intern will require direct supervision. Junior residents, senior residents, and faculty may all participate in both direct and indirect supervision of interns. When an intern is under indirect supervision there must be direct supervision immediately available. In emergency situations it is recognized that interns may temporarily need to provide patient care without a supervisory physician.

Requires Direct Supervision by Faculty or Junior and Senior Residents:

- All elements of surgical procedures
- Fracture reduction
- Reduction of joint dislocations
- Placement of skeletal traction
- Casting / Splint Placement
- Central line placement
- Fluoroscopic examinations of the extremity
- Regional anesthetic blocks (Bier Blocks)
- Wound debridement and or drainage

Requires Indirect Supervision with Direct Supervision immediately available by Faculty or Senior Residents for procedures performed in the Operating Room / Indirect Supervision with Direct Supervision available by Faculty or Senior Residents for procedures performed in the Emergency Room:

- History and physical examination of patients
- Review of radiographic studies
- Diagnosis of musculoskeletal and medical conditions
- Prescription of medications
- Management of perioperative surgical and medical conditions
- Simple wound care
- Arthrocentesis and joint injection
- Peripheral IV line placement
- Vac dressing changes

Junior Resident

During the PG-2 and PG-3 training years, the resident is expected to have significant growth with respect to competency in providing appropriate orthopedic and medical patient care and the amount of autonomy granted by supervisory physicians. In general, it is expected that junior residents will be able to provide procedural patient care outside of the operating room in an environment of indirect supervision. The junior resident may request direct supervision of procedural patient care by senior residents or faculty for any patient care scenario at any time. Upon such request, direct supervision will be provided. Senior residents and faculty may participate in both direct and indirect supervision of junior residents. In emergency situations it is recognized that junior residents may temporarily need to provide patient care without an appropriate supervisory physician.

Requires Direct Supervision by Faculty or Senior Residents:

- Critical elements of surgical procedures
- Halo placement for cervical spine fractures
- Percutaneous pinning of simple hand fractures
- Surgical instrumentation in fracture care

Requires Indirect Supervision with Direct Supervision immediately available by Faculty or Senior Residents for procedures performed in the Operating Room / Indirect Supervision with Direct Supervision available by Faculty or Senior Residents for procedures performed in the Emergency Room:

- Management of perioperative surgical and medical conditions
- Fracture reduction
- Reduction of joint dislocations
- Placement of skeletal traction
- Casting / Splintage
- Wound debridement and / or drainage
- Wound irrigation
- Fluoroscopic examinations of the extremity
- History and physical examination of patients
- Review of radiographic studies
- Diagnosis of musculoskeletal and medical conditions
- Prescription of medications
- Simple wound care including closure
- Arthrocentesis and joint injection
- Irrigation and debridement of hand fractures
- Completion of finger tip amputations
- Regional anesthetic blocks (Bier block)
- Vac dressing changes
- Extensor tendon (hand) repair

Senior Resident

During the PG4 and PG5 training years, the resident is expected to function at near faculty level when providing orthopedic and medical patient care outside of the operating room. In general, it is expected that senior residents will be able to provide procedural patient care duties outside of the operating room in an environment of indirect supervision. When performing patient care outside of the operating room, the senior resident may request direct supervision by faculty at any time in which case direct supervision by faculty will be provided. Faculty will provide direct supervision of senior residents for the critical elements of surgical procedures performed in the operating room. In emergency situations it is recognized that senior residents may temporarily need to provide patient care without a supervisory faculty physician.

Requires Direct Supervision by Faculty or Junior and Senior Residents:

- Critical elements of surgical procedures

Requires Indirect Supervision with Direct Supervision immediately available by Faculty or Senior Residents for procedures performed in the Operating Room / Indirect Supervision with Direct Supervision available by Faculty or Senior Residents for procedures performed in the Emergency Room:

- Halo placement for cervical fractures
- Management of perioperative surgical and medical conditions
- Percutaneous pinning of simple hand fractures
- Extensor tendon (hand) repair
- Irrigation and debridement of hand fractures
- Completion of finger tip amputations
- Fracture reduction
- Reduction of joint dislocations
- Placement of skeletal traction
- Casting / Splintage
- History and physical examination of patients
- Review of radiographic studies
- Wound debridement and / or drainage & irrigation
- Diagnosis of musculoskeletal and medical conditions
- Prescription of medications
- Simple wound care including closure
- Arthrocentesis and joint injection
- Fluoroscopic examinations of the extremity
- Regional anesthetic blocks (Bier Blocks)
- Vac dressing changes
- Surgical instrumentation in fracture care (excluding critical elements)

University of Mississippi Medical Center
Department of Orthopedic Surgery & Rehabilitation
Orthopedic Surgery Residency Program
Resident Protocol – The Superb/Safety Model – When to call?

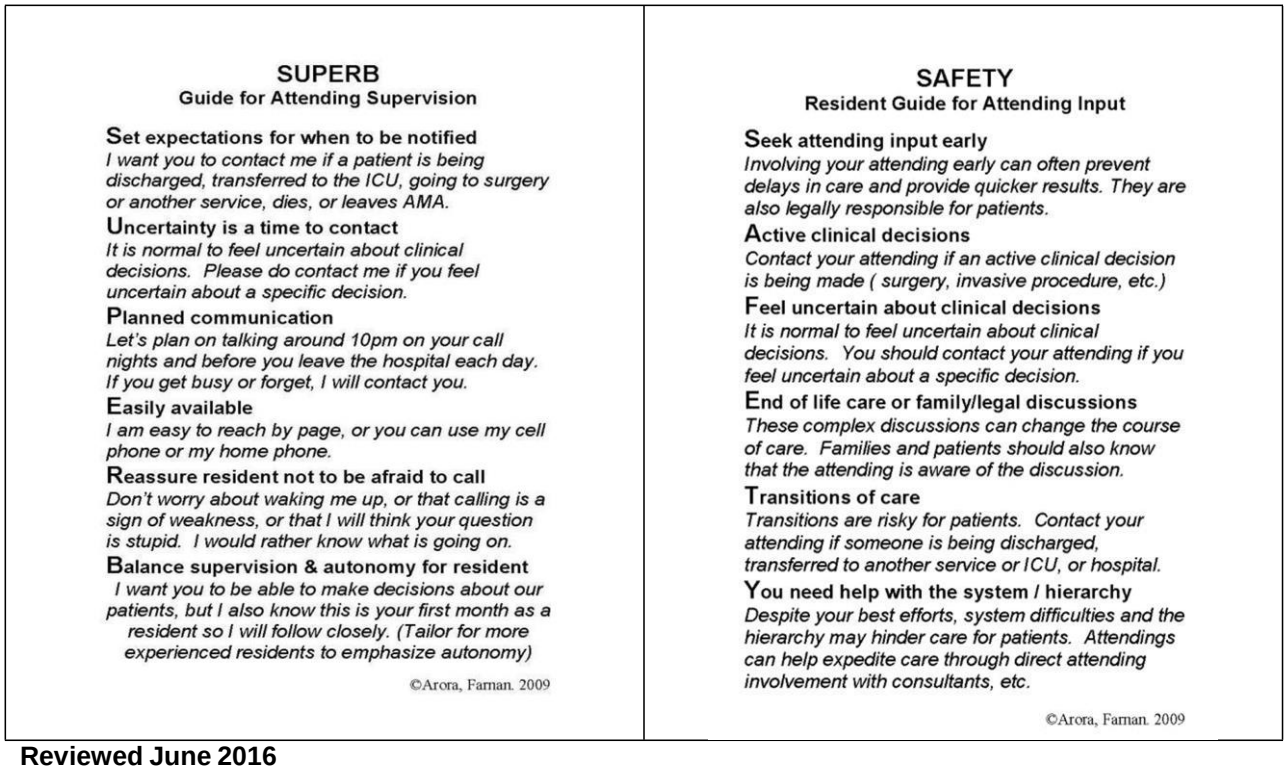
Purpose:

Define the events and/or situations where individual residents need to contact upper level residents and/or faculty members.

Protocol:

Residents are provided a Supervision Packet prior to the start of their PG1 Orthopedic Trauma rotation. This packet includes laminated pocket cards to keep with them through-out their training, as well as articles, bibliographies, education tools and presentations regarding resident supervision.

- Laminated SUPERB/SAFETY pocket cards
- Biography: Jeanne M. Farnan, MD, MHPE
- Biography: Vineet M. Arora, MD, MAPP
- Article: Farnan JM, Johnson JK, Meltzer DO, Harris I, Humphrey HJ, Schwartz A, Arora VM. *Strategies for Effective On-Call Supervision for Internal Medicine Residents: The Superb/Safety Model*. J Grad Med Educ. 2010 Mar;2(1):46-52.
- Article: Farnan JM, Johnson JK, Meltzer DO, Humphrey HJ, Arora VM. *On-call supervision and resident autonomy: from micromanager to absentee attending*. Am J Med 2009;122(8):784-88.
- Article: Farnan JM, Johnson JK, Meltzer DO, Humphrey HJ, Arora VM. *Resident uncertainty in clinical decision making and impact on patient care: a qualitative study*. Qual Saf Health Care 2008;17:122-126.
- Video: Attending Supervision: First Day on the Wards available at http://www.youtube.com/MergeLab
- Research Tools / Resident and attending surveys used in Farnan et al. Am J Med 2009 article.



**SUPERB**
**Guide for Attending Supervision**

**S**et expectations for when to be notified
*I want you to contact me if a patient is being discharged, transferred to the ICU, going to surgery or another service, dies, or leaves AMA.*

**U**ncertainty is a time to contact
*It is normal to feel uncertain about clinical decisions. Please do contact me if you feel uncertain about a specific decision.*

**P**lanned communication
*Let's plan on talking around 10pm on your call nights and before you leave the hospital each day. If you get busy or forget, I will contact you.*

**E**asily available
*I am easy to reach by page, or you can use my cell phone or my home phone.*

**R**eassure resident not to be afraid to call
*Don't worry about waking me up, or that calling is a sign of weakness, or that I will think your question is stupid. I would rather know what is going on.*

**B**alance supervision & autonomy for resident
*I want you to be able to make decisions about our patients, but I also know this is your first month as a resident so I will follow closely. (Tailor for more experienced residents to emphasize autonomy)*

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**SAFETY**
**Resident Guide for Attending Input**

**S**eek attending input early
*Involving your attending early can often prevent delays in care and provide quicker results. They are also legally responsible for patients.*

**A**ctive clinical decisions
*Contact your attending if an active clinical decision is being made ( surgery, invasive procedure, etc.)*

**F**eel uncertain about clinical decisions
*It is normal to feel uncertain about clinical decisions. You should contact your attending if you feel uncertain about a specific decision.*

**E**nd of life care or family/legal discussions
*These complex discussions can change the course of care. Families and patients should also know that the attending is aware of the discussion.*

**T**ransitions of care
*Transitions are risky for patients. Contact your attending if someone is being discharged, transferred to another service or ICU, or hospital.*

**Y**ou need help with the system / hierarchy
*Despite your best efforts, system difficulties and the hierarchy may hinder care for patients. Attendings can help expedite care through direct attending involvement with consultants, etc.*

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**Reviewed June 2016**

# Evaluations

**Department of Orthopedic Surgery and Rehabilitation**
**Evaluation Forms**

Resident / Fellow Evaluation by Faculty – Formative

An evaluation is generated as scheduled by the E-Value system administrative, to email out to the faculty member(s) mid-point in the rotation. This evaluation serves to provide feed-back to residents regarding their strengths and weaknesses so they can work to make any improvements necessary.

Resident / Fellow Evaluation by Faculty – Summative

This evaluation is generated as scheduled by the E-Value system administrative, to email to the faculty member(s) at the end of the resident's rotation. This provides an evaluation of the performance and is compiled for the resident's semi-annual evaluation with the PD. Should any evaluation come in below the set low mark, the Education Administrator and the PD are notified immediately via email to address prior to the semi-annual evaluation.

Faculty Evaluation by Residents / Fellow

Residents are emailed a link to evaluate the faculty members on the rotation they are currently completing. The residents can also send an evaluation "on the fly" should something need to be addressed earlier. These evaluations are combined and provided to the PD and chair for the annual evaluation of the program. All evaluations in this category are kept confidential from the faculty member being evaluated.

Quality of Resident Education – Rotation by Resident / Fellow

Residents are emailed a link to evaluate the education service on each service, at the end of their rotation. The residents can also send an evaluation "on the fly" should something need to be addressed earlier. These evaluations are combined and provided to the PD and chair for the annual evaluation of the program. All evaluations in this category are kept confidential from the Faculty / Service being evaluated.

Quality of Resident Education – Program by Faculty

Faculty members are emailed a link to evaluate the education program, i.e. journal club, rotations, faculty, physical facilities, etc. This compiled report is presented and discussed at the annual review of the program each year.

Resident / Fellow 360 Degree Evaluation

Ancillary nurses, NPs, etc who work closely with residents in administrative roles, are emailed a link to evaluate the residents. All residents / fellows will be evaluated when rotating on specific services, or in clinic areas. All information is compiled for the resident evaluations, as to provide confidentiality. No names are ever given to residents.

Resident Peer to Peer Evaluation

Residents are emailed a link to evaluate each other after each rotation regarding all six competencies. Evaluations are strictly confidential unless patient safety is involved.

Resident / Fellow Evaluation – End of Residency / Fellowship by PD

The PD completes this evaluation a the end of residency training based on all prior evaluations, skills training, as well as other factors. This evaluation serves as the final evaluation of the abilities of the residents / fellow. Both the PD and the resident / fellow sign this evaluation. A copy is kept in the resident's permanent file.

Program Director Evaluation of Resident – Semi Annual Check Off Form

Residents are reviewed semi-annually by the PD. This form is completed by the PD to document any discussions, counseling, promotion, issues, probation, etc. discussed during the resident's semi-annual review with the PD. Both the PD and the resident / fellow sign this form which is kept in the resident's permanent evaluation file.

Resident Portfolio Form – Semi Annual Documentation by Resident

This form is to help residents prepare for their semi-annual review with the PD. It provides structure, i.e. updated CV, Operative case reports, long-term goals, research project status, etc. This form is kept in the resident's permanent Portfolio file.

The University of Mississippi Medical Center
Jackson, Mississippi

## RESIDENT EVALUATION FACTORS:

In evaluating the resident, compare him or her with a completely trained and competent orthopaedic surgeon.

Factor 1. Knowledge of basic science as they relate to orthopaedics.

This factor is concerned with the resident's knowledge of Anatomy, Bacteriology, Biochemistry, physiology, pathology, biophysics, and biomechanics that is necessary to adequately diagnose and treat orthopaedic patients.

| The ineffective resident does not know surgical anatomy of cases assigned, does not show evidence of understanding of patho-mechanics in trauma and does not show evidence of understanding of basic Bacteriology, Physiology and Pathology in patient management. He/She lacks understanding of aseptic technique and appropriate selection and use of antibiotics. | The effective resident routinely is well prepared at surgery with a knowledge of Anatomy and Pathology of a given case. He understands the mechanisms of injury of most fractures and is aware of the affects of disease and trauma on the physiology of his patients. He utilizes appropriate antibiotics, medications and treatment adjuncts. He demonstrates a good understanding of aseptic technique. |
|---|---|

Factor 2. Knowledge of Clinical Orthopaedics

This factors is concerned with the resident's knowledge of clinical entities, methods of treatment and expected results in Trauma, Adult and Reconstructive Orthopaedics, Children's Orthopaedics and Rehabilitation.

| The ineffective resident shows a lack of knowledge of awareness of musculoskeletal conditions affecting patients. He is not aware of treatment alternative and methods. | The effective resident shows evidence of knowledge of the literature, methods of management, and the use of prostheses, orthoses and other appliances. He is aware of the advantages and disadvantages of various treatment alternatives. |
|---|---|

Factor 3. Information Gathering

This factor is concerned with the resident's willingness, ability and skill in gathering information necessary for diagnosis.

| The ineffective resident limits his/her interview and physical examination to the area of complaint and fails to pursue alternative hypotheses.<br><br>He/she frequently uses therapy to substantiate clinical impressions. | The effective resident routinely takes a comprehensive initial history and physical examination. He records the information received in a systematic fashion, and pays careful attention to progress notes.<br><br>He/she is aware of information other than the medical and indicates this by initiating further procedures and questions. |
|---|---|

Factor 4. Problem-Solving

This factor is concerned with the resident's ability and skill in using information gained to develop a diagnosis and support clinical activity.

| The ineffective resident has an incomplete | The effective resident realized the importance of |
|---|---|
| comprehension of the implications of the data he/she has collected.<br><br>He/she is unable to interpret unexpected results and often ignores them.<br><br>He/she makes decisions on the basis of experience, disregarding the context in which that experience was gained.<br><br>His/her thinking is rigid and unimaginative, including his recognition of associated problems. | unexpected findings and seeks to determine their implications.<br><br>He/she understands the nature of probability and uses this to illuminate his experience.<br><br>He/she takes all the data into account before reaching a decision and routinely tests alternative hypotheses. |

Factor 5. Clinical Judgement

This factor is concerned with the resident's ability to use sound judgement in planning for and carrying out treatment.

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| The ineffective resident is overly concerned with treatment techniques at the expense of overall goals.<br><br>He/she often delegates pre- and post- operative care to others.<br><br>He/she plans treatment without sufficient familiarity with the procedures he/she selects.<br><br>His/her treatment choice is rigid-using a set formula for treating each clinical problem or using a favorite technique when more effective ones are available. | The effective resident is familiar with the uses and limitations of the procedure he/she attempts. He/she recognizes his/her own capabilities and uses procedures which correspond to them.<br><br>He/she considers simple procedures first.<br><br>His/her clinical judgement encompasses information beyond the pathologic.<br><br>He/she demonstrates regard for patient needs, desires and life conditions.<br><br>He/she is flexible enough to modify his treatment plans when the situation warrants. |

Factor 6. Surgical Technique

This factor is concerned with the resident's ability and skill in carrying out operative procedures.

| | |
|---|---|
| The ineffective resident has insufficient skill for the procedures he/she attempts.<br><br>His/her overall handling of instruments and tissue lacks finesse.<br><br>His/her operating time is often prolonged through unfamiliarity with procedures or inadequate planning.<br><br>He/she takes unnecessary operative risks or terminates operation before maximum results are achieved. | The effective resident handles tissues gently, uses careful hemostasis, and makes a proper and adequate exposure of the operating field.<br><br>He/she carefully attends to details such as sterilization of instruments and proper choice of same.<br><br>He/she makes proper application of fixation devices or prosthesis and makes proper closure of wounds.<br><br>He/she carefully monitors his patients during operative procedure. |

Factor 7. Relating to Patient

This factor is concerned with the resident's effectiveness in working with patients.

| | |
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| The ineffective resident does not communicate with his patients, either through aloofness, indifference or the pressure of time.<br><br>He/she has difficulty understanding patient needs.<br><br>He/she is unable to evoke patient confidence, tending even to alarm them.<br><br>He/she reacts negatively to hostility or other emotional displays | The effective resident's manner elicits patient confidence and cooperation and relieves anxiety.<br><br>He/she is interested in his patient's well-being and demonstrates this without becoming emotionally involved.<br><br>He/she is honest with the patient and his family.<br><br>Patients like him/her and readily feels they can ask questions and discuss problems with him. |

Factor 8. Continuing Responsibility

This factor is concerned with the resident's willingness to accept the responsibility for long-term patient care.

| | |
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| The ineffective resident either loses interest after initial treatment or does not take the time for adequate follow-up.<br><br>He/she becomes discouraged with slow progress and cannot cope with a poor prognosis. He/she is unable to communicate realistic expectations to the patient. | The effective resident is able and willing to work with the patient to achieve maximum rehabilitation. He motivates the patient to strive for his/her own rehabilitation.<br><br>He/she monitors patient's progress, altering therapy or treatment as indicated. |

Factor 9. Emergency Care

This factor is concerned with the resident's ability to act effectively in emergency situations, in the operating theatre or the emergency room.

| | |
|---|---|
| The ineffective resident panics easily and makes inappropriate use of time available.<br><br>He/she becomes confused under pressure and has difficulty establishing priorities. He/she is unable to delegate aspects of care to others.<br><br>He/she is careless about applying protective measures.<br><br>He/she is unable to make decisions alone. | The effective resident quickly assesses the situation, pays attention to life-saving procedures and demonstrates understanding of triage concepts.<br><br>He/she is able to obtain and organize assistance of others.<br><br>He/she is able and willing to make decisions along if necessary.<br><br>He/she is aware of consequences of delay. |

Factor 10. Relating to Colleagues

This factor is concerned with the resident's ability to work effectively with his colleagues and other members of the health team.

| | |
|---|---|
| The ineffective resident has difficulty relating to others and lacks the ability either to give or take gracefully.<br><br>He/she tends to be tactless and inconsiderate and does not evoke the confidence and cooperation of those with whom he/she works.<br><br>He/she habitually gives unsolicited advice, and in an offensive manner.<br><br>He/she is unwilling to make referrals or seek consultation and fails to support his/her colleagues in their contacts with his/her patients. | The effective resident relates well to others and communicates easily, working well in a team situation.<br>He/she seeks consultation when appropriate and respects others' views.<br><br>He/she demonstrates self-control.<br><br>He/she gives credit to others for their contributions and creates an atmosphere of working together-not working for. |

Factor 11. Moral and Ethical Values

This factor is concerned with the resident's attitudes and standards as an individual.

| | |
|---|---|
| The ineffective resident attempts to cover up his errors.<br><br>He/she is frequently absent from assigned duty or unavailable when needed.<br><br>He/she has unethical contacts with non-medical professions and allows his/her personal finances to unduly influence treatment.<br><br>He/she discusses medical mismanagement with patients. | The effective resident's conduct reflects kindness, respect, honesty and humility.<br><br>He/she reports facts accurately, including his/her own errors.<br><br>He/she respects the confidences of colleagues and patients.<br><br>He/she places patients care above personal considerations.<br>He/she respects the property of others.<br>He/she recognizes his own professional capabilities |

# The Orthopaedic Surgery Milestone Project

*A Joint Initiative of*

The Accreditation Council for Graduate Medical Education

and

The American Board of Orthopaedic Surgery

# The Orthopaedic Surgery Milestone Project

The milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

## Orthopaedic Surgery Milestones

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*Acknowledgements: Special thanks to Stephen Albanese, MD and Shepard R. Hurwitz, MD, who were active members of both the Working and Advisory Groups.

## Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe each resident's current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page v).

**Level 1:** The resident demonstrates milestones expected of an incoming resident.

**Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

**Level 3:** The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.

**Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

**Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

**Additional Notes**

Level 4 is designed as the graduation *target* but does not represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the residency program director. Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether milestones in the first four levels appropriately represent the developmental framework, and whether milestone data are of sufficient quality to be used for high-stakes decisions.

Examples are provided with some milestones. Please note that the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to the ACGME supervision guidelines, as well as institutional and program policies. For example, a resident who performs a procedure independently must, at a minimum, be supervised through oversight.

*Answers to Frequently Asked Questions about the NAS and milestones are available on the ACGME's NAS microsite: http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf.*

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

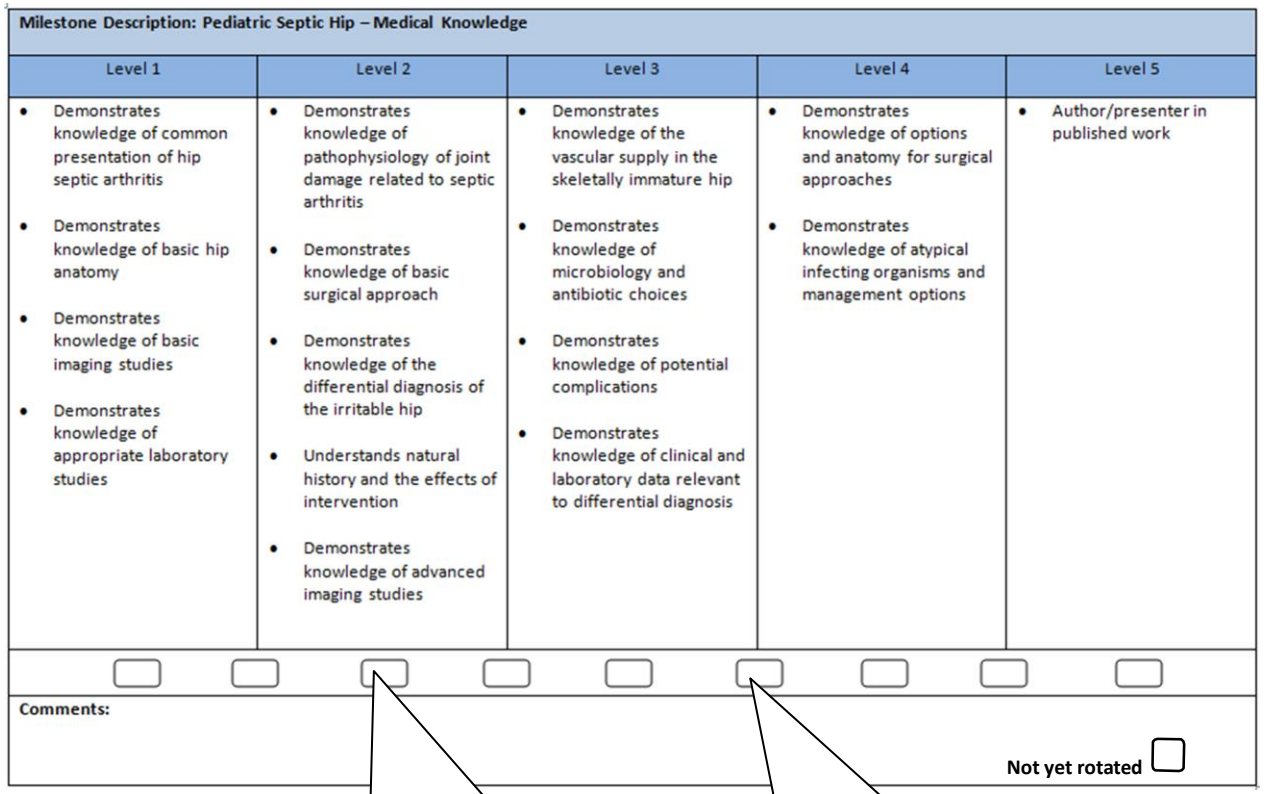
- Selecting the level of milestones that best describes that resident's performance in relation to the milestones

or

- For Patient Care and Medical Knowledge milestones, selecting the option that says the resident has "Not yet rotated"

or

- For Interpersonal and Communication Skills, Practice-based Learning and Improvement, Professionalism, and Systems-based Practice, selecting the option that says the resident has "Not yet achieved Level 1"



**Milestone Description: Pediatric Septic Hip – Medical Knowledge**

| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|
| • Demonstrates knowledge of common presentation of hip septic arthritis<br>• Demonstrates knowledge of basic hip anatomy<br>• Demonstrates knowledge of basic imaging studies<br>• Demonstrates knowledge of appropriate laboratory studies | • Demonstrates knowledge of pathophysiology of joint damage related to septic arthritis<br>• Demonstrates knowledge of basic surgical approach<br>• Demonstrates knowledge of the differential diagnosis of the irritable hip<br>• Understands natural history and the effects of intervention<br>• Demonstrates knowledge of advanced imaging studies | • Demonstrates knowledge of the vascular supply in the skeletally immature hip<br>• Demonstrates knowledge of microbiology and antibiotic choices<br>• Demonstrates knowledge of potential complications<br>• Demonstrates knowledge of clinical and laboratory data relevant to differential diagnosis | • Demonstrates knowledge of options and anatomy for surgical approaches<br>• Demonstrates knowledge of atypical infecting organisms and management options | • Author/presenter in published work |

**Comments:**

**Not yet rotated**

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

| **Anterior Cruciate Ligament (ACL) – Medical Knowledge** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to ACL injury (e.g., mechanisms of injury)<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies<br>• Has knowledge of natural history of ACL injury<br>• Demonstrates knowledge of ACL injury anatomy and basic surgical approaches (e.g., ACL bundles) | • Understands pathophysiology of concomitant injuries (e.g., secondary restraints of knee [PL Corner])<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies<br>• Ability to grade instability (e.g., translations grade and end point)<br>• Understands the effects of intervention on natural history of ACL injury<br>• Understands alternative surgical approaches (e.g., miniopen, 2 incision)<br>• Understands basic pre-surgical planning and templating<br>• Understands advantages and disadvantages of graft types | • Demonstrates knowledge of current literature and alternative treatments<br>• Understands rehabilitation mechanics (e.g., phases of rehabilitation, closed versus open chain exercises)<br>• Understands biomechanics of the knee and biomechanics of implant choices | • Understands controversies within the field (e.g., graft type, brace treatment, surgical technique and fixation, surgical techniques to include skeletally immature knee)<br>• Applies understanding of natural history to clinical decision-making<br>• Understands how to prevent/avoid potential complications | • Primary author/presenter of original work within the field |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| **Anterior Cruciate Ligament (ACL) – Patient Care** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam (e.g., age, gender, history of present illness [HPI], past medical history [PMHx], social history, range of motion, effusion, neurovascular status)<br>• Appropriately orders basic imaging studies (e.g., knee radiographs)<br>• Prescribes non-operative treatments (e.g., range of motion [ROM], weight-bearing (WB) status)<br>• Provides basic peri-operative management (e.g., neurovascular status, brace, WB status)<br>• Lists potential complications (e.g., infection, loss of motion, graft failure, neurovascular compromise) | • Obtains focused history and performs focused exam (e.g., mechanism of injury, past knee history, past treatments, Lachman, anterior drawer, pivot shift, meniscal pain)<br>• Appropriately interprets basic imaging studies (e.g., alignment, joint space, patella alignment)<br>• Prescribes and manages non-operative treatment (e.g., closed chain quad strengthening)<br>• Completes pre-operative planning with instrumentation, graft selection and implants<br>• Examines injury under anesthesia (e.g., complete ligament examination)<br>• Provides post-operative management and rehabilitation (e.g., WB status, brace, ROM, quad strength)<br>• Capable of diagnosis and early management of complications (e.g., graft failure, tunnel placement) | • Recognizes concomitant associated injuries (e.g., lateral collateral ligament [LCL], multi ligament, osteochondritis dissecans [OCD], posterior cruciate ligament (PCL), collateral ligaments, posterolateral corner instability, reverse pivot shift)<br>• Appropriately orders and interprets advanced imaging studies (e.g., standing views, magnetic resonance imaging [MRI], Segond fracture, bone bruising)<br>• Provides complex non-operative treatment (e.g., WB status, bracing as appropriate, vascular studies)<br>• Completes comprehensive pre-operative planning with alternatives<br>• Performs diagnostic arthroscopy, notchplasty, and/or graft harvest<br>• Modifies and adjusts post-operative treatment plan as needed (e.g., loss of knee motion treatment, sport specific drills, return to sport) | • Performs graft passage and fixation<br>• Capable of treating complications both intraoperatively and post-operatively (e.g., graft harvest failure, tunnel malposition, chondral injury) | • Performs revision/ transphyseal ACL reconstruction (e.g., hardware removal, outside in drilling techniques)<br>• Develops unique, complex post-operative management plans<br>• Surgically treats complex complications |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:** **Not yet rotated** ☐ | | | | |

| **Ankle Arthritis – Medical Knowledge** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to ankle/mid-foot/hind-foot arthritis<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., osteophyte formation, joint narrowing, subchondral cysts and sclerosis)<br>• Demonstrates basic knowledge of natural history of ankle/mid-foot/hind-foot arthritis<br>• Demonstrates knowledge of gait mechanics (e.g., phases of gait) and normal limb alignment<br>• Demonstrates knowledge of ankle/mid-foot/hind-foot arthritis anatomy and basic surgical approaches (e.g., anterior, lateral-transfibular)<br>• Demonstrates knowledge of non-operative treatment options and surgical indications | • Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., bone loss, articular deformity, subluxation)<br>• Understands the effects of intervention on natural history of ankle/mid-foot/hind-foot arthritis (e.g., effects of NSAIDs, steroid injections, brace, rocker bottom shoes)<br>• Demonstrates knowledge of abnormal gait mechanics of ankle/mid-foot/hind-foot arthritis (e.g., antalgic gait, circumduction, decreased stance) and abnormal limb alignment and adjacent joint function<br>• Understands alternative surgical approaches (e.g., posterior, posterolateral, posteromedial)<br>• Understands basic pre-surgical planning and templating<br>• Understands non-operative treatment options and surgical indications | • Demonstrates knowledge of current literature and alternative treatments (e.g., non-operative, cheilectomy, fusion, replacement, distraction)<br>• Understands abnormal gait mechanics of ankle/mid-foot/hind-foot arthritis (e.g., identifies abnormal gait patterns in patient)<br>• Applies general understanding of non-operative treatment options and surgical indications | • Understands controversies within the field<br>• Applies understanding of natural history to clinical decision-making (e.g., considers patient-specific characteristics of disease to select most appropriate treatment)<br>• Applies biomechanics to implant and procedure selection | • Primary author/presenter of original work within the field |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| **Ankle Arthritis – Patient Care** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies (e.g., three weight-bearing views)<br>• Prescribes non-operative treatments<br>• Provides basic peri-operative management (e.g., pre- and post-operative orders, labs, consults)<br>• Lists potential complications | • Obtains focused history and performs focused exam and gait analysis<br>• Appropriately interprets basic imaging studies<br>• Prescribes and manages non-operative treatment (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], steroid injections, brace, rocker bottom shoes)<br>• Completes pre-operative planning with instrumentation and implants<br>• Performs one basic surgical approach to the ankle/mid-foot/hind-foot arthritis (e.g., anterior or lateral transfibular)<br>• Provides post-operative management and rehabilitation (e.g., prothrombin time [PT] orders with goals and restrictions)<br>• Capable of diagnosis and early management of complications (e.g., wound healing problems, infection, deep vein thrombosis [DVT]) | • Appropriately orders and interprets advanced imaging studies/lab studies<br>• Completes comprehensive pre-operative planning with alternatives<br>• Modifies and adjusts post-operative treatment plan as needed | • Provides patient specific non-operative treatment (e.g., diagnostic injections)<br>• Capable of performing straight forward ankle/mid-foot/hind-foot reconstruction such as Tarsometatarsal joint arthrodesis, tarsal joint arthrodesis, triple, talonavicular or subtalar joint arthrodesis and ankle fusion (e.g., with minimal deformity or bone defect)<br>• Capable of surgically treating simple complications (e.g., incision and drainage [I&D]) | • Performs complex surgical approaches and reconstruction to the ankle/mid-foot/hind-foot arthritis (e.g., posterior, posterolateral, posteromedial)<br>• Develops unique, complex post-operative management plans<br>• Surgically treats complex complications (e.g., nonunion, malunion) |
| ☐ | ☐ | ☐ | ☐ | ☐ ☐ ☐ ☐ ☐ |
| **Comments:** | | | | |
| | | | | **Not yet rotated** ☐ |

| **Ankle Fracture – Medical Knowledge** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to ankle fractures<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies<br>• Demonstrates knowledge of non-operative treatment options and surgical indications | • Demonstrates ability to describe and classify fractures<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies<br>• Demonstrates basic knowledge of natural history of ankle fractures<br>• Demonstrates knowledge of ankle fractures anatomy and basic surgical approaches<br>• Understands basic pre-surgical planning and templating<br>• Understands implication of open fractures and soft tissue injury | • Demonstrates knowledge of current literature and alternative treatments<br>• Understands the effects of intervention on natural history of ankle fractures<br>• Understands alternative surgical approaches | • Understands controversies within the field (e.g., syndesmotic fixation, indications and options)<br>• Applies understanding of natural history to clinical decision-making<br>• Understanding of biomechanics and implant choices | • Primary author/presenter of original work within the field |
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| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| **Ankle Fracture – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies<br>• Prescribes non-operative treatments<br>• Splints fracture appropriately<br>• Provides basic peri-operative management<br>• Lists potential complications | • Obtains focused history and performs focused exam; recognizes implications of soft tissue injury<br>• Appropriately interprets basic imaging studies<br>• Prescribes and manages non-operative treatment<br>• Performs a closed reduction<br>• Completes pre-operative planning with instrumentation and implants<br>• Performs surgical exposure of the lateral malleolus<br>• Provides post-operative management and rehabilitation<br>• Capable of diagnosis and early management of complications | • Appropriately orders and interprets advanced imaging studies (e.g., stress views, computed tomography [CT] scan)<br>• Provides a comprehensive assessment of most fractures on imaging studies<br>• Completes comprehensive pre-operative planning with alternatives<br>• Performs surgical reduction and fixation of a simple fracture (e.g., lateral or bimalleolar ankle fracture)<br>• Modifies and adjusts post-operative treatment plan as needed<br>• Capable of treating complications both intra-operatively and post-operatively (e.g., wound breakdown following malleolar fixation) | • Provides comprehensive assessment of complex fracture patterns on imaging studies (e.g., pilon fracture)<br>• Recognizes indications for and provides non-operative treatment of an unstable fracture (e.g., diabetes, medical comorbidities, non-compliance)<br>• Performs surgical reduction and fixation of a moderately complex fracture (e.g., open reduction internal fixation [ORIF] trimalleolar ankle fracture or simple pilon fracture) | • Performs surgical reduction and fixation of a full range of fractures and dislocations (e.g., ORIF complex pilon fracture)<br>• Develops unique, complex post-operative management plans<br>• Surgically treats complex complications (e.g., revision fixation after failed ORIF) |
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| **Carpal Tunnel – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Understands the anatomy of carpal tunnel/median nerve<br>• Understands the normal physiology of the median nerve | • Demonstrates knowledge of the differential diagnosis of neuropathic surgery (e.g., pronator syndrome, cubital tunnel, thoracic outlet, cervical radiculopathy, peripheral neuropathy)<br>• Understands risk factors associated with Carpal Tunnel Syndrome (CTS) (e.g., diabetes, inflammatory arthritis, pregnancy, hypothyroidism)<br>• Demonstrates knowledge of median nerve motor/ sensory distribution, thumb abduction, thenar numbness, anterior interosseous nerve (AIN) weakness, cervical radiculopathy<br>• Understands natural history of CTS<br>• Understands the pathophysiology of nerve compression (e.g., increased carpal tunnel pressure, nerve ischemia)<br>• Understands surgical options (e.g., open, endoscopic) | • Demonstrates knowledge of current literature and alternatives to surgery<br>• Understands the capabilities and limitations of electrodiagnostic studies<br>• Understands influence of comorbidities<br>• Demonstrates knowledge of complications of surgical management (e.g., location of median nerve [MN] with respect to superficial arch, recurrent motor branch, palmar cutaneous branch, Guyon's canal) | • Understands controversies within field (e.g., endoscopic versus open, use of electrodiagnostics) | • Primary author/presenter of original work within the field |
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| **Carpal Tunnel – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains basic history and performs basic physical exam<br>• Lists potential surgical complications (e.g., infection, scar sensitivity, neurovascular injury) | • Obtains focused history, including identifying night pain, paresthesias<br>• Performs median nerve motor/sensory evaluation (e.g., MN numbness, thumb abduction)<br>• Performs provocative maneuvers (e.g., Tinel, Phalen, MN compression test)<br>• Appropriately considers electrodiagnostic test<br>• Prescribes non-operative treatments (e.g., night splints, steroid injection when appropriate)<br>• Capable of diagnosing surgical complications (e.g., injury to the median nerve or its branches and vascular injury)<br>• Provides simple post-operative management and rehabilitation | • Evaluates other sites of MN compression (e.g., pronator syndrome, cervical radiculopathy)<br>• Interprets electrodiagnostic tests | • Performs Carpal Tunnel Release (CTR) (e.g., open or endoscopic)<br>• Capable of treating simple complications (e.g., infection, wound healing)<br>• Capable of performing complex postoperative management (e.g., worsening numbness, worsening pain, additional radiating symptoms) | • Capable of surgical management of major complications (e.g., injury to superficial arch, ulnar artery, branches of median nerve, or median nerve)<br>• Capable of opposition transfer (e.g., palmaris longus, extensor indicis pollicis [EIP], or flexor digitorum superficialis [FDS])<br>• Capable of performing revision carpal tunnel surgery |
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| **Degenerative Spinal Conditions – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to lumbar and cervical degenerative conditions<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., cervical or lumbar radiographs)<br>• Demonstrates knowledge of physical exam of cervical and lumbar spine and related neurologic and provocative signs<br>• Demonstrates knowledge of general peri-operative patient care | • Describes specific clinical syndromes of lumbar and cervical degenerative conditions (e.g., radiculopathy from herniated nucleus pulposus [HNP] vs. stenosis vs. spondylolisthesis, back pain, cervical radiculopathy, or myelopathy)<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., magnetic resonance imaging [MRI], Myelogram/CT)<br>• Demonstrates knowledge of biological theories of pain generation<br>• Demonstrates knowledge of natural history of lumbar and cervical degenerative conditions<br>• Demonstrates knowledge of anatomic changes resulting from lumbar and cervical degenerative disorders and basic surgical approaches (e.g., anterior cervical, posterior cervical or lumbar)<br>• Demonstrates knowledge of basic pre-surgical planning and criteria for acceptable intra-operative result for simple primary cases (e.g., laminotomy for herniated nucleus pulposus [HNP], single-level anterior cervical discotomy and fusion [ACDF])<br>• Demonstrates knowledge of non-operative treatment options | • Demonstrates knowledge of current literature and alternative treatments<br>• Demonstrates knowledge of biology of fusion healing<br>• Demonstrates knowledge of the effects of intervention on natural history of lumbar and cervical degenerative conditions<br>• Demonstrates knowledge of alternative surgical approaches, complications of approaches<br>• Demonstrates knowledge of presurgical planning and criteria for acceptable intra-operative result for cases of moderate complexity (e.g., spondylolisthesis, multi-level decompression and fusion)<br>• Demonstrates knowledge of surgical indications<br>• Demonstrates knowledge of basic implant choices | • Demonstrates knowledge of controversies within the field (e.g., epidural blocks, arthroplasty vs. fusion, and fusion techniques)<br>• Demonstrates knowledge of cervical and lumbar biomechanics and alterations by decompression or implants<br>• Demonstrates knowledge of influence of natural history and comorbidity on clinical decision-making<br>• Demonstrates knowledge of alternative implant choices/biomaterials | • Primary author/presenter of original work within the field |
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| **Degenerative Spinal Conditions – Patient care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies<br>• Prescribes non-operative treatments: non-steroidal anti-inflammatory drugs (NSAIDs), rehabilitation, initiates basic care<br>• Recognizes indications for and initiates immediate additional work-up ("Red Flags") or urgent surgical care (progressive deficit, cauda equina syndrome)<br>• Provides basic/general peri-operative management<br>• Lists potential complications | • Obtains focused history and performs focused exam; appropriately interprets neurological exam<br>• Appropriately interprets basic imaging studies<br>• Assists in exposure for anterior and posterior cervical spine, posterior lumbar spine, performs closure<br>• Provides procedure and patient specific post-operative management and rehabilitation<br>• Capable of diagnosis and early management of complications | • Extends examination to non-spinal differential diagnostic possibilities (vascular claudication, hip arthritis, etc.)<br>• Appropriately orders and interprets advanced imaging studies (MRI, myelogram, CT); correlates clinical and imaging findings to form clinical diagnosis<br>• Prescribes and manages non-operative treatment: injections, referrals to other professionals<br>• Recommends appropriate surgical procedures considering indications and contraindications, risks and benefits for simple cases (e.g., single-level HNP with radiculopathy)<br>• Completes comprehensive pre-operative planning with alternatives and criteria for acceptable intraoperative result for straightforward cases (single-level HNP)<br>• Capable of performing anterior and posterior cervical, posterior lumbar surgical exposure, assisting with implant placement<br>• Modifies and adjusts post-operative treatment plan according to clinical situation (e.g., modifies for comorbid conditions or complications)<br>• Capable of treating simple complications both intra- and post-operatively (e.g., medical complications, hemostasis) | • Provides complex non-operative treatment (e.g., individualized care, shared decision making, comprehensive informed consent)<br>• Recommends appropriate surgical procedures considering indications and contraindications, risks and benefits for complex cases (e.g., multi-level stenosis with deformity)<br>• Completes comprehensive pre-operative planning with alternatives and criteria for acceptable intraoperative result for complex cases (e.g., multi-level stenosis with deformity)<br>• Capable of decorticating for posterolateral fusion, placing grafts<br>• Capable of surgically treating simple complications (e.g., drainage of hematoma, debridement of infection) | • Completes comprehensive pre-operative planning with alternatives and criteria for acceptable intra-operative result for highly complex cases (e.g., revision surgery)<br>• Capable of performing decompression, posterior lumbar interbody fusion (PLIF), transforaminal lumbar interbody fusion (TLIF), places complex implants (e.g., fusion cages, pedicle screws)<br>• Develops unique complex post-operative management plans when indicated<br>• Capable of surgical treatment of complex complications (e.g., revise displaced hardware or graft, durotomy repair) |
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| **Diabetic Foot – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to Diabetes mellitus (e.g., neuropathy, retinopathy, renal disease, peripheral vascular disease)<br>• Knowledge of medical management of Diabetes mellitus (e.g., glycemic control, diabetic diet)<br>• Demonstrates some knowledge of natural history of Diabetes mellitus<br>• Demonstrates knowledge of foot anatomy | • Understands diabetic foot conditions and staging systems (e.g., infection vs. Charcot, Eichenholz classification)<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., x-ray signs of osteomyelitis, Charcot changes)<br>• Demonstrates some knowledge of diabetic foot conditions (neuropathic ulcer risk factors) and the effects of intervention (e.g., offloading and immobilization for Charcot, debridement and antibiotics for infection)<br>• Demonstrates some knowledge of gait mechanics (e.g., phases of gait and normal limb alignment)<br>• Demonstrates knowledge of basic surgical approaches (e.g., dorsomedial and dorsolateral approaches, amputations of the foot)<br>• Understands basic pre-surgical planning<br>• Demonstrates knowledge of non-operative treatment options and surgical indications<br>• Understands basic science of wound healing | • Demonstrates knowledge of current literature and alternative treatments (e.g., debridement, off-loading, immobilization)<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., CT and MRI signs of osteomyelitis)<br>• Demonstrates some knowledge of abnormal gait mechanics and limb alignment and adjacent joint function, diabetic shoe wear and orthotics (e.g., apropulsive gait, antalgic gait, loss of proprioception and balance) | • Understands controversies within the field (e.g., non-operative vs. operative management of osteomyelitis)<br>• Applies understanding of natural history to patient-specific clinical decision-making<br>• Understands alternative surgical approaches (e.g., Plantar approach, complex amputations of the foot) | • Primary author/presenter of original work within the field |
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| **Diabetic Foot – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies (e.g., three or four weight-bearing views of the foot<br>• Provides basic peri-operative management (e.g., pre- and post-operative orders, labs, consults)<br>• Lists potential complications | • Obtains focused history and performs focused exam<br>• Appropriately interprets basic imaging studies<br>• Prescribes and manages non-operative treatment (e.g., wound care, antibiotics, off-loading, immobilization, depth shoes, accommodative orthotics)<br>• Completes pre-operative planning including vascular assessment and the potential for wound healing (e.g., ankle-brachial indicis [ABIs] endovascular consultation)<br>• Performs one basic surgical approach to the Diabetic foot (e.g., medial or lateral)<br>• Provides post-operative management and rehabilitation (PT orders with goals and restrictions)<br>• Capable of diagnosis and early management of complications (e.g., wound healing problems, infection, DVT) | • Appropriately orders and interprets advanced imaging studies (e.g., CT and MRI with or without contrast)<br>• Completes comprehensive pre-operative planning with alternatives for limb salvage (e.g., revascularization combined with reconstruction)<br>• Modifies and adjusts post-operative treatment plan as needed | • Provides complex non-operative treatment (e.g., multiple co-morbidities, non-compliant, etc.)<br>• Capable of performing alternative surgical approaches to the Diabetic foot (e.g., multiple or plantar approaches)<br>• Capable of treating complications, both intra- and post-operatively | • Develops unique, complex post-operative management plans<br>• Surgically treats complex complications |
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| Diaphyseal Femur and Tibia Fracture – Medical Knowledge | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to diaphyseal femur and tibia fractures<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies<br>• Demonstrates knowledge of medical and surgical comorbidities | • Able to describe and classify fractures<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies<br>• Demonstrates knowledge of associated injuries and impact on surgical care (e.g., femoral neck fracture, associated skeletal injuries)<br>• Understands implication of open fractures and soft tissue injury<br>• Demonstrates knowledge of bone biology, osteoporosis and bone health management<br>• Demonstrates knowledge of natural history of diaphyseal femur and tibia fractures<br>• Demonstrates knowledge of diaphyseal femur and tibia fractures anatomy and basic surgical approaches<br>• Understands basic pre-surgical planning and templating<br>• Demonstrates knowledge of non-operative treatment options and surgical indications<br>• Demonstrates knowledge of surgical and non-operative complications (e.g., compartment syndrome, fat emboli, infection) | • Demonstrates knowledge of current literature and alternative treatments<br>• Demonstrates knowledge of impact on polytrauma on management of diaphyseal femur and tibia fractures<br>• Understands biomechanics and implant choices<br>• Understands the effects of intervention on natural history of diaphyseal femur and tibia fractures<br>• Understands alternative surgical approaches<br>• Recognizes surgical indications in complex fractures and the polytrauma patient | • Understands controversies within the field (e.g., initial management of femur fracture in the polytrauma patient)<br>• Applies understanding of natural history to clinical decision-making | • Primary author/presenter of original work within the field |
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| Diaphyseal Femur and Tibia Fracture – Patient Care | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies<br>• Splints fracture appropriately<br>• Provides basic peri-operative management<br>• Assesses for limb perfusion and compartment syndrome<br>• Lists potential complications | • Obtains focused history and performs focused exam<br>• Appropriately interprets basic imaging studies<br>• Prescribes and manages non-operative treatment<br>• Performs a closed reduction<br>• Completes pre-operative planning with instrumentation and implants<br>• Performs basic surgical approaches<br>• Performs patient positioning for operative fixation (e.g., use of fracture table)<br>• Provides post-operative management and rehabilitation<br>• Performs basic open wound management and debridement<br>• Initiates management of limb reperfusion and compartment syndrome<br>• Recognizes the needs of the polytrauma patient<br>• Capable of diagnosis and early management of complications | • Appropriately orders and interprets advanced imaging studies<br>• Provides complex non-operative treatment<br>• Completes comprehensive pre-operative planning with alternatives<br>• Performs surgical repair to a simple fracture<br>• Effectively uses intraoperative imaging<br>• Modifies and adjusts post-operative treatment plan as needed<br>• Capable of performing compartment release | • Performs surgical repair to a moderately complex fracture (e.g., able to perform intramedullary nailing of segmental femur fracture)<br>• Performs alternative surgical approaches for femur and tibia fractures (e.g., open reduction techniques)<br>• Performs complex wound management and debridement (e.g., understands need for consultation for flap coverage)<br>• Prioritizes the needs of the polytrauma patient (e.g., timing of long bone fixation, works with consulting teams)<br>• Capable of treating complications both intraoperatively and post-operatively (e.g., manages post-operative infection) | • Performs surgical repair to a complex fracture (e.g., able to perform intramedullary nail nailing of distal tibia fracture with intraarticular extension)<br>• Develops unique, complex post-operative management plans<br>• Surgically treats complex complications (e.g., treats femoral neck fracture identified after femoral nailing) |
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| **Distal Radius Fracture (DRF) – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of anatomy<br>• Understands basic imaging | • Demonstrates knowledge of fracture description and soft tissue injury: angulation, displacement, shortening, comminution, shear pattern, articular parts<br>• Understands mechanism of injury<br>• Understands biology of fracture healing<br>• Understands advanced imaging<br>• Understands surgical approaches and fixation tech: percutaneous pinning, volar plating, external fixation, dorsal plating, fragment specific, combinations | • Demonstrates knowledge of current literature, fracture classifications and therapeutic alternatives<br>• Demonstrates knowledge of associated injuries: median nerve injury, scaphoid fracture; scapholunate (SL) ligament injury, triangular fibrocartilage complex (TFCC) injury, elbow injuries<br>• Understands natural history of distal radius fracture<br>• Understands biomechanics and implant choices: understand the advantage and disadvantages of different fixation techniques | • Understands controversies within field: fixation techniques and fracture pattern, correlation between radiographic and functional outcomes in elderly patient | • Participates in research in the field with publication |
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| Distal Radius Fracture (DRF) – Patient Care | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Orders/interprets basic imaging studies<br>• Splints fracture appropriately<br>• Provides basic post-operative management and rehab<br>• Lists potential complications (e.g., infections, hardware failure tendon injury, Complex Regional Pain Syndrome [CRPS], carpal tunnel syndrome, malreduction) | • Obtains focused history and physical, recognizes implications of soft tissue injury (e.g., open fracture, median nerve dysfunction, distal radioulnar joint [DRUJ] instability)<br>• Orders/interprets advanced imaging (e.g., CT for comminuted articular fractures)<br>• Recognizes stable/unstable fractures (e.g., metaphyseal comminution, volar/dorsal Barton's, die-punch pattern; multiple articular parts)<br>• Able to perform a closed reduction and splint appropriately<br>• Recognizes surgical indications (e.g., median nerve dysfunction, instability, articular step off/gap, dorsal angulation, radius shortening)<br>• Performs surgical exposure<br>• Modifies and adjusts post-operative plan when indicated<br>• Recognizes/evaluates fragility fractures (e.g., orders appropriate work-up and/or consult)<br>• Diagnoses and provides early management of complications | • Performs pre-operative planning with appropriate instrumentation and implants<br>• Capable of surgical reduction and fixation of extraarticular fracture<br>• Interprets diagnostic studies for fragility fractures with appropriate management and/or referral | • Capable of surgical reduction and fixation of simple intraarticular fractures (e.g., no more than two articular fragments)<br>• Capable of surgically treating simple complications (e.g., infections, open carpal tunnel release) | • Capable of surgical reduction and fixation of a full range of fractures and dislocations (e.g., comminuted or very distal articular fractures, dorsal and volar metaphyseal fractures, greater arc perilunate injuries, Scapholunate ligament injuries)<br>• Capable of surgically treating complex complications (e.g., osteotomies, revision fixation) |
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| **Adult Elbow Fracture – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of fractures (e.g., olecranon, radial head, coronoid fracture, terrible triad fracture, distal humerus fracture, fracture dislocation)<br>• Demonstrates knowledge of anatomy (e.g., elbow joint, radial head, coronoid, olecranon, distal humerus, elbow ligaments)<br>• Understands basic imaging studies | • Understands mechanism of injury and knowledge of fracture classification and soft tissue injury (e.g., olecranon, radial head, coronoid fracture, terrible triad fracture, distal humerus fracture, fracture dislocation)<br>• Demonstrates knowledge of imaging studies/lab studies (e.g., radiographs anteroposterior [AP]/lateral/oblique/axial)<br>• Understands surgical approaches (e.g., soft tissue envelope, cutaneous nerves, ulnar nerve treatment)<br>• Understands biology of fracture healing<br>• Understands advanced imaging studies (e.g., post-operative x-rays, CT scans for fracture healing) | • Demonstrates knowledge of current literature and alternatives (e.g., fracture repair vs. replacement, post-operative stiffness concepts)<br>• Understands rehabilitation mechanics (e.g., range of motion therapy, dynamic/static stretch splinting)<br>• Understands biomechanics and implant choices (e.g., radial head replacement, compression headless screws, elbow replacement types) | • Understands controversies within field (e.g., tension band vs. plating olecranon fractures, elbow replacement for elderly distal humerus fractures; radial head repair vs. replacement)<br>• Understands how to avoid/prevent potential complications<br>• Demonstrates knowledge of pathophysiology of elbow stiffness (e.g., intrinsic, extrinsic, hardware placement)<br>• Understands post-operative imaging studies/implant positioning | • Participates in research in the field with publication |
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| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| **Adult Elbow Fracture – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and basic physical (e.g., age, gender, mechanism of injury, deformity, skin integrity, open/closed injury)<br>• Splints fracture appropriately<br>• Provides basic peri-operative management (e.g., post-operative orders, ice, elevation, compression)<br>• Lists potential complications (e.g., infection, hardware failure, stiffness, reflex sympathetic dystrophy [RSD], neurovascular injury, posttraumatic arthritis) | • Obtains focused history and physical, recognizes implications of soft tissue injury (e.g., open fracture, compartment syndrome, ligamentous injury)<br>• Able to order appropriate imaging studies (e.g., radiographs, CT scan/3D reconstruction)<br>• Performs basic surgical approach to elbow fractures<br>• Reduces fracture if necessary (e.g., provisional fixation, fluoroscopic checks)<br>• Recognizes surgical indications (e.g., fracture displacement, elbow instability, transolecranon injury<br>• Provides post-operative management and rehabilitation (e.g., splinting and ROM therapy)<br>• Capable of diagnosis and early management of complications (e.g., diagnosis from peri-operative x-rays, recognize infection, recognize fracture displacement/dislocation) | • Performs pre-operative planning with instrumentation and implants (e.g., patient positioning, plates/screws, fluoroscopy)<br>• Capable of surgical reduction and fixation of a simple fracture (e.g., olecranon fracture)<br>• Provides post-operative management and rehabilitation (e.g., increase ROM as healing progresses, adequate/proper post-operative x-rays) | • Performs comprehensive pre-operative planning/alternatives (e.g., use of external fixation, radial head replacement, elbow arthroplasty)<br>• Capable of surgical reduction and fixation of moderately complex fractures (extraarticular and simple intraarticular distal humerus fracture)<br>• Modifies and adjusts post-operative plan as needed (e.g., dynamic/static stretch splinting, revise therapy)<br>• Treat simple complications both intra- and post-operatively (e.g., revise hardware placement, recognize improper hardware position) | • Capable of surgical reduction and fixation of a full range of fractures and dislocations<br>• Understands how to avoid/prevent potential complications<br>• Surgically treats complex complications (e.g., elbow release for stiffness, ID infection, revision hardware failure, nonunion treatment) |
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| **Comments:**<br>**Not yet rotated** ☐ | | | | |

| Hip and Knee Osteo Arthritis (OA) – Medical Knowledge | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to hip and knee arthritis<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies<br>• Demonstrates some knowledge of natural history of hip and knee arthritis<br>• Demonstrates knowledge of hip and knee arthritis anatomy and basic surgical approaches<br>• Demonstrates knowledge of non-operative treatment options and surgical indications | • Able to classify disease stage/severity and recognizes implications of disease processes (OA, Femoroacetabular impingement [FAI], inflammatory arthritis, osteonecrosis)<br>• Understands the importance of comorbidities, thromboembolic prophylaxis, infection prevention and diagnosis<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies<br>• Understands the effects of intervention on natural history of hip and knee arthritis<br>• Understands basic pre-surgical planning and templating<br>• Understands basic implant choices (e.g., cement and uncemented fixation, levels of constraint ) | • Demonstrates knowledge of current literature and alternative treatments<br>• Understands biomechanics<br>• Understands alternative surgical approaches (e.g., non-arthroplasty: arthroscopy, osteotomy)<br>• Understands alternative implant choices/biomaterials (e.g., alternative bearings, unicompartmental approaches) | • Understands controversies within the field<br>• Applies understanding of natural history to clinical decision-making<br>• Understands principles of failure mechanism of total hip replacement (THR) and total knee replacement (TKR) (e.g., loosening, fracture, infection, osteolysis, instability)<br>• Understands basic principles of revision THR and TKR | • Primary author/presenter of original work within the field<br>• Understands revision THR and TKR implants (e.g., metaphyseal vs. diaphyseal fixation, tapered vs. fully-porous implants) |
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| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| Hip and Knee Osteo Arthritis (OA) – Patient Care | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies<br>• Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)<br>• Provides basic peri-operative management (e.g., pre- and post-operative assessment)<br>• Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise) | • Obtains focused history and performs focused exam<br>• Appropriately interprets basic imaging studies<br>• Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)<br>• Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)<br>• Capable of performing one basic surgical approach to the hip and knee<br>• Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)<br>• Capable of diagnosis and early management of complications (e.g., infections, dislocations)<br>• Assesses for risk of thromboembolic disease | • Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)<br>• Appropriately recommends surgical intervention<br>• Completes comprehensive pre-operative planning with alternatives<br>• Modifies and adjusts post-operative treatment plan as needed<br>• Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)<br>• Provides prophylaxis and manages thromboembolic disease | • Capable of performing alternative surgical approaches to the hip and knee arthritis<br>• Capable of performing primary THR and TKR<br>• Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability) | • Competently performs two or more approaches to the hip and knee<br>• Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)<br>• Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)<br>• Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability) |
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| **Hip Fracture – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to hip fracture<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies<br>• Demonstrates knowledge of non-operative treatment options and surgical indications | • Able to describe and classify fractures<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies<br>• Demonstrates knowledge of bone biology, osteoporosis and bone health management<br>• Demonstrates knowledge of natural history of hip fracture<br>• Demonstrates knowledge of hip fracture anatomy and basic surgical approaches<br>• Understands basic pre-surgical planning and templating<br>• Understands comorbidities and impact on fracture treatment | • Demonstrates knowledge of current literature and alternative treatments<br>• Understands the effects of intervention on natural history of hip fracture<br>• Understands alternative surgical approaches | • Understands controversies within the field (e.g., hemiarthroplasty vs. total hip for displaced femoral neck fracture)<br>• Applies understanding of natural history to clinical decision making<br>• Understands biomechanics and implant choices | • Primary author/presenter of original work within the field |
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| **Hip Fracture – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Appropriately orders basic imaging studies<br>• Prescribes non-operative treatments<br>• Provides basic peri-operative management<br>• Lists potential complications | • Obtains focused history and performs focused exam<br>• Appropriately interprets basic imaging studies<br>• Prescribes and manages non-operative treatment<br>• Recognizes and evaluates fragility fractures (e.g., orders appropriate workup and/or consult)<br>• Interacts with consultants regarding optimal patient management (e.g., timing of surgery, medical management)<br>• Completes pre-operative planning with instrumentation and implants<br>• Capable of performing a basic surgical approach to the hip fracture<br>• Provides post-operative management and rehabilitation<br>• Capable of diagnosis and early management of complications<br>• Assesses risk for thromboembolic disease | • Completes comprehensive assessment of fracture patterns on imaging studies-recognizes reverse obliquity fractures<br>• Interprets diagnostic studies for fragility fractures with appropriate management and/or referral<br>• Arranges for long-term management of geriatric patients (e.g., management of bone health, discharge planning to long-term care)<br>• Completes comprehensive pre-operative planning with alternatives<br>• Capable of surgical repairs to a simple fracture (e.g., stable intertrochanteric femur fracture, minimally displaced femoral neck fracture)<br>• Modifies and adjusts post-operative treatment plan as needed<br>• Provides prophylaxis and manages thromboembolic disease | • Capable of surgical repair to moderately complex fractures (e.g., unstable intertrochanteric femur fracture)<br>• Capable of treating complications both intra- and post-operatively (e.g., manages a post-operative infection) | • Capable of surgical repair of complex fractures (e.g., open reduction internal fixation of femoral neck fracture)<br>• Capable of surgical treatment of complex complications (e.g., revision fixation after failed ORIF, intertrochanteric osteotomy) |
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| **Metastatic Bone Lesion – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of normal bone development<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., plain radiographs)<br>• Demonstrates knowledge of most common sites of metastatic disease and primary sites of disease (e.g., primary sites breast, prostate, lung, kidney, thyroid) | • Demonstrates knowledge of pathophysiology related to destructive bone lesion (e.g., understands the function of receptor activator of nuclear factor kappa-B ligand [RANKL], osteoprotegerin [OPG] and osteoclasts in the bone turnover in skeletal metastasis)<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., CT scan of chest/abdomen/ pelvis, MRI of spine)<br>• Demonstrates some knowledge of natural history of destructive bone lesion (e.g., understands behavior of various histologies [i.e., lung vs. breast cancer]; understands the different behavior of primary bone sarcoma vs. bone metastasis)<br>• Demonstrates knowledge of destructive bone lesion anatomy and basic surgical approaches (e.g., understands the location of neurovascular | • Demonstrates knowledge of current literature and alternative treatments (e.g., alternative treatments, including external beam radiation, radiofrequency ablation, cryoablation, bisphosphonate use)<br>• Understands indications for prophylactic fixation (e.g., be aware of at least one scoring system [Mirels, Beals] as well as more nuanced factors [histology, response to treatment, etc.])<br>• Understands the effects of intervention on natural history of destructive bone lesion<br>• Understands alternative surgical approaches (e.g., understands the role of resection/prosthetic replacement vs. intramedullary stabilization depending on location of lesion)<br>• Understands role of radiation or medical therapy (vs. surgical options; their use post-operatively; specific role of chemotherapy, | • Understands controversies within the field (e.g., resection/prosthetic reconstruction vs. intramedullary fixation; short vs. long stem hip reconstruction; bipolar vs. total hip arthroplasty (THA) for hip lesions; resection of solitary bone metastasis)<br>• Formulates differential diagnosis based on imaging studies<br>• Able to perform risk assessment of operative vs. non-operative care (e.g., understands concepts of nutritional status, current function/ activity, medical comorbidities/American Society of Anesthesiologists [ASA] level)<br>• Applies understanding of natural history to clinical decision making (e.g., understands balance of expected lifespan to planned intervention [i.e., complex acetabular reconstruction for patient with widespread lung metastasis and six weeks to live]; develop | • Primary author/presenter of original work within the field |

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| | structures in upper/lower extremities and pelvis; understand basic surgical approach to humeral and femoral nails)<br>• Understands basic pre-surgical planning and templating<br>• Demonstrates knowledge of non-operative treatment options and surgical indications (e.g., understands non-operative options, including protected weight-bearing/radiation of lower extremity lesions, as well as bracing of upper extremity lesion) | hormonal therapy, bisphosphonates for common primary cancers that spread to bone)<br>• Demonstrates knowledge of alternatives for primary sarcoma of bone (e.g., understand role of resection vs. palliative care; understands role of limb salvage vs. amputation) | shared-decision making skills for patient discussions/interactions)<br>• Understands biomechanics and implant choices (e.g., understands concepts of failure in compression vs. tension; understands the benefit of supplemental methylmethacrylate; understands the pros/cons of plate vs. rod fixation) | |
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| **Metastatic Bone Lesion – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam (e.g., pain, function, past medical/surgical/social/ family history, review of systems, heart, lungs, extremity exam, including range of motion, strength, sensation, skin changes, tenderness)<br>• Appropriately orders basic imaging studies (e.g., plain radiographs, including AP/lateral of the lesion Joint above and below the lesion)<br>• Prescribes non-operative treatments (e.g., including protected weight-bearing bracing, no intervention)<br>• Provides basic peri-operative management (e.g., intravenous [IV] antibiotics, IV fluids, DVT prophylaxis, pain control, nutrition)<br>• Lists potential complications (e.g., including Infection, wound complications, neurovascular compromise, tumor | • Obtains focused history and performs focused exam (e.g., history: specific questions re: past history of cancer or radiation, prior treatments, pre-existing pain, smoking or chemical exposure, constitutional symptoms such as fever; physical exam: notes lymph node involvement, lumps/nodules)<br>• Appropriately interprets basic imaging studies (e.g., able to describe the radiographic appearance [osteolytic, osteoblastic, etc.])<br>• Prescribes and manages non-operative treatment (e.g., understands when to have the patient back to clinic for follow-up; understands when to order new radiographic imaging studies)<br>• Completes pre-operative planning with instrumentation and implants<br>• Performs one basic surgical approach to the destructive bone lesion<br>• Provides post-operative management and rehabilitation (e.g., understands weight-bearing issues and role of physical/occupational therapy [PT/OT])<br>• Capable of diagnosis and early management of complications | • Appropriately orders and interprets advanced imaging studies/lab studies (e.g., 3D radiographic studies to include CT and MRI, lab studies including role of serum protein electrophoresis [SPEP]/urine protein electrophoresis [UPEP], prostate specific antigen [PSA], other tumor markers)<br>• Recommends complex non-operative treatment (radiofrequency ablation [RFA] or cryoablation, bisphosphonates kyphoplasty or vertebroplasty)<br>• Completes comprehensive pre-operative planning with alternatives<br>• Completes pre-operative preparation and consultation (e.g., oncology, radiation oncology, counseling<br>• Modifies and adjusts post-operative treatment plan as needed | • Recommends appropriate biopsy, including biopsy alternatives and appropriate techniques (e.g., understands role of open biopsy vs. needle biopsy)<br>• Capable of performing prophylactic fixation based on diagnosis and risk (e.g., able to perform prophylactic intramedullary stabilization of femur, prophylactic bipolar hemiarthroplasty of the hip)<br>• Capable of performing internal fixation on impending or actual pathologic fractures (e.g., able to perform intramedullary stabilization of pathologic femoral or humeral fracture, bipolar hip hemiarthroplasty for pathologic femoral neck fracture)<br>• Capable of performing alternative surgical approaches to the destructive bone lesion (e.g., understands approaches to the hip | • Discusses prognosis and end-of-life care with patients and family<br>• Independently performs open biopsy<br>• Performs endoprosthetic reconstruction for periarticular lesions (options include: megaprosthesis of proximal humerus, proximal femur, distal femur, proximal tibia)<br>• Develops unique, complex post-operative management plans<br>• Surgically treats complex complications (e.g., surgical treatment of hardware failure, periprosthetic fracture, progression of disease) |

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| progression, prosthetic hip dislocation, DVT/ pulmonary embolism [PE], pneumonia) | (e.g., able to diagnose: infection, DVT/PE, wound breakdown, neurovascular compromise, hardware failure) | • Capable of treating post-operative complications (e.g., non-operative treatment of: infection, wound breakdown, DVT/PE) | for prosthetic reconstruction; understands approaches for resection of proximal humerus, distal femur and proximal tibia)<br>• Capable of surgical treatment of infection or wound breakdown | |
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| **Meniscal Tear – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to meniscal tear<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., joint space height, Fairbank changes)<br>• Understands mechanism of injury<br>• Demonstrates some knowledge of natural history of meniscal tear | • Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., tear personality, chondral injury/changes)<br>• Understands biology of meniscal healing<br>• Understands the effects of intervention on natural history of meniscal tear<br>• Demonstrates knowledge of meniscal anatomy and basic surgical approaches<br>• Demonstrates knowledge of non-operative treatment options and surgical indications | • Demonstrates knowledge of current literature and alternative treatments<br>• Understands rehabilitation mechanics (e.g., quad strength closed vs. open chain)<br>• Understands biomechanics and implant choices<br>• Understands alternative surgical approaches (e.g., repair vs. debridement) | • Understands controversies within the field (e.g., repair techniques)<br>• Understands how to prevent/avoid potential complications<br>• Applies understanding of natural history to clinical decision-making | • Primary author/presenter of original work within the field |
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| **Meniscal Tear – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam (e.g., age, gender, HPI, PMHx, social history, ROM, joint tenderness, effusion, neurovascular status<br>• Appropriately orders basic imaging studies (e.g., plain film radiographs)<br>• Prescribes non-operative treatments<br>• Provides basic peri-operative management (e.g., neurovascular status, ROM, brace)<br>• Lists potential complications (e.g., pain, infection, neurovascular injury, loss of motion, degenerative joint disease [DJD]) | • Obtains focused history and performs focused exam (e.g., McMurray, Steinmann, applies compression)<br>• Appropriately interprets basic imaging studies (e.g., standing radiographs as needed, Fairbank changes)<br>• Prescribes and manages non-operative treatment (e.g., quad strength closed chain)<br>• Injects/aspirates knee<br>• Examines knee under anesthesia<br>• Provides post-operative management and rehabilitation (e.g., ROM, quad strength closed chain, WB status)<br>• Capable of diagnosis and early management of complications | • Appropriately orders and interprets advanced imaging studies (e.g., MRI findings)<br>• Provides complex non-operative treatment (e.g., concomitant injuries—ligament, fractures)<br>• Capable of performing diagnostic arthroscopy and meniscal debridement<br>• Modifies and adjusts post-operative treatment plan as needed (e.g., knee arthrofibrosis, continued pain) | • Capable of performing meniscal repair—all techniques open and arthroscopic<br>• Capable of performing alternative surgical approaches to a meniscal tear<br>• Capable of treating complications both intra- and post-operatively | • Capable of performing revision of meniscal repair or meniscal transplant<br>• Capable of treating complex complications |
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| **Pediatric Septic Hip – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of common presentation of hip septic arthritis<br>• Demonstrates knowledge of basic hip anatomy<br>• Demonstrates knowledge of basic imaging studies<br>• Demonstrates knowledge of appropriate laboratory studies | • Demonstrates knowledge of pathophysiology of joint damage related to septic arthritis<br>• Demonstrates knowledge of basic surgical approach<br>• Demonstrates knowledge of the differential diagnosis of the irritable hip<br>• Understands natural history and the effects of intervention<br>• Demonstrates knowledge of advanced imaging studies | • Demonstrates knowledge of the vascular supply in the skeletally immature hip<br>• Demonstrates knowledge of microbiology and antibiotic choices<br>• Demonstrates knowledge of potential complications<br>• Demonstrates knowledge of clinical and laboratory data relevant to differential diagnosis | • Demonstrates knowledge of options and anatomy for surgical approaches<br>• Demonstrates knowledge of atypical infecting organisms and management options | • Participates in research in the field with publication |
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| **Pediatric Septic Hip – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam<br>• Orders appropriate initial imaging and laboratory studies<br>• Provides initial management<br>• Lists potential complications | • Obtains focused history and physical, recognizes findings commonly associated with hip septic arthritis<br>• Orders appropriate advanced imaging studies (e.g., MRI, ultrasound)<br>• Interprets basic imaging and laboratory studies<br>• Selects appropriate antibiotics<br>• Diagnoses complications (e.g., drug reactions) | • Recognizes factors that could predict complications or poor outcome<br>• Appropriately orders and capable of performing hip aspiration<br>• Interprets advanced imaging studies and results of hip aspiration<br>• Able to develop a basic pre-operative plan | • Assimilates all diagnostic testing and make a decision about the need for surgical drainage<br>• Capable of performing hip arthrotomy and drainage<br>• Modifies post-operative plan based on response to treatment (e.g., patient fails to improve post-operatively)<br>• Capable of treating simple complications; repeat incision for persistent wound drainage, drug reaction | • Able to develop a comprehensive pre-operative plan that includes options based on intra-operative findings (e.g., managing dislocated hip)<br>• Manages complex complications; late hip dislocation, fracture, osteomyelitis, chondrolysis, avascular necrosis |
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| **Rotator Cuff Injury – Medical Knowledge** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Understands surgical anatomy (e.g., rotator cuff muscles/tendons, deltoid, axillary nerve position, acromion, biceps, labrum)<br>• Demonstrates knowledge of basic imaging studies: radiographs (e.g., true AP, axillary, supraspinatus outlet) | • Demonstrates knowledge of surgical indications (e.g., non-operative management, therapy, injections, rotator cuff repair, subacromial decompression)<br>• Demonstrates knowledge of basic surgical approaches and portal placement (e.g., anterior, subacromial, posterior, accessory posterior)<br>• Understands pathophysiology related to rotator cuff injury (e.g., impingement, partial thickness cuff tears, extrinsic versus intrinsic theory of cuff tearing)<br>• Understands biology of soft tissue tendon healing<br>• Demonstrates knowledge of advanced imaging studies/lab studies (e.g., MRI, ultrasound, CT arthrogram) | • Demonstrates knowledge of current literature and alternatives<br>• Understands pathophysiology of concomitant injuries (e.g., biceps tendinitis, acromioclavicular joint disease, labral pathology, arthritis)<br>• Understands rehabilitation mechanics (e.g., Neer Phase 1-3)<br>• Understands biomechanics and implant choices<br>• Understands natural history of rotator cuff disease (e.g., symptomatic vs. asymptomatic cuff tears, impingement, intrinsic versus extrinsic mechanisms) | • Understands controversies within field. Examples: single vs. double row repairs, partial repair of massive tears, suprascapular nerve dysfunction<br>• Understands end stage rotator cuff tear arthropathy and treatment options<br>• Understands tear pattern, appropriate repair, biceps tenodesis (e.g., L-shaped, concentric, U-shaped, tissue quality, biceps subluxation)<br>• Understands pathophysiology of failed rotator cuff repair (e.g., biology, implant failure, stiffness, infection, smoking, tendon quality, vascularity) | • Participates in research in the field with publication cites/teaches junior residents appropriate outcomes studies<br>• Understands treatment for massive/irreparable tears<br>• Understands treatments of intra-operative complications (e.g., misalignment of suture anchor, poor exposure, hemostatis, tuberosity fracture, and anchor breakage) |
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| **Rotator Cuff Injury – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical examination (e.g., age, gender, smoker, trauma, night pain, weakness, inspection for atrophy, ROM)<br>• Lists surgical complications (e.g., infection, stiffness, RSD, retear) | • Obtains focused history and performs physical examination (e.g., provocative tests, Neer/Hawkins, O'Briens, lag signs, pseudoparalysis, lift-off, belly press, scapular dyskinesia)<br>• Orders basic imaging studies<br>• Performs basic surgical approaches and portal placement (e.g., anterior, subacromial, posterior, accessory posterior)<br>• Performs simple shoulder procedures (e.g., subacromial injection)<br>• Prescribes non-operative treatment<br>• Provides basic post-operative management (e.g., phases of cuff repair rehab, Phase 1-3)<br>• Diagnoses surgical complications | • Interprets basic imaging studies (e.g., rotator cuff tear on MRI, muscle atrophy on MRI, proximal humeral migration on x-ray)<br>• Completes pre-operative planning with instrumentation and implants (e.g., patient positioning, arthroscopic equipment, anchors)<br>• Capable of performing diagnostic arthroscopy, subacromial decompression, distal clavicle resection, biceps tenotomy | • Able to order and interpret advanced imaging studies (e.g., tear size, muscle atrophy, labral tears, arthritis, subscapularis tears)<br>• Completes comprehensive pre-operative planning and alternatives<br>• Capable of performing rotator cuff repair<br>• Appropriately interprets post-operative imaging studies/implant positioning<br>• Modifies and adjusts post-operative rehabilitation plan as needed (e.g., modify for massive cuff repairs, post-operative stiffness)<br>• Treats complications both intra- and post-operatively (e.g., irrigation/debridement for infections, proper infection treatment protocol, infectious disease consultation) | • Capable of performing complex arthroscopic rotator cuff repairs, revision rotator cuff repair, tendon transfers<br>• Surgically treats complex complications (e.g., revision rotator cuff repair with tendon transfer, reverse shoulder replacement for anterosuperior escape) |
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| Pediatric Supracondylar Humerus Fracture – Medical Knowledge | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Demonstrates knowledge of pathophysiology related to supracondylar humerus fracture (e.g., fall on outstretched hand, extension mechanism most common; fracture occurs initially on tension side with disruption of periosteum and soft tissues on convexity)<br>• Demonstrates knowledge of elbow anatomy (e.g., ossification centers in growing elbow, bone anatomy, soft tissue anatomy)<br>• Correlates anatomic knowledge to imaging findings on basic imaging studies (e.g., location of fracture, involvement of articular surface or not)<br>• Demonstrates knowledge of non-operative treatment options and surgical indications (e.g., safe casting/splinting principles to minimize risk of compartment syndrome/vascular insufficiency) | • Understands the biology of fracture healing (e.g., hematoma formation, inflammation, early soft callus, hard callus, remodeling) and the importance of periosteum and periosteal bone formation in pediatric fractures<br>• Correlates anatomic knowledge to imaging findings on advanced imaging studies (e.g., rare need for arthrogram/MRI to assess articular surface)<br>• Understands mechanism of injury and fracture classification (e.g., extension vs. flexion types, Gartland classification, elbow hyperextension common in 4-7-year old children)<br>• Demonstrates knowledge of natural history of supracondylar humerus fracture (e.g., high incidence malunion in displaced fractures treated closed, vast majority of nondisplaced fractures and displaced fractures treated with closed reduction and | • Demonstrates knowledge of current literature and alternative treatments (e.g., immobilization for non-displaced fractures; closed reduction and pinning for displaced fractures; alternatives rarely used—olecranon traction for severe swelling)<br>• Demonstrates knowledge of nerve anatomy relative to pin fixation (e.g., location of ulnar nerve and changes with elbow position; locations of median and radial nerves)<br>• Understands rehabilitation protocol (e.g., regaining motion over six weeks-to-six months)<br>• Understands the effects of intervention on natural history of supracondylar humerus fracture; avoid malunion, Volkmann's ischemic contracture<br>• Understands biomechanics and implant choices (e.g., impact of pin size, pin placement [spread at | • Understands controversies within the field; indications for reduction of mildly angulated type II fractures, indications/criteria for open reduction in closed fractures; management of perfused pulseless supracondylar fracture<br>• Understands how to avoid/prevent potential complications (e.g., malunion, nerve injury, vascular complications, ischemic contracture, compartment syndrome, pin tract infections)<br>• Applies understanding of natural history to clinical decision making (e.g., intervention to improve outcome, prevent complications)<br>• Understands alternative surgical approaches (e.g., anterior, anteromedial, anterolateral, medial, posterior approaches) | • Primary author/presenter of original work within the field |

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| | percutaneous pinning [CRPP] function well, and possible vascular injury<br>• Demonstrates knowledge of supracondylar humerus fracture anatomy and basic surgical approaches (e.g., direction of displacement and neurological/vascular structures at risk affects choice of approach)<br>• Understands basic pre-surgical planning; anticipates obstacles to reduction, understands reduction maneuvers | fracture], fracture pattern/comminution) | | |
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| **Pediatric Supracondylar Humerus Fracture – Patient Care** | | | | |
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| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Obtains history and performs basic physical exam (e.g., injury mechanism, radial and ulnar pulse assessment)<br>• Appropriately orders basic imaging studies (e.g., AP and lateral elbow radiographs, oblique views if concern for condylar component)<br>• Prescribes non-operative treatments<br>• Provides basic peri-operative management<br>• Lists potential complications | • Recognizes vascular, nerve or other associated injuries; assess median, radial and ulnar nerves, role of Doppler arterial assessment and perfusion assessment, differentiates anterior interosseous nerve vs. complete median nerve palsy<br>• Appropriately interprets basic imaging studies and recognizes fracture patterns<br>• Splints or casts fracture appropriately (e.g., flexion less than 90 degrees, accommodates for swelling potential)<br>• Completes pre-operative planning with instrumentation and implants<br>• Performs basic management of supracondylar humerus fracture; uncomplicated closed reduction<br>• Provides post-operative management and rehabilitation (e.g., cast or splint care, manage swelling, monitor neurological and vascular status, office pin | • Recognizes factors that could predict difficult reduction and post-operative complication risk (e.g., abnormal vascular examination, neurological deficits, brachialis sign or severe soft tissue swelling, associated forearm fracture)<br>• Appropriately orders and interprets advanced imaging studies<br>• Completes comprehensive pre-operative planning with alternatives; recognizes fracture patterns that may preclude lateral entry only pinning or necessitate ORIF<br>• Modifies and adjusts post-operative treatment plan as needed (e.g., recognizes deviations from typical postoperative course) | • Capable of performing a closed reduction and pinning<br>• Capable of removing obstacles to reduction through closed or open methods (e.g., milking maneuver, open reduction)<br>• Capable of performing alternative surgical approaches to the supracondylar humerus fracture (e.g., milking maneuver, open approaches)<br>• Capable of surgically treating simple complications (e.g., compartment release, wound problems) | • Manages open fractures and fractures with neurological and vascular complications; open approaches and dissect out vascular and neurological structures, appropriate exposure and debridement for open fractures<br>• Develops unique, complex post-operative management plans<br>• Capable of surgically treating complex complications; revision fixation, malunion (e.g., osteotomy for severe cubitus varus) |

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| | removal)<br>• Capable of diagnosis and early management of complications, including compartment syndrome, pin tract sepsis, cast problems | | | |
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| **Comments:**<br><br>**Not yet rotated** ☐ | | | | |

| **Compassion, integrity, and respect for others as well as sensitivity and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. Knowledge about respect for and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice – Professionalism** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Consistently demonstrates behavior that conveys caring, honesty, and genuine interest in patients and families<br>• Recognizes the diversity of patient populations with respect to gender, age, culture, race, religion, disabilities, sexual orientation, and socioeconomic status<br>• Recognizes the importance and priority of patient care, with an emphasis on the care that the patient wants and needs; demonstrates a commitment to this value | • Demonstrates an understanding of the importance of compassion, integrity, respect, sensitivity, and responsiveness while exhibiting these attitudes consistently in common and uncomplicated situations<br>• Consistently recognizes ethical issues in practice; discusses, analyzes, and manages in common and frequent clinical situations including socioeconomic variances in patient care | • Exhibits these attitudes consistently in complex and complicated situations<br>• Recognizes how own personal beliefs and values impact medical care<br>• Knowledgeable about the beliefs, values, and practices of diverse patient populations and the potential impact on patient care<br>• Recognizes ethical violations in professional and patient aspects of medical practice | • Develops and uses an integrated and coherent approach to understanding and effectively working with others to provide good medical care that integrates personal standards with standards of medicine<br>• Consistently considers and manages ethical issues in practice<br>• Consistently practices medicine as related to specialty care in a manner that upholds values and beliefs of self and medicine | • Demonstrates leadership and mentoring regarding these principles of bioethics<br>• Manages ethical misconduct in patient management and practice |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:**<br><br>**Not yet achieved Level 1** ☐ | | | | |

| **Accountability to patients, society, and the profession; personal responsibility to maintain emotional, physical, and mental health – Professionalism** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Understands when assistance is needed and willing to ask for help<br>• Exhibits basic professional responsibilities, such as timely reporting for duty, being rested and ready to work, displaying appropriate attire and grooming, and delivering patient care as a functional physician<br>• Aware of the basic principles and aspects of the general maintenance of emotional, physical, mental health, and issues related to fatigue/sleep deprivation | • Recognizes limits of knowledge in common clinical situations and asks for assistance<br>• Recognizes value of humility and respect towards patients and associate staff<br>• Demonstrates adequate management of personal, emotional, physical, mental health, and fatigue | • Consistently recognizes limits of knowledge in uncommon and complicated clinical situations; develops and implements plans for the best possible patient care<br>• Assesses application of principles of physician wellness, alertness, delegation, teamwork, and optimization of personal performance to the practice of medicine<br>• Seeks out assistance when necessary to promote and maintain personal, emotional, physical, and mental health | • Mentors and models personal and professional responsibility to colleagues<br>• Recognizes signs of physician impairment and demonstrates appropriate steps to address impairment in colleagues | • Develops organizational policies and education to support the application of these principles in the practice of medicine<br>• Practices consistent with the American Academy of Orthopaedic Surgeons (AAOS) Standards of Professionalism |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:**<br><br>**Not yet achieved Level 1** ☐ | | | | |

**Self-Directed Learning – Practice-based Learning and Improvement**

1. **Identify strengths, deficiencies, and limits in one's knowledge and expertise.**
2. **Assess patient outcomes and complications in your own practice.**
3. **Set learning and improvement goals.**
4. **Identify and perform appropriate learning activities.**
5. **Use information technology to optimize learning and improve patient outcomes.**

| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|
| • Acknowledges gaps in personal knowledge and expertise, and frequently asks for feedback from teachers and colleagues<br>• Demonstrates computer literacy and basic computer skills in clinical practice | • Continually assesses performance by evaluating feedback and assessments<br>• Develops a learning plan based on feedback with some external assistance<br>• Demonstrates use of published review articles or guidelines to review common topics in practice<br>• Uses patient care experiences to direct learning | • Accurately assesses areas of competence and deficiencies and modifies learning plan<br>• Demonstrates the ability to select an appropriate evidence-based information tool to answer specific questions while providing care | • Performs self-directed learning without external guidance<br>• Critically evaluates and uses patient outcomes to improve patient care | • Incorporates practice change based upon new evidence |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments:**

**Not yet achieved Level 1** ☐

| **Locate, appraise, and assimilate evidence from scientific studies to improve patient care – Practice-based Learning and Improvement** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning<br>• Categorizes the study design of a research study | • Ranks study designs by their level of evidence<br>• Identifies bias affecting study validity<br>• Formulates a searchable question from a clinical question | • Applies a set of critical appraisal criteria to different types of research, including synopses of original research findings, systematic reviews and meta-analyses, and clinical practice guidelines<br>• Critically evaluates information from others: colleagues, experts, industry representatives, and patient-delivered information | • Demonstrates a clinical practice that incorporates principles and basic practices of evidence-based practice and information mastery<br>• Cites evidence supporting several common practices | • Independently teaches and assesses evidence-based medicine and information mastery techniques |
| ☐ | ☐ | ☐ | ☐ | ☐ ☐ ☐ ☐ ☐ |
| **Comments:** | | | | |
| **Not yet achieved Level 1** ☐ | | | | |

| **Systems thinking, including cost-effective practice – Systems-based Practice** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Describes basic levels of systems of care (e.g., self-management to societal)<br>• Understands the economic challenges of patient care in the health care system | • Gives examples of cost and value implications of care he or she provides (e.g., gives examples of alternate sites of care resulting in different costs for individual patients) | • Orders and schedules tests in appropriate systems for individual patients balancing expenses and quality<br>• Successfully navigates the economic differences of the health care system | • Effectively manages clinic team and schedules for patient and workflow efficiency<br>• Uses evidence-based guidelines for cost-effective care | • Leads systems change at micro and macro level (e.g., manages operating room [OR] team and patient flow in a multi-case OR day) |
| ☐ | ☐ | ☐ | ☐ | ☐ ☐ ☐ ☐ |
| **Comments:** | | | | |
| **Not yet achieved Level 1** ☐ | | | | |

| Resident will work in interprofessional teams to enhance patient safety and quality care – Systems-based Practice | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Recognizes importance of complete and timely documentation in teamwork and patient safety | • Uses checklists and briefings to prevent adverse events in health care | • Participates in quality improvement or patient safety program and/or project | • Maintains team situational awareness and promote "speaking up" with concerns<br>• Incorporates clinical quality improvement and patient safety into clinical practice | • Develops and publishes quality improvement project results<br>• Leads local or regional quality improvement project |
| ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | | | | |
| **Comments:** | | | | |
| **Not yet achieved Level 1** ☐ | | | | |

| Uses technology to accomplish safe health care delivery – Systems-based Practice | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Explains the role of the Electronic Health Record (EHR) and Computerized Physician Order Entry (CPOE) in prevention of medical errors | • Appropriately and accurately enters patient data in EHR<br>• Effectively uses electronic medical records in patient care | • Reconciles conflicting data in the medical record | • Contributes to reduction of risks of automation and computerized systems by reporting system problems | • Recommends systems re-design for faculty computerized processes |
| ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | | | | |
| **Comments:** | | | | |
| **Not yet achieved Level 1** ☐ | | | | |

| **Communication – Interpersonal and Communication Skills** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Communicates with patients about routine care (e.g., actively seeks and understands the patient's/family's perspective; able to focus in on the patient's chief complaint and ask pertinent questions related to that complaint) | • Communicates competently within systems and other care providers, and provides detailed information about patient care (e.g., demonstrates sensitivity to patient—and family—related information gathering/sharing to social cultural context; begins to engage patient in patient-based decision making, based on the patient's understanding and ability to carry out the proposed plan; demonstrates empathic response to patient's and family's needs; actively seeks information from multiple sources, including consultations; avoids being a source of conflict; able to obtain informed consent [risks, benefits, alternatives, and expectations]) | • Communicates competently in difficult patient circumstances (e.g., able to customize emotionally difficult information, such as end-of-life or loss-of-limb discussions; supports patient and family; engages in patient-based decision making incorporating patient and family/cultural values and preferences) | • Communicates competently in complex/adversarial situations (e.g., understand a patient's secondary motivations in the treatment of his or her care—drug seeking, disability issues, and legal cases; able to sustain working relationships during complex and challenging situations, including transitions of care—treatment of a metastatic pathologic fracture; able to manage conflict with peers, subordinates, and superiors) | • Demonstrates leadership in communication activities (e.g., coaches others to improve communication skills; engages in self-reflection on how to improve communication skills |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments:**

**Not yet achieved Level 1** ☐

| **Teamwork (e.g., physician, nursing and allied health care providers, administrative and research staff) – Interpersonal and Communication Skills** | | | | |
|---|---|---|---|---|
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| • Recognizes and communicates critical patient information in a timely and accurate manner to other members of the treatment team<br>• Recognizes and communicates role as a team member to patients and staff<br>• Responds to requests for information<br><br>*Examples:*<br>Lab results, accurate and timely progress notes, answers pages in a timely manner | • Supports and respects decisions made by team<br>• Actively participates in team-based care; Supports activities of other team members, communicates their roll to the patient and family<br><br>*Examples:*<br>Hand-offs, transitions of care, communicates with other health care providers and staff members | • Able to facilitate, direct, and delegate team-based patient care activities<br>• Understands the Operating Room team leadership role and obligations<br><br>*Examples:*<br>Leads daily rounds, communicates plan of action with OR personnel | • Leads team-based care activities and communications<br>• Able to identify and rectify problems with team communication<br><br>*Example:*<br>Organizes and verifies hand-off rounds, coverage issues | • Seeks leadership opportunities within professional organizations<br>• Able to lead/facilitate meetings within organization/system |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Comments:** | | | | Not yet achieved Level 1 ☐ |

**University of Mississippi Orthopedic Surgery**
**Trainee Evaluation: Formative Assessment**

| | | | |
|---|---|---|---|
| **Evaluator:** | Faculty Name - Title | **Subject:** | Resident's Name – PGY Level |

## Formative Evaluation - Mid-Rotation

**Formative Evaluation Completed:** *(Question 1 of 2 - Mandatory)*

I have had face to face feedback with this resident/fellow.

| Selection | Option |
|---|---|
| X | Yes |
| | No |

**Provide a summary** *(Question 2 of 2 - Mandatory)*

Please comment on resident's performance at the mid-point of the current rotation.

Evaluation of the Resident's Performance –

# Summative Evaluation of Resident by Educator

**University of Mississippi Orthopedic Surgery**
**Trainee Evaluation: Resident Summative**

| | | | |
|---|---|---|---|
| **Evaluator:** | Faculty Name - Title | **Subject:** | Resident's Name – PGY Level |
| **Activity:** | Rotation | **Site:** | University of Mississippi Medical Center |
| **Evaluation Type:** | Resident – Summative Evaluation | **Completion Date:** | XX/XX/20XX |
| **Request Date:** | XX/XX/20XX | | |
| **Period:** | Month - Month 20XX | **Dates of Activity:** | XX/XX/20XX **To** XX/XX/20XX |
| **Subject Participation Dates:** | XX/XX/20XX **To** XX/XX/20XX | | |

****Please Note - House Officers Are Evaluated On Ratings of 1-5, Based On Their Current Training Level.****

## Competency - Patient Care

**Judgment:** *(Question 1 of 23 - Mandatory)*

Common sense, decisiveness, ability to draw sound conclusions, willingness to admit mistakes. Regard for patient's needs and life conditions.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

## Competency - Patient Care

**Caring:** *(Question 2 of 23 - Mandatory)*

Compassionate, appropriate and effective care of patients for the treatment of health problems and the promotion of health.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Patient Care Comments:** *(Question 3 of 23)*

## Competency - Medical Knowledge

**OR Performance:** *(Question 4 of 23 - Mandatory)*

Exhibits knowledge of anatomy, physiology, pathology of case. Understands mechanics. Dexterity, efficiency, thoroughness. Concern for patient. Maintenance of professional OR atmosphere.

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Competency - Medical Knowledge

**Decision Making:** *(Question 5 of 23 - Mandatory)*

Make informed decisions about diagnostic-therapeutic treatment based on patient info, preferences, up-to-date scientific evidence and clinical judgment. Develop and carry out patient management plans. Demonstrate investigatory and analytic thinking approach to clinical situations.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | |

**Medical Knowledge Comments:** *(Question 6 of 23)*

## Competency - Practice-Based Learning and Improvement

**Motivation:** *(Question 7 of 23 - Mandatory)*

Exhibits active and aggressive attitude toward learning and work.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | |

## Competency - Practice-Based Learning and Improvement

**Leadership:** *(Question 8 of 23 - Mandatory)*

Ability to elicit cooperation from nursing staff, technicians, and orderlies in the discharge of their functions in patient care.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | |

**Practice-Based Learning and Improvement Comments:** *(Question 9 of 23)*

## Competency - Interpersonal and Communication Skills

**Communication Skills: Oral** *(Question 10 of 23 - Mandatory)*

Clarity of expression, articulateness, grammar. Skills that allow for effective information exchange with patients, their families and other health professionals.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

## Competency - Interpersonal and Communication Skills

**Communications Skills: Written** *(Question 11 of 23 - Mandatory)*

Must observe and document observations accurately and in good time. Progress, operative, and discharge notes should be written completely and promptly.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Interpersonal and Communication Skills Comments:** *(Question 12 of 23)*

## Competency - Professionalism

**Reliability:** *(Question 13 of 23 - Mandatory)*

Acceptance of responsibility, punctuality, availability.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

## Competency - Professionalism

**Integrity:** *(Question 14 of 23 - Mandatory)*

Honesty, discretion accountability to patients, society, and the profession; a commitment to excellence and on-going professional development.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

## Competency - Professionalism

**Appearance:** *(Question 15 of 23 - Mandatory)*

Poise, alertness, cleanliness, weight, appropriateness of dress.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Professionalism Comments:** *(Question 16 of 23)*

## Competency - Systems-Based Practice

**System of Health Care:** *(Question 17 of 23 - Mandatory)*

Ability to demonstrate an awareness and responsiveness to the large context and system of health care. The ability to effectively call on system resources to provide care for optimal value. Advocate for quality patient care and help patients deal with system complexities.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Systems-Based Practice Comments:** *(Question 18 of 23)*

**Emotional Stability and Stress Management:** *(Question 19 of 23 - Mandatory)*

Performance in emergency situations, response to opposition or frustration, mood stability, control.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Stamina:** *(Question 20 of 23 - Mandatory)*

Physical endurance, perseverance, health.

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent 0 |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

**Other Factors Comments:** *(Question 21 of 23)*

**Overall Rating:** *(Question 22 of 23 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|

**Additional Comments:** *(Question 23 of 23)*

**University of Mississippi**
**Orthopedic Surgery**

## Educator Evaluations by Resident / Fellow

| | | | |
|---|---|---|---|
| **Subject:** | Faculty Name, Title | **Evaluation Type:** | Faculty |
| **Activity:** | Rotation Name | **Site:** | University of Mississippi Medical Center |
| **Period:** | Month - Month 20XX | **Dates of Activity:** | XX/XX/20XX **To** XX/XX/20XX |
| **Evaluator:** | Resident's Names, PGY Level | **Completion Date:** | XX/XX/20XX |
| **Subject Participation Dates:** | XX/XX/20XX **To** XX/XX/20XX | | |

**He/she was available when needed for consultation, including requests for help on nights and weekend.** *(Question 1 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**His/her attitude towards resident staff facilitated learning.** *(Question 2 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she displayed a caring and compassionate attitude toward patients.** *(Question 3 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she delegate appropriate responsibility at the bedside.** *(Question 4 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she delegate appropriate responsibility in the emergency room.** *(Question 5 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| >> 0 << | 1 | 2 | 3 | 4 | 5 |

**He/she delegate appropriate responsibility in the operating room.** *(Question 6 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she delegate appropriate responsibility in general decision making.** *(Question 7 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she contributed to my education in conference.** *(Question 8 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she contributed to my education at the bedside/on rounds.** *(Question 9 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she contributed to my education in clinic.** *(Question 10 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| >> 0 << | 1 | 2 | 3 | 4 | 5 |

**He/she contributed to my education in the operating room.** *(Question 11 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**He/she contributed to my education in performing research.** *(Question 12 of 13 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Additional Comments:** *(Question 13 of 13)*

# Resident Evaluation of the Rotation and Instructors (Reported anonymously)

**The level of faculty supervision is appropriate for your level.** *(Question 1 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**If you disagree, is the level of supervision:** *(Question 2 of 11)*

Too Little Too Much

**The quality of staff/resident interaction is appropriate for patient care and your professional development.** *(Question 3 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**Please rate the educational quality and the rotation for learning clinical management skills.** *(Question 4 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**Please rate the educational quality of the rotation for learning technical skills.** *(Question 5 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**For the educational experience of the resident, the number of patients admitted to or followed by the service is appropriate.** *(Question 6 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**If you disagree, are there:** *(Question 7 of 11)*

Too Few Too Many

**The number of residents assigned to the service is appropriate.** *(Question 8 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**If you disagree, are there:** *(Question 9 of 11)*

Too Few Too Many

**For educational purposes, the operative caseload is adequate.** *(Question 10 of 11 - Mandatory)*

| Unable To Rate | Strongly Disagree | Slightly Disagree | Slightly Agree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 |

**Additional Comments:** *(Question 11 of 11)*

**Review your answers in this evaluation. If you are satisfied with the evaluation, click the SUBMIT button below. Once submitted, evaluations are no longer available for you to make further changes.**

## University of Mississippi Orthopedic Surgery
**Trainee Evaluation: Resident 360 (Reported Anonymously)**

| | | | |
|---|---|---|---|
| **Evaluator:** | Evaluator's name - Title | **Subject:** | Resident/Fellow Name – PGY Level |
| **Activity:** | Rotation Name | **Site:** | University Mississippi Medical Center |
| **Evaluation Type:** | Resident 360 | **Completion Date:** | XX/XX/XXXX |
| **Request Date:** | XX/XX/XXXX | | |
| **Period:** | December 20XX – February 20XX | **Dates of Activity:** | 12/01/20XX **To** 02/29/20XX |
| **Subject Participation Dates:** | 12/01/20XX **To** 02/29/20XX | | |

**Is respectful and caring of others** *(Question 1 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Communicates treatment plan to patient/family** *(Question 2 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Explains patient education measures to patient/family** *(Question 3 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Practices Listening Skills** *(Question 4 of 20 - Mandatory)*

Practices listening skills that allow patient/family to fully express their symptoms/concerns

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Establishes a professional relationship with patient/family** *(Question 5 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Is sensitive to the needs of patients/families** *(Question 6 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Explains Operative Procedures** *(Question 7 of 20 - Mandatory)*

Explains operative procedures, risks and aftercare to patient/family

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Sensitive to Differences** *(Question 8 of 20 - Mandatory)*

Is sensitive and responsive to differences in culture, gender, age, and impairment

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Uses Health Care System Resources** *(Question 9 of 20 - Mandatory)*

Uses health care system resources to provide optimal patient care outside the acute hospital system

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Is attentive to timely completion of patient personal forms** *(Question 10 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| >> 0 << | 1 | 2 | 3 | 4 | 5 |

**Maintains Professional Communications** *(Question 11 of 20 - Mandatory)*

Maintains professional communications and relationships with ancillary staff

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Is reliable and responsible** *(Question 12 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Works effectively as a treatment team player** *(Question 13 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Takes steps to prevent wrong site surgery** *(Question 14 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| >> 0 << | 1 | 2 | 3 | 4 | 5 |

**Takes measures to prevent/report medical errors** *(Question 15 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

Has detailed notation on electronic file *(Question 16 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | >> 4 << | 5 |

**Enters Electornic documentation in a timely manner** *(Question 17 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Facilitates the learning of other members of the treatment team** *(Question 18 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**Is receptive to constructive criticism** *(Question 19 of 20 - Mandatory)*

| Unknown | Poor | Marginal | Average | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | >> 5 << |

**General Comments** *(Question 20 of 20)*

Please provide any additional comments or suggestion which you feel may be helpful

**University of Mississippi**
**Orthopedic Surgery**

**Trainee Evaluation – Peer to Peer (Reported Anonymously)**

| | | | |
|---|---|---|---|
| **Evaluation Type:** | Peer (Trainee to Trainee) | **Completion Date:** | XX/XX/20XX |
| **Request Date:** | XX/XX/20XX | | |
| **Period:** | Month – Month 20XX | **Dates of Activity:** | XX/XX/20XX **To** XX/XX/20XX |
| **Subject Participation Dates:** | XX/XX/20XX **To** XX/XX/20XX | | |

**Observations:** *(Question 1 of 13 - Mandatory)*

On average how many clinical observations did you have of the resident?

| Selection | Option |
|---|---|
| | < 4 |
| | 5 - 10 |
| | 10 - 20 |
| X | > 20 |

**Communications; Patients and Families:** *(Question 2 of 13 - Mandatory)*

Communicates clearly; is willing to answer questions and provide explanations; willing to listen to patients and families

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Communication; Nursing and Allied Health Staff:** *(Question 3 of 13 - Mandatory)*

Consistently demonstrates willingness to listen to nursing and allied health staff

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Respectfulness; Patients:** *(Question 4 of 13 - Mandatory)*

Treats others with respect; does not demean or make others feel inferior; provides equitable care to patients; uses respectful language when discussing patients; is sensitive to cultural needs of patients

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Respectfulness; Nursing and Allied Health Staff:** *(Question 5 of 13 - Mandatory)*

Consistently courteous and receptive to nursing and allied health staff; acknowledges and respects roles of other health care professionals in patient care

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Compassion:** *(Question 6 of 13 - Mandatory)*

Is kind to patient and families; appreciates patients and families special needs and accepts inconvenience when necessary to meet the needs of the patient; consistently attentive to details of patient comfort

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Reliability:** *(Question 7 of 13 - Mandatory)*

Completes and fulfills responsibilities; responds promptly when on call or when paged; assists and fills in for others when needed

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Honesty/Integrity:** *(Question 8 of 13 - Mandatory)*

Knows limits of ability to asks for help when appropriate; is honest and trustworthy; does not falsify information; committed to ethical principles

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Responsibility:** *(Question 9 of 13 - Mandatory)*

Accepts responsibility (does not blame others or the system); committed to self-assessment; responds to feedback; committed to excellence and self-learning

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >> 9 << |

**Advocate:** *(Question 10 of 13 - Mandatory)*

An advocate for patient needs, effectively accesses and coordinates medical system resources to optimize patient care, seeks to find and correct system causes of medical error

| Unable to Assess | Unsatisfactory | | | Satisfactory | | | Excellent | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | >> 8 << | 9 |

**Comments:** *(Question 11 of 13)*

**Resident's Strengths:** *(Question 12 of 13)*

**Improvements:** *(Question 13 of 13)*

How can the resident improve?

## End of Residency Evaluation by Program Director

## University of Mississippi Orthopedic Surgery

## Trainee Evaluation: End of Residency / Fellowship Evaluation of Competencies

| | | | |
|---|---|---|---|
| **Evaluator:** | Program Director - Title | **Subject:** | Resident – PGY Level |
| **Activity:** | End of Residency/Fellowship Evaluation of | **Site:** | University of Mississippi Medical |
| **Evaluation Type:** | Resident – End of Residency | **Completion Date:** | XX/XX/20XX |
| **Request Date:** | XX/XX/20XX | | |
| **Period:** | 20XX-20XX End of Residency Evaluation | **Dates of Activity:** | 07/01/20XX **To** 06/30/20XX |
| **Subject Participation Dates:** | 07/01/20XX **To** 06/30/20XX | | |

## Competency - Patient Care

**Judgment:** *(Question 1 of 40 - Mandatory)*
Common sense, decisiveness, ability to draw sound conclusions, willingness to admit mistakes. Regard for patient's needs and life conditions.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Caring:** *(Question 2 of 40 - Mandatory)*
Compassionate, appropriate and effective care of patients for the treatment of health problems and the promotion of health.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Communication:** *(Question 3 of 40 - Mandatory)*
Gather essential and accurate information about patients-work with health care professionals to provide patient focused care.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Patient Care Comments:** *(Question 4 of 40)*

## Competency - Medical Knowledge

**Intellectual Ability:** *(Question 5 of 40 - Mandatory)*
Retention, comprehension, abstraction, discrimination, logical thinking.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**OR Performance:** *(Question 6 of 40 - Mandatory)*
Exhibits knowledge of anatomy, physiology, pathology of case. Understands mechanics. Dexterity, efficiency, thoroughness. Concern for patient. Maintenance of professional OR atmosphere.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

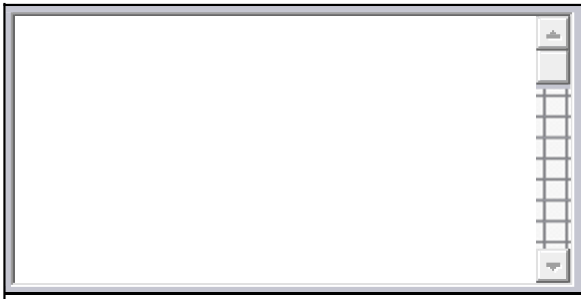
**Conference Performance:** *(Question 7 of 40 - Mandatory)*
Punctuality organization, preparation. Show knowledge of current literature and treatments.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Decision Making:** *(Question 8 of 40 - Mandatory)*
Make informed decisions about diagnostic-therapeutic treatment based on patient info, preferences, up-to-date scientific evidence and clinical judgment. Develop and carry out patient management plans. Demonstrate investigatory and analytic thinking approach to clinical situations.

| No opinion | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

**Medical Knowledge Comments:** *(Question 9 of 40)*



## Competency - Practice-Based Learning and Improvement

**Motivation:** *(Question 10 of 40 - Mandatory)*
Exhibits active and aggressive attitude toward learning.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Knowledge of Field:** *(Question 11 of 40 - Mandatory)*
Shows evidence of the literature, methods of management, advantages and disadvantages of alternative treatments of their own patient care. Appraisal and assimilation of scientific evident and improvements in patient care.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Leadership:** *(Question 12 of 40 - Mandatory)*
Ability to elicit cooperation from nursing staff, technicians, and orderlies in the discharge of their functions in patient care.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Research Aptitude:** *(Question 13 of 40 - Mandatory)*
Curiosity, creativity, ability to evaluate and analyze data. Utilization of resources. Independent work.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Work Habits:** *(Question 14 of 40 - Mandatory)*
Initiative, amount of prodding or supervision needed, responsibility, quality, amount.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Relating to Students:** *(Question 15 of 40 - Mandatory)*
Accepts role of teacher. Explains and elaborates. Recognized student's interests and needs.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

**Information Technology** *(Question 16 of 40 - Mandatory)*
Use information technology to management information, access on-line medical info to support their own education.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Practice-Based Learning and Improvement Comments:** *(Question 17 of 40)*

## Competency - Interpersonal and Communication Skills

**Communication Skills: Oral** *(Question 18 of 40 - Mandatory)*
Clarity of expression, articulateness, grammar. Skills that allow for effective information exchange with patients, their families and other health professionals.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Communications Skills: Written** *(Question 19 of 40 - Mandatory)*

Must observe and document observations accurately and in good time. Progress, operative, and discharge notes should be written completely and promptly.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Relating to Patients:** *(Question 20 of 40 - Mandatory)*
Interested, honest, and understanding. Explains clearly and to the patient's satisfaction details and related to diagnosis, proposed treatment, and it's implications.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | |
| | | | | | |

**Interpersonal and Communication Skills Comments:** *(Question 21 of 40)*

## Competency - Professionalism

**Concern for Others:** *(Question 22 of 40 - Mandatory)*
Sensitivity to and consideration of others, tactfulness. Committed to ethical principles and sensitivity to a diverse patient population (culture, age, gender, disabilities).

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Reliability:** *(Question 23 of 40 - Mandatory)*

Acceptance of responsibility, punctuality, availability.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Integrity:** *(Question 24 of 40 - Mandatory)*
Honesty, discretion accountability to patients, society, and the profession; a commitment to excellence and on-going professional development.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Appearance:** *(Question 25 of 40 - Mandatory)*
Poise, alertness, cleanliness, weight, appropriateness of dress.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Ethical Principles:** *(Question 26 of 40 - Mandatory)*
A commitment to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

**Professional Promise:** *(Question 27 of 40 - Mandatory)*

Desirability of letting this person treat you or your family.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Professionalism Comments:** *(Question 28 of 40)*

## Competency - Systems-Based Practice

**Resourcefulness:** *(Question 29 of 40 - Mandatory)*
Management of available resources. Understand roles of support personnel and makes maximum use of their assistance. Resourcefulness in obtaining information about patients.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**System of Health Care:** *(Question 30 of 40 - Mandatory)*
Ability to demonstrate an awareness and responsiveness to the large context and system of health care. The ability to effectively call on system resources to provide care for optimal value. Advocate for quality patient care and help patients deal with system complexities.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Systems-Based Practice Comments:** *(Question 31 of 40)*

**Emotional Stability and Stress Management:** *(Question 32 of 40 - Mandatory)*
Performance in emergency situations, response to opposition or frustration, mood stability, control.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

**Stamina:** *(Question 33 of 40 - Mandatory)*

Physical endurance, perseverance, health.

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Other Factors Comments:** *(Question 34 of 40)*

**Overall Rating:** *(Question 35 of 40 - Mandatory)*

| No opinion | Poor | Fair | GoodVery good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Additional Comments:** *(Question 36 of 40)*

**DO NOT COMPLETE THE QUESTIONS BELOW;** they will be completed at the time of the program director meeting.

**The resident/fellow has demonstrated sufficient professional ability to practice competently and independently upon completion of this program on:** *(Question 37 of 40)*

**Residency / Fellowship Dates:** *(Question 38 of 40)*

**Program Directors signature:** *(Question 39 of 40)*

**Resident/fellow signature:** *(Question 40 of 40)*

# Annual Program Evaluation by Faculty

## Administrative

**Administrative responsibilities clearly identified** *(Question 1 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Yearly evaluation performed with program director** *(Question 2 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Educational/computer resources easily available** *(Question 3 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Administrative/secretarial support adequate** *(Question 4 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Curriculum reviewed and updated regularly** *(Question 5 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Patient Care

**Front office support** *(Question 6 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Nursing support** *(Question 7 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Quality of care patients receive at our clinic** *(Question 8 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Faculty given opportunity to grow as teachers and continued improvement** *(Question 9 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Program provides faculty development on individual basis** *(Question 10 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Scholarly Activity

**Faculty actively involved with academic endeavors (research, writing, etc.)** *(Question 11 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Faculty involved in local, state, regional, national committees** *(Question 12 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Program Director

**Program Director accessible to faculty and deals with concerns/issues timely** *(Question 13 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Program run effectively and allows resident/faculty participation** *(Question 14 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Support

**Resources for faculty support/impairment known and available** *(Question 15 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Faculty cohesive and work well together** *(Question 16 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery Good | Excellent |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

## Residency Program

**Did you discuss goals and objectives with the residents at the start of the rotation?** *(Question 17 of 36 - Mandatory)*

N/A No Yes

**Do you have time to teach residents while on service?** *(Question 18 of 36 - Mandatory)*

N/A No Yes

**Is there adequate volume for resident education?** *(Question 19 of 36 - Mandatory)*

N/A No Yes

**Is there adequate patient diversity for Resident education?** *(Question 20 of 36 - Mandatory)*

N/A No Yes

## Please evaluate your teaching experience as an attending.

**Adequate time to teach orthopaedic surgery to the residents.** *(Question 21 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Adequate opportunities to interact with residents.** *(Question 22 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 |

**Adequate opportunities to help improve the program.** *(Question 23 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | ○ 1 | 2 | ○ 3 | ○ 4 | 5 |

**Adequate opportunity to participate in conferences.** *(Question 24 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 |

**Your impression as to the effectiveness of the residency program in preparing the residents for careers in Orthopaedic Surgery.**

**Overall adequate patient population.** *(Question 25 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | ○ 1 | 2 | ○ 3 | ○ 4 | 5 |

**Adequate education of fellow in cost-effective patient care.** *(Question 26 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 |

**Adequate teaching of awareness and responsiveness to healthcare system.** *(Question 27 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Adequate opportunities for research.** *(Question 28 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 |

## Please evaluate the various Didactic Conferences / Grand Rounds.

**Preoperative Conference** *(Question 29 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| 0 | ○ 1 | 2 | ○ 3 | 4 | 5 |

\

**Morbidity and Mortality Conference** *(Question 30 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Rounds** *(Question 31 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Journal Club** *(Question 32 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Anatomy Lab** *(Question 33 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Grand Rounds** *(Question 34 of 36 - Mandatory)*

| Not Applicable | Poor | Fair | GoodVery | Good | Excellent |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**Your suggestions for improvements to the program.** *(Question 35 of 36 - Mandatory)*

**Your overall rating of the program.** *(Question 36 of 36 - Mandatory)*

**UMMC ORTHOPAEDIC SURGERY RESIDENCY PROGRAM**
**Semi-Annual Resident PD Evaluation**
**Date**

Name: _____ PGY level: ___

**Medical Knowledge, Patient Care**
□ Discussed operative log
- □ Appears to have adequate cases/distribution for level of training
- □ RRC minimal requirements met for all cases
- □ Deficiency in volume or case distribution

□ Discussed OITE results by Year Percentile _____

**Professionalism**
□ Reviewed duty hours documentation:
- □ Compliant with duty hours
- □ Up to date on Documentation of Duty Hours

□ Medical Records
Number of Deficiencies _____

**System Based Practice**
□ 360/ Peer Evaluations
□ iCare Reports filed by resident _____

**Practiced Based Learning and Improvement**
□ Provided updated CV
□ Local/Regional/National presentation
□ Ongoing research
□ QI Project Update Completed

**Interpersonal and Communication Skills**
□ Documented complaints by patients, nurses, others (iCare Reports)
□ Documented commendations by patients, nurses, others
□ Discussed evaluations received since last semi-annual review

**Comments / Concerns raised by the resident:**

**Comments / Concerns raised by the PD:**

□ Given Credit
□ Academic Remediation
□ Placed on Probation
□ Chief Resident – On Track to Graduate

_____ _____
Resident Signature Program Director Signature

| **OITE** | PG1 | PG2 | PG3 | PG4 | PG5 |
|---|---|---|---|---|---|
| %ile | | | | | |

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street
JACKSON, MISSISSIPPI 39216-4505

# House Officer Portfolio Requirements

** Forms need to be completed prior to arrival for Semi-Annual Evaluation**

You will be required to provide this information semi-annually at your evaluation period and upon your final evaluation when exiting the program. This portfolio is a collection of your products and achievements during residency. Feel free to add anything else that you feel is pertinent to your file.

1. Current Curriculum Vitae
2. Minimums / Activity Reports - case log from ACGME web site
3. SMART GOALS – define three goals (FORM)
4. Quality Improvement Project – updates & summary (Form)
5. Research Project (Form)

**Forms will be sent out prior to semi-annual evaluation**

Please remember to prep the below listed items for your evaluation.

- Case logs – Update Logs (A copy of the most recent ACGME Activity Report will be on file)
- Duty hours – Make sure to update in MedHub
- Three SMART Goals – Please complete the attached form
- Research – brief printed update for file
- QIP Detailed Form – Required by GME
- CV Updated (Sample / Guideline attached)
- Make sure to Completed the Self –Eval / Milestones in MedHub (if not already done in the fall)
- MedHub – Complete program / Faculty Evals – they remain anonymous and are reported in aggregate
- USMLE Step 3 report for files – make sure to send once received
- I-Care Reports – the department asks that you use I-Care reporting for System-Based Practice. Please enter at least one/6 month block – quality & safety improvement measures (OR Equipment / Case Delay / etc…)
- Semi-Annual PD Evaluation form - Graves will have this and review w/ you

**Bring all completed forms / documents to this meeting.**

**S**

- **SPECIFIC**
- Define the goal as much as possible with no unclear language
- **WHO** is involved, **WHAT** do I want to accomplish, **WHERE** will it be done, **WHY** am I doing this – reasons, purpose, **WHICH** constraints and /or requirements do I have?

**M**

- **MEASURABLE**
- Can you track the progress and measure the outcome?
- How much, how many, how will I know when my goal is accomplished?

**A**

- **ATTAINABLE / ACHIEVABLE**
- Is the goal reasonable enough to be accomplished? How so?
- Make sure the goal is not out of reach or below standard performance.

**R**

- **RELEVANT**
- Is the goal worthwhile and will it meet your needs?
- Is each goal consistent with the other goals you have established and fits with your immediate and long term plans?

**T**

- **TIMELY**
- Your objective should include a time limit. Ex: I will complete this step by month/day/year.
- It will establish a sense of urgency and prompt you to have better time management.

# UMMC Orthopaedic Surgery Residency Program

## Define Three S.M.A.R.T. Goals

**S.M.A.R.T** goals are specific, measurable, attainable, relevant, and time based.

| Name: _____ | | | Date: _____ | | |
|---|---|---|---|---|---|
| **Specific:** | **Measurable:** | **Attainable:** | **Realistic:** | **Timely:** | **Notes:** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Use the information above to summarize each goal.

*1.* Goal Statement:_____

2. Goal Statement:_____

3. Goal Statement:_____

# Quality Improvement / Patient Safety Projects
## Orthopaedic Surgery Residency Program
## University of Mississippi Medical Center

| OPPORTUNITY / PROBLEM IDENTIFIED (Plan) | PROJECT TITLE | PROJECT TEAM (* Residents) | IMPLEMENTATION STEPS (Do-Study-Act) | COMPLETION DATE OF CYCLE | MEASURED OUTCOME(s) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2.. | | | | | |
| 3. | | | | | |

**Relevant supporting documentation (PDSA form, etc.) should be attached to the spreadsheet, as needed.**

**RESIDENT:** **DATE:**

# RESEARCH PROJECT

**TITLE:**

**MENTOR:**

**CURRENT STATUS:**

# CV Development

- **Format**

  -Use white, ivory, or gray paper with 20-24 pound quality
  -All pages should be "balanced" with consistent margins, text placement, and white space
  -All pages should be "parallel" with similar sentence structure, fonts, use of bold/italics/lines
  -Margins should be 1"-1.5"
  -Font size should be 11-12
  - Font style should be Serif (Times New Roman) or San serif (Arial) because it is easier to read
  -Don't use strange fonts
  -Do not use the word "resume," "CV," or "curriculum vitae" on your actual resume/CV
  -Use emphasis indicators (lines, bullets, asterisks, bolding, italics, all caps) sparingly if at all

- **Content**

  -Each CV may include the following areas:
  - ✓ Contact Information
  - ✓ Education (exclude high school)
  - ✓ License/Certification
  - ✓ Honors/Awards
  - ✓ Professional Associations/Memberships
  - ✓ Publications
  - ✓ Abstracts/ Presentations
  - ✓ Other Research Activity
  - ✓ Teaching
  - ✓ Employment
  - ✓ Professional Activities
  - ✓ Community Service

  -Information in each area should be listed by date, with the most recent first

  ✓ Contact information
  Name (resolve any discrepancies and use middle name)
  Address (current and permanent)
  Phone (professional number with appropriate message on voice mail)
  Email

- ✓ Education (most recent first)
  - Residency
  - Medical School
  - College/University
  - Be sure to include:
    - Location
    - Date of graduation (anticipated)
    - Degree
    - Academic distinction (Summa cum laude, magna cum laude)
    - Majors, minors, concentrations (if applicable)

- ✓ Certification/License
  - List dates, expiration, and states

- ✓ Honors/Awards (most recent first)
  - Professional awards/recognitions
  - Academic awards
  - Scholarships
  - Honor organizations
  - Special Schools (e.g., Honors College)
  - Community service awards/achievements (e.g, Eagle Scout)

- ✓ Publications
  - List full citations with all authors

- ✓ Abstracts /Presentations
  - List full citation of all abstracts, poster presentations, presentations at scientific/professional meetings

- ✓ Other Research Activity
  - List additional research experiences/involvement even if no resulting article/manuscript and be sure to include time frame, title, description, mentors

- ✓ Teaching Experiences
  - List courses/lectures/workshops/simulation if you were an instructor

- ✓ Employments (list dates)
  - Identify position
  - Emphasize those medical/research related
  - Use action verbs to describe duties

- ✓ Professional Activities
  List departmental institutional, state, and national committee involvement

- ✓ Community Service
  List all volunteer work and community service (e.g., Jackson Free Clinic, Big Brothers Big Sisters, etc.)

- **Things to Remember**

  -Be clear and concise
  - Be accurate and truthful
  -Check for errors and ask someone to proofread
  -Update CV regularly and often
  -Emphasize strengths

- **Resources**


Chambler, AFW, Chapman-Sheath, PJ, Pearse, MF. A model curriculum vitae: what are the trainers looking for? Hospital Medicine, 1998 April; 59(4): 324-326.

Emory University School of Medicine
http://medicine.emory.edu/research/documents/Action%20Verbs.pdf

Iserson, K.V. (2006) Iserson's getting into a residency: A guide for medical students (7th Ed.) Galen Press, LTD: Tucson, Arizona.

Patel, MV, Pradhan, BB, Meals, RA. Misrepresentation of research publications among orthopedic surgery fellowship applicants. Spine (Phila Pa 1976), 2003 Apr 1; 28(7):631-

Purdue Online Writing Lab http://owl.english.purdue.edu/owl/resource/641/01/

Wordpress http://contemporesume.wordpress.com/2011/01/12/is-your-resume-sabotaging-your-job-search/

# Education


**Minimum Program Requirements Language**
***Approved by the ACGME, September 28, 1999***

**General Competencies (six) / Educational Program**

The residency program must require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

**ACGME Outcome Project – page 2**

## Evaluation

*Evaluation of Residents*

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. This plan should include:

a. use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
b. mechanisms for providing regular and timely performance feedback to residents
c. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance

Programs that do not have a set of measures in place must develop a plan for improving their evaluations and must demonstrate progress in implementing the plan.

*Program Evaluation*

a. The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
b. The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

## 5. ACGME Competencies
### a. Patient Care

**Common Program Requirement:**

*5. ACGME Competencies*
*The program must integrate the following ACGME competencies into the curriculum:*
*a. Patient Care*
*Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:*
*[As further specified by the Review Committee]*

**Explanation:**

While each specialty has specific requirements for patient care, some principles are common. Early in their education, residents should demonstrate patient care skills relevant to that specialty for patients with common diagnoses and for uncomplicated procedures. As residents progress in educational level, they should be able to demonstrate patient care skills with non-routine, complicated patients and under increasingly difficult circumstances, while demonstrating compassionate, appropriate and effective care. Likewise, they should demonstrate proficiency in performing increasingly complex procedures and handling unexpected complications, while demonstrating compassion and sensitivity to patient needs and concerns.

The types of patient care experiences residents/fellows must have are included in the specialty-specific program requirements. Requirements may indicate numerical requirements, settings in which experiences should occur, and indications for graduated responsibility. Evaluation methods for technical proficiency in patient care are essential and may include direct observation. Methods that assess patient care skills from the patient perspective are also needed to provide information on intangible elements of care such as compassion and sensitivity (components of professionalism). Methods such as patient surveys and multi-source evaluations can provide such insight. (See CPR V. Evaluation.)

Consult the specialty-specific program requirements for more information on patient care requirements, including curricular components and evaluation methods.

## 5. ACGME Competencies
## b. Medical Knowledge

**Common Program Requirement:**

> *5. ACGME Competencies*
> *The program must integrate the following ACGME competencies into the curriculum:*
> *b. Medical Knowledge*
> *Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:*
> *[As further specified by the Review Committee]*

**Explanation:**

Medical knowledge (knowledge of biomedical, clinical, epidemiological-behavioral sciences and application of this knowledge to patient care) within each specialty is included as part of the specialty-specific program requirements. Formal teaching usually occurs within the didactic curriculum, but most learning takes place within clinical experiences. Thus, competence in medical knowledge is inextricably linked with competence in patient care.

In addition to the specialty-specific knowledge content that is assessed with local, in-training, and Board exams, it is important that each resident, regardless of specialty, demonstrates his/her ability to acquire and access new knowledge (i.e., stay up-to-date with the current literature), interpret the information they uncover, and then apply it in the clinical setting. Prior to the incorporation of the ACGME core competencies, this was called "learning around the patient" but now is often referred to as lifelong learning skills. These are learned skills and may be applied to other competency domains, especially Practice-based Learning & Improvement (PBLI) and Systems-based Practice (SBP). Structured approaches for teaching these skills may include journal club, critically appraised topic, educational prescription (a structured technique for following up on clinical questions that arise during rounds and other venues)[1], or other learning experience. This may be accompanied by a specific evaluation tool that identifies the criteria and standards for achievement of competence. (See CPR V.A.1. explanation section of this Guide.) Consistency among programs within each specialty may allow the development of national standards for these related medical knowledge skills, as has been done for Board exams.

[1] http://www.cebm.utoronto.ca/practise/formulate/eduprescript.htm

## 5. ACGME Competencies
## c. Practice-based Learning and Improvement

**Common Program Requirement:**

*5. ACGME Competencies*

*The program must integrate the following ACGME competencies into the curriculum:*

*c. Practice-based Learning and Improvement*

*Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:*

*(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;*

*(2) set learning and improvement goals;*

*(3) identify and perform appropriate learning activities;*

*(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Review Committees should define expectations regarding quality improvement within specialty specific program requirements.)*

*(5) incorporate formative evaluation feedback into daily practice;*

*(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;*

*(7) use information technology to optimize learning; and,*

*(8) participate in the education of patients, families, students, residents and other health professionals.*

*[As further specified by the Review Committee]*

**Explanation:**

At the core of proficiency in Practice-based Learning & Improvement (PBLI) is lifelong learning and quality improvement. These require skills in and the practice of self evaluation and reflection (CPR IV.A.5.c.1) to engage in habitual Plan-Do-Study-Act (PDSA) cycles (CPR IV.A.5.c.2-5) for quality improvement at the individual practice level, as well as skills and practice using Evidence-based Medicine (EBM) (CPR IV.A.5.c.6-7). In addition, residents must learn and practice teaching skills to enable them to effectively educate patients, families, students, residents and other health professionals (CPR IV.A.5.c.8).

Some specialties have identified tools to support development of **self assessment and reflection** skills and habits. For example, residents in ACGME accredited pediatrics programs must maintain an individual learning plan that must be documented annually

(PR IV.A.5.c.(9)). Other tools might address attributes important to the practicing physician, such as time management, stress management, or elements of the competencies. Or, a simple prompt to think about what went well, what didn't, and what the resident would like to do differently can help residents to think beyond context and to share meaning. Effective use of such tools involves assessment by both the resident (self assessment) and faculty member, as well as subsequent discussion of strengths and areas for improvement that emerge. We know that 'we don't know what we don't know' so discussing differences in self-assessed abilities and faculty member-assessed abilities is a good way to gain awareness and develop better self assessment skills. Reflection is critical for gaining greater self knowledge (link to professionalism); it functions as a personal PDSA cycle (establish goals, monitor progress, question things as they happen, assess what is/is not working).

Didactic training for **EBM-related skills** will help residents develop the needed skills and habits: locating information, using information technology, appraising information, assimilating evidence (from scientific studies as well as practice data), and applying information to patient care. Resources for accomplishing this may include library professionals and a variety of articles, books, and learning modules. (For example, see the RSVP website: http://www.acgme.org/outcome/implement/rsvp.asp.) In addition, residents should have the opportunity to apply these skills in a structured activity such as journal club that is evaluated using a tool structured to provide meaningful feedback. Faculty oversight of this activity as teachers, mentors, and role models will aid resident development of these skills and habits.

**Quality improvement (QI)** skills may be obtained by active participation on a QI committee (planning; implementation; analysis of an intervention on a practice outcome; incorporation into practice if improvement has occurred; initiation of a new PDSA cycle if improvement has not occurred). Different specialties may have specific expectations regarding requirements for quality improvement related to PBLI.

A final area addressed by this competency domain is **teaching skills** used for the education of patients, families, students, residents, and other health professionals. While this overlaps the Interpersonal & Communication Skills domain, this requirement addresses the need for specific teaching skills. This is linked to practice improvement, because patients who lack a clear understanding of their condition and how they can participate in self care are likely to have worse outcomes than those who can be partners in their care because their physician has educated them effectively. Similarly, physicians who are able to effectively educate consulting physicians rather than just asking for a yes/no answer are more likely to get the information they need to provide better care.

There may be additional specialty-specific requirements for PBLI.

## 5. ACGME Competencies
### d. Interpersonal and Communication Skills

**Common Program Requirement:**

*5. ACGME Competencies*

*The program must integrate the following ACGME competencies into the curriculum:*

*a) Interpersonal and Communication Skills*

*Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:*

(1) *communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;*

(2) *communicate effectively with physicians, other health professionals, and health related agencies;*

(3) *work effectively as a member or leader of a health care team or other professional group;*

(4) *act in a consultative role to other physicians and health professionals; and,*

(5) *maintain comprehensive, timely, and legible medical records, if applicable.*

*[As further specified by the Review Committee]*

**Explanation:**

This competency domain consists of two distinct skill sets, **communication skills** (used to perform specific tasks such as obtain a history, obtain informed consent, telephone triage, present a case, write a consultation note, inform patients of a diagnosis and therapeutic plan) and **interpersonal skills** (inherently relation and process oriented, such as relieving anxiety, establishing trusting relationships). The outcome "communicate effectively with patients, families, and the public…" requires good verbal, non-verbal and written communication skills, but also requires good relationship-building skills. A structured curriculum may include both didactics and experiential components for addressing verbal, non-verbal, and written communication skills as well as modes of interactions that contribute to relationship building across a broad range of socioeconomic and cultural backgrounds. Interactive teaching methods may include role playing, review of videotapes, and small group discussion of vignettes. **Teamwork** training is also needed. "On-the-job" training without structured teaching is not sufficient for this skill. Simulation is increasingly used as an effective method for teamwork training. (See several articles in the ACGME Bulletin December, 2005.) A final but very important area in this competency domain relates to completing and maintaining comprehensive, timely and legible **medical records**. Programs must have a mechanism in place for monitoring and evaluating this skill as well as providing timely formative feedback.

There may be specialty-specific requirements for Interpersonal & Communication Skills.

## 5. ACGME Competencies
### e. Professionalism

**Common Program Requirement:**

*5. ACGME Competencies*

*The program must integrate the following ACGME competencies into the curriculum:*

*e. Professionalism*

*Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:*

*(1) compassion, integrity, and respect for others;*

*(2) responsiveness to patient needs that supersedes self-interest;*

*(3) respect for patient privacy and autonomy;*

*(4) accountability to patients, society and the profession; and,*

*(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.*

*[As further specified by the Review Committee]*

**Explanation:**

Proficiency in this competency domain is primarily behavioral and attitudinal and is demonstrated as part of all other competency domains. Therefore, teaching and evaluation is most effective when done in the context of patient care and related activities (e.g., conducting QI projects, leading a team, presenting M&M, reflections on practice, conversations with mentors). Evaluations are mainly perceptions, making it important that evaluators share a common belief about the components of professionalism and description of what those are. **The major components of professionalism are commitment, adherence, and sensitivity**.

- Y Commitment means respect, altruism, integrity, honesty, compassion, empathy, and dependability; accountability to patients and society; and professional commitment to excellence (demonstrated by engaging in activities that foster personal and professional growth as a physician).
- Y Adherence means accepting responsibility for continuity of care; and practicing patient-centered care that encompasses confidentiality, respect for privacy and autonomy through appropriate informed consent and shared decision-making as relevant to the specialty.
- Y Sensitivity means showing sensitivity to cultural, age, gender and disability issues of patients as well as of colleagues, including appropriate recognition and response to physician impairment.

Professionalism, including medical ethics, may be included as a theme throughout the program curriculum that includes both didactic and experiential components (e.g., may

be integrated into already existing small group discussions of vignettes or case studies and role plays, computer-based modules) and may be modeled by the faculty in clinical practice and discussed with the resident as issues arise during their clinical practice.

Faculty development is critically important for **promoting professionalism behavior** because of past assumptions that since all physicians are professional, professionalism does not need to be discussed, taught or evaluated. Faculty development may include not only faculty but also residents as much as possible and include both structured workshops as well as ongoing discussion (e.g., inclusion as a discussion point in every M&M presentation). These discussions may address the impact of situational circumstances on the degree to which a professional manifests these attributes (e.g., post-call, times of personal stress, competing priorities). Such an approach will contribute to the development of a learning environment that explicitly values and encourages professionalism in all who teach, learn, and provide healthcare as part of the training program.

**Remediation** is important for all the competency domains, but may be especially critical in the domain of professionalism. It is challenging to teach and assess, and lapses may not be noticed until habits are formed that are then more difficult to address. There are many resources available to help. For example the LIFE Curriculum (Learning to Address Impairment and Fatigue to Enhance Patient Safety): http://www.lifecurriculum.info/) contains modules on disruptive behavior, substance abuse, impairment, and boundary violations. This resource is available free of charge. The April, 2006 issue of the ACGME Bulletin contains several articles about remediation: http://www.acgme.org/acWebsite/bulletin/bulletin04_06.pdf.

There may be specialty-specific requirements for professionalism.

## 5. ACGME Competencies
### f. Systems-based Practice

**Common Program Requirement:**

*5. ACGME Competencies*

*The program must integrate the following ACGME competencies into the curriculum:*

*f. Systems-based Practice*

*Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:*

*(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;*

*(2) coordinate patient care within the health care system relevant to their clinical specialty;*

*(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;*

*(4) advocate for quality patient care and optimal patient care systems;*

*(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,*

*(6) participate in identifying system errors and implementing potential systems solutions.*

*[As further specified by the Review Committee]*

**Explanation:**

At the heart of systems-based practice (SBP) is a focus on the broader context of patient care within the multiple layers of a **healthcare system** including purchasers (employers, government), insurers (commercial, Medicare, Medicaid), delivery systems (hospitals, physician networks, drug and technology companies, community resources), work group (local entity providing care such as a group practice, hospital service), providers (physicians, nurses, and others both as individuals and teams that provide direct care), and the users (patients and families). Awareness and effective use of these resources are advocated by entities such as the Institute for Healthcare Improvement to increase patient care quality and reduce error. These include: how national and local structures, systems, rules and regulations contribute to the experience of a specific patient and populations of patients; who pays for care and why it matters to both patient and physician; and factors within the culture, organization, management, and financing of the local care system that impact care of individuals and populations.

This competency domain is closely linked to PBLI because it is often through analysis of one's practice that system-level issues are revealed. Residents need to develop abilities

in this competency domain not only to provide safe and effective care, but also to enable them to act as effective practitioners within a variety of different medical practice/delivery models.

Teamwork skills are important to demonstrating competence in SBP. Participation as members and leaders of interdisciplinary teams will allow residents opportunities to develop and demonstrate abilities in using a variety of tools and teamwork skills to identify, analyze, implement, evaluate and report improvement initiatives as well as identifying **system errors**.

There may be specialty-specific requirements for SBP.

1. **Overall educational goals**
2. **Competency-based goals and objectives for each assignment**
3. **Didactic sessions**
4. **Delineation of resident responsibilities**

**Common Program Requirement:**

> *A. The curriculum must contain the following educational components:*
>
> *1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;*
>
> *2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;*
>
> *3. Regularly scheduled didactic sessions;*
>
> *4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,*

**Explanation:**

**Overall program educational goals** describe a general overview of what the program is intended to achieve. These create a framework for expectations on the part of residents, faculty, and others in the program, and should not be a 'laundry list' of learning objectives. These must be distributed to residents and faculty annually, either electronically or on paper. While the program requirements do not specifically state that goals be reviewed with residents, programs may have a process in place that assures the residents both know and understand these overall goals.

Each assignment in which the resident is expected to participate must have a set of **competency-based goals and objectives**. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation. The goal(s) communicate the general purpose and direction of the assignment. Objectives are the intended results of the instructional process or activity. They communicate to residents, faculty, and others involved the expected results in terms of resident outcomes and typically are the basis for items within evaluation instruments.

The phrase "competency-based goals and objectives" means that the goals and objectives clearly relate to one or more of the six ACGME competency domains. Typically, short term assignments such as a journal club will have one or two goals and

several objectives that are related to some, but not all six competency domains. For example, the goals and objectives for a specific simulated learning experience may relate only to Interpersonal & Communication Skills.

Sample goal for a simulated learning experience:
Improve performance in communicating effectively with patients.

Sample objectives for this simulation experience:
Provide precise information to a patient that is clearly understood.
Express openness to feedback from patients.
Pay close attention to patients and actively listen to them.

The goals and objectives for each assignment at each educational level must be distributed annually to residents and faculty. If the program has created a program handbook, all curriculum design materials (goals and objectives for each curricular element, assessment instruments used for each) could be included and the handbook distributed to residents or made available online. Residents should be reminded to review the competency-based goals and learning objectives for each learning assignment at the start of the assignment. Some specialties require that goals and objectives be reviewed with residents at the start of every assignment.

All programs must have regularly scheduled **didactic sessions**. A didactic session instructs by communicating information, such as a lecture, conference, journal club, directed case discussion, seminar, or assigned online learning module, in contrast to an independent project, practicum, mentoring session, or clinical preceptor session which are self-directed or experiential. Specific requirements for the expected kinds of didactic sessions are contained in the specialty-specific requirements. Some specialties have requirements for attendance.

An important element throughout the curriculum is clear communication of **residents' responsibilities** for patient care, level of responsibility for patient management and how they will be supervised (and by whom). Care should be taken to assure that clinical responsibilities emphasize clinical education over service. This information could be part of the rotation orientation and be included in the written materials describing the rotation, including the "who, what, when, where, and how" of the rotation, expectations in terms of goals and objectives as well as resident and faculty responsibilities.

**PM&R Requirements: Practice Based Learning and Improvement:**
**Learning Plans**

IV.A.5.c (1-8) Residents are expected to develop skills and habits to be able to meet the following goals:
(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;
(2) set learning and improvement goals;
(3) identify and perform appropriate learning activities;
(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
(5) incorporate formative evaluation feedback into daily practice;
(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
(7) use information technology to optimize learning; and,
(8) participate in the education of patients, families, students, residents and other health professionals.
(a) The training program must stress the importance of self-evaluation, continuing medical education, and continued professional development after graduation.

**Learning Plan**

Residents will develop a self directed learning plan and provide evidence of learning and achievement. These may be related to any of the competencies, such as patient care (procedures); medical knowledge (SAE and program exams); practice based learning and improvement (quality improvement project); interpersonal and communication skills (360 evals); professionalism (360 evals); systems based practice (M&M, identification of systems errors).

Quarterly, residents will establish self learning objectives and evaluate their progress in achieving them. At the start of the next quarter, the resident will assess progress toward the learning objectives and write a new plan for the next quarter. The process is reiterative:

Establish Learning Objectives:
- What do I want to learn?
- Why is this important to me?
- How will I accomplish it?

Self-assessment and reflection
- Gather evidence to document learning
- Monitor progress
- Revise objectives as needed

The learning plan is not a repository for every professional experience. It is a statement of outcomes the individual resident plans to or has achieved.

Minimum expectations

Quarterly update with written documentation

Review twice a year with faculty advisor and program director

Suggestions for learning plans are given below.

Preparing for a presentation:
- Resident outlines topic
- Makes a plan for reading (content knowledge), or learning presentation skills
- Documents what was read/consulted
- Assesses how the presentation was received
- Makes plan for how to do next presentation differently or ends process

Rotation specific objectives:
- Resident reviews objectives at start of rotations

Compares written objectives to what know so far
Makes a plan for reading/learning
Documents information read
Assesses sufficiency and currency of learning at midpoint or end of rotation
Revises plan or end process

Faculty observation ratings (ROCA)
Resident reviews observation ratings
Identify areas that need improvement
Make a plan for learning
Document achievements
Assess sufficiency (perhaps by asking an attending to reassess that skill area)
Revise plan or end process

End of rotation evaluations
Resident reviews several end-of-rotation evaluations
Identify areas that need improvement
Make a plan for learning
Document achievements
Assess sufficiency and currency of learning
Revise plan or end process

360 Evals
Resident reviews (semi annual) summaries of 360 evals
Identify areas that need improvement
Make a plan for learning
Document achievements
Assess sufficiency
Revise plan or end process

EMG or procedure logs
Resident tabulates EMGs by diagnosis
Identify diagnoses to either do more procedures or read more about
Make a plan for doing more or reading
Document achievements
Assess sufficiency
Revise plan or end process

Didactics, courses, journal club
Resident reviews goals and objectives for didactic activity, suggested reading list
Identify personal learning objectives
Make a plan for reading/learning
Document achievements
Assess sufficiency
Revise plan or end process

SAE exam
Resident reviews performance on SAE by subject area
Identify areas needing improvement
Make a plan for reading/learning
Document achievements
Assess sufficiency and currency of learning (e.g. could retest using old exams)
Revise plan or end process

Scholarly project
Resident reviews options for scholarly activity
Identify project
Make a plan for reading/learning, data analysis, writing up results, submitting to national meeting, making presentation to department
Document achievements
Assess sufficiency
Revise plan or end process

Other ideas:

- Case reports
- Community service projects
- Personal narratives related to specific patient encounters:
  - Describe your experience as a learner and as a teacher
  - What did you learn from relationships with patients
  - What role did systems issues play in patient care
  - What did you learn about cultural issues
  - What did you learn about yourself
  - Ethical dilemmas faced and how they were handled
  - Critical incidents (i.e. things that got resident in trouble)
- Awards/Achievements
- A summary of research literature reviewed to select a treatment option
- Conflict resolution experiences
- A product or quality improvement project to enhance patient care
- Preparing for fellowship application

**Resident Name:** **Year of Training:** ☐**PGY 2** ☐**PGY3** ☐**PGY4**

**Date:**

**Establishing a Learning Objective**

1. What do you want to learn in the next academic quarter?

2. How will you use this information or why do you want to learn it?

**3.** How will you accomplish this? What is your plan?

**Date:**

**Self-assessment**

1. What evidence can you list to document your learning?

2. Are you satisfied with your progress? Have you been able to apply this knowledge? Has it changed your practice?

3. Is what you have done to date sufficient? If not, revise your plan.

# IV
# MINIMUM EDUCATIONAL REQUIREMENTS FOR ABOS BOARD CERTIFICATION

The ABOS has established the following minimum educational requirements for certification. These requirements should not be interpreted as restricting programs to minimum standards.

## A. Time Requirements

1. Five years of accredited post-doctoral residency are required.

2. One year must be served in an accredited graduate medical education program whose curriculum fulfills the content requirements for the PGY-1 (see Section IV.B.l) and is determined or approved by the director of an accredited orthopaedic surgery residency program. An additional four years must be served in an accredited orthopaedic surgery residency program whose curriculum is determined by the director of the accredited orthopaedic surgery residency.

3. Each program may provide individual leave and vacation times for the resident in accordance with overall institutional policy. However, one year of credit must include no more than 50 weeks of full-time orthopaedic education per year; and at least 46 weeks of full time orthopaedic education per year; averaged over five years. Graduation prior to 60 months from initiation of training is not allowed.

4. Program directors may retain a resident for as long as needed beyond the minimum required time to ensure the necessary degree of competence in orthopaedic surgery. According to the current Special Requirements of the RC for Orthopaedic Surgery, the committee must be notified of such retention. This information must also be provided to the ABOS on the Record of Residency Assignment form.

## B. Content Requirements

1. Requirements for postgraduate year one. (PGY-1)

   The residency program director must be responsible for the design, implementation, and oversight of the PGY-1 year. PGY-1 education must include:

   a. Six months of structured education on non-orthopaedic surgery rotations designed to foster proficiency in basic surgical skills, the perioperative case of surgical patients, musculoskeletal image interpretation, medical management of patients, and airway management skills.

      i. At least three months must be on surgical rotations chosen from the following: general surgery, general surgery trauma, plastic/burn surgery, surgical or medical intensive care, and vascular surgery.
      ii. The additional three months must be on rotation chosen from the following: anesthesiology, basic surgical skills, emergency medicine,

general surgery, general surgery trauma, internal medicine, medical or surgical intensive care, musculoskeletal radiology, neurological surgery, pediatric surgery, physical medicine and rehabilitation, plastic/burn surgery, rheumatology, and vascular surgery.

iii. During the six months of non-orthopaedic rotations, each rotation must not exceed 2 months.

b. Six months of orthopaedic surgery rotations designed to foster proficiency in basic surgical skills, the general care of orthopaedic patients both as inpatients and in the outpatient clinics, the management of orthopaedic patients in the emergency department, and the cultivation of an orthopaedic knowledge base.

c. Formal instruction in basic surgical skills which may be provided longitudinally or as a dedicated rotation during either the orthopaedic or non orthopaedic rotations. This skills training must be designed to integrate with skills training in subsequent post graduate years and should prepare the PGY-1 resident to participate in orthopaedic surgery cases. To facilitate skills training there must be:

i. goals and objectives and assessment metrics;

ii. skills used in the initial management of injured patients, including splinting, casting, application of traction devices, and other types of immobilization; and basic operative skills, including soft tissue management, suturing, bone management, arthroscopy, fluoroscopy, and use of basic orthopaedic equipment.

2. Orthopaedic requirements beyond the PGY-1.

a. *Minimum distribution.* Orthopaedic education must be broadly representative of the entire field of orthopaedic surgery. The minimum distribution of educational experience must include:

i. Forty-six (46) weeks of adult orthopaedics

ii. Forty-six (46) weeks of fractures/trauma

iii. Twenty-three (23) weeks of children's orthopaedics

iv. Twenty-three (23) weeks of basic and/or clinical specialties

Experience may be received in two or more subject areas concurrently. Concurrent or integrated programs must allocate time by proportion of experience.

b. *Scope*. Orthopaedic education must provide experience with all of the following:

i. *Children's orthopaedics*. The educational experience in children's orthopaedics must be obtained either in an accredited position in the specific residency program in which the resident is enrolled or in a children's hospital in an assigned accredited residency position.

ii. *Anatomic areas*. All aspects of diagnosis and care of disorders affecting the bones, joints, and soft tissues of the upper and lower extremities, including the hand and foot; the entire spine, including intervertebral discs; and the bony pelvis.

iii. *Acute and chronic care*. Diagnosis and care, both operative and nonoperative, of acute trauma (including athletic injuries), infectious disease, neurovascular impairment, and chronic orthopaedic problems including reconstructive surgery, neuromuscular disease, metabolic bone disease, benign and malignant tumors, and rehabilitation.

iv. *Related clinical subjects*. Musculoskeletal imaging procedures, use and interpretation of clinical laboratory tests, prosthetics, orthotics, physical modalities and exercises, neurological and rheumatological disorders and medical ethics.

v. *Research*. Exposure to the evaluative sciences, clinical, and/or laboratory research.

vi. *Basic science*. Instruction in anatomy, biochemistry, biomaterials, biomechanics, microbiology, pathology, pharmacology, physiology, and other basic sciences related to orthopaedic surgery. The resident must have the opportunity to apply these basic sciences to all phases of orthopaedic surgery.

c. *Options*. Up to fourty-six (46) weeks of the four required years under the direction of the orthopaedic surgery residency program director may be spent on services consisting partially or entirely of:

i. Additional experience in general adult or children's orthopaedics or fractures/trauma.

ii. An orthopaedic clinical specialty.

iii. Orthopaedics-related research.

iv. Experience in a graduate medical education program whose educational content is pre-approved by the director of the orthopaedic surgery residency program.

## C. Residency Program Accreditation Requirements

1. The educational experience in orthopaedic surgery obtained in the United States must be in an approved position in programs accredited by the RC for Orthopaedic Surgery and by the ACGME except as provided in Sections IV.C.2 and IV.C.5 herein.

   All other clinical education obtained in the United States must be in programs accredited by the ACGME and by the appropriate RC. The *Graduate Medical Education Directory* published annually by the American Medical Association lists accredited rotations of six months or longer.

2. During the five years of accredited residency, a total period of no more than six months may be served in unaccredited institutions.

3. Credit for time spent in residency education will be granted only for the period during which the residency program is accredited and only for time served in an approved position within an accredited program.

4. If an orthopaedic residency program has its accreditation withdrawn by the RC for Orthopaedic Surgery and the ACGME, no educational credit will be granted for training periods after the effective date of withdrawal of accreditation.

5. The ABOS does not grant credit for foreign educational experience, other than as permitted in Section IV.C.2. above. Also see Section IV.F.

6. The term "fellow" is not synonymous with the term "resident" for the purpose of obtaining ABOS credit for educational experience. A resident is an individual enrolled in an approved position in an accredited educational program.

## D. Achievement Requirements

1. The director of the program providing general graduate medical education must certify a resident's satisfactory completion of that segment of education.

2. In orthopaedic surgery residency programs, the program director must certify a resident's satisfactory completion of each rotation for which credit is awarded. (See Section IV.F below)

3. The program director responsible for the final year of the resident's education must certify that the resident has achieved a satisfactory level of competence and is qualified for the certifying process. This would include sufficient and consistently demonstrated: acquisition of medical knowledge with the ability to appropriately apply knowledge to patient care, interpersonal skills and effective qualities needed by an orthopaedic surgeon, manual capabilities, ethics, and professionalism.

4. The certification referred to in Section IV.D.2 and IV.D.3. above must be made on the appropriate Record of Residency Assignments (RRA) form.

5. Medical practice activity outside of residency duties must not be allowed to interfere with the educational experience. Residents may not engage in such activities without the specific prior approval of the program director. Approval must be based on the judgment that rotations are being completed without compromise and that the circumstances of the resident warrant such activity.

## E. Continuity Requirements

To qualify for the certifying process, a resident must progress in increasing patient care responsibility. A part-time or piecemeal approach to residency requirements is discouraged. The final two academic years of orthopaedic residency education must be obtained in a single orthopaedic residency program unless prior approval of the Credentials Committee is obtained.

## F. Documentation Requirements

*(NOTE: As of October 2018 the ABOS is in the process of revising the documentation requirements for orthopaedic surgery residents and revising the portal through which residents and residency programs submit the required documents. The documentation requirements listed below will be incorporated into the pending revisions. Any questions should be directed to the ABOS Office.)*

1. For orthopaedic education obtained in the United States, the program director must provide the Board with yearly documentation during the residency. Each June, program directors will receive by email necessary information to complete each resident's RRA information. Completed RRA forms must be signed by the program director and submitted to the ABOS office.

2. The RRA forms are to be completed for each resident as follows:

    a. Form 1 must be submitted the year the resident enters the program.

    b. Form 1-A must be submitted at the end of the academic year for each PGY-1 resident.

    c. Form 2-A must be submitted at the end of the academic year for each PGY-2 through PGY-5 resident.

    d. Form 3 must be submitted on each resident who graduates or leaves the program prematurely.

Resident Operative Experience Documentation - via ACGME

As of July 1, 2000 it is mandatory that you document your operative experience on the new ACGME web based log. This log is maintained at the central ACMGE site and is consistently backed up daily. This system will also enable you to easily locate or verify the correct CPT code. As previously, you will also need to keep up with all closed manipulations (such as in the ER). You will still need to document your experience in the manner in which you were previously (paper, printing reports, etc.) as this system does not keep up with patient names and other details you will find necessary. You can access this log at the location shown below.

http://www.acgme.org

Please see Amy if you have any questions regarding this system. The residents using this system previously may also assist you with questions. These reports are checked by the department administrator periodically as they are necessary for accreditation requirements. Please enter your information consistently throughout the year – NOT at the end of the year.

Your Login and password will be generated by the ACGME and sent to your UMMC email.

**NOTE : PGY-1 residents are to enter Operative Cases – Primary / Secondary notation**

**Interns: Please note to include all CPT codes (i.e. even if you don't do a closed reduction prior to splinting), there is a CPT code for closed fracture treatment with/without manipulation that should be added.**

## Meetings and Courses

Financial assistance is provided to residents to attend the meetings/courses listed below. Residents who have papers, research, etc. accepted at meetings will also receive financial assistance. There is a CME calendar at the American Academy of Orthopaedic Surgeon's website (AAOS.org).
You may log on with your resident AAOS ID#.

| | |
|---|---|
| PGY-1 | AO/ASIF Principles of Fractures Management Course for Residents (January of First Year) |
| PGY-3-4 | Approved Courses with Travel Grants<br>AO Advanced Course (Department reimburses registration / Grant sought for travel expenses)<br>AANA as available |
| PGY-3/4 | Approved Courses with Travel Grants |
| PGY-5 | Orthopaedic Board Review Course<br>AAOS Annual Meeting and Courses (Approved as directed by the PEC.) |

Funds for resident travel will be subject to change dependent upon the department's finances. Please keep up with all receipts and turn in for your reimbursement. The department pays for registration, hotel rooms, transportation to and from the meeting, airfare/car rental/mileage (dependent upon course location), and food ($ 50.00 per day with receipts).

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## AO Fellowship (upon availability)

Applications for the AO Fellowship (taken during the PGY-4 year) MUST be completed in accordance with AO regulations. Visit AO International website for application deadlines. Residents are encouraged to apply for travel grants.

# TRAVEL PROCEDURES

* Meetings that the resident chooses to attend should be coordinated through the Education Office. Requests for advance travel pay (for course tuition, airline tickets, etc.) should be made at least eight weeks prior to travel.

* RE: Airline Tickets - these arrangements must be made at least 21 days in advance to insure the lowest priced airfare available! You may forward your online receipt via email to speed up reimbursement.

  Receipts must be obtained for all expenses for which reimbursement is desired, including those expenses covered by a travel advance. Receipts as well as travel mileage should be turned immediately upon return from the trip. Illegible receipts will not secure a reimbursement of your funds.

- **Reimbursable Items:**

  Transportation to and from course location (city) – a copy of the ticket
  Taxi / shuttle from airport to hotel and from hotel to airport
  Course registration / tuition
  Airport parking
  Hotel room charges plus any taxes- must have itemized receipt
  Food - $50.00 average per day with receipts; mileage is .545 cents per mile

- **A Travel Form requesting administrative leave must be completed. Foreign travel forms (outside the Continental U.S.) must be approved by the IHL Board 60 days in advance - with the form completed 30 days prior to that date.**

- **Leave should be submitted to the Education Office via email per Leave policy.**

Guidelines for Howorth Orthopaedic Library

A reservation calendar is maintained on the 7th floor for scheduling use of the room.

Re-shelve books and materials in their proper location after use. Please leave notification of any books, tapes, etc. you check out with the Education Office. The conference room telephone is located on the textbook shelving section, ext 45147.

**Journals:**
Journals should not be removed from the Howorth Library except to copy and then be properly re-shelved. Many current journals have their information online for easy access through UMMC's Rowland Medical Library.

Current issues of journals are maintained in alphabetical order on the east wall of the library. Preceding issues are located underneath the current issues unless they have been sent to the bindery. Bound journals are maintained alphabetically and located after the current issues. Printed bibliographies and indexes to orthopaedic material are located at the beginning of the bound journals. All items removed from the library need to be documented.

**Books:**
Books are maintained according to the National Library of Medicine numbering system Reference materials are located in the closed cabinets on the South end of the library. The reference materials include items not to be removed – such as study guides by AAOS, etc.

**Videos:**
Video tapes are located behind the closed doors on the back wall. These video tapes are entered into an Excel database and can be easily searched.

**Rowland Medical Library Searches:**
Electronic access is available through the UMMC's Rowland Medical Library website
https://www.umc.edu/library/

**Please note:**
If you have trouble locating a book or journal that is missing consistently, please let the Education Office know. The book or journal may have been misplaced or lost and needs to be replaced.

**Orthopaedic Skills Labs**
The department is fortunate to have skills labs. The computer lab, located in H365 near the residents' lounge, furnishes you with your mailbox, a storage locker, along with the learning lab comprised of computers and a printer - enables you to access online learning. You may also use this area to enter your operative cases, check email or do literature searches. Please make sure to log off when leaving a station.

CW200 – Skills Lab will be used for saw bones and further simulated learning.

SM420 VR Skill Trainer (Knee / Shoulder) Badge Access

# Liability Coverage & Expectations

# UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

## RESIDENT PROFESSIONAL LIABILITY PROGRAM

The Mississippi Supreme Court has ruled that physicians and dentists, who are residents, interns or fellows (hereinafter “House Officers”) at the University of Mississippi Medical Center, are employees of the State of Mississippi and are entitled to the protection and immunity from liability under the terms of the Mississippi Tort Claims Act. Pursuant to the Act, the University will provide a defense and indemnity to all House Officers against claims for actions or omissions occurring within the course and scope of their employment while at UMMC and/or on official rotation at other Mississippi hospitals or clinics. The same protection is afforded to former house officers for such claims made after their employment, if the claims relate to conduct during the term of their internship, residency, or fellowship.

***University of Mississippi Medical Center***
***Office of Risk Management***
***2500 North State Street***
***Jackson, Mississippi 39216-4505***
***Telephone: (601) 984-1980***

# CERTIFICATE OF COVERAGE

*ISSUED TO*

## University of Mississippi Medical Center

*The Mississippi Tort Claims Board certifies the participation of the above named state agency in the Mississippi Tort Claims Fund as set forth in Chapter 46, Title 11, Mississippi Code 1972, as amended. The Tort Claims Fund provides protection for tort claims against state employees and agencies subject to terms and limitations established by law.*

***This certificate shall expire at the end of one (1) year from the issued date hereof.***

*Issued this XX day of December, 20XX.*

**Mississippi Tort Claims Board**

## General Orthopaedic Resident Responsibilities

The following are general responsibilities that each resident is expected to fulfill:

1. Be on time for surgery.
2. If the surgical case is first in the morning, the resident is required to be there at 7:15 a.m. and assist in preparing the patient for surgery.
3. Maintain the dress code as outlined previously in the Orthopaedic Resident's Handbook.
4. Be courteous, kind and tactful in all relationships.
5. Promptly answer all pages.
6. A good resident history and physical must be on the chart of each patient.
7. All residents (all levels) are to attend Tuesday conference/grand rounds – 7:00 to 10:00 am.
8. Admissions from clinic will be done by history number. If the patient has been previously admitted, he goes to the staff involved with the initial surgery.
9. The first-call beeper is never to be left unattended. It is to be handed off at 7:00 a.m. and new patients should be signed out at that time.
10. The chain of command is to be used at all times concerning on-call patients.
11. All potential admissions, especially surgical candidates, are to be evaluated personally by the chief resident on call.
12. The on-call resident is to discuss admissions with the senior resident on call, coordinate emergency surgery and be responsible for seeing that the necessary equipment is available.
13. After the on-call resident evaluates an admission, he should notify the Senior Resident on call and discuss the plan.
14. Residents are expected to attend all conferences and be on time unless they are involved in surgery or urgent patient care.
15. All orthopaedic patients are the direct responsibility of every resident. When asked to see a patient, respond immediately, act appropriately and cheerfully.
16. No one leaves the hospital on surgery days without permission of the Senior Resident. Remember, the surgery schedule is a team effort.
17. A team member for each service will be responsible for that service's patients and rounding on those patients every weekend.
18. The on-call resident is responsible for the proper set-up and equipment pulling for on-call cases (fracture table, skytron, c-arm, etc.). This should be discussed with the Chief Resident on call if there are any questions.

# The following are specific orthopaedic requirements.

** You are responsible for applying and obtaining your **
DEA Certificate immediately upon receiving your
Medical License.
(a copy must be placed in your file in the Education Office)

**Chief Resident**

1. Is responsible for the daily activities of the service, which includes inpatient, outpatient and the operating area.
2. Is responsible for coordinating and posting the surgery schedule in consultation with the Senior Resident on the other service.
3. Is responsible for getting staff okay and/or coverage for each case going to the operating room.
4. Is responsible for the monthly rotation schedule.
5. Is responsible for the overall management of the inpatients.
6. Is responsible as a resource for first, second and third year residents.
7. Is responsible for organizing and maintaining control in all conferences.

**Senior Resident (PGY-4 and PGY-5)**

1. Is to support the Chief Resident.
2. Gives outpatient and inpatient care per category for the Junior Resident.
3. Serves in a direct supervisory category for the Junior Resident.
4. The Senior Resident on the service of the on-call staff for the day is responsible for seeing or assigning consults received for the day.
5. If a specific staff member is consulted, the senior resident on his service is responsible for the consult.
6. A Junior Resident is not permitted to perform surgery unless he can demonstrate a workable knowledge of the anatomy entailed. The Senior Resident is to determine if the Junior Resident is properly prepared.
7. The Senior Resident on the service is responsible for supervising patient care and is to make daily rounds with the Junior Residents.
8. Staff is not to be consulted about patient care except by the Senior Resident.
9. The Senior Resident notifies and consults with the staff on all surgical patients and admissions.

**Junior Resident (PGY-2 and PGY-3)**

1. Takes first call for emergencies and inpatient care problems.
2. Is primarily responsible for histories and physicals, preoperative notes, discharge summaries, daily visits to the inpatients, the work-ups on new patients which should be complete, and to fill out all areas on the chart as pertains to the Social Service, Welfare, etc.
3. To directly support the Senior Resident.
4. To provide leadership and teaching for third and fourth year medical studies.
5. No Junior Resident is to lend or borrow beds.
6. Staff is not to be consulted on clinic patients by a Junior Resident.
7. Junior Residents are primarily responsible for all ward care and are to write meaningful daily progress notes.
8. A Junior Resident is not permitted to perform surgery unless he can demonstrate a workable knowledge of the anatomy entailed. The Senior Resident is to determine if the Junior Resident is properly prepared.
9. A Junior Resident is not to leave the hospital during the day without notifying his Senior Resident first.

**University of Mississippi Medical Center**
**Orthopedic Surgery Residency Program**

## Program Goals and Objectives

### Objectives of Residency Program

- Prepare physicians for the independent practice of clinical and academic Orthopaedic Surgery
- Focus on clinical skills and compassionate patient care
- Achievement of Professional competencies
- Acquisition of Medical Knowledge
- Achievement of scholarly activity through Research

### Goals of Residency Program

Provide an organized program of education in Orthopaedic Surgery through:

- Providing the resources and leadership needed to achieve educational pre-eminence
- Provide an environment which will facilitate the professional, ethical, and scholarly achievement of each individual while providing outstanding patient care and service excellence
- Provide an environment which will perpetuate the curricular requirements for scholarly activity and general competencies
- Conduct regular assessments of the quality of the curriculum and the educational activities to assure that general competencies are being met and the monitoring of those competencies achieves the purpose of advancing the education of the resident
- Foster an environment for the faculty to achieve and excel in research, clinical care and education
- Assume the responsibility to develop, cultivate and maintain the reputation of excellence in order to continue to attract the highest caliber residents and faculty

### ACGME Core Competencies

The educational goals and objectives are predicated on the six core competencies, as directed by the Accreditation Council for Graduate Medical Education (ACGME).

#### *Patient Care*

- Able to perform clinical evaluations and appropriate documentation
- Surgical/Non-surgical decision making
- Evaluation and interpretation of laboratory tests and imaging studies
- Surgical techniques including those specific to each sub specialty
- Recognizes and institutes initial therapies for emergency and life threatening situations
- Understands the principles of reliving pain and decreasing suffering of patients

#### *Medical Knowledge*

Core subspecialty information

- Classic journal articles
- Appropriate text books / text book chapters
- Conferences
- Pathogenesis of disease
- Principles of health maintenance and disease prevention
- Epidemiology, clinical manifestations and differential diagnosis
- Relevant pharmacology and therapeutics
- Basic concepts of risk management in medical practice
- Use of the scientific method in establishing the causation of diseases and the efficacy of traditional or non-traditional therapies

***Professionalism***

- Practices ethical conduct at all times
- Accepts responsibility for patient care
- Learns to be an advocate at all times for the interest of patients
- Displays behaviors that foster and reward patient's trust
- Demonstrates a commitment to service of patients in need

***Systems-Based Practice***

- Makes appropriate use of psychosocial and other resources to maximize patient care
- Ability to work with different members of the health care delivery team
- Demonstrates knowledge of HIPAA regulation
- Provides cost effective care with an awareness of third party payer involvement
- Discharges patients in a timely and appropriate manner

***Practice Based Learning and Improvement***

- Comprehends principles of office notes, surgical dictation, hospital records and their role in patient care, reimbursement and medical legal affairs
- Uses information technology to access and manage clinical information
- Evaluates and critically reviews scientific evidence appropriate to the care of individual patients
- Identifies errors in medicine and basic strategies to reduce medical errors
- Appreciates the need for patient confidentiality and exhibits behavior consistent with this end

***Interpersonal and Communication Skills***

- Uses effective communication skills including explanations, questioning and writing skills
- Elicits and records a complete history
- Uses appropriate skills and strategies for communicating during difficult situations
- Respects the rights of all patients to make informed decisions
- Understands how family, culture and religious beliefs can influence health care decisions
- Uses appropriate techniques for collaborating with and teaching fellow residents and other health care professionals
- Acknowledges and seeks assistance and counsel when needed

# An Outline of the Critical Performance Requirements for Orthopaedic Surgeons

## I. Skill in Gathering Clinical Information

A. Eliciting Historical Information
   1. Obtaining adequate information from the patient
   2. Consulting other physicians
   3. Checking other sources

B. Obtaining Information by Physical Examinations
   1. Performing thorough general examinations
   2. Performing relevant orthopaedic checks

## II. Effectiveness in Using Special Diagnostic Methods

A. Obtaining and Interpreting X-rays
   1. Directing and Interpreting x-rays
   2. Obtaining unusual, additional, or repeated films
   3. Rendering complete and accurate interpretation

B. Obtaining Additional Information by Other Means
   1. Obtaining biopsy specimen
   2. Obtaining other laboratory data

## III. Competence in Developing a Diagnosis

A. Approaching Diagnosis Objectively
   1. Double checking stated or referral diagnosis
   2. Persisting to establish definite diagnosis
   3. Avoiding prejudicial analysis

B. Recognizing Condition
   1. Recognizing primary disorder
   2. Recognizing underlying or associate problem

## IV. Judgment in Deciding on Appropriate Care

A. Adapting Treatment to the Individual Care
   1. Initiating suitable treatment for condition
   2. Treating with regard to special needs
   3. Treating with regard to age and general health
   4. Attending to contraindications
   5. Applying adequate regimen for multiple disorders
   6. Inventing, adopting, applying new techniques

B. Determining Extend and Immediacy of Therapy Needs
    1. Choosing wisely between simple and radical approach
    2. Delaying therapy until diagnosis better established
    3. Testing milder treatment first
    4. Undertaking immediate treatment

C. Obtaining Consultation on Proposed Treatment
    1. Asking for opinions
    2. Incorporating suggestions

**V. Judgment and Skill in Implementing Treatment**

A. Planning the Operation
    1. Reviewing literature, x-rays, other material
    2. Planning approach and procedures

B. Making necessary preparations for operating
    1. Preparing and check patient
    2. Readying staff, operating room, supplies

C. Performing the Operation
    1. Asking the confirmation of the involved one
    2. Knowing and observing anatomical principles
    3. Using correct surgical procedures
    4. Demonstrating dexterity or skill
    5. Taking proper precautions
    6. Attending to details
    7. Persisting for maximum result

D. Modifying Operative Plans According to Situation
    1. Deviating from preplanning procedures
    2. Improvising with implements and materials
    3. Terminating operating when danger in continuing

E. Handling Operative Complications
    1. Recognizing complications
    2. Treatment complications promptly and effectively

F. Instituting a Non-Operative Therapy Program
    1. Using appropriate methods and devices
    2. Applying methods and devices correctly

## VI. Effectiveness in Treatment Emergency Patients

A. Handling Patient
   1. Properly applying splints and other protective measures
   2. Handling and transporting carefully

B. Performing Emergency Treatment
   1. Determining locations and extend of injuries
   2. Attending immediately to lifesaving procedures
   3. Treatment most critical needs first
   4. Obtaining and organizing help

## VII. Competence in Providing Continuing Care

A. Paying Attention Post-Operatively
   1. Administering suitable post-operative care
   2. Recognizing post-operative complications
   3. Adequately treatment post-operative complications

B. Monitoring Patient's Progress
   1. Checking on effectiveness of therapy
   2. Reassessing, altering or repeating treatment

C. Providing Long-Term Care
   1. Arranging for rehabilitative care, socio-economic assistant
   2. Explaining and monitoring home and rehabilitative care

## VIII. Effectiveness of Physician-Patient Relationship

A. Showing Concern and Consideration
   1. Taking personal interest
   2. Acting in discreet, tactful and dignified manner
   3. Avoiding needless alarm, discomfort or embarrassment
   4. Speaking honestly to patient and family
   5. Persuading patient to undertake needed care or only needed care

B. Relieving Anxiety of Patient and Family
   1. Reassuring, supporting or calming
   2. Explaining condition, treatment, prognosis or complication(s)

## IX. Accepting Responsibilities of a Physician

A. Accepting Responsibility for Welfare of Patient
1. Heeding the call for help
2. Devoting necessary time and effort
3. Meeting commitments
4. Insisting on primacy of patient welfare
5. Delegating responsibilities wisely
6. Adequately supervising residents and other staff

B. Recognizing Professional Capabilities and Limitations
1. Doing only what experience permits
2. Asking for help, advice or consultation
3. Following instructions and advice
4. Showing convictions and decisiveness
5. Accepting responsibility for own errors
6. Referring cases to other orthopaedists and facilities

C. Relating Effectively to Other Medical Persons
1. Supporting the actions of other physicians
2. Maintaining open and honest communication
3. Relating in discreet, tactful manner
4. Respecting other physician's responsibility to his patient

D. Displaying General Medical Competence
1. Detecting, diagnosing, (treating) non-orthopaedic disorders
2. Obtaining appropriate referrals
3. Preventing infection in hospital patients
4. Effectively keeping and following records

E. Manifesting Teaching, Intellectual and Scholarly Attitudes
1. Lecturing effectively
2. Guiding and supporting less experiences orthopaedist
3. Encouraging and contributing to fruitful discussion
4. Contributing to medical knowledge
5. Developing own medical knowledge and skills

F. Accepting General Responsibilities to Profession and Community
1. Serving the profession
2. Serving the community
3. Maintaining personal and intellectual integrity

Teaching Responsibilities of Residents – per UMMC

Residents have long been a primary source of learning both for medical students and other residents. A relatively small body of literature exists on the teaching roles of residents. It seems to be an accepted duty of residents even though little reward and virtually no training exists for teaching responsibilities. As with many other medical school traditions, teaching takes place in the same ways, both good and bad, that it has for generations of physicians.

As we enter an era of rapid change in healthcare delivery, teaching centers must become more competitive with other systems seeking patients in the same markets. Residency programs must prepare physicians to compete successfully as business partners as well as to practice medicine competently and with compassion. The teaching center has to re-evaluate all of its resources as more precise demands are placed on faculty. The role of resident as teacher has never been more important. The same level of care for patients and continued education of residents must take place, yet the teaching center must fully utilize the ski8lls and enthusiasm of residents in assuming a greater role as teachers.

**How can residents become better teachers?**

Resident teaching can take many forms; teaching during rounds using both prepared short, didactic presentations and at the bedside, making the most of teaching moments during routine activities of the day, formal presentations, small group meetings for tutorial or discussion, and role-modeling professional competence, compassion, and attitudes in order for students to received feedback that is actually useful to the learning process, residents should evaluate students presenting fair criticism that assesses both the strengths and weaknesses of the learners.

**General teaching tips:**

1. Be available and approachable. Remember when you felt so uncomfortable, perhaps out of place, and confused.
2. Clarify your expectations and the goals of the rotations.
   How many times did you have to guess what was really expected?
3. Be enthusiastic about your topic and your learners
   Ever notice how boring a bored or apologetic speaker is?
4. Reward success
   Talk to a good first grade teacher; you will be reminded that success breeds success.
5. Treat others as you would wish to be treated.
   I know, no one ever gave you a break, but some traditions need to be broken.

**Bedside teaching/rounds:**

1. Be respectful of the patients' rights and feelings.

2. Think aloud as you reason out patient problems and management.

3. Ask probing questions of students and that they justify their answers. Assign students mini-tasks to look up and report to the group when a student has incomplete or incorrect information to a question. If one student is found to have a knowledge or skill deficit for their level, you can bet there are others who are just low-profiling their way through as well. These tasks are to be viewed as an on-going part of developing good reading habits, **not as punishment**.

4. Require students to present patients in a formally written, verbally cohesive and efficient manner. Role-model the way you wish them to prepare case presentations and brief lectures. Explain what appropriately goes where in a presentation; you can do this without being insulting to other faculty or residents who may have developed poor habits over the years. Don't mention all the wrong ways; just clearly set forth what is most helpful to know about the patient or topic and how you go about putting that information together.

**Small group meetings for tutorial or discussion or formal lectures:**
**Interactions between students and teachers if the key to successful discussion groups, tutorials, and even lectures.**

1. Clarify "ground rules" and encourage open exchange of questions and answers among learners – not just between instructor and learners.

2. Use open-ended questions to promote critical thinking. Allow students the freedom within a reasonable time limit, to think before answering. Silences should be tolerated by students and instructors. This time to product logical, orderly patterns of thought is part of the process of learning critical thinking, so once that is accepted, silence is less uncomfortable.

3. Arrange seating to promote discussion instead of giving it the traditional lecture room appearance. Even during a formal lecture, permission to ask questions and to make brief comments can be established at the beginning of the presentations.

4. Prepare a handout for students of your outline and/or an article that is especially helpful.

5. If performing a demonstration or working in a tutorial setting, the following guide: may be helpful:

    a. use an organized teaching approach to
        1. explain rationale
        2. demonstrate (and verbalize) the whole procedure from beginning to end to give a visual image of the entire sequence.
        3. Break the sequence into individual steps, if possible
        4. Provide practice, and
        5. Give feedback during practice (manual and verbal)
    b. provide for repeated practice over time
    c. catch the teachable moments

**Evaluation:**

Assessment of knowledge, skills, and even attitudes is a vital part of medical education. Residents can contribute to the clinical and professional growth of physicians-in-training by doing the following:

1. Ask your students to assess their own performance.

2. Be non-judgmental in your language and be very specific; this lessons the possibility of criticism that is too personal and focuses on just certain skills or knowledge.

3. Give timely feedback, neither too soon not days or weeks later. Immediate reinforcement offers the best opportunity for learning to occur. This process can be facilitated by intermittent evaluations ending with a summative evaluation of the student's overall performance.

4. Ask for and graciously receive feedback on yourself as a teacher and on your program. Do not do this as a time when students will perceive the information given to have an affect on their grades. Most students are appreciate of your efforts and will be truthful about changes that may be needed as well as positive aspects of your teaching program.

PUTTING THE PRINCIPLES OF GOOD PRACTICE FOR RESIDENT'S TEACHING INTO ACTIONS

**Good Practice . . .**

1. Emphasizes the need for a solid foundation of knowledge in a given discipline and explains how it relates to knowledge in other disciplines.

   Is knowledge of current medical literature and able to cite it when appropriate
   Is aware of standard practice and routinely explains any deviations
   Shares knowledge of available resources for assistance in the clinical care of patients
   Explains the appropriate process in obtaining consults and etiquette in providing consults

2. Establishes and communicates high expectations for teachers and learners.

   Participates in a defined orientation process for students and residents new to the service or discipline.
   Goals for each rotation are communicated both verbally and in writing.
   Evaluation methods are discussed prior to the evaluation process
   Unwritten expectations, such as outside readings during: "down time", should be communicated at the beginning of the rotation rather than at evaluation time.
   Attendance and punctuality issues should be clearly communicated the first day.

3. Establishes and communicates clear student objectives for knowledge, skills, and attitudes on teachings rounds, in lectures, clinics, tutorials, and other teachings moments.

   discusses written objectives for the month or rotations.
   Prepared lectures with good audiovisual support and handouts
   Actively employs adult learning principles in rounding, clinics, and tutorials:
   - Adults prefer to participate in assessing their learning needs. Pretests are helpful
   - Adults want to use what they learn as soon as possible
   - Adults are interested in concepts and applications that can be linked to existing knowledge and experience.
   - Adults want a problem-solving approach. Case reviews and case studies are helpful.
   - Adults prefer measures of self-progress over competition with others. Self-assessments can be encouraged as an adjunct to more formal evaluation.

4. Models the behavior of treating others (patients, students, healthcare team members) with compassion, dignity, and respect.

Refers to patients by name, not diagnosis; e.g. The gall bladder in room 405
Calls patients and healthcare team members by their proper, not familiar names unless agreed to by both parties.
Employs three characteristics of friendship that are important to learn:

- friends treat each other with courtesy
- friends share humor and laughter
- friends talk to each other

Corrects students' and other residents' knowledge, behavior and skills without using personally demeaning remarks or name-calling.
Recognizes that repeated threats of failure or punishment created antagonism.

5. Provides adequate time for teaching and learning activities through accessibility and through willingness to clarity what is being taught.

Is a careful listener
Uses clarifying questions, rather than probing ones, in the hospital setting
Uses discussion to cross-check findings, symptoms, differential diagnosis, etc.
Limits hallway lectures to brief, relevant case-related issues
Encourages problem-solving skills by using open-ended questions, especially in clinic settings.
Uses honest questions, not trickery, that allow for analysis and application of clinical data.
Does not provide "over-helping" behaviors that complete a procedure for students rather than with them.

6. Encourages learning beyond a specific activity by recommending additional reading, identifying faculty resources, and encouraging discussion.

Identified reading as the cornerstone of self-directed learning
Uses skills in questioning, listening, and responding in formal and informal discussion groups rather than giving mini-lectures.
Matches students who have particular areas of interest with like-minded faculty to motivate additional learning.
Role-models effective use of resources and strong continuing education habits.

7. Provides prompt, evaluative feedback on student performance which is based on measurable changes in students' knowledge, skills, and attitudes.

Is descriptive rather than judgmental
Is specific rather than general
Is well timed
Focuses on behavior rather than person
Contains positives as well as suggestions for change.

Goals and Objectives are stored in SharePoint and reviewed quarterly with Faculty & Residents. Copies will be distributed to interns under separate cover.

Lecture Topics and Didactic Schedules are also stored in SharePoint and on the Google Calendar

Didactics are updated regularly to the Google Calendar.

orthoummc@gmail.com

# 2020 Monthly Didactic Assignments – Orthopedic Surgery

| Sunday / Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|
| Elec & Spine Week | 1st Tuesday 6:15 – 7:00am<br>Foot & Ankle – Reed | 1st Wednesday 6:15 –6:50am<br>Chairman Hour<br>7:00 – 7:50am<br>Hand - Geissler / HF | 1st Thursday 6:15 – 7:00am<br>Sports – Hurt | Subspec. Conf. | |
| | 2nd Tuesday 6:15 – 7:00am<br>Adult Recon – Stronach/ Anand/ Fellows | 2nd Wednesday 6:15 – 6:50am<br>Chairman Hour<br>7:00 – 7:50am<br>M&M | 2nd Thursday 6:15 – 7:00am<br>Sports – Hurt or Spine – Ward | Subspec. Conf. | |
| Trauma Week | 3rd Tuesday 6:15 – 7:00am<br>Trauma - Morellato | 3rd Wednesday 6:15 – 6:50am<br>Chairman Hour<br>7:00 – 7:50am<br>Trauma/EBM - Bergin | 3rd Thursday 6:15 – 7:00am<br>Trauma – Graves | Subspec. Conf. | |
| Peds | 4th Tuesday 6:15 – 7:00am<br>Peds / Business – Leitch | 4th Wednesday 6:15 – 6:50am<br>Chairman Hour<br>7:00 – 7:50am<br>Oncology - Barr | 4th Thursday 6:15 – 7:00am<br>Peds – Leitch/Wright/ Brooks/Sukkarieh | Subspec. Conf. | |
| 5th Week | 5th Tuesday 6:15 – 7:00am<br>Open for Special Topics | 5th Wednesday 6:15 – 6:50am<br>Chairman Hour<br>7:00 – 7:50am<br>Radiology Lecture/Special Topic | 5th Thursday 6:15 – 7:00am<br>Open for Special Topics | Subspec. Conf. | |

# Medical Licensure

Mississippi temporary medical or podiatric licenses may be issued to applicants for licensure in Mississippi under the following conditions:

1. A restricted temporary medical or podiatric license may be issued upon proper completion of an application to an applicant who otherwise meets all requirements for licensure except successful completion:
   a. of the postgraduate training requirements provided below:
      i. If a graduate from a medical college or college of osteopathic medicine in the United States, Canada or Puerto Rico, applicant must present documentation of having completed at least one (1) year of postgraduate training in the United States accredited by the ACGME or by the AOA; or training in Canada accredited by the RCPS.
      ii. If a graduate from a foreign medical school, applicant must present documentation of having completed either:
         (1) three (3) or more years of ACGME-approved postgraduate training in the United States or training in Canada approved by the RCPS; or
         (2) one (1) year of ACGME-approved postgraduate training in the United States or training in Canada approved by the RCPS and be currently board certified by a specialty board recognized by the ABMS; and/or
         (3) of Step 3 of USMLE, Level 3 of COMLEX, or Part 3 of the APMLE.

Such restricted temporary license shall entitle the physician to practice medicine or podiatric medicine only within the confines of an ACGME, AOA or APMA approved postgraduate training program in this state and may be renewed annually for the duration of the postgraduate training for a period not to exceed five (5) years.

In addition to the above requirements for licensure by credentials, an individual shall meet the following requirements:

1. Applicant must be twenty-one (21) years of age and of good moral character.
2. Present a diploma from a reputable medical college or college of osteopathic medicine, subject to the following conditions:
   a. If the degree is from a medical college or a college of osteopathic medicine in the United States or Puerto Rico, the medical college must be accredited at the time of graduation by the LCME, a Joint Committee of the Association of American Medical Colleges (AAMC) and the AMA or the College of Osteopathic Medicine which must be accredited by the AOA.
   b. The degree is from a Canadian medical school, the school must be accredited at the time of graduation by the LCME and by the Committee on Accreditation for Canadian Medical Schools.
   c. If the degree is from a foreign medical school, an applicant must either (i) possess a valid certificate from the ECFMG or (ii) document successful completion of a Fifth Pathway program and be currently board certified by a specialty board recognized by the ABMS. The Board will accept for licensure only those individuals completing Fifth Pathway Programs by December 31, 2009. Credentialing via Fifth Pathway Programs will be considered on an individual basis.
   d. Any diploma or other document required to be submitted to the Board by an applicant which is not in the English language must be accompanied by a certified translation thereof into English.

Mississippi restricted temporary medical licenses are issued under the condition that the licensee shall not apply to the U.S. Drug Enforcement Administration for a Controlled Substances Registration Certificate.

## IMPORTANT

Upon submission of an application for licensure to the Board, the applicant shall promptly provide all information deemed necessary by the Board to process the application, including, but not limited to certification of graduation from medical school, photograph of applicant, internship certificate and birth certificate. The Board shall have a reasonable period of time within which to collect and assimilate all required documents and information necessary to issue a medical license. If, after submitting an application for medical license, an applicant has failed to respond or make a good faith effort to pursue licensure for a period of three (3) months, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Additionally, if after one year from the date of receipt of application, applicant has not received a medical license, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Under no circumstances will the one year time limit be waived.

Questions regarding applications should be directed to the licensing professionals at the following email addresses. If last name begins with:

A-F: licofficer1@msbml.ms.gov

G-N: licofficer3@msbml.ms.gov

O-Z: licofficer2@msbml.ms.gov

**(A) Questions 1-25.** Questions 1-25 must be completed by the applicant. Please either type or print this page. If there is an affirmative answer for questions 7-25, please explain in detail on a separate sheet.

**(B) Section I.** Applicant must list medical education and give dates and addresses.

**(C) Section II.** Applicant must account for the time since graduation from medical school. The intentional failure to cover any time period shall constitute falsification which is grounds for denial of the application.

**(D) Section III.** Applicant must list all states where applicant has been licensed or applied for a license whether application was granted or denied, withdrawn or left incomplete.

**(E) Photograph.** Applicant must attach a photograph taken within the last sixty (60) days of the date of affidavit. This should be a wallet-size, passport-type photograph attached to the application. Informal snapshots, colored paper photos or computer generated photos will not be accepted.

**(F) Section IV.** Applicant shall read carefully the oath of the truthfulness of information supplied in this section which gives consent to release information to and from the Board. Applicant must sign and notarize (see notary guide) this section.

**(G) Foreign Language Documents.** Any document required to be submitted to the Board by an applicant which is not in the English language must be accompanied by a certified translation thereof into English by a recognized translator. The Board will accept a notarized (see notary guide) copy of certified translation.

# MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

1867 CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MISSISSIPPI 39216
(601) 987-3079

## APPLICATION FOR SPECIAL VOLUNTEER LICENSE

1. NAME IN FULL _____
(FIRST) (MIDDLE) (LAST) (DEGREE)

2. ADDRESS _____
(STREET OR P O BOX) (CITY) (STATE) (ZIP)

3. PLACE OF BIRTH _____ DATE OF BIRTH _____
(CITY AND STATE OR COUNTRY) (MM/DD/YYYY)

4. SOCIAL SECURITY # _____ GENDER _____

5. TELEPHONE (W) _____ (H) _____ FACSIMILE _____

6. EMAIL ADDRESS _____

| | | YES | NO |
|---|---|---|---|
| 7. | Have you ever been convicted of a felony? | _____ | _____ |
| 8. | Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? | _____ | _____ |
| 9. | Have you ever been convicted of any violation of a state or federal law relating to controlled substances? | _____ | _____ |
| 10. | Are any charges against you for violation of state or federal drug laws currently pending in any court? | _____ | _____ |
| 11. | Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed? | _____ | _____ |
| 12. | Have you ever surrendered a state or federal controlled substance certificate for any reason? | _____ | _____ |
| 13. | Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation? | _____ | _____ |
| 14. | Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? | _____ | _____ |
| 15. | Have you ever resigned from the medical staff of any hospital or health care facility while an investigation or disciplinary proceeding was being conducted or pending? | _____ | _____ |

| | | YES | NO |
|---|---|---|---|
| **16.** | **Have you ever been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?** | | |
| **17.** | **Are you now, or have you ever used any controlled substances or other drugs having addiction-forming or addiction-sustaining liability to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?** | | |
| **18.** | **Have you ever prescribed to yourself any controlled substance or other drug having addiction-forming or addiction-sustaining liability, or obtained said medications for your own use and consumption through any sources, other than by prescription or order of a licensed physician?** | | |
| **19.** | **Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?** | | |
| **20.** | **If your answer to any one of the three preceding questions is "yes", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in illegal use of controlled substances or other drugs having addiction-forming or addiction-sustaining liability?** | | |
| **21.** | **Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism or voyeurism, bipolar disorder, sexual disorder, schizophrenia, paranoia or other psychiatric disorder?** | | |
| **22.** | **Have you ever had a malpractice claim made or suit filed against you pertaining to any aspect of your medical practice, regardless of whether or not such a claim was dismissed, never pursued, settled, resulted in a favorable or adverse judgment, or is now pending? Please use separate sheet to address each claim or suit.** | | |
| **23.** | **Have you ever been denied medical malpractice liability insurance?** | | |
| **24.** | **To your knowledge, have you ever been or are you now, the subject of an investigation or disciplinary proceeding by any licensing Board/Agency as of the date of this application?** | | |
| **25.** | **Have you ever been arrested, other than minor traffic citations?** | | |

**IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.**

## I. MEDICAL EDUCATION

**List all medical schools attended, dates and complete addresses of institutions. Do not list internship and/or residency training.**

| | | Name of School | City/State |
|---|---|---|---|
| 1. | From_____to_____ | | |
| 2. | From_____to_____ | | |

## II. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

**List all activities since completion of medical school, giving dates and complete addresses. If any period did not include practice experience, give explanation. All activities following medical school must be accounted for. Use separate sheet if necessary.**

| | | Place | Address |
|---|---|---|---|
| 1. | From_____to_____ | | |
| 2. | From_____to_____ | | |
| 3. | From_____to_____ | | |

## III. STATE LICENSURE

**List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms included with your application.**

| License Number | State | Year Issued | License Number | State | Year Issued |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**PHOTOGRAPH**
**(wallet-size, passport-type)**

**TAKEN WITHIN**
**SIXTY (60) DAYS**

**must be attached here with**

**tape. Do not paste.**

**INFORMAL SNAPSHOT**

**WILL NOT BE ACCEPTED**

## IV. AFFIDAVIT AND RELEASE

**I,_____, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.**

**I further authorize the release of this application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.**

**I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.**

**I further acknowledge that my practice under the special volunteer medical license will be exclusively and totally devoted to providing medical care to needy and indigent persons in Mississippi or persons in medically underserved areas in Mississippi.**

**I further acknowledge that I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any medical services rendered under the special volunteer medical license.**

**Date _____** **_____**
**Applicant's Signature**

**County of _____**

**State of _____**

**SWORN to and subscribed before me this_____day of_____, in the year**

**of_____.**

**(SEAL)** **_____**
**Notary Public**

**My Commission Expires: _____**

FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY

**SPECIAL VOLUNTEER LICENSE NUMBER:_____**

**ISSUED ON:_____**

**WALL CERTIFICATE MAILED:_____**

## Instructions for Completing Licensure Application (Volunteer)

**Verifications requested by the applicant**

Duplicate as many copies of each appendix as you need. Primary source verifications are required. These verifications will be accepted only if sent directly from the institution to the Board. Do not have the institutions send verifications back to the applicant. Board policy requires original documents from primary source. Verifications may be returned to the Board via U.S. Postal Service or email. International medical schools must return via mail; emails from out of the country and faxes are not acceptable.

**(A) Appendix A.** Applicant shall send this form to each medical school attended and request the medical school to forward the completed form to the Board.

**(B) Appendix B.** Applicant must account for all time since graduation from medical school. All activities following medical school and training must be accounted for. Each activity must be verified by the institution. Applicant shall send this form to the institution where activities were performed.

**(C) Appendix C.** Applicant must complete top portion and forward one to each state in which he/she holds or has held a license to practice medicine. Include temporary, limited, restricted, revoked, active and inactive licenses.

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WWW.MSBML.MS.GOV

**FAX NOT ACCEPTABLE** **APPENDIX A**

MEDICAL/OSTEOPATHIC SCHOOL CERTIFICATION

| | | | |
|---|---|---|---|
| Name of Physician | | | |
| Name of Institution | | | |
| Institution Address | | | |
| City, State, Zip | | | |
| Country | | | |
| Total number of weeks of medical education | | | |
| Dates of Attendance | | From: | To: |
| Type of Degree | | Award Date of Degree | |
| Was physician ever dropped, suspended, placed on probation, or asked to resign? (If yes, please explain) | | | ☐ Yes ☐ No |
| Did the physician attend medical/osteopathic school for a period other than the normal curriculum, or was he/she required to repeat any medical education? (If yes, please explain) | | | ☐ Yes ☐ No |
| Did physician take any type of break or leave of absence for any reason during medical/osteopathic school? (If yes, please explain) | | | ☐ Yes ☐ No |
| Signature of certifying official | | School Seal | |
| Title | | | |
| Email address | | | |
| Date of signature | | | |

**INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:**

**Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address or email a PDF format to certification@msbml.ms.gov. International medical schools must return via mail; emails are not acceptable. Do not send this certification back to the applicant as the Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. A fax is not acceptable.**

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**FAX NOT ACCEPTABLE**

## APPENDIX B

ACTIVITY CERTIFICATION

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Applicant | | | | | | | | | | | |
| Name of Employer | | | | | | | | | | | |
| Employer Address | | | | | | | | | | | |
| City, State, Zip | | | | | | | | | | | |
| Position/Title of Applicant | | | | | | | | | | | |
| Type of Activity | | Medical | | Non-Medical | | Educational | | | | | |
| Activity Status | | Inactive | | Active | | Volunteer | | Other | | | |
| Dates of Activity | From: | | | To: | | | | | | | |

| | | |
|---|---|---|
| Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain) | ☐ Yes<br>☐ No |
| Were any limitations or special requirements placed upon applicant because of questions of incompetence, disciplinary problems or any other reasons? (If yes, please explain) | ☐ Yes<br>☐ No |
| Was applicant in good standing during the above stated period of time? (If no, please explain) | ☐ Yes<br>☐ No |
| Did applicant take any type of leave of absence or break from this activity? (If yes, please explain) | ☐ Yes<br>☐ No |

| | | | |
|---|---|---|---|
| Signature of Certifying Official | | | |
| Title | | Signature Date | |
| Email address | | Telephone No. | |

**INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:**

**Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address or email a PDF format to certification@msbml.ms.gov. Do not send this certification back to the applicant as the Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. A fax is not acceptable.**

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**FAX NOT ACCEPTABLE** **APPENDIX C**

STATE MEDICAL BOARD LICENSURE CERTIFICATION

| | |
|---|---|
| Name of State Medical Board | |
| State Medical Board Address | |
| City, State, Zip | |

| | |
|---|---|
| Name of Applicant | |
| Applicant Address | |
| City, State, Zip | |

| | | | |
|---|---|---|---|
| Medical License # | | Current Status | |
| Area of Specialty | | Type of License | |
| Issue Date | | Expiration Date | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Licensure Base | | Endorsement | | Reciprocity | | State Board |
| | | NBME | | FLEX | | USMLE |
| | | LMCC | | Combination | | NBOME |

| |
|---|
| Has applicant's license ever been suspended, revoked or had restrictions imposed? (If yes, please attach documents.) |
| Is applicant currently under investigation for any reason? (If yes, please explain.) |

| | | | |
|---|---|---|---|
| Signature of Certifying Official | | | |
| Title | | Signature Date | |
| Email address | | Telephone No. | |

**INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:**

**Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address or email a PDF format to certification@msbml.ms.gov. Do not send this certification back to the applicant as the Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. A fax is not acceptable.**

# VOLUNTEER LICENSE ACKNOWLEDGMENT

I,_____, acknowledge that I will be exclusively and totally devoted to providing medical care to needy and indigent persons in Mississippi or persons in medically underserved areas in Mississippi; and

I,_____, acknowledge that I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any medical services rendered under the special volunteer medical license.

_____
Physician Signature

_____
Date

Sworn to and subscribed in my presence this_____day of_____, 20_____.

_____
Notary Public

Seal

This form is to be signed, dated, notarized, and returned to the offices of the Mississippi State Board of Medical Licensure before volunteer medical license will be issued.

Federation of State Medical Boards –
INFORMATION REGARDING USMLE STEP 3

Eligibility Requirements for Step 3
The following requirements must be completed prior to submitting a Step 3 application:

Obtain an M.D. degree (or its equivalent) or a D.O. degree (or its equivalent).
Pass both USMLE Steps 1 and 2.
If a graduate of a foreign medical school, obtain certification by the ECFMG or successfully complete a "Fifth Pathway" program.
Meet the requirements for taking Step 3 imposed by the individual licensing authority to which you are applying to sit Step 3.
For the answers to frequently asked questions about USMLE Step 3. Computer-based Testing (CBT) Updates

Practice Sessions: Please note that practice sessions are not available on major holidays and will not be available between June 1 and July 15.

Score Release Information
Score reports for most examinees who took Step 3 prior to April 1 were mailed on April 26. Now that the initial score release is complete, those examinees testing after April 1 should have a score report mailed approximately six to eight weeks after their exam date. However, there are many factors that may delay an individual's score release. If you have not received your score within eight weeks of your test date, contact the FSMB examination department at usmle@fsmb.org or by calling (817) 868-4041.

Early Summer Scheduling for Step 3

The busiest testing times for USMLE testing at Prometric testing centers are May and June. Examinees who plan to take Step 3 during this time need to be flexible in scheduling the date and site of the exam. Examinees should call for an appointment with Prometric as soon as a scheduling permit is received. Examinees are encouraged to select a date as early in the eligibility period as possible and keep scheduled appointment.

Special Conditions That May Exist When Taking Step 3

Please be aware, the File and Help functions available on the computer case simulations Step 3 - Informational CD included with the registration materials may not be available when taking the Step 3 examination. The CD contains a File function that allows users to exit early from the simulation. Examinees who want to exit early from the case during the Step 3 examination—when the File function is not available— should use the clock feature labeled “Obtain Results or See Patient Later” and select “Call/see me as needed.” By selecting those options it will allow examinees to continue the clock advance, reaching the end of the case.

The CD Help function contains the Primum CCS Overview and Frequently Asked Questions (FAQs). During the Step 3 examination, the overview will be provided for review before the cases, regardless of whether the Help function is operational. The FAQs only will be displayed if the Help function is operational. It is strongly suggested that examinees be thoroughly familiar with all of the materials on the Informational CD prior to taking the exam.

Eligibility for Step 3

Because testing for all three USMLE Steps is continuous throughout the year, some Step 3 applicants may try to expedite the registration process by submitting their Step 3 application prior to receiving confirmation of their passing score on the Step 1 or Step 2 prerequisite exam.
Step 3 examinees are reminded that, at the time their application is submitted, they must meet all USMLE and state board eligibility requirements for sitting Step 3. Passing results of prerequisite examinations (Steps 1 and 2) must have already been received by the applicant prior to submitting the Step 3 application. Those applicants failing to meet all USMLE and state board eligibility criteria for Step 3 at the time of application are deemed ineligible and their application is cancelled.
Scheduling the Examination

Computerized testing offers increased flexibility and improved access for examinees wishing to take USMLE Step 3. However, because Step 3 is a two-day examination that must be taken on two consecutive business days, examinees may experience some difficulty in getting the two consecutive days desired. The difficulty may increase for examinees that delay making an appointment after receiving a scheduling permit. To minimize this potential, examinees are advised to call for an appointment as soon as a scheduling permit is received, select the earliest date possible within the eligibility period and keep scheduled appointments.

Scheduling a Practice Exam with Prometric, Inc.

Step 3 examinees can schedule a practice exam session with Prometric at its U.S. locations. The cost is $48. It is important to note that the practice exam materials duplicate the sample materials provided in CD and paper form in the Step 3 registration packet. No new or different items are presented in the practice exam administered at Prometric testing centers. Consult the USMLE web site (www.usmle.org) about scheduling a practice session with Promectric. Practice sessions are not available on major holidays and will not be available between June 1 and July 15.

Computer-based Testing for USMLE Step 3

CBT offers several distinct advantages: improved examination security, enhanced assessment methods, and flexible scheduling.

1. Physical security will be enhanced through computerized, electronic transmission of encrypted data; the use of audio and video monitors; different test forms used on different days, in different locations and even on the same day within the same center.
2. New assessment methods include clinical and laboratory simulations as well as multimedia
presentations of medical images and sounds.
3. CBT provides for testing throughout the year. If an examinee fails a Step, they can
retest sooner and more frequently.

Changes in the USMLE Steps with CBT

Step 3 will include multiple-choice questions administered in "blocks" of 30-60 questions. Within the defined time and active block, you may answer questions in any order, review responses and change answers. However, once you exit a block, or when time expires, no further review of questions or changing answers will be possible.

Computer-based testing provides the means to deliver a multidimensional administration of Step 3. One benefit is the examination can be structured to allow for the use of enhanced assessment methodologies, which include straightforward question-and-answer formats and the addition of computer-based case simulations.

Computer-based Case Simulations (CCS)

CCS allows you to provide care for a simulated patient. You must balance the clinical information available with evidence of the acuity of the clinical problem in deciding what treatment to begin and when, monitoring the patient's response appropriately throughout.

In CCS, you may request information from the patient's history and physical examination, order lab studies, procedures and consultants, and start medications and other therapies. When there is nothing further you wish to do, you decide when to re-evaluate the patient by clicking on the clock to advance time. With the passage of time, the patient's condition changes based upon the underlying problem and your interventions. You cannot go back in time, but you can change orders to reflect an updated patient management plan. You can review vital signs, progress notes, nurses' notes, test results and reports from your orders. You may see and move the patient among the office, home, emergency department, intensive care and ward settings. After you complete the cases for a group of patients, your management strategy will be compared with those of experts. Actions closer to the ideal will produce a higher score.

## Test Centers

USMLE Step 3 will be administered at Prometric testing centers throughout the United States. (Some U.S. medical schools are establishing test centers in order to administer Steps 1 and 2 on campus.) Prometric centers provide the uniform environment and resources necessary for secure administration of USMLE. Security provisions include video and audio monitoring, digital photo IDs and electronic fingerprinting. For test center information, click here.

## Preparing for Step 3

The best preparation is a thorough medical education that is directed toward providing medical care for patients in the United States and a comprehensive review of the material covered by the examination, as outlined in the general instructions, content descriptions and sample items contained in the USMLE Bulletin of Information on Computer-based Testing (CBT). The CBT software is simple and easy to understand. Still, it is recommended that you acquaint yourself with the software before testing. Each USMLE applicant will be provided a copy of the software as well as sample test questions. Software resembling the actual test delivery system will be available at www.usmle.org. It is important to take advantage of these opportunities prior to the exam, as extensive practice time cannot be accommodated on the test day.

When taking Step 3, it is essential that examinees review the CCS orientation materials and practice with the sample cases prior to the testing day. You should practice with at least four cases so that you have a thorough understanding of how the simulation system works. A demonstration version of CCS is available at www.usmle.org. Additionally, the CCS software is contained on the CD provided with your Step 3 application. Failure to practice with the software will not be an acceptable explanation for poor performance on the CCS portion of Step 3.

For those wishing to practice the entire computer-based testing experience, for an extra cost of $48, a sample examination is available through a Prometric testing center. Please note that only those individuals registered for CBT Step 3 and in possession of their scheduling permit are eligible for this practice session. Furthermore, the sample questions shown at the practice session are identical to those provided in paper and CD form within the application packet.

## Applying for, Scheduling and Taking Step 3

The Federation registers applicants for Step 3 on behalf of the following licensing authorities.* To obtain an application for sitting Step 3 on behalf of the states listed below, and to determine Step 3 eligibility, contact the Federation at (817) 868-4041 or via email at usmle@fsmb.org. You should include your name, phone number, mailing address, USMLE number (if known) and identify the licensing authority for whom you wish to sit Step 3.

# Department of Orthopedic Surgery and Rehabilitation / 2020 –2021 Resident Rotation Schedule – Final

| NAME | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Brown, James Turner 07/01/2016 – 06/30/2021** | **UE & Hand** | | | **F&A / Sports** | | | **Adult Recon** | | | **Peds** | | | Basic Sci |
| **Elmallah, Randa K. 07/01/2016 – 06/30/2021** | **Adult Recon** | | | **Peds** | | | **UE & Hand** | | | **F&A / Sports** | | | Basic Sci |
| **Robertson, Michael J. 07/01/2016 – 06/30/2021** | **Peds** | | | **UE & Hand** | | | **F&A / Sports** | | | **Adult Recon** | | | Basic Sci |
| **White, Parker A. 07/01/2016 – 06/30/2021** | **F&A / Sports** | | | **Adult Recon** | | | **Peds** | | | **UE & Hand** | | | Basic Sci |
| **Crabtree Jr., Reaves M. 07/01/2017 – 06/30/2022** | **MSMOC** | | | **Spine** | | | **Trauma** | | | **Elec / Res** | | | |
| **Drake, Luke C. 07/01/2017 – 06/30/2022** | **Trauma** | | | **Elec / Res** | | | **MSMOC** | | | **Spine** | | | |
| **Lensing, Gabriel S. 07/01/2017 – 06/30/2022** | **Spine** | | | **Trauma** | | | **Elec / Res** | | | **MSMOC** | | | |
| **Purcell, Kevin F. 07/01/2017 – 06/30/2022** | **Elec / Res** | | | **MSMOC** | | | **Spine** | | | **Trauma** | | | |
| **Badon, Justin T. 07/01/2018 – 06/30/2023** | **Peds** | | | **F&A / Sports** | | | **Oncology** | | | **Trauma** | | | |
| **Dale, Wood W. 07/01/2018 – 06/30/2023** | **Trauma** | | | **Peds** | | | **F&A / Sports** | | | **Oncology** | | | |
| **Schryver, Eric M. 07/01/2018 – 06/30/2023** | **F&A / Sports** | | | **Oncology** | | | **Trauma** | | | **Peds** | | | |
| **Walters, Murphy M. 07/01/2018 – 06/30/2023** | **Oncology** | | | **Trauma** | | | **Peds** | | | **F&A / Sports** | | | |
| **Dynako, Joseph A. 07/01/2019 – 06/30/2024** | **Float / Trauma** | | | **Float / Trauma** | | | **UE & Hand** | | | **Adult Recon** | | | |
| **Smithey, Jacob A. 07/01/2019 – 06/30/2024** | **Trauma / Float** | | | **Trauma / Float** | | | **Adult Recon** | | | **UE & Hand** | | | |
| **Steward, William M. 07/01/2019 – 06/30/2024** | **UE & Hand** | | | **Adult Recon** | | | **Trauma / Float** | | | **Trauma / Float** | | | |
| **Sullivan II, Billy Lee 07/01/2019 – 06/30/2024** | **Adult Recon** | | | **UE & Hand** | | | **Float / Trauma** | | | **Float / Trauma** | | | |
| **Akalonu, Chibuzo C. 07/01/2020 – 06/30/2025** | | **Basic Surg Skills** | **ANES** | **Ortho Trauma** | **SICU** | **MSK Rad** | **PLAS** | **Ortho Trauma** | **Ortho Spine** | **Ortho Trauma** | **Ortho Peds** | **Trauma Surg** | **Ortho** |
| **Greene, Steven T. 07/01/2020 – 06/30/2025** | | **Basic Surg Skills** | **Ortho Trauma** | **ANES** | **Ortho Trauma** | **Ortho Peds** | **SICU** | **MSK Rad** | **Trauma Surg** | **PLAS** | **Ortho Spine** | **Ortho Trauma** | **Ortho** |
| **Powers, Evan H. 07/01/2020 – 06/30/2025** | | **Basic Surg Skills** | **PLAS** | **Ortho Trauma** | **MSK Rad** | **Ortho Trauma** | **Trauma Surg** | **Ortho Spine** | **Ortho Trauma** | **ANES** | **SICU** | **Ortho Peds** | **Ortho** |
| **Wahl, Matthew L. 07/01/2020 – 06/30/2025** | | **Basic Surg Skills** | **Ortho Trauma** | **PLAS** | **Trauma Surg** | **ANES** | **Ortho Trauma** | **Ortho Peds** | **SICU** | **Ortho Spine** | **Ortho Trauma** | **MSK Rad** | **Ortho** |
| **Emergency Med (Float)** | | | Lindgren Shafi | Lake | Garza | Webb | Mussarat | Liapin | Browning /Golan | Bowman Keeling | Zaran | Desmedt Williams | Lynch McCuller |
| **Plastic (Day)** | | Benedict,Kacy | | | | | | | | | | | |
| **Peds EM Fellows** | | | | | | | | | | | | Lares 2-13 | Landry 6-17 |