Orthopaedic Surgery Residency Program Handbook

Medical College of Wisconsin

2018 - 2019

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Welcome

As a resident in the Department of Orthopaedics at the Medical College of Wisconsin, you will experience a private, academic institution dedicated to leadership and excellence. The foundation of knowledge and skill come from the expertise of our faculty who bring honor and acclaim to the college, as well as to themselves. Surrounded by expertise, you can expect to become one of the best in your specialization.

Every faculty member is deeply committed to educating and engaging residents in the process of delivering the best care to patients. In an environment of collegiality, you will find a professionalism that is able to instill the best in each resident. Deliberate effort is made to continually evaluate and provide feedback that facilitates the growth and knowledge of residents. You should anticipate progressive development throughout your residency program that will develop your professional knowledge, skills, and attitudes as an orthopaedic surgeon.

The orthopaedic program is intentionally designed to develop technically skilled physicians who are competent in the ACGME competencies. The competencies are imbedded throughout the program, and each rotation addresses the various knowledge, skills, and attitudes. Different formats are used so that by the end of your residency, you will be proficient in each competency. Regardless of the specialization you choose, your knowledge and skills will demonstrate your ability to initiate change that makes a difference in lives.

We invite you to join the legacy of leadership and excellence at MCW and look forward to working with you.

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Introduction

This policy and procedure manual contains information you will need throughout your residency. These polices are meant to supplement the Institutional Policies of the Medical College of Wisconsin Affiliated Hospitals Inc.

Mission Statement

The Orthopaedic Surgery Residency Program's mission is to foster the development of the orthopaedic resident into an independent orthopaedic physician who is clinically competent, academically minded, ethically upstanding, compassionate surgeon who will remain passionate about their profession.

Overall Program Goals & Objectives

The goal of the Orthopaedic Residency Program is to provide a well-monitored academic learning environment that will:

- Cultivate and instill confidence in each resident the clinical skills in all fields of orthopaedic surgery.
- Foster in each resident an inquiring mind and a life-long commitment to learning and skills development through critical reading of the literature and careful consideration, as well as scientific inquiry.
- Develop in each resident the ability to practice competently and independently.
- Nurture the professional development of each resident with expertise in all areas of orthopaedics.

This is achieved through:

- Experiences that are structured to meet all ACGME and ABOS requirements.
- Evaluations that monitor the resident's progression in the program.
- Graded responsibility that determines and appropriately assigns each resident's opportunities for decision making, clinical care, and surgical care.
- Mentoring throughout the entire spectrum of orthopaedic specialties that guides professional development.
- Scholarly activities that advance knowledge in the care of orthopaedic patients.
- Individualized learning that assists each resident in realizing his/her full potential as an orthopaedic surgeon.

At the conclusion of the residency program, the resident is expected to be competent in the study and prevention of musculoskeletal diseases, disorders, and injuries, and their treatment by medical, surgical, and physical methods. The educational objectives are grounded in the ACGME competencies, and focus on preparing the resident to:

Patient Care and Procedural Skills:

- Provide patient care that is compassionate, appropriate, and effective for the treatment of orthopaedic problems and the promotion of health
- Competently perform all essential orthopaedic medical, diagnostic, and surgical procedures to include demonstrating competence in:

- gathering essential and accurate information about their patients
- making informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.
- developing and carrying out treatment plans, and
- providing health care services aimed at preventing health problems or maintaining health

- Demonstrate competence in diagnosing and managing all adult and pediatric orthopaedic disorders.

Medical Knowledge:

- 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 are expected to:
  - demonstrate expertise in their knowledge of those areas appropriate for an orthopaedic surgeon
  - demonstrate an investigatory and analytic thinking approach to clinical situations

Practice-based Learning & Improvement:

- 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 self-evaluation and life-long learning.
- Develop skills and habits to be able to meet the following goals:
  - identify strengths, deficiencies, and limits in one's knowledge and expertise
  - set learning and improvement goals
  - identify and perform appropriate learning activities
  - systematically analyze practice using quality improvement changes with the goal of practice improvement
  - incorporate formative evaluation feedback into daily practice
  - locate, appraise, and assimilate evidence from scientific studies related to patients' health problems
  - use information technology to optimize learning
  - participate in the education of patients, families, students, and residents and other health professionals
  - apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

Interpersonal & Communication Skills:

- 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:
  - communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
  - communicate effectively with physicians, other health professionals, and health related agencies
  - work effectively as a member or leader of a health care team or other professional group

- act in a consultative role to other physicians and health professionals
- maintain comprehensive, timely, and legible medical records, if applicable
- create and sustain a therapeutic and ethically sound relationship with patients, and
- use effective listening skills, and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills

Professionalism:

- Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
  - compassion, integrity, and respect for others
  - responsiveness to patient needs that supersedes self interest
  - respect for patient privacy and autonomy
  - accountability to patients, society and the profession
  - sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
  - commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices and
  - sensitivity and responsiveness to fellow health care professionals' culture, age, gender, and disabilities

Systems-based Practice:

- 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:
  - work effectively in various health care delivery settings and systems relevant to their clinical specialty
  - coordinate patient care within the health care system relevant to their clinical specialty
  - incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
  - advocate for quality patient care and optimal patient care systems
  - work in interprofessional teams to enhance patient safety and improve patient care quality; and
  - participate in identifying system errors and implementing potential systems solutions

Eligibility and Selection

*The Orthopaedic Surgery Residency Program complies with the MCWAH's **Eligibility and Selection of Residents** Institutional policy. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The Orthopedic Surgery Residency Program uses the same criteria for the eligibility and selection of residents as is outlined in MCWAH's Institutional Policy and the ACGME Common Program Requirements.

The program selects residents from among eligible candidates on the basis of residency related criteria such as their preparedness, ability, aptitude, academic credentials, and communication skills and personal qualities such as motivation and integrity. The program does not discriminate with regard to gender, race, age, religion, color, national origin, disability, sexual orientation, or any other applicable legally protected status. In selecting from qualified candidates, the program will participate in and abide by the rules and regulations established by the National Resident Matching Program.

Resident Appointment

Contract

GME Training Agreements are issued by MCWAH annually for the resident's review and signature. Original contracts are retained in MCWAH's office.

Duties and Responsibilities

- Abide by the terms set forth in MCWAH's GME Training Agreement.
- Further abide by the Medical Staff Bylaws set forth for by MCWAH, the sponsoring institution, as well as by each of the participating institutions.
- Follow the policies and procedures implemented for the Orthopaedic Residency Training Program which may be amended at the discretion of the Program Director.
- Participate in education, research, quality improvement projects and patient care experiences of the Orthopaedic Surgery Residency Program.
- Provide safe, compassionate patient care under supervision commensurate with the resident's level of advancement and responsibility.
- Assume responsibility for supervising and teaching medical students and other residents.
- Enter work hours in New Innovations on a daily basis.
- Enter operative cases into the ACGME Resident Case Log System weekly.
- Actively participate in appointed committees.
- Complete evaluations of the residency program and of the program faculty.

Teaching of Medical Students

The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy ***Teaching of Medical Students by Housestaff.*** *Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Educating medical students is a professional responsibility of every MCWAH housestaff. Housestaff are expected to teach, provide feedback regularly, and complete medical student evaluations in a timely manner.

The orthopaedic residency program provides resources and training to enhance the resident's ability to teach. One of the strengths of this program is the resident's willingness and ability to perform in the role of an educator.

Scholarly Activity

*The Orthopaedic Surgery Residency Program complies with the Institutional Policy on **Scholarly Activity**. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Each resident must demonstrate scholarship through at least one of the following activities: participation in sponsored research, preparation of an article for a peer-reviewed publication, presentation of research at a regional or national meeting or participation in a structured literature review of an important topic.

Each PGY-5 resident is expected to give a Case Presentation during the Milwaukee Orthopaedic Society Meeting. They are also required to submit their completed research manuscript to a reputable journal and give a 10-minute presentation of the research conducted while in the program during the Annual John Gould Lectureship/Scientific Day.

Research Recommended Timeline

To monitor your progress and help you navigate through the various stages of research,the Resident Research Committee has developed the following timeline. This timeline highlights the expectations for both assignments, presentations, and manuscript drafts.

PGY I /Interns

- CITI Training
- Research Project Meeting with Resident Research Committee
- Establish a faculty research mentor
- Resident Research Proposal Submission
- Evidence Based Literature Review presentation
- Manuscript Introduction written
- Preliminary draft of Materials and Methods is written
- Consult with biostatistician on design and sample size

PGY 2

- Peer Review Presentation of Methods
- IRB completed
- Materials and Methods section is written
- Data Collection

PGY 3

- Meet with biostatistician regarding data analysis
- Progress Presentation to Resident Research Committee
- Manuscript Results section is written
- Manuscript Discussion is written

PGY 4

- Final Manuscript with abstract is submitted

PGY 5

- John Gould Resident Research Day - Final Presentations!

Wisconsin Medical License and DEA

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy **on Licensure, Resident Educational License, and DEA Number Requirements for Housestaff.** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

All residents are required to acquire and maintain proper medical licensure and DEA number.

- Residents must obtain a Wisconsin Resident Education License (REL) by the start of their 1st year of GME Training.
- Orthopaedic residents must pass the Step 2 CK and CS of the United States Medical Licensing Examination (USMLE) prior to taking Step 3. Email the program coordinator a transcript of your scores if not already provided with your ERAS application.
- Orthopaedic residents begin the process of applying for an unrestricted Wisconsin medical license and take Step 3 of the USMLE during February Bioskills Rotation (see **MCWAHs Licensure Process Guide**)
- Residents are encouraged to obtain a medical license as soon as possible, but they are required to have an unrestricted Wisconsin license ***before entering into third year*** of a GME ACGME accredited program.
- Residents must also obtain a **DEA number** within 3 months of receiving their unrestricted Wisconsin medical license

Failure to possess an unrestricted license may result in: non-promotion to the third year of training, unpaid leave of absence or the non-renewal of the training agreement.

Wisconsin Medical Licenses are valid for a maximum of two years. It is important to update the State of Wisconsin Department of Safety and Professional Services (*formerly Department of License and Regulation*) regarding any change to your personal information (i.e., name change, address change, etc.). Renewal forms must be submitted, with proper fee, at least one month prior to the expiration date. This will allow the Department of Safety and Professional Services the appropriate processing time. Please refer to their website for information specific to your license: ***http://drl.wi.gov***

Wisconsin Licensing and USMLE Step 3 Timelines

Orthopaedic Surgery Residency Program Guidelines

SEPTEMBER

Apply for USMLE Step 3 via the **Federation of State Medical Boards (FSMB) website**. Allow appropriate processing time. Sit to sit for your USMLE Step Examination at the end of February.

FEBRUARY

Sit for the USMLE Step 3 Examination.

During Bioskills month, administrative time is built into the schedule for you to begin the process for Applying for your Wisconsin License.

To start view MCWAH's "Licensure Process Guide" which provides instructional information when beginning the Step-By-Step Process for Applying Wisconsin License. You may apply online via OLAS or download forms from the Department of Safety and Professional Services (DSPS). Allow 15-20 business days for processing of your paperwork.

MARCH/APRIL/MAY/JUNE

Check the DSPS website for the status of your application; attend to any outstanding items to avoid any delays in receiving your Wisconsin License on time. Be sure to monitor your online checklist until a Wisconsin license is issued. If outstanding issues are not responded to in a timely manner, various forms may need to be resubmitted as well as additional forms that the DSPS may request (i.e., NPDB, an updated CPGT form, etc.).

Once your USMLE Exam Scores are released you will need to request USMLE transcript online to be sent to Wisconsin Medical Examining Board.

JULY

After completing 12 months of GME training and passing USMLE Step 3 you must request the Self-Query from the National Practitioner Data Bank's website.

AUGUST / SEPTEMBER /OCTOBER

Program Coordinator will submit the Certificate of Postgraduate Training (CPGT) form **2165** to the DSPS **after** you have passed USMLE Step 3 **and** completed twelve months of accredited GME.

Important! Be sure to monitor your online checklist on the DSPS website until a Wisconsin license is issued. If outstanding issues are not responded to in a timely manner, various forms may need to be resubmitted as well as additional forms that the DSPS may request (i.e., NPDB, an updated CPGT form, etc.)

Educational Program

ACGME Curriculum and Resident Experience

PGY1 Year

During the PGY1 year, residents are provided opportunities to:

- Formulate principles and assess, plan, and initiate treatment of both adult and pediatric patients with surgical and/or medical problems.
- Care for patients with surgical and medical emergencies, multiple organ system trauma, soft tissue wounds
- Care for critically-ill patients; and
- Develop an understanding of surgical anesthesia, including risks and benefits

PGY1 Year Requirements

Non-orthopaedic surgery rotations (6 months): designed to foster proficiency in basic surgical skills, the peri-operative care of surgical patients, musculoskeletal image interpretation, medical management of patients, and airway management skills;

3 months must be on surgical rotations:
General Surgery Trauma, Plastic/Burn Surgery, Vascular Surgery

3 months must be on rotations:
Internal Medicine, Surgical Intensive Care, Musculoskeletal Radiology

Basic Surgical Skills: Formal Instruction in Basic Surgical Skills is provided as a dedicated rotation during the orthopaedic rotation designed to integrate skills training and prepare PGY-1 residents to participate in orthopaedic surgery cases.

Curriculum includes:

- initial management of injured patients, including splinting, casting, application of traction devices and other types of immobilization
- basic operative skills, including soft tissue management, suturing, bone management, arthroscopy, fluoroscopy, and use of basic orthopaedic equipment

Orthopaedic surgery rotations (6 months): 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.

Rotations include: General Orthopaedics, Pediatric Orthopaedics, Hand and Upper Extremity, Basic Surgical Skills, (2 months) Trauma-Emergency

PGY2-5 Requirements

The PGY2-5 years must include at least 36 months of rotations on orthopaedic services; with the final 24 months of education in a single program.

Each resident's experience must include:

- the diagnosis and management of adult and pediatric orthopaedic disorders, including: joint reconstruction, trauma, including multisystem trauma, surgery of the spine, including disk surgery, spinal trauma, and spinal deformities, hand surgery, foot surgery, athletic injuries, orthopaedic rehabilitation, orthopaedic oncology, including metastatic disease; and amputations and post-amputation care.
- non-operative outpatient diagnosis and care, including all orthopaedic anatomic areas;
    - must have at least one half-day per week and should have two half-days per week of outpatient clinical experience in physician offices or hospital clinics with a minimum of 10 patients per session on all clinical rotations
    - must be supervised by faculty and instructed in pre- and post-operative assessment as well as the operative and non-operative care of general and subspecialty orthopaedic patients
    - Opportunities for involvement in all aspects of outpatient care of the same patient should be maximized
- increasing responsibility for patient care, under faculty supervision (as appropriate for each resident's ability and experience), as he or she progresses through the program
    - must have inpatient and outpatient experience with all age groups
- clinical experience for PGY-1-5 residents must be tracked in the ACGME Case Log System; each graduating resident must log between 1000 and 3000 procedures

Typical Rotation Schedule

PGY-1 Rotations	
Adult Orthopaedics	2 months
Bioskills	1 month
General Surgery Trauma	1 month
Orthopaedic Med Consult	1 month
Orthopaedic Hand & Upper Extremity	1 month
Orthopaedic VA	1 month
Pediatric Orthopaedic Surgery	1 month
Plastic Surgery	1 month
Radiology	1 month
Surgical Intensive Care Unit	1 month
Vascular Surgery	1 month
PGY-2 Rotations	
Orthopaedic Adult Reconstruction	10 weeks
Orthopaedic Hand & Upper Extremity	10 weeks
Orthopaedic Sports Medicine	10 weeks
Orthopaedic Trauma Surgery	10 weeks
Pediatric Orthopaedic Surgery	10 weeks
PGY-3 Rotations	
Orthopaedic Foot & Ankle	10 weeks
Orthopaedic Oncology	10 weeks
Orthopaedic Spine	10 weeks
Orthopaedic VA	20 weeks
PGY-4 Rotations	
Orthopaedic Surgery Community Elective	10 weeks
Orthopaedic Adult Reconstruction	10 weeks
Orthopaedic Hand & Upper Extremity	10 weeks
Orthopaedic Trauma Surgery	10 weeks
Pediatric Orthopaedic Surgery	10 weeks
PGY-5 Rotations	
Orthopaedic Surgery Community Elective	10 weeks
Orthopaedic Sports Medicine	10 weeks
Orthopaedic Trauma Surgery	10 weeks
Pediatric Orthopaedic Surgery	10 weeks
Orthopaedic VA	10 weeks

Conferences

The residency program conference curriculum is based at the primary institution, Froedtert Hospital. The program conference schedule includes regularly scheduled didactic sessions that provide knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care.

Resident Attendance

Resident's attendance to departmental educational conferences and didactic sessions is mandatory. All residents including first year residents are relieved of clinical responsibilities in order to attend. Residents rotating on services other than orthopaedics must attend all scheduled lectures. Residents are required to sign-in to each conference to ensure their attendance is properly documented.

Conference Dress Code and Etiquette

Residents attending Orthopaedic Grand Rounds, Basic Science, John S. Gould Lectureship, and other conferences with guest speakers are to dress in Professional Attire with or without a white coat. Scrubs are not acceptable attire.

Residents attending conferences are expected to arrive on time, prepared (i.e. assigned readings completed). Pagers and phones are to be set on vibrate or silent mode. Residents should eat and drink very discretely.

OITE REVIEW
Mondays, 6:30 – 7:15 am, Wednesdays, 8:30 – 9:30 am, Fridays, 6:30 – 7:15 am
Location: Bruce Brewer Library

The OITE Review is held during the months of July and August in the Bruce Brewer Library.

ANATOMY
Wednesdays, 6:30 – 8:30 am
Location: MCW – Form/Function Lab, 2nd Floor

Anatomy is held every Wednesday from 6:30 – 8:30 am during the months of July and August. It is the responsibility of the third-year resident, with the assistance of the fifth-year resident assigned to Anatomy, to do the dissection for the following week. Dissections occurs on Friday and/or off hours with didactic and review of dissection as well as some additional dissection being performed on the following Wednesday.

GRAND ROUNDS
Wednesdays, 7:00 -8:00 am,
Location: CHW Auditorium

The Department of Orthopaedic Surgery Grand Rounds conference is primarily a didactic session offering topics on orthopaedic musculoskeletal disorders targeting diagnosis, management, treatment indications, surgical interventions, complications and rehabilitation. The goal of these sessions are to provide healthcare professionals with cutting edge knowledge and as well as new options that will lead to modified practice and improved patient outcomes.

CORE CONFERENCES

The resident's core conferences are held on Monday, Wednesday, and Fridays. These didactic sessions review established and evolving biomedical, clinical, and epidemiological information, as well as the application of this knowledge to patient care. Conferences are organized by specialty, with each section having 18 conferences per year. Specialty divisions repeat the subject matter every two years such that each resident will review each topic at least twice during their residency. All resident, including PGY1 residents on non-orthopaedic rotations, attend all conferences. Conferences are formatted to provide core orthopaedic knowledge and promote the evaluation of medical literature and research.

BASIC SCIENCE

Wednesdays, 8:00 – 9:00 am
Location: CHW Auditorium

The AAOS Orthopaedic Knowledge Update and AAOS Orthopaedic Basic Science textbooks are the foundation for this didactic series. Topics are presented on a two-year cycle.

MORBIDITY & MORTALITY (M&M)

Wednesdays, 7:00 – 9:00 am
Location: CHW Auditorium

Morbidity and Mortality is a two-hour conference held 5 times per year, near the end of each clinical rotation. Residents on each service compile lists of cases performed and complications and 3-5 are commonly selected for in depth review. The residents and attendings discuss the case in a boards style fashion and prepare literature reviews to apply evidence-based medicine principles to improve medical knowledge and patient care. Residents discuss physician and system errors, patient safety issues and methods of improvement.

JOURNAL CLUB

Journal club is organized by a small group of residents and faculty and held at the end of each rotation. Articles from core and speciality orthopaedic journals are selected by the faculty. Residents are then assigned these papers and are expected to present to the group. The discussions examine the scientific methods of the studies and their clinical relevance. Each paper is critically reviewed followed by a group discussion. The goal of journal club is to promote evidence-based medicine, keep up–to-date, demonstrate continuing medical education, and learn critical appraisal skills.

PATIENT SAFETY QUALITY IMPROVEMENT CONFERENCE (PSQI)

The Patient Safety Quality Improvement Conference meets once a month that consists of orthopaedic faculty, staff, and residents. The purpose of this conference is to identify a process or system in need of improvement and instituting a system-based change to improve orthopaedic patient care.

Evaluation of Residents

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Evaluation of Housestaff** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Clinical Competency Committee

A Clinical Competency Committee has been appointed by the residency program director who are responsible for not only reviewing, preparing and ensuring the reporting of Milestones evaluations of each resident semi-annually to the ACGME but also advising the program director regarding resident progress, including promotion, remediation, and dismissal.

Clinical Competency Committee Policy

Formative Evaluations

The orthopaedic residency program has multiple evaluators complete objective assessments of competence in patient care and procedure skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on Orthopaedic Milestones to document progressive resident performance improvement appropriate to educational level. The results of these assessments are provided to each resident at the end of each block rotation as well as a review of case volume and breadth to ensure residents are entering cases into the ACGME Case Log System accurately and timely.

Assessments measure resident progression in the residency program continuously. The assessments provide data that is competency-based to guide the professional development of each resident. The Program Director and Associate Program Director meet with each resident at the end of each block rotation. At each meeting, all evaluations that have been completed since the last meeting are reviewed and discussed. Resident progress in meeting the requirements of the program are also reviewed and discussed. If there are areas that indicate the need for improvement, the resident and program director develop a self-improvement plan for resident self-directed learning. All assessments, as well as documentation of the meeting and resident progress are maintained in the resident's permanent file.

Mid-Rotation Evaluation

Mid-Rotation evaluations give residents the opportunity to receive feedback and improve their performance prior to the end of the rotation. The resident completes the left side of the form by recording areas of accomplishment and areas in need of improvement. Then, the resident takes the form to the faculty to complete the right side of the form that requests the same information. Any differences between the resident and faculty responses on the mid-term are to be followed by a discussion. The resident returns the mid-term to the program coordinator to be filed for the end of rotation review meeting.

End-of-Rotation Evaluation

Supervising faculty evaluate each resident's performance at the end of each rotation. These evaluations are available for residents to view in New Innovations.

Allied Health Professional Evaluation

Allied Health Professionals are given an opportunity to provide anonymous constructive feedback in the areas of professionalism and interpersonal communication. Residents receive a summary of these evaluations on a semi-annual basis.

Patient Evaluation

Patients have an opportunity if they choose to evaluate residents in a confidential manner in the areas of professionalism and interpersonal communication. The patient evaluations are part of the multiple assessors required by the ACGME.

Peer Evaluation

Residents have an opportunity to provide an anonymous evaluation of 3 of their peers over a 6-month period. The peer evaluations are part of the multiple assessors required by the ACGME and provided to the residents in a summary format semi-annually.

Summative Evaluation

Upon completion of the program, the Program Director provides a summative evaluation for each resident. The Orthopaedic Surgery Milestones are one of the tools utilized to ensure residents are able to practice core professional activities without supervision upon completion of the program. The evaluation documents the resident's performance during the final period of education, verifies the resident has demonstrated sufficient competence to enter practice without direct supervision and ultimately becomes a part of the resident's permanent record.

Promotion of Residents

General criteria for promotion to the next PGY level:

PGY-1

- Successfully complete all rotations demonstrating competency in all 6 domains
- Pass USMLE Step III
- Successfully complete all Bioskills modules
- Possess Fluoroscopy Certification
- Maintain Professional Behavior relating to conference attendance, timely and accurately logging case logs into the ACGME and work hours into New Innovations
- Fulfill research requirement for PGY-1 level as noted in Research Recommended Timeline

PGY-2

- Successfully complete all clinical rotations as outlined by the rotation goals and objectives
- Possess an unrestricted Wisconsin medical license
- Possess a DEA number within 3 months of receiving Wisconsin medical license
- Maintain Professional Behavior relating to conference attendance, timely and accurately logging case logs into the ACGME and work hours into New Innovations, timely completing assigned curriculums assigned by Program or MCWAH
- Obtain satisfactory marks in all Competencies
- Fulfill research requirement for PGY-2 level as noted in Research Recommended Timeline

PGY-3

- Successfully complete all clinical rotations as outlined by the rotation goals and objectives
- Maintain an unrestricted Wisconsin medical license and DEA number
- Maintain Professional Behavior relating to conference attendance, timely and accurately logging case logs into the ACGME and work hours into New Innovations, timely completing assigned curriculums assigned by Program or MCWAH
- Obtain satisfactory marks in all Competencies
- Fulfill research requirement for PGY-3 level as noted in Research Recommended Timeline

PGY-4

- Successfully complete all clinical rotations as outlined by the rotation goals and objectives
- Maintain an unrestricted Wisconsin medical license and DEA number
- Maintain Professional Behavior relating to conference attendance, timely and accurately logging case logs into the ACGME and work hours into New Innovations, timely completing assigned curriculums assigned by Program or MCWAH
- Obtain satisfactory marks in all Competencies
- Fulfill research requirement for PGY-4 level as noted in Research Recommended Timeline

PGY-5

- Successfully complete all clinical rotations as outlined by the rotation goals and objectives
- Maintain an unrestricted Wisconsin medical license and DEA number
- Maintain Professional Behavior relating to conference attendance, timely and accurately logging case logs into the ACGME and work hours into New Innovations, timely completing assigned curriculums assigned by Program or MCWAH
- Obtain satisfactory marks in all Competencies
- Fulfill research requirement for PGY-5 level as noted in Research Recommended Timeline
- Demonstrate sufficient professional ability to practice competently and independently

Substandard Performance

The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on ***Management of Substandard Housestaff Performance.*** *Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Failure to meet expected performance standards, violation of a MCWAH policy or training site policy, unprofessional behavior, unsafe practices and/or egregious conduct may result in measures as outlined in MCWAH's Management of Substandard Housestaff Performance policy.

Evaluation of Faculty

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Evaluation of Faculty** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Annually the program evaluates faculty performance as it relates to the educational program and includes: a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, scholarly activity and confidential evaluations by the residents.

Resident Evaluations of Faculty

Faculty evaluations are continuous and measure faculty performance based on the ACGME responsibilities and requirements of faculty. PGY 2-5 residents are sent an email with a link at the end of each rotation. It is a requirement that residents complete an evaluation of each faculty member on the service. Evaluations are held until the end of the year in order to maintain resident anonymity. Faculty members receive a summary of the evaluation data at a meeting with the chairman of the orthopaedic department.

Resident Evaluations of Rotation

Rotation evaluations are continuous and measure the learning environment based on ACGME requirements. PGY 2-5 residents are sent an email with a link at the end of each rotation. It is a requirement that residents complete one evaluation of each rotation. Residents have ten days to complete the evaluation. The Program Director is notified of delinquencies. All dates and names are removed when the evaluations are submitted. Evaluations are held until the end of the year in order to maintain resident anonymity. A summary of each rotation's evaluation data is provided to the faculty in the designated service.

Program Evaluation and Improvement

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Program Evaluation Committee** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Program Evaluation Committee (PEC)

Program Evaluation Committee Members selected by the program director actively participate in:

- Planning, developing, implementing and evaluating educational activities of the program
- Reviewing and making recommendations for revision of competency-based curriculum goals & objectives
- Addressing areas of non-compliance with ACGME standards
- Reviewing the program annually and rendering a written annual program evaluation (APE) including residence performance, faculty development, graduate performance, program quality and progress on the previous year's action plans.

Program Evaluation Committee Policy

ACGME Resident/Fellow and Faculty Surveys

These online surveys are issued annually by the ACGME and are comprised of a bank of questions that may vary depending upon a person's responses, their level of education, or their role in a program. 100% completion compliance is required. The aggregated survey data is provided in a report to the program providing national, institutional, ans specialty comparative averages.

MCWAH Housestaff / Faculty Surveys

These confidential surveys are issued annually by MCWAH providing programs with an aggregated report of the survey data for program review and improvements. 100% completion compliance is required.

The Learning and Working Environment

Patient Safety and Quality Improvement

It is the professional responsibility of physicians to deliver safe patient care. Residents must:

- Be rested and fit to provide care.
- Be appropriately supervised.
- Actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- Understand their role in assuring the safety and welfare of their patients.
- Provide patient and family centered care.
- Manage their time before, during and after clinical assignments.
- Recognize impairments, including illness and fatigue, in themselves and others.
- Monitor their patient care practice through performance improvement indicators.
- Honestly and accurately report patient data regarding outcomes and clinical experience.
- Accurately and effectively communicate patient information with others.

Event Reporting

Reporting events allows clinical sites to identify vulnerabilities in the system and make changes to prevent similar errors from occurring in the future. It also allows data to be aggregated over time, so trends can be identified, and the impact of any improvement efforts can be measured. Aggregated data also assists sites in determining where resources should be focused to improve patient safety.

Frontline caregivers are the best source of information when it comes to identifying events that may impact patient safety. As a physician in training you have an important role in patient safety and an ethical responsibility (**AMA Ethics Opinion 8.121**) (DOCX) to identify, reduce and prevent health care errors. Reporting an event takes just a few minutes and by doing so you are taking an important step toward improving safety for patients at the sites where you train.

Events reported should include not only medical errors but also any deviation from usual medical care that causes injury or poses a risk of harm to patients. This includes reporting near misses and unsafe conditions which both provide an opportunity to learn and change processes before a patient is harmed. Here are **examples of events** (DOCX) that should be reported.

MCWAH and its affiliate clinical sites recognize that the vast majority of events reported are caused by system and process issues and are not the result of individual performance. Reporting is the first part of a process that includes evaluation and analysis of events reported from a system-based perspective, initiation of appropriate system-based changes and dissemination of lessons learned. Housestaff are an important part of this process and are encouraged to participate in root cause analysis, peer review, system-based M&Ms, development of action plans to address findings and other process improvement activities at their clinical sites.

While we hope that the culture is such that any caregiver, including housestaff, would feel comfortable reporting an event we realize that occasionally there may be situations where they are not. To facilitate

reporting under these circumstances events can be reported anonymously in all reporting systems and also by calling **MCWAH's Helpline** at (414) 955-4798.

Events can also be reported, and safety concerns discussed directly with MCWAH's Director of Risk Management by calling (414) 955-4847.

For more information about how to report an event at a MCWAH training site please select from the applicable facility below:

Froedtert Hospital (PDF)

Children's Hospital of Wisconsin (PDF)

Clement J. Zablocki VAMC (PDF)

Ascension Wheaton Franciscan (PDF)

Optimal Clinical Workload

The clinical responsibilities for each resident will be based on PGY-level and level of competence, patient safety, resident education, severity and complexity of patient illness/condition and available support services

Supervision of Residents

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Supervision of Housestaff.** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The purpose of this policy is to outline supervision requirements for the program that ensures (a) patients receive safe and effective care and (b) residents develop the skills, knowledge, and attitudes required to enter the unsupervised practice of orthopaedic surgery.

Policy

1. The program is committed to ensuring that the appropriate level of supervision is in place for all residents who care for patients. Supervision is focused on the individual learning needs of the resident to progress in developing the continuum of care in all patient care settings. As the resident encounters increasingly complex cases and demonstrates competence in knowledge, skills, and attitudes, increased independence and responsibility are awarded.

2. The program director is responsible for ensuring that each resident in the program is supervised appropriately regardless of the training site. It is the obligation of the program director to ensure that residents are properly supervised by faculty or attending physicians at each site in which the resident is assigned. All patient care provided by a resident is done under the direction and supervision of the attending physician. Junior residents may be supervised by more senior residents to the limit of the senior resident's own responsibility level.

3. Supervision is carried out through procedures in concert with MCWAH supervision policies. The residents will be supervised in accordance with the written descriptions of their responsibility for the care of patients on their rotating services. Such guidelines will be communicated to all residents by the attending surgeon. The residents will be provided with prompt, reliable systems of communication and interaction with the supervisory physician and the senior resident on their service. Supervision will be appropriately assigned to the resident's level of training as determined by the program director and faculty.

   To ensure oversight of resident supervision while providing for graded authority and responsibility, the program uses the following classification of supervision as defined by the ACGME:

Levels of Supervision

Direct Supervision: the supervising physician is physically present with the resident and patient.

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.

Indirect Supervision:

with Direct Supervision available – the supervising physician is not physically 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.

PGY- 1 Residents

Direct Supervision – PGY-1 residents must have a supervising physician physically present with the residents and patient until competency is demonstrated for:

A. Patient Management Competencies
   1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations
   2. evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria
   3. evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
   4. management of patients in cardiac or respiratory arrest
   5. management of patient with major fractures that are displaced
   6. evaluation and management of patients with infections of the spine, pelvis, or extremities

B. Procedural Competencies
   1. repair of surgical incisions of the skin and soft tissues
   2. repair of lacerations of the skin and soft tissues
   3. excision of lesions of the skin and subcutaneous tissues
   4. repair of nail bed lacerations or distal digit amputation injuries that do not require management in an operating room setting
   5. incision and drainage of paronychias, felons, or other abscesses of the hand and forearm that do not require management in an operating room setting
   6. endotracheal intubation
   7. bedside wound debridement
   8. insertion of skeletal traction pins
   9. arthrocentesis
   10. closed reduction of fractures and dislocations

11. placement of casts
12. placement of splints for displaced fractures
13. administration of local anesthetic
14. measurement of compartment pressure

Indirect Supervision:

A. Patient Management Competencies for which indirect supervision is allow:
   1. evaluation and management patients admitted to the hospital, including initial history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan
   2. pre-operative evaluation and management, including history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan
   3. evaluation and management of post-operative patients, including monitoring patients and ordering medications, tests, and other indicated treatments
   4. transfer of patients between hospital units or hospitals
   5. discharge of patients from the hospital
   6. interpretation of laboratory results
   7. interpretation of radiographs
   8. consultation of appropriate inpatient services

B. Procedural competencies for which indirect supervision is allowed:
   1. performance of basic venous access procedures, including establishing intravenous access
   2. placement and removal of nasogastric tubes and Foley catheters
   3. arterial puncture for blood gases
   4. removal of surgical drains
   5. application of dressings and prefabricated splints
   6. placement of splints for non-displaced fractures
   7. removal of non-absorbable sutures or skin staples

PGY-2 – PGY-5 Residents

PGY-2 – PGY-5 residents may be supervised through either method:

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.

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.

Professionalism

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Professional Behavior.** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Policy

It is the policy of the Medical College of Wisconsin Affiliated Hospitals, Inc., that its housestaff conduct themselves in a professional manner including but not limited to not engaging in unethical or disruptive behavior, resolving conflicts in an appropriate manner at all times, holding patient information confidential, and using discretion in communications regarding MCWAH affiliates and their employees.

Residents are expected to report all disruptive behavior or harassment that is directed at them, or that they observe, to MCWAH's Designated Institutional Official (DIO) & Executive Director or Director of Risk Management. Reports may also be made **anonymously through the MCWAH Hotline (414-955-4798)**.

Unprofessional conduct or attitude is not acceptable. Unprofessional behavior is grounds for disciplinary action and may result in termination form the training program.

Residents who report disruptive or unethical behavior will be protected from reprisal or retaliation.

Professional Behavior

Professional behavior creates an environment that promotes safe and high-quality patient care and engenders a constructive learning environment. Physicians, along with all healthcare providers, have an ethical and professional duty to maintain a patient care environment that promotes the safe care of patients and fosters learning.

Examples of Professional Behavior

- Clearly identifies oneself to patient and staff
- Maintains a clean, neat appearance
- Maintains composure
- Treats patients with dignity and respect
- Collaborates with other members of the healthcare team and treats them with respect
- Answers questions and explains the patient's plan of care to patient, family (with patient's permission) and healthcare team members
- Answers phone calls and pages in a timely and courteous manner
- Respects cultural and religious differences of others
- Is truthful in verbal and written communications
- Communicates differences in opinion and good faith criticism respectfully in the appropriate forum
- Is on time for meetings and appointments
- Keeps patient information confidential
- Complies with the policies of MCWAH and the rules of any facility where training occurs

Disruptive or Professional Behavior

Disruptive or unprofessional behavior may be viewed along a spectrum. Although there is no agreed upon definition and the term "disruptive" is sometimes interchangeable with the term "abusive", it generally refers to a style of interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care. Such behavior may be expressed verbally by using foul or threatening language, or through non-verbal behavior such as facial expressions or manners. (See AMA Council on Ethical and Judicial Affairs, Report 2-A-00 and Disruptive or unprofessional behavior is a threat to patient safety (AHRQ Patient Safety Primer, Patient Safety Network, 2010).

Examples of Disruptive or Unprofessional Behavior

- Conduct that could be characterized as harassment or discrimination. (See MCWAH's policy on **Harassment** and Reporting in MCWAH's Handbook)
- Verbal threats of violence, retribution or lawsuits
- Verbal outbursts
- Insults, verbal comments or criticism intended to belittle or berate others
- Arguing in front of patients and families
- Physical actions that threaten others such as throwing or knocking down objects
- Inappropriate physical touching or contact
- Inappropriate communication of protected healthcare information whether in verbal, written or electronic format
- Disparaging remarks about other healthcare providers or facilities
- Illegal activities

Clinical Responsibilities, Teamwork, and Transition of Care

Transition of Care - Hand Offs

The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Transitions of Care.** *Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Clinical responsibilities for each resident is based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. Residents care for patients in an environment in which they are provided opportunities to work as a member of an interprofessional team that are appropriate to the delivery of care in the speciality of orthopaedics and in the larger health system.

Hand Off Policy: Froedtert Memorial Lutheran Hospital

The following protocol was established to ensure continuity of care and standardize the handoff process. All residents are expected to be fully compliant. As such, this protocol is applicable to all residents on the inpatient orthopaedic services and those residents taking call at Froedtert Hospital including:

Trauma, Oncology, Foot, Spine, Adult Joint Reconstruction, Hand & Upper Extremity, Sports Medicine

Each service maintains an electronic spreadsheet of patients on that service. The list is accessible by all residents through the hospital hard drive, which is also accessible through remote access from home. These lists are an integral part of handoffs and sign-outs and include, but are not limited, to the following information:

> Patient name, age, room number, date of admission, staff covering the patient, relevant medical history, dates of surgery, surgical procedure(s) performed, weight bearing status, anticoagulation, active issues (i.e., abnormal vitals, pending labs), consulting services, and plan for any anticipated events in the near future (i.e., surgery tomorrow, discharge Tuesday)

Weekdays

A hand-off occurs between residents on each service at the end of the workday to the resident's on-call that evening. Critical information on the patients admitted to each service is passed to the on-call resident through a formal, verbal sign-out. Emphasis is placed on any patient who is anticipated to need care during the night, or for those patients having surgery the following day. In addition, the on-service residents update the list at the end of the working day.

The resident on-call will update patient lists on the respective services with new admissions, consults, or any other pertinent changes. The on-call resident will also contact the resident team covering each service for a sign-out, again with emphasis on any significant overnight events on admitted patients and new patients. The on-call resident also performs a formal sign-out in the early morning following call with the orthopaedic trauma team, including the staff.

Weekends and Holidays

Patients are verbally signed out in advance to the residents expected to round that weekend and to those residents that are on-call, who are covering for their service. This handoff also includes the material listed on the shared spreadsheets with an emphasis of any active issues (i.e., concerning wound) and upcoming events (i.e., procedures, tests, discharge)

The on-call resident relays significant overnight events (i.e., blood transfusion, fever, new consult) on admitted patients to the resident rounding that weekend. Staff (who are not necessarily on-call) are routinely contacted on the weekends with updates of patients on their service. This sign-out is also given to the next resident on-call.

Hand Off Policy: Children's Hospital of Wisconsin

General Rounding Guidelines:

- All residents (including the Chief) rotating at Children's Hospital (CHW) will round each weekday morning and evening as a team.
- Weekend rounds will be conducted by CHW residents.
- Information (about inpatients) both verbal and written (via Electronic Medical Record) will be shared by all residents at CHW after rounding or admitting new patients.
- Coverage on weekdays and weekends by non CHW residents
    - CHW residents will pass pertinent patient information both verbally and written (through Electronic Medical Record) to non CHW residents that are covering evening and weekend calls.
    - Non CHW residents will call CHW residents by 6:00 am the following morning of on-call to update them both verbally and written (through Electronic Medical Record) even if there are no new admissions
- Rotation change: The on-coming team will round with the off-going team on the Sunday of the rotation change.
- Further responsibilities and information are available in the Pediatric Orthopaedic Rotation Packet.

Resident Call and Coverage

The call schedule has been designed to abide by the rules set forth by the ACGME resident guidelines. These guidelines are strictly enforced with zero tolerance for non-compliance.

Froedtert Hospital – Orthopaedic Trauma On-Call

- The Administrative Chief Resident is responsible for making the resident call schedule. Donna Miskov (414-955-3242) enters the call schedule on the AMCOM system. Any changes required in the call schedule after it is published should be made by contacting Donna Miskov.
- Consultations are taken by the orthopaedic pager carried by a member of the orthopaedic trauma team from 7AM-4:30PM on weekdays.
- On weekdays, primary call is taken by an intermediate level resident (**PGY-2**, **PGY-3**) from 4:31PM until 6:59AM.
- On weekends and holidays, primary call is taken by an intermediate level resident (**PGY-2, PGY-3**) from 7AM until 6:59AM the following day.
- A senior resident also takes call during these times and is available to assist the intermediate resident and to assist with cases that go to the OR.
- A staff member takes call during these times and is available to assist the residents and must be notified of any case that requires an immediate operation.
- The traction tech is to be paged by nursing staff to set up skeletal traction on any patient for whom it is ordered.
- Residents must notify the covering staff the following morning of non-urgent consults.
- Faculty call schedules change often, so be sure to check the appropriate **web-based On-Call system** each day you are on call so that the correct orthopaedic surgeon is identified for consultations.

Orthopaedic Trauma Service Expectations

CONSULTS

- See every consult to start until you know what consults don't need to be seen
- X-ray all joints above and below the injury
- Thoroughly evaluate for open fractures
  - take down splints put on by outside hospitals
  - look at the entire extremity to evaluate for open fractures (lift up extremities to make look for wounds posteriorly)
  - do not trust the ED or trauma's exam
- Upload consents in Haiku
  *Remember to add serial to I&D and consents for VACs, as well
- Look at all images that could show an orthopedic injury (i.e. look at scapulas on CT chests, femoral necks on CTs of the pelvis, etc) even if you were only consulted for an ankle fracture.
  *Follow up on all reads on images.
- **Pelvic Ring Injuries**:
  - Order Inlet/outlet/AP pelvis x-rays
  - Order thin cuts of CTs for pelvic rings

- **Acetabular Fractures**:
  - Order AP/Judets
  - Order thin cuts and 3D recons for all acetabular fractures
- **Femur Fractures:**
  - If they have a CT abd/pelvis and they have a femur fracture, order thin cuts to look for a femoral neck fracture. (place a new order for CT pelvis and in the comments write thin cuts pelvis off previous CT c/a/p or call CT)
- **Shoulder Dislocations**: get axillary x-rays to document the reduction (sling and swathe view if cannot get an axillary)
- **Distal Tibia Shaft Fractures**: Dr Schmeling is ok with distal tibia shafts going into short legs. Dr Beck and Dr Martin are not. Put on a long leg splint unless you know it's going to Dr Schmeling.
- Follow up on patients you get called about who you recommend d/c home from the ED. Know if they end up getting admitted so they can be placed on the list and made NPO if they have an operative injury.
- If nonurgent injuries get admitted, make them NPO just in case (ankles, tibias)
  - Dr Martin & Dr Beck are usually ok with nailing tibias the next day
- Make sure injuries that are immobilized above the knee get DVT ppx. Tell the ED the dose. Use your discretion about DVT ppx in injuries that don't normally require DVT ppx if they have risk factors for blood clots.
- Do not say in consult notes "recommend 30 mg Lovenox bid" or "DVT PPX per primary". Instead, say what needs to be given so it will get done.
- Do not recommend the primary team order some X-ray or an MRI. Just order it yourself. It will likely not get done otherwise.
- All stuff going home from the ED gets seen in clinic next available appointment. Not in 7-10 days.
- Do not be on an island. Call you senior if you can't get a reduction or aren't sure about something. Be mindful of what you're calling about in the middle of the night and try to have read and have a plan when you call. But if you really don't know what to do, ask for help. Same goes for seniors calling staff.

ROUNDING *(timing, handover to on call resident, communication to chief/staff)*

- ALL senior residents are expected to round with their teams to direct care and teach each weekday unless on leave
- On weekends and holidays, the resident rounding on the OTS patients and the residents rounding on other team's patients (i.e., Oncology, Arthroplasty, etc.) will begin at or before 0700 and be done by 1000
- Handoffs must occur on weekends/holidays from the resident(s) rounding (OTS, Oncology, Arthroplasty, etc) to the on-call person for any significant patient issues
  - Handoffs will occur Monday – Friday with the faculty or chief resident

Monday: Outside IPP area, third floor at 0700 if no conference & 0715 if there is a conference, with OTS faculty

Tuesday: Outside IPP area, third floor at 0700, with OTS faculty

Wednesday: Before teaching conferences with senior resident on trauma service

Thursday: Outside IPP area, third floor at 0700, with OTS faculty

Friday: Orthopaedic Clinic 0800, with OTS faculty

- Handoffs for all cases Fri-Sun will be seen by OTS faculty if they are on call at 0800 outside IPP area, third floor OR will be presented on Monday at Handoff if an OTS staff is not on call
- The Orthopaedic Trauma Service "LIST" is critical to assist in communication and handoffs. It must be accurately kept up to date including surgical procedures by the residents on the OTS and residents on call
  - On call residents are expected to add ALL inpatient consults and admissions with accurate notes on diagnoses and procedures
  - The "List" is owned by the PGY2 on the OTS. The PGY4 is responsible for the PGY2.

POSTING CASES

- Post for everything to be done in the procedure section (**not in the comments section**) so everything gets picked and pans are ready.
- When you add a procedure to the procedure section, it generates a "pick card" for the OR regarding what instruments to have available.
  - Do not use antegrade nail (post for TFN or recon nail or retrograde nail)
  - If Dr Beck is doing a femoral shaft, it can still be posted for a retrograde nail (it's the same bed and nail whether it's being placed antegrade or retrograde)
  - Post for debridement + whatever else to be done
  - **Pelvis:** if you think it's just percutaneous screws, post for just that. ORIF pelvis pulls a lot of pans.
  - **Acetabulum:** if you know what approach is gonna be used, put that in the comments so the OR knows. If you're not sure, do not write anything and ask.

LIST/DOCUMENTATION

- In consult notes, please do not document that you discussed the plan of care with anyone that you actually didn't discuss it with prior to signing the note
- Please keep the list updated with all injuries including non-orthopaedic injuries.
- Make sure Progress Notes have all ortho injuries and Discharge Summaries, too. Otherwise, the correct X-rays won't get ordered for clinic.
- Make sure the correct staff who needs to see the patient in follow up is documented in Progress Notes and Discharge Summaries. When there are multiple staff listed, it makes it confusing for the trauma clinic nurses to know who to schedule patients with.
- Orthopedic sign off notes should be written with full plans. Do not forget injuries on this, especially non-operative fractures

PATIENT CALLS

- You are ALWAYS expected to speak with the patient. No exceptions
  - If you are in surgery, ask nurse to let call center know when patient should expect a call back
- No narcotics are prescribed off hours, tell them to call faculty office next business day
- DO NOT default to "send patient to ED"
  - Do not tell the access center RN's to send patient to ED
  - Patients may be sent to the ED but only as a last resort if their concern cannot be addressed/solved over the phone
  - If you do send a patient to the ED, call the triage desk and let them know the patient is coming in and what your evaluation plan is.

SENIORS

- Help the juniors. Teach them. Come into see a consult with them if there's a question.
- Weekend call - seniors should know what the cases are, have a plan for each patient and the order, know who's cleared and who's not. Call staff early in the am to go through the plan. You may want to call staff the night before and ask when they want to be called in the am.
- On call, it's expected that the junior is in the OR helping with cases unless there is an urgent consult to be seen. Other nonurgent consults should be triaged appropriately.
- Everything needs to get signed out at some point. Weekends with **Trauma Staff** if they are on call. otherwise Monday am. Consults seen during the weekday need to get staffed fully. No consults should come to the **Orthopaedic Faculty's Inbox** without getting discussed by the next day.

OTHER

- Read Tiffany Mauer's Tip Sheet when she sends it out when you start on the trauma service and follow it appropriately.
- Use the PA's as resources. They know their attending's preferences.

Froedtert Hospital – Hand Trauma On-Call

Hand Trauma call is split between the Orthopaedic Surgery and Plastic Surgery attendings at Froedtert and Children's Hospitals. Hand call is taken in typical 1-2 day blocks. When the Orthopaedic Hand staff is on call, the Orthopaedic resident (**PGY-2** or **PGY-4**) is the primary "Hand Trauma call" with a Hand fellow and attending available at all times should the junior residents need assistance. All Emergency Department consults seen by the junior resident are discussed with the fellow and attending as appropriate. Any emergent surgical procedures are managed by the attending, fellow and resident with graduate responsibility as appropriate.

Froedtert Hospital – Spine On-Call

Call for coverage of emergency / new patient spine issues is covered by both Neurosurgery and Orthopaedic Surgery attendings at Froedtert Hospital. Orthopaedic surgery will typically cover spine call for a 7-day block every month, typically Monday-Sunday.

When Orthopaedics is on call for new spine issues: 1) The Orthopaedic resident (**PGY-3**) on the spine service will cover spine call from 7:30AM-4:30PM. 2) Evenings and weekends during spine call week will be covered by the orthopaedic residents on call for general orthopaedic services.

Children's Hospital – On-Call

- The Chief Resident on the Pediatric Orthopaedic service is responsible for making the resident call schedule. Becky Vogel (x337-7320 or RVogel@chw.org) enters the call schedule for CHW. Any changes required in the call schedule after it is published should be made by contacting Becky Vogel.
- Day Call and Consultations are taken by a member of the Pediatric Orthopaedic team from 6AM until 6PM on weekdays.
- On weekdays, primary call is taken by an intermediate or senior level resident (**PGY-2**, **PGY-3**, and **PGY-4**) from 4:30PM until 6AM.
- On weekends and holidays, primary call is taken by an intermediate or senior level resident (**PGY-2**, **PGY-3**, and **PGY-4**) from 6AM until 6AM the following day.
- A staff member takes call during these times and is available to assist the resident and must be notified of any case that requires an immediate operation.
- Faculty call schedules change often, so be sure to check the appropriate **web-based On-Call system** each day you are on call so that the correct orthopaedic surgeon is identified for consultations.

Unscheduled (new consult) patients will be seen by the resident and discussed with the attending on call, unless a specific attending is requested by the parents or referring physician. The resident should contact and discuss with the attending all cases except those in which:

- The diagnosis and treatment are obvious
- The risk of complications or problems is extremely low
- The family and referring physician do not object to the resident providing treatment without attending contact.

You are responsible for anything you perform on a patient if you do not notify your attending. Document in the Emergency Room Record that a case was discussed with your attending whenever such discussion has occurred. Do not omit this documentation. This documentation protects you. **Every** patient seen in the Emergency Room must be staffed (that night or following AM) with the attending on call, or the Chief Resident.

Each patient must have a note in the electronic medical record noting the following information: Patient name; date; time; and referring physician (ER staff); diagnosis; treatment; and follow-up. It should be stated at the beginning of the dictation/note that it is an "Emergency Room Consult/Procedure Report". Non-emergent cases (routine care and simple casting) may be staffed on rounds the next morning. Do not take any materials from the cast room without notifying the clinic manager.

- Residents must notify the covering staff the following morning of non-urgent consults
- Cases seen over the weekend which require urgent operative intervention within the next week shall be discussed with Julie Desorcy (if they are in-house). If they went home from the ED, then call the nurse line at 266-2411 or e-mailed to the Staff responsible and their administrative

assistant. These names are found in all the clinic work spaces. Leave the patient's name, medical record number and the staff responsible.

- Parent calls will be relayed to Julie Desorcy and the Staff responsible for the patient on Monday morning following call weekend. Parent calls will be discussed with Julie Desorcy and the Staff responsible for the patient the day following call.

1. When the Junior Resident is on call, the Chief Resident is on call.
   a. The Junior Resident may do consults independently, but they all need to be discussed with the Chief Resident.
   b. ED consults requiring intervention (e.g. reduction) will need the Chief Resident present until the final radiographs are obtained and a planned is formalized.
      i. This is in effect both during the day and night.
      ii. The junior resident may discuss the case, review radiographs and formulate a plan with the chief resident over the phone. However, the Chief Resident needs to be present at the start of conscious sedation.
      iii. This will be in effect until the junior resident has met certain competencies.
      iv. To establish competency, consultations and fracture reductions will need to be presented to the responsible staff.
2. If the Chief Resident is not available, then the Senior Resident (PGY-4's) will step in as the Chief and the above rules apply.
3. The Chief Resident or Senior Resident is responsible for discussing any questions or surgical cases with the staff.

Children's Hospital - Spine Call Guidelines

Spine call is split based on anatomic location of injury and is shared between Orthopedics and Neurosurgery. While taking call at Children's Hospital, the orthopedic resident will be responsible for the injuries outlined below every day. Unlike in the Froedtert call pool where there are specific days that are covered by Neurosurgery and Orthopedic surgery, while at Children's we cover spine every day.

Orthopedics Manages:

- Thoracic spine injuries without neurologic deficit
- Lumbar spine injuries without neurologic deficit

Neurosurgery Manages:

- All cervical spine injuries
- Any cervical, thoracic and lumbar spine injury with a neurologic deficit
- All spine injuries (including thoracic and lumbar spine trauma) in patient with a neurologic deficit due to a head injury

Brace Ordering / Hangar Orthotics

1. Place order in Epic for brace/prosthesis and specify the specific device needed.
2. Call the appropriate number as outlined below

3. Communicate the plan to the ED or floor communicator so they can fax the script to Hangar
    - Weekday, business hours braces (Hours Monday – Friday 8:30 AM – 5:00PM)
        - Call: 414-266-6990
    - After hours/weekends braces
        - Call: 414-322-8889

Workflow

As with all issues while taking call, if you see a patient and are comfortable with the injury and treatment plan, you can execute it. If you have questions, then you can contact your faculty. If your faculty is uncomfortable managing the injury, then you may contact the faculty on backup call. Backup faculty will be the day call staff from the preceding workday

Follow Up

2 courses of action for follow up depending on the patient:

1. Isolated spine trauma – Will follow up with the spine team including Drs. Thometz, Tassone, and Escott

2. Combined spine trauma and extremity trauma – Will follow up with the on-call staff. As with all call patients, if a patient is admitted while on call with one of the adult surgeons taking call at CHW, the patient will follow up with the day call staff from the preceding work day. For weekends, follow up should be arranged with the staff on Friday day call.

Escalation of Care Policy

Alert Senior Resident/Chief for:

- All new admissions and consultations
- Sudden decline in mental status
- Sudden worsening of neurologic function in extremity
- Sudden drop in SaO2 > 8% from baseline
- Worsening of medical condition requiring urgent consultation to another service (Medicine, Cardiology, Respiratory, Neurology, etc.) or transfer to a higher-level unit of care
- Death of a patient
- Code 4 called for a patient
- Pain out of proportion to expected level based on procedure/injury; not controlled by narcotics; worrisome for compartment syndrome
- Concern for post-op wound infection – increased wound drainage, redness, etc.
- A family or patient is requesting patient representative to make a formal complaint
- End of life

Alert Attending Physician for:

- All new admissions and consultations
- Worsening of medical condition requiring transfer to a higher-level unit of care
- Death of a patient
- Code 4 called for a patient
- A family or patient is requesting patient representative to make a formal complaint
- End of life decisions and discussion
- Senior or Chief concerned about the medical/surgical condition of a floor patient
- Any patient taken to the operating room On Call

Whenever there is a transfer of a surgical case from a night call attending to a trauma room attending or to weekend call attending or from the daytime trauma room attending to the night call attending communication about the transfer will be done at the attending to attending level for these situations and not be left to the resident. This is important and will help facilitate efficiency in patient care.

Resident Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. The orthopaedic residency program, in partnership with MCWAH, are committed to making wellness a priority.

Residents are provided the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

Well-Being Index

The Well-Being Index is a tool to help residents and faculty to assess their well-being. It is an anonymous online self-assessment **which provides immediate, individualized feedback including tools and local and national resources to help faculty enhance their well-being.**

The Well-Being Index tool is based on validated research conducted by the Mayo Clinic and is offered to MCW faculty and MCWAH residents as a free resource.

Assess Your Well-Being Online (Code=MCWAH)

Resident Behavioral Health Program

All inquiries and treatment are held in the strictest confidence.

MCWAH is aware of the multiple demands of residency training. In an effort to meet the unique needs of the residents, a Resident Behavioral Health Program has been designed to assist MCWAH housestaff in obtaining the highest quality of behavioral health care in a confidential manner. This benefit also applies to spouses and children.

Types of Problems

Resident Mental Health Services provides a comprehensive program designed to meet the professional and personal needs of you and your family. We offer counseling and therapy for personal and job-related issues. These issues may include but are not limited to: Anxiety, Depression, Substance abuse, martial concerns, sexual dysfunction as well as child adolescent and family problems.

Call Resident Mental Health Services at (414) 955-8933 Monday through Friday, 8:00 am to 5:00 pm.

If you are calling after hours or on the weekend, please leave a message. We will return your call the next working day.

In case of an after-hours emergency, please call (414) 805-6700 and ask for the Department of Psychiatry clinician on call. This clinician will be contacted by the paging operator and will get back to you as soon as possible.

Fatigue

*The Orthopaedic Surgery Residency Program complies with the MCWAH's **Housestaff Fatigue** Institutional policy. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The Orthopaedic Residency Program strives to provide a supportive environment with high quality education and safe, effective patient care. Orthopaedic faculty and residents are educated to recognize the signs of excessive fatigue and sleep deprivation as well as utilizing fatigue management and the fatigue mitigation processes when appropriate.

Faculty receive education on fatigue and substance abuse training via MCWAH's web videos **Sleep Related Fatigue** and **Substance Abuse**. All residents are required to complete Sleep-related Fatigue and Substance Abuse courses via Desire2Learn (D2L) Platform.

To prevent and counteract the potential negative effects of fatigue and stress, the following measures have been implemented: strict adherence to the 80-hour maximum duty period length, and one-day-off in seven standards. Residents who approach the 80-hour limits or the 24+4 hour limits are instructed to notify the attending physician, chief resident on service, the Program Director and/or the Associate Program Director at which time they will be relieved of duties.

The following is a general guideline for those recognizing or observing excessive resident fatigue and/ or stress.

Attending Physician:

- If the attending physician or senior resident notices evidence of excessive fatigue and/ or stress, the resident should be released from any further patient care responsibilities at time of recognition.
- The attending or senior resident should privately discuss his/ her opinion with the resident, attempt to identify the underlying reason for the fatigue, and discuss the amount of rest needed to alleviate the situation.
- The resident should rest at the hospital (call room) prior to driving home or be advised that the Orthopaedic Residency Program will reimburse the resident for the cost of a taxi for a ride home. The resident will need to provide the taxi receipt to Deb Soik In order to be reimbursed.

Residents:

- Other residents who notice a colleague's fatigue have the professional responsibility to notify the supervising attending or chief resident without fear of reprisal.
- A resident who feels fatigued has the professional responsibility to notify the supervising attending or chief resident without fear of reprisal.

Program Director/ Chairman:

If the problem is recurrent:

- The resident's call schedule, patient care responsibilities, and personal problems/ stressors will be discussed.
- The rotation will be reviewed for potential changes and improvements.

Post-Shift Fatigue Resources

Post-Shift Fatigue Resources - sleep facilities if you are too fatigued to safely return home.

Stress*

Residents may experience periods of mild to profound distress at some point during their training years. Often this is a temporary response to demands of the training. Stress occurs when the individual perceives that the demands or constraints of the situation exhaust personal and other resources. To offset the imbalance, each of us relies on physiological, psychological or behavioral processes. These coping processes may be adaptive or maladaptive. Generally, an adaptive coping mechanism is one which deals with the source of the stress, thereby alleviating its effects. A maladaptive response is one which ends up ignoring the effects of stress or dealing with its symptoms without treating the underlying cause.

The psychiatric sciences have provided no hard and fast rules regarding appropriate coping strategies. For example, after a difficult and frustrating day at work one might go out for a drink. If the time is spent with friends and the alcohol allows you to blow off steam talking over the day's events, it is probably adaptive in the short run. If one drinks alone, in excess, or without discussion of the problem, alcohol is merely providing symptomatic relief. This could be maladaptive - a hangover the next day and a stress-related drinking pattern in the future.

Acute or chronic job stress which is dealt with inappropriately can potentially impair the individual in his professional or personal capacity. The AMA defines physician impairment as the inability to practice medicine safely due to physical or mental disability, including substance addiction. Conservative estimates suggest that 1 in 10 physicians may be impaired in their technical ability to function as a doctor. Not included in these morbidity figures are those who die prematurely; physician suicide is quite high compared to the general population. It has been estimated that for all physicians under the age of 40, suicide is 3 times as likely among female physicians and 4 times as likely among male physicians, as compared to the general age adjusted population. Excluding suicide, alcoholism and drug addiction account for the equivalent of 7 medical school classes of physicians lost per year.

Stress that is not dealt with adequately more often results in a subtler form of emotional impairment not included in the statistics: depression, chronic anger, anxiety and controlled substance abuse. These in turn may manifest themselves in marital problems, divorce, sexual dysfunction and self-destructive habits or risk-taking.

There are few adequate statistics concerning stress-related problems in residents. The stressors indigenous to the training have been chronicled: sleep deprivation; financial worries due to school debts; discord between academic medicine and the realities of practice; and perpetually changing workloads. Other sources of strain can include: the "crisis of competence"; the unmotivated, uncooperative or ungrateful patient; disproportionate amount of "scut work"; and frustration in developing supportive and collaborative relationships.

**Section taken from MCWAH" s Housestaff Handbook*

Symptoms of Stress

How much stress is a problem? This is largely a question of self-examination. One indication is your outward behavior. Are your feelings getting in the way of performances as a physician or spouse? Has your behavior been cause for comment or concern by a friend, a colleague, or those who love you? Listed below are symptoms which may indicate that a person is having difficulty with stress. One or another in isolation may not be necessarily significant, but when patterns of problems develop in various areas and the usual methods of coping are not successful, it's time to look for professional help. This may be an opportunity for even greater growth on your part and can lead to being a more skilled and artful physician.

The stress-related symptoms include:

Attitudinal

Loss of positive feelings toward patients
Cynicism regarding patients
Stereotyping patients and co-workers
Self-preoccupation
Rigidity in thinking
Inappropriate responses to patients
Inappropriate involvement with patients

Drug & Alcohol Use

Mention of death wish or suicidal thoughts
Slowed behavior and attention
Chronic exhaustion off and on work
Risk-taking behavior
Tearfulness
Flat or sad affect
Excessive agitation, edginess
Wide swings in behavior or mood
Self-medication with psycho-tropic drugs
Alcohol on breath at work
Uncontrolled drinking
Blackout drinking
Complaints or nervousness of spouse/partners regarding social drinking

Emotional

Discouragement & sense of failure
Indifference
Suspicion
Negativism
Sense of futility
Depression
Feeling immobilized
Anger and resentment

Hospital Behaviors

Unexplained absences
Spending excessive time at hospital
Coming in late inappropriate to caseload or needs of peers
Decreasing quality of or interest in work
Inappropriate orders
Postponing or resisting from co-workers
Isolation and withdrawal
Increasingly going “by the book”
Inappropriate responses to telephone calls
Clock watching
Inability to concentrate or listen
Overmedicating patients for behavior control
Moroseness and increasing difficulties with other staff

Physical

Sleep disorders
Deterioration in personal hygiene or appearance
Multiple physical complaints
Accidents
Eating Disorders
Fatigue, exhaustion

Social

Withdrawal from outside activities
Isolation from peers
Interaction with police
Driving while intoxicated
Behavioral excess
Unpredictability

Family

Fights
Disturbed spouse
Sexual problems - impotence, extramarital affairs
Separation or divorce proceedings
Withdrawal from family members, contact with patients

**Section taken from MCWAH” s Housestaff Handbook*

Response to Stress

Regardless of the training program you've chosen, stress is inevitable. Your response may be unplanned, and basically a reflection of how you subconsciously cope with many of life's stresses. Or the responses may be the result of insightful reflection on the nature of the situation and on the coping strategies you find effective. What can a resident or fellow do? It is difficult to change most of these external realities. Your primary source of control lies in educating yourself to the upcoming risks, to those variables within yourself which predispose you to risk, and how you can deal adaptively and effectively in your responses to those conditions. Even the most well-intentioned program cannot do that for you.

The decision to seek support or advice may be made confidentially. The most important thing to remember is that, if you feel "backed up against the wall", call the **Behavioral Health Center (414) 955-8933**. Stress relief is often brief and easy to accomplish. Often, therapy is something worth considering.

Stress Resources

The following additional resources are available to deal with stress:

Resources Available Within the Milwaukee Community	
• MCWAH Behavioral Health Center	(414) 955-8933
• Milwaukee County Crisis Hot Line	(414) 257-7222
• Help Line (Impact 211)	(414) 773-0211
• Women's Crisis Line	(888) 542-3828
• Mental Health Association of Wisconsin	(414) 276-3122
• Alcoholics Anonymous	(414) 771-9119
• IMPACT (Milwaukee Council on Alcohol and Drug Dependence)	(414) 649-4380

**Section taken from MCWAH" s Housestaff Handbook*

Alcohol & Substance Abuse

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy **Alcohol and Substance Abuse Diversion**.*

Abuse of drugs and alcohol by healthcare providers can have serious adverse effects on patient safety and the health and well-being of those who abuse such substances. It also impacts performance and safety of others in the workplace.

MCWAH and the residency program does not tolerate the use of alcohol and/or controlled substances without a valid prescription from a treating physician in the workplace. MCWAH has a zero-tolerance policy for the diversion of controlled substances, pharmaceuticals and medical supplies. Failure to comply with this policy will result in disciplinary action that may include termination from the training program.

Work Hours

*The Orthopaedic Surgery Residency Program complies with the MCWAH's **Work Hours For Housestaff** Institutional policy. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The residency program in partnership with MCWAH is committed to provide residents with educational and clinical experience opportunities as well as reasonable opportunities for rest and personal activities.

Clinical working hours (formerly Duty Hours) are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Residents must be given opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours *must be* limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

All clinical, research, and academic activities related to the residency program must be counted against your duty hour limits. This includes: patient care, In-house call, night/day float, patient handoffs, administrative duties that you do for patients or for the program such as interviewing resident candidates.

If you are on call at-home and return to the hospital, those hours spent in the hospital are counted towards the 80-hour limit. However, reading and preparing for conferences away from the hospital such as the library do not count.

When calculating your hours per week, look at the length of the rotation. If you take vacation while on the rotation, exclude that amount of time when averaging your hours per week. For example, if you are on a four-week rotation and take a week of vacation, you must not average more than 80 hours per week during the remaining 3 weeks to be compliant with this duty hour requirement.

Mandatory Time Free of Clinical Work and Education

Residents should have 8 hours off between scheduled clinical work and educational periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of clinical experience and education. This must occur within the context of the 80-hour and 1 day off in 7 requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents must be scheduled for a minimum of 1 day in 7 free of clinical work and required education (when averaged over 4 weeks). At-home call *cannot* be assigned on these free days.

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

- Up to 4 hours of additional time may be used for activities related to patient safety, such as providing effective transition of care, and/or resident education.
- Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- to continue to provide care to a single severely ill or unstable patient
- humanistic attention to the needs of a patient or family; or,
- to attend unique educational events

These additional hours of care or education will be counted towards the 80-hour weekly limit.

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety

Time spent by residents in internal moonlighting must be counted toward the 80-hour maximum weekly limit.

PGY-1 residents are not permitted to moonlight

In-House Night Float

Night float must occur within the context of the 80-hour and 1-day-off-in-7 requirements. Night float may not exceed three months per year.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequency than every 3rd night (when averaged over a 4-week period).

At-Home Call

Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly 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 free of clinical work and education

when averaged over four weeks. 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 provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

MCW Orthopaedic Surgery 1 to 5 am Rule

Any junior resident (**PGY-2** or **PGY-3**) on home call who is physically in the hospital between the hours of 1am and 5am for "on call" activity must be dismissed home by 8am that morning and may not return until the following morning. Any senior resident (**PGY-4** or **PGY-5**) on home call and physically in the hospital between the hours of 1am and 5am for "on call" activity may use their discretion as to their level of fatigue and may dismiss themselves home by 8am that morning.

Recording Work Hours

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Work Hours for Housestaff**. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Honest and accurate recording of work hours is an ACGME program requirement. All residents are required to record their work hours in the New Innovations Residency Management Suite (NI) on a **DAILY** basis. Failure to comply with this requirement may result in a probationary status for lack of professionalism and this will become a permanent part of the trainee's file. Lack of compliance will not be tolerated. The Residency Program Coordinator and Director will check compliance with this policy regularly.

If, during the academic year, the resident is delinquent in entering time into New Innovations:

- On the first occurrence, the resident will receive an e-mail notifying the resident they are in violation of the Policy from the Program Director's office.
- A second occurrence within the academic year will result in a "letter of serious concern" from the Program Director and will be attached to the resident's permanent records.
- A third occurrence will result in the resident meeting with the Designated Institutional Official (DIO) of MCWAH. During that meeting the DIO will consider placing the resident on suspension without pay or possibly reporting the resident to the Wisconsin Medical Examining Board for the "pattern of unprofessional behavior". This could result in the resident losing their license to practice medicine.

Recording Hours in New Innovations

3 Categories to use when recording work hours:

- **Working** – regular scheduled work hours or shift, conferences, administrative meetings
- **Pager/Home Call-Working** – (replaces Pager/Home Call-In Hospital) time spent doing clinical work in the hospital or elsewhere ex. home
- **Pager/Home Call-Not Working** – (replaces Pager/Home Call-Not in Hospital) time NOT involved in clinical work
- **Moonlighting**

Vacation Time is entered by the Residency Program Administrative Staff.

Moonlighting

*The Orthopaedic Surgery Residency Program complies with the ACGME's Common Program Requirements and MCWAH's Institutional Policy on **Moonlighting**. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Purpose

The purpose of this policy is to outline the moonlighting requirements for residents

MCWAH Moonlighting in General

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. The Program Director will monitor the resident performance and may prohibit or rescind approval of moonlighting if he/she believes the 0resident's performance in the program suffers, or for any other cause deemed appropriate.
2. Resident's in Formal Counseling, Probation, or on Administrative Leave as described in MCWAH's "Management of Substandard Housestaff" Policy are prohibited from moonlighting.
3. All moonlighting hours must be counted along with the resident's other work hours. The total number of hours worked must comply with the ACGME clinical experience and education standards.
4. The program will maintain documents related to resident's moonlighting activities in file.

Internal Moonlighting for MCWAH Employed Resident

1. Internal moonlighting is defined as additional hours worked voluntarily at a MCWAH affiliate that are beyond the training program's regularly scheduled hours. Internal moonlighting hours are considered part of training.
2. All internal moonlighting performed by MCWAH employed resident must be consistent with the scope of practice within the medical classification of their given Graduate Medical Education training program.
3. All internal moonlighting performed by MCWAH employed resident must be under the supervision of an attending physician.
4. Internal moonlighting performed by MCWAH employed resident is considered to be part of training; therefore, professional liability insurance for medical malpractice is provided by MCWAH.

Program Internal Moonlighting

1. Only PGY4 & PGY5 Residents are allowed to do Internal Moonlighting at the OrthoNow Clinic at the Sports Medicine Center
2. Internal Moonlighting is not allowed while on the Orthopaedic Trauma Rotations
3. Residents must records hours worked as "Moonlighting" in New Innovations in order to get paid
4. Supervising Faculty: On-call Froedtert Orthopaedic Faculty
5. Internal Moonlighting is voluntary
6. Be sure to log cases you see appropriately in the ACGME Case Log System.

Epic Documentation - When Covering OrthoNow

1. Documentation needs to include the line indicating who the indirect supervising faculty was. The supervising faculty should be the faculty that is on call for that day.

2. You are responsible to enter all components to complete the encounter. Meaning the chief complaint, the note, the diagnosis, any applicable procedure charges and the level of service.

3. Encounters should be completed by the end of the shift. On Monday morning, Heather Rivera will review for accuracy and close the encounter. She will provide feedback, as needed, regarding any coding or billing concerns.

Operative Case Logs Recording Policy

The Orthopaedic Residency Program requires residents to record their operative case experiences as well as closed fracture care cases seen in the ER, outpatient clinics, and in-patient consults into the ACGME Resident Case Log System on a **daily** basis to ensure the information they are entering is accurate and complete.

The Residency Program monitors and reviews residents ACMGE Case Logs on a weekly basis (9:00 am Monday morning) for compliance with this policy. Failure to comply with this policy may result in a probationary status for lack of professionalism and become a permanent part of the trainee's file. Lack of compliance will not be tolerated.

If, during the academic year, the resident is delinquent in entering their procedure log:

- On the first occurrence, the resident will receive an e-mail warning from the Program Director's office.
- A second occurrence within the academic year will result in a "letter of serious concern" from the Program Director and will be attached to the resident's permanent records.
- A third occurrence will result in the resident being placed on suspension without pay until the resident has accurately completed their case log. They will also need to meet with the Designated Institutional Official (DIO) of the MCWAH. During that meeting the DIO will consider reporting the resident to the Wisconsin Medical Examining Board for the "pattern of unprofessional behavior". This could result in the resident losing their license to practice.

ACGME Case Log Guidelines

ACGME Case Log Guidelines – Review Committee for Orthopaedic Surgery

Guidelines Include:

- Level 1 or Level 2 Procedural Experience
- Orthopaedic Surgery Case Log Definitions
- Frequently Asked Questions
- Types of Case Log Reports

Board Certification

Board certification for orthopaedic surgeons is through the **American Board of Orthopaedic Surgery**.

Board certification is a valuable way physicians can demonstrate their commitment to the highest quality care, and to receive recognition for the many long years of work they have put into achieving expertise. Board certification sets the physician apart as a recognized specialist in the eyes of patients, hospitals, employers, and insurers. Certification is the gold standard for medical specialization in the United States.

Board certification is a voluntary process. It is different and distinct from licensure to practice medicine, a function regulated by state government. A valid medical license is required to be Board certified, but certification is not necessary for licensure. A Board-certified physician has met certain standards and passed tests that are developed to assure the public that he or she has been adequately trained in a given specialty.

Education

In order to be allowed to begin the process of becoming Board certified, a surgeon must be a graduate of an accredited four-year medical school and have successfully completed a five-year accredited orthopaedic residency program in the United States or Canada. The final 24 months of the training must be obtained in a single program.

Part I: Written Examination

Upon successfully completing an accredited orthopaedic residency program, you may apply to take the written examination. The exam is a timed, secure, computer-administered consisting of approximately 320 multiple choice questions covering all of orthopaedics. It is given at Prometric testing sites throughout the United States on a single day in July. It involves eight hours of testing time divided into seven sections.

A surgeon who has passed the Part I written examination and is practicing while awaiting admission to Part II is deemed Board Eligible. This term is not appropriate for surgeons who have not passed Part I, or who have been refused admission to Part II. The limit of Board Eligibility is five years; surgeons who have not passed Part II within 5 years of taking Part I are no longer Board Eligible and must re-take Part I before moving on to Part II.

Part II: Oral Examination

After passing Part I, candidates have a period of five years to apply for and pass the Part II oral examination. If they do not, they must re-take Part I to be admitted to the oral examination. It is each candidate's responsibility to know deadlines and make a correct, complete application if they wish to be Board certified. In order to be admitted to the oral examination, a candidate must have a full and unrestricted medical license and have been in practice for 20 months in one location, association and affiliation. The Board will obtain peer review of the candidate from certified orthopaedic surgeons who are familiar with their work, and get evaluations from the hospital chief of staff, chief of orthopaedics,

surgery, anesthesia, and nursing staff in the operating room and orthopaedic wards. This information is reviewed by the credentials committee of the ABOS, who will decide which applicants are admitted to sit for the Part II examination.

After passing Part II, a surgeon receives a certificate and becomes a diplomate of the ABOS for 10 years.

Leave Policies and Procedures

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Vacation and Leave of Absence** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The MCW Department of Orthopaedic Surgery seeks to provide all residents with appropriate time off to ensure resident well-being and to conform to both the ACGME and ABOS regulations. Any time away from the training program must adhere to MCWAH and department policy, and ABOS Board requirements.

Leave Benefits

Holidays

Residents are considered to be available to be scheduled 365 days a year including all religious and secular holidays. Due to variations among programs' training and clinical requirements, requests for time off will be granted based on specific policies of each program regarding scheduling, requesting time off and vacation.

Vacation Leave

Residents are allowed annual paid vacation of three weeks (one week=5 business days), provided the vacation schedule does not conflict with their duties and it is approved by the Program Director. Vacation time is not cumulative from year to year. Unused Vacation Leave is not paid upon completion of training or termination. Residents must request Vacation Leave per **Department of Orthopaedic Surgery Leave Request Procedures**.

Educational Leave

Residents (**PGY-2 and above**) are allowed ***up to*** one week (one week=5 business days) of Educational Leave, without interruption of pay or benefits, contingent upon the approval by the Program Director.

Educational Leave time is not cumulative from year to year and unused educational leave cannot be carried over to another year. Unused educational leave is not paid upon separation of employment or the end of Trainee's term or Agreement.

PGY-1 Orthopaedic surgery residents are not allowed Educational Leave. Educational Leave time is not cumulative from year to year.

PGY-2 and PGY-5 Orthopaedic surgery residents have preset Educational Leave which is reimbursed 100% by the Department of Orthopaedic Surgery. **PGY-2** residents attend the AO trauma course as their Educational Leave. **PGY-5** residents attend the AAOS Annual Meeting as their Educational Leave.

Residents must request Educational Leave per **Department of Orthopaedic Surgery Leave Request Procedures**.

Sick Leave

Sick leave accrues at the rate of two weeks (1 week= 5 business days) per year to a maximum of four weeks from previous academic years. Unused sick leave is not paid upon separation of employment or the end of Trainee's term or Agreement

When ill, a resident will use their previously accrued days first, utilize the two weeks from the current academic year next, and then may borrow two weeks from the next academic year providing their training program extends throughout another academic year. Residents requiring more paid leave than this may utilize Vacation Leave.

In the event that you are sick you must inform the faculty of the service you are working on as well as the Program Director and Coordinator as soon as possible.

FMLA Leave

The program abides by MCWAH's policies and procedures regarding Family Medical Leave Act.

Please refer to MCWAH's Housestaff Handbook for information on Family Medical Leave Eligibility Requirements, Basic Entitlement, Definition of Serious Health Conditions, Benefits and Protections, Use of Leave, and Requesting a Leave of Absence: ***http://www.mcw.edu/GME/Resources/Housestaff-Handbook.htm***

****Residents in the Department of Orthopaedic Surgery customarily take paternity leave of 5 business days, which should be taken within 30 days of the birth of the child.**

Funeral Leave

Residents may be granted up to three days off with pay for funerals of immediate family members, defined as spouses, parents, parents of spouse, grandparents, grandparents of spouse, foster parents, children, grandchildren, foster children, brothers (and their spouses), and sisters (and their spouses). In the event of the death of a close relative, not in the immediate family, a resident may be granted Funeral Leave at the Program Director's discretion.

Jury Duty Leave

While jury duty is considered a civic responsibility, there may be an occasion when residents may wish to request a deferral of this obligation. As a trainee in a Graduate Medical Education program, you may qualify for such a deferral.

Please contact the Program Coordinator to have a letter sent to the appropriate court. There is no guarantee that this approach will be successful.

Interview Leave (PGY-4 Fellowship & PGY-5 Employment)

Orthopaedic surgery residents in their fourth year of training are allowed one week (5 business days) of Interview Leave. These days must be preapproved. Time away from the program on Interview Leave is **not** subject to the "5 day limit" of leave per rotation rule. Residents requesting more than 5 business days will need to use Vacation Leave which is subject to the "5 day limit" of leave per rotation rule.

Orthopaedic surgery residents in their fifth year of training are allowed one week (5 business days) of Interview Leave. These days must be preapproved. Time away from the program on Interview Leave is

not subject to the "5 day limit" of leave per rotation rule. Residents requesting more than 5 business days will need to use Vacation Leave which is subject to the "5 day limit" of leave per rotation rule.

Residents must request Interview Leave per **Department of Orthopaedic Surgery Leave Request Procedures.**

Review Course Leave (PGY-5)

Orthopaedic surgery residents in their fifth year of training are allowed 3 business days of leave to attend a board review course. Time away from the program is **not** subject to the "5 day limit" of leave per rotation rule. Residents must request Review Course Leave per **Department of Orthopaedic Surgery Leave Request Procedures**.

Research Leave

Orthopaedic surgery residents who have a research poster or paper presentation accepted to a national meeting are allowed one week (5 business days) of Research Leave. These days must be preapproved. Time away from the program on Research Leave is **not** subject to the "5 day limit" of leave per rotation rule. Residents must request Research Leave per **Department of Orthopaedic Surgery Leave Request Procedures**.

Mission Rotation (PGY-5)

Orthopaedic surgery residents in their fifth year of training are allowed one week (5 business days) of going on a Mission Rotation. This Global Rotation must be preapproved through MCWAH. Time away from the program on a Mission Rotation is **not** subject to the "5 day limit" since it is a rotation. Residents must request Mission Rotation per **Department of Orthopaedic Surgery Leave Request Procedures**.

Leave of Absence – Effect on Advancement to the Next Level of Training and Completion of Training

Each Member Board of the American Board of Medical Specialties has policies regarding absence from training and the impact that absence may have on the Board eligibility of the candidates. A resident who takes a leave of absence during their residency should communicate with their Program Director to ensure that their total leave time does not exceed the maximum allowed by the Board. The Program Director should communicate with the Specialty Board on behalf of the resident if necessary for clarification.

A leave of absence may necessitate that the advancement to the next level of training be delayed. At the conclusion of the training program, the Program Director must certify that the resident/fellow has mastered each component of clinical competence and has acquired proficiency in each of the various procedural skills identified in the program's curriculum. In the case the trainee does not meet the requirements of the Board because of a sick leave or leave of absence, the Program Director may require the individual to extend the training beyond the usual time required to complete the program.

American Board of Orthopaedic Surgery Time Requirements
The American Board of Orthopaedic Surgery Rules and Procedures state one year of credit must include at least 46 weeks in full-time orthopaedic education. A resident may be absent from their residency program for no more than six weeks during an academic year. An absence exceeding a total of six weeks for any reason during an academic year must be made up. The Program Director will determine how the time is made up.

Department of Orthopaedic Surgery Specific Leave Policies

5 Day Limit: Orthopaedic surgery residents **(PGY-2 and above)** are allowed one week (5 business days) of leave during any single rotation block *(See exceptions below)*. Educational Leave and Vacation Leave are allowed during the same service rotation block but Vacation Leave and Education Leave together must not exceed the maximum of one week (5 business days) during a single rotation. Unused Educational Leave in the same academic year may be used to attend a second educational meeting or course. If the days off for second educational course exceed the previously unused Educational Leave time, vacation days must used. The combined time off still must be within the maximum time off of 5 business days during any given rotation.

Vacations will not be granted for the following days: First and last month of your residency, during an ACGME site visit, the day of the annual Orthopaedic In-Training Examination, and graduation. Vacation leave cannot be taken during the last two full weeks in June or the month of July unless there are extraordinary circumstances. Extraordinary circumstances will be reviewed by the Program Director.

Service Coverage: Only one resident can be on leave from a particular service (hand, adult reconstruction, sports, trauma, pediatrics) or hospital (VAH, CHW) at a time. Only one **PGY-5** resident covering trauma call at FMLH can be on leave at any time (Exception: the AAOS meeting).

Conflicts will be settled by the Program Director based on resident seniority and a first come, first serve basis. Residents should not make any travel arrangements until receiving written confirmation that leave has been approved.

Department of Orthopaedic Surgery Leave Request Procedures

MCWAH Policy on Requesting a Leave of Absence

Housestaff assignments are made by the Program Directors, who must verify that those assignments were met. The Program Director must be notified promptly by the housestaff in the event of absence due to illness or any other reason.

Housestaff should request a Leave of Absence through their programs, using the standard Leave of Absence form that is readily available on MCWAH's website. All Leaves of Absence must be approved by MCWAH and the Program Director. The completed form needs to be promptly forwarded to the MCWAH office by the Program Coordinator. If additional information is needed in order to determine if the housestaff qualifies for Federal Family and Medical Leave (FMLA)\Wisconsin Family and Medical Leave (WFMLA) and\or to approve the LOA, the Program Director or Program Coordinator must contact the MCWAH Office. The MCWAH Office will follow up as needed directly with the housestaff and obtain the necessary information on a confidential basis.

The MCWAH Office does not need to be notified of an absence of seven calendar days or less if the housestaff remains on the payroll (using available sick, vacation, or educational leave days; on jury duty, or similar); nor does the MCWAH office need to be notified if the housestaff is taking scheduled vacation using their available vacation days. MCWAH does not grant indefinite leaves of absence.

Computing Leave Days

Housestaff are considered to be available for duty on a continuous basis throughout their training period and are paid accordingly. In a 15-day pay period, housestaff are entitled to 15/365 of their annual stipend. Thus, when counting leave days, include weekends and holidays. If a housestaff member is ill on a Thursday and returns on the following Tuesday, they should be charged for 5 days of sick leave (Thursday, Friday, Saturday, Sunday and Monday). This method is used for computing all leave days including leave days under FMLA and WFMLA.

PGY-1 residents must submit their vacation leave requests before starting the program on July 1st. The Program Coordinator will notify residents of the exact deadline for requests. **PGY-1** residents should not schedule vacations during their three months on orthopaedic services (adult orthopaedics or pediatric orthopaedics).

PGY-2, PGY-3, PGY-4, and PGY-5 residents must submit leave requests at least 21 days prior to the desired leave dates. Late requests will not be considered.

A resident must submit all vacation requests by using the "Leave Request" form which is available in Dropbox, the Resident Library or the Residency Program Coordinator's office.

Vacation Request Required Procedures:

- A **Leave Request Form** must be submitted to the program coordinator 21 days prior to the first day of start of the leave. Leave requests submitted within 21 days of the requested leave will not be considered. If the program coordinator determines that the resident is eligible for leave, the

coordinator will sign the form and return it to the resident. If the time off requested is questionable, the coordinator will forward the form to the Program Director for approval.

- Once the program coordinator has approved the leave, the resident must submit the form for signature to the senior resident on the service and all Attending Physicians on the service they are assigned. ***Please note for CHW Rotation*: 1st obtain senior resident signature, then to program coordinator who will forward it CHW faculty for faculty signatures
- After obtaining all signatures, the leave form must be submitted back to the program coordinator for logging leave dated into the resident's duty log in New Innovation. The form must be returned to the Program coordinator prior to the start date of the leave. A copy of the form will be placed into the resident's mailbox and permanent fill.

This policy is subject to change at the discretion of the Program Director.

References:
United States Department of Labor, Wage and Hour Division: November 17, 2008. 29 CFR Part 825
The Family and Medical Leave Act of 1993, Final Rule. Federal Register Vol. 73 No. 222.
United States Department of Labor, Wage and Hour Division: WHD Publication 1420.
Revised January 2009.
Updated 07-08 Wis. Stats. Database 103.10
State of Wisconsin, Department of Workforce Development: Wisconsin Family and Medical Leave Act Publication ERD-7983-P (R-01/2010).

Educational Leave Reimbursement Policy

Residents are encouraged to attend national educational meetings once a year. The purpose of this experience is to broaden their education. Approval is required before taking any educational leave.

1. **Scientific Presentation** (must be approved by the Program Director)
   - **a. Paper** at scientific meeting—once per project
     - **i.** A resident will be reimbursed 100% for travel, tuition or registration fee, and hotel room.
     - **ii.** Food is reimbursed at a per diem rate for individual cities
   - **b. Poster** at scientific meeting--once per project
     - **i.** A resident will be reimbursed 100% for travel, tuition or registration fee, and hotel room.
     - **ii.** Food is reimbursed at a per diem rate for individual cities
   - **c.** Paid leave of absence is granted to attend the meeting. One project can be presented for reimbursement only once
     - **i.** If the same project is presented as a poster or paper at another meeting, that meeting will be treated as education leave and will count as that resident's meeting for that year. The reimbursement for this is described below in #2.
2. **Educational Course** (must be approved by the Program Director)
   - **a. AO Basic Resident Course (PGY-2)**
     - **i.** A resident will be reimbursed 100% for travel, tuition or registration fee, and hotel room.
     - **ii.** Food is reimbursed at a per diem rate for individual cities
     - **iii.** Educational leave is used
   - **b. Yearly Education Course (PGY-3 and 4)**
     - **i.** A resident will be reimbursed 50% for travel, tuition or registration fee, and hotel room.
     - **ii.** Food is reimbursed at a per diem rate for individual cities
     - **iii.** Educational leave is used
   - **c. AAOS (PGY-5 year)**
     - **i.** A resident will be reimbursed 100% for travel, tuition or registration fee, and hotel room.
     - **ii.** Food is reimbursed at a per diem rate for individual cities
     - **iii.** Leave is available for the entire AAOS course
   - **d. Review Course (Board Review Course for PGY-5s)**
     - **i.** A resident will be reimbursed 50% for travel, tuition or registration fee, and hotel room
     - **ii.** Food is reimbursed at a per diem rate for individual cities
     - **iii.** Review Course Leave is used (3 business days)
3. **Miscellaneous**
   - **a.** For PGY-5's only: remaining educational leave days become vacation days to be used in accordance with the vacation leave policy.
   - **b.** Completion of education leave form is required as outlined in the departmental leave policy.
   - **c.** Airline tickets must be obtained as soon as the course is approved to get the lowest fare and will be reimbursed at the lowest coach fare available.
   - **d.** Rental cars are not reimbursed unless pre-approved by the program director and must clearly show a cost savings / business purpose. Car insurance coverage is not reimbursed.
   - **e.** Vacation leave is used for travel days to and from a foreign country for all educational meetings and courses
   - **f.** Reimbursement will only be made if the original receipts (including original cancelled check) are submitted along with the course documentation.
   - **g.** The hotel room rate will be reimbursed based on a maximum of $150.00.

h. Tuition/registration fees for the meeting can be paid in advance in some cases. Please see Deb Soik. This must be pre- approved.

i. Travel receipts and a signed travel reimbursement form from Deb Soik must be submitted within seven (7) days of return. Receipts include charges for course registration, airfare, hotel, airport shuttles and luggage fees. An itemized, zero balance receipt must be obtained from the hotel, and all non-reimbursable items must be deducted. Items not reimbursed include entertainment, some room service, and bar/courtesy charges. Failure to keep airfare or other required receipts might result in the resident's travel reimbursement being reduced or denied.

General Information

MCWAH Hotline (414) 955-4798

The staff at MCWAH recognize that it can be uncomfortable for residents and fellows to report some of the issues they encounter during training. To facilitate reporting of such concerns MCWAH has implemented a Helpline where you can call to report concerns. This voicemail will be checked on a regular basis. You are free to report your concerns anonymously or you may leave your name and contact information.

Housestaff may want to report such issues as non-compliance with duty hours, inappropriate conduct or other issues that you may not be comfortable discussing.

MCWAH will use the information received on the Helpline to make improvements. The more details you report, the better MCWAH will be able to follow-up.

The **Helpline** voicemail number is **(414) 955-4798**.

Library Maintenance

The Bruce Brewer Resident Library is intended to be an educationally supportive environment for the residents. Housekeeping staff remove the trash and recycling materials. However, residents are responsible for maintaining the tidiness and cleanliness of the resident library.

Malpractice Insurance

MCWAH provides a certificate of insurance for **professional liability insurance** for the residents it employs after they become licensed and then each year thereafter. Residents who are not licensed in Wisconsin are covered by MCWAH's corporate policy. MCWAH and each of its employed, licensed physicians have limits of $1,000,000 per occurrence/$3,000,000 per aggregate loss per year. Professional liability insurance covers legal defense costs, jury awards or settlements and other expenses related to malpractice claims and lawsuits.

The malpractice insurance covers the residents while they perform duties within the scope of their training program except when they rotate at Zablocki Veterans Affairs Medical Center (VAMC) where they are covered under the Federal Tort Claims Act and the U.S. Government is responsible for malpractice liability at the VAMC.

Residents should retain all certificates of insurance in a permanent file as they will be needed throughout their professional career.

MCWAH's Director of Risk Management is available to residents and fellows to assist them with concerns about patient safety, liability exposure and disclosure.

MCWAH's Director of Risk Management: (414) 955-4847

Reimbursement of Expenses

Prior to requesting reimbursement for expenses, the resident MUST have received approval for the expense from the Program Director. Once the expense has been incurred, the resident should obtain the appropriate reimbursement form from the Program Coordinator. Forms are processed monthly. Submissions received by the 10th day of the month will be paid on your next month's paycheck.

The following forms should be used for reimbursement:

- Travel – MCW Travel Expense Report Form
- Educational Purchase In lieu of Educational Course Form

Be sure to attach all ***original*** receipts to the reimbursement form. In lieu of receipts, copies of your credit card or bank statement with account numbers blacked out should be submitted.

Departmental Benefits to Residents

Partial Department Coverage

- **Course Reimbursement:**
  - PGY3 & 4s: The department pays 50% to attend an Educational Course
  - PGY5s: The department pays 50% to attend a Board Review Course
- **Educational Purchase in Lieu of Educational Course**: The department pays a maximum of $250 towards an educational purchase in lieu of attending an educational course during PGY3 or PGY4 years.
- **Lead Glasses:** The department pays $100 towards the cost the lead glasses.
- **Loupes:** The department pays 75% towards the cost of Loupes.
- **Resident Gear:** The department pays $50.00 towards the cost of gear selected.
- **Skits & Picnic**: The department contributes $2,000.00 towards the cost of the skits meal.

100% Department Coverage

- **ATLS Training**
- **AAOS ResStudy & Instructional Course Lectures**
- **Courses & Travel Reimbursement**
  - WOS Annual Meeting
  - PGY2 - AO Fracture Trauma Course
  - PGY5 - AAOS Annual Meeting
  - Residency Program Research
  - OREF/AO Resident Research Forum
- **iPad (with 2yr AppleCare+):** resident can opt to pay an additional $100.00 for more memory.
- **Lead Aprons:** Standard apron ($325) and the thyroid collar ($49).
- **Lab Coats/Laundry Services:** PGY1: 2 labs coats PGY2-5: 1/year
- **Meal Cards:** $10.00/day on call at Froedtert & Children's Hospital
- **Textbooks**
  - AAOS Orthopaedic Basic Science: Foundations of Clinical Practice
  - AAOS Orthopaedic Knowledge Update
  - AAOS Orthopaedic Knowledge Update: Pediatric
  - AAOS Comprehensive Orthopaedic Review
  - Skeletal Trauma
  - Atlas of Orthopaedic Pathology
  - Miller's Review of Orthopaedics
  - Surgical Exposures in Orthopaedics
- **Transitional Retreat** – PGY4 Residents
- **Office 365**
  - **Go to**: portal.office.com
  - Login using your MCW Login/Password

Medical Information Access and Resources

Medical College of Wisconsin Libraries

The Medical College of Wisconsin Libraries comprises of three facilities maintaining a virtual library of more than 12,700 electronic journals, 78 databases and more than 7,000 electronic books providing resources for education and patient care. MCW Libraries serve as the primary provider of information services for more than 17,000 MCW faculty, residents, students, staff and hospital employees.

Locations

Todd Wehr Library is located on the 3rd Floor of the Health Research Center (HRC)

Froedtert & Dynacare Community Health Hospital Library is located on the 2nd floor of the Froedtert Specialty Clinics Building.

Children's Hospital of Wisconsin Library is located on the first floor of Children's Hospital of Wisconsin in the Daniel M. Soref Family Resource Center.

Training File Record Keeping and Access

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Records and Record Retention** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

The Orthopaedic Residency Program maintains a training file, either electronically and/or in paper form, that houses all documentation related to the evaluation of residents' performance.

The following are included in the training files:

- Copy of Medical School Diploma (for housestaff starting before 9/1/2001)
- Results of in-training exams and any other data related to performance
- Evaluations
- Correspondence such as emails or notes regarding housestaff performance
- Attendance at lectures and conferences
- Summative evaluations
- Documents related to adverse education actions
- Copies of Housestaff rotation schedules
- Documents related to moonlighting activities such as Program Director's approval letters
- Specialty specific requirements such as case logs
- Copies of documents provided to another program for housestaff who transferred to that program
- Documentation of program completion

Access to Files

Residents have access to all documents related to his or her evaluations and performance including documents submitted as being confidential. Resident should contact the Program Director or Program Coordinator to arrange a time to view the record. The record must be viewed in the presence of the Program Director or Program Coordinator.

Residents may request a copy of his/her training file by submitting a written request to the Program which will be filed in the training record. Copies of training files should be provided within 10 working days (Monday – Friday).

Social Media Policy

*The Orthopaedic Surgery Residency Program complies with the MCWAH's Institutional Policy on **Social Media Policy** Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

Purpose

Social media may be used by residents employed by The Medical College of Wisconsin Affiliated Hospitals, Inc. (MCWAH). MCWAH recognizes that the use of social media can be a positive experience and supports the use when beneficial to advancing the mission of graduate medical education. These guidelines are intended to ensure compliance with legal and regulatory requirements as well as patients' rights to privacy and confidentiality. Social media includes items such as blogs, podcasts, discussion forums, and social networks.

Policy

This policy applies to Housestaff using social media while at work. It also applies to Housestaff use of social media when away from work when his or her relationship with MCWAH or its affiliated institutions is identified, known, or presumed. It does not apply to content that is non-health care related or is otherwise unrelated to MCWAH, its affiliates or to their patients.

When using social media Housestaff are expected to be professional and ethical, keep patient information confidential and private, and restrain from harassing or discriminatory statements or behavior towards others as is required by MCWAH's policies and MCWAH's Housestaff Handbook. Additionally, Housestaff must comply with the policies of MCWAH's affiliates regarding confidentiality and privacy of patient information, compliance, the use of their electronic medical records and the use of their electronic equipment.

Housestaff are required to comply with the MCW Social Media Policy available at **http://infoscope.mcw.edu/CorporatePolicies/Social-Media.htm**.

Personal, Non-Official, Use of Social Media

•Housestaff may not disclose any confidential or proprietary information of or about MCWAH, its employees, or its affiliates including but not limited to business and financial information, represent that they are communicating the views of MCWAH, or do anything that might reasonably create the impression that they are communicating on behalf of MCWAH.

•Housestaff may not use or disclose any patient identifiable information of any kind on any social media without the written permission of the patient. Even if an individual is not identified by name within the information you wish to use or disclose, if there is a reasonable basis to believe that the person could still be identified from that information, then its use or disclosure could constitute a violation of the Health Insurance Portability and Accountability Act (HIPAA).

•Housestaff may not use social media to establish a personal relationship with a patient or with a former patient for 2 years after terminating services or for 2 years after the patient reaches the age of majority.

•The use of MCWAH's or its affiliates' logos, trademarks and intellectual property is not allowed.

•Threatening or disparaging statements against MCWAH, it's employed Housestaff, staff, or affiliates should not be made.

General Guidelines to Follow for Personal Use of Social Media

•Do not discuss patients even in general terms.

•Assume anything put online could be seen by anyone. Do not post anything you would not want to turn up in the media.

•Take particular care when replying to people in real-time venues like Twitter or texting. You don't have to respond right away, and if you have any doubt at all as to the recipient of the information, don't respond at all.

•Don't mix personal and professional lives. Don't "friend" patients on Facebook or other social media websites if your only relationship with the person is professional.

•Check privacy settings on social media websites monthly because they can change from time to time.

Medical Records - Documentation/Completion Standards

General Documentation Guidelines:

- Include the patient name, medical record #, service, and date of service
- Hand-written documentation, such as consent forms, must be legible
- All medical records are legal documents
- Sign, date, and time on all written documents
- If not documented, it is as though it did not happen

Record Completion:

Timely Completion of Medical Records is needed for continuity of patient care; JCAHO, and HCFA, and; third party payment; and, legal protection for the patient, physician, and hospital.

Discharge Summary:

- Dictation delinquency: 5 days post discharge
- Signature deficiency: 14 days post discharge
- Responsibility: Attending physician

Operative Reports:

- Dictation delinquency: 24 hours after surgery
- A brief operative note is required to be present in the medical records immediately post-op.
- Signature deficiency: 14 days post-surgery
- Responsibility: Attending physician

History and Physical:

- **Completion time frame**: Performed no more than 30 days prior to admission or **within 24 hours of admission**.

Verbal Orders:

- Completion time frame: Within 24 hours of order.

Designated Attending:

- The responsible Resident shall ensure that information regarding the correct responsible Attending and designated Resident is kept current in EPIC.

Appendix

Clinical Competency Committee Policy

POLICY: **Clinical Competency Committee**
EFFECTIVE DATE: **July 1, 2013**

The Orthopaedic Surgery Residency Program complies with the MCWAH's Clinical Competency Committee Institutional Policy. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.

PURPOSE:

The Program Director must appoint the program's Clinical Competency Committee, and ensure the Committee's effective evaluation of each resident's competence as demonstrated through achievement of the ACGME specialty's milestones.

POLICY:

The Clinical Competency Committee (CCC) will review all resident evaluations; prepare and assure the reporting of the Milestone evaluations of each resident to ACGME; and advise the program director regarding resident progress, including promotion, remediation and dismissal.

PROCEDURE:

1. The Program Director of the Orthopaedic Surgery Residency Program must appoint the members of the Clinical Competency Committee.

    a. The Clinical Competency Committee must be composed of at least three members of the program's faculty.

    b. Residents/fellows cannot be appointed as CCC members.

    c. Others eligible for appointment to the Clinical Competency Committee include faculty from other programs and non-physician members of the healthcare team. A non-physician appointee must be one who serves as a faculty member in the program.

    d. All members should work directly with the program's residents on a regular basis.

2. Responsibilities of the Clinical Competency Committee include:

    a. Members must meet, at a minimum, semi-annually. Ad hoc meetings may occur as necessary.

    b. The Committee will select a Committee Chair.

    c. Review all resident evaluations semi-annually.

    d. Complete the standard specialty Milestone reporting form; ensure reporting of Milestone evaluations of each resident semi-annually to ACGME through direct entry into ADS, or other method as directed by ACGME policy.

    e. Make recommendations to the Program Director regarding resident progress, including promotion, remediation and dismissal.

    f. Make recommendations to the Program Director for additional or revised formative evaluations needed to assess resident performance in the Milestone sub-competency level.

Program Evaluation Committee Policy

POLICY: **Program Evaluation Committee and the Annual Program Evaluation**

EFFECTIVE DATE: **July 1, 2013**

*The Orthopaedic Surgery Residency Program complies with the MCWAH's **Program Evaluation Committee** Institutional Policy. Should there be a conflict between the MCWAH policy and the program information outlined below, MCWAH's policy takes precedence.*

PURPOSE:

To establish the composition and responsibilities of the Program Evaluation Committee, and to establish a formal, systematic process to annually evaluate the educational effectiveness of the MCW Orthopaedic Surgery Residency Program curriculum, in accordance with the program evaluation and improvement requirements of the ACGME and the Medical College of Wisconsin Affiliated Hospitals (MCWAH) GMEC.

POLICY:

Each ACGME-accredited residency program will establish a Program Evaluation Committee to participate in the development of the program's curriculum and related learning activities, and to annually evaluate the program to assess the effectiveness of that curriculum, and to identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

PROCEDURE:

Program Evaluation Committee

1. The program director will appoint the Program Evaluation Committee (PEC).
2. The Program Evaluation Committee will be composed of at least 2 members of the residency program's faculty and include at least one resident (unless there are no residents enrolled in the program.) The PEC will function in accordance with the written description of its responsibilities, as specified in item 3, below.
3. The Program Evaluation committee will participate actively in
   a. planning, developing, implementing, and evaluating all significant activities of the residency program;
   b. reviewing and making recommendations for revision of competency-based curriculum goals and objectives
   c. addressing areas of non-compliance with ACGME standards, and
   d. reviewing the program annually, using evaluations of faculty, residents, and others, as specified below.

Annual Program Evaluation

The program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).

1. The annual program evaluation will be conducted on or about the second Monday in August of each year, unless rescheduled for other programmatic reasons.
2. Approximately four months prior to the review date, the Program Director will:

- facilitate the Program Evaluation Committee's process to establish and announce the date of the review meeting
- identify an administrative coordinator to assist with organizing the data collection, review process, and report development
- solicit written confidential evaluations from the entire faculty and resident body for consideration in the review (if not done previously for the academic year under review)

3. At the time of the initial meeting, the Committee will consider:
   - achievement of action plan improvement initiatives identified during the last annual program evaluation
   - achievement of correction of citations and concerns from last ACGME program survey
   - resident performance and outcome assessment, as evidenced by:
     - ACGME Case Log Reports
     - Resident Evaluations /Milestone Assessments
     - Orthopaedic In-Training Examination Performance
     - Resident Scholarly Activity
   - faculty development/education needs and effectiveness of faculty development activities during the past year
   - graduate performance, including performance on the certification examination and graduate survey results
   - program quality, as evidence by:
     - ACGME Letter of Notification / other correspondences
     - Duty Hours Reports
     - Faculty Scholarly Activity
     - Match Results
     - Goals and Objectives
     - Rotation Schedule
     - ACGME Program Requirements
     - Faculty Program Evaluations (ACGME/MCWAH Survey)
     - Resident Program Evaluations (ACGME/MCWAH Survey)
     - MCWAH/GMEC Correspondences
     - Program Handbook
4. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes will be taken of all meetings.
5. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in one or more of these areas:
   - resident performance
   - faculty development
   - graduate performance
   - program quality
   - continued progress on the previous year's action plan

The plan will delineate how those performance improvement initiatives will be measured and monitored.

6. The final report and action plan will be reviewed and approved by the program's teaching faculty and documented in faculty meeting minutes. A report will be provided to the GMEC and discussed at a full meeting of the GMEC.