SUNY UPSTATE MEDICAL UNIVERSITY

DEPARTMENT OF ORTHOPEDIC SURGERY

ORTHOPEDIC SURGERY RESIDENCY TRAINING PROGRAM MANUAL

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Revised July 2012
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Introduction:
The SUNY Upstate Medical University Orthopedic Surgery residency education program takes great pride in the quality of the education program. The purpose of this manual is to provide you with a clear description of the residency program. This manual provides you with critical information that will be of value throughout your years in the program. Please carefully read through this manual. It is also available on Department of Orthopedic Surgery website at:
http://www.upstate.edu/ortho/.

The web site includes additional information about the program and Department, including the calendar of events and listing of the faculty. The site also provides information about the Department’s research and clinical programs.

Program Overview:
The primary objective of the SUNY Upstate Orthopedic Surgery Residency Program is to provide a well-balanced educational experience for residents that will allow them to develop into knowledgeable, competent, compassionate and ethical orthopedic surgeons. The program is structured to provide a broad exposure to all aspects of orthopedic surgery and provide graduated responsibility as residents gain more experience.

The first year (PGY-1) of the education program provides residents with experience in all of the key patient care areas, including the operating room, emergency department and intensive care units. Residents gain experience in the management of patients in the SICU and Burn unit. They complete rotations on the general trauma service, vascular surgery service and at the VA. There are rotations on pediatric surgery, radiology and emergency medicine. They also gain a background in anesthesia techniques through their interaction with the anesthesia service. Residents completing this year are skilled in the care of both adult and pediatric patients with serious illnesses and multi-system trauma.

The PGY-2 and PGY-3 years introduce residents to all aspects of general orthopedics and trauma care at a basic level. During the PGY-2 year, residents spend three months on the trauma rotation at University Hospital. This experience allows them to develop the skills required for splinting, triage and hemostasis, as well as a clear understanding of the indications for surgical treatment of trauma-related conditions. The three month pediatric orthopedic (PGY-2), spine surgery (PGY-2) and hand surgery (PGY-3) rotations also serve as the initial introductions to these subspecialty areas. During the PGY-2 through PGY-4 years, there are three rotations during which the resident spends significant amounts of time with fellowship trained orthopedic surgeons at community hospital who are committed to resident education. This educational experience broadens the resident’s understanding of disease processes, provides them with an excellent experience in patient management, and facilitates the development of surgical skills.

During the PGY-4 and PGY-5 years the residents gain experience with graduated responsibility in the operating room and clinics. These years provide a focused, more senior level experience, in subspecialty areas including pediatric orthopedics, sports medicine, hand surgery, spine surgery, orthopedic oncology, trauma and adult...
reconstruction. These rotations also allow specialized skill development and foster interest in areas for possible future study or fellowship education.

Balancing this clinical experience is a comprehensive didactic conference schedule that covers all subspecialty areas. Included are grand rounds, morbidity and mortality conferences, and journal club that encompasses both general and subspecialty journals. Both basic science and clinical topics are covered in this year round conference schedule. All residents attend weekly cadaver dissections during the summer months to enhance their understanding of surgical anatomy and approaches. Furthermore, residents are provided funding for attendance at a fracture fixation course during their PG-3 year as well as the AAOS Annual meeting during their PG-5 year.

Research opportunities abound for the residents with clear direction from numerous orthopedic researchers in both the clinical and basic science arenas. The Institute for Human Performance Building on campus has remarkable laboratory facilities that residents can utilize for basic research and surgical skills development. All residents are educated in the research process via a quarterly research conference that begins in the second year. Residents receive formal instruction on formulation of a research question. Their research efforts are supported by dedicated research half-days over the course of the four years of core rotations. Prior to graduation, all residents are required to complete at least one research project and compose a manuscript suitable for publication. Departmental funding for start-up projects and national presentations is available.

There is a Department education committee made up of members of the full-time faculty and two residents (PG 4 and PG 5). The committee is chaired by the residency program director. The education committee meets monthly, is active in defining and supervising resident responsibilities, works to ensure that all residents are provided with a complete education in the discipline of orthopaedic surgery. The residency program is compliant with New York State Health Department Code 405 and ACGME duty hour regulations at all sites. Regular survey of duty hours is coordinated through the Office of Graduate Medical Education.

**Residency Applications**

Applications for the residency program are accepted through ERAS. After review of the application materials and reference letters, approximately 50 candidates per year are interviewed. The candidates are divided between two Saturday interview days. Each of these days is preceded by a Friday evening social event where the candidates have opportunities to interact with the current residents. Each candidate is interviewed by the program director, and individually by several members of the full-time faculty. There are also resident interviewers. Areas that are stressed during the ranking of candidates are academic achievement, research experience, USMLE scores, involvement in extracurricular activities and the interview results. There is no discrimination on the basis of race, age, gender, religion, national origin, martial status or sexual orientation. The program recognizes the value of diversity in the residency program.
Core Competencies:

The program goals and objectives are structured to follow the ACGME core competencies. Resident evaluation is based on assessment in the core competencies. Below is a general description of the six core competencies.

a. **Patient Care** (PC) that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

b. **Medical Knowledge** (MK) about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

c. **Practice-Based Learning and Improvement** (PBL) that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

d. **Interpersonal and Communication Skills** (IC) that result in effective information exchange and teaming with patients, their families, and other health professionals

e. **Professionalism** (P) as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

f. **Systems-Based Practice** (SBP) as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Rotation Objectives and Expectations:

While developing competence in all six competency areas defined by the ACGME is paramount to residency education, residents also need clear descriptions of goals and objectives for each of the major orthopaedic rotations that they complete during their five years of training. The structure of these objectives should allow residents to develop short term goals with specific focus on their daily and weekly education. The listings that follow on the next pages of this manual serve as this guide for residents.

Also included for each rotation is a list of rotation-specific expectations that clearly outline the structure, daily routine and expected resident behaviors for each major rotation. Please review the relevant rotation objectives and expectations at the beginning of each rotation. You should personally review this information with the rotation director at the start and completion of the rotation, so that both of you can agree on attainment of rotation objectives. The core competencies addressed by each objective is listed in parenthesis.
PGY-1 Rotations: Objectives and Expectations
OVERVIEW OF OBJECTIVES AND EXPECTATIONS
NON-ORTHOPAEDIC PGY-1 ROTATIONS

The primary goal of the PGY-1 year is to develop the fundamental cognitive and technical skills required for the care of surgical patients. This knowledge will serve as basis for the remainder of training specific to orthopedic surgery. These skills will be developed in a variety of settings with a variety of people.

In the Emergency Department (ED), PG1 residents will build their abilities in the assessment and initial management of both adult and pediatric patients with a wide spectrum of presenting complaints. The PG1 resident is expected to participate in a wide variety of non-orthopedic care during his/her time in the ED.

On the General Surgery Trauma rotation the PG1 resident is expected to gain proficiency in the early assessment and daily management of patients with traumatic injuries. Awareness and basic management of problems related to hemodynamic stability, coagulopathy, chest and abdominal injury, respiratory compromise and comorbid conditions are among the competencies expected to be acquired.

On the other General Surgery rotations the PG1 resident is expected to develop expertise in the care of post-operative patients including diagnosis and initial management of common complications including wound infection, wound dehiscence, DVT/pulmonary embolus, cardiac ischemia, TIA/stroke, ileus, and urinary track infection. PG1 residents are also expected to develop their basic surgical skills in making incisions, assisting appropriately and effectively in the OR, performing basic procedures with supervision, and in closure of fascial, subcutaneous and skin layers.

In the Intensive Care Unit the PG1 resident is expected to develop skill in the care of critically ill and injured patients. Basic management of ventilators, fluid and electrolyte balance, and complications that occur in the cardiac, pulmonary, renal and vascular systems are among the cognitive skills that should be acquired. Technical skills learned should include placement of venous and arterial lines as well as central lines.

The Surgical Anesthesia rotation includes time spent in both the Adult and Pediatric Operating Rooms, as well as in pre-operative evaluation. During this rotation PG1 residents should gain a basic understanding of the patient conditions and risk factors that must be assessed during a pre-operative evaluation, the principles of induction and maintenance of anesthesia, risks and benefits of different types of anesthesia, and basic principles behind the management of pain. PG1 residents should acquire skill in intubation, placement of venous and arterial lines, and placement of regional blocks.

The Musculoskeletal Radiology rotation is designed to give PG1 residents an introduction to the interpretation of X-rays, CT scans, MRIs, angiograms, and ultrasounds of the spine and extremities.

Overall, the PGY-1 year is designed to build a foundation in the cognitive and technical skills required of an orthopedic surgeon. During this year, PG1 residents are also expected to hone their skills in effective communication with patients and colleagues, documentation and maintenance of a medical record, and fulfilling their educational, clinical and administrative responsibilities maintaining the highest standards of honesty and professionalism.
EDUCATIONAL OBJECTIVES
ORTHOPAEDIC SURGERY TRAUMA ROTATION
PGY 1

GOALS

GOAL 1  To introduce the new resident physician to the diagnosis and treatment of basic orthopaedic disorders and diseases.

GOAL 2  To introduce the new resident physician to the surgical skills required in the treatment of basic orthopaedic disorders and diseases.

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the new resident physician to the diagnosis and treatment of basic orthopaedic disorders and diseases.

Objective 1.  To learn a systematic approach to the evaluation of patients presenting in an office or emergency setting, with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, PBL, IC, P)

Objective 2. To learn the appropriate indications for the use of various diagnostic tests and radiographic techniques for patients with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, SBP)

Objective 3.  To develop an understanding of the non-surgical or surgical treatment options for patients presenting with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, IC)

GOAL 2  To introduce the new resident physician to the surgical skills required in the treatment of basic orthopaedic disorders and diseases.

Objective 4.  To develop basic skills required in surgical procedures for patients presenting with symptoms secondary to disorders of the musculoskeletal system. (PC, MK)
GOAL 1
Objectives 1, 2, 3:
   a. musculoskeletal history
   b. musculoskeletal physical exam
   c. radiographs, computed tomography, MRI, nuclear medicine
   d. long bone fractures of the skeletal system, extra-articular and intra-articular
   e. ligamentous derangements and dislocations of major joints of the extremities
   f. musculotendinous lacerations and contusions
   g. bone and soft tissue derangements of the spine, including spinal cord injury
   h. arthritidies of the skeletal system
   i. infections and osteomyelitis

GOAL 2
Objective 4:
   a. closed reduction techniques
   b. casting and splinting techniques
   c. suture techniques and knot tying
   d. lacerations
   e. surgical approaches to long bones and the spine
   f. pinning, external fixation, plating and intramedullary devices
PGY 1 Orthopaedic Surgery Rotation Expectations

1. Learn principles of orthopaedic trauma and reconstruction. The resident will be assigned to the adult trauma service which includes both acute and selected chronic trauma patients. Morning and afternoon patient care rounds in conjunction with the PGY-2 & PGY-4 on service patients is expected.

2. The resident will be involved in the overall treatment of trauma and ED orthopedic patients, from assessment in the emergency room and office, through to the operating room, and post-operatively up to discharge.

3. On call, the resident is to assist the junior residents in the emergency room to learn to reduce fractures and dislocations, as well as repair lacerations.

4. The resident is to assist in the operating room or office according to his assigned schedule. If you are not busy seek out operative cases – you will learn more than you can imagine even as a second assistant.

5. The resident is to attend the various lectures and conferences regarding trauma, sports medicine, joint reconstruction, hand surgery, foot and ankle surgery and spine surgery.

6. Compliance with Code 405 is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.

7. The resident is expected to help in the Monday and Friday AM Orthopedic Clinic.
EDUCATIONAL OBJECTIVES
EMERGENCY MEDICINE ROTATION
PGY 1

GOALS

GOAL 1  To develop the resident physician’s knowledge and skills in assessment and initial management of a variety of patients in the Emergency Department

EDUCATIONAL OBJECTIVES

GOAL 1

Objective 1. To be able to evaluate adult patients presenting to the Emergency Department with a variety of medical, surgical and psychiatric complaints and develop a plan for diagnostic testing (laboratory and/or radiologic) and/or consultation as appropriate. (MK, PC, PBL, SBP)

Objective 2. To be able to evaluate pediatric patients presenting to the Emergency Department with a variety of medical, surgical and psychiatric complaints and develop a plan for diagnostic testing (laboratory and/or radiologic) and/or consultation as appropriate. (MK, PC, PBL, SBP)

Objective 3. To be able to present concisely and effectively to more senior residents and/or attendings patients presenting to the Emergency Department. (MK, PC, IC, P)

GOAL 1

Objectives 1, 2, 3:

a. Traumatic injuries
b. Chest pain
c. Shortness of breath/respiratory compromise
d. Abdominal pain/vomiting/constipation
e. Delirium/dementia

Expectations
1. Participate fully in the Emergency Department Service in the role assigned to the PG1 resident.
2. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
RADIOLOGY/ANESTHESIA ROTATION
PGY 1

GOALS

GOAL 1  To have the resident physician begin to develop an understanding of the role and interpretation of musculoskeletal imaging in the care of orthopedic patients

GOAL 2  To introduce the resident physician to the principles behind surgical anesthesia and some of the associated procedures

EDUCATIONAL OBJECTIVES

GOAL 1  To have the resident physician begin to develop an understanding of the role and interpretation of musculoskeletal imaging in the care of orthopedic patients

Objective 1.  To begin to develop proficiency in indications for ordering and interpretation of various radiologic imaging modalities. (MK, PC, SBP)

GOAL 2  To introduce the resident physician to the principles behind surgical anesthesia and some of the associated procedures

Objective 2.  To begin to understand the factors evaluated in determining the most appropriate form of surgical anesthesia. (MK, PC, IC)

Objective 3.  To begin to understand the principles of induction and maintenance of anesthesia and of pain management. (MK, PC)

Objective 4.  To learn to perform basic procedures associated with the administration of anesthesia. (MK, PC, SBP)

GOAL 1
Objective 1:
   a.  x-rays (radiographs)
   b.  computed tomography scans (CT)
   c.  magnetic resonance imaging (MRI)
   d.  ultrasound
   e.  angiogram
GOAL 2
Objectives 2,3:
   a. pre-operative evaluation (including risk factors related to: cardiac disease, pulmonary disease, renal disease, coagulopathy, hypercoagulability, cognitive disorders, social factors)
   b. principles of induction and maintenance of anesthesia
   c. risks and benefits of different types of anesthesia
   d. basic principles of pain management

Objective 4:
   a. intubation
   b. venous line placement
   c. arterial line placement
   d. regional blocks
Expectations

1. During the three weeks on Musculoskeletal Radiology, the resident is expected to follow the following schedule:

<table>
<thead>
<tr>
<th>Day</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>ER reading</td>
<td>Cohen/Hojnowski/Inzinna</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Cohen/Hojnowski/Inzinna</td>
<td>Chang/Joy/Craig (Spine)</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Ultrasound (Levinsohn/Inzinna)</td>
<td>Cohen/Hojnowski/Inzinna</td>
</tr>
<tr>
<td>Thursday</td>
<td>ER reading</td>
<td>Cohen/Hojnowski/Inzinna</td>
</tr>
<tr>
<td>Friday</td>
<td>Cohen/Hojnowski/Inzinna</td>
<td>Chang/Joy/Craig (Spine)</td>
</tr>
</tbody>
</table>

2. During the week on Anesthesiology, the resident is expected to follow the following schedule:

<table>
<thead>
<tr>
<th>Day</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Adult OR</td>
<td>Preop</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Peds OR</td>
<td>Pain Service</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Adult OR</td>
<td>Preop</td>
</tr>
<tr>
<td>Thursday</td>
<td>Peds OR</td>
<td>Pain Service</td>
</tr>
<tr>
<td>Friday</td>
<td>Adult OR</td>
<td>Pain Service</td>
</tr>
</tbody>
</table>

3. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
VA GENERAL SURGERY ROTATION
PGY 1

GOALS

GOAL 1  To have the resident learn the core knowledge required for the appropriate pre-operative and post-operative care of surgical patients.

GOAL 2  To develop the resident’s knowledge and skills in evaluation and treatment of less complicated problems in surgical patients.

GOAL 3  To introduce the resident physician to performing general surgical procedures.

EDUCATIONAL OBJECTIVES

GOAL 1  To have the resident learn the core knowledge required for the appropriate pre-operative and post-operative care of surgical patients.

Objective 1. To demonstrate an understanding of the physiology of pre- and post-operative care. (MK)

Objective 2. To begin to develop a fund of knowledge of infectious disease as it relates to the surgical patient. (MK)

Objective 3. To begin to develop a fund of knowledge in the physiology and pathology of common surgical diseases. (MK)

GOAL 2  To develop the resident’s knowledge and skills in evaluation and treatment of less complicated problems in surgical patients.

Objective 4. To be able to evaluate appropriately patients with surgical diseases and trauma. (MK, PC)

Objective 5. To be able to order and evaluate appropriate diagnostic testing of the surgical patient. (MK, PC, SBP)

Objective 6. To be able to see consults in the Emergency Department, formulate a plan, and present to more senior residents. (MK, PC, IC, P)
GOAL 3  To introduce the resident physician to performing general surgical procedures.

Objective 7. To learn to perform simpler surgical procedures with appropriate supervision and assist in more complicated procedures. (MK, PC)

GOAL 1
Objectives 1, 2, 3:
  a. fluid and electrolyte management
  b. nutrition
  c. wound healing
  d. knowledge of infectious disease and therapeutics
  e. physiology and pathology of common surgical diseases of the endocrine system, GI tract, hepatobiliary tract, breast, skin and soft tissues, abdominal wall.

GOAL 2
Objectives 4, 5, 6:
  a. appendicitis
  b. diverticulitis
  c. cholecystitis
  d. breast disease
  e. thyroid disease
  f. blunt abdominal trauma
  g. hernias

GOAL 3
Objective 7:
  a. chest tube insertion
  b. gastrostomy
  c. jejunostomy
  d. herniorrhaphy
  e. appendectomy
  f. amputation
  g. hemorhoidectomy
  h. diagnostic laparoscopy
  i. lymph node biopsy
  j. soft tissue masses
  k. abscess
  l. wound infections
  m. breast biopsy
Expectations

1. Participate fully in the VA General Surgery Service in the role assigned to the PG1 resident.
2. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
VASCULAR SURGERY ROTATION
PGY 1

GOALS

GOAL 1  To develop the resident physician’s core knowledge underlying the care of patients with vascular disease

GOAL 2  To develop the resident physician’s knowledge and skills for the evaluation and management of patients with vascular disease

GOAL 3  To introduce the resident physician to performance of vascular surgery

EDUCATIONAL OBJECTIVES

GOAL 1  To develop the resident physician’s core knowledge underlying the care of patients with vascular disease

Objective 1. To demonstrate an understanding of the pathophysiology of and risk factors for vascular disease. (MK, PC)

Objective 2. To understand the indications for medical, endovascular, and operative treatments of vascular disease. (MK, PC)

GOAL 2  To develop the resident physician’s knowledge and skills for the evaluation and management of patients with vascular disease

Objective 3. To be able to perform an appropriate physical exam to evaluate a patient for vascular disease. (MK, PC, IC, P, PBL)

Objective 4. To be able to order (or perform) and interpret appropriate diagnostic tests to evaluate a patient for vascular disease (MK, PC, PBL, SBP)

Objective 5. To be able to institute appropriate initial therapy for vascular problems. (MK, PC, PBL)

Objective 6. To be able to provide appropriate postoperative care to vascular surgery patients. (MK, PC, IC, P, PBL)
GOAL 3  To introduce the resident physician to performance of vascular surgery

Objective 7. To be able to perform basic procedures in the care of vascular surgery patients, and to assist in more complex procedures. (MK, PC)

GOAL 1
Objective 1:
  a. anatomy of arterial and venous systems
  b. pre-morbid conditions leading to vascular disease
  c. prevention and counseling regarding vascular disease
  d. aneurysmal vascular disease
  e. occlusive vascular disease
  f. thromboembolic disease
  g. visceral ischemia

Objective 2:
  a. non-operative management of vascular disease
  b. role of anticoagulant agents
  c. indications for operative/endovascular treatment

GOAL 3
Objective 3:
  a. ankle/brachial indices
  b. palpable/dopplerable pulses

Objective 4:
  a. duplex ultrasound
  b. other vascular laboratory methodologies

Objective 5:
  a. vascular occlusion
  b. aneurysm
  c. indications, performance and limits of endovascular procedures

Objective 6:
  a. graft surveillance
  b. optimization of graft flow
  c. infection
  d. associated complications

GOAL 3
Objective 7:
  a. incision and closure
b. simple vascular exposure
c. simple vascular clamping
d. handling of graft materials
e. preparation of vein grafts
f. Fogarty embolectomy
g. Doppler evaluation of vessel patency
h. portions of dialysis access procedures
i. portions of uncomplicated anastamosis
j. basic angiographic skills (including arterial puncture and wire exchanges)

Expectations

1. Participate fully in the Vascular Surgery service in the role assigned to the PG1 resident.
2. Participate in at least one half-day in vascular clinic.
3. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
TRAUMA GENERAL SURGERY ROTATION
PGY 1

GOALS

GOAL 1  To introduce the resident physician the core knowledge required for the care of patients sustaining trauma

GOAL 2  To develop the resident physician’s knowledge and skills in evaluation and initial management of trauma patients

GOAL 3  To be able to perform appropriately procedures required in the evaluation and initial management of patients who have sustained trauma

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the resident physician the core knowledge required for the care of patients sustaining trauma

Objective 1.  To demonstrate an understanding of the pathophysiology associated with trauma patients. (MK, PC)

GOAL 2  To develop the resident physician’s knowledge and skills in evaluation and initial management of trauma patients

Objective 2.  To be able to evaluate appropriately patients presenting following trauma including interpretation of clinical, laboratory, and imaging findings. (MK, PC, PBL)

Objective 3.  To be able to institute appropriate initial management of trauma patients. (MK, PC, PBL, IC)

Objective 4.  To be able to provide appropriate non-operative, pre-operative, and post-operative care to trauma patients. (MK, PC, IC, P, PBL, SBP)

GOAL 3  To be able to perform appropriately procedures required in the evaluation and initial management of patients who have sustained trauma
Objective 5. To be able to perform simple procedures required in the care of trauma patients. (MK, PC, PBL)

**GOAL 1**
Objective 1:
- a. principles of mechanism of injury
- b. pathophysiology of shock
- c. fluids and electrolytes
- d. nutrition
- e. wound healing

**GOAL 2**
Objective 2:
- a. ATLS
- b. abdominal trauma
- c. thoracic trauma
- d. extremity trauma
- e. radiographs
- f. CT scans
- g. ultrasounds

Objective 3:
- a. ATLS
- b. resuscitation
- c. “team concept” of trauma care

Objective 4:
- a. fluids and electrolytes
- b. nutrition
- c. wound healing
- d. penetrating trauma
- e. blunt trauma
- f. splenic lacerations
- g. liver lacerations
- h. bowel injuries
- i. diaphragmatic injuries
- j. shock
- k. pulmonary contusion

**GOAL 3**
Objective 5:
- a. central venous line insertion
- b. chest tube insertion and removal
- c. diagnostic peritoneal lavage
- d. simple and complex laceration repair
e. foreign body removal
f. laparotomy closure

Expectations

1. Participate fully in the Trauma Service in the role assigned to the PGY-1.
2. See and present most patients on morning rounds.
3. See and present straightforward consultations in the Emergency Department including a plan for evaluation and treatment.
4. Participate in trauma resuscitations with graded responsibility.
5. Participate in weekly Trauma Clinic.
6. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
SICU (CRITICAL CARE MEDICINE) ROTATION
PGY 1

GOALS

GOAL 1 To introduce the resident physician to the core knowledge required to evaluate and manage critically ill surgical patients.

GOAL 2 To develop the resident physician’s knowledge and skills in performance of procedures required in the management of critically ill surgical patients.

EDUCATIONAL OBJECTIVES

GOAL 1 To introduce the resident physician to the core knowledge required to evaluate and manage critically ill surgical patients.

Objective 1. To demonstrate an understanding of the pathophysiology of the critically ill surgical patient. (MK, PC)

Objective 2. To demonstrate an understanding of monitoring equipment used in the care of critically ill surgical patients. (MK, PC, PBL)

Objective 3. To be able to order appropriate diagnostic tests and interpret results. (MK, PC, PBL, SBP)

Objective 4. To begin to develop the ability to manage critically ill surgical patients. (MK, PC, PBL, IC, P)

Objective 5. To develop an understanding of ethical issues and dilemmas encountered in the care of critically ill patients. (MK, PC, IC, SBP, P)

GOAL 2 To develop the resident physician’s knowledge and skills in performance of procedures required in the management of critically ill surgical patients.

Objective 6. To be able to perform appropriately procedures (primarily for monitoring and resuscitation) often required by critically ill surgical patients. (MK, PC, PBL)
GOAL 1
Objective 1:
   a. hemodynamic pathophysiology
   b. pulmonary pathophysiology
   c. renal pathophysiology
   d. immunologic pathophysiology
   e. nutrition
   f. fluids and electrolytes
   g. antibiotics
   h. organ failure

Objective 2:
   a. ventilators
   b. hemodynamic monitors
   c. intensive neuromonitoring

Objective 3:
   a. laboratory tests for fluid and electrolyte status
   b. laboratory tests for hemodynamic status
   c. laboratory tests for organ failure
   d. nutritional analysis
   e. bacterial cultures

Objective 4:
   a. use of fluids, pressors, inotropes
   b. use of antibiotics
   c. use of ventilators
   d. nutritional repletion
   e. decreased levels of consciousness
   f. increased intracranial pressure
   g. impact of operative interventions on organ physiology
   h. sedation
   i. anxiolytics
   j. neuromuscular blockade

Objective 5:
   a. end of life issues
   b. resource utilization issues

GOAL 2
Objective 6:
   a. insertion of central venous catheters
   b. insertion of pulmonary artery catheters
   c. insertion of arterial lines
   d. intubation
Expectations

1. Participate fully in the Critical Care Medicine service in the role assigned to the PG1 resident.
2. Daily contact with the CCM attending.
3. All procedures will be performed under supervision.
4. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
BURNS ROTATION
PGY 1

GOALS

GOAL 1  To introduce the resident to the core knowledge that guides the clinical care of burn patients

GOAL 2  To develop the resident’s ability to perform appropriate initial evaluation and management of burn patients

GOAL 3  To have the resident learn appropriate follow-up care of burn patients

GOAL 4  To have the resident develop competence in performing basic procedures required in the care of burn patients

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the resident to the core knowledge that guides the clinical care of burn patients

Objective 1.  To understand the pathophysiology of thermal injury both in terms of initial injury and long-term sequelae. (MK)

Objective 2.  To understand non-thermal physiologic changes associated with burns. (MK)

GOAL 2  To develop the resident’s ability to perform appropriate initial evaluation and management of burn patients

Objective 3.  To be able to appropriately evaluate patients presenting with burn injuries. (MK, PC, PBL, IC)

Objective 4.  To be able to institute appropriate initial management of patients with burn injuries (MK, PC, PBL)

GOAL 3  To have the resident learn appropriate follow-up care of burn patients
Objective 5. To evaluate burn patients in follow-up in an outpatient setting. (MK, PC, PBL, IC, P)

GOAL 4 To have the resident develop competence in performing basic procedures required in the care of burn patients

Objective 6. To be able to perform basic procedures in the care of patients with burn injuries. (MK, PC)

GOAL 1
Objectives 1, 2:
  a. skin anatomy related to thermal injury
  b. fluid shifts
  c. electrolyte imbalance
  d. wound healing
  e. infection
  f. antimicrobials
  g. wound coverage

GOAL 2
Objectives 3, 4:
  a. estimate burn depth and size
  b. fluid resuscitation
  c. understand indications for invasive monitoring
  d. treatment of respiratory failure
  e. treatment of sepsis
  f. understanding and treatment of associated organ dysfunction
  g. define indications for wound coverage
  h. be able to select most appropriate resurfacing material
  i. prepare patient for surgery related to burns
  j. provide post-operative care to burn patients
  k. understand principles of burn rehabilitation and appropriate consultations

GOAL 3
Objective 5:
  a. understand long-term issues and treatments of patients surviving burn injuries

GOAL 4
Objective 6:
  a. escharotomy
  b. tangential debridement of burn wounds
  c. full-thickness debridement of burn wounds to fascia
  d. split-thickness skin grafting
  e. bedside placement of monitoring lines
f. complex burn wound dressing changes

Expectations

1. Participate fully in the Burn Service in the role assigned to the PG1 resident.
2. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
EDUCATIONAL OBJECTIVES
PEDIATRIC SURGERY ROTATION
PGY 1

GOALS

GOAL 1  To introduce the resident physician to the core knowledge required in the care of pediatric surgical patients

GOAL 2  To develop the resident physician’s knowledge and skills for the evaluation of pediatric surgical patients

GOAL 3  To develop the resident physician’s knowledge and skills for developing appropriate operative or non-operative treatment plans for pediatric patients

GOAL 4  To introduce the resident to performing surgery and minor procedures on pediatric patients

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the resident physician to the core knowledge required in the care of pediatric surgical patients

Objective 1.  To demonstrate an understanding of the pathogenesis, diagnosis, and surgical management of common, and some uncommon, pediatric surgical disease processes. (MK, PC)

Objective 2.  To develop an understanding of principles of pre- and post-operative care of pediatric surgical patients. (MK, PC)

Objective 3.  To develop an understanding of differences between pediatric and adult surgical patients. (MK, PC)

GOAL 2  To develop the resident physician’s knowledge and skills for the evaluation of pediatric surgical patients

Objective 4.  To develop proficiency in examination of pediatric patients. (PC, MK, IC, P, PBL)

Objective 5.  To be able to order appropriately order and evaluate diagnostic tests for pediatric surgical patients. (MK, PC, SBP)
GOAL 3 To develop the resident physician’s knowledge and skills for developing appropriate operative or non-operative treatment plans for pediatric patients

Objective 6. To be able to formulate a differential diagnosis and treatment plan for common, and some uncommon, pediatric surgical diseases. (MK, PC, IC, PBL, SBP)

GOAL 4 To introduce the resident to performing surgery and minor procedures on pediatric patients

Objective 7. To be able to perform some minor surgical procedures on pediatric patients. (MK, PC)

Objective 8. To be able to assist with and/or perform surgical procedures on pediatric patients (commensurate with training/experience/ability). (PC, MK, PBL)

GOAL 1
Objectives 1, 2, 3:
  a. pediatric vs adult physiology
  b. fluid management
  c. pain management
  d. nutrition
  e. common pediatric surgical diseases
  f. uncommon, but important to recognize, pediatric surgical diseases

GOAL 2
Objectives 4, 5:
  a. examination of frightened/uncooperative/nonverbal children
  b. unique psychosocial needs of children/families
  c. appropriate imaging (and how may be different from adults)

GOAL 3
Objective 6:
  a. appendicitis
  b. hernia
  c. pyloric stenosis
  d. abscess
  e. pectus excavatum
  f. intussusception

GOAL 4
Objectives 7, 8:
   a. circumcision
   b. line placement
   c. appendectomy
   d. herniorrhaphy
   e. pylomyotomy

Expectations

1. Participate fully in the Pediatric Surgery Service in the role assigned to the PG1 resident.
2. Attend office hours of attending pediatric surgeons
3. Participate in pre- and post-operative management of all pediatric surgical patients.
4. Residents will have a graded operative experience depending on level of training experience and ability.
5. Compliance with Code 405 is mandatory.
EDUCATIONAL OBJECTIVES
CROUSE HOSPITAL GENERAL SURGERY ROTATION
PGY 1

GOALS

GOAL 1 To have the resident learn the core knowledge required for the appropriate pre-operative and post-operative care of surgical patients.

Objective 1. To demonstrate an understanding of the physiology of pre- and post-operative care. (MK)

Objective 2. To begin to develop a fund of knowledge of infectious disease as it relates to the surgical patient. (MK)

Objective 3. To begin to develop a fund of knowledge in the physiology and pathology of common surgical diseases. (MK)

GOAL 2 To develop the resident’s knowledge and skills in evaluation and treatment of less complicated problems in surgical patients.

Objective 4. To be able to evaluate appropriately patients with surgical diseases and trauma. (MK, PC)

Objective 5. To be able to order and evaluate appropriate diagnostic testing of the surgical patient. (MK, PC, SBP)

Objective 6. To be able to see consults in the Emergency Department, formulate a plan, and present to more senior residents. (MK, PC, IC, P)
GOAL 3  
To introduce the resident physician to performing general surgical procedures.

Objective 7.  To learn to perform simpler surgical procedures with appropriate supervision and assist in more complicated procedures. (MK, PC)

GOAL 1
Objectives 1, 2, 3:
   a. fluid and electrolyte management
   b. nutrition
   c. wound healing
   d. knowledge of infectious disease and therapeutics
   e. physiology and pathology of common surgical diseases of the endocrine system, GI tract, hepatobiliary tract, breast, skin and soft tissues, abdominal wall.

GOAL 2
Objectives 4, 5, 6:
   a. appendicitis
   b. diverticulitis
   c. cholecystitis
   d. breast disease
   e. thyroid disease
   f. blunt abdominal trauma
   g. hernias

GOAL 3
Objective 7:
   a. chest tube insertion
   b. gastrostomy
   c. jejunostomy
   d. herniorrhaphy
   e. appendectomy
   f. amputation
   g. hemorhoidectomy
   h. diagnostic laparoscopy
   i. lymph node biopsy
   j. soft tissue masses
   k. abscess
   l. wound infections
   m. breast biopsy
Expectations

1. Participate fully in the Couse Hospital General Surgery Service in the role assigned to the PGY-1.
2. Compliance with Code 405 and ACGME duty hour regulations is mandatory.
PGY-2 Rotations: Objectives and Expectations
EDUCATIONAL OBJECTIVES
TRAUMA ROTATION
PGY 2

GOALS

GOAL 1 To introduce the resident physician to diagnosis and treatment of emergent orthopaedic conditions.

GOAL 2 To introduce the resident physician to the surgical skills required in the treatment of emergent orthopaedic conditions.

EDUCATION OBJECTIVES

GOAL 1 To introduce the resident physician to diagnosis and treatment of emergent orthopaedic conditions.

Objective 1. To learn a systematic approach to the evaluation of patients presenting in the emergency room setting, with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, IC, PBL, P)

Objective 2. To learn the appropriate indications for the use of various diagnostic tests and radiographic techniques for patients with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, SBP)

Objective 3. To develop an understanding of the non-surgical or surgical treatment options for patients presenting with symptoms secondary to disorders of the musculoskeletal system. (PC, MK, C)

Objective 4. To develop an understanding of the postoperative care of trauma patients, including trauma and fracture related complications (PC, MK, SBP)

GOAL 2 To introduce the resident physician to the surgical skills required in the treatment of orthopaedic trauma conditions.

Objective 5. To develop basic skills required in surgical procedures for patients presenting with symptoms secondary to disorders of the musculoskeletal system. (PC, MK)
**GOAL 1**

Objectives 1, 2, 3:

a. musculoskeletal history and physical exam
b. radiographs, computed tomography, MRI, nuclear medicine
c. interaction with various services in caring for trauma patients
   i. priorities of multiply injured patients with orthopedic injuries
   ii. triage decisions and work under pressure
d. ligamentous derangements and dislocations of major joints of the extremities
e. musculotendinous lacerations and contusions
f. long bone fractures of the skeletal system
   i. diaphyseal
   ii. metaphyseal
   iii. intra-articular
g. pelvic and acetabular fractures
   i. control of hemorrhage in closed, open and pelvic fractures
   ii. evaluate and understand the importance of energy of injury and soft tissue injury
h. bone and soft tissue derangements of the spine
   i. fractures
   ii. dislocations
   iii. spinal cord injury
   i. infections and osteomyelitis

Objective 4:

a. open fracture wound care
b. post operative infection
c. hemorrhage and hematoma
d. compartment syndrome
e. DVT and pulmonary embolus
f. ileus, urinary retention
g. pain control

**GOAL 2**

Objective 5:

a. closed reduction techniques
b. casting and splinting techniques
c. suture techniques and knot tying
d. laceration repair
e. surgical approaches to long bones and the spine
f. principles of fracture fixation
g. fixation choices in diaphyseal, metaphyseal and articular fractures
h. amputations
PGY 2 Trauma / Emergency Care Rotation Expectations

1. Each resident is expected to have a copy of the call schedule for the upcoming month. New York State Health Department Code 405 Regulations regarding resident work hours violations are to be strictly avoided – without compromising patient care. Please check with fellow residents to ensure patient coverage.

2. One resident will cover the service during the day. This resident will be assigned to the trauma service for morning rounds, but will be expected to help cover inpatients for all services at various times in conjunction with the floor NP’s and PA’s. Rounds will be conducted in conjunction with the senior resident and intern. Daily notes are required.

3. The resident is expected to dialogue with their assigned attendings daily – either through a clinical rounds or telephone discussion. Significant problems or complications should be communicated immediately to the attending responsible for the patient.

4. When covering the ER and wards at the same time, calls from the wards take first priority. For any emergency on the wards – you are only physician available. The emergency room is full of ER physicians to look after their emergencies!

5. All admissions and consults in the emergency room should be discussed with the senior resident/fellow on call. Attendings need to know about all admissions and consults once they have been discussed with the senior resident/fellow. Check with the senior resident on when to call an attending.

6. Admission cards/sheets are posted on the resident room door and a formal face-to-face handover with attendings is carried out at 6:45 am on weekday mornings.

7. The residents are responsible for maintaining an orderly, professional appearance in the resident areas.

8. With the exception of emergencies, attendance at scheduled conferences should be top priority. Ward emergencies should be dealt with promptly.

9. General Ortho clinics occur on Monday and Friday mornings. These are to be attended during slow periods, with absences acceptable to deal with urgent ward matters or emergency room responsibilities.

10. Residents are encouraged to scrub on any operative case, time permitting – scrub in for as long as you can. There is a lot to learn and limited time, so make the most of it. Even second assisting for fifteen minutes can be beneficial.

11. The trauma reading list can be found in the orientation package.

12. The formalized resident vacation policy applies to this rotation

13. Performance on this rotation is via E-value reviews.

14. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory.
EDUCATIONAL OBJECTIVES
PEDIATRIC ORTHOPAEDIC ROTATION
PGY 2

GOALS

GOAL 1  To introduce the resident physician to the diagnosis and treatment of pediatric orthopaedic diseases and trauma.

GOAL 2  To introduce the resident physician to the skills required in the treatment of pediatric orthopaedic diseases.

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the resident physician to the diagnosis and treatment of pediatric orthopaedic diseases and trauma.

Objective 1. To learn a systematic approach to evaluation and treatment of pediatric fractures in an ER setting. (PC,MK,PBL,IC)

Objective 2. To learn a systematic approach to the evaluation of patients presenting with pediatric orthopaedic disorders in an office setting, so that a differential diagnosis can be generated. (PC,MK,PBL,IC)

Objective 3. To learn the appropriate indications for the use of diagnostic tests for children presenting with pediatric musculoskeletal disorders. (PC, MK, SBP)

Objective 4. To develop an understanding of appropriate non-surgical or surgical treatment for patients presenting with pediatric orthopaedic disorders. (PC,MK, IC)

GOAL 2  To introduce the resident physician to the skills required in the treatment of pediatric orthopaedic diseases.

Objective 5. To develop proficiency in casting, aspiration and minor surgical procedures appropriate to the treatment of patients presenting with a variety of symptoms secondary to pediatric musculoskeletal disorders. (PC,MK,SBP)
GOAL 1
Objectives 1, 2, 3, 4
a. pediatric fractures, a) poly trauma b) abuse, acute and mal-union, non-union
b. evaluation of the limping child
c. evaluation of back pain
d. pediatric orthopedic infections
e. rotational & angular deformities of the lower extremity
f. idiopathic scoliosis
g. congenital scoliosis and kyphosis
h. Scheuermann’s disorder
i. spondyloysis & spondylolisthesis
j. pediatric cervical spine
k. SCFE
l. LCPD (Legg-Calve-Perthes disease)
m. DDH
n. tibial deformity
o. leg length inequality
p. knee disorders
q. clubfoot
r. miscellaneous foot disorders
s. neuromuscular disorders

GOAL 2
Objective 5
a. casting of fractures
b. casting of foot deformities, such as clubfeet
c. proper placement of Pavlik harness
d. aspiration of joints, ie. hip & knee in pediatric patients
e. percutaneous pinning of SCFE
f. percutaneous pinning of elbow fractures
g. muscle lengthening, releases and transfers in lower extremity
h. epiphysiodesis & hemiepiphysiodesis procedures
i. closed & open reduction & fixation of pediatric fractures with external fixation or ORIF
j. pediatric halo & vest placement
PGY 2 & 5 Paediatric Orthopaedics Rotation Expectations

1. Attendance at conferences should be a top priority; surgical cases that begin during conference will be started by the attending.
2. Office hours should be attended on a regular basis. Because the schedule shifts from week to week there is not a specific assignment. However, residents are expected to arrive on time and ready to learn.
3. Residents are responsible for preparing and presenting pre-operative cases for the upcoming week at the pre op/postop conference.
4. Residents are required to read about cases they will attend and should feel free to ask questions about cases at the pre-operative conference.
5. Residents are responsible for presentation of some of the pediatrics indications conferences scheduled while they are on the pediatric rotation. Residents should work with one of the pediatric orthopedic attendings when preparing these conferences.
6. Residents are required to read the entire Lovell and Winter’s Pediatric Orthopaedics (Sixth Edition) during the three month rotation.
7. Residents are responsible for preparing presentations on specific topics as directed by the pediatric orthopedic attendings.
8. Rounds should be made twice daily on all in house patients.
9. The formalized resident vacation policy applies to this rotation. Residents are responsible to find coverage for all surgical cases in his/her absence and to let attendings know about this coverage.
10. The resident not in the OR on Monday mornings should be in the Fly Road office. When assistance is needed in the General Orthopedic Clinic, the resident will be excused from pediatric orthopedic office hours and expected to assist at the General Orthopedic Clinic at Harrison Center.
11. Residents should be spending one half-day every other week as dedicated time for research on this rotation. This will be the resident’s responsibility to arrange, and the time should be coordinated with the pediatric attendings based upon their schedules.
12. Residents are required to attend office hours a minimum of one day a week and any other time the OR doesn’t conflict.
13. Participation in cases should be chosen based on resident level and difficulty of cases.
14. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
EDUCATIONAL OBJECTIVES
SPINE SURGERY ROTATION PGY2

GOALS

GOAL 1 To introduce the resident physician to the core knowledge underlying the clinical care of spinal disorders.

GOAL 2 To develop the resident physician's knowledge and skills for the evaluation of patients with spinal disorders.

GOAL 3 To develop the resident physician's knowledge and skills for formulating a non-operative treatment plan for patients with spinal disorders. The resident should develop experience in the non-operative management of spinal disorders.

GOAL 4 To introduce the resident physician to performing surgery on the spine.

EDUCATIONAL OBJECTIVES
GOAL 1 To introduce the resident physician to the core knowledge underlying the clinical care of spinal disorders.

Objective 1. To demonstrate an understanding of the pathophysiology and natural history of the various common spinal disorders. (PC,MK)

Objective 2. To demonstrate an understanding of the biomechanical concepts of spinal stability and the effects of internal and external fixation on the stability of the spine. (MK)

GOAL 2 To develop the resident physician's knowledge and skills for the evaluation of patients with spinal disorders.

Objective 3. To be able to appropriately evaluate patients presenting with spinal disorders in a variety of clinical settings, including the emergency department and the outpatient clinic. This would include competency with the physical and neurological examination of the patient. (PC,MK,PBL,IC)

Objective 4. To be able to appropriately order and evaluate diagnostic imaging of the spine. (PC,MK,SBP)

GOAL 3 To develop the resident physician's knowledge and skills for formulating a non-operative treatment plan for patients with spinal
disorders. The resident should develop experience in the non-operative management of spinal disorders.

Objective 5 To be able to formulate and articulate a treatment plan for patients with spinal disorders. (PC, IC, PBL)

Objective 6 To be able to manage the initial care of patients with spinal trauma. (P, MK)

Objective 7 To be able to treat non-operative spinal disorders in the outpatient setting. (PC, PBL, IC)

GOAL 4 To introduce the resident physician to performing surgery on the spine.

Objective 8 To be able to participate in spine surgery at a level appropriate for a general orthopedic surgeon. (PC, MK)

Goal 1
Objectives 1, 2:
  a. spinal anatomy and histology
  b. biomechanics
  c. physiology
  d. pathophysiology of degenerative disease
  e. trauma and spinal cord injury
  f. infection
  g. neoplastic disease
  h. osteoporosis
  i. deformity

Goal 2
Objective 3:
  a. herniated disc
  b. spinal stenosis
  c. spinal fractures
  d. spinal cord injury
  e. infection
  f. tumors
  g. spondylolisthesis
  h. back and neck pain

Objective 4:
  a. plain radiographs
  b. CT
  c. MRI
d. Myelogram
e. Discogram
f. Nuclear medicine studies
g. Electrophysiologic studies

Goal 3
Objectives 5, 6, 7:
   a. Cervical, thoracic, and lumbar trauma
   b. Spinal immobilization
   c. Placement of skeletal traction
   d. Medical and hemodynamic management of patients with acute spinal injuries
   e. Management of low back pain
   f. Management of neck pain
   g. Role of nonoperative modalities of spinal care

Goal 4
Objective 8:
   a. Disc herniation surgery
   b. Decompressive laminectomy/foraminotomy
   c. Noninstrumented posterolateral fusion
   d. Anterior and posterior bone graft harvest
   e. Instrumentation of spinal fractures

This document refers to the PGY-2 resident rotating on the adult spine service. The resident receives additional training in spinal disorders, especially deformity, while on the pediatric orthopedic service.

In developing these goals and objectives we utilized the following published guidelines:


* The Resident/Fellow Education Committee of the North American Spine Society.
PGY2 Spine Surgery Resident Rotation Expectations

1. Attendance at scheduled conferences should be top priority. Surgical cases that begin during conference time will be started by the Attending.
2. All Spine cases should be covered by the Spine Residents and/or the fellow. Exceptions can be made when there is multiple spine cases or a shortage of available residents.
3. Office hours should be attended when there is no conflict with scheduled conferences, Spine cases, or the Friday Outpatient Clinic at Upstate.
4. The PGY-2 Spine Resident will attend the Upstate Clinic for a half day of outpatient clinical patient care.
5. All spine in-patients and consults should be attended on a twice-daily basis by the spine residents, and more frequently as required. The exception to this is the emergent care of a spine trauma patient. Weekend rounds should be performed daily, and coverage must be arranged to allow proper transition of care.
6. All activity required for appropriate patient care is to be done by the Spine Residents. Forwarding tasks to ER On-Call Resident is not appropriate unless the resident is involved in an OR and delay is detrimental to patient care.
7. The residents will be responsible for presentation of the Spine Indications Conferences which are scheduled during their three-month block. These should be coordinated with the scheduled attending.
8. The resident is required to give one months advance notice to all Spine Attendings for any absences, such as vacation, interviews, conferences, etc. It is the Resident's responsibility to arrange appropriate coverage for all surgical cases in his or her absence, and to inform attendings regarding this coverage.
9. The reading list can be found in the orientation package. You should complete this reading, as well as read around your cases in order to cover spine surgery adequately.
10. Residents and fellows are welcome to observe any case. If your attending is on vacation – don’t take one yourself. There is a lot to know and limited time, so make the most of it.
11. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
EDUCATIONAL OBJECTIVES
VETERAN’S ADMINISTRATION HOSPITAL ROTATION
PGY 2

GOALS

GOAL 1  To develop the resident physician’s knowledge and skills for pre-operative assessment, and hospital and postoperative management of common orthopedic disorders.

GOAL 2  To develop the resident physician’s knowledge and surgical skill in the treatment of common orthopedic disorders, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1  To develop the resident physician’s knowledge and skills for pre-operative assessment, and hospital and postoperative management of common orthopedic disorders.

Objective 1  To appropriately assess patients presenting with a variety of musculoskeletal disorders, and learn appropriate surgical indications. (PC, MK)

Objective 2  To begin to manage, in an inpatient setting, patients recovering from surgical treatment of a variety of musculoskeletal disorders. (PC, MK, PBL, IC)

Objective 3  To learn to diagnose and treat peri-operative complications arising as a result of the surgical treatment of a variety of musculoskeletal disorders. (PC, MK, PBL, SBP)

GOAL 2  To develop the resident physician’s knowledge and surgical skill in the treatment of common orthopedic disorders, at a level appropriate for a general orthopedist.

Objective 4  To begin the development of technical proficiency in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to common musculoskeletal disorders. (PC, MK)
GOAL 1 and 2
Objectives 1, 2, 4:
  a. joint replacement surgery; hip, knee, shoulder, straightforward revisions
  b. trauma care, including open reduction internal fixation, traction, closed reduction percutaneous fixation, external fixation of long bone and peri-articular fractures
  c. arthroscopic surgery, including diagnostic and operative arthroscopy of the knee and shoulder
  d. surgery of the foot and ankle, including fusions, osteotomies, tendon transfers, nonunion procedures
  e. surgery of the hand, including arthritis, infection, dupuytren’s disease and simple fractures

GOAL 1
Objective 2:
  a. deep venous thrombosis, pulmonary embolus
  b. adult respiratory distress syndrome, fat embolism syndrome
  c. wound dehiscence, seroma, hematoma
  d. post-operative infection
  e. compartment syndrome
  f. prosthetic joint dislocations
  g. loss of fracture fixation
  h. peri-operative blood loss
PGY2 Veterans Resident Rotation Expectations

1. Prepare for and participate in all elective inpatient surgeries.
2. Participate in all outpatient clinics, developing a clear understanding of VA policies and practices.
3. Perform daily morning rounds and notes, including consults and off service patients. Discuss problems with the chief resident, nurse practitioner and/or attending.
4. Prepare for Monday morning case conferences and therapy conferences.
5. Attend all University Hospital teaching conferences, including Grand Rounds.
6. Teach medical students basics of orthopaedic care during their rotation.
7. Include medical students into rounds and surgical coverage.
8. Strict observation of New York State Health Department Code 405 Regulations regarding resident work hours – no exceptions! Each resident is expected to know their schedule for the upcoming week, and avoid conflicts by proper patient care transfer.
9. Complete VA rotation evaluation at the end of the rotation.
10. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory.

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<tr>
<th>PGY 2</th>
<th>MONDAY</th>
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PGY-3 Rotations: Objectives and Expectations
EDUCATIONAL OBJECTIVES
CROUSE ADULT RECONSTRUCTION ROTATION
PGY 3

GOALS

GOAL 1  To develop the resident physician’s knowledge and ability to assess common orthopedic degenerative disorders in the emergency room, hospital, and outpatient office.

GOAL 2  To introduce the resident physician to the surgical skills required in the treatment of common orthopedic reconstruction disorders, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1  To develop the resident physician’s knowledge and ability to assess common orthopedic degenerative disorders in the emergency room, hospital, and outpatient office.

Objective 1. To learn a systematic approach to the assessment of patients in the office and outpatient settings (PC,MK,PBL,IC,P)

Objective 2  To learn to manage patients recovering from emergent or elective treatment of a variety of musculoskeletal disorders in inpatient and outpatient settings.(PC,MK,PBL)

Objective 3  To be able to diagnose and treat peri-operative concerns or complications arising as a result of the surgical treatment of a variety of musculoskeletal disorders. (PC,MK,PBL,IC,P)

GOAL 2  To introduce the resident physician to the surgical skills required in the treatment of common orthopedic reconstruction disorders, at a level appropriate for a general orthopedist.

Objective 4  To develop the techniques required in surgical procedures appropriate for the treatment of patients presenting with a variety of symptoms secondary to common musculoskeletal disorders. (PC,MK)
**GOAL 1 and 2**
Objectives 1, 2, 4:
  a. joint replacement surgery; hip, knee, shoulder
  b. trauma care, including open reduction internal fixation, closed reduction
     percutaneous fixation, external fixation of long bones and peri-articular fractures;
     traction

**GOAL 1**
Objective 3:
  a. pain management
  b. collaboration with consultant physicians and allied health professionals
  c. deep venous thrombosis, pulmonary embolus
  d. adult respiratory distress syndrome, fat embolism syndrome
  e. wound dehiscence, seroma, hematoma
  f. post-operative infection
  g. compartment syndrome
  h. prosthetic joint dislocations
  i. loss of fracture fixation
  j. peri-operative blood loss
PGY-3 Adult Reconstruction Rotation Expectations

1. Participate fully in the Crouse Adult Reconstruction Service in the role assigned to the PGY-3 resident.

2. The weekly schedule is as follows:

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<th>PGY 3</th>
<th>MONDAY</th>
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<th>WEDNESDAY</th>
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<td>post-call</td>
<td>OR (Lasda)</td>
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3. Prepare for and participate in all elective inpatient and outpatient surgeries.

4. Perform daily morning rounds and write notes, including consults and off service patients. Discuss problems with the nurse practitioner and/or attending.

5. Prepare for Monday morning conference. Each week will highlight a selected topic.

6. Attend all University Hospital teaching conferences, including Grand Rounds - surgical cases that begin during conference will be started by the attending.

7. Teach medical students basics of orthopaedic care during their rotation.

8. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
EDUCATIONAL OBJECTIVES
CROUSE HOSPITAL – SPORTS MEDICINE/TRAUMA ROTATION
PGY 3

GOALS

GOAL 1 To develop the resident physician’s knowledge and assessment of common orthopedic sports medicine disorders in the hospital and office.

GOAL 2 To develop the resident physician’s surgical skill in the treatment of common orthopedic sports medicine disorders, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician’s knowledge and assessment of common orthopedic sports medicine disorders in the hospital and office.

Objective 1 To develop a systematic approach to assessment of patients in the office and outpatient settings. (PC,MK,PBL, IC,P)

Objective 2 To become proficient at managing patients recovering from emergent or elective treatment of a variety of musculoskeletal disorders in inpatient and outpatient settings. (PC,MK,PBL)

Objective 3 To be able to diagnose and treat peri-operative concerns or complications arising as a result of the surgical treatment of a variety of musculoskeletal disorders. (PC,MK,IC,P)

GOAL 2 To develop the resident physician’s surgical skill in the treatment of common orthopedic sports medicine disorders, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to common musculoskeletal disorders. (PC,MK)
**GOAL 1 and 2**

Objectives 1, 2, 4:

a. arthroscopic surgery, including diagnostic and operative arthroscopy of the knee, shoulder and hip
b. open and arthroscopic surgery of the joints and muscles, specifically tendon and ligamentous repair/reconstruction, cartilage repair.

c. post-operative therapy considerations after various arthroscopic and open sports medicine surgeries.

**GOAL 1**

Objective 3:

a. pain management
b. collaboration with consultant physicians and allied health professionals
c. deep venous thrombosis, pulmonary embolus
d. adult respiratory distress syndrome, fat embolism syndrome
e. wound dehiscence, seroma, hematoma
f. post-operative infection
g. compartment syndrome
h. prosthetic joint dislocations
i. loss of fracture fixation
j. peri-operative blood loss
PGY 3 Crouse Sports Medicine Rotation Expectations

1. Prepare for and participate in all elective inpatient and outpatient surgeries.
2. Perform daily morning rounds and write notes, including consults and off service patients. Discuss problems with the nurse practitioner and/or attending.
3. Prepare for and run Monday morning conference. Each week will highlight a selected topic.
4. Attend all University Hospital teaching conferences, including Grand Rounds - surgical cases that begin during conference will be started by the attending.
5. Teach medical students basics of orthopaedic care during their rotation.
6. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory.

Summary of Attending Schedules – as of 6-01-2010

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<th>Monday</th>
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<tr>
<td><strong>Crouse OR</strong></td>
<td>Wiese (PM)</td>
<td>DiChristina (PM)</td>
<td>DiChristina (AM/PM)</td>
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<td><strong>Harrison</strong></td>
<td>Wiese (PM)</td>
<td>DiChristina (PM)</td>
<td>DiChristina (AM/PM)</td>
<td>post-call</td>
<td>DiChristina</td>
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Clarification:
Mondays: AM – office with DiChristina; PM – OR with Wiese
Tuesdays: AM – office with DiChristina; PM – OR with DiChristina
Wednesdays: OR all day with DiChristina; on call at night
Thursdays: post-call
Fridays: Office or OR with DiChristina, depending on his schedule
EDUCATIONAL OBJECTIVES
HAND SURGERY ROTATION
PGY 3

GOALS

GOAL 1  To introduce the resident physician to the diagnosis and treatment of diseases of the hand and wrist

GOAL 2  To introduce the resident physician to the surgical skills required in the treatment of disease of the hand and wrist.

EDUCATIONAL OBJECTIVES

GOAL 1  To introduce the resident physician to the diagnosis and treatment of diseases of the hand and wrist

Objective 1. To learn a systematic approach to the evaluation of patients presenting in an office setting, with symptoms secondary to disorders of the hand and wrist; including differentiation from referred symptoms.

Objective 2. To learn the appropriate indications for the use of diagnostic tests for patients presenting with symptoms secondary to disorders of the hand and wrist.

Objective 3. To develop an understanding of the appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to disorders of the hand and wrist.

GOAL 2  To introduce the resident physician to the surgical skills required in the treatment of disease of the hand and wrist.

Objective 4. To develop proficiency in surgical procedures appropriate to the treatment of patients presenting with a variety of symptoms secondary to disorders of the hand and wrist.
**GOAL 1**

Objectives 1, 2, 3:

a. disorders of the distal radius: acute fractures, malunion, arthritis
b. disorders of the DRUJ: fractures, instability, ulnar impaction, arthritis
c. disorders of the carpal bones: carpal fractures, dislocations, instability, arthritis, stiffness
d. disorders of the bones of the hands: fractures, dislocations, arthritis, stiffness, amputations
e. disorders of the nails and nailbed: crush injury, tumors, infections
f. disorders of the flexor tendons: lacerations, tenovaginitis, tenosynovitis, adhesions, chronic deficiency
g. disorders of the extensor tendons: lacerations, ruptures, tenosynovitis, adhesions, dislocations, chronic deficiency
h. disorders of the neurovascular structures of the hand: lacerations, neuromas, vasospastic disorders
i. rheumatologic disorders of the hand and wrist
j. peripheral nerve compression in the upper extremity
k. paralytic conditions of the hand, with and without tendon transfers
l. reflex sympathetic dystrophy
m. masses and tumorous conditions of the hand and wrist

**GOAL 2**

Objective 4:

a. open reduction and internal fixation, as well as percutaneous reduction techniques, for distal radius fractures
b. ORIF and percutaneous techniques for carpal and hand fractures
c. extensor and flexor tendon repair
d. peripheral nerve decompression
e. peripheral nerve and vessel repair
f. wrist arthroscopy: diagnostic and therapeutic, including synovectomy and debridement
g. excision of masses and tumors
PGY3 Hand Surgery Resident Rotation Expectations

1. Each resident is expected to obtain a copy of the assigned attending’s schedule for the upcoming week. Please check with Julie or the hand fellows for a copy of the monthly attending assignments so you know to whom you are assigned.

2. The resident is expected to dialogue with the assigned attending so that it is clear which activities for the upcoming week absolutely require their attendance. Absences from these activities (for Walsh clinic, conferences, meetings, post-call, etc) should be communicated to the attending and alternate coverage arranged.

3. Attendance at scheduled conferences should be top priority – surgical cases that begin during conference will be started by the attending

4. Hand clinic at the hospital on Wednesday afternoon begins at 12:30 pm and is mandatory. Coverage of the cases booked from this clinic are supervised by the fellow/attending and represent an excellent operative opportunity if your schedule permits.

5. Office hours should be attended on a regular basis. Refinement of diagnostic skills and non-operative treatment of hand problems is an integral part of this rotation. Time in the office/clinic should represent 50% of patient care on this rotation.

6. Residents need to read and prepare for cases – no exceptions. Residents have first priority with regard to surgical cases of their assigned attendings. The only exception is microsurgery and free flaps, for which fellows may “take over” a case.

7. Residents and fellows are welcome to observe any case. If your attending is on vacation – don’t take one yourself. There is a lot to know and limited time, so make the most of it.

8. The PGY-3 resident on the Hand service is on in-house call at University Hospital every Monday night and therefore is post-call every Tuesday.

9. The reading list can be found in the orientation package. You have two rotations to complete it!

10. The formalized resident vacation policy applies to this rotation.

11. Compliance with New York State Health Department Code 405 Regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.

12. Residents should be spending one half-day every other week as dedicated time for research on this rotation. This will be the resident’s responsibility to arrange, and the time should be coordinated with the hand attendings based upon their schedules.
EDUCATIONAL OBJECTIVES
ADULT FOOT AND ANKLE/SHOULDER AND ELBOW ROTATION
PGY-3

PART I – FOOT AND ANKLE

GOALS

GOAL 1 To develop the resident physician’s knowledge and skills for treatment of disorders of the foot and ankle.

GOAL 2 To develop the resident physician’s surgical skill in the treatment of disorders of the foot and ankle, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician’s knowledge and skills for treatment of disorders of the foot and ankle.

Objective 1 To be able to appropriately evaluate, in an office setting, patients presenting with symptoms secondary to musculoskeletal disorders of the foot and ankle; including differentiation from referred symptoms. (PC, MK, PBL, IC)

Objective 2 To be able to appropriately order and evaluate diagnostic tests for patients presenting with symptoms secondary to musculoskeletal disorders of the foot and ankle. (PC, SBP, IC)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to musculoskeletal disorders of the foot and ankle. (PC, MK, IC, PBL)

GOAL 2 To develop the resident physician’s surgical skill in the treatment of diseases of the foot and ankle, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to musculoskeletal disorders of the foot and ankle. (PC, MK)
**GOAL 1**

Objective 1, 2, 3:

a. fractures of the calcaneus, talus, mid-foot, forefoot, ankle, and distal tibia
b. dislocations about the ankle, hindfoot, midfoot and forefoot
c. tendon injuries, including acute and chronic ruptures
d. osteochondral fractures of the talar dome, acute and chronic
e. sprains of the ankle, hindfoot and midfoot, and their sequelae, including soft-tissue impingement and recurrent instability
f. nerve pathologies including entrapments, neuromas, neuritidies, and polyneuropathy
g. neuromuscular conditions including Charcot-Marie-Tooth, cerebral palsy, muscular dystrophy, multiple sclerosis, paralysis
h. foot and ankle sequelae of the inflammatory arthritides, including great and lesser toe deformities, midfoot/hindfoot/ankle malalignment and joint degeneration
i. diabetic ulcers, neuropathic arthropathy and fractures, infections, painful neuropathies
j. bunions and other disorders of the hallux and sesamoid apparatus, lesser toe deformities

**GOAL 2**

Objective 4:

a. reduction and fixation of fractures and dislocations
b. tendon repair, transfers, lengthenings
c. arthroscopic surgery of the ankle including osteochondral fracture debridement, soft-tissue debridement, fusion, synovectomy, loose body removal, osteophyte excision
d. open treatment of osteochondral lesions including bone grafting, drilling, auto and allograft techniques
e. repair of ankle ligaments, primary and delayed
f. nerve decompression, including tarsal tunnel, interdigital nerves; neuroma excision
g. reconstruction of neuromuscular deformities, including tendon lengthenings and transfers, osteotomies, joint fusions, joint releases
h. reconstruction of sequelae of inflammatory arthritides, including tendon lengthenings and transfers, osteotomies, joint fusions, joint releases, synovectomies
i. debridement of ulcers, ostectomy, osteotomies, tendon transfers, deformity realignment and fusion
j. bunion correction, osteotomies and soft-tissue procedures, small joint fusions, ostectomy, resection arthroplasties
PART II - SHOULDER AND ELBOW

GOALS

GOAL 1 To develop the resident physician's knowledge and skills for treatment of diseases of the shoulder and elbow.

GOAL 2 To develop the resident physician's surgical skill in the treatment of diseases of the shoulder and elbow, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician's knowledge and skills for treatment of diseases of the shoulder and elbow.

Objective 1 To be able to appropriately evaluate, in an office and sports facility setting, patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow; including differentiation from referred symptoms.(PC,MK,IC,PBL)

Objective 2 To be able to appropriately order and evaluate diagnostic tests for patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow.(PC,SBP)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow.(PC,MK,IC,P)

GOAL 2 To develop the resident physician's surgical skill in the treatment of diseases of the shoulder and elbow, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to musculoskeletal disorders of the shoulder and elbow.(PC,MK)

GOAL 1 Objectives 1, 2, 3:
  a. sternoclavicular joint disorders; acute and chronic subluxations and dislocations, arthritis
b. acromioclavicular joint disorders; acute and chronic dislocations, arthritis, distal clavicular osteolysis

c. glenohumeral joint instability; acute and chronic subluxations and dislocations; uni- and multi-directional

d. glenohumeral arthritis; inflammatory and degenerative

e. scapulothoracic strains, scapular winging

f. rotator cuff and bicipital disorders; strains, tendinopathies, tears, calcific tendonitis, subacromial bursitis/impingement syndrome

g. adhesive capsulitis; primary and secondary

h. clavicle fractures and nonunions
i. avascular necrosis of the humeral head
j. neurologic entrapment syndromes; suprascapular, median, ulnar and radial nerves
k. elbow dislocation, acute and chronic instability
l. capitellar osteochondritis dissecans
m. distal biceps rupture

n. tendinopathies about the elbow

o. post-traumatic, degenerative, and inflammatory arthritis of the elbow; loose bodies

p. elbow stiffness; with and without heterotopic ossification

q. olecranon bursitis

r. thoracic outlet syndrome

s. cervical radicular syndromes

t. reflex sympathetic dystrophy

**GOAL 2**

Objective 4:

a. shoulder arthroscopy: diagnostic and operative, including synovectomy, debridement, and subacromial decompression

b. shoulder instability; uni- and multi-directional reconstructive procedures

c. rotator cuff repair, debridement and open subacromial decompression

d. distal clavicle stabilization and excision

e. debridement/release elbow tendinopathies

f. manipulation of the shoulder under anesthesia
Foot & Ankle Rotation Expectations

1. Care of the in-house patients: As the primary service for inpatients followed by the Foot/Ankle Service the resident is responsible for all aspects of the patient’s medical/surgical care. This includes a working up-to-date knowledge of test and lab results, as well as a knowledge of the activities, recommendations and opinions of the consulting and ancillary (e.g. PT, OT, Nutrition) services as they pertain to care of the patient. This can be accomplished by discussions with these services and/or a daily review of the chart for their services’ notes, as well as orders written on the patient. With those patients followed by Internal Medicine Consults, primary medical care can be assumed by that service. The responsibility for awareness of activities, recommendations and opinions remains.

2. Daily contact with the attending regarding the status of the inpatients: ideally this is via daily ward rounds. Because of 405 limitations this may not be possible on certain days. Alternative contact includes discussions after educational conferences or “phone rounds”. Initiating the daily contact is the responsibility of the Resident.

3. Preparation for the Operating Room: the resident will review the service’s upcoming cases far enough in advance to allow for adequate preparation for the case. This review, predominantly via discussion with the attending, will include indications, radiographic studies, surgical approaches, and surgical technique. The resident will receive from the attending’s secretary the schedule for the upcoming week via email.

4. The weekly schedule is as follows:
   a. Mondays: Setter
   b. Tuesdays: Lemley [??]
   c. Wednesdays: Setter
   d. Thursdays: Setter
   e. Fridays: Setter
   f. Call varies as the Foot resident covers vacations

5. Presentations at Foot Conference: the Resident will be responsible for organizing the Foot Conference. The format of the conference will vary based on planning with the attending.

6. Notification up Upcoming Absences: the resident will notify the attending of upcoming meetings, vacations, etc. at least one month in advance.

7. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
PGY-4 Rotations: Objectives and Expectations
EDUCATIONAL OBJECTIVES
ST. JOSEPH’S HOSPITAL – GENERAL ORTHOPAEDICS ROTATION
PGY - 4

GOALS

GOAL 1  To develop the resident physician’s knowledge and assessment of common orthopedic disorders in the office, emergency room, and hospital.

Objective 1  To be able to appropriately manage patients presenting for, and recovering from, emergent or elective treatment of a variety of musculoskeletal disorders in multiple settings. (PC,MK,PBL)

Objective 2  To become proficient at diagnosis and treatment of peri-operative concerns or complications arising as a result of the surgical treatment of a variety of musculoskeletal disorders. (PC,MK,IC)

GOAL 2  To develop the resident physician’s surgical skills in the treatment of common orthopedic disorders, at a level appropriate for a general orthopedist.

Objective 3  To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to common musculoskeletal disorders. (PC,MK)
GOAL 1 and 2
Objectives 1, 3:
   a. joint replacement surgery; hip, knee, shoulder including revisions
   b. trauma care, including open reduction internal fixation, closed reduction
      percutaneous fixation, external fixation of long bone and peri-articular fractures

GOAL 1
Objective 2:
   a. pain management
   b. collaboration with consultant physicians and allied health professionals
   c. peri-operative blood loss
   d. deep venous thrombosis, pulmonary embolus
   e. wound dehiscence, seroma, hematoma
   f. post-operative infection
   g. compartment syndrome
   h. prosthetic joint dislocations
   i. loss of fracture fixation
PGY-4 St. Joseph’s Resident Rotation Expectations

1. Prepare for and participate in elective inpatient surgeries. This rotation provides a significant opportunity to advance your education in inpatient surgical exposures and techniques – primarily arthroplasty, revision arthroplasty and spine surgery.
2. Alternate time on Fridays between outpatient surgeries and use of this time for academic responsibilities (research projects, rounds preparation). Residents are expected to spend one half-day every other week on research projects. Use this time wisely.
3. A minimum of one half day per week office experience is required. The requirement for office experience takes precedence over OR and hospital responsibilities. Arrangements for the office experience are to be directed by Dr. Seth Greenky.
4. Complete daily morning rounds and notes, including consults and off service patients. Discuss problems with the nurse practitioner and/or attending.
5. Cover ER during day in conjunction with nurse practitioners and attending on call.
7. Mandatory attendance at University Hospital Grand Rounds.
8. Attend University Hospital teaching conferences
9. Teach family practice residents basics of orthopaedic care during their rotation
10. Coordinate vacation schedule with attendings in advance.
11. Complete rotation evaluation at the end of the rotation.
12. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
Educational Objectives
SPINE SURGERY ROTATION
PGY - 4

GOALS

GOAL 1 To develop the resident physician's core knowledge underlying the clinical care of spinal disorders.

GOAL 2 To develop the resident physician's knowledge and skills for the evaluation of patients with spinal disorders.

GOAL 3 To develop the resident physician's knowledge and skills for formulating a non-operative treatment plan for patients with spinal disorders. The resident should develop experience in the non-operative management of spinal disorders.

GOAL 4 To provide the resident physician's with experience in performing surgery on the spine.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician's core knowledge underlying the clinical care of spinal disorders.

Objective 1. To demonstrate an understanding of the pathophysiology and natural history of the various common spinal disorders. (PC,MK)

Objective 2. To demonstrate an understanding of the biomechanical concepts of spinal stability and the effects of internal and external fixation on the stability of the spine. (MK)

GOAL 2 To develop the resident physician's knowledge and skills for the evaluation of patients with spinal disorders.

Objective 3. To be able to appropriately evaluate patients presenting with spinal disorders in a variety of clinical settings, including the emergency department and the outpatient clinic. This would include competency with the physical and neurological examination of the patient. (PC,MK,PBL,IC)

Objective 4. To be able to appropriately order and evaluate diagnostic imaging of the spine. (PC,MK,SBP)
GOAL 3  
*To develop the resident physician's knowledge and skills for formulating a non-operative treatment plan for patients with spinal disorders. The resident should develop experience in the non-operative management of spinal disorders.*

Objective 5  
To be able to formulate and articulate a treatment plan for patients with spinal disorders. (PC,MK,IC)

Objective 6  
To be able manage the initial care of patients with spinal trauma. (PC)

Objective 7  
To be able to treat non-operative spinal disorders in the outpatient setting. (PC,MK,IC,P)

GOAL 4  
*To develop the resident physician's experience in performing surgery on the spine.*

Objective 8  
To be able to participate in spine surgery at a level appropriate for a general orthopedic surgeon. (PC,MK)

*Goal 1*

Objectives 1, 2:

a. spinal anatomy and histology  
b. biomechanics  
c. physiology  
d. pathophysiology of degenerative disease  
e. trauma and spinal cord injury  
f. infection  
g. neoplastic disease  
h. osteoporosis  
i. deformity

*Goal 2*

Objective 3:

a. herniated disc  
b. spinal stenosis  
c. spinal fractures  
d. spinal cord injury  
e. infection  
f. tumors  
g. spondylolisthesis  
h. back and neck pain

Objective 4:
a. plain radiographs  
b. CT  
c. MRI  
d. Myelogram  
e. discogram  
f. nuclear medicine studies  
g. electrophysiologic studies

Goal 3  
Objective 5, 6, and 7:  
a. cervical, thoracic, and lumbar trauma  
b. spinal immobilization  
c. placement of skeletal traction  
d. medical and hemodynamic management of patients with acute spinal injuries  
e. management of low back pain  
f. management of neck pain  
g. role of nonoperative modalities of spinal care

Goal 4  
Objective 8:  
a. disc herniation surgery  
b. decompressive laminectomy/foraminotomy  
c. noninstrumented Posterolateral fusion  
d. anterior and posterior bone graft harvest  
e. instrumentation of spinal fractures

This document refers to the PGY-4 resident rotating on the adult spine service. The resident receives additional training in spinal disorders, especially deformity, while on the pediatric orthopedic service.


* The Resident/Fellow Education Committee of the North American Spine Society.
PGY4 Spine Surgery Resident Rotation Expectations

1. Attendance at scheduled conferences should be top priority. Surgical cases that begin during conference time will be started by the Attending.
2. All Spine cases should be covered by the Spine Resident and/or the fellow. Exceptions can be made when there is another spine case or a shortage of available residents.
3. Office hours should be attended when there is no conflict with scheduled conferences, Spine cases, or the Friday Outpatient Clinic at Upstate.
4. The PG-4 Spine Resident will attend the Upstate Clinic every Friday for a half day of outpatient clinical patient care.
5. All spine in-patients and consults should be attended on a twice-daily basis by the spine residents, and more frequently as required. The exception to this is the emergent care of a spine trauma patient. Weekend rounds should be performed daily, and coverage must be arranged to allow proper transition of care.
6. All activity required for appropriate patient care is to be done by the Spine Resident. Forwarding tasks to ER On-Call Resident is not appropriate unless the resident is involved in an OR and delay is detrimental to patient care.
7. The residents will be responsible for presentation of the Spine Indications Conferences which are scheduled during their three-month block. These should be coordinated with the scheduled attending.
8. The resident is required to give one months advance notice to all Spine Attendings for any absences, such as vacation, interviews, conferences, etc. It is the Resident's responsibility to arrange appropriate coverage for all surgical cases in his or her absence, and to inform attendings regarding this coverage.
9. The senior resident is expected to poll attendings for complications and M&M cases for presentation at the Hand M&M conference held every third month.
10. The reading list can be found in the orientation package. You should complete this reading, as well as read around your cases in order to cover spine surgery adequately.
11. Residents and fellows are welcome to observe any case. If your attending is on vacation – don’t take one yourself. There is a lot to know and limited time, so make the most of it.
12. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
EDUCATIONAL OBJECTIVES
MUSCULOSKELETAL ONCOLOGY ROTATION PGY4

This document refers only to the three-month rotation on the musculoskeletal oncology service. While the resident physicians do receive some additional exposure to various benign conditions on the Pediatric, Hand, and Emergency Room rotations as well as to metastatic disease on the Adult Reconstruction and Trauma rotations, their concentrated exposure to these and all other musculoskeletal oncology conditions occurs during this three month rotation.

GOALS

GOAL 1 To develop the resident physician’s knowledge and skills for recognition and appropriate decision making regarding care for musculoskeletal oncology conditions and their simulators.

GOAL 2 To develop the resident physician’s surgical skill in the treatment of those musculoskeletal oncology conditions and simulators appropriately cared for by the general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician’s knowledge and skills for recognition and appropriate decision making regarding care for musculoskeletal oncology conditions and their simulators.

Objective 1 To be able to appropriately evaluate, in an office setting, patients presenting with symptoms and/or findings secondary to musculoskeletal oncology conditions of all extremity and axial sites, including differentiation between common metabolic, infectious, neoplastic, endocrinologic, traumatic, vascular, autoimmune, and degenerative categories of musculoskeletal oncologic conditions and simulators.(PC,MK,PBL,IC)

Objective 2 To be able to appropriately order and evaluate appropriate laboratory, radiologic, and histologic tests for patients presenting with symptoms secondary to musculoskeletal oncology disorders and their simulators.(PC,MK,SBP)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients with musculoskeletal oncology disorders and their simulators.(PC,MK,PBL,P)
GOAL 2  To develop the resident physician’s surgical skill in the treatment of those musculoskeletal oncology conditions and diseases appropriately cared for by the general orthopedist. (PC, MK)

Objective 4 To become technically proficient in surgical procedures appropriately applied by the general orthopedist in the evaluation (biopsy) and treatment of patients presenting with the wide variety of symptoms or findings attributable to musculoskeletal oncologic diseases and their simulators.

SPECIFIC ENTITIES
GOAL 1
Objectives 1, 3: (While this is not meant to be an all-encompassing list of orthopedic oncologic entities, it is meant specifically to include common entities which the resident physician should be exposed to through direct patient care and/or reading while on the Musculoskeletal Oncology service.

I. Bone Disorders
   a. Metabolic bone diseases
      i. Osteoporosis
      ii. Osteomalacia
      iii. Paget’s disease of bone
   b. Infectious bone diseases
      i. Acute osteomyelitis
      ii. Chronic osteomyelitis (including Garre’s sclerosing osteomyelitis and Brodie’s abscess)
      iii. Tuberculosis of bone
      iv. Fungal osteomyelitis
   c. Benign bone tumors
      i. Fibrous dysplasia
      ii. Enchondroma and Ollier’s disease
      iii. Enostosis
      iv. Eosinophilic granuloma (and other presentations of Langerhan’s cell histiocytoses/granulomatoses)
      v. Giant cell tumor of bone
      vi. Non-ossifying fibroma
      vii. Ossifying fibroma
      viii. Osteoid osteoma
      ix. Osteoblastoma
      x. Osteochondroma and multiple hereditary exostoses
      xi. Aneurysmal bone cyst
      xii. Simple bone cyst
      xiii. Hemangioma
      xiv. Chondroblastoma
      xv. Chondromyxoid fibroma
   d. Primary malignant bone tumors
      i. Osteosarcoma (all types)
ii. Ewing’s sarcoma/Primitive neuroectodermal tumor
iii. Chondrosarcoma (all types)
iv. Multiple myeloma
v. Plasmacytoma
vi. Extranodal lymphoma of bone
vii. Chordoma
viii. Angiosarcoma
ix. Hemangioendothelioma
e. Metastatic bone disease
f. Endocrine bone disorders (eg. Hyperparathyroidism)
g. Vascular bone disorders (eg. Avascular necrosis, Gorham’s disappearing bone disease, hemangiomatosis with skeletal involvement, skeletal-extraskeletal lymphangiomatosis)
h. Autoimmune bone disorders (eg. Sarcoidosis with bone involvement)
i. Degenerative bone disorders (eg. Intraosseous ganglion, degenerative geode, Charcot joint)

II. Soft Tissue Disorders
a. Metabolic soft tissue disorders (eg. Diabetic skeletal muscle necrosis, benign soft tissue extension of Paget’s disease of bone)
b. Infectious soft tissue disorders (eg. Abscess, cellulitis)
c. Benign soft tissue tumors
   i. Glomus tumor
   ii. Lipoma
   iii. Rhabdomyoma
   iv. Leiomyoma
   v. Neurilemoma
   vi. Neurofibroma
   vii. Hemangioma
   viii. Lymphangioma
   ix. Fibromatosis, plantar and Dupuytren’s
   x. Desmoid tumor
d. Primary malignant soft tissue tumors
   i. Malignant fibrous histiocytoma
   ii. Liposarcoma
   iii. Rhabdomyosarcoma
   iv. Leiomyosarcoma
   v. Malignant peripheral nerve sheath tumor
   vi. Angiosarcoma
   vii. Hemangioendothelioma
   viii. Fibrosarcoma
   ix. Synovial sarcoma
   x. Extraskeletal osteosarcoma
   xi. Extraskeletal Ewing’s sarcoma
   xii. Extranodal lymphoma of soft tissue
   xiii. Malignant melanoma
e. Endocrine soft tissue disorders (eg. Hyperparathyroidism, tumoral calcinosis)

f. Traumatic soft tissue disorders (eg. Calcific myonecrosis, hematoma, epidermal inclusion cysts)

g. Vascular soft tissue disorders (eg. Hemangiomatosis, skeletal-extraskeletal lymphangiomatosis)

h. Synovial proliferative disorders  
   i. Giant cell tumor of tendon sheath
   ii. Pigmented villonodular synovitis
   iii. Synovial chondromatosis
   iv. Synovial cysts

Objective 2:
I. Laboratory evaluation pertinent to evaluation of both bone and soft tissue conditions

II. Radiological evaluation of both bone and soft tissue conditions
   a. Plain radiographic evaluation
   b. Computerized tomographic evaluation
   c. Magnetic resonance imaging evaluation
   d. Nuclear medicine evaluation
      i. Technitium-99 bone scan
      ii. Indium scan
      iii. Gallium scan
      iv. PET scan

III. Histological evaluation of both bone and soft tissue conditions
   a. Frozen section
   b. Permanent histologic section

GOAL 2

Objective 4:
I. Biopsy techniques, all sites
   a. Trucut core biopsy of soft tissue masses
   b. Open biopsy of bone and soft tissue masses

II. Excision of benign bone tumors, all sites
   a. Simple curettage
      i. Autogenous iliac crest bone grafting
      ii. Allograft bone grafting
      iii. Bone graft substitute grafting
   b. Extended curettage
      i. Adjuvant treatment for aggressive benign tumors
      ii. Cementation of bone defects
   c. Excision of osteochondromas
   d. Prophylactic stabilization following curettage

III. Marginal excision of benign soft tissue tumors, all sites

IV. Surgical management of myeloma, lymphoma, and metastatic disease
   a. Internal fixation of pathological fractures, all sites
   b. Prophylactic internal fixation of impending pathological fractures, all sites

V. Surgical treatment of synovial processes
a. Marginal excision of synovial cysts, all sites  
b. Synovectomy and loose body removal, major joints
PGY 4 Oncology Rotation Expectations and Preferences

OPERATING ROOM

• First, music: if you don’t bring your own, you may have to listen to something I bring.
• Please let me know as far as possible in advance if you are unable to join me in the OR for any scheduled case. Please let me know which resident I may anticipate being present for alternative coverage.
• I prefer to have you prepare for cases before the OR. Since I generally keep most tumor case radiographs in my office and bring them to the OR myself, please plan to review them with me in my office ahead of time (such as a lull in or following office hours).
• Please do not remove any films from my office without discussing it with me first.
• Templates are available in my office for joint cases. You are encouraged to use them.
• Reading materials for cases, conference presentations, and orthopedic oncology education are available for your use in my office. Because I frequently utilize the same resources, please feel free to xerox using our office copier, but do not remove materials without letting me know first.

• PREPPING AND DRAPING
  U-drape around tourniquet with webril beneath for most extremity cases
  Betadine scrub and paint unless patient allergic
  Leave paint wet while draping
  No clips/snaps on fluoro cases…use staples instead
  After draping, dry betadine and seal off with 10-50 cut into thirds

• TOTAL JOINT PATIENTS
  Drains out when approximately <40 cc/shift unless otherwise specified

  Intravenous antibiotics
  Primaries: until drains and foley out
  Revisions: 5 days postoperative
  Structural allografts: 5 days postoperative, then home on P.O. antibiotics for 3-6 months

  DVT prophylaxis
  • Total Knees & Hip Fractures:
    In House:
    Low dose Coumadin
    Daily PTs to keep between 15.0-17.0 (INR < 2.0)
    Thigh high TEDs bilaterally (apply to post op knee after 1st dressing)
    Sequential Compression Devices (SCDs) bilaterally until out of bed
    On Discharge:
    ECASA 325mg PQ QD for 6 weeks
    NO coumadin
Thigh high TEDs for 6 weeks

- Total Hips & All patients at high risk for thromboembolic event

**In House:**
Same as for TKAs

**On Discharge:**
Continue low dose **Coumadin**
Bi-weekly outpatient monitoring per local MD if possible, or with me if necessary for 6 weeks
Thigh high TEDs for 6 weeks

**Heterotopic Ossification Prophylaxis:**
Single dose XRT 700 cGy within 48 hours of surgery.
Call Radiation Oncology office for consult as soon as possible after surgery.

**TOTAL HIPS:**
Positioning:Usu. Lateral with beanbag and hip holders; gluteal fold parallel to floor, shoulders perpendicular to floor

**Medium (not large) hemovac:** place deep to fascia, exit distally
Abduction pillow: apply in OR for all pts with posterior or Straight lateral approaches
* Notify nurses early, as these come from central supply*
Closure: #1 vicryl for fascia, 2-0 undyed vicryl for subcutaneous layer, staples or 3-0 nylon for skin
Dressing: Tape (usually foam) applied **transversely**-no longitudinal taping unless you want to be forever remembered as “The Blister Resident”
Change dressing at least one shift or day after drains removed
Paint wound with betadine sticks and apply hip spica dressing QOD until prolonged serosanguineous drainage abates

OOB POD #1
Physical Therapy POD #2
- **Hip Precautions for Posterior Approach**
  - No hip flexion > 90 degrees
  - No adduction past neutral
  - No internal rotation past neutral
- **Additional Precautions for Transtrochanteric (Lateral) Approach**
  - No active abduction for 6 weeks minimum
  - No passive abduction for 6 weeks minimum
- **Use regular abduction pillow for 6 weeks: Posterior / Transtrochanteric**
- **Regular pillow between legs for 6 weeks: Anterolateral Approach**
- **Touch-down weight bearing (20 - 40#) for 6 weeks if un cemented; If cemented, WBAT**
RTC 2-3 weeks for staple/suture removal

**TOTAL KNEES:**
Flexion bump: tape to table  
Closure: #1 vicryl; 2-0 undyed vicryl; staples or 3-0 nylon  
Medium hemovac drain, deep to extensor mechanism; exit proximal-lateral aspect  
Bulky Jones dressing using PLASTER slabs medially and laterally (no boards, no posterior splints-I can provide you with original Jones article if you want proof)  
No CPM unless specifically requested  
OOB POD #1  
Verbal instructions to work on active knee extension (push knee into bed) on POD #1  
Change dressing POD #2 (unless drain in place) so ROM can begin in PT  
Physical Therapy POD #2  
  - AROM knee, Quad Sets, Straight Leg Raises  
  - WBAT with ambulatory aids for 6 weeks if all components cemented  
  - Hold Physical Therapy and notify me if wound looks stressed

**ONCOLOGY PATIENTS**

**PATIENT AND FAMILY DISCUSSIONS**  
You are welcome to observe any discussions I have with the patient and their family. I would prefer that residents, interns, physician’s assistants, nurse practitioners, nurses and medical students defer to me questions regarding diagnosis, prognosis, operative treatment, findings or complications, or other sensitive issues of care. This will be greatly appreciated.

**BIOPSIES**
  - Fluoroscopy unit, when needed for localization, should be in the room and a preliminary picture obtained (to confirm ability to localize lesion) **before prepping begins.** Help me notify circulator as early as possible.  
  - **NO antibiotics preoperatively** unless I specifically request them  
  - Give antibiotics after biopsy and cultures obtained and after tourniquet deflated  
  - “Culture all tumors, biopsy all infections” is a good rule to live by

  - **No manual exsanguination** (applies to tumors and infections)  
  - Elevate limb for 2 minutes (minimum) before inflating tourniquet  
    If limb kept elevated during prepping, draping, skin marking there should be no additional delay to allow for gravity exsanguination
• If anterior iliac crest bone graft harvest is planned after biopsy of lower extremity lesion, please make sure sterile tourniquet is available and all appropriate areas prepped
• Drains should exit in line with and just at the distal end (within a few millimeters) of the incision

METASTATIC DISEASE PATIENTS

All patients:
• Preop…
  Check Ca++, PT/PTT, CBC with diff, LDH
• Intraop…
  Generally use 3-0 nylon interrupted vertical mattress skin sutures
• Postop…
  Make sure the oncology attending covering in-house patients knows of admission
  Check with oncology before transfusing to see if they want radiated or leukodepleted blood products
  Consult radiation oncology if appropriate; usually 5-7 day delay before treatment started

Lower Extremity patients:
• Postop DVT prophylaxis
  • ECASA 325mg PO QD for 6 weeks total
  • Thigh high TEDs bilaterally for 6 weeks
  • Sequential Compression Stockings bilaterally while in-house
  • No coumadin unless requested by oncology

DEAD SPACE MANAGEMENT: For all soft tissue sarcoma or large soft tissue mass resections and some bone sarcoma resections
• Two 10-flat Jackson-Pratt drains--exiting in line with and just at end of incision-sewn in with 3-0 nylon or silk
• 3-0 nylon interrupted vertical mattress skin sutures unless otherwise specified
• Plaster splints if applicable
• Drains and bedrest for 4-5 days for lower extremity procedures
• Discuss drain removal and first dressing change with me
• Pull 1st drain on a.m. of 4th or 5th POD if <30 cc/day (after you discuss with me); cut sutures on 2nd drain at same time, but leave drain in. Tug 2nd drain to dislodge clots
• Pull 2nd drain at least one shift after 1st drain removal. Leave in if large new outflow.
• Change dressing at least 1 shift after removing 2nd drain; I usually will want to be present for dressing change
• DVT prophylaxis while on bedrest and after discharge:
  • ECASA 325mg PO QD for 6 weeks total
  • Thigh high TEDs for 6 weeks
  • SCDs unilateral (contralateral) or bilateral while in house

**STRUCTURAL ALLOGRAFTS**
• Intravenous antibiotics for 5 full days
• Then switch to PO antibiotics (gram + coverage): continue for 3 - 6 months
• Touch-down weight bearing (20 - 40#)

**Office**
• Mon, Wed, Fri in Suite 130-let me know in advance if you will not be present in time for first scheduled patient
• Please use my letterhead, prescriptions, etc. and my name for all paperwork on office patients (this will decrease the number of pages you will receive in response)
• Please use the new patient information sheets to document any pertinent information. Review PMHx, PSHx, Meds, Allergies, SHx, FHx, and review of symptoms with patient and correct omissions and errors.
• For oncology and total joint patient visits, help me to fill in appropriate follow up / scoring forms
• Any assistance you can provide in completing radiology requests and other forms will be appreciated
• Follow up chest CT scans should have a wet reading done (circle on request form)
• Try to notify nursing staff as soon as possible if office biopsy to be performed.

**Rounds**
• Please contact me when you want to round Mon-Fri
• On weekends and holidays, feel free to contact me to review specific concerns about any of my patients

**Conferences**
• Mondays, 7:30am: Tumor conference with radiology, pathology. Help me identify interesting cases.
• Tuesdays, 7am
  • Keep a list of all tumor cases and present as soon as possible
  • Outside films: usually in my office or with Julie; please make sure these are returned immediately after conference

**Pathology**
Please help the pathologist by filling out appropriate forms for intraoperative or office biopsy specimens, and by assisting him/her in locating x-rays if appropriate. If you want
slides made of gross or histologic specimens, this can be requested on the pathology form when specimen obtained.

**Research**

Wednesday afternoons can generally be set aside to work on resident research projects. Please use this time wisely.
Educational Objectives
Trauma and Operative Fracture Care
PGY 4

GOALS

GOAL 1   To develop the resident physician’s knowledge of the diagnosis and treatment of orthopaedic trauma conditions.

GOAL 2   To develop the resident physician’s surgical skills required in the treatment of orthopaedic trauma conditions.

EDUCATIONAL OBJECTIVES

GOAL 1   To develop the resident physician’s knowledge of the diagnosis and treatment of orthopaedic trauma conditions.

Objective 1. To become proficient with a systematic approach to the evaluation of patients presenting in the emergency room setting, with symptoms secondary to trauma of the musculoskeletal system, and to understand the importance of resuscitation and surgical timing on patient outcome. (PC,MK,PBL,SBP)

Objective 2. To identify appropriate indications for the use of various diagnostic tests and radiographic techniques for patients with symptoms secondary to trauma of the musculoskeletal system. (PC,MK,SBP)

Objective 3. To develop clear understanding of the resuscitation, non-surgical and surgical treatment options for patients presenting with symptoms secondary to trauma of the musculoskeletal system. (PC,MK,SBP)

Objective 4. To develop clear understanding of the postoperative care of trauma patients, including trauma and fracture related complications (PC,MK,IC,P)

GOAL 2   To develop the resident physician’s surgical skills required in the treatment of orthopaedic trauma conditions.

Objective 5. To develop advanced skills required in surgical procedures for patients presenting with symptoms secondary to trauma of the musculoskeletal system. (PC,MK)
GOAL 1
Objective 1, 2, 3:
  a. musculoskeletal trauma history and physical exam
  b. radiographs, computed tomography, MRI, nuclear medicine
  c. interaction with various services and family members in caring for trauma patients
     i. priorities of multiply injured patients with orthopedic injuries
     ii. triage decisions and work under pressure
     iii. preoperative lab values (base deficit, lactate, etc) and their relationships with resuscitation, surgical timing and choices of operative procedures
  d. ligamentous derangements and dislocations of major joints of the extremities
  e. long bone fractures of the skeletal system
  f. pelvic and acetabular fractures
     i. control of hemorrhage in closed and open pelvic fractures
  g. evaluate and understand the importance of energy of injury and soft tissue injury
  h. trauma resuscitation and damage control orthopaedics

Objective 4:
  a. open fracture wound care
  b. post operative infection, osteomyelitis
  c. hemorrhage and hematoma
  d. compartment syndrome
  e. DVT and pulmonary embolus
  f. ileus, urinary retention
  g. pain control

GOAL 2
Objective 5:
  a. principles of fracture fixation
     i. open reduction, internal fixation
     ii. lag screws, compression techniques
     iii. external fixation
     iv. intramedullary fixation
     v. bridging techniques
     vi. fixed angle devices
  b. fixation choices in diaphyseal, metaphyseal and articular fractures
  c. percutaneous fracture fragment manipulation, and reduction techniques
  d. comminuted intra-articular fracture fixation
  e. pelvic and acetabular fixation
  f. soft tissue preservation and reconstruction
  g. amputations and prosthetics
PGY 4 Trauma Chief Resident Rotation Expectations

1. Rounds on all trauma patients will be conducted in conjunction with the junior residents and medical students assigned to the service. Daily notes are required.
2. The chief is expected to coordinate transfer of care of all trauma patients at a morning conference with the surgeon assigned to the trauma room (between 6:45-7:00). Scheduling of cases and equipment needs for trauma room cases will be coordinated with the responsible attending. The chief is expected to have seen all trauma patients admitted and/or operated upon from the previous day before this conference begins and have received clear transfer of care information from the other junior or senior residents who have cared for the patients who need to attend this am sign over conference for clarity.
3. All trauma patients 13 years of age and older are cared for by the adult trauma surgery service and are generally operated upon in the main OR. The chief resident should check with the orthopaedic attending on call, and the orthopaedic surgeon covering the trauma room, to coordinate care for these patients, and where the orthopaedic care of all minors is to be carried out. The orthopaedic paediatric service will cover patients treated by pediatric attendings.
4. The resident is responsible for coverage of trauma cases in the main OR and should arrange for PA/NP coverage for cases running at the same time.
5. The resident is expected to dialogue with attendings of trauma patients daily – either through a clinical rounds or telephone discussion. Significant problems or complications should be communicated immediately to the attending responsible for the patient.
6. Attendance at scheduled conferences should be top priority – surgical cases that begin during conference will be started by the attending.
7. The chief resident is responsible for organizing x-rays and cases in conjunction with the junior resident for presentation at Tuesday morning trauma and fracture conferences. Morbidity and Mortality cases on the trauma service should be logged for presentation at M&M rounds.
8. General Ortho clinics for the hospital occur on Monday and Friday mornings. The chief resident is partly responsible for the coverage of this clinic in conjunction with the other senior residents. Teaching of junior residents and medical students, as well as booking cases are part of this responsibility.
9. The formalized resident vacation policy applies to this rotation.
10. Violations of the New York State Health Department Code 405 Regulations are to be strictly avoided – without compromising patient care. Please check with fellow residents to ensure proper patient coverage.
PGY-5 Rotations: Objectives and Expectations
EDUCATIONAL OBJECTIVES
SPORTS MEDICINE ROTATION – PGY - 5
Part I - KNEE

GOALS

GOAL 1 To develop the resident physician’s knowledge and skills for treatment of diseases of the knee.

GOAL 2 To develop the resident physician’s surgical skill in the treatment of diseases of the knee, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES
GOAL 1 To develop the resident physician’s knowledge and skills for treatment of diseases of the knee.

Objective 1 To be able to appropriately evaluate, in an office and sports facility setting, patients presenting with symptoms secondary to musculoskeletal disorders of the knee; including differentiation from referred symptoms.(PC,IC)

Objective 2 To be able to appropriately order and evaluate diagnostic test for patients presenting with symptoms secondary to musculoskeletal disorders of the knee.(MK,SBP)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to musculoskeletal disorders of the knee.(PC,IC,P)

GOAL 2 To develop the resident physician’s surgical skill in the treatment of diseases of the knee, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to musculoskeletal disorders of the knee.(PC,MK)

GOAL 1
Objectives 1, 2, 3:
   a. meniscal tears; acute and degenerative, meniscal cysts
b. ligamentous injuries; anterior cruciate, posterior cruciate, collateral, and combined

c. patellofemoral disorders; subluxations, dislocations, peripatellar tendinopathies, chondromalacia patella and patellofemoral stress syndrome

d. osteochondritis dissecans of the distal femur and patella

e. chondral lesions; acute and chronic

f. fractures about the knee; tibial spine, patella, tibial plateau

g. tendinopathies about the knee

h. tendon ruptures about the knee; patella, quadriceps

i. post-traumatic, degenerative and inflammatory arthritis of the knee; loose bodies

j. reflex sympathetic dystrophy

k. arthrofibrosis of the knee

**GOAL 2**

Objective 4:

a. knee arthroscopy: diagnostic and operative, including meniscal repair and resection, chondroplasty, debridement, anterior and posterior cruciate ligament reconstruction

b. patellofemoral reconstruction: lateral release, medial patellofemoral ligament/retinacular reconstruction, distal realignment (tibial tubercle transfer)

c. extra-articular ligament reconstruction/repair: medial, lateral, posterolateral corner

d. patellar and quadriceps tendon repair

e. treatment of osteochondritis dissecans, including arthroscopic fixation or debridement, retrograde drilling

f. treatment of fractures about the knee, including arthroscopic or arthroscopic assisted tibial spine, tibial plateau fixation; patellar open reduction and internal fixation
Part II - SHOULDER AND ELBOW

GOALS

GOAL 1 To develop the resident physician's knowledge and skills for treatment of diseases of the shoulder and elbow.

GOAL 2 To develop the resident physician's surgical skill in the treatment of diseases of the shoulder and elbow, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician's knowledge and skills for treatment of diseases of the shoulder and elbow.

Objective 1 To be able to appropriately evaluate, in an office and sports facility setting, patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow; including differentiation from referred symptoms. (PC, MK, IC, PBL)

Objective 2 To be able to appropriately order and evaluate diagnostic tests for patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow. (PC, SBP)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to musculoskeletal disorders of the shoulder and elbow. (PC, MK, IC, P)

GOAL 2 To develop the resident physician's surgical skill in the treatment of diseases of the shoulder and elbow, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to musculoskeletal disorders of the shoulder and elbow. (PC, MK)

GOAL 1 Objectives 1, 2, 3:
  u. sternoclavicular joint disorders; acute and chronic subluxations and dislocations, arthritis
GOAL 2
Objective 4:
g. shoulder arthroscopy: diagnostic and operative, including synovectomy, debridement, and subacromial decompression
h. shoulder instability; uni- and multi-directional reconstructive procedures
i. rotator cuff repair, debridement and open subacromial decompression
j. distal clavicle stabilization and excision
k. debridement/release elbow tendinopathies
l. manipulation of the shoulder under anesthesia

Part III - MISCELLANEOUS

GOALS

GOAL 1 To develop the resident physician’s knowledge and skills for treatment of sports-related disorders of the hip, back, foot, and ankle.
**GOAL 2** To develop the resident physician’s surgical skill in the treatment of sports-related disorders of the foot and ankle, at a level appropriate for a general orthopedist.

**EDUCATIONAL OBJECTIVES**

**GOAL 1** To develop the resident physician’s knowledge and skills for treatment of sports-related disorders of the hip, back, leg, foot, and ankle.

Objective 1 To be able to appropriately evaluate, in an office and sports facility setting, patients presenting with symptoms secondary to sports-related disorders of the hip, back, leg, foot and ankle. (PC,PBL,IC)

Objective 2 To be able to appropriately order and evaluate diagnostic tests for patients presenting with symptoms secondary to sports-related disorders of the hip, back, leg, foot and ankle. (PC,SBP)

Objective 3 To be able to recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to sports-related disorders of the hip, back, leg, foot and ankle. (PC,IC,P)

**GOAL 2** To develop the resident physician’s surgical skill in the treatment of sports-related disorders of the leg, foot and ankle, at a level appropriate for a general orthopedist.

Objective 4 To become technically proficient in surgical procedures appropriate in the treatment of patients presenting with symptoms secondary to a variety of sports-related disorders of the leg, foot and ankle. (PC,MK)
GOAL 1
Objectives 1, 2, 3:

a. muscle/tendon strains and tendinopathies about the hip, including iliopsoas, iliobibial, rectus, sartorius, tendonitis
b. apophyseal avulsion fractures about the hip
c. “athletic pubalgia” (athletic hernia)
d. disorders about the back, including muscle strain, disc degeneration and herniation, pars interarticularis stress fractures, facet injury
e. stress fractures, including hip, femur, tibia, fibula, navicular, fifth metatarsal, etc.
f. exertional compartment syndrome
g. medial tibial stress syndrome
h. ankle sprains, acute and recurrent
i. tendinopathies about the foot and ankle
j. Achille’s tendon ruptures
k. ankle impingement
l. osteochondritis dissecans of the talus

Objective 4:

a. ankle arthroscopy, diagnostic and operative, for treatment of ankle impingement, debridement of chondral/osteochondral lesions
b. reconstruction of ankle ligaments for treatment of instability
c. internal fixation +/- bone grafting of fifth metatarsal fractures
d. fasciotomies for treatment of exertional compartment syndrome
e. repair of Achille’s tendon ruptures
f. hip arthroscopy diagnostic and operative for treatment of hip impingement, labral tears and loose bodies
PGY-5 Sports Medicine Resident Rotation Expectations

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*Resident participation highlighted in BOLD*

**Abbreviations:**
- HC Harrison Center Office, suite 100
- HCOS Harrison Center Outpatient Surgery
- UH University Hospital Operating Room

1. Attendance at scheduled conferences should be top priority; surgical cases that begin during conference time will be started by the attending.
2. Sports cases should be covered by the sports resident. Non-sports cases done by sports attendings should be covered by residents on responsible chief services (rare exceptions when shortage of available residents)
3. Sports clinics should be attended whenever there is not a conflict with scheduled conferences or sports cases.
4. Office hours should be attended on a regular basis, when not participating in scheduled conferences or sports cases. Participation is required at the “Bold Faced” hours noted above. Refinement of diagnostic skills and the non-operative treatment of athletic injuries is an important part of this rotation. Time in the office setting should represent 50% of patient care time on this rotation.
5. It is helpful to coordinate with the Sports PA (Matthew Burnett) regarding weekly activities.
6. Residents will be responsible for presentation of sports indications conferences which are scheduled during their 3 month block. Please coordinate with the scheduled attending.
7. One month advance notice to all sports attendings must be given for any resident absences (vacations, interviews, conferences, etc.) It is the resident responsibility to get coverage for all surgical cases in his/her absence and to let attendings know regarding coverage.
8. Residents should be spending one half-day every other week working on research while on this rotation. This will be the resident’s responsibility to arrange, and the time should be coordinated with the sports attendings based upon their schedules / vacations.
9. Sports resident covers general Ortho Clinic Monday AM – with the exception of when a PGY-5 from the Hand service covers this clinic.
EDUCATIONAL OBJECTIVES
PEDIATRIC ORTHOPEDIC ROTATION
PGY 5

GOALS

GOAL 1  To develop the resident physician’s knowledge and skill in the diagnosis and treatment of pediatric orthopedic diseases and trauma.

GOAL 2  To develop the resident physician’s skills in the treatment of pediatric orthopedic diseases, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1  To develop the resident physician’s knowledge and skill in the diagnosis and treatment of pediatric orthopedic diseases and trauma.

Objective 1. To appropriately evaluate and treat pediatric fractures in an ER setting. (PC,MK,SBP,IC)

Objective 2. To appropriately evaluate patients presenting with pediatric orthopedic disorders in an office setting, including generation of a differential diagnosis. (PC,MK,IC)

Objective 3. To order appropriate diagnostic tests for children presenting with pediatric musculoskeletal disorders. (PC,MK,SBP)

Objective 4. To recommend appropriate non-surgical or surgical treatment for patients presenting with pediatric orthopedic disorders. (PC,MK,IC,P)

GOAL 2  To develop the resident physician’s skills in the treatment of pediatric orthopedic diseases, at a level appropriate for a general orthopedist.

Objective 5. To develop proficiency in the resident physicians’ surgical skills in the treatment of pediatric musculoskeletal disorders. (PC,MK)
GOAL 1
Objectives 1, 2, 3, 4
   a. pediatric fractures, a) poly trauma b) abuse, acute and mal-union, non-union
   b. evaluation of the limping child
   c. evaluation of back pain
   d. pediatric orthopedic infections
   e. rotational & angular deformities of the lower extremity
   f. idiopathic scoliosis
   g. congenital scoliosis and kyphosis
   h. Scheuermann’s disorder
   i. spondylolysis & spondylolisthesis
   j. pediatric cervical spine
   k. SCFE
   l. LCPD (Legg-Calve-Perthes disease)
   m. DDH
   n. tibial deformity
   o. leg length inequality
   p. knee disorders
   q. clubfoot
   r. miscellaneous foot disorders
   s. neuromuscular disorders

GOAL 2
Objective 5.
   a. continued training in procedures required in PGY2 year
   b. osteotomies for correction of angular deformities independent of or subsequent to fractures
   c. exposure of posterior & anterior spine for fusion & instrumentation
   d. thoracoplasty
   e. anterior approach to pediatric hip
   f. drainage of septic hip
   g. open and closed reduction of DDH
   h. pelvic osteotomies
   i. femoral osteotomies
   j. leg lengthening or shortening
   k. patella realignment
   l. surgical correction of clubfoot
   m. resection of tarsal coalitions
   n. accessory navicular excision
   o. hind-foot, mid-foot & forefoot osteotomies
   p. triple arthrodesis
PGY 2 & 5 Paediatric Orthopaedics Rotation Expectations

1. Attendance at conferences should be a top priority; surgical cases that begin during conference will be started by the attending.
2. Office hours should be attended on a regular basis. Because the schedule shifts from week to week there is not a specific assignment. However, residents are expected to arrive on time and ready to learn.
3. Residents are responsible for preparing and presenting pre-operative cases for the upcoming week at the pre op/postop conference.
4. Residents are required to read about cases they will attend and should feel free to ask questions about cases at the pre-operative conference.
5. Residents are responsible for presentation of some of the pediatrics indications conferences scheduled while they are on the pediatric rotation. Residents should work with one of the pediatric orthopedic attendings when preparing these conferences.
6. Residents are required to read the entire Lovell and Winter’s Pediatric Orthopaedics (Sixth Edition) during the three month rotation.
7. Residents are responsible for preparing presentations on specific topics as directed by the pediatric orthopedic attendings.
8. Rounds should be made twice daily on all in house patients.
9. The formalized resident vacation policy applies to this rotation. Residents are responsible to find coverage for all surgical cases in his/her absence and to let attendings know about this coverage.
10. The resident not in the OR on Monday mornings should be in the Fly Road office. When assistance is needed in the General Orthopedic Clinic, the resident will be excused from pediatric orthopedic office hours and expected to assist at the General Orthopedic Clinic at Harrison Center.
11. Residents should be spending one half-day every other week as dedicated time for research on this rotation. This will be the resident’s responsibility to arrange, and the time should be coordinated with the pediatric attendings based upon their schedules.
12. Residents are required to attend office hours a minimum of one day a week and any other time the OR doesn’t conflict.
13. Participation in cases should be chosen based on resident level and difficulty of cases.
14. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
EDUCATIONAL OBJECTIVES
VETERAN’S ADMINISTRATION HOSPITAL ROTATION
PGY 5

GOALS

GOAL 1 To develop the resident physician’s knowledge and skills for preoperative assessment, and hospital and postoperative management of common orthopedic disorders.

GOAL 2 To develop the resident physician’s knowledge and surgical skill in the treatment of common orthopedic disorders, at a level appropriate for a general orthopedist.

EDUCATIONAL OBJECTIVES

GOAL 1 To develop the resident physician’s knowledge and skills for preoperative assessment, and hospital and postoperative management of common orthopedic disorders.

Objective 1 To appropriately assess patients presenting with a variety of musculoskeletal disorders, and offer appropriate surgical and nonsurgical treatment.(PC,MK,IC,P)

Objective 2 To appropriately manage, in an inpatient setting, patients recovering from surgical treatment of a variety of musculoskeletal disorders.(PC,MK)

Objective 3 To appropriately diagnose and treat peri-operative complications arising as a result of the surgical treatment of a variety of musculoskeletal disorders.(PC,PBL,IC,P)

Objective 4 To develop skills in the interaction with allied health professionals, with the objective of organizing sound patient treatment plans, including surgery.(PC,IC,P,SBP)

GOAL 2 To develop the resident physician’s knowledge and surgical skill in the treatment of common orthopedic disorders, at a level appropriate for a general orthopedist.

Objective 5 To develop technical proficiency in surgical procedures appropriate in the treatment of patients presenting with a variety of symptoms secondary to common musculoskeletal disorders.(PC,MK)
**GOAL 1 and 2**

Objectives 1, 2, 4:

a. joint replacement surgery; hip, knee, shoulder, straightforward revisions
b. trauma care, including open reduction internal fixation, traction, closed reduction percutaneous fixation, external fixation of long bone and peri-articular fractures
c. arthroscopic surgery, including diagnostic and operative arthroscopy of the knee and shoulder
d. surgery of the foot and ankle, including fusions, osteotomies, tendon transfers, nonunion procedures
e. surgery of the hand, including arthritis, infection, dupuytren’s disease and simple fractures

**GOAL 1**

Objective 3:

a. deep venous thrombosis, pulmonary embolus
b. adult respiratory distress syndrome, fat embolism syndrome
c. wound dehiscence, seroma, hematoma
d. post-operative infection
e. compartment syndrome
f. prosthetic joint dislocations
g. loss of fracture fixation
h. peri-operative blood loss

**GOAL 1**

Objective 4:

a. coordination of outpatient care plans
b. interaction with medical center therapists and nurse practitioners
c. operative case bookings
d. coordination of orthopaedic implant acquisition and technical instruction
e. coordination of post operative treatment plans
PGY5 Veterans Resident Rotation Expectations

1. Prepare for and assume primary surgeon responsibility in all elective inpatient surgeries.
2. Participate in all outpatient clinics exhibiting behavior consistent with an orthopaedic surgeon in charge of patient care. Oversee and facilitate sound patient care plans in conjunction with the PGY 2 resident and attending surgeon and via interaction with all allied health staff.
3. Perform daily morning rounds and notes, including consults and off service patients. Discuss problems with the junior resident, nurse practitioner and/or attending as appropriate.
4. Prepare for Monday morning case conferences and therapy conferences.
5. Collect and prepare cases for VA M&M conferences and Indications conferences at University Hospital.
6. Attend all University Hospital teaching conferences, including Grand Rounds.
7. Teach medical students basics of orthopaedic care during their rotation.
8. Include medical students into rounds and surgical coverage.
10. Strict observation of New York State Health Department Code 405 Regulations regarding resident work hours – no exceptions! Each resident is expected to know their schedule for the upcoming week, and avoid conflicts by proper patient care transfer.
11. Complete VA rotation evaluation at the end of the rotation.
12. Cover senior resident call at University Hospital.
13. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory.

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<th>PGY 5</th>
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EDUCATIONAL OBJECTIVES
HAND SURGERY ROTATION
PGY 5

GOALS

GOAL 1  To develop the resident physician’s knowledge and skill in the diagnosis and treatment of diseases of the hand and wrist

GOAL 2  To develop the resident physician’s surgical skills in the treatment of disease of the hand and wrist, at a level appropriate for a general orthopaedist.

EDUCATIONAL OBJECTIVES

GOAL 1  To develop the resident physician’s knowledge and skill in the diagnosis and treatment of diseases of the hand and wrist

Objective 1. To appropriately evaluate patients presenting in an office setting, with symptoms secondary to disorders of the hand and wrist; including differentiation from referred symptoms (PC,MK,IC)

Objective 2. To appropriately order and evaluate diagnostic tests for patients presenting with symptoms secondary to disorders of the hand and wrist. (PC,MC,SBP)

Objective 3. To recommend appropriate non-surgical or surgical treatment for patients presenting with symptoms secondary to disorders of the hand and wrist. (PC,IC,PBL,P)

GOAL 2  To develop the resident physician’s surgical skills in the treatment of disease of the hand and wrist, at a level appropriate for a general orthopaedist.

Objective 4. To become proficient in surgical procedures appropriate to the treatment of patients presenting with a variety of symptoms secondary to disorders of the hand and wrist. (PC,MK)
GOAL 1
Objectives 1, 2, 3:
   a. disorders of the distal radius: acute fractures, malunion, arthritis
   b. disorders of the DRUJ: fractures, instability, ulnar impaction, arthritis
   c. disorders of the carpal bones: carpal fractures, dislocations, instability, arthritis, stiffness
   d. disorders of the bones of the hands: fractures, dislocations, arthritis, stiffness, amputations
   e. disorders of the nails and nailbed: crush injury, tumors, infections
   f. disorders of the flexor tendons: lacerations, tenovaginitis, tenosynovitis, adhesions, chronic deficiency
   g. disorders of the extensor tendons: lacerations, ruptures, tenosynovitis, adhesions, dislocations, chronic deficiency
   h. disorders of the neurovascular structures of the hand: lacerations, neuromas, vasospastic disorders
   i. rheumatologic disorders of the hand and wrist
   j. peripheral nerve compression in the upper extremity
   k. paralytic conditions of the hand, with and without tendon transfers
   l. reflex sympathetic dystrophy
   m. masses and tumorous conditions of the hand and wrist

GOAL 2
Objective 4:
   a. open reduction and internal fixation, as well as percutaneous reduction techniques, for distal radius fractures
   b. ORIF and percutaneous techniques for carpal and hand fractures
   c. Extensor and flexor tendon repair
   d. Peripheral nerve decompression
   e. Peripheral nerve and vessel repair
   f. Wrist arthroscopy: diagnostic and therapeutic, including synovectomy and debridement
   g. excision of masses and tumors
PGY5 Hand Surgery Resident Rotation Expectations

1. Each resident is expected to obtain a copy of the assigned attending’s schedule for the upcoming week. Please check with Julie or the hand fellows for a copy of the monthly attending assignments so you know to whom you are assigned.
2. The resident is expected to dialogue with the assigned attending so that it is clear which activities for the upcoming week absolutely require their attendance. Absences from these activities (for conferences, meetings, etc) should be communicated to the attending and alternate coverage arranged.
3. Attendance at scheduled conferences should be top priority – surgical cases that begin during conference will be started by the attending.
4. Hand clinic at the hospital on Wednesday afternoon begins at 12:15 pm and is mandatory. Coverage of the cases booked from this clinic are supervised by the fellow/attending and represent an excellent operative opportunity if your schedule permits.
5. Office hours should be attended on a regular basis. Refinement of diagnostic skills and non-operative treatment of hand problems is an integral part of this rotation. Time in the office/clinic should represent 50% of patient care on this rotation.
6. The senior resident is expected to poll attendings for complications and M&M cases for presentation at the Hand M&M conference held every third month.
7. Residents need to read and prepare for cases – no exceptions. Residents have first priority with regard to surgical cases of their assigned attendings. The only exception is microsurgery and free flaps, for which fellows may “take over” a case.
8. Residents and fellows are welcome to observe any case. If your attending is on vacation – don’t take one yourself. There is a lot to know and limited time, so make the most of it.
9. Residents are encouraged to arrange time to meet with Dr. Mosher to practice microsurgical skills throughout their rotation. Communicate with your attending your desire to find a few hours for microsurgical training in the animal laboratory, and time can be found!
10. The reading list can be found in the orientation package. You are running out of time to complete it!
11. The formalized resident vacation policy applies to this rotation.
12. Compliance with New York State Health Department Code 405 Regulations regarding resident work hours is mandatory. Please arrange proper transfer of inpatient care in instances when you must leave the hospital.
13. Residents should be spending one half-day every other week as dedicated time for research on this rotation. This will be the resident’s responsibility to arrange, and the time should be coordinated with the hand attendings based upon their schedules.
14. Compliance with New York State Health Department Code 405 and ACGME regulations regarding resident work hours is mandatory.
Reading List:

RESIDENT'S REQUIRED READING LIST
DEPARTMENT OF ORTHOPEDIC SURGERY
04/01/09

The Education Committee has compiled a list of reference texts that are to be considered required reading for each resident in this program. The list represents a minimum requirement, and should be supplemented with additional readings for specific cases, and as recommended by individual attendings. Further, we support the role of the senior residents as educators and mentors, and encourage their regular input to the junior residents in this regard.

PGY 1: Trauma – Brown & Jupiter or Rockwood & Green
Hoppenfeld’s Surgical Exposures
Orthopaedic Basic Science (AAOS)

PGY 2: Pediatrics – Lovell & Winter, or Tachdjian
Spine – OKU Spine and spinal trauma chapters in the Skeletal Trauma text

General principles
Anesthesia
Amputations
Arthrodesis
Arthroplasty
Arthroscopy
Stiff joints
Dupuytrens
Intrinsic contracture
RSD
Elbow
Fractures and Dislocations
Infections
Principles of microvascular surgery
Replantation
Nails
Nerve Injury and compression (Not thoracic outlet)
Nerve reconstruction
Rheumatoid arthritis
Skin grafts
Flexor and Extensor tendons
Ganglions
Vascular disorders
Sports – OKU sports medicine

PGY 4-5:
Self directed reading (case based), Instructional Course Lectures (AAOS), Current Concepts (JBJS), Journal Articles, etc. – to continue through the PGY 4 & 5 years.
Resident Research Project Requirements:

Over the course of the five-year program, each resident is expected to complete at least one major research project of a quality suitable for submission to a major medical journal. Each resident project will be completed under the direction of one or more of the clinical or research faculty here in Syracuse. The coordinators for compliance with this project are Dr. Brian Harley, MD and Mr. Fred Werner, MME. The timeline of this process is as follows.

Over the course of your first two years in the program, you should come up with a research question. While at first this might seem quite simple, remember that there are two aspects to this that you will find critical. First, has it been already answered? There is no point performing a project if quality research has clearly answered your question. Second, can you answer your question? (given that the timeline for your involvement in this program is five years!) Obviously, some questions are easier to answer than others, so make sure you get some direction early on – ask the senior residents and attendings for important advice and ideas.

As you can gather, both of these processes can take some time. To help you along, during your second year, you will be expected to present your research topic at a quarterly research conference. At this time, you will be expected to formulate your question into a hypothesis, and also be able to provide a clear description on the relevant recent literature. If you are having trouble deciding on a topic and a research preceptor, please contact Fred Werner or Brian Harley. Each has a listing of possible topics (both basic science and clinical) and preceptors. The quarterly conferences are held to make sure that you are on track, and so that you can get valuable input.

By early in your third year, you need to have formulated a methodology in order to answer your question, and by the end of third year you should have a good start on the project. You will be expected to present the methodology and early results of your project at the Annual Alumni Day at the end of your fourth year, and the final project results in your chief year. This is not the time to find out that your methodology is flawed. Please utilize the research conferences, the resident research coordinators as well as your project preceptor early on in the development process to help foresee issues like bias and confounding. Statistical methods are likely not your area of expertise, but you need to know what you’re going to do before you acquire a whole data set!

Now the finale, and keep this in mind, because it takes some time to complete this requirement. You can’t do it in your last two weeks in Syracuse! You need to have your project written up in a format suitable for submission to a major journal, with references in place, submitted to the chairman’s office before by May 1st. Submission of the manuscript is a requirement to finish the residency program. No exceptions. Once again, seek out help liberally.

The purpose of this component of your training is to help you appreciate the research process, and gain a healthy understanding of what constitutes quality (and not so quality) results. While it is likely that only the minority of graduating residents will ever again undertake a major research project, the skills you acquire during the completion of this project will provide you with significant respect for the whole process. This will allow you to become more critical of the vast majority of published research, with the result being your cautious but effective incorporation of new ideas and new techniques into your lifelong practice of orthopaedic surgery.
A formalized research rotation is not provided. However, to facilitate your progress, on the St. Joe’s, sport’s, both pediatric, oncology and both hand rotations you are expected to take at least one half day every second week to help complete your research requirements. Please check the expectations section for these rotations to determine the exact policy for each rotation. You are also expected to complete your project during breaks in your daily schedule on other rotations.

Lastly, realize that many orthopaedic research projects do not prove to be fruitful. We would suggest that you plan to do a minimum of at least two projects during your residency, so that you end up with at least one complete project. While at first this may seem daunting, remember that in the past, many residents from this program have completed up to four projects that ended up in publications during their time in the residency program.

Case logs and credentialing

Residents are required to keep their ACGME case logs up to date. The data if reviewed monthly by the education committee and residents contacted if they are more than one month behind entering cases. The total number of cases entered to date are also reviewed and addressed if the resident’s case log numbers are below the expected level for his or her level in the program.

Residents are required to be credentialed for clinical activities. All credentialing must be completed prior to the end of the PG 2 year in order to be promoted. Residents must be credentialed for any clinical activity they complete independently.

Conference participation

Resident attendance at morning education conferences, journal club, grand rounds and rotation specific conferences is mandatory. Residents are excused if attendance will result in duty hour violations. Residents are expected to actively participate in these education activities. They are required to present at grand rounds and may be asked to present at some of the morning education conferences. Completion of journal club assignments is also required.

Resident Requirements for Promotion/Renewal

The Department of Orthopaedic surgery follows the guidelines for appointment, promotion, graduation and termination established by the Office of Graduate Medical Education. These policies are detailed on the web at:

http://www.upstate.edu/gme/medical_res.shtml

All residents sign annual contracts of appointment. Promotion to each subsequent year is determined by the program director and the Education committee based upon: satisfactory completion of educational objectives and administrative duties (as detailed on preceding and subsequent pages), demonstration of ethical and professional conduct, as
well as acceptable performance on rotation evaluations and departmental examinations (see detail in subsequent pages). All evaluations and information pertinent to the resident is documented in a database and hard copy file available for review by the resident with the permission of the program chairman.

**Resident Supervision**

The residency program is ACGME accredited and follows all guidelines established by the institutional Office of Graduate Medical Education. At all times residents are under the supervision of a faculty orthopedic surgeon. Residents must notify the attending physician whenever a patient is admitted to the hospital or a consult is requested. All emergency department and inpatient consults must be reviewed during morning sign out rounds with the attending on call the previous 24 hours and the attending assigned to the trauma room for the current day.

The supervisory lines of responsibility are as follows. All junior and senior residents report directly to the faculty member supervising their specific rotation and/or patient interactions. However, it is understood that a significant portion of resident education occurs as a result of the senior to junior resident interaction.

All PGY 1 residents will be directly supervised or indirectly supervised with direct supervision immediately available. When PGY 1 residents participate in call, there will always be a more senior resident immediately available in the hospital to provide direct supervision.

All faculty members involved in resident education report to the Orthopedic Department Chairman. The department education committee is extremely active in defining and supervising all resident responsibilities, and meets regularly to ensure that all residents are provided with a complete education in the discipline of orthopaedic surgery.

**Resident Discipline and Grievances**

In the unfortunate situation where a resident is not maintaining the standards required by the Department, the resident will be asked to meet with the program director. Strategies for remediation will be provided, and all residents will be given extensive opportunities to meet departmental requirements. Repeated failure to meet minimum standards will result in non-renewal of the resident’s annual appointment, and in extreme cases, immediate termination. Any such action is performed in consultation with the Office of Graduate Medical Education, according to University policy, so that the resident is fully informed of the process, and an appeal can be entered.

At the end of each rotation, the residents are given the opportunity to provide constructive feedback of the rotation and preceptors, and this information is reviewed on a regular basis by the education committee. An anonymous annual review of the program and faculty by the residents is collected by the program director. The residents complete annual anonymous evaluations of the program conducte by the ACGME and the Upstate
GME office. The results of these surveys are used as part of the program evaluation and may lead to program changes. The Office of Graduate Medical Education also provides a mechanism for registration of residents’ grievances at http://www.upstate.edu/gme/medical_res.shtml.

Fitness for Duty Policy

A resident or fellow who does not feel fit for duty should consult with the Orthopedic Surgery program director or Employee Health. Additionally, a supervisor who has concerns regarding a resident or fellow’s fitness for duty should also consult with the Program Director and/or Associate Dean for Graduate Medical Education.

Back-up Support:

Appropriate use of sick call includes unexpected illness, death in the family or other personal emergency. Sick call is not to be used for scheduled absences, e.g., doctor’s visits, family responsibilities, interviews, etc. For such scheduled absences, the resident/fellow will follow their department procedures in compliance with human resources/payroll policy.

Procedure for Back-up Support:
1. The resident will contact the senior resident on the service and residency program director or designee when the program director is unavailable to inform them of his/her illness or situation. The resident/fellow will talk directly to the senior resident or program director. No voicemail messages should be left. If the resident unable to perform his/her duties is the senior resident on the service, the resident should inform the administrative chief resident (PG5 resident on the pediatric orthopedic service) and the program director.
2. The resident/fellow will discuss the work type and duration for which coverage is needed. The senior resident and program director will ascertain what responsibilities need to be covered to ensure safe, comprehensive transfer of duties to the covering colleague. This will occur prior to each shift for which the resident is ill unless otherwise determined by program director.
3. As a general rule, each resident/fellow will be expected to complete an equal share of weekend and holiday calls. If the resident/fellow is unable to meet this responsibility due to illness or another situation as listed above, the resident/fellow will complete the requisite number of calls at a later date as determined by the Program Director or Chief. It should be understood that receiving return coverage is a courtesy but is not an absolute requirement and may not be possible in all situations. SUNY Upstate Medical University’s institutional policy allows employees to be out for a number of sick days without consequences. It is in this regard that professionalism and courtesy should exist.

Repayment of coverage may never result in an ACGME or New York State duty hours regulation violation, no matter what the circumstances.
4. If a resident/fellow is out sick greater than three days, documentation must be brought to the Program Director’s attention within 24 hours of returning to work. Documentation needs to show the name, date, time, and place where the resident/fellow was seen. Diagnosis does not need to be disclosed as this information is confidential. Failure to comply with the documentation requirement could lead to comments regarding professionalism in the final evaluation of the resident/fellow or disciplinary action.

5. For extended absences/illness, please refer to the institutional policy on Leaves of Absence available on SUNY Upstate’s website. Residents and fellows should be mindful of individual Board requirements that may set limits on the amount of leave one may take at any level. In most cases, vacation time cannot be forfeited for leave.

6. While every attempt will be made to cover a resident or fellow with another resident or fellow, the final authority for patient care and supervision lies with the attending. In all cases when another resident or fellow cannot cover or cannot be reached, the attending on service will provide this coverage.

**Resident & Physician Work Hours Policy:**

To maintain working conditions and working hours of physicians and post-graduate trainees that promote the provision of quality medical care, University Hospital shall follow the policies as set forth in Code 405 and the ACGME, regarding working hours for post-graduate trainees and certain members of the medical staff.

The Orthopedic Duty hour policies are consistent with the University Hospital and ACGME policies. Additional ACGME specialty specific clarifications are being developed. These will be posted on the ACGME web site. These policies must be followed on all rotations and at all residency education sites. Additional information and responses to frequently asked questions are available on the ACGME site:

[http://www.acgme.org](http://www.acgme.org)

Additional Institution information is available in the Upstate Resident Handbook:

[http://www.upstate.edu.libproxy2.upstate.edu/forms/pdf/F83163.pdf](http://www.upstate.edu.libproxy2.upstate.edu/forms/pdf/F83163.pdf)

**Resident & Physician Work Hours Procedure:**

1. Schedules of postgraduate trainees with inpatient care responsibilities shall meet the following criteria:
   A. The scheduled workweek shall not exceed an average of 80 hours per week over a four week period (inclusive of all in-house call activities and all moonlighting).
   B. Duty periods of PGY1 residents must not exceed 16 hours in duration.
   C. Postgraduate trainees shall not be scheduled to work for more than 24 consecutive hours.
D. In determining limits on working hours of postgraduate trainees as set forth in Code 405, the medical staff shall require that scheduled on-duty assignments be separated by not less than 8 non-working hours [Note: To meet ACGME requirements the separation should be 10 hours]. Postgraduate trainees must have at least one 24-hour period of scheduled non-working time per week. “On call” duty at home may not be scheduled during this time. Following an assigned shift, a trainee may stay additional time not to exceed 3 hours for the purposes ensuring the appropriate transfer of patient information, but this transition period may not be scheduled in advance. This time may not be spent on new patient care responsibilities but to complete paper work, participate in rounds or in general, transfer patient information to incoming staff. If a resident exceeds 24-hours of continuous duty the resident must document the reasons for remaining to care for patients in writing to their program director. The additional time worked will be counted into the 80-hour working limitation. The trainee may not return on duty for at least 14 hours from his/her departure.

E. “On call” duty taken at home does not count as part of the postgraduate trainee’s working hours. Time spent onsite at the hospital during this call period does count and must be calculated into work hours and is subject to the other restrictions of this policy. “On call” duty taken onsite at the hospital does count as time worked, with the limited exception for surgical trainees provided for in section 2 of this policy below.

F. When assigning responsibilities to postgraduate trainees, the supervising physician will take into account work hour constraints, particularly as the duration of their on-duty assignment progresses.

G. Residents must not be scheduled for more than 6 consecutive nights of nightfloat.

H. PGY2 residents and above must be scheduled for in-house call no more frequently than every third night.

I. Please refer to duty hour regulations for your specialty at www.acgme.org and viewing your program’s requirements.

2. Night Shift On-call for Surgery Trainees

A. “On call” duty in the hospital during the night shift hours by trainees in surgery will not be included in the 24-consecutive hour limit contained in clause 1(B) and the 80-hour limit contained in clause 1(A) if, and only if:

1. The Administrative Resident documents that during the on-call night shift, the postgraduate trainee was generally resting and that interruptions for patient care were infrequent and limited to patients for whom the postgraduate trainee has had continuing responsibility. The postgraduate trainee must have received at least 5 hours of uninterrupted sleep during the on-call shift at the hospital; and

2. Night-shift duty in the hospital is scheduled for each trainee no more often than every third night;

3. A continuous assignment that includes night shift “on-call” duty is followed by a non-working period of no less than 16 hours.

B. Trainees will be immediately relieved from a continuing assignment when fatigue due to an unusually active “on call” period is observed. It is the
responsibility of the trainee to report a situation of fatigue to the supervising physician or Administrative Resident.

C. Post-call duties. All intern-level surgical trainees (PGY 1) must leave the hospital following their hospital night shift on-call. If additional time to transition is required, it must be done as provided in paragraph 1C of this policy. Surgical trainees beyond the PGY 1 year may stay to carry out duties following night shift on-call if, and only if, they have received adequate sleep while on call at the hospital during the night shift, which is clearly documented by the Administrative Resident as provided for in paragraph 2(A)(1) above. They may only continue to work until 11 a.m. and must not return on duty for at least 16 hours following their departure.

**Call Schedules**

Resident call responsibility varies throughout the five years of residency. At all times, compliance with New York State Health Department Code 405 Regulations and ACGME policies regarding resident duty hours is mandatory.

You are required to arrange proper transfer of inpatient care in instances when you must leave the hospital. Pagers are provided by the department. Cell phones are the responsibility of each resident.

During the PGY-1 year, call on the off-service rotations is coordinated by the individual specialty service. Duty hours on these services must be in compliance with duty hour requirements.

During during the PGY-2 and 3 years, call at Upstate is in-house. Call is generally busy. A call room is provided. At Crouse and the Veteran’s Hospital, call is from home.

During the PGY-4 and 5 years, residents cover the trauma, pediatrics, hand and spine services at a senior level from home. This is a position of responsibility consistent with a resident’s experience and level of training. The resident must provide advice and occasional personal assistance to the junior residents in their evaluation and treatment of emergency department patients and inpatient consults. The resident is expected to cover all operative cases while on-call. Each night, one resident is on first call, while a second senior resident is designated as a back up in the case of multiple cases. Furthermore, the senior resident on call is expected to provide for accurate and complete transfer of patients onto their respective services in the morning following call.

Moonlighting by orthopaedic residents is not allowed.

**Vacation Policies**

During the PGY-1 year, residents are allocated three weeks of vacation. This vacation is coordinated though the Department of Surgery.
During PGY-2 through 5, residents are allocated one week of vacation every three months. All vacation must be cleared by the administrative chief resident for the respective three month period and the attending responsible for the service. It also must be approved by the attending designated to oversee time off for the entire program. The program coordinator must be notified of all vacations or absences. If more than one resident wants vacation at the same time, conflicts will be resolved with priority given to more senior residents.

**Other Upstate GME Policies**

The Upstate Medical University Department of Orthopedics complies with the policies established by the Upstate Medical University GME office. A listing of the GME policies is available in the Resident Handbook and can be accessed online at:

http://www.upstate.edu.libproxy2.upstate.edu/forms/pdf/F83163.pdf

**Examinations and Evaluations**

Included below are the important dates for exams, at which your attendance is mandatory:

1. **Orthopaedic in training exam (OITE)** – PGY2-5, usually the second Saturday in November annually.

2. **Orthopaedic Oral examination** – PGY3-5, mid May annually.

Other important tools used to evaluate residents include end of rotation evaluations, journal club participation, and grand rounds presentations. Resident progress with their research projects is monitored, and satisfactory completion of the residency program requires submission of at least one publishable manuscript. There is an anonymous 360 degree evaluation of resident professionalism conducted annually.

Residents are responsible for a varying amount of hospital chart documentation, employee health documentation and educational administration. Prompt completion of all records, notices and evaluations is expected, and repeated violations will result in assessment of penalties, and in extreme cases even non-renewal.

The program director or designated faculty member meets semi-annually with each resident to review evaluations and discuss progress in the program. An extensive annual review of each resident is conducted by the faculty members on the education committee. The format for the annual resident review, as well as examples of rotation evaluations, grand rounds evaluations, oral exam template and evaluation is included on the following pages.
### DEPARTMENT OF ORTHOPEDIC SURGERY - ATTENDING EVALUATION OF RESIDENT
(Quarterly—End of each Rotation – E*Value)

**THIS FORM IS TO PREVIEW AN EVALUATION ONLY!**

**DO NOT ATTEMPT TO COMPLETE THIS FORM!**

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<th>Rapport with Patients, Staff (Question 7 of 13 - Mandatory)</th>
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<th>Work as part of the Health Care Team (Question 8 of 13 - Mandatory)</th>
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<th>Documentation Skills (Patient work-up, op notes, etc.) (Question 9 of 13 - Mandatory)</th>
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https://www.e-value.net/admin/evalsetup/dsp_evaltest_preview.cfm?thisact=88934&moduleid=16... 4/21/2010
### Initiative (extra work) (Question 10 of 13 - Mandatory)

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### Rotation Specific Objectives (Question 11 of 13 - Mandatory)

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### Rotation Specific Objectives - Expand as necessary: (Question 12 of 13)

### Additional Comments (Question 13 of 13)

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

![Save For Later](Image)

![Submit](Image)

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https://www.e-value.net/admin/evalsetup/dsp_evaltest_preview.cfm?thisact=88934&moduleid=16... 4/21/2010
DEPARTMENT OF ORTHOPEDIC SURGERY - RESIDENT EVALUATION OF ROTATION
(QUARTERLY—EVALVALUE)

THIS FORM IS TO PREVIEW AN EVALUATION ONLY!

DO NOT ATTEMPT TO COMPLETE THIS FORM!

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Strong points: (Question 7 of 8)

Weak points: (Question 8 of 8)

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

Save For Later   Submit

https://www.e-value.net/admin/evalsetup/dsp_evaltest_preview.cfm?hisact=88934&moduleid=11... 4/21/2010
GRAND ROUNDS EVALUATION

Resident: ______________________________          Date: __ / __ / _______

Topic: ____________________________________________________________________

Moderator: _____________________________

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Comments: ________________________________________________________________

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__________________________________________________________________________
**Oral Exam Case and Resident Assessment**

**Resident__________**

**Case e.g. – Tibia fracture**
24 y.o. male – hit by car crossing street – brought in to ER by ambulance orthopaedic service asked to come assess

**Key Points:**

**History –**
- Events around injury – **slow crush by car bumper**
  - no LOC
- Treatment to date – ATLS work up by ER staff
- Current condition – stable, ATLS clear
  - C/O left leg pain

**PMHx**
- No prior surgery
- Otherwise healthy

**Last meal**
- in am

**Prior injuries**
- none

**Medications**
- Methadone
  - NKDA

**PE-**
- inspection – **swollen**, contusion, no open wounds
- palpation – pain distal midshaft
- neurologic exam – **peroneal, tibial, sural, saphenous (numb)** - Motor & sens N

**X-rays**
- Identify fracture location – ask for better views of knee

**Impression**
- Identifies major problems – reasons for providing treatment

**Plan**
- Surgical options – explain operative approach and technique,
  - (table, fluoroscopy, informed consent)
  - pre op planning – fixation,
  - pre op antibiotics
  - intra op x-rays to observe reduction, hardware
- Post op course – pain control – considers issues of methadone

**Complication**
- Post Op – increasing pain in leg
  - Re take history and physical
  - Recognize symptoms of compartment syndrome
- Plan: fasciotomies – describe technique in detail, what to do post op with non-viable muscle

**Comments:**
- Examinee: displayed clear understanding of patients condition **Y** **N**
- displayed safe, practical, cost effective decision making **Y** **N**
- recognized complication, and dealt with it appropriately **Y** **N**
- displayed knowledge of anatomy and surgical approach **Y** **N**
- displayed good organizational thinking and communication skills **Y** **N**
- displayed clear understanding of ethical issues and dealt with them in a professional manner **Y** **N**

**Overall:**
- 4. Safe and competent, good judgment
- 3. Unsure on some concepts, but overall acceptable
- 2. Poor grasp of concepts, acceptable treatment nonetheless
1. Failed to identify concepts, executed poor decision making
DEPARTMENT OF ORTHOPEDIC SURGERY END OF YEAR RESIDENTS OF FACULTY
(Anonymous Annual in E*Value)

THIS FORM IS TO PREVIEW AN EVALUATION ONLY!
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Involved me at an appropriate level in the surgical treatment of orthopedic patients. (Question 1 of 15 - Mandatory)

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Involved me at an appropriate level in the office care of orthopedic patients. (Question 2 of 15 - Mandatory)

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Explained his/her thought processes. (Question 3 of 15 - Mandatory)

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Demonstrated and conveyed a thorough knowledge of their field within Orthopedic Surgery (Question 4 of 15 - Mandatory)

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Participated in non clinical teaching forums. (Question 5 of 15 - Mandatory)

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Available when needed (Question 6 of 15 - Mandatory)

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Provided adequate and appropriate feedback (Question 7 of 15 - Mandatory)

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Allowed me to formulate a diagnosis and treatment plan. (Question 8 of 15 - Mandatory)

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Allowed me to free think  (Question 9 of 15 - Mandatory)

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Demonstrated ethical behavior  (Question 10 of 15 - Mandatory)

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Interacted appropriately with staff, peers, residents, and employees  (Question 11 of 15 - Mandatory)

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Served as a role model for me  (Question 12 of 15 - Mandatory)

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Demonstrated conscientious care of patients  (Question 13 of 15 - Mandatory)

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Demonstrated ethical care of patients  (Question 14 of 15 - Mandatory)

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Comments  (Question 15 of 15)

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

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DEPARTMENT OF ORTHOPEDIC SURGERY 360° EVALUATION (E-VALUE)

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For each item, select the number that corresponds with how characteristic the behavior is of the resident you are evaluating.

Note: An average resident should rate a (3) - Satisfactory

Follows through on tasks he/she agreed to perform. (Question 1 of 13 - Mandatory)

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Respects patient's privacy and autonomy. (Question 2 of 13 - Mandatory)

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Takes responsibility for actions, admits mistakes and does not blame others. (Question 3 of 13 - Mandatory)

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Makes patient care and well-being a priority. (Question 4 of 13 - Mandatory)

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Provides equitable care regardless of patient culture and socioeconomic status. (Question 5 of 13 - Mandatory)

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Is honest in interactions with others. (Question 6 of 13 - Mandatory)

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Is respectful and considerate in interactions with patients. (Question 7 of 13 - Mandatory)

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Is willing to answer questions and provide explanations. (Question 8 of 13 - Mandatory)

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Is courteous to and considerate of nurses and other staff. (Question 9 of 13 - Mandatory)

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Discusses patient issues clearly with staff and faculty. (Question 10 of 13 - Mandatory)

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Listens to and considers what others have to say about relevant issues. (Question 11 of 13 - Mandatory)

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Maintains complete and legible medical records. (Question 12 of 13 - Mandatory)

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Comments (Question 13 of 13)

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

[Save For Later] [Submit]
Annual Resident Review

Date ____ / ____ / _____    Resident ______________________________

1. Rotation Evaluation Forms ________________________________

2. OITE Marks ____________________________________________

3. Oral Exam Marks ________________________________________

   Handout of Answers to resident _______________________

4. Grand Rounds Evaluations ________________________________

5. Journal Club Evaluations _________________________________

6. Case Logs _____________________________________________

7. Professionalism / Ethics Portfolio _________________________

8. Orthopaedic Credentialing ________________________________

9. Miscellaneous Letters _________________________________

10. Research project_______________________________________

11. Competencies __________________________________________

12. Comments: ____________________________________________

   ______________________________________________________

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   ______________________________________________________
ANNUAL RESIDENT EVALUATION

For the Academic Year

Resident Name:

Program: Orthopedic Surgery

PGY Level:

Yes/No

☐ ☐ The above Resident has completed the appropriate clinical and educational requirements for this PGY Level.

☐ ☐ I have reviewed the progress made toward required credentialing and, if needed, advised the trainee of areas to be addressed.

☐ ☐ I am unaware of any indications of physical or mental disabilities or substance abuse (drugs or alcohol) that would impair professional functioning.

☐ ☐ The above Resident has been the subject of professional misconduct proceedings/malpractice litigation/disciplinary measures.

☐ ☐ I have reviewed the above Resident’s status file and recommend continuation of appointment.

Comments:

Program Director/Department Chair
Revised 1/24/06

Date
### FINAL EVALUATION FORM

This evaluation form is used for a (please check one):

- resident transferring to another institution ☐
- resident/fellow completing training ☐
- resident/fellow was terminated ☐

To whom it may concern:

This letter will certify that [name of resident] participated in the residency program in [insert name of specialty] at SUNY Upstate Medical University from [enter start date] through [enter end date].

During the course of [his or her] training at SUNY Upstate, Dr. [name of resident]’s overall performance was [choice of exceptional, satisfactory, or unsatisfactory]. [S/he] completed the following rotations:

[His/Her] evaluations in terms of the ACGME core competencies and program assessment indicated the following:

<table>
<thead>
<tr>
<th>ACGME Competency</th>
<th>Completed Satisfactory</th>
<th>Completed Unsatisfactory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical Knowledge</td>
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<tr>
<td>Practice-Based Learning</td>
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<tr>
<td>Professionalism</td>
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<tr>
<td>Interpersonal &amp; Communication Skills</td>
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<td></td>
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<tr>
<td>Systems-Based Practice</td>
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<tr>
<td>Program Assessment</td>
<td>Completed Satisfactory</td>
<td>Completed Unsatisfactory</td>
<td>Comments</td>
</tr>
<tr>
<td>Technical Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperativeness/Ability to Work With Others</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Additional comments [if needed]:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please indicate one of the following:

___ As a faculty, we are not aware of any personal or professional circumstances which would indicate that the privileges of the resident/fellow should be limited, postponed or denied.

___ As a faculty, we believe that there might be personal or professional circumstances which would indicate that the privileges of the resident/fellow should be limited, postponed or denied. (Explanation attached)
The resident did not complete the program and, therefore, we do not have the information to determine whether or not the privileges of the resident/fellow should be limited, postponed or denied.

Summary:

Yes  No (circle one) The trainee has demonstrated sufficient professional ability to practice competently and independently.

☐ We are unable to comment upon the resident’s/fellow’s competence.

Signature: ______________________________________

Print Your Name: ________________________________

Date:  __________________________________________

Academic Title or Position: ________________________

Phone Number:  __________________________________

cc: Office of Graduate Medical Education

Revised 2/13/09
Appendix A: ACGME Program Requirements for Residency Training in Orthopaedic Surgery

Program requirements for residency education in orthopaedic surgery can be found at:
http://www.acgme.org