Department of Orthopaedic Surgery

Resident Handbook

Revised June 2015

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Introduction and Welcome

Message from the Chair

You have chosen the University of Virginia for your Orthopaedic Surgery Residency and we are delighted to have you. Our faculty is committed to ensuring that your training will be challenging yet rewarding, and that you will have the experiences needed to be an outstanding Orthopaedic surgeon. Furthermore, the opportunities which will be made available to you should prepare you well for any setting, private or academic, and any specialty. My expectation is that all interactions, whether between resident colleagues, faculty, or patients, be based on mutual respect and cooperation. Ideally, your education will be an active and interactive process of professional exchanges including information gathering and implementation of care pathways with increasing levels of responsibility. With that in mind, please recognize that we will be working **together** to achieve excellence in patient care, Orthopaedic education and research.

This handbook is designed to furnish you with information about the Department of Orthopaedic Surgery and to answer questions you may have concerning our everyday operations. If you have any questions that this handbook doesn't answer, do not hesitate to ask any member of the faculty.

Message from the Residency Directors

With great pleasure we welcome you to the University of Virginia, Department of Orthopaedic Surgery Residency Training Program. Our mission is to attain a national and international reputation as a leader in academic Orthopaedics in the areas of patient care, Orthopaedic education, and musculoskeletal research. The strength of our program includes our dedicated faculty and our outstanding residents and fellows.

Our mission requires commitment to teamwork. This is essential for optimizing patient care and your education. We look forward to getting to know each of you and working closely with you to help you achieve your personal and academic goals.

Special Notice to All Employees

The personal pronoun "he" as used in this handbook is used for convenience and refers to people of both sexes. It is not to be considered a reflection of superiority or inferiority of either sex.

UVA Department of Orthopaedic Surgery

The Department of Orthopaedic Surgery is a national leader in the areas of patient care, Orthopaedic education, and musculoskeletal research. We provide state-of-the-art comprehensive care for all musculoskeletal disorders, treatment by responsive physicians in the highest quality facilities, and broad based primary and tertiary care. The department treats patients without regard to their ability to pay. We also provide quality graduate Orthopaedic education through an intensive teaching and evaluation process and participate in national, professional and educational activities.

The University of Virginia Medical Center serves as the home institution for residents during the five years of the Orthopaedic Surgery Residency Program. All but 40 weeks of training are spent in Charlottesville at the University of Virginia Medical Center, the UVA Children's Hospital, the UVA Outpatient Surgery Center (OSPC), the Fontaine Orthopaedic Center, the UVA Hand Center, the UVA Sports Center, and the UVA Spine Center. The hospital, a Level-One Trauma Center, and the associated facilities provide the core clinical experience for the Orthopaedic resident. Full-time UVA Professors in the Department of Orthopaedic Surgery represent all Orthopaedic subspecialties. The formal educational program includes structured Orthopaedic teaching conferences in fracture management, subspecialty core conferences, Grand Rounds, Quality Assurance conferences, small group service-specific conferences, and Basic Science and Anatomy conferences to provide a comprehensive curriculum of fundamental Orthopaedic knowledge. Involvement with research is required and encouraged for all Orthopaedic residents. With opportunities for research activity, residents gain invaluable experience in all facets of research: from proposal preparation and experimental design to podium presentations and manuscript submission.

Brief History of UVA Orthopaedics

The Department of Orthopaedic Surgery at the University of Virginia is one of the oldest in the country and dates back to 1932. From that year until 1949, Dr. Robert Funsten chaired the department. He was followed by Dr. J. Hamilton Allen, who in turn was succeeded by Dr. Warren G. Stamp in 1968. Dr. Funsten and Dr. Allen were excellent Orthopaedic surgeons who by all accounts had an outstanding department. Dr. Stamp brought the department into the modern era – a department that not only excelled in clinical Orthopaedics, but also in research and medical education, especially residency and fellowship training. At the time Dr. Stamp took the helm, the department consisted of two Orthopaedic surgeons. Dr. Stamp successfully recruited a wide variety of excellent Orthopaedic surgeons and research personnel and established an active and productive research lab. Several Orthopaedic surgeons, who served either as faculty or as residents in the Stamp era, have served as chairmen of Orthopaedic surgery departments across the country. Two have been presidents of the American Academy of Orthopaedic Surgery, the organization that represents

Orthopaedic surgeons in this country, and many others have held similar positions in other regional, national and international organizations.

Dr. Gwo-Jaw Wang took over as chair in 1992. Dr. Wang expanded the department to thirteen full-time Orthopaedic surgeons and developed the Division of Prosthetics and Orthotics. The Department expanded its divisions by adding Foot and Ankle and Orthopaedic Oncology. Dr. Wang also added two additional fellowships – Adult Reconstruction and Spine to the Department.

Dr. Cato T. Laurencin became the fifth Chair of the department in 2003. Clinically trained at Harvard, and Sports Medicine and Shoulder Fellowship trained, Dr. Laurencin brought a large research group with him from Drexel University in Philadelphia. The Department expanded a number of clinical divisions, including Adult Reconstruction and Sports Medicine. In addition, Dr. Laurencin created a University Research Center for Musculoskeletal Repair.

Dr. Mark Abel served as the sixth permanent Chair of the department, named in 2008. Dr. Abel's training included a surgical internship at Barnes Hospital, Washington University in St. Louis, MO, followed by residency training at the University of California San Diego (UCSD), which included a year of Orthopaedic research. A fellowship year in Pediatric Orthopaedics and Scoliosis Surgery followed at the Children's Hospital of San Diego. Here he developed his expertise in Motion Analysis for use as a clinical and research tool. Dr. Abel entered the United States Navy following fellowship and worked at the Portsmouth Naval Hospital. He joined the faculty of the University of Virginia in 1993. He has served on numerous medical school and hospital committees during his tenure, including the promotions and tenure committee, faculty search committees, Health Services Foundation Physician Advisory Committee, and the Children's Medical Center Leadership Committee. He is an international expert in clinical management of pediatric neuromuscular and spinal disorders.

Dr. A. Bobby Chhabra became Chair of Orthopaedics in August 2013 after serving as Vice-Chair for Dr. Abel since 2008. He has been a faculty member since 2002, and was instrumental in the creation of the University of Virginia Hand Center. Dr. Chhabra's strength has been in Orthopaedic education for which he is nationally recognized. He has also served on a variety of committees and positions within the University of Virginia Health System and School of Medicine including a two-year term as the Associate Chief Medical Officer for Surgical Services. His advocacy skills helped create significant changes in the OR with regard to patient centric care, resource utilization, efficiency, quality, work place environment improvement, as well as employee satisfaction and accountability. During Dr. Chhabra's early tenure as Chair, the department expanded to 26 clinical faculty members and 15 physician assistants. He helped reinvigorate the department's research enterprise by hiring nationally recognized scientists in the area of tissue engineering, clinical trials research and human performance. His priority is to respond to the changing health care landscape

which is moving toward a value-based care system. In addition, his objectives include improving the educational curriculum for our residents and fellows while incorporating the ACGME milestones and surgical simulation and enhancing musculoskeletal research and clinical trial productivity.

Orthopaedic Faculty

The department prides itself on having a very approachable and proactive faculty. The Chair and Residency Program Directors meet with the Chief residents frequently to discuss any issues related to the training program. Through the Chief residents, the junior residents have a voice in departmental affairs without fear of bias. These meetings, as well as the placement of junior and senior level residents on the education committee, have frequently led to revisions of departmental policy or curriculum. Any resident is free to address individual issues with the Residency Directors at any time. Each subspecialty that has a fellowship program (Sports Medicine, Hand/Upper Extremity, Adult Reconstruction, Foot & Ankle Surgery, and Spine Surgery) has multiple attending physicians participating in the subspecialty, in order to avoid diluting resident experience. Since this is a group practice, other staff members provide coverage for staff members that are called away from their practices. This facilitates continuity of patient care and resident training.

Orthopaedic Divisions

Orthopaedic Services	Faculty
Adult Reconstruction	James Browne (Division Head) Thomas Brown Quanjun Cui
Foot and Ankle Surgery	Joe Park (Division Head) Truitt Cooper Venkat Perumal
Hand, Upper Extremity and Microvascular Surgery	Bobby Chhabra (Division Head) Rashard Dacus Nicole Deal Aaron Freilich
Orthopaedic Oncology	Greg Domson
Orthopaedic Trauma	David Weiss (Division Head) David Kahler Seth Yarboro
Pediatric Orthopaedics	Mark Abel (Division Head) Leigh Ann Lather Mark Romness
Sports Medicine	Mark Miller (Division Head) Stephen Brockmeier Eric Carson David Diduch

	Winston Gwathmey
Spine Surgery	Frank Shen (Division Head) Hamid Hassanzadeh Adam Shimer Anuj Singla
Prosthetics and Orthotics	Don Payne Mark Grant Kevin King

Research

The department's research has recently gained national and international recognition. Both the research faculty and facilities have markedly expanded. The department has several Ph.D. primary and joint faculty members. The influx of research funding provides multiple opportunities for residents to actively contribute and participate in cutting-edge research. During their training here all residents are exposed to experimental design and are taught the process of producing scientifically sound research, from drafting proposals to presenting their data at national meetings. All residents are provided opportunities for research, and are required to complete one research project worth of submission to a peer-reviewed publication each year of training with a faculty mentor. es.

Medical School Affiliation

Being a part of the University and the Health Sciences Foundation provides numerous financial and academic benefits. Ready access to the Medical School faculty and facilities provides the residents with excellent research and academic opportunities. The University, through its Research and Development Fund, provides startup funding up to $30,000 for junior faculty to initiate research projects with the residents. Most of the faculty have funded clinical and basic science research programs.

Medical Library Facilities

The Claude Moore Health Sciences Library (https://www.hsl.virginia.edu/) is staffed with experienced employees and is well stocked with current Orthopaedic textbooks and journals. A vast array of journals, textbooks, computers, and databases are available from 7:30am to 12:00am in the library. Additional computers are available to the residents in the call room, ED, inpatient floor, and departmental offices. Off-site access is available to residents and fellows through the password protected UVA Health System intranet.

The Orthopaedic Department has its own Orthopaedic library at the Department office at Fontaine Research Park and there are also work cubicles available for residents in the departmental office space. Surgical simulation equipment including an arthroscopy simulator, suturing stations, and power instrumentation are available in the Orthopaedic library for all residents and fellows to practice their skills.

Surgical Skills Training Lab

The state-the-art Surgical Skills Lab opened in Spring 2015 in the space behind the Medical School Anatomy Lab in Jordan Hall. The lab is located in Jordan Hall, Room 1031, in the Gross Anatomy corridor. The creation and construction of the lab has been a three-year journey. The only one of its kind throughout our region, the lab serves all surgical services, respond to evolving training requirements for resident and fellow surgical simulation, and provide a site for CME and industry-sponsored courses.

University of Virginia Health System

Patient Population

UVA is the major referral center for a large area in Central Virginia and the Appalachians to the West. The next closest level-one trauma center is 75 miles to the East, with a much larger radius extending to the North, West, and South. A high percentage of difficult and challenging cases are referred in from outside sources as far away as West Virginia, Tennessee, and North Carolina. This referral base complements the more routine cases available from the local community. The department's share of local Orthopaedic care has increased commensurate with the improved facilities in the last decade, and we now control well over 70% of the local Orthopaedic care.

Inpatient and Surgical Facilities

The UVA Medical Center, opened in 1990, remains a state-of-the-art facility, providing the residents with the latest in technology and resources. There is a dedicated Orthopaedic inpatient unit, with a full-time nursing staff, Physical & Occupational Therapy staff, and a social worker. The University Hospital has 27 state-of-the-art operating rooms and was the first hospital in the country with the capability to perform 3-D computer-guided and Virtual Fluoroscopic pelvic and extremity surgery.

The Outpatient Surgery Center (OPSC) is in the basement of the adjacent Battle Building and provides twelve operating rooms for outpatient surgery

Outpatient Facilities

The main clinic is on the first floor of the Fontaine Orthopaedic Center, adjacent to the 50-bed inpatient HealthSouth Rehabilitation hospital. The clinic features free patient parking; physician workstations with computers and online clinical archive and radiograph access in each pod; five Orthopaedic clinic pods with four exam rooms each and a cast room; a minor surgical treatment room; in-house dedicated Orthopaedic radiology technicians with four x-ray pods, onsite MRI, ultrasound, and fluoroscopy; in-house radiologists; and handicapped patient parking and access.

The UVA Hand Center and The UVA Spine Center are located at the 415 Building at Fontaine Research Park. These state-of-the-art clinics provide convenient specialty specific care with all ancillary services located in clinic.

Prosthetics and Orthotics (P&O) is located at the Townside Shopping Center on 250 West). This facility fabricates artificial limbs and braces on site for both UVA patients and other patients of Central Virginia physicians. Because P&O is a division of Orthopaedics, it is important to properly order and medically document P&O services. All P&O prescriptions and Letters of Medical Necessity must be signed and dated by the ordering physician. Please make certain that the Letter of Medical Necessity has been correctly and fully completed with an appropriate diagnosis for the ordered service. Also, UVA Compliance requires that all P&O prescriptions for Medicare/Medicaid patients that are signed by residents be documented by the attending physician within his/her clinic note.

The Pediatric Orthopaedic Division is located on the 4th floor of the University Children's Hospital at the Battle Building. In addition to these clinic services, Dr. Abel has a Motion Analysis and Motor Performance Laboratory for both clinical and research purposes. This laboratory is just one of four on the East Coast.

Roanoke Affiliation

Residents spend two ten-week rotations in their third year and two ten-week rotations in their fourth year for a total of 40 weeks in Roanoke at the Carilion Memorial Hospital (https://www.carilionclinic.org/hospitals/carilion-roanoke-memorial-hospital). This is an important part of the residents' education as it allows them to have one-on-one surgical experience with board certified/fellowship-trained attending physicians, unfettered by the presence of medical students, junior residents, or fellows. This rotation is widely viewed by both faculty and residents as a time for significant maturation in surgical skills.

Contact Information

Note that when dialing in the hospital, the first two digits of the phone number are omitted, and frequently phone numbers and pages will not utilize the full seven digits of the phone number. The first two digits for phone numbers that start with "2", "3", and "4" are "98**2**", "24**3**", and "92**4**", respectively. This is reflected in how the numbers are listed below.

Orthopaedic Department Offices

Physical address:
400 Ray C. Hunt Drive, Suite 330
Charlottesville, VA 22903

Mailing address:
Department of Orthopaedic Surgery
University of Virginia Health System
P.O. Box 800159
Charlottesville, VA 22908

Phone: 434.243.0270
Fax: 434.243.0242

Faculty

Physician	Office Phone	PIC	Administrative Assistant	Asst Phone	Fax
Abel, Mark	4-2364	3076	Brenda Lawson	2-4215	2-1727
Brockmeier, Steve	3-0273	3574	Vickie Blackwell	3-0067	3-0242
Brown, Thomas	3-0293	3795	Vallerie Staton-Bickley	3-0278	3-0290
Browne, James	3-0279	3512	Vallerie Staton-Bickley	3-0278	3-0290
Carson, Eric	2-6539	6467	Kathy Johnson	2-4832	3-0290
Chhabra, A. Bobby	3-0268	3637	Marla Langdon	3-0218	3-0290
Cooper, Truitt (clinical)	3-0245	2747	Debbie Handy	3-0245	3-0242
Cooper, Truitt (admin)	3-0067	2747	Vickie Blackwell	3-0067	3-0242
Cui, Quanjun	3-0236	3725	Susan Fitzgerald	3-0266	3-0242
Dacus, A. Rashard	2-6704	3317	Diane Sullivan	3-0270	3-0242
Deal, D. Nicole	3-0282	6134	Vickie Blackwell	3-0067	3-0242
Diduch, David	3-0275	4137	Marla Langdon	3-0218	3-0290
Domson, Gregory	3-0266		Susan Fitzgerald	3-0266	3-0242
Freilich, Aaron	4-1796	3324	Vickie Blackwell	3-0067	3-0242
Gwathmey, Winston	4-2375	3062	Debbie Handy	3-0245	3-0242
Hassanzadeh, Hamid	3-0266	7207	Susan Fitzgerald	3-0266	3-0242
Kahler, David	3-0237	2434	Diane Sullivan	3-0270	3-0242
Lather, Leigh Ann	2-4832	6004	Sarah Spangler	2-4832	3-0290

Miller, Mark	2-4801	4073	Vallerie Staton-Bickley	3-0278	3-0290
Park, Joseph	3-5381	3947	Debbie Handy	3-0245	3-0242
Perumal, Venkat	3-0825	3984	Debbie Handy	3-0245	3-0242
Romness, Mark	4-2301	3392	Ashlynn Hughes	2-4214	2-1727
Shen, Frank	3-0276	3007	Sarah Spangler	2-4832	3-0290
Shimer, Adam	3-0276	6278	Lora Everly	3-0291	3-0242
Singla, Anuj	3-0291	3118	Lora Everly	3-0291	3-0242
Weiss, David	3-0292	3148	Kathy Johnson	3-0274	3-0290
Yarboro, Seth	3-0267	6843	Kathy Johnson	3-0274	3-0290

Staff

Orthopaedics Business Office, Fax 3-0230

Mike Boblitz, Administrative Director, Phone 3-0225
Mary-Leigh Thacker, Accounting and Billing Manager, Phone 3-0226
Rose Herndon, Accounts Payable, Phone 3-0220

Orthopaedics Office

Marla Langdon, Drs. Chhabra's and Diduch's Office, Phone 3-0218
Mindy Franke, Program Coordinator, Phone 3-0265, PIC 4667
Diane Sullivan, Dr. Dacus' Office, Phone 3-0270
Laura Simmons, Orthopaedic Grants Administrator, Phone 3-5647

Battle Building, Fax 2-1727

Karen M. Sisco Johnson, RN, CRRN, Nurse, Phone 4-5861
Patricia Morris, RN (Romness' nurse), Phone 2-4000

Fontaine Clinic, Fax 3-5460

Main Line Appointments, Phone 3-5432, Fax 3-0382
Authorization/Referrals, Phone 3-9167
Return Appointments, Phone 3-5433
Staff Notes/Supply Orders, Phone 3-5436
Registration, Phone 3-5428 or 3-5427
HSF Patient Accounts, Phone 3-0388, Fax 3-5612
Cast Technician, Phone 3-5444, Fax 3-5486
Surgery Scheduling, Phone 3-5435, Fax 3-0295
Triage Nurses, Phone 3-5440, Fax 3-5486

Hand Center

Appointments 982-HAND (4263)
Fax 924-1124
Surgery Scheduling (Vickie Musselman), Phone 2-6233

Spine Center

Front Desk 243-1531
Internal Scheduling Phone 5-7370
Surgery Scheduling (Kim Vest), Phone 243-1537

Sports Center

Front Desk 243-7778
Internal Scheduling Phone 3-7778
Surgery Scheduling (Amanda Davis), Phone 3-5066

Primary Care Center, Fax 3-0235

Medical Record Requests/Forms, Phone 3-0233
Patient Lists, Phone 3-0234

Hospital

6 East 4-2485
OR Front Desk 2-0655
X-Rays 3-6700
OPSC 2-6100

Orthopaedic Research

George Christ, Phone 4-5794 (MR5), 2-0682 (Cobb)
Joe Hart, Phone 3-0236
Shawn Russell, Phone 3-0247 (office), 3-6847 (lab)
John Miller, Phone 4-8994

Research Coordinators:
Wendy Novicoff –Adult Reconstruction, 3-5653, wmn2v
Vasantha Reddi –Trauma Division, 3-5682, vr8n
Rachel Koldenhoven –Pediatric division, 4-5938, rmk7ye
John Goetschius – Foot/Ankle, 3-0256, jg2uu
Grant Norte – Sports, 3-0256, gen5e

Lab 1 (Room B065) 4-1717
Lab 2 (Room B057 4-1716
Lab 3 (Room B051) 4-0269
Lab 4 (Room B035) 4-5989

Hannah Baker, Phone 4-5793
Gina Beck, Phone 4-5181
Abhijit Dighe, Phone 3-2598
Mengmeng (Morgan) Ding
Yongfei Guo
Jin Li, Phone 4-2949
Joshua Li, Phone 2-4135
Daniel Lovell, Phone 4-5793
Ellen Mintz, Phone 4-5793
Juliana Passipieri, Phone 4-5793
Xinlin Yang, Phone 4-0269

Musculoskeletal Radiology Faculty

Mark Anderson, Chief of Service, Phone 2-0275, PIC 4132
MSK Reading Room – 545 Building, Fontaine, Phone 2-6382

Anesthesiology Faculty

Lynda T. Wells, MD, Rotation Director, Phone 4-2283, PIC 4015

Emergency Medicine Faculty

William Woods, Residency Director, Phone 4-8770, PIC 3553
Travis Harris, Residency Coordinator, Phone 2-1800

Roanoke Carilion

Ted Shuler, Residency Director, Phone 540 981-8345
Rhea Jordan, Medical Education Coordinator, Phone 540 981-8345

Graduate Medical Education Office

GMEO Office – 243-6297
GMEO Fax Number – 244-9438
Risk Management (Malpractice/Claims History) – 924-5595

Medical Records

Office of the Director -- 4-2196
McKim 1099
Coordinates management of the entire medical records department.

Coding -- 4-5890
East Hospital G022
Compiles pertinent and accurate patient information that drives both the financial and reporting functions of the hospital; assigns comprehensive diagnosis and procedure codes that fully describe the patient's condition.

Incomplete Records Management -- 2-0717
Transcription -- 4-5386
East Hospital G028
Houses recently discharged medical records that require physician completion; assesses the quality of the medical record documentation; maintains controls relating to the completion of dictation, transcription, and their necessary signatures; maintains correspondence with referring physicians, patients, and other outside agencies.

Records Management -- 4-5283
McKim B127

Serves as the repository for all complete hospital medical records; maintains and controls access to inpatient and outpatient medical records for both patient care and administrative purposes; maintains automated systems for both record tracking and master patient indexing.

Release of Information -- 4-5136
McKim 1092
Controls the release of information from the medical record of any patient treated at UVA Health System; responds to all requests for access upon receipt of proper authorization; works closely with Risk Management to provide confidentiality and security of medical records.

Statistical Reports & Research -- 4-2196
Audits -- 4-2245
Following completion of the necessary form, medical records will be available in the Research Area of HIS.

Paging

Residents are responsible for updating their Status/Location codes in the Registry System on a regular basis. Access to the Registry System is made by dialing 511 from within the hospital or by dialing 982-3501 from outside the hospital.

The system Status/Location codes are:
10 – Available for Radio Paging
16 – Calls are being taken by (PIC/Name)
17 – Can be reached at (telephone number)
18 – Unavailable until (date or time)
19 – Not on Call
20 – Not available, Messages being stored
21 – Available on outside pager

Direct Dial Paging

(500 plus PIC)
To place a direct page to medical staff and employees without operator assistance, dial 500 plus the user's PIC from any University telephone. The system will prompt you through each transaction. Once familiar with the system, you can overdial any prompt to speed your transaction.

Housestaff frequently sign their pages with their four digit PIC number by separating it from the callback number with "00".

Use a # at the end of your call back number (message) or just hang up.

From outside the University dial 982-3500 plus the user's PIC.

University of Virginia Orthopaedic Residency

Duty Hour Requirements

UVA Policy

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call, not including vacation leave. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
5. In-house call must occur no more frequently than every third night, averaged over a four-week period.
6. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in the Specialty Program Requirements for Duty Hours.
7. No new patients, as defined in the Specialty Program Requirements for Duty Hours, may be accepted after 24 hours of continuous duty.
8. At-home call (pager call) is defined as call taken from outside the assigned institution.
    a. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

b. When residents are called into the hospital from home, the hours the resident spends in-house are counted toward the 80-hour limit (but not the 10 hour rest period).
c. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Resident call schedules are arranged in order to maximize free time for the resident, while not adversely affecting patient care and safety and resident education. Residents work as teams, and these teams share the responsibility of rounding on weekends when they are not on call.

Residents taking in-house call are excused from all clinical duties by 12:00 noon (at the latest) the following day. This provides them with ample time to rest and prepare for the upcoming educational readings, etc. Mid-level and Chief residents take home call both during the weekdays and weekend days. Chief Residents take home-call and are summoned to the hospital for consultation with the junior residents on evaluation and management issues, and for all operative cases.

UVA Orthopaedics Policy

The Department of Orthopaedic Surgery follows the ACGME Duty Hours guidelines, requiring PGY2 – PGY5 residents to work no more than 80 hours in a week, to have 1 day in 7 free from all clinical duties (averaged over four weeks), to have 10 hour breaks between shifts, to have call no more frequently than one in three days (averaged over four weeks), and to work no shift more than 24 hours. Resident Duty Hours are to be recorded daily in the New Innovations Software system. The following delineates our policies on duty hours for Orthopaedic Surgery Residents.

Rule: 80 hours

Duty Hours must be limited to 80 hours per week

Every resident is required to monitor their own duty hours for each week, and anticipate when violations may occur based on their services' upcoming clinical duties and their own upcoming call schedule. If violations are anticipated, they must be reported in a timely fashion so that adequate intervention can occur. Duty hour reports are to be submitted to the chief residents every two weeks. Junior residents on each service are to report problems to their Chief Resident.
If an adequate resolution cannot be achieved to avoid duty hour violations, the issue must be immediately referred to the Administrative Chief Residents.

Residents on services with no other residents are to report anticipated duty hour violations to the Administrative Chief Residents.

Rule: 1:7

Residents must be provided, at minimum, 1 day in 7 free from all clinical duties

Rule: 10-Hours

10-hour time period provided between all daily duty periods
The Chief residents and Attendings of service are responsible for ensuring that clinical duties are completed in a timely fashion each day to ensure compliance with the 10-hour off rule.

The Night Float chief will have to cover daytime elective cases still running at 6:00pm to ensure that the daytime residents are relieved in time to get a full 10 hours off before returning to work the next morning. The Night Float Chief will be responsible for checking with the OR front desk at the beginning of the evening to ensure that all daytime residents are relieved by 6:00pm.

Rule: 1:3

In-house call must occur no more frequently than every third night, averaged over a four-week period
This should not be an issue with anyone, as we have the Night Float system in place at UVA, and four residents alternating call in Roanoke. Interns are not allowed to take overnight call.

Rule: 24 hours (24+4)

Continuous on-site duty must not exceed 24 consecutive hours, but residents may remain on duty for up to 4 additional hours for transfer of patient care (28 hour rule).

In-house, on-call residents must work efficiently to ensure their call duties are complete by the end of their 24-hour shift. If new consults are still not seen by the end of 24 hours, they must be handed off to the oncoming on-call resident.

Intern Rule: 16 hours & Supervision

Interns are allowed to work a maximum of 16 continuous hours per shift. Interns should be supervised either directly or indirectly with direct supervision immediately available.

Intermediate Residents: PGY-2 and PGY-3

Intermediate residents should have 10 hours free of duty between shifts but MUST have at least 8 hours between shifts. They MUST have at least 14 hours free of duty after 24 hours of in-house duty.

Senior Residents: PGY-4, PGY-5 and PGY-6

Residents in the final years of Orthopaedic education are allowed, on selective basis, to care for patients over irregular or extended periods of time. These

circumstances are defined as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. The supervisor will need to approve all overages of this type on a case-by-case basis, residents should put in comments on their duty hours when such occurrences happen.

Specialty Program Requirements for Duty Hours

All Services

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care. This may include resident participation in the first surgical case of the day. The resident should have evaluated the patient before participating in surgery.

Recording Resident Hours and Case Logs

All residents are required to log their time into the New Innovations system on a daily basis. See the Graduate Medical Education Manual for GME Policy No. 23, “New Innovations.”

Duty Hours and Case Logs must be entered each week. This is an ACGME requirement. Failure to comply with this requirement may result in a probationary status for lack of professionalism and this will become a permanent part of the trainee’s file. Lack of compliance places the program at risk and will not be tolerated. Random checks of compliance will be performed by the residency coordinator and directors. Any resident who falls behind logging cases or duty hour greater than 4 weeks will be held out of the operating room until up-to-date.

If, during the academic year, the resident is persistently delinquent entering cases into the ACGME Case Logs, entering time into New Innovations, or misses >10% of lectures for the calendar month, the resident will receive an e-mail warning from the Residency Coordinator. A second occurrence within the academic year will result in a “letter of serious concern” from the Program Directors. Such letter will be attached to the resident’s permanent records. A third occurrence will result in the resident sitting before the Resident Advocacy & Remediation Committee facing potential remediation.

Resident Call and Coverage

The following policies are in effect regarding resident call and coverage.

Orthopaedic Call

Call Schedule and Responsibilities

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

PGY-2 and PGY-4 residents rotate on the Night Float service which covers 7pm to 7am Sunday through Thursday each week. Rotating daytime PGY-1 (Monday) or PGY-2 residents take over during the weekdays. Friday 7am through Sunday 7pm the PGY-2 residents take in-house call every second weekend on average. PGY-3 through PGY-5 residents take no in-house call. The PGY-3 and PGY-4 residents take primary pager ED call every third weekend on average. Chief (PGY-5) residents take second call from home every third weekend on average, and are responsible for all patients seen in the ER and all consults and must be available to immediately assist junior residents with difficult patients in the ED or on the floor.

During Roanoke rotations (40 weeks of the residency spread over the PGY-3 and PGY-4 years) residents take first call from home once every fourth night on average. Even though the residents take no in-house call in Roanoke, the call workload is such that the program directors require that the residents be free of all clinical responsibilities after 12:00PM on their post call days. Only two of the four residents that are rotating in Roanoke remain to cover weekends, consequently residents have every other weekend free from all clinical responsibilities.

The resident call schedules are reviewed by the Program Directors to ensure compliance with ACGME mandates regarding duty hours. The New Innovations system now provides more rapid recognition and response to deviations from accepted duty hour practices.

Detailed UVA Call Schedule

Pager #1206 (Ortho In-House Resident on call)

- Monday – Thursday 7am to 7pm, Friday 7am to 4pm: Day call junior resident
    - Monday – Intern on Adult Reconstruction or Spine
    - Tuesday – PGY-2 on Pediatrics
    - Wednesday – PGY-2 on Adult Reconstruction
    - Thursday – PGY-2 on Sports
    - Friday – PGY-2 on Spine
- Sunday – Thursday nights 7pm to 7am: Night float junior resident

- Friday 4pm to Saturday 6am: Weekend Friday/Sunday junior resident on call
- Saturday 6am to Sunday 6am: Weekend Saturday junior resident on call
- Sunday 6am to 7pm: Weekend Friday/Sunday junior resident on call

  The junior resident is required to talk to the Chief on call about all consults and admissions. The Chief Resident should be involved in all decisions regarding in-patient and out-patient consults and is to direct triage and patient management of all consults. **The Chief Resident on call is to review all fracture and joint reductions, particularly before a patient is discharged from the ER.**

Pager #1251 (Ortho ER Resident on call)

- Monday – Thursday 7am to 7pm, Friday 7am to 4pm: Day call junior resident (see above)
- Sunday – Thursday nights 7pm to 7am: Night float junior resident
- Friday 4pm to 11pm: Weekend Friday/Sunday mid-level resident on call
- Friday 11pm to Saturday 6am: Weekend Friday/Sunday junior resident on call
- Saturday 6am to 11pm: Weekend Saturday mid-level resident on call
- Saturday 11pm to Sunday 6am: Weekend Saturday junior resident on call
- Sunday 6am to 7pm: Weekend Friday/Sunday mid-level resident on call

  The in-house junior resident takes over primary call at 11:00pm. **The PGY-3 and 4 resident covering E.R. calls on Friday and Saturday must be available even after 11pm.** While the senior does not get direct E.R. consults after 11pm they must be available to assist the junior resident and be involved in all operative cases that go to the O.R. on Friday and Saturday nights.

Pager #1218 (Ortho Chief Resident on call)

- Monday – Thursday 6am to 6pm, Friday 6am to 4pm: Trauma service chief resident
- Sunday – Thursday nights 6pm to 6am: Night float chief resident
- Friday 4pm to Saturday 6am: Weekend Friday/Sunday chief resident on call
- Saturday 6am to Sunday 6am: Weekend Saturday chief resident on call
- Sunday 6am to 7pm: Weekend Friday/Sunday chief resident on call

  The night float chief and the chief resident covering weekend call is required to be involved in every consult that is seen during call coverage and be the **direct contact** to the faculty on call for all operative cases and admissions. The chief residents are required to provide guidance for posting all surgical cases so that appropriate equipment and positioning is on the posting slip so that there are no

delays during surgical intervention. **The Chief Resident or Night Float Chief is required to see all admissions, operative cases, and patients with a change in status (transfer to unit).**

If the chief residents do not follow these new guidelines regarding involvement in all consults and direct evaluation of all admissions, operative cases, and patients with a change in status during call, then chief residents and senior residents will be required to take in-house call on Friday and Saturday nights.

Night Float

- Night float residents (PGY-2 and PGY-4) rotate on in-house call from 7pm – 7am Sunday through Thursday and are allowed to operate until noon on Fridays ONLY.
- The remaining residents take call from Friday night through Sunday at 7pm when the night float residents return.
- Conference attendance is required for all residents on the night float rotation. Night float residents will be expected to join the Trauma service for Thursday morning service specific conference.

Weekend Call

- Friday: Friday 4pm to Saturday 6am
- Saturday: Saturday 6am to Sunday 6am
- Sunday junior and mid-level residents: Sunday 6am to Sunday 7pm
- Sunday chief resident: Sunday 6am to Sunday 6pm
- Night float junior resident: Sunday – Thursday nights 7pm to 7am
- Night float senior resident: Sunday – Thursday nights 6pm to 6am
- Day call junior resident: Monday – Thursday 7am to 7pm, Friday 7am to 4pm
- Day call chief resident: Monday – Thursday 6am to 6pm, Friday 6am to 4pm

The PGY-3 and 4 resident covering E.R. calls on Friday and Saturday must be available even after 11 pm to assist in operative cases and to assist the in-house junior resident who takes over primary call at 11 pm. While the senior may not get direct E.R. consults after 11 pm they must be available to assist the junior resident and provide guidance and be involved in all operative cases that go to the O.R. on Friday and Saturday nights.

Call Coverage During Special Events

1. **OITE Examination** (November) – Two (Adult Recon) fellows take call (Friday 8pm – Saturday 6pm), covering floor and ER call. All residents are off call from Friday 8pm through Saturday 6pm when normal call resumes.

2. **ORS/AAOS** (Winter/Early Spring) – PGY-4 assumes role of Chief resident Friday through Sunday as follows:
   - **Tuesday** – **Thursday** – Night Float Residents (normal)
   - **Friday** – **Saturday** – PGY-4 (Chief), PGY-3 (ER), PGY-2 (In-House)
   - **Sunday** until 7pm – PGY-4 (Chief), PGY-3 (ER), PGY-2 (In-House)
   - **Sunday** after 7pm – Night Float Residents (normal)
3. **Visiting Professor Lectureship** (Graduation Weekend, May/June)
   - Visiting Professor arrives in Charlottesville late Thursday night or early Friday morning. The academic program will take place on Friday afternoon and all chiefs will make 10-15 minute presentation to the Visiting Professor, suitable for publication but not necessarily submitted. An outline or manuscript is required to be delivered 2 – 4 weeks prior to lectureship to the Program Director for review and approval
   - The Friday program culminates with Visiting Professor dinner with the chief resident, program directors, and chair.
   - Additional educational activities should be planned for Saturday morning.
   - Graduation banquet is held on a Saturday evening
   - Chiefs are excused from call on Friday at noon. The rising chiefs will start call on Sunday at 7 am. Graduation call:
     - **Thursday** – Night Float Residents (normal)
     - **Friday** – Trauma chief will remain Orthopaedic chief resident on call until noon after which time the Sports Fellow will take over as chief resident. Please arrange sign-out in a timely fashion so that the Trauma chief can attend the educational program on Friday afternoon at Fontaine. The PGY-2 on day call will maintain normal responsibilities. **Friday and Saturday will be normal call days except the chief resident (1218) will be covered by the Sports Fellows until Sunday morning at 7AM.**
     - **Sunday** – 7am – 7pm – Regular Call Schedule with new classes taking the updated roles.
   - Roanoke call – All residents will work through Thursday, with the on-call resident being released Thursday evening at 10pm so they can make it back to Charlottesville for Friday morning's lectureship start. All residents are free of clinical duties on Friday and Saturday. The on-call resident is to return for call by 6AM Sunday morning.

Weekend Rounding and OR coverage

Over a 4-week period, each resident must have four 24-hour time periods off from clinical duties.

1. Weekend (6 residents total) call teams will round on all Orthopaedic in-house patients over the weekend (Saturday and Sunday).
2. Each service will provide a detailed/updated sign-out for all primary patients and active consults. (This sign-out will be detailed per department policy as approved by program directors and chief residents).

3. Attendings will be notified each weekend of the residents designated to round on their respective patients. The weekend rounding team residents will be available for rounding and patient care. No resident will work beyond the 24 + 4 duty hour period. Furthermore, all residents will have at least 10 hrs between weekend duty periods.
4. Weekend Chiefs will facilitate OR case starts as well as participate in and oversee all weekend rounding. As all chiefs have at some point in their training completed each Orthopaedic rotation, they will serve as the conduit reference for questions/patient care direction for all patient issues over the weekend. This is similar to current policy.
5. Residents not on call for a said weekend will be off of pager call or clinical duty from Friday afternoon until Monday morning 6 am. This will provide, at minimum, 48 hrs off of clinical duty. As residents on average take call 2 weekends (Fri/Sun or Sat) over a 4 week period this will policy will provide each resident, at minimum and on average 1 day off in 7 and be in compliance with the ACGME 1:7 duty hour regulation.
6. To ensure compliance and facilitate problems as they arise, the Orthopaedic administrative chief residents will keep an active 4-wk period log of all duty hours and shifts, as well as days off.
   - This will be facilitated by residents **REQUIRED** to report their duty hours to the administrative chiefs on a weekly basis.
   - Duty hours will be reviewed by PDs and Chief Residents monthly, with service/educational adjustments made as needed to maintain a ACGME compliant, optimal educational training environment with delivery of quality patient care.
7. Ortho in-patient consults, ER consults, and urgent floor issues take priority over double and triple scrubbing cases. We are expected to be responsive to patient consults as this is good patient care. If it is not busy, the residents should be in the OR as much as possible. Some cases may require 2 residents (multiple extremity injuries). The Chief resident on call is responsible for allocating duties and OR coverage each day.

Saturday Elective Time

To keep up with the increasing Orthopaedic volumes, elective time has been allocated to Orthopaedic surgery on Saturdays. As of now, Foot and Ankle and Spine utilize this time most routinely. While physician assistant and fellow coverage has been arranged for some of the days, at least one Foot and Ankle day per month will be covered by an Orthopaedic intern who does not have rounding or floor responsibilities..

If there are add-on cases posted in the Trauma room as well as cases posted in the Elective room, the Chief and PGY-2 resident on call will operate in the Trauma room, and the PGY-3/4 will operate with the attending in the Elective room. If there is also an urgent ER consult at the same time, the Chief and

Attending on call will operate in the Trauma room and the PGY-2 will see the ER consult.

If there is a particularly interesting Saturday elective case or a case that requires extra manpower, the resident on that service may participate in the Saturday elective case, but must arrange ahead of time with the other resident on service to ensure a total of 4 days off in the 4 week period, and to work within the 80-hr duty hour rule.

For complex cases to be done on the weekend by services with fellows (sports, hand, spine, joints); the staffing attending will determine if fellow coverage will be needed. The fellows must remain compliant with all duty hour regulations.

Resident Responsibilities

Chief Resident – General Responsibilities

The chief residents are directly responsible to the attending physicians on each of the services. Their duties are, in part, to:

1. Supervise patient care and operating room procedures
2. Round with attending physicians and associated residents
3. Take night call in rotation with other chief residents
4. Directly supervise emergency room care when on call, including review of records and imaging of patients treated by the assistant or associate resident for that particular on-call period
5. Coordinate and direct the interns, assistant residents and associate residents to provide service with minimal delay to Emergency Department patients
6. Be in attendance at all emergency or semi-emergency operative procedures when on-call
7. Participate in the outpatient clinic with the attending Orthopaedic surgeons
8. Organize conference schedules for Basic Science, Fracture Conference, Core Curriculum, Grand Rounds and Journal Club
9. Supervise the preparation of Quality Assurance (QA) Conference and Grand Rounds
10. Participate in the clinical education of the Orthopaedic associate residents, assistant residents, housestaff, and medical students

Administrative Chief Resident (ACR)

One or two residents will serve as the administrative chief residents and are directly responsible to the Chairman of the Department and the Residency Program Directors. The ACR will provide supervision to all of the Orthopaedic residents. Specific duties include:

1. Preparation of a weekly schedule of conferences each month
2. Supervision and staffing of all outpatient clinics
3. Arrangement of vacation and meeting schedules, with approval of the Program Director

4. Maintenance of communication between Department Chair, Vice Chair, Program Director, and residents

Other Specific Chief Resident Responsibilities

The chief resident on each service is directly responsible for coordinating patient care on that service. Communication between department faculty and residents is essential to optimize patient care.

Residents Assigned to UVA Medical Center

The resident is responsible to the chief resident and attending surgeon on the various services. Duties are, in part:

1. The primary care of patients on the service
2. Daily work rounds on the patients and accompanying the attending and chief resident on rounds. Work rounds and dressing changes are to be completed prior to surgery. Appropriate notes in the patients' charts are to be made at that time
3. Workups, which should include complete history and physical examination on all elective and emergency admissions on the individual service. The elective admission list may be found in the Admitting Office, and it should be checked daily. Emergency and/or scheduled admissions are to be recorded on the electronic board
4. To see all Orthopaedic consultations in the ER and emergency consultations in-house with the attending

Residents Assigned to Affiliated Hospitals

During the third and fourth years of the Orthopaedic Residency Program, each resident will have rotations at the Roanoke affiliated hospitals as well as at the University of Virginia. At each of the hospitals, the residents are responsible for the care of Orthopaedic patients, preparation for conferences and rounds, and the teaching of medical students, surgical residents, and interns in the various hospitals. The residents must be available for emergency operative procedures, which are assigned to affiliated faculty.

The chief residents will be responsible for preparing and presenting one Orthopaedic Grand Rounds during the academic year in addition to organizing and presenting conferences at each of the respective hospitals. The staff service Orthopaedic clinic will be the primary outpatient responsibility of the Orthopaedic residents at each of the respective hospitals.

The GME office provides a furnished two-bedroom apartment to each resident during his/her Roanoke rotation.

PGY-1 Rotation and Coverage Responsibilities

This will maximize exposure to services with large in-patient volumes and prepare the PGY-1 for the Orthopaedic residency years.

Interns rotate on a monthly basis per the General Surgery schedule with two interns rotating on Orthopaedics each month. Six months out of the year, three interns will be rotating on Orthopaedics. The interns will be assigned to the Adult Reconstruction and Trauma service. When a third intern (PGY-1) is on the Orthopaedic Service during even months, this resident will work with the Orthopaedic Spine Service. Duties include rounding, the OR, and clinic.

Intern/PGY-1 Call When on Orthopaedics

1. The intern on Adult Reconstruction covers 1206/1251 first call on Monday of each week.
2. In addition, each intern will take one buddy call Saturday night shift (7pm Saturday - 7am Sunday) to learn how things function at night on a weekend. On these weekends they will be off the preceding Friday 7pm - Sat 7pm at minimum. The call shift will end at 7a Sunday with no clinical duties or pager call until Monday at 7a.
3. The intern will also take one Sunday day buddy call (7a - 7pm). They will be off the Saturday before this call shift.

This will give them 4 to 5 day calls a month, and 2 weekend shifts a month all within duty hour regulations and will aid in their future transition to PGY-2 level call the following year.

Intern schedules and call will be reviewed and scheduled by the chiefs and recorded. These will be reviewed by the PDs to ensure compliance.

Note: PGY-1 residents on Orthopaedic service will cover the (with the NP) Orthopaedic inpatient floor every weekday until 12:30pm to assist with patient discharges and floor issues. After 12:30pm, the intern may attend OR cases or clinic duties if all floor duties are completed.

Emergency Room

All patient encounters in the Emergency Room must be discussed with the Attending on call. PGY-1 or PGY-2 residents must also communicate with the Chief Resident on call, and the Chief resident **MUST** be present for the performance of procedures with which the junior resident is not yet proficient or experienced. Documentation of Emergency Room encounters must reflect that the case was discussed with the Attending on call. In addition, if follow-up care is to be provided by another attending based on subspecialty, this must be so noted in the dictation, with the name of the particular Attending with whom the patient will follow-up.

Other General Resident Responsibilities

1. New Innovations time entry is not optional. Residents are reminded of the University’s Honor Code when entering time into the New Innovations System.

Resident work hours are monitored by the Program Directors, the Program Coordinator, and the GME Office. The New Innovations system records and monitors resident work hours and reports any violations to the Residency Coordinator and Program Directors. Duty hours MUST be entered daily.

2. ACGME Case Logs – Additional references including procedure (CPT) codes are available at the ACGME website http://www.acgme.org

Moonlighting

No moonlighting is allowed in the Department of Orthopaedic Surgery. Educational and service activity that UVA Orthopaedic Surgery Residents provide for local varsity sports activity (physical exams, presence at games, etc) will count toward duty hours and any stipends will be placed in the Resident Education fund within the UVA Alumni Association account. All money received will be shared by residents in the form of books, subscriptions, or the year-end visiting professor activity.

High School Football Coverage

Resident physicians in the department of Orthopaedic Surgery at the University of Virginia may elect to cover high school football games in the city of Charlottesville, Albemarle County, and other neighboring counties. This is an elective outreach program sponsored by the Department of Orthopaedics that will abide by the following guidelines:

1. Each resident will be linked to an attending physician. Prior to each session each resident physician will be assigned to an attending physician for supervision, call, etc.
2. Resident coverage of high school sports is not required as a part of the residency curriculum; this is an elective. Those who desire this educational experience provide coverage on a strictly volunteer basis. Goals and objectives of this elective will be reviewed with the resident prior to the elective.
3. Each resident who covers a high school sports team will be required to attend the annual athletic team coverage orientation which is held annually during the first week of August. UVA attending physicians provide current information regarding athletic injury recognition, management, and return-to-play guidelines. CPR training/certification is also offered during this orientation course.
4. Resident physicians will not directly receive payment or compensation in any form from the high schools they are covering. Travel cost reimbursement of no more than $10 per game covered may be paid directly to the resident by the school. All other monetary contributions from high schools will be paid directly to the University of Virginia, Department of Orthopaedic Surgery Alumni Fund. This money will be earmarked for use by residents providing coverage to purchase books, fund additional

conference travel/registration fees, etc. Funds from this source may also be used to support the annual athletic team coverage orientation.

5. The residents will be covered by their University of Virginia liability insurance when providing coverage of these games.
6. As this is a recognized elective educational activity, time spent covering sporting events **does count** against duty hour work requirements. It is not considered moonlighting as resident physicians do not receive direct payment for their services.
7. Since this is an elective, all residents participating will be evaluated by the attending providing supervision.

Consultations & Referrals

All requests for Orthopaedic consultation from the Adult and Pediatric Emergency Room must be seen in a timely fashion. Please be courteous in your interactions with the residents and faculty in the Emergency Room.

The Emergency Room on-call resident will cover emergency room consultations throughout the day and will report to the Orthopaedic chief resident and attending covering consultations for that day.

After 7pm during the work week, the Emergency Room will be covered by the night float on-call residents with consultations going to the attending physician on call.

Please keep in mind that residents and attendings in the Emergency Room count on Orthopaedic Residents to provide courteous and effective guidance for consultations. PLEASE COMPLETE EPIC NOTE FOR ALL ER AND IN-HOUSE CONSULTATIONS IMMEDIATELY AFTER COMPLETING CARE OF THE PATIENT. IF THE ENTIRE NOTE CANNOT BE WRITTEN IMMEDIATELY DUE TO TIME CONSTRAINTS, LEAVE A BRIEF NOTE WITH THE DIAGNOSIS AND PLAN AND COMMUNICATE THAT PLAN WITH THE EMERGENCY ROOM TEAM..

Orthopaedic Surgery Escalation of Care Policy

Alert Senior Resident/Chief for:

1. All new admissions and consultations
2. Sudden decline in mental status
3. Sudden worsening of neurologic function in extremity
4. Sudden drop in SaO_2 > 8% from baseline
5. Worsening of medical condition requiring urgent consultation to another service (Medicine, Cardiology, Respiratory, Neurology, etc.) or transfer to a higher level unit of care
6. MET code or Code 12 called for a patient
7. Death of a patient

8. Pain out of proportion to expected level based on procedure/injury; not controlled by narcotics; worrisome for compartment syndrome
9. Concern for post-op wound infection – increased wound drainage, redness, etc.
10. A family or patient is requesting patient representative to make a formal complaint

Alert Attending Physician for:

1. All new admissions and consultations
2. Worsening of medical condition requiring transfer to a higher level unit of care
3. MET code or Code 12 called for a patient
4. Death of a patient
5. A family or patient is requesting patient representative to make a formal complaint
6. Senior or Chief concerned about the medical/surgical condition of a floor patient

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

Documenting an Orthopaedic Consultation - A Guideline

This is a guideline and not a template. You need to ask the specific attending or the Chief Resident on call what the individual attending would like to see included in a consult.

1. ***All consults are formal consults. There are no "curbside" consults.***
2. Getting started: all consults should entered into EPIC as a Consult Note / H&P with the name of the Orthopaedic attending of record and, if known, the name of the faculty orthopaedist or service who will take care of the patient on a follow-up appointment. Specifically state the attending on call and the follow-up attending.
3. All consults begin after establishing who the consulting team is and what they wish to know or what need as a procedure for the patient. All consults should begin with "I was consulted by Dr. {insert name} of the {name of service} to evaluate OR and treat …."
4. Don't document unnecessary, irrelevant and speculative information, i.e., "The patient was injured in an MVA" not "This drunken, unrestrained driver of a stolen Hummer missed a curve on an unfinished stretch of State Road 39 and crashed into a bridge piling." Unless you were riding in the vehicle and witnessed it, it is just hearsay and best left off the record.

5. Pertinent positives and negatives in both history and physical findings. Not a complete head-to-toe review of systems and exam. But focus your questions and exam to the injured or pathologic systems and body parts.
6. Before formulating an opinion and plan, discuss with a senior level resident and document that resident's level of participation – if they examined the patient with you or helped with a reduction or helped determine if surgery or MSK procedure was indicated.
7. If the patient needs surgery or an invasive procedure, be certain to mention that the senior level resident and attending were informed and agreed with this plan.
8. Formulating a plan: these are suggestions and you are to be as specific as you can about who will be following up on these suggestions. If there is urgency to anything, be sure to document that you made that fact clear to a named person on the consulting team. Do not provide treatment suggestions if you were asked to make a diagnosis only.
9. For outpatient follow-up for ED and in-patient consults always give a narrow range of possible return dates and communicate this to the receiving service in as many ways as possible, particularly if the problem has urgency (i.e. needs to be seen in 1-2 days). If you've discussed the situation with the ultimate receiving service, it is acceptable to say that the patient may be contacted with a follow-up appointment by the resident or the attending (or someone designated by that attending to make appointments) of that service.
10. If you are being asked to accept the patient and have Orthopaedics be the responsible service, be certain to speak with the accepting attending or his resident and document that. Always mention that the attending is aware of what is happening. In the event that the faculty orthopaedist does his or her own evaluation, try to make the evaluation and treatment plan you document coincide with that of the attending.
11. The consultation should include: Why you were consulted, who the patient was, what the problem was you were asked to solve, who helped you solve the problem, what you believed the situation was (diagnosis), what needed to be done, how your suggestions were to be implemented, and when the service was or can be provided.

Operating Room Schedules

Surgery is to be scheduled through each service's surgery schedulers. The Chief Resident on each service is responsible for the sequence of cases, for any additions or subtractions, and for the appropriate equipment and positioning. The information required includes a realistic appraisal of the amount of time necessary to complete the procedure, use of the intensive care unit postoperatively, and estimated blood loss. The 'physician section' of the Surgical Safety Admission Ticket should be filled out completely and checked with the attending.

The Orthopaedic residents responsible for first cases at OPSC or the main OR will be in the operating room and changed into OR attire by 7:10am (9:10am on Wednesdays).

Emergent cases should be booked with the OR Staff and the Anesthesia Department only after all pertinent workups have been completed. The information provided should be detailed.

Main OR and OPSC Scheduling

Posting Cases

All residents should be familiar with the logistics of posting cases for the main operating room for both elective and emergent cases. It is the Chief Resident's responsibility to notify the Attending on call when a patient is "sent for" as well as when the patient enters the operating room.

Add-ons:

- For OPSC: If a case is an add on (a case posted within 3 business days of the DOS) you must call and ask permission and the posting slip must be faxed (817-8470) with the pre-auth written on it.
- For Main: If a case is a late post (added on or after noon the day before the DOS) it must be faxed (2-3972) or be turned into the Control Desk. The resident must also page 1311 and speak to the Anesthesia resident. All add-ons for the day of must go through the Control Desk.

Trauma Room

- The Trauma chief is responsible for all cases posted in the Trauma room as well as the organization and staffing of those cases. The Trauma chief will work directly with the Trauma Room attending to ensure the order of cases and coverage.
- The night float chief will be responsible for ensuring that all cases for the trauma room the next day have appropriate paperwork, labs, and clearance and will communicate status and updates with the day Trauma chief.

Medical Documentation

Adapted from the March 5, 2008 Medical Documentation Message, from Dr. Susan Kirk, DIO.

A complete legible medical record is the permanent way to document a patient's condition, plan of care and response to treatment. Patient safety depends on clear communication both verbal and written.

Please remember the following:

- Include **time and date** on all medical record documentation
- Sign every note in **legible** format with your **credentials** (MD, DO, etc)

- Always include your **PIC number** to further clarify the author of the note
- At each contact point make sure the medications “match up.” This is medication reconciliation. Medication list must be complete and do not use the phrase “resume home meds.” **The complete list of medications should be in the discharge summary with name, dose, route and duration if it is limited.** Medication reconciliation is done more efficiently now through the EPIC electronic medical record.
- When dictating the operative note, do not add that attending was present during the case. The signing attending will document his/her presence for the critical portions of the case.

Never use these abbreviations:

- U, write out **units**
- IU, write out **international units**
- QD, write out **daily**
- QOD, write out **every other day**
- MS or MSO4, write out **morphine sulphate**
- Don’t use a trailing zero, 1.0 can be mistaken for 10

Always

- Use a leading zero if the amount is less than one, e.g., 0.25 mg of Digoxin. Even better would be 250 micrograms
- Indicate your plan of care in the admission or clinic note

Documentation/Completion Standards

General Documentation Guidelines:

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

Record Completion:

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

Discharge Summary:

- Documentation deliquency: 5 days post discharge
- Signature deficiency: 14 days post discharge
- Responsibility: Attending physician

Note: "Transfers" of patients between inpatient units and Psychiatric Medicine, Physical Medicine/Rehabilitation, or KCRC are treated as discharges and re-admissions. A final Discharge Summary must be entered when a patient is

discharged from the current unit. Contact the Admissions Office (4-2264) for assistance with questions.

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

History and Physical:
- A complete and updated history and physical is required for all patients going to the operating room.
- Completion time frame: Performed no more than 7 days prior to admission or within 24 hours of admission.

Verbal Orders:
- Completion time frame: Within 24 hours of order.

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

Medical Record Requests:

Patient Care Requests:
- Emergency Room: Call 4-5283 to have medical records delivered immediately.
- Inpatient: HIS is notified of all admissions. Record deliveries are made to the nursing units every two hours.
- Outpatient: The Resource Scheduling System provides the opportunity to request medical records upon scheduling. Other requests must be submitted to HIS at least 3 days prior to the patient's visit. The medical records are made available to the clinic one-day prior to the patient's appointment date. Most medical records will be available on EPIC.

Clinical Studies/Non-Patient Care:
- Contact 4-2196

Record Management/Chart Control:

Responsibilities for Ensuring Timely & Confidential Provision of Information:
- Medical records are NOT TO BE REMOVED from the patient care units, except by HIS staff after patient discharge.

- Medical records must be "CHARGED OUT" to the location in which they are being used. Notify HIS (4-5283) immediately of any changes in the medical record's location, destination or requestor.

Returning the record:

- Inpatient Admission: 24 hours post discharge
- Emergency Room: 24 hour following patient's visit
- Outpatient Clinics: 48 hours following patient's visit
- Studies and Research: Within 7 working days after they are made available

Release of Medical Information:

- Original records are never to be given to external requestors or removed from the hospital complex.
- Medical information cannot be released to individuals without the written consent of the patient, subpoena, a court order or statute.
- Access to patient care and financial data shall be strictly controlled and given to an individual only on a job function NEED-TO-KNOW basis.

Patient Information Sign-Out Policy and Transition of Care

SERVICES

Joints/Adult Reconstruction/Oncology

Trauma	Spine
Pediatrics	Foot and Ankle
Hand	Sports

MORNING SIGN-OUT (Sunday – Saturday) –MOST IMPORTANT

The primary resident from each service and/or team must place a copy of their service EPIC patient list on the 6-East workroom board after morning rounds (these lists will be for the floor NP's information). Communication should also be reinforced through the EPIC system and verbally at minimum. When necessary, additional sign-out details over email should be provided. The list should include (in brief) the following for each primary Orthopaedic patient:

1. Surgery and POD
2. Activity: WB status/Restrictions
3. Anticoagulation plan/restrictions (if applicable)
4. Discharge status (if applicable)
    a. NP will assist with Final D/C "medically cleared" orders, and D/C orders **ONLY** when asked and/or notified to do so by primary team). This request may be placed on EPIC list.
    b. Each team remains responsible for completing its own patients' discharge instructions, summaries, and follow-up appointments.
5. Pertinent and/or active critical issues over past 24hrs (low BP, SOB, AMS, etc.) that could possibly alter hospital course and need follow-up by the primary team at the close of each day.
6. The NP will call to clarify any major floor issues/questions that she is unsure about.

EVENING SIGN-OUT(Monday – Friday)

The primary resident on each service should update their service's patient information as follows at the close of each day.

1. Newly Admitted Patients - Should be added to that team's EPIC patient list (with the same information required in the morning) and a copy of that list placed in 6-East workroom or on the electronic board. This is for main OR and new ER/clinic/direct admits. *(Note: Residents should NOT have to come back from OPSCor Fontaine for sign-out purposes after morning sign-out unless they have admitted a patient and/or deem it necessary.)*
2. Old Patients - Pertinent issues/changes that occurred throughout the day should be communicated to the night float/overnight resident as necessary.

NIGHT FLOAT/OVERNIGHT RESIDENT

1. The NF/ON resident coming on each evening will be provided with copies of the EPIC patient lists used during the day or will have direct communication from the daytime call residents. This will be left in the 6-East workroom by the NP upon her leaving each evening. This information will be supplemented by emails, pages, and/or phone calls regarding any issues handled by the resident(s) on call during the day. Communication is important both by phone and by email, and the night float resident should be paged if important tasks are pending.
2. Each morning following the NF/ON resident(s) shift, they will be responsible for relaying patient care information to the resident(s) coming on call for that day. This will include, but not be limited to:
    a. Cases on call to the OR
    b. Active/outstanding/pending inpatient/ER consultations
    c. Orthopaedic inpatient issues overnight

External Transfer Requests

When an outside referring physician calls in through the page operator or call center they are asked if the call is about a potential patient transfer or for a consult. If for a potential transfer, then the call is immediately linked into the Bed Center; if for a consult then the resident and/or attending would be paged.

Leaves of Absence / Time Away from the Program

Leave Policy

Allotted Leave and Terms

PGY2 - PGY5 Residents will have the following vacation allowance during an academic year (July 1 – June 30):

- 2 weeks of personal time off (10 business days)
- 1 week of conference time (5 business days)
  - conference must be preapproved by the residency directors
  - junior resident fracture course and chief resident AAOS annual meeting counts toward conference time
  - ***additional conference time (over the allotted 5 business days) will count against personal time off***
- 1 week of professional time (5 business days)
  - includes meeting presentations, fellowship interviews, job interviews, other conferences, relocation, etc.
  - chief resident ABOS review course counts toward professional time.
  - ***additional professional time (over the allotted 5 business days) will count against personal time off***
- 1 week off during the Holiday Season of Christmas-New Year's

PGY-1 interns have three weeks of personal vacation time per year:

- 1 week during Musculoskeletal Radiology (MSK)
- 1 week on the Emergency Service (ER)
- 1 week on Plastics (the first week of the month's rotation), or Anesthesiology (Anes)

Holiday Vacation

- Residents are granted personal vacation by the chair during one of the two weeks around Christmas and New Year's Eve. This is a privilege and does not count toward the two weeks of personal time off.
- Scheduling of holiday vacation and arrangement of coverage will be managed by the administrative chief residents and residents will be given the opportunity to request which week they have off.
- Night float will be suspended during the holiday two weeks and the administrative chief residents will coordinate call.
- With five residents in each class, there will be a slight imbalance in the level of resident for each week. One PGY-4 resident will act as a chief resident during one of the week for call purposes.
- Holiday vacation priority will be based on prior year's OITE performance. Those residents with a higher OITE score will be given first choice between Christmas and New Year's weeks.

- ***The chair and program directors consider holiday leave a gift for the hard work performed during the year and reserve the right to modify or remove this gift if performance standards are not met.***

Notes about Vacation

- All vacation requests must be submitted via the web form on www.uvaortho.com. Holiday vacation weeks do not need to be submitted by this form.
- The two weeks dedicated to conference and interview/meeting presentation time may NOT be used as personal vacation time.
- Vacation may not be longer than seven days (5 business days and one weekend), without prior written "exemption" approval by the UVA Residency Directors.
- If time off is used inappropriately or without prior approval, probation will automatically be instituted and the resident involved will lose the remainder of their vacation time for the year.
- Unused vacation and conference time does not carry over to the next year.
- No personal vacation time is allowed the 3rd week of June through July, yearly. In the case of emergencies, exception leave may be permitted with the approval of the Program Directors. Emergencies consist of births, deaths, and other extraordinary circumstances beyond the resident's control. No other leave will be authorized during these two months.
- Residents, as soon as possible, should submit for 1 week of personal leave during the first half of the year [Aug – Dec] and 1 week the second half [Jan – June].
- For PGY-1 residents, no vacation is allowed while on Orthopaedic Rotations (6 months). PGY-1 residents should request vacation time by July 31st for August - December time away and 6 months in advance for other vacation.
- All leave must be placed on the schedule by the ACR following approval of Residency Program Directors six weeks in advance. Emergencies and special occasions are excluded from this advance notice and need only Resident Program Director approval.
- Resident vacation time cannot be restricted to specific services except as noted in Roanoke and at UVA during the night float rotations. No vacation/conference time should be taken during the two night float rotations unless special circumstances arise and only with approval from the Residency Directors.
- Efforts should be made to coordinate vacation when faculty members on your service are out of town, when possible.
- Junior resident leave must be coordinated and approved by the Chief Resident on the service prior to submission to the Program Director.
- No more than one member of a given class may take personal vacation at any given time and no more than two residents from the program may

take personal vacation at any given time. PGY-4 fellowship interviews are an exception to this rule although interviewing residents should be cognizant of the coverage strain that occurs during fellowship interview time and make every effort to minimize time away. (Special circumstances must be discussed in advance with the Residency Directors – conferences are an exception if pre-approved by the Residency Directors).

- Review courses (other than the Chief Resident year) will be at the residents' own expense, and must be taken as vacation time included in the four weeks leave time allotted.
- All approved time off must be recorded by the Residency Coordinator.
- The ACR will keep an updated calendar with approved vacations.
- In the unlikely event that a resident is absent for more than twenty (20) business days without approval or extenuating circumstances, he risks being denied residency certification.
- Special circumstances will be reviewed by the Residency Program Directors.

OITE Performance and Travel Policy

No department-sponsored travel will be allowed to any meetings unless 40th percentile is obtained on the Orthopaedic In-Training Examination. The exceptions are the Fracture Course, a Board Review Course during the chief year, and if a resident has a **podium presentation** accepted at a major national meeting such as the AAOS or a primary subspecialty meeting. Travel to meetings is a privilege and should be earned based on appropriate performance metrics. This policy is similar at most Orthopaedic Residency Training Programs

Scheduling Leave

The program directors, ACR, and on-service Chief resident of the affected rotation will be involved at the onset of all vacation planning. Efforts should be made to schedule vacations prior to or at the beginning of a rotation block. All leave must follow terms of leave policy above. Scheduling of vacation should proceed as follows:

Step 1: Resident must submit all leave requests (except for holiday week vacation) by web form on www.uvaortho.com.

1. Vacation form at: www.uvaortho.com/residency
2. Vacation will be approved on seniority (when there are overlapping requests), followed by first-come-first-serve basis.
3. The Chief class and on-service Chief resident will assist with identifying alternate vacation time if initial request is not available.

Step 2: The Program Directors and ACR will review the leave request and respond to the resident within one week of submission.

Step 3: Upon approval, the resident will work with the ACR and on-service Chief Resident to identify needed coverage. Efforts must be made for coverage to come from on-service personnel resources as defined in "Coverage" section below.

Step 4: Following approval, resident must submit final coverage plan to the Program Directors, Chief Resident class, on-service Attendings and ancillary staff (PAs, NPs, clinic/scheduling nurse) as soon as available, but no later than **Thursday at 5pm** the week prior to planned vacation.

Special Conditions

When identifying coverage is not possible from the specific service, the ACR will work with the Chief resident class to assign and maintain resident coverage.

The ACR and Chief class reserve the right to adjust coverage for Program Director Approved vacations.

The resident and ACR will be responsible for submitting a coverage schedule to each service affected by resident vacation the **Friday prior** to planned vacation.

Residents must be active participants in the coverage pool in order to utilize pooled resources for non-emergent vacation coverage. Residents who violate conditions of vacation scheduling and coverage forfeit the right to use said resources in the future.

Fellowship Interviews

As the majority of residents go on to pursue fellowship training out of this residency, we recognize the need to schedule and attend multiple fellowship interviews. This obviously puts a strain on the residency as many members of the PGY-4 class take leave in a condensed amount of time. Time taken off for fellowship interviews is considered professional leave and the department leave policy applies. Residents who schedule fellowship interviews are allotted 5 business days for professional leave. Additional leave beyond 5 business days is considered personal time off and will be applied to vacation leave. No more than 10 business days of vacation leave is allotted during the calendar year.

Leave during Roanoke Rotations

1. During the Ortho year 3 rotations the junior resident may only take 1 week of vacation during their 20 week rotation. This 1 week of vacation will be during the junior emergency room rotation. The junior resident will not be allowed to take vacation during the junior elective block.
2. The senior residents may take only 10 business days off for vacation and fellowship interviews total during their 20 week rotation. No personal time

may be taken during a block if the resident has already scheduled professional time off for interviews.

3. The holiday call schedule in Roanoke during Christmas and New Years will be based on the Carilion General Surgery call schedule and will either be 5 or 6 days to remain compliant with ACGME duty hours.

Coverage

Coverage includes, but is not limited to, OR, clinic, weekday and weekend rounding, weekday and weekend call. Additionally, residents much check the conference schedule to ensure that assigned conferences are not scheduled during potential vacation time. Coverage will only be provided for PD approved leave.

All efforts should be made for call responsibilities to be covered by residents at that call level (i.e. 1206 by PGY 2s; 1251 by PGY 3/4s; 1218 by PGY 4/5s). When this is not possible, the ACR will assign call coverage outside the designated in-training level to ensure the maintenance of clinical/patient care and functionality of the vacation coverage policy. Leave coverage cannot result in ACGME duty-hour violations by the cross-covering resident(s).

AAOS Leave Policy

A limited number of residents will be allowed to attend the AAOS Annual meeting. An appropriate number of residents must be available at UVA to cover this time period.

- Chief residents may attend IF they meet the below criteria. Note that leave for the AAOS meeting is applied toward the 5 days of conference leave.
- Residents who are primary podium presenters may attend

No PGY-1 and PGY-2 residents will be able to attend unless they are primary podium presenters or have special approval from the program director. Night Float residents will not be able to attend. At least two PGY-3 and two PGY-4 residents are to be available at UVA during this week. A resident may attend the ORS or the AAOS but not both.

Any PGY-1 through PGY-4 resident who attends the meeting (presenting a paper) must provide a detailed report of their educational experience during their time at the AAOS or ORS. This will include a daily description of all seminars and ICLs attended. This report will be due one week after the AAOS. If a resident attends the ORS or the AAOS and does not dedicate time to the educational experience or their report is inadequate; they will lose future conference time.

Attending the AAOS as a chief is considered a privilege and certain criteria must be met in order for the department to sponsor travel to the AAOS:

1) OITE score PGY-5 year of >40th percentile

2) Case logs are up-to-date and ACGME minimum case requirements are met or the resident is clearly on track to meet requirements to graduate
3) Mandatory resident research requirements have been completed
4) Resident is in good standing with the program and is not actively under probation or remediation. Resident must be on track to graduate at year end.
5) Resident has not used allotted conference time during chief year and has otherwise abided by the leave policy as outlined

PGY-5 Review Course Policy

The Department will sponsor the chief residents to attend either the Miller Review Course or the AAOS Review Course. No more than 3 residents may attend one course. The ideal scenario is for the 5 chiefs to be split between the courses so that not all chief residents are gone at the same time. If a chief resident wishes to attend the Maine Review Course then he/she will be required to take the last week of the year as a vacation week so they may leave early for the Maine Review Course. If the residents cannot decide which course to attend, then this will be done randomly by the program director with the residents being divided up between the Miller Review Course and the AAOS Review Course.

Recommended Conference / Course Attendance

In the course of the five year residency training program, each resident should try to attend 3 conferences / courses (including a Basic Trauma Course and ABOS Review Course).

Approved courses include but are not limited to:

- Basic Trauma Course (mandatory by end of PGY-3)
  - Basic AO Fracture Course in Continental US
  - OTA Basic Residents Course
- Sub-specialty Annual Meeting (AOSSM, AAHKS, POSNA, ASSH, etc.)
- Southeastern Fracture Symposium
- AAOS Annual Meeting (Chief Year)
- ORS Annual Meeting
- AOA Residents' Conference
- AAOS Review Course or Miller Resident Review Course (Chief Year)

In addition to the above, residents will be allowed to attend legitimate national meetings at which they are presenting papers for the first time (not posters), which have been accepted.

Funding for other meeting presentations are to be provided by the PI of the study. Supplemental funding by the Department will be considered on a case by case basis.

Departmental Funding for Resident Travel

Residents and fellows are allotted monies each year for travel to conference or courses is as follows:

- Intern– $0 (exceptions for research presentations at discretion of chair)
- PGY-2 – Fracture course (not to exceed $2000)
- PGY-3/4 – $1250 total for both years
- Chief Residents – AAOS, Review Course (not to exceed $4000 total)
- Fellows – $2,000

Additional funding for conferences and courses are at the chair's discretion.

Residents presenting their primary research at the podium at a major national conference will be supported up to $1000 per presentation. Additional expenses are to be covered by the resident or the faculty principal investigator. Departmental support for poster presentations at major Orthopaedic meetings will be subject to review by the chair and faculty principal investigator.

Residents are reminded that the goal of a podium and poster presentation is a published manuscript. Residents who fail to submit a manuscript for publication associated with a podium presentation may lose funding for subsequent presentations.

Funding for these meetings is in addition to each resident's individual allotment, and **MUST** be done in advance to ensure reimbursement. Receipts need to be turned in within 5 working days and need to be submitted to the Business Office within 10 working days. All questions regarding travel funding should be directed to the Department's Business Office.

No travel outside of the continental US are supported. Exceptions may be made in the case of research presentations at a major international conference where the resident is the primary podium presenter. Prior to submitting an abstract to an international conference, however, the resident must receive approval from the chair and a tentative funding plan that includes the faculty investigator must be established.

Travel Policy

Residents traveling to conference on educational funds should consult with the Program Directors and Program Coordinator for pre-approval submission guidelines. A pre-travel authorization workbook will need to be completed as early as possible that includes flight, mileage, hotel, registration fees, parking, and per diem for the destination location. Please fill out any associated attachments out completely and accurately, using UVA's Travel website for guidance on Per Diem rates and current Travel Workbook forms. http://www.procurement.virginia.edu/main/travel/TravelBasics.html.

Residents are responsible for keeping all travel receipts and should submit a signed and completed travel workbook within seven (7) days of return. Receipts include credit card statements showing charges for registration, air fare, and hotel. An itemized, zero balance receipt must be obtained from the hotel, and all non-reimbursable items must be deducted. Items not reimbursed include entertainment, some room service, and bar/courtesy charges. Receipts for parking, taxis/shuttles, luggage fees, and boarding passes must be submitted. Failure to keep boarding passes or other required receipts may result in the resident's travel reimbursement being reduced or rejected.

Expanded and updated Per Diem rates can be found at the procurement travel site listed above. The times of departure and arrival at the beginning and end of the trip will determine if any deductions need to be taken on travel days. Travel must be submitted, approved by the department, and keyed within 30 days of travel or the traveler risks non-reimbursement of their traveling expenses.

Accurate expense accounts and receipts of activities must be returned by the resident to the Residency Coordinator within 7 days of travel to comply with IRS and University regulations. Please see the web for current directions and forms to complete www.healthsystem.virginia.edu/internet/Orthopaedics/travel.cfm

UVA Policy

Please see the Housestaff webpage regarding leaves and request for absence included in the Graduate Medical Trainee Manual at http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm. Scroll down to the Policies and Manuals section and click on the link to Graduate Medical Trainee Manual for the most current policies for Housestaff.

The department of Orthopaedic Surgery seeks to provide all residents and fellows with appropriate time off to ensure resident well-being and to conform to both the ACGME and ABOS regulations. Any time away from the training program must adhere to university and department policy, and board requirements. All Orthopaedic department residents may take up to four weeks of paid "medical leave" per year without extending the length of their training if they have an unexpected medical problem (i.e., broken leg) separate from vacation leave.

Maternity Leave

The resident must inform the department chair, vice chair, and program directors and coordinator of their pregnancy or adoption date as soon as this information is confirmed in order to facilitate appropriate planning, which may include a revised education plan for the remainder of the resident's training and must be sent to the board. Under normal circumstances, the resident should expect to take six weeks of maternity leave without extending her residency training period. Four weeks would be paid as "medical leave" with the addition of up to two weeks being allowed to be taken as vacation leave if the resident has this leave

available to them. Additional time taken away from the program due to medical necessity will need to be made up at the end of the resident's residency in order to fulfill all requirements for sitting for the boards. It will be the program's responsibility to create an appropriate makeup program for the additional time.

The resident's obstetrician will determine the date of return to duty. It is recommended that the resident try to schedule less demanding rotations during her third trimester and for the first month post-partum. Decisions about call during the third trimester and the first month post-partum will be made in conjunction with the resident's obstetrician. Residents will not be expected to "make up" call nights missed while away on maternity leave. Loss of time from training for maternity leave will not be reason for termination from the residency. The resident must comply with all OSHA and safety regulations as they apply. The resident will make every attempt to schedule elective tests and appointments outside of working hours. In no case will a resident be not allowed to attend or be forced to reschedule her appointments or tests simply because they occur within the normal working day.

The resident may take full benefit of the Family Medical Leave Act of 1993, which states that an employee has up to 12 weeks of job-protected unpaid leave during any 12 month period, if the resident is eligible to do so.

Paternity Leave

One week paid vacation around the time of birth, in addition to other vacation time is allowed by the department.

General Information

2015-2016 Rotation Schedule

The 2015-16 Resident Rotation Schedule has been emailed to faculty and residents.

USMLE Step 3

All residents are required to take the USMLE Step 3 exam during their intern year. Residents must have successfully completed Step 3 before graduation. Please see the Graduate Medical Education Manual http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm for the policy, "Passing USMLE, Steps 2 and 3." See Attachment K.

Medical License and Malpractice Insurance

The Code of Virginia requires each resident or fellow to obtain a Virginia Medical License to practice medicine for bonafide hospital patients who are being seen as an official part of this department's approved residency training program.

The malpractice insurance, which the hospital has purchased for housestaff, provides coverage only while the resident is acting within the scope of his employment.

Lab Support

Microvascular Laboratory

The department will pay the expenses for the resident's time spent in the Microvascular Laboratory.

Phone Access

It is the responsibility of each resident to contact the Housestaff Office for a long-distance telephone access code. This access code is necessary to make any long-distance calls. Please be advised that the State has the right to monitor long-distance calls to determine if abuses are occurring.

Abuse of Resident Support

Any abuses where the department is charged for services not permitted as officially-approved by a resident will result in possible forfeitures of that resident's financial support from the department. Also, please remember that supplies and equipment are for departmental use only and not for friends, family, or other departments.

Printing and Copying Services

All photocopies should be made using the copiers at the Orthopaedic Offices or clinics. Residents may obtain copy cards from the GME Office to make copies elsewhere on grounds.

Lab Coats

Each resident receives three (3) monogrammed laboratory coats upon arrival with the University to be worn during patient-care activities.

Optical Loupes

The Department will reimburse each resident a maximum of $500 towards the purchase of one pair of optical loupes. The resident should order the loupes personally from the vendor in order to obtain the resident discount. The resident is responsible for paying for the loupes up front, and needs to supply the Residency Coordinator with an original invoice and a copy of his cancelled check or credit card bill during the same fiscal year. Reimbursement is processed through the Health Sciences Foundation and the resident should receive reimbursement within two weeks.

Bulletin Board and Website

A residency bulletin board is maintained outside the Gwo Jaw Wang Conference Center in the Orthopaedic Offices. It features upcoming conferences, and newsworthy items. Additionally, the Orthopaedic departmental website at www.uvaortho.com is a helpful resource for residency information.

Personnel Records

Resident personnel records are kept in a locked filing cabinet within the Residency Office, and are continually updated. Access to your file is granted with the coordination of the Residency Coordinator.

Objectives of the UVA Orthopaedic Surgery Residency Program

The purpose of our Orthopaedic training program is to provide the Orthopaedic residents with opportunities to:

- Acquire medical knowledge as it pertains to Orthopaedic Surgery
- Develop the technical skills required to safely and effectively perform Orthopaedic procedures and surgeries
- Mature in medical and ethical decision-making and judgment
- Develop a basic understanding of various health care models
- Actively participate in the education of fellow residents and medical students
- Improve interpersonal and communication skills with patients and other health care workers
- Demonstrate a high level of professionalism and ethical behavior with regards to patient care and medical training

Orthopaedic residency is designed to provide the trainee with all of the tools necessary to become a highly competent Orthopaedic Surgeon and should serve as the foundation for continued intellectual growth and development throughout one's professional career. At the completion of training, residents should be able to function independently as Orthopaedic Surgeons and be capable of qualifying for and completing the examinations required by the American Board of Orthopaedic Surgery (ABOS).

The responsibility of the Orthopaedic Residency is to provide the residents with the opportunity to learn both the clinical and basic science of Orthopaedics. It is the responsibility of the resident to fully utilize those opportunities to maximize their professional development and expertise.

The residency training program is five years in duration. During this time period the resident is assigned to rotations and given responsibilities commensurate with his/her level of training, capabilities and competencies. When it is considered in the resident's best interest, the residency may be extended in

order to ensure the development of the necessary skills, knowledge and competencies to function as an Orthopaedic Surgeon.

In accordance with the general competencies endorsed by the ACGME, residents are required to develop competency in the following six areas in order to develop into professional, ethical, medically knowledgeable and technically competent Orthopaedic Surgeons:

- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice

Learning objectives for each service are drafted and refined each academic year to reflect the specific competencies needed for residents at each level of training.

In addition, during their training here all residents are exposed to experimental design and are taught the process of producing good research, from drafting proposals to presenting their data at national meetings. All residents are provided dedicated time for research, and are required to produce one peer-reviewed publication prior to graduation.

Completion Criteria

In order to sit for Part I of the American Board of Orthopaedic Surgeons, each resident must achieve a minimum distribution of education during their time in Orthopaedic Surgery residency. The minimum distribution of educational experience must include:

1. 12 months of adult Orthopaedics
2. 12 months of fractures/trauma
3. 6 months of children's Orthopaedics
4. 6months of basic and/or clinical specialties

Additionally, the ACGME requires that each resident demonstrate scholarship through at least one of these activities:

1) participation in sponsored research
2) preparation of an article for a peer-reviewed publication
3) presentation of research at a regional or national meeting
4) participation in a structured literature review of an important topic

Program Requirements: Overview

The Residency Program at the University of Virginia requires that all residents obtain competence in the six areas listed below. The six competencies will be taught and evaluated through a variety of techniques: didactic presentations, clinical experience, teaching rounds, attending observation, Journal Club discussion, individual study and review, 360 degree evaluations, In-Training

examinations, and successful completion of web-based training modules (NetLearning).

1. **Patient Care**: Effective, appropriate and compassionate evaluation and treatment of patients. This includes information gathering, decision-making, safe and effective performance of procedures, and communication with other members of the health care team.
2. **Medical Knowledge**: The acquisition and integration of medical knowledge pertinent to Orthopaedic Surgery. The ability to utilize and analyze basic and clinical scientific literature in support of appropriate treatment decisions.
3. **Practice-Based Learning and Improvement**: The ability to objectively appraise one's own ability (as well as the specialty's) to evaluate patient care with regards to scientific literature and information technology as well as the teaching of other health care professionals and trainees.
4. **Interpersonal and Communication Skills**: The ability to effectively listen and communicate with patients, families and health care professionals via written communication, verbal and non-verbal methods.
5. **Professionalism**: Develop respect, compassion and integrity for gender, age, and cultural differences in the patient population as well as in the health care workforce. A commitment to ethical principles and practice, continued professional education and development of selflessness in the providing of medical care.
6. **Systems-Based Practice**: Develop an awareness and understanding of health care delivery systems and the interaction of health care with society with respect to health care cost, access to care, and optimal patient care.

Resident Milestones

Part of the program's accreditation is measuring each resident according to the Orthopaedic Surgery Milestone Project. The project is a joint venture of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Orthopaedic Surgery (ABOS) and was published in August of 2013.

The milestones are targets of knowledge, skills, behaviours, and attitudes and attributes that the ACGME and ABOS believe hallmark successful education in the specialty of Orthopaedic Surgery. There are sixteen milestones procedures (Medical Knowledge and Patient Care):

- ACL
- Ankle Arthritis
- Ankle Fracture
- Carpal Tunnel
- Degenerative Spinal Conditions
- Diabetic Foot
- Diaphyseal Femur and Tibia Fracture
- Distal Radius Fracture (DRF)

- Adult Elbow Fracture
- Hip and Knee Osteo Arthritis (OA)
- Hip Fracture
- Metastatic Bone Lesion
- Meniscal Tear
- Pediatric Septic Hip
- Rotator Cuff Injury
- Pediatric Supracondylar Humerus Fracture

The other competencies' milestones are:

- Systems-based Practice – Systems thinking, including cost-effective practice
- Systems-based Practice – Resident will work in interprofessional teams to enhance patient safety and quality care
- Systems-based Practice – Uses technology to accomplish safe health care delivery
- Practice-based Learning and Improvement – Self-directed Learning
- Practice-based Learning and Improvement – Locate, appraise, and assimilate evidence from scientific studies to improve patient care
- Professionalism – Compassion, integrity, and respect for others as well as sensitivity and responsiveness to diverse patient populations including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. Knowledge about and respect for and adherence to ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice
- Professionalism – Accountability to patients, society, and the profession; personal responsibility to maintain emotional, physical, and mental health
- Interpersonal and Communication Skills – Communication
- Interpersonal and Communication Skills – Teamwork (e.g., physician, nursing and allied health care providers, administrative and research staff)

Orthopaedic Surgery Minimum Numbers of Cases for Graduation

Orthopaedic Surgery Minimum Numbers
Review Committee for Orthopaedic Surgery

Category	Minimum
Knee arthroscopy	**30**
Shoulder arthroscopy	**20**
ACL reconstruction	**10**
THA	**30**
TKA	**30**
Hip fractures	**30**
Carpal tunnel release	**10**
Spine decompression/posterior spine fusion	**15**
Ankle fracture fixation	**15**
Closed reduction forearm/wrist	**20**
Ankle and hind and mid-foot artho	**5**
Suprachondylar humerus perc	**5**
Operative treatment of femoral and tibial shaft fractures	**25**
All pediatric procedures	**200**
All oncology procedures	**10**

CPT Codes in Each Category

Knee arthroscopy (29850, 29851, 29855, 29856, 29866, 29867, 29868, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887)

Shoulder arthroscopy (29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828)

ACL reconstruction (29888)

THA (27130, 27132, 27134, 27137, 27138)

TKA (27442, 27443, 27445, 27446, 27447, 27487)

Hip fractures (27235, 27236, 27244, 27245)

Carpal tunnel release (29848, 64721)

Spine decompression lumbar spine/posterior spine fusion thoracic or lumbar (22612, 22630, 22800, 22802, 22804, 63005, 63012, 63017, 63030, 63042, 63047)

Ankle fracture fixation (27766, 27769, 27792, 27814, 27822, 27823, 27826, 27827, 27828, 27829)

Closed reduction forearm and wrist fractures (25505, 25520, 25535, 25565, 25605, 25624, 25675, 25680, 25690)

Ankle and hind and mid-foot arthrodeses (27870, 28705, 28715, 28725, 28730, 28735, 28737)

Supracondylar humerus percutaneous treatment (24538, 24566, 24582)

Operative treatment of femoral and tibial shaft fractures (27506, 27507, 27758, 27759)

Total All Cases: at least 1000 but no more than 3000

Updated 9/10/2014

Continuing Medical Education / Resident Lecture Series

A minimum of one hour each week is devoted to didactic presentations in the basic sciences. A formal lecture is presented weekly, either by a resident, basic science faculty member, staff orthopedist, or visiting consultant. All resident lectures are supervised and backed-up by one or more designated attending physicians. Additional Orthopaedic Pathology lectures are given one to two times per month by our Orthopaedic oncologist. While these lectures are often clinical topics, the basic science issues relevant to these topics are incorporated into each didactic lecture. Additional basic science review is provided immediately prior to the OITE. Additional basic science presentations are integrated into the Grand Rounds and Chairman’s conference schedules. An annual conference evaluation form is filled out by the residents at the endpoint of each academic year to ensure improvement and enhancement of the resident learning experience.

Conferences: Resident Requirements

Attendance at conference is mandatory; residents whose presence is required in the operating room will be excused at 07:10. Non-emergent patients in the clinic or ER should not be a reason for missing any conference. Residents are required to sign-in to each conference to ensure their attendance is properly noted. Sign-in sheets will be delivered to the Residency Coordinator on a weekly basis. Residents are reminded of the University's Honor Code when recording conference attendance.

If, during the academic year, the resident is delinquent entering cases into the ACGME Case Logs, entering time into New Innovations, or misses >10% of lectures for the calendar month, the resident will receive an e-mail warning from the Residency Coordinator. A second occurrence within the academic year will result in a "letter of serious concern" from the Program Directors. Such letter will be attached to the resident's permanent records. A third occurrence will result in the resident sitting before the Resident Advocacy & Remediation Committee facing potential remediation. Being more than 10 minutes late for conference without an excuse counts as a missed conference.

Conference Schedule

Skeleton weekly conference schedule:

Day	Time	Conference
Monday	6:15-6:30	Fracture conference – didactic session
	6:30-7:15	Fracture conference – cases
Tuesday	6:15-7:15	Core Curriculum conference
Wednesday	7:00-9:00	Quality Assurance (first Wed/month) Grand Rounds Oncology Lectures Research meetings
Thursday	6:30-7:30	Service-specific Conference
Friday	6:30-7:30	Basic Science/Anatomy (didactic/dissection) Lecture

Journal Club — One Thursday every month at the home of an attending

Graduation VP — Held at the end of year in conjunction with resident graduation

Fracture Conference

Monday mornings, 6:15-7:15, Moss Amphitheater (1st floor main hospital)

Over the course of each academic year, we attempt to cover all major topics relating to adult and pediatric fractures. We use a discussion of the previous week's fractures following a scheduled didactic presentation with representative

cases. It is expected that the junior residents will have read the assigned topic in Rockwood and Green (reading assignments are on the conference schedule).

Assigned residents will present a lecture on the scheduled topic. The lecture should last no more than 15 minutes, and should include detailed discussion of at least one recent or classic paper from the literature. The speakers should try to concentrate on the current concepts and controversial aspects of the specific fracture being discussed, so as to supplement, rather than reiterate, the assigned reading. A slide presentation with a handout is required. One of the Trauma attendings will then present either a short didactic lecture or a case-based interactive exercise for the junior residents. There will be significant interaction with the junior residents, and adequate preparation for the scheduled topic is expected.

One to two Mondays each month will be devoted to pediatric fractures. The first 15 minutes of conference will be topic specific, followed by presentation of the week's cases.

The junior residents will be responsible for presenting x-rays of all the previous week's surgical and non-surgical cases to each conference. Junior residents who have initially seen the patients should be prepared to present and discuss the management of these cases at every fracture conference.

Core Curriculum Conference

Tuesday mornings, 6:15-7:15, Operating Room Classroom (2nd floor main hospital)

The subspecialty conference ensures that all residents are exposed to a core curriculum covering all Orthopaedic subspecialties. All conferences are given by an appropriate attending and resident, with the format of the lecture left to the discretion of the attending (case review, slide presentation, article review, etc). Assigned readings are provided to the residents one week in advance to reinforce the presented materials. The subspecialty conference rotates services and topics on a 2-year schedule.

In 2015, the AAOS Comprehensive Review (2nd edition) was adopted as a template for the Core Curriculum Conference. The conference schedule will reflect these chapters and an assigned reading from the textbook will be included for each lecture. The resident is expected to have read the chapter prior to the lecture.

Grand Rounds

Wednesday mornings, 7:00-9:00, Fontaine Conference Room, 3rd Floor

Appropriate "clinic" attire with white coats are expected for these lectures. Wednesday morning is an institution-wide dedicated conference time; surgical

cases start at 9:30am. The Wednesday Orthopaedic conference schedule is divided into two lectures.

Each chief resident and fellow is required to present one grand rounds presentation during the academic year. Throughout the year, the department also hosts several visiting lecturers during the Grand Rounds schedule. These are invited speakers from within the University community, as well as eminent National and International speakers. Many of these presenters are funded by industry, and some are invited by the senior residents and paid for with departmental funds. Topics include clinical Orthopaedics, osteoporosis, medical ethics, systems-based practice, and other related topics.

Quality Assurance Conference

During this conference, held the first Wednesday of the month, residents present complications to all residents and faculty. Complications are documented for departmental Continuous Quality Improvement, including the nature of the complication, the root cause, contributing factors, and strategies for future prevention. Chief or Senior residents are required to submit a report for each service including the number of surgical procedures, number of admissions and the number of complications for the previous month. This information as well as a description of the complication and action taken must be submitted on the appropriate form to Dr. James Browne. One case of good educational value should be presented (with x-rays) to the department from each service. Cases should be submitted via www.uvaortho.com/qa.

Ethics & Professionalism Conference

The University of Virginia School of Medicine is fortunate to have a very active in-house Department of Medical Ethics. This department provides a 24-hour ethics consultation service for inpatients. Residents are encouraged to consult the Ethics service for any questions regarding difficult decisions with informed consent and refusal of care. This service has responded with rapid input in issues regarding informed consent, competency, and withdrawal of support for Orthopaedic patients in the past year. For obtunded patients without an identifiable surrogate, the Ethics service has helped to arrange court-appointed surrogates with medical power of attorney in short order.

All of the faculty strive to provide ethical and cost-effective care to patients, without regard to ability to pay for care, and in doing so teach by example. According to institutional policy, clinics are not separated or stratified with regard to the patient's socioeconomic status, and all care is provided without regard to the patients' insurance status or ability to pay.

Since the inception of the bi-monthly Ethics feature in the Journal of Bone and Joint Surgery in 2000, and the inception of the AMA's Virtual Mentor, we have included these features in our monthly Journal Club discussions.

Lectures in medical ethics are integrated into the Grand Rounds and Basic Science Conferences. Past topics have been thought provoking supplements to the journal club reviews and clinical teaching.

In addition, residents in the research laboratory attend eight hours (four sessions, two hours each) of meetings during the research year or during the ten-week lab rotation. Each session consists of a lecture followed by a discussion group that includes postdoctoral fellows and graduate students in the Health Sciences and the Graduate School of Arts and Sciences Research Training Programs. The ethics mini-course is designed to emphasize the ethical standards practiced at the University of Virginia in Medicine and Research.

Service-Specific Conference

Thursday mornings, 6:30-7:30, various locations

Each service holds an informal rotating schedule of 10-20 topics for these meetings. Residents, fellows, and medical students assigned to each service participate. The Senior Resident on service will pick the topic for the week and will provide reading assignments if applicable. These meetings may take the format of interesting case discussions pertinent to the clinical or operative schedule of the week, review of classic articles, review of service-specific OITE questions, or small group, interactive didactic presentations by one of the attendings on service. The result is a core of essential topics that are covered on a yearly basis in a small group, interactive format.

Journal Club

One of the senior residents selects articles from the current edition of the JBJS for discussion each month at the home of one of the Orthopaedic attendings. The attendings are also asked to suggest seminal articles from the subspecialty journals and the British journal for inclusion in the journal club schedule. The Ethics features in JBJS and AMA's Virtual Mentor are discussed bi-monthly as part of the ethics curriculum. Approximately two hours per month are devoted to journal club.

Basic Science & Anatomy Conference

Friday mornings, 6:30-7:30, UVA Hospital 6th Floor Conference Room or Anatomy Lab

A weekly conference offers comprehensive coverage of Orthopaedic Basic Science and Applied Surgical Anatomy over the course of each academic year. Attending physicians with appropriate subspecialty interest are designated to participate in each weekly conference. Basic science topics are covered twice monthly, one session is devoted to didactic anatomy presentations or radiology correlates presented by the musculoskeletal radiologists. The final session monthly is devoted to a cadaveric prosection (prepared by the research resident) to review the important anatomical material for the particular body region.

Attending physicians are assigned to the sessions with which they have the most expertise.

The AAOS Comprehensive Orthopaedic Review (2nd edition) will be used as the textbook for the Basic Science curriculum.

OITE Review Sessions

An intensive OITE Review is performed the month or two before the exam with faculty from all specialties presenting a review of their specialty. A junior resident will arrange with the faculty dates and times for the sessions in the evenings, and these will be established as optional but strongly recommended for attendance.

Visiting Professorship

A formal visiting professorship is sponsored each year in conjunction with the graduation banquet for the senior residents. The Chief Residents choose an eminent speaker for a one-day lectureship. The visiting professor generally gives two to three hours of didactic lectures, followed by two to three hours of case presentations by the residents. Chief Residents join the visiting professor for breakfast, lunch, and dinner on the Friday of the Professorship. The end of year banquet and awards ceremony is traditionally held at the Rotunda, a central campus structure designed by Thomas Jefferson, where all doctorates have been granted since the University's founding in 1825.

Multi-disciplinary Core Competency Lecture Series

These monthly conferences are held in Jordan Hall Amphitheater on the second Wednesday of the month from 7-8am. Two residents (intern on service and 1 second year) are assigned to attend each meeting and are therefore excused from participation in that Wednesday's Orthopaedics Grand Rounds lectures. These residents are responsible for signing-in for the lecture and taking enough notes to present the topic to their fellow residents in the form of a 1-page report, due to the Directors and Coordinator within a week of the conference.

Resident Requirements in Lecture Attendance

If, during the academic year, the resident is delinquent entering cases into the ACGME Case Logs, entering time into New Innovations, or misses >10% of lectures for the calendar month, the resident will receive an e-mail warning from the Residency Coordinator. A second occurrence within the academic year will result in a "letter of serious concern" from the Program Directors. Such letter will be attached to the resident's permanent records. A third occurrence will result in the resident sitting before the Resident Advocacy & Remediation Committee facing potential remediation, with the potential loss of conference funding.

Resident Conference Time will be protected and respected by the faculty. **Attendings may not pull residents out of conference to round**.

Residents will only be excused from conference for patient care urgencies or emergencies.

Resident Research

Research during residency is an ACGME requirement and we expect residents to be active in clinical research, basic science research, and/or the writing of original articles and chapters. Ongoing research projects and research ideas are discussed at service-specific monthly research meetings and residents are encouraged to involve themselves and initiate projects.
The Orthopaedic Department has ready access to the anatomy laboratories and the new Surgical Skills lab at the University of Virginia Medical School.

The Orthopaedic research laboratories at Cobb Hall are available for biomechanics, cell level research, and microvascular research. Additionally, an outstanding gait analysis laboratory is available for projects. The ongoing cellular, cartilage, gait lab, and growth factor research laboratories are staffed by experienced technicians.

Clinical research and outcome studies are administered through the Fontaine Offices.

Research Expectations

PGY-2 through PGY-5 residents will be expected to participate in 1 basic science or clinical research project per year for each year in training. A quality improvement project is expected from each resident by the end of PGY-3. Prior to graduation, all residents are expected to have submitted one first author peer-reviewed publication or two book chapters.

Resident Research Day

Resident research day will be held during grand rounds the week prior to graduation. All residents are expected to present a research project to the faculty and other residents and fellows. An abstract should be submitted by June 1. The research presentations will be judged and an award given at graduation.

Committee Opportunities

- All residents are invited and encouraged to participate in the Department's educational committees. The committees include the Program Evaluation Committee (PEC), Curriculum Committee, the Residency Recruitment Committee, the Rotating Student Committee, and the Resident Advocacy & Remediation Committee.
- Two interested residents each year are tasked with membership in the Housestaff Council, though all residents are invited to participate at their level of interest.

- R-3 (4th) year residents interested in academics may submit a request for nomination to the AOA Resident Leadership Fellowship and the American Academy of Orthopaedic Surgeons (AAOS) UVA Resident Representative positions.
- There are opportunities for resident involvement in committees with the AAOS and the ACGME; please check their websites and resident newsletters for openings.
- All residents are encouraged to participate and seek positions in University and Medical Center Resident Committees including the Housestaff Executive Council and the Residency Advocacy Committee.

Description of Services

Adult Reconstruction/Oncology – responsible for education in evaluation and treatment of joint disorders in adult Orthopaedics. This includes metastatic and primary neoplasia of the musculoskeletal system.

Foot & Ankle / Trauma – responsible for education concerning common problems of the foot and ankle, and complex reconstructive procedures for degenerative and traumatic conditions of the foot, as well as multi-system trauma, complex pelvic and acetabular and peri-articular fractures.

Hand/Upper Extremity/Microvascular Surgery – responsible for education in upper extremity anatomy and function, and the evaluation and management of traumatic, degenerative, and congenital disorders. Also responsible for education in evaluation and treatment of complex trauma of the upper extremity, nerve repair and microvascular reconstruction.

Pediatric Orthopaedics – responsible for education in pediatric Orthopaedic examination, fracture treatment and treatment of musculoskeletal disease in the growing child, with emphasis on congenital and developmental conditions in Pediatric Orthopaedics. Residents on this service also gain experience in the management of pediatric spinal deformities.

Spine Surgery – responsible for education in adult spine trauma and reconstructive spine surgery, including correction of adult spine deformity.

Sports Medicine – responsible for education in sports medicine. Additional exposure to total knee and shoulder arthroplasty as well as participating with sports team coverage.

Assessment of Resident Performance

UVA Policy

POLICY AND PROCEDURES FOR
THE ASSESSMENT OF PERFORMANCE OF RESIDENTS

This document is maintained on UVA's Graduate Medical Education Office website at
http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm

ACGME Policy

Documents for program requirements are housed on the ACGME website at http://www.acgme.org/acgmeweb/tabid/140/ProgramandInstitutionalAccreditation/SurgicalSpecialties/OrthopaedicSurgery.aspx

Department Policy

Block Evaluations

At the end of each rotation throughout the program, standardized evaluations are completed by the supervising faculty member(s) on each service, by the resident of the faculty member(s), peer review by the residents, PAs and fellows, nurse's evaluations on the residents, and resident evaluation of the rotation. These evaluations reflect the six competencies identified by the ACGME. These evaluations are completed mainly within the New Innovations Software system. The faculty evaluation of the resident should be discussed directly with the resident prior to submission to the Residency Coordinator for filing in the resident's records. Resident evaluations of the faculty are kept confidential and are blinded and randomized before comments are shared with the faculty during their annual review. Rotation evaluations are blinded and randomized and are reviewed annually by the Education & Curriculum Committee for resident education improvement.

Any significant deficiencies are discussed at the next Orthopaedic Faculty meeting. Significant or recurring deficiencies in performance warrant a referral to the Resident Advocacy & Remediation Committee. This committee has the authority to act on these identified deficiencies. Sanctions may include assigning a faculty mentor for more frequent evaluations; remediation with committee recommendations for improvement in performance and review after each rotation; and in extreme cases, failure to promote to the next year or termination. All sanctions are subject to institutional (UVA Health System) Grievance policies.

Assessment of Training Program

Program effectiveness is critically evaluated at least annually at the PEC Meetings. The quality and content of the conferences are reviewed and recommendations are made concerning positive changes. Clinical evaluations of resident performance are not specifically reviewed during these meetings. Performance on the OITE is used as one benchmark regarding the effectiveness of the education program. Resident input regarding conferences are sought by faculty and resident members of the committee. As the Program Directors have an open door policy, residents often voice concerns or complaints regarding

conferences and faculty, and these are taken into consideration when scheduling the upcoming academic conference calendar.

Policies and Practices

Employee Warnings

Initial intervention for resident difficulties with respect to performance, behavior and conduct are handled with face-to-face conference with the Program Directors. If the conference does not resolve the problem, the Resident Advocacy & Remediation Committee is convened to discuss the issue and to formulate an action plan. If remediation is recommended, the resident is notified in writing. Remediation is continued until satisfactory information is available for the committee to recommend removal of remediation status. If remediation status has not been lifted, and it is apparent that behaviors or problems resulting in remediation have not changed despite specific recommendations from the Committee, the resident will be notified in writing of suspension of clinical activities or termination, depending on the problem.

All policies regarding remediation, suspension, termination and the appeals process are described in detail below and in the University's GME Manual at http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm

UVA Grievance Procedure

GME GRIEVANCE POLICY AND PROCEDURE

This policy is kept electronically and is available on the web on the GME Current Housestaff Page under Policies and Manuals at http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm.

Benefits

Payday

Payday for GME members is bi-weekly. If you attended the mid-June orientation, you will receive a partial check in early July to cover that time. Your first full bi-weekly check will be received in mid-July.

Reimbursement of Expenses

Please refer to the following websites for information and processes regarding resident travel and reimbursement policy:

- Travel Policy and all forms
  http://www.procurement.virginia.edu/pagetravelbasics

Health Insurance and Retirement Benefits

Health insurance and retirement benefits are detailed fully on the GME Current Housestaff Page under the Benefits and Work Life section at http://www.healthsystem.virginia.edu/internet/housestaff/housestaff.cfm.

Computer, AV Equipment and the Resident Library

The main medical library is staffed with exceptional employees and is well stocked with current Orthopaedic textbooks and journals. A vast array of journals, textbooks, computes, and databases are available from 7am to midnight daily in the library. Additional computers are available to residents in the call room, ER, inpatient floor, and department offices.

The Orthopaedic Department has its own Orthopaedic library, with current journals and textbooks, which can be used for quick reference work. Additionally, there are work cubicles available for resident use. A collection of Academy OKU and self-assessment CD's are available for checkout. There is also an extensive in-house video library. Computer terminals with internet access are available in all clinical settings.

On-Call and Meal Allotment

ON-CALL MEALS

Housestaff members required to remain overnight in the hospital in an on-call capacity are eligible to receive meal money to be used in the Hospital Cafeterias. Information regarding the issuance of these meals is available in the Graduate Medical Education Office.

ON-CALL ROOMS

Programs that require housestaff to take overnight call have call rooms available for use by housestaff members. Information regarding usage of and access to these rooms may be obtained from your Chief Resident or in the Graduate Medical Education Office.

Housestaff Parking Policy

Please see the Housestaff Policy webpage at http://www.healthsystem.virginia.edu/internet/housestaff/benefits.cfm#parking for current parking information.

Counseling Services

The pressures and demands of medical training can be stressful both to the individual and to relationships. Confidential evaluation and treatment services are available through a number of resources. Should service be desired, contact the MSRO and/or the Faculty and Employee Assistance Program (FEAP).