

RESIDENCY PROGRAM MANUAL

2009-2010

**ORTHOPÆDIC SURGERY
DETROIT MEDICAL CENTER and PROVIDENCE HOSPITAL**

Date Tuesday, June 23, 2009

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I. Introduction

Mission of the Orthopædic Residency Program

Orthopædic surgery is the medical specialty that includes the investigation, preservation, and restoration of the form and function of the limbs, spine, and associated structures by medical, surgical, and physical methods.

The mission of residency education in the Detroit Medical Center and Providence Hospital Orthopædic Residency Program is to provide a superior clinical education to physicians in the science and art of the specialty of Orthopædic surgery. All functions of the Program are intended to support this educational mission, in the context of providing superb patient care.

The Program is designed to provide a broad foundation in all the subspecialties of Orthopædic surgery. During the five years of the Residency Program, residents will develop their clinical and surgical skills by working closely with faculty members in providing patient care. As they progress through the Program, residents will be given increased responsibility for assessing musculoskeletal problems and developing appropriate plans of care. All clinical responsibilities will be performed under the supervision of a faculty member. Clinical practice will be supplemented with didactic instruction, clinical conferences, and independent study. All Orthopædic residents will have the opportunity and responsibility to pursue research activities under faculty supervision.

The Program promotes the ethical standards and practice guidelines as set forth by the American Academy of Orthopædic Surgeons. One major goal of the Program is to instill in the residents, by example and study, a personal code of ethics. The ethical standards and practice guidelines as set forth by the American Academy of Orthopædic Surgeons are referenced for resident study in Section VIII.

At the conclusion of the Residency Program, graduates will be proficient in the fundamentals of Orthopædic surgery and will be competent to practice Orthopædic surgery in the community. Those graduates who wish to pursue a career in one of the Orthopædic subspecialties will have a sufficient knowledge base to allow them to compete successfully for a fellowship in their chosen subspecialty. All graduates will have received sufficient education to prepare them for successful completion of the Orthopædic certifying examinations.

Goals and Objectives of the Orthopædic Residency Program

Goal 1: That the resident graduates will be eligible to take the Orthopædic Board examinations.

Objective 1, in support of Goal 1: The entire Residency Program must remain in substantial compliance with the published requirements of the Orthopædic Residency Review Committee.

Objective 2, in support of Goal 1: The experience of each resident must be in compliance with the published requirements of the American Board of Orthopædic Surgery.

Goals 2A and 2B: That the resident graduates will actually pass the Orthopædic Board examinations (written (Goal 2A) and oral (Goal 2B) examinations).

Objective 3, in support of Goal 2A: The residents will be given didactic education (lectures and conferences) on topics of basic science and clinical Orthopædics. During the subspecialty rotations, the residents will have discussions with and guided reading assignments from their rotation mentors. The residents will take the Orthopædic In-Training Examinations annually for practice and to monitor their progress against national standards.

Objective 4, in support of Goal 2B: The residents will have supervised experience in the presentation and discussion of cases in front of an audience of their peers in their clinical rotations and every Wednesday morning (typically history, examination, radiographs, diagnosis, and treatment).

Objective 5, in support of Goal 2B: The residents will have the opportunity to take one or more oral examinations in Orthopædic surgery which simulate the Orthopædic Board oral examinations, conducted by the faculty of this Program.

Goal 3: That the resident graduates will have a broad enough knowledge base to be safe, will have good clinical judgment, and will have good surgical skills.

Objective 6, in support of Goal 3: Clinical knowledge, judgment, and surgical skills typically come from experience. That's why it takes five years. The residents will have a large volume of experience in common Orthopædic patient problems.

Objective 7, in support of Goal 3: The residents will have some experience in difficult, even esoteric, Orthopædic patient problems.

Objective 8, in support of Goal 3: The residents will have experience in supervised Orthopædic decision-making in actual patient care.

Goal 4: That the resident graduates will be able to get a good fellowship and go into academic practice if that is what they choose.

Objective 9, in support of Goal 4: The faculty maintains their academic productivity and maintains professional contact with their peers in their subspecialty interest groups, so as to maintain credibility when recommending a resident graduate for fellowship.

Objective 10, in support of Goal 4: Each resident is required to complete a research project of a type which might be publishable. Funds to conduct the research are paid by the Program.

Objective 11, in support of Goal 4: The residents are encouraged to present and publish their research. If resident research is presented, the resident travel expenses are paid by the Program.

Goal 5: That the residents have a satisfactory lifestyle, and may even have fun, during residency.

Objective 12, in support of Goal 5: Night call is limited on the average to no more than one night in three, and on the average one whole day is given off work each week.

Objective 13, in support of Goal 5: The residents are given a large say in the management of their Residency Program, through their Chief Resident who participates in Orthopaedic Residency Education Committee meetings.

Objective 14, in support of Goal 5: Food and comfortable call rooms are provided.

Objective 15, in support of Goal 5: Socialization between residents and between residents and faculty are promoted at non-work parties.

Since July 01, 2002, the ACGME / RRC is requiring six additional goals and their supporting objectives. Teaching toward these new goals was phased in over a period of four years. We are offering this material now. The new goals specified by the ACGME / RRC and our objectives in support of those goals are:

Goal A: The resident will learn to deliver patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Objective 16, in support of Goal A: Communicate effectively with patients and families to gather accurate historic and physical information.

Objective 17, in support of Goal A: Develop and carry out management plans.

Objective 18, in support of Goal A: Perform surgical procedures.

Objective 19, in support of Goal A: Work effectively with other health care providers.

Goal B: The resident will learn medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Objective 20, in support of Goal B: Know and apply basic and clinical medical science.

Objective 21, in support of Goal B: Demonstrate analytical thinking.

Goal C: The resident will develop interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health care professionals.

Objective 22, in support of Goal C: Demonstrate effective patient/family interviewing skills.

Objective 23, in support of Goal C: Prepare and deliver effective medical case presentations and lectures.

Goal D: The residents will live a life of professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Objective 24, in support of Goal D: Understand the value of respect and compassion.

Objective 25, in support of Goal D: Understand the value of integrity which supercedes self-interest.

Objective 26, in support of Goal D: Express a commitment to ethical principles.

Objective 27, in support of Goal D: Understand issues of culture, religion, race, age, gender, sexual-orientation, disability, etc., in patients and other health care providers.

Goal E: The resident will conduct a lifelong program of practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

Objective 28, in support of Goal E: Locate, analyze, evaluate, and assimilate evidence from scientific studies.

Objective 29, in support of Goal E: Demonstrate knowledge of scientific study design and statistical methods.

Objective 30, in support of Goal E: Use information technology.

Objective 31, in support of Goal E: Teach more-junior residents, residents-in-general, faculty, and other health care providers.

Goal F: The resident will be able to thrive in an environment of systems-based practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

Objective 32, in support of Goal F: Understand various types of medical practice, especially with respect to how each controls costs and allocates resources.

Objective 33, in support of Goal F: Practice cost-effective care.

Objective 34, in support of Goal F: Advocate for quality patient care.

II. Resident Rights and Responsibilities as an Employee

The relationship between the residents and the residency is a complex one. The residents are employees on one hand and trainees (educees) on the other hand. In general, the resident has more rights as an employee than as a trainee.

Employment contract

The resident relationship to the Program as an employee is set forth in the "Residency Agreement," which is an employment contract. The actual contract that the resident actually signed governs. The text set forth in Section X is to be used for reference only:

Employment benefits

As an employee, the resident is provided with certain benefits. There is a summary of benefits set forth in Section XI.

Maternal short-term disability

Guidelines for maternal short-term disability: As an employee, an uncomplicated delivery from a resident of a baby typically merits 6 weeks of FMLA leave. A Caesarian delivery typically merits 8 weeks of FMLA leave. If there is a medical necessity, a resident can have 12 weeks of leave under the FMLA. As a trainee in the Program, ordinarily a resident cannot miss more than 6 weeks of education without having to make up the lost time.

Radiation exposure

Radiation is a small risk inherent to the practice of Orthopædic surgery. Relatively safe x-ray emitters, portable radiation shields, and radioprotective garments are made available. Two radiation-monitoring badges (one for the waist to be worn inside protective gear and one for the neck to be worn outside of protective gear) are provided to all Orthopædic residents and monitoring is offered monthly. All resident employees are required to participate in this radiation dose monitoring.

Pregnant residents are directed to refer to US Health and Human Services guidelines regarding radiation exposure and pregnancy (Section K of the USHHS Radiation Safety Manual, dated August 1999) and are directed as follows:

1. Pregnant residents will avoid all work-exposure to radionuclides. (Pregnant residents will perform no bone-scans, no lung-scans, etc.)
2. Pregnant residents will avoid X-ray exposure insofar as is possible, leaving cases uncovered, as necessary. If a pregnant resident does participate, she must be certain to always wear protective lead garments and stand behind portable metal shields made for the purpose.

3. There is an absolute ceiling of 500mrem exposure during any one pregnancy.
4. The pregnant resident must notify the Radiation Safety Officer of each hospital in which she works of her situation.
5. A pregnant resident is never required to do any case which exposes her to either radiation or fumes from PMMA.

Illness or family emergency, reporting requirement:

If the resident is ill or has a family emergency (or has some other unforeseen problem) such that the resident cannot perform his/her normal and expected duties, he/she must notify someone in authority. The hierarchy of notification includes Residency Program Director (currently Blasier), Department Chairman (currently Markel), Program Manager (currently Barbara Calati). The resident must not stop until someone in authority has been notified. As the employer, we have a moral and legal right to know when any resident is unable to perform. As mentors, we have a moral and legal right to know when any resident is unable to learn. If the resident's condition is medically unstable, medical treatment must not be delayed to conduct this reporting. Reporting should be delayed until the resident's condition has been stabilized. If the resident is dead, this reporting requirement is excused.

Resolution of serious problems related to employment:

Resolution of serious problems between the resident and the Program is governed by the "Detroit Medical Center Graduate Medical Education Program Corrective Action Procedures." Most of the provisions of this document apply to the resident's role as a trainee, and the whole text is included in this handbook in Section XIII. However, the DMC (or Providence Hospital) as an employer can suspend or dismiss a resident.

2009-20010 Stipend rates

PGY	STIPEND
1	\$45,715
2	\$47,087
3	\$48,499
4	\$49,955
5	\$51,453

III. Resident Rights and Responsibilities as a Trainee

1. *The Role of Administrative Chief Resident*

The Administrative Chief Resident is responsible for a variety of activities related to the residency Program, which are to be carried out in concert with the Program Director and the Program Manager. These include: coordinating vacation requests, arranging coverage during conferences when a significant number of residents are unavailable, coordinating conferences and case presentations, monitoring attendance at conferences, and maintaining the professional and collegial interaction between residents, faculty, and support staff. The Chief Resident will interact on a regular basis with the Program Director and will provide input regarding the academic program, residents who are experiencing difficulty, problems involving the various hospitals, etc. Resident problems and concerns should be brought to the attention of the Chief Resident.

2. *Vacations*

PGY-1s are eligible for two weeks of paid vacation. All other residents (PGY-2 and higher) receive three weeks of vacation per year. Unused vacation time does not accumulate or carry over from year to year. Vacation must be scheduled in advance. During July and December of each year, residents may submit vacation requests for the upcoming academic year. Requests will be honored according to the following rules:

- A. Vacation may not be scheduled during the week of major Orthopædic conferences (e.g. AAOS, Mid-America, MOS).
- B. No more than one of the residents assigned to Detroit Receiving Hospital, Children's Hospital of Michigan, or Providence Hospital should be on vacation at the same time. The Chief at these locations may grant exceptions to this rule.
- C. Conflicts in requested vacations will be resolved by: 1. the Chief Resident if he can; 2. by the faculty site-Chief if he can; 3. by the Program Director if he can; or 4. by the Chairman.
- D. All vacation requests must be submitted in writing.

Requests for vacations submitted outside of July and December will be adjudicated based on the needs of the Program. Vacation requests should be submitted at least three months in advance.

3. *Interview Days*

Requests for interviewing days should be directed to the staff physician responsible for the service on which the resident is rotating. Reasonable requests for interviewing time will ordinarily be granted; however, as with vacation time, the staff physician has the right to approve or deny time off.

4. *Illness and Disability*

A doctor's statement will not normally be required to document illness. However, the Program Director reserves the right to request verification of illness. Residents who are off for more than seven consecutive days due to illness or injury will be reported to the G.M.E. Office. Residents with verifiable illness may be paid their full stipend for up to 90 days. Should a period of incapacitation extend beyond 90 days, the resident may apply for long-term disability benefits at 60 percent of salary. Residents who miss six or more weeks of education in total or two or more weeks of a particular rotation due to illness or disability may be required to make up the lost educational time prior to graduation. The Program Director will have final authority in determining whether, when, and how lost time will be made up.

5. *Leave of Absence*

A resident may request a leave of absence for up to one year. A leave of absence may be granted for medical or personal reasons. The Program Director has final authority to approve or deny a request for a leave of absence. Residents in good academic standing who are on an approved leave of absence may resume their residency program at the conclusion of the leave of absence. Taking a leave of absence will normally have the effect of delaying the date of graduation by a period equal to that of the leave of absence. The Program Director will have final responsibility for determining the effect of a leave of absence on the resident's date of graduation.

6. *Logging of Procedures*

All residents are required to maintain a log of all procedures in which they have participated. The log must be recorded in a standardized, web based reporting system maintained by the ACGME at their web site URL = <www.acgme.org>. Computers are available at all the participating hospital Orthopaedic libraries for data entry. Logs will be reviewed on a regular basis by the Program Director. Residents who are not current in maintaining their surgical logs will not be permitted to take vacation or professional travel until they have brought their logs up to date. Graduation may be placed on hold. Certification of completion of residency education may be placed on hold. Failure to maintain the surgical log may result in sanctions, including suspension, termination, or any other action consistent with the DMC Corrective Actions Procedures.

Historically, there was a distinction made between doing and assisting in a procedure. This is no longer true. Any resident who participated in the operation (as surgeon, assistant, second assistant, etc) must log the procedures.

Historically, manipulations of fractures and dislocations done outside of the operating room were not recorded. Now they must be. The ACGME system has codes to be used for manipulations of fractures and dislocations, and these procedures must be logged, no matter where performed.

The ACGME system has an optional field on the procedure log which may contain any text the resident desires to record. The residents are hereby warned that there may be adverse legal consequences under patient privacy legislation to recording information which might identify any particular patient. The ACGME believes that their system is physically secure and undiscoverable under Illinois law, but this Program is unable to confirm that security. Therefore, residents are hereby warned: 1. Not to use patient-specific data in this field; or 2. To use a personal code for such data and safeguard the key to the code.

The CPT codes for the procedures logged on the ACGME system are the SAME billing codes that surgeons in practice use to get paid. The skills developed “coding” resident procedures are the same skills surgeons in practice use to get paid. One case (an “operation” on one patient) can generate more than one “procedure.” For a diagnosis of “rotator cuff tear, chronic (727.61),” it IS acceptable to bill for 23412 (Open repair of rotator cuff, chronic) AND 23130 (acromioplasty, partial acromionectomy). It is NOT correct to bill for 23420 (reconstruction of rotator cuff) with 23130 (acromioplasty), because 23420 already INCLUDES the acromioplasty. It takes a long time (months or years) to learn the subtleties, and that’s why it is good to practice now. There have been several requests from recent resident graduates to print out for them their ACGME case logs to support new privileges at a new (for them) hospital. The hospitals know about and want the ACGME case logs for their credentialing processes. If the procedures are not recorded, the graduate will have a hard time getting privileges. Please log your cases contemporaneously and thoroughly.

7. *Daily Rounds List*

Residents at Detroit Receiving Hospital and Children’s Hospital are expected to submit a copy of the daily rounds list, updated to show all admissions and discharges to the Orthopædic service. The rounds list should be turned in to the Orthopædic office by 8:00 a.m. each morning (at CHM, by 7:00 a.m.). It is especially important that an updated rounds list be prepared on Monday morning to reflect weekend activity.

8. *Dress Code*

Residents must dress and present themselves in a professional manner at times when patient contact is anticipated.

- A. Scrubs never, ever, may be worn out of the hospital.
- B. Scrubs may never, ever, be worn more than six hours.
- C. After six hours, new scrubs must be applied.
- D. In every situation in which awake patients may be encountered from 8am to 3pm, a shirt-and-tie (or equivalent—skirt or pants and blouse) must be worn.
- E. From 3pm to 8am scrubs are allowed, but only if clean.

For example, blue jeans, shorts, sandals, tee-shirts, and other casual attire are not appropriate for outpatient clinics and hospital rounds. The staff physician responsible for a particular rotation may require a specific dress standard for that rotation, e.g. coat and necktie. The staff physician responsible for a particular rotation may relax the dress required, e.g. polo shirt. Scrubs are appropriate for emergency visits and for outpatient situations where surgical procedures may be performed. When scrubs are worn in an outpatient setting, a lab coat should be worn over the scrubs. At the beginning of each year, residents will receive lab coats from the Department at no cost. Residents are responsible for cleaning their lab coats. Residents should not wear soiled, stained, or torn lab coats during patient encounters.

9. *Moonlighting Policy*

Moonlighting is NOT permitted in this Program at this time. Possibly some are moonlighting without permission. This is risky. The professional liability insurance provided as an employment benefit does NOT provide coverage during moonlighting. All residents are hereby warned of this danger.

If at some future time this Program does decide to allow moonlighting, then the minimum requirements for moonlighting would be: 1. In good standing (not on probation): and 2. 50%ile or higher on the most recent past OITE.

10. *Library*

Orthopædic libraries are maintained at all clinical training sites. These libraries include journals and texts needed by residents in preparing for case presentations, as well as their routine studies. Because the same periodicals and texts will frequently be needed by more than one resident, residents may not remove library materials from the premises.

11. *Equipment*

Residents are responsible for all medical and other equipment issued to them. Residents will be asked to pay for lost or stolen equipment, as well as any equipment which is damaged through negligence or abuse. Residents on the hand rotation will receive their own individual loupes which they may keep for their own use after they complete their rotation. All other equipment issued to residents (beepers, Dictaphones, etc.) must be returned prior to graduation.

12. *Professional Travel*

The opportunity to attend national Orthopædic conferences is an important aspect of the training program. Each resident will receive an allocation of \$2,000 each year over the five years of the training program. These funds may be used for travel. Residents are encouraged to submit papers for presentation at professional conferences. The abstract must be approved by the Research Committee prior to its submission. The Program will absorb travel expenses for residents presenting an approved paper, abstract, or poster. Expenses for presenters will not count against the \$2,000 allocation. Residents may present the same paper at only one national or regional conference. If the paper includes multiple authors, travel expenses will be paid only for the presenting author. Travel expense reimbursement will be limited by per diem rates established for the conference location. Residents are expected to save on hotel expenses by sharing rooms whenever possible, and by obtaining the least expensive air fares.

13. *Resolution of Serious Problems*

Resolution of serious problems between the resident and the Program is governed by the, "Detroit Medical Center Graduate Medical Education Corrective Action Procedures." See text in Section XIII.

15. *Clinic Dictations*

Do not dictate race, nation of origin, nor religion, unless it is germane to the disease in question.

Do dictate the patient's name!

Do dictate the patient's "FIN."

Do dictate your own name!

Do dictate the date!

Do dictate your staff's name!

(every time)

History is in past tense.

Physical examination is in present tense.

If (and only if) it is true, dictate:

"Dr Attending-staff-name repeated the key portions of the (1) history and (2) physical examination and guided the (3) decision-making."

Exception: If he/she did two of the above three items, and it is a return visit, then dictate what he/she did, such as:

"Dr "Attending-staff-name" repeated the key portions of the (2) physical examination and guided the (3) decision-making."

“Dr “Attending-staff-name” repeated the key portions of the (1) history and (2) physical examination.”

“Dr “Attending-staff-name” repeated the key portions of the (1) history and guided the (3) decision-making.”

The teaching point is that Medicare (and by inference, Medicaid) will only pay for an initial patient visit if the attending staff does and charts all three of these “elements.” Medicare (and by inference, Medicaid) will pay for a return visit if the attending staff does and charts any two of these three “elements.”

If the attending staff did not actually do these things, then do not waste time dictating extraneous material, such as “patient was seen with Dr Attending-staff-name,” “Dr Attending-staff-name supervised the care of this patient,” etc.

This topic is not important enough to compromise your virtue by lying. Dictate the strict truth; we can live with that; we want to live with that.

IV. The Academic Program

A. *Residency Program Description.*

A block diagram of the internship rotation schedule is shown below:

Resident Name		Sample Resident, M.D.						Date to Complete Program				June 30, 2011	
PGY-1	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
		Orthopaedics DRH			T(D)	T(S)	NS	RR	ICU	PS	Anes	Ped	VS
PGY-2	Orthopaedics DRH			Pediatric CHM			General Orthopaedics and arthroplasty Providence			Research			
PGY-3	Orthopaedics DRH			Sport 1 MiOSH			Spine Providence			Hand			
PGY-4	Orthopaedics DRH			Pediatric CHM			General Orthopaedics and arthroplasty Providence			Research			
PGY-5	Orthopaedics DRH			Sport 2 Providence			General Orthopaedics and arthroplasty Providence			tba			

PG-2 to PG-5 rotations

Research = Research and Basic Science
 DRH = Detroit Receiving Hospital
 CHM = Childrens Hospital
 Providence = Providence Hospital
 Hand = Hand Surgery Associates
 Sport-1 = Lemos, Teitge, and Plagens
 Spine = Bono and Claybrooks at Providence
 Sport-2 = Michaelson

PG-1 rotations

DRH = Detroit Receiving Hospital
 T(D) = Trauma surgery at DRH
 T(S) = Trauma surgery at SGH
 NS = Neurosurgery at Prov
 RR = Rheumatology and Rehabilitation Medicine at Prov
 ICU = ICU at SGH
 PS = Plastic surgery at DRH
 Anes = Anesthesia at SGH
 Ped = Pediatric surgery at CHM
 VS = Vascular surgery at Prov

Specific educational goals have been established for each rotation as set forth in Section VII. Broader goals are outlined immediately below.

The Program strongly believes that Orthopædics is a cognitive as well as a procedural specialty. Evaluation and management in the ambulatory setting is emphasized, including patients who are managed without an operation, along with longitudinal (i.e. pre- and post-operative) exposure to the surgical patient.

Proficiency is the ability to understand and handle a problem in a minimally-satisfactory way, avoiding pitfalls. What is minimally acceptable in this regard is in keeping with the national and/or regional expectations and standards of Orthopædics, medicine, and the public.

Expertise is proficiency plus additional time, study, and experience, making one an expert.

- B. During the *first postgraduate year*, the Orthopædic resident is expected to become proficient in the hospital care of patients and be introduced to cognitive disciplines important in the diagnosis and management of musculoskeletal disorders. These objectives will be achieved through (ACGME requirements in *italics*):

A minimum of six months of structured education in surgery, to include multi-system trauma, plastic surgery/burn care, intensive care, and vascular surgery:

Two months of Trauma (one month at Sinai-Grace and one month at DRH), Plastic Surgery at Providence, Pediatric Surgery at CHM, Surgical ICU (half at Sinai-Grace, half at Providence), and Neurosurgery at Providence.

A minimum of one month of structured education in at least three of the following: emergency medicine, medical/cardiac intensive care, internal medicine, neurology, neurological surgery, rheumatology, anesthesiology, musculoskeletal imaging, and rehabilitation:

Anesthesiology at Sinai-Grace, Rheumatology at Providence, and Rehabilitation Medicine at Providence.

A maximum of three months of Orthopædic surgery:

Three months of Orthopædic surgery at DRH.

- C. During the *second and fourth postgraduate years*, the Orthopædic resident is expected to become proficient in the evaluation of the Orthopædic patient— history, physical examination, and interpretation of imaging studies. He/she will be introduced to reduction of fractures, preoperative planning, and basic Orthopædic surgical techniques. These objectives will be achieved through supervised direct patient care in adult and pediatric Orthopædics, ambulatory as well as surgical, and adult and pediatric trauma.

The residents will study the Orthopædic basic sciences and will develop skills and knowledge in the critical appraisal of the literature and research design. A research mentor will be identified, and a project submitted to the research committee no later than the PGY-3 year.

- D. During the *third postgraduate year*, the Orthopædic resident is expected to become proficient in the evaluation of Orthopædic subspecialty patients, while continuing to develop surgical skills. These objectives will be achieved through subspecialty rotations, providing supervised, direct patient care in the office and hospital setting. The resident will begin to learn essentials of practice management, coding and reimbursement, workman's compensation, and quality assurance.
- E. During the *fifth postgraduate year*, the Orthopædic resident becomes proficient in all aspects of general Orthopædic care. Expertise in defined areas may develop through individual study and interest. These objectives will be achieved through increasing responsibility for patient care evaluation and management decisions.
- F. The Detroit Medical Center / Providence Hospital Orthopaedic Residency Program meets or exceeds the Program Requirements for residency education in Orthopædic surgery, as defined by the Residency Review Committee for Orthopædic Surgery of the ACGME set forth as Section IX.
- G. Fellowship Programs: The Department currently has an accredited fellowship program in the Orthopædic subspecialty of Sports Medicine. Descriptions and applications for the Sports fellowship program may be obtained from the faculty sponsors. It remains the strongly-held opinion of the Department that resident education remains the primary educational priority.
- H. The Orthopædic faculty and Chief Resident meet semi-annually or more often as the Orthopaedic Residency Education Committee (OREC) to oversee the residency Program. Resident education is the principal topic of this recurring meeting, though other topics are always included as well. Annually in February, OREC meets to evaluate the role of every rotation and service in the Program to ensure that each activity has a high education to service ratio, to identify and address Program weaknesses and deficiencies, and to plan future changes and evaluate the effect of past changes.

- I. The Program has some authority to ensure that faculty and attending staff, perform according to expectations. Regarding paid faculty, the Chairman can terminate the stipend payment for failure to perform to expectations. This encompasses most of the surgeons who provide the closest teaching of residents. Regarding unpaid (voluntary) faculty, the Chairman can terminate the faculty involvement in teaching.
- J. The Orthopædic Residency Program exists solely to educate residents. It is important to understand that the Orthopædic Residency Program does not exist for the purpose of serving the needs of patients or the attending staff. With the rarest exceptions, the attending staff are fully able to take care of all of their patients without help from, or even the existence of, the residents. Obviously, patients are valuable assets in the course of resident education. The attending staff share their patients with the residents. In this Program (as in all residency programs), there is a trade of education in exchange for service. The attending staff provide:
1. Access to their patients in the office or clinic.
 2. Access to their patients in the operating room.
 3. Bedside and office teaching.
 4. Didactic lectures.
 5. Research mentorship

In trade, the residents provide:

1. First emergency room evaluation of patients (with supervision by more senior residents and attending staff).
2. Assistance during surgery.
3. Assistance in office management.
4. Labor for work rounds on inpatients.
5. Case presentations.
6. Labor during research

K. Conferences:

The principal teaching day in this Program is Wednesday. All residents not out of town attend and are excused from all clinical duties. On a typical Wednesday, the first one hour lecture is an Orthopædic lecture by a faculty person. Some of these are outside lecturers from other institutions. More often, these lecturers are faculty of the Program. The second conference is one hour and consists of cases presented by a senior resident or faculty. This generally is taught from computer-to-screen projection. The cases are discussed by faculty, and typically several faculty are present. The third hour is a basic science or core-curriculum lecture.

As an exception, the first Wednesday of each month consists of Grand Rounds with the Orthopædic Surgery Department of Henry Ford Hospital at 7:00am. Following this is a formal Deaths and Complications Conference at 9:00am at Kresge Auditorium. All cases of mortality are presented. Any morbidities may be presented. This forum provides a critical evaluation of complications and invites our colleagues to criticize rather aggressively.

In the evening of the third Thursday of each month, there is a Journal Club. Attendance at this Journal Club is required by every resident who is in town, with exceptions made only for emergencies and in-house call. Faculty attendance typically is a minimum of six, and occasionally up to ten. Discussion of the journal articles does include their content, but also their methodology. A good deal of discussion is devoted to statistics, such as the meaning of significance, randomization, power, bias, etc.

In the evening of the second Thursday of each month, there is a Sports Journal Club. Attendance at this Sports Journal Club is required by every resident who is in town, with exceptions made only for emergencies and in-house call. Faculty attendance typically is a minimum of four, and occasionally up to six. Discussion of the journal articles does include their content, but also their methodology. A good deal of discussion is devoted to statistics, such as the meaning of significance, randomization, power, bias, etc.

For the residents assigned to Providence, there is a weekly Thursday morning conference held by the Providence Orthopædic education director.

For the residents assigned to Sports Orthopædic rotations at Michigan Orthopaedic Specialty Hospital, there is a conference each week, typically run by the Sports medicine fellow.

For the residents assigned to the pediatric Orthopædic rotation at Childrens Hospital of Michigan, the residents attend Pediatric Orthopædic Topic Conferences each week. It is supervised by Dr Richard Reynolds. This conference consists of a rotating topic schedule for which the residents prepare, by text and literature review, for discussion in Socratic format. On the fourth Friday each month, there is a Pediatric Journal Club. On Monday mornings, preoperative and postoperative cases and x-rays are reviewed.

L. Resident Portfolio

In 2006, the Executive Committee of the SACME announced its intention to host a web-based system to store resident portfolios some time in 2010. I have learned that this effort is somewhat behind schedule. We will be proactive and start maintaining resident portfolios now. The portfolios will be maintained on DMC servers, accessed through Citrix Desktop. Portfolios will be maintained by each resident. Resident Portfolios will contain:

- ACGME Case Log reports.
- OITE Score reports
- Net Learning Transcripts
- Rotations Evaluations.
- Anatomy Test Scores.
- Pathology/oncology Test Scores.
- July Test Scores.
 - Professionalism.
 - Communication.
 - Systems-based Practice.
 - Practice-based Learning and Improvement.
- Moments of Insight (quarterly).
- Moments of Frustration (quarterly).
- Topical Literature Look-up (monthly).
- Report on "Systems" topic (annually).
- Every Case-presentation or Topic-presentation given.
- Research Project.
- Research Presentations.
- Publications.
- ABOS-1
- ABOS-2.

V. Academic Policies and Procedures

1. *Conference Attendance*

Wednesday morning conferences are the primary vehicle for Program-wide didactic education and case presentation. A monthly conference schedule is prepared and distributed in advance. Unless otherwise noted, conferences begin at 7:15 a.m. each Wednesday morning. All Orthopædic residents and interns are expected to attend Wednesday conferences. Repeated unexcused absence will be noted and may result in disciplinary action. Residents are excused from clinical duties to attend the Wednesday conferences, with the exception of *bona fide* emergencies. There have been rare problems in the past with a few attending staff scheduling non-emergent cases during conference time. If this ever happens, the residents are requested to discreetly notify the Program Director who will then try to resolve the apparent conflict as gently as possible.

2. *External Conferences*

Throughout their training program, residents will be expected to attend and participate in a number of external conferences and courses, including an AO Basic Course at the PG-2 level and the Northwestern University Prosthetic and Orthotics Course at the PG-3 level. Residents are encouraged to submit papers and posters for presentation at local, regional, and national meetings. Refer to the section "Resident Travel Policies" regarding scheduling and funding of attendance at external conferences.

3. *OITE Examinations*

During each year of the residency program, each resident is required to take the Orthopædic- In-Training Examination. The purpose of this examination is to provide a national benchmark against which a resident's progress can be monitored. Resident scores are graded according to year-in-training, so that direct comparisons can be made between an individual resident and a national cohort of peers of a similar level of training. OITE scores will not be used, by themselves, to determine promotion or dismissal of a resident. However, a low OITE score is usually an indication that there are significant gaps in a resident's knowledge base. For this reason, an OITE score of 30th percentile or less after the PG-2 year will generally result in a letter of academic warning or probation, per provision 1.1-5b of the DMC Corrective Action Procedures. Any resident who does not score at least at the 30th percentile for YIT at least once in years PG-2, PG-3, or PG-4, WILL NOT BE promoted to PG-5. Such a situation may alone be a sufficient basis to terminate a resident's Orthopædic education.

4. *Oral Examinations*

There are oral examinations of certain classes of residents in May of each year. There are two reasons for requiring these examinations. The first is to enable the Program to better evaluate each resident's progress through Orthopædic education. The second is to simulate, and thus provide practice for, the real oral examinations that each resident must pass after residency to become Board certified.

The residents required to take the examination are all PG-3s, all PG-4s, and any PG-5 resident who is in academic trouble. Each resident taking the oral examination is required to select four cases for discussion, which must include one case of significant trauma, one of pediatrics, one of adult reconstruction, and one of any topic of the resident's choice. Each resident must submit a list of cases for approval by the faculty, at least two weeks before the examination.

At a minimum, the resident must provide the following for each case:

1. Patient name if known.
2. Treating Institution name.
3. Treating attending physician name.
4. Diagnosis (or name of clinical problem).
5. Patient gender.
6. Patient age.
7. Actual x-ray films from the initial patient presentation, plus more if more films are needed to make the diagnosis or discuss treatment.
8. History at initial presentation (typed, no more than one-half page).
9. Physical examination findings at initial presentation (typed, no more than one-half page).

Possible grades in each room include: honors, high pass, pass, marginal pass, and fail. Possible grades for the whole examination include: honors, high pass, pass, marginal pass, and fail. Failing two rooms causes failure on the examination. Room scores of three marginal passes and one fail causes failure on the examination. Failure of the examination is a serious matter which will be managed in accordance with the DMC Corrective Actions Procedures. Each resident must pass at least one Oral examination during this residency to be promoted beyond the PG-4 year. Between the two oral examinations, each resident must pass every section of the examination at least once to be promoted beyond the PG-4 year. Failure to take the examination will result in failure of promotion beyond the PG-4 year. Failure of promotion beyond the PG-4 year may alone be a sufficient basis to terminate a resident's Orthopædic education.

5. *Research Activities*

Completion of at least one clinical or basic science research project is a requirement for graduation from the Residency Program. This requirement exists to ensure that graduating Orthopædic surgeons understand and appreciate the concepts that lead to advances within medical science and possess the knowledge to evaluate scientific research and scientific advances. Resident research will be conducted under the guidance of a mentor. A research proposal must be submitted to, and must be approved by, the Orthopædic Research and Education Committee prior to the pursuit of the resident research project. The proposed research should seek to test a hypothesis and will have specific aims and objectives. The research will be performed in accordance with an approved timetable. Upon completion of the research, a written report of the findings will be generated by the resident. Final project approval requires presentation of the research findings in an appropriate critical scientific forum. Failure to complete a research project will result in the delay of resident graduation. Failure to make satisfactory progress (as determined by the Orthopaedic Research and Education Committee) on an approved research project or failure to complete a research project may alone be a sufficient basis to terminate a resident's Orthopædic education.

6. *Evaluation of Residents*

At the end of each rotation, residents will be graded by those faculty members supervising the rotation. Grades will be available for the residents to review following the completion of the rotation. Ideally, the faculty member should review the evaluation with the resident before submitting it to the Program Director. In addition to written grades, faculty members should discuss the resident's progress, strengths, weaknesses, educational objectives and areas for continued study. These discussions should take place throughout the rotation, as well as at the conclusion. A standard performance evaluation is completed following each rotation. Residents who wish to question their grades should do so first with the faculty member involved. If the matter is not resolved to the mutual satisfaction of the resident and faculty member, the resident may appeal the grade to the Program Director, whose decision is final. On a semi-annual basis, the Program Director or his designee will meet with each resident to assess his or her progress in the program and prepare a written report for the file and for each resident. In addition to a discussion of academic performance, this meeting will be an opportunity to review the resident's educational goals, positive and negative experiences, career plans, and other matters of concern. A final written evaluation is prepared by the Program Director for the file and for each resident, as each completes the program. This record will be maintained permanently to assist in future credentialing.

Since 2002, the ACGME has required all residency programs in all specialties to teach:

1. Interpersonal skills;
2. Practice-based learning and improvement;
3. Professionalism; and
4. Systems-based practice.

Within a few years, the ACGME will require all programs to evaluate individual residents on their performance in these competencies. This data will affect the promotion and graduation of residents and will be used to affect the contents of the Program.

Since July 2008, "FACULTY EVALUATION OF ORTHOPAEDIC RESIDENT" and "360° EVALUATION OF ORTHOPAEDIC RESIDENT" will be done on-line via "New Innovations."

7. *Evaluation of the Program*

On an annual basis, the Program Director and the faculty meet to review and assess the overall educational effectiveness of the program. To assist this process, the residents are required to perform a formal evaluation of the program on-line via "New Innovations." Results of this process are used by the Program Director in assessing the overall educational effectiveness of the Program. Efforts are made to assure confidentiality of the resident opinions.

8. *Corrective Action*

When a resident is found to be having academic difficulty (as evidenced by grades, OITE score, evaluation by faculty, etc.), corrective action will be taken by the Program in strict accordance with the DMC / Providence Orthopaedic Residency Program Corrective Action Procedures. The emphasis will be on positive efforts to improve academic performance, rather than punitive measures, but any action allowed under the DMC Corrective Action Procedures may be taken. Corrective action may also be necessary to address behavioral problems not related to academic performance. The program may take actions which may include temporary suspension of operative privileges, reassignment of rotations, suspension from the Residency, or termination.

9. *Academic Warning and Probation*

In accordance with the DMC / Providence Orthopaedic Residency Program Corrective Action Procedures, a resident may be placed on academic warning by the Program Director for reasons which include the following:

- Rotation evaluation of marginal or failure;
- For PGY-3 and above, an OITE score below the 30th percentile.

In accordance with the DMC / Providence Orthopaedic Residency Program Corrective Action Procedures, a resident may be placed on probation by the Program Director for the following reasons:

- Multiple rotation evaluations of marginal or failure.
- Failure to comply with a previously-imposed program of academic remediation.

In accordance with the DMC / Providence Orthopaedic Residency Program Corrective Action Procedures, probationary status will be confirmed in writing and will be accompanied by goals and objectives to be completed in a reasonable amount of time. If the identified deficiencies are not remedied during the probationary period, the resident may be subject to additional corrective actions, up to and including termination.

10. *Suspension or Termination*

In accordance with the DMC / Providence Orthopaedic Residency Program Corrective Action Procedures, the Program Director may suspend or terminate a resident at any time for serious violation of Departmental or Hospital policies and procedures, or ethical standards. For serious violations, it is not necessary for the resident to be placed on probation prior to suspension or termination. Suspension or termination may also be initiated by any hospital to which the resident has been assigned.

11. *Board Certification*

A goal of this residency program is to prepare residents to pass both the written and oral sections of the examination for Board certification in Orthopaedic surgery. During PGY-4, residents may elect to attend a review course in preparation for the boards. The Program will fund a board review course as professional travel, subject to the Program's overall dollar restriction on travel during the residency. It is the responsibility of the Program Director to determine and certify that each resident has satisfactorily completed the prescribed length of residency training in order to take the written qualifying examination of the Board.

12. *Graduation*

Prior to completing their program, graduating residents will be expected to submit a graduation check list concerning the following items:

- Return all keys
- Return pager
- Clear all outstanding travel advances and expenses
- Provide forwarding address
- Hand in completed surgical logs
- Complete all outstanding charts
- Return all books to library

VI. Patient Care

1. *General Policy Regarding Patient Care*

Quality, compassionate patient care is the heart of the medical profession. All clinical activities involving residents should be conducted with the well-being of the patient uppermost. Faculty members are expected to act as role models in setting the standard for patient care, and residents are expected to adhere to these standards. Technical competence and scientific knowledge do not, by themselves, constitute quality patient care. Quality care involves communicating with the patient and family, addressing questions and concerns raised, treating the patient with dignity and respect, and taking responsibility to assure appropriate follow-up and continuity of care. Throughout the training program, residents will be evaluated on their interpersonal skills as well as their knowledge and technical competence. It is recognized that excessive patient care demands would diminish from the educational experience. For this reason, every effort will be made to ensure that residents have sufficient opportunity to fulfill their educational expectations. Patient care activities will not be scheduled to conflict with didactic educational activities (including conferences, grand rounds, case presentations, etc.). However, it must be recognized that rare medical emergencies will take precedence over educational activities.

2. *Resident Supervision and Patient Care*

2A. *General rules regarding supervision of residents:*

All patients in the care of the Orthopædic Department have a faculty member who is ultimately responsible for that care. In the majority of cases, the faculty member is physically present or immediately available during care of the patient. After-hours consultations or emergency department procedures may be performed by the resident on call, but in all cases the faculty surgeon must be available by telephone or pager, and will quickly respond to the scene if required.

Under no circumstances is the resident to proceed on a path of patient management in which he/she is unclear without first presenting the patient to a faculty physician. Under no circumstances is a patient to be taken to the operating room without a faculty surgeon being physically present.

The closeness of staff supervision over residents will be determined by a number of factors, including: the resident's year of postgraduate training, the skill and knowledge of the resident, the complexity of the patient's medical condition, and the difficulty of any procedures or treatments being administered. The attending faculty member will have the responsibility of determining, on a case-by-case basis, the degree of independence exercised by a resident. Regardless of how much or how little independence is permitted, the final responsibility for all aspects of patient care remains with the faculty physician.

At every education site, at every moment, for every patient, there is an identifiable attending staff physician who has supervisory responsibility and authority over every action taken by every resident.

The next section covers site-specific rules to determine which attending staff has the authority. If these specific rules break down, do not engage the patient. First, call the Program Director. If that fails, call the Chief of Orthopaedic Surgery for the facility. If that fails, call Chairman Markel. Do not proceed until there is an attending staff physician identified to oversee and take responsibility for your actions. The attending staff physician may exercise his/her supervision by phone or in person at his/her discretion. If a patient must be taken to the operating room, the supervising attending staff physician must be physically present.

A special warning about conscious sedation: Conscious sedation is the single most dangerous procedure any resident might be tempted to do. Do not do conscious sedation alone. Of all the procedures an Orthopaedist might be called upon to do, and do by whatever circumstance with less than perfect skill, conscious sedation is the only one that is apt to kill the patient. A plaster burn doesn't kill; a badly reduced fracture doesn't kill; a traction pin in a joint doesn't kill; but conscious sedation can and has killed. At every location where conscious sedation might be contemplated, equipment and professional help are available. Minimum equipment includes cardiac and oxygen monitoring, an Ambu-Bag and oxygen, a good IV, and available reversing drugs. Minimum help necessary before proceeding is a doctor or nurse to monitor the patient, such helper NOT to be distracted by having to help with the Orthopaedic problem.

2B. Site-specific rules regarding supervision of residents:

At Providence Hospital, the resident will not be involved with any patient until or unless directed by an Orthopaedic attending staff physician who holds admitting privileges at Providence. For example, if someone wants an Orthopaedic consultation on an inpatient, the person wanting the consultation must contact the Orthopaedic attending staff physician who will then decide whether or not to involve the resident. For another example, if someone wants an Orthopaedic consultation on an emergency room patient, the person wanting the consultation must contact the Orthopaedic attending staff physician, who will then decide whether or not to involve the resident. In no case will the resident involve himself/herself in the cases unless directed to do so by the attending staff physician. The attending physician of record then bears all real and medicolegal responsibility in the case. If a patient is already admitted on the service of a named Orthopaedic attending surgeon, the resident may immediately participate in the care of that patient. The attending physician of record then bears all real and medicolegal responsibility in the case.

At Receiving and Childrens Hospitals, any given patient may or may not already have an identifiable attending Orthopaedic surgeon who is on staff at the DMC. If there is such an attending staff member, the resident must contact that staff to see if he/she is both available and willing to accept responsibility for care of the patient. Only if yes to

both, then that attending assumes all responsibility, and the resident may participate in the care of that patient. If not yes to both, then responsibility reverts to the attending staff physician named on the published call schedule for each Hospital. By allowing his/her name to be used on the call schedule, the attending physician has pre-agreed to assume responsibility for patient care by resident physicians. Therefore, the resident may engage the patient for diagnosis and/or treatment before communicating with the attending staff physician. The attending physician must be called immediately if the resident faces a clinical situation of which he/she is unsure, or if the patient needs to go to the operating room. Otherwise, the attending staff member must be notified within a "reasonable" time.

3. *Medical Records*

Residents are expected to adhere to the standards regarding completion and maintenance of medical records as determined by each Hospital. Chart notes are to be legible, with a clearly identifiable signature including the resident's own beeper number. Use of the on-call beeper number is not acceptable. Residents are responsible for dictating operative notes and discharge summaries within 24 hours. Charts should be signed within seven days of discharge. All abnormal laboratory studies and test results should be mentioned in a progress note and all of these items must be addressed with an appropriate plan for follow-up. Outpatient notes should be dictated on the day of the patient encounter. Delinquent medical records may be a cause for disciplinary action. Outpatient charts are not to be removed from the outpatient location where they are stored. X-ray films which are needed for presentations, conferences, etc. must be checked out from the file room. Films should be returned promptly to the file room once the conference has been completed.

4. *Written Orders*

Orders on patient charts should be written at the time they are given. Some flexibility is provided by individual nursing stations as is reasonable and appropriate. All signed orders, consult requests, progress notes, etc. should be accompanied by the physician's beeper number, as this will facilitate the interpretation of illegible writing. When a verbal order is accepted by the floor staff, residents should remember that the floor staff is doing them a favor. It is the resident's obligation to countersign that order before leaving the hospital (if given during the day) or first thing in the morning (if given during the night).

5. *Resident On-Call Procedures*

A monthly call schedule for each hospital will be prepared. Residents are responsible for all call-taking for the location and dates they are scheduled. Vacations and professional travel should be scheduled in advance of the call schedule; once the schedule has been prepared, vacation and other requests for time off will not be honored except in case of emergency. Because of the confusion they sometimes cause, "trades" of call days are discouraged. Residents may trade call days only with

the approval of the Chief Resident and the attending Orthopædic Chief at the hospital affected. Trades may not be reflected on the call schedule. It is the responsibility of the resident requesting the trade to notify key hospital personnel of the trade.

It is the intention of this Program that residents' work schedules be designed so that, on average, residents have at least one day out of every seven free of clinical responsibilities and be on call no more often than every third night. This policy is slightly more protective than the RRC requires.

VII. Specific Goals of Clinical Rotations.

The pre-Orthopaedic year: The PG-1 Orthopaedic resident is expected to become proficient in the hospital care of patients and be introduced to cognitive disciplines important in the diagnosis and management of musculoskeletal disorders, through rotations on Trauma surgery, Neurosurgery, Rheumatology and Rehabilitation, Intensive-care medicine, Plastic surgery, Anesthesiology, Pediatric surgery, Vascular surgery, and Orthopaedic surgery.

Pediatric Orthopaedics Childrens Hospital of Michigan: PG-2 = 1; PG-4 = 1.

At the completion of the pediatric Orthopaedic rotations, the resident will be expected to:

- Understand normal growth and development in a pediatric age group;
- Appreciate the dynamics of growth and its effects on musculoskeletal conditions;
- Recognize the broad spectrum of normal musculoskeletal findings in the pediatric age group;
- Become proficient in clinical evaluation of normal and abnormal conditions by history and physical examination;
- Learn the natural history of pediatric Orthopaedic conditions and interventional options and results of these interventions;
- Develop adroitness with use and interpretation of various radiological imaging modalities;
- Recognize the need for interaction with family in a family-oriented care system;
- Learn the role of other members of the clinical care team and the need for interaction and appropriate referral;
- Learn the role of the Orthopaedic surgeon as an advocate of prevention of childhood musculoskeletal conditions;
- Develop progressive facility in diagnosis and treatment of pediatric and adolescent musculoskeletal conditions due to trauma, congenital, degenerative, developmental, and neoplastic diseases by operative and non-operative means.

Detroit Receiving Hospital: PG-5 = 1, PG-4 = 1, PG-3 = 1, PG-2 = 1.

Objectives:

(At the PG-2 and PG-3 years)

- I. Learn the basics of inpatient non-operative management, largely by performing the day-to-day rounding and order-writing for hospitalized patients. Develop simple surgical skills by assisting in the operating room on any case, and performing fixation of ankle fractures and fixation or replacement of hip fractures.
- II. Examine patients in the clinic and put together an effective oral case presentation for the senior resident or the faculty.

(At the PG-4 year)

- III. Develop intermediate surgical skills by assisting in the operating room on any case, and performing fixation of tibia fractures, wrist fractures, etc.
- IV. Examine patients in the clinic. Design treatment plans for the easier cases.
- V. Develop intermediate surgical skills by assisting in the operating room on any case, and performing fixation of difficult tibia fractures, knee joint fractures, wrist fractures, rotator cuff surgery, and elective primary joint replacements.
- VI. Examine patients in the clinic. Design treatment plans for any case.

(At the PG-5 year)

- VII. Sharpen surgical skills by teaching. Do all surgical cases, including joint revisions, corrective osteotomies, management of Orthopædic infection, etc. Teach surgical technique to junior residents.
- VIII. Supervise the examination and treatment of all patients in the clinic (under the supervision of the faculty). Design and implement treatment plans for any case. Plan and schedule surgeries clinic (under the supervision of the faculty). Teach the junior residents the evaluation and management of Orthopædic clinic patients.

Providence Hospital: PG-5 = 1, PG-4 = 1, PG-2 = 1.

Goal: Experience a community-based, general Orthopædic surgical practice, especially including arthroplasty.

Objectives:

(At the PG-2 year)

- I. Learn the basics of inpatient non-operative management through:
 - A. Rounding with faculty;
 - B. Developing order-writing skills for hospitalized patients;
 - C. Participation in case-management and utilization review, to learn efficient use of hospital resources.

(At the PG-4 year)

- II. Develop simple surgical skills. Assist in the operating room on any case, and perform fixation of ankle fractures, fixation or replacement of hip fractures, and knee arthroscopy for chronic meniscal pathology.
 - A. Demonstrate proficiency in evaluation of the lower limb in the adult with special attention to the physical examination of the lower back, pelvis, hip and knee.
 - B. Understand the various surgical approaches to the hip and knee, including the anterior, anterolateral, trans-trochanteric and posterior approaches to the hip, and the medial para-patellar, lateral para-patellar and subvastus approaches to the knee, and be able to describe the advantages and disadvantages of each approach.
 - C. Demonstrate an understanding of the use of postoperative anticoagulant medications including the risks and benefits of anticoagulant therapy, and the drugs involved with their advantages and disadvantages.
 - D. Demonstrate an understanding of antibiotic prophylaxis as it relates to reconstructive surgery.
- III. Develop intermediate surgical skills. Assist in the operating room on any case, and perform primary hip and knee replacement.
 - A. Demonstrate technical expertise in planning and executing primary hip and primary knee replacement surgery.
 - B. Understand the various treatment options relating to infected joint replacements.

(At the PG-5 year)

- IV. Develop advanced surgical skills.
- A. Perform any Orthopædic case, including revision joint replacement
 - B. Teach surgical technique to the junior residents.

Spine surgery: Providence Hospital: PG-3:

The Adult Spine Surgery rotation provides an exposure to a variety of spine disorders from the cervical spine to the lumbar spine in adults. At the completion of this rotation, the resident will show proficiency in:

- Physical examination of the cervical, thoracic and lumbar spine;
- Neurological examination of the upper and lower extremities;
- Recognizing the indications for and interpretation of appropriate diagnostic tests, including myelography, MRI, CT scans, EMGs, etc.;
- The diagnosis and management of common cervical, thoracic and lumbar abnormalities including:
 - (a) Degenerative disease
 - (b) Disk disease, including herniation
 - (c) Spondylolisthesis
 - (d) Spondylolysis
 - (e) Infection
 - (f) Spinal stenosis
- The diagnosis and management of fractures of the spine from the cervical to lumbar, including classification, mechanism of injury and neurological examination of the extremities.
- Applications of cervical traction, including halo.

The resident will be exposed to, but may not be proficient in:

- Surgery of the cervical spine, including:
 - a) Anterior approach
 - b) Cervical corpectomy
 - c) Cervical anterior fusion with or without fixation
 - d) Fusion of the cervical spine posteriorly, including C1 and C2

- Surgery of the lumbar spine, including:
 - a) Laminectomy
 - b) Posterior fusion
 - c) Instrumentation posteriorly, including pedicle screws

Hand surgery: Office and outpatient experience with Drs. Burke, Singer: PG-3

At the completion of the rotation, the resident will show proficiency in:

- Physical examination techniques specific to the elbow, wrist and hand;
- Indications for and interpretation of upper extremity diagnostic tests;
- Diagnosis and management of common elbow, wrist and hand disorders, including:
 - a) Epicondylitis
 - b) Entrapment neuropathies
 - c) Trigger digits
 - d) Ganglion cysts
 - e) Infections
 - f) Fractures/dislocations
 - g) Tendon injuries
 - h) Amputations
 - i) Degenerative arthritis

The resident will be exposed to, but may not be proficient in:

- Microneurovascular surgery, including replantation and free tissue transfer;
- Diagnosis and management of complex elbow, wrist and hand disorders, including:
 - a) Rheumatoid arthritis
 - b) Carpal instability
 - c) Congenital Anomalies
 - d) Brachial plexus/tetraplegia
 - e) Cerebral palsy
 - f) Dupuytren's contracture
 - g) Tendon reconstruction
 - h) Tendon transfers

Sports 1 and 2: DMC Surgical Hospital PG-3, Providence Hospital PG-5.

Sports Medicine is the study of soft tissue pathology. In particular, it can be considered the study of soft tissue tension alterations and how this affects performance activity. Alterations in ligament strength or length will result in joint instability which is most often not manifested until a load is applied. The tension developed in muscles with time determines motion and stability, and the architecture of the skeleton determines the lever arms against which both ligaments and musculotendinous units must operate. Sports Medicine evolved through the observations of disabilities manifested in athletes who were subjecting their tissues to higher than average loads. While the pragmatic approach to treatment is merely to reduce the imposed loads upon the body by restricting activity, the greater intellectual challenge is to understand the mechanism of stress generation, then the imposition of this stress on the body and finally to use this knowledge to diagnose and devise methods of treatment of the tissue failure. A profound knowledge of anatomy and functional mechanics is essential for this to begin. With completion of the rotation, the resident should be expected to:

- Be able to discuss intelligently the major topics of Sports Medicine.
- Obtain the basic science perspective for each topic.
- Develop the physical examination skills for the knee, elbow, shoulder, foot, and major muscles.
- Develop the knowledge base to discuss how surgical and non-surgical treatments will scientifically work to alter the pathophysiology of the common sports injuries
- Develop the “triangulation” skills necessary to do safe arthroscopic surgery of the shoulder and the knee, sufficient to treat knee meniscal pathology and shoulder impingement.

VIII. CODE OF ETHICS FOR ORTHOPÆDIC SURGEONS

Previous versions of this handbook included the text of the American Academy of Orthopædic Surgeons' stated Code of Ethics, as adopted October, 1988, amended October, 1991, amended December, 1995, and amended February, 2001. The Code of Ethics is available at <aaos.org>.

IX. Program Requirements for Residency Education in Orthopædic Surgery,
effective July 1, 2002

Previous versions of this handbook included the text of the ACGME Program Requirements for Residency Education in Orthopædic Surgery, which became effective July 1, 2002. Program Requirements are available at <acgme.org>.

X. RESIDENCY AGREEMENT (EMPLOYMENT CONTRACT)

This Agreement is made by and between the Detroit Medical Center Graduate Medical Education Program ("DMC"), whose address is 4201 St Antoine, Detroit, Michigan 48201, and ____ ("Resident"), whose address is ____.

WHEREAS, DMC desires to appoint Resident to serve as a ____ (year) resident in a training program of the Detroit Medical Center at either Children's Hospital of Michigan, Detroit Receiving Hospital and University Health Center, Grace Hospital, Harper Hospital, Huron Valley Hospital, The Orthopaedic Specialty Hospital, The Rehabilitation Institute, Inc., Sinai Hospital (collectively, the "DMC Hospitals") or other affiliated hospitals, on the terms and conditions set forth herein; and

WHEREAS, Resident desires to receive such training and to provide such services on such terms and conditions;

NOW, THEREFORE, in consideration of the premises and mutual promises contained herein, DMC and Resident hereby agree as follows:

1. Appointment

DMC, upon the recommendation of the Program Director of the training program to which Resident is being appointed (the "Program Director"), hereby appoints Resident as a (year level) year resident in the Orthopaedic Surgery Residency Program of the Detroit Medical Center to serve at one or more DMC Hospitals or other affiliated hospitals during the period beginning ____ (date) and ending ____ (date). Resident hereby accepts this appointment.

This Agreement, effective as of the beginning date of the appointment specified in the preceding paragraph, shall expire, unless earlier terminated, upon the ending date specified in such paragraph. Anything to the contrary in this Agreement or in any manual or other writing notwithstanding, this Agreement may be renewed upon its expiration only upon the mutual consent of Resident and DMC as reflected in a writing executed by the parties and only after DMC has determined, in its sole discretion, that Resident has satisfactorily fulfilled his or her duties and obligations hereunder.

2. Obligations of DMC

DMC agrees to cause the DMC Hospitals and other affiliated hospitals to provide a training program which meets the standards established in the Essentials of Approved Residencies as formulated by the Accreditation Council for Graduate Medical Education.

DMC will monitor the provision or implementation of each of the following by the hospital where the resident is receiving training:

- a. Living Quarters: The hospital shall provide suitable on-call quarters

b. **Liability Insurance:** The hospital will provide insurance or other indemnity for liability of the resident and the hospital while acting in the performance of his/her duties or in the course and scope of his/her assignment. Claims made after termination of training will be covered if based on acts or omissions of the resident within the course and scope of his/her assignments during training. Insurance or other liability coverage will be provided to the resident on rotations outside a DMC hospital, provided a request for such has rotation has been approved by the DMC Graduate Medical Education Office.

c. **Lab Coats:** The hospital will provide lab coats to residents through the residency program office.

d. **Meals:** The hospital will provide meals to an on-call resident required to spend the night in any DMC hospital as part of his/her training program.

e. **Duty Hours:** Resident duty hours and on call schedules will conform with the Accreditation Council on Graduate Medical Education (ACGME) requirements. All residents are expected to be rested and alert during duty hours. Program faculty will determine whether a resident is able to perform duties. Residents must not regularly report for duty without sufficient rest.

f. **OSHA and CDC Recommendations:** The hospital will comply with OSHA and CDC recommendations which assumes that every direct contact with a patient's blood and other body substances is infectious and requires the use of protective equipment to prevent parenteral, mucous membrane and non-intact skin exposures to the health care provider. The hospital agrees to provide, and make readily available, personal protective equipment to include gloves, face protection (masks and goggles), and cover gowns.

3. Obligations of Resident

Resident agrees:

(a) to perform the duties and responsibilities required of him or her hereunder to the best of his or her abilities and to provide care commensurate with his or her level of advancement and competence under the general supervision of appropriately privileged attending staff and faculty and to competently perform such other services as may be required of residents in the training program at his or her level of training. Resident understands and agrees that the services Resident is to perform and his or her duties and responsibilities hereunder, including Resident's hours of duty, shall be determined from time to time by the Program Director and/or the Chief of the Department or Section to which Resident is assigned;

(b) to participate in the educational activities of the training program and, as appropriate, assume responsibility for teaching and supervising other residents or students and participate in institutional orientation and education programs and other activities involving the clinical staff;

- (c) to participate in institutional committees and councils as invited or appointed;
- (d) to develop an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and how to apply cost containment measures in the provision of patient care;
- (e) to comply with the policies, procedures (including corrective action, harassment and grievance policies and/or procedures) and rules and regulations of DMC, the training program to which Resident is being appointed, and the DMC Hospitals and other hospitals to which Resident is assigned or in which Resident's training takes place, as well as any additional policies, procedures or rules and regulations which may be established by the Program Director and/or the Chief of the Department or Section to which Resident is assigned, as the same may be established regarding completion of medical records in a timely manner. Policies and procedures of DMC hospitals that are applicable to Residents are highlighted in the GME Information Booklet for Postgraduate Trainees and are available for review in the GME Office during regular business hours. Resident acknowledges and agrees that in the event medical records are not complete, DMC may, in its discretion, withhold payment of any stipend due or any letters of recommendation or certification until such time as such records are completed;
- (f) to acquire and maintain the appropriate Michigan medical license and controlled substance registration required to fulfill the duties of Resident under this Agreement;
- (g) to devote such time and effort as may be required to fulfill all of Resident's responsibilities under this Agreement, including reporting to work during hours scheduled, unless prevented from doing so by sickness, injury or other reason approved by the Program Director and/or Chief of the Department or Section to which Resident is assigned;
- (h) to pay all financial obligations owed to DMC, any DMC Hospital, or other hospital to which resident is assigned prior to termination of this Agreement, Resident acknowledging and agreeing that any outstanding obligations may, at the discretion of DMC, be deducted from the final paycheck of Resident at the end of the term of this Agreement;
- (i) to promptly submit to a complete physical and/or mental examination upon the request of DMC to enable DMC to make a determination of the health status of the Resident, and to make available to DMC the results of such examination; and
- (j) to undertake any immunization program reasonably requested by DMC.

4. Compensation

DMC agrees to provide, as the sole compensation to be received by Resident for the services to be provided hereunder, a stipend at the annual rate of \$ ____ , payable bi-weekly, and such other benefits including professional liability insurance, as may be accorded from time to time by DMC. DMC reserves the right to add, delete or otherwise change benefits (other than stipend amounts) without advance notice at DMC's discretion

and as DMC deems appropriate. No compensation of any kind or nature shall be paid to or accepted by Resident from patients or third parties for any services rendered pursuant to this Agreement.

DMC will insure that the benefits (including vacation, leaves of absence, disability insurance, etc.) described in the Summary of Benefits attached to this Agreement are provided to each resident.

5. Outside Professional Activities

Resident shall devote all of his or her professional efforts to the performance of Resident's obligations under this Agreement, and shall not participate or engage in any outside professional work of any kind or nature whatsoever; (i) unless and until Resident has obtained a permanent license to practice medicine in Michigan; (ii) unless and until Resident has presented his/her Program Director with evidence of professional liability insurance in such amounts as DMC, in its sole discretion, deems appropriate, insuring Resident against any malpractice liability, and Resident has agreed to indemnify and hold harmless DMC, DMC Hospitals, all other hospitals to which Resident is assigned, and the officers, directors, employees and agents of each of the foregoing, from any and all losses and expenses resulting from or caused by such activities; and (iii) unless and until Resident receives the written approval of the Program Director and the Chief of the Department or Section to which Resident is assigned, it being understood that the Program Director and the Chief of the Department or Section to which Resident is assigned may withhold or withdraw his or her consent at any time, as he or she, in his or her sole discretion, deems appropriate. Resident hereby acknowledges that while engaging in any activities other than those required to be performed under this Agreement, Resident is not acting as an employee or agent of DMC, any DMC Hospital, or other hospital to which Resident is assigned, and that Resident is therefore not covered by the insurance or self-insurance programs of any such entity. Resident further acknowledges that he or she shall be expected to perform all duties as assigned even in the event consent is given to engaging in other activities, and if Resident is unable to perform his or her duties as assigned or otherwise violates the terms of this Paragraph 5 Resident will be subject to corrective action including dismissal.

6. Evaluation of Performance

The Program Director, with the participation of program faculty, will at least semi-annually evaluate the knowledge, skills, and professional growth of a Resident. The results of this evaluation will be made known to the Resident. The written records of the evaluation will be accessible to the Resident.

7. Corrective Action

Upon the determination of any of the following: (i) any DMC Hospital or other hospital to which Resident is or has been assigned or in which Resident has performed any of his or her duties under this Agreement, (ii) DMC, (iii) the Chief of the Department or Section to

which Resident is assigned, if other than the Program Director, or (iv) the Program Director, that Resident has not fulfilled or cannot fulfill each of his or her obligations under this Agreement, or that any action, conduct or the health of Resident is adverse to the best interests of patient care or the institutions to which Resident is assigned hereunder, Resident shall be subject to corrective action. The action to be taken shall be in accordance with such procedures as may be determined from time to time by DMC, which procedures shall provide for the due process of law to which the Resident is otherwise entitled. Corrective action may include suspension, reappointment without advancement, decision not to reappoint, termination of this Agreement, and other action including, but not limited to, probation and issuance of a letter of warning, admonition or reprimand.

Notwithstanding the provisions of the preceding paragraph, Resident's participation in any program of any DMC Hospital or other hospital to which Resident is assigned may be limited, restricted or suspended in accordance with the policies of such hospital. Action by a hospital may include, but is not limited to, the summary or other suspension of Resident.

8. Termination by Resident

(a) In the event of incapacitating illness on the part of Resident, Resident may terminate this Agreement by giving written notice of such termination to DMC and the Program Director.

(b) Except as provided in Section 8(a) above, Resident shall not terminate this Agreement without providing DMC ninety days prior written notice and without providing DMC an opportunity to discuss any differences, dissatisfaction or complaints.

9. Access to Books and Records

(a) In the event that the Secretary of Health and Human Services or the Comptroller General of the United States or their representatives determine that this Agreement is a contract described in Section 1861 (v)(1)(I) of the Social Security Act, 42 U.S.C. § 1395x(v)(1)(I), Resident agrees that until the expiration of four years after the furnishing of services pursuant to this Agreement, Resident will make available, upon written request, to the Secretary of Health and Human Services, DMC, any DMC Hospital, or other hospital to which the Resident is assigned, or upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and books, documents and records that are necessary to certify the nature and extent of costs paid pursuant to this Agreement.

(b) If Resident carries out any of his or her duties under this Agreement through a subcontract, with a cost or value of \$10,000 or more over a twelve month period, with a related organization as defined in 42 C.F.R. § 405.427, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organizations shall make available, upon written request, to the Secretary of Health and Human Services, or upon request, to the Comptroller General of the United States or any of their duly authorized representatives,

the subcontract, and books, documents and records of such organizations that are necessary to verify the nature and extent of such costs.

(c) In the event access to this Agreement, or books, documents and records is requested pursuant to this Section by the Secretary of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives, Resident shall immediately notify DMC in writing of such request.

10. Entire Agreement

Except as expressly provided herein, this Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof, and supersedes any and all other agreements, either oral or written, between Resident and either DMC, any DMC Hospital, or other hospital to which Resident is assigned with respect to this subject matter. This Agreement, including this Section 10, cannot be changed, modified, or discharged orally, but only by an agreement in writing, signed by the party or parties against who enforcement of the change, modification or discharge is sought. No person has authority to modify this Agreement orally, and any such oral modification shall not be valid or binding upon DMC.

11. Assignment

This Agreement may not be assigned by Resident.

12. Limited Enforcement

Except as expressly provided herein, this Agreement shall be enforceable only by Resident, DMC, any DMC Hospital, or other hospital to which Resident is assigned, and their successors in interest by virtue of an assignment which is not prohibited under the terms of this Agreement, and no other person shall have the right to enforce any of the provisions contained herein, including, without limitation, any patient or parent, guardian, or personal representative of any patient of any DMC Hospital or any other hospital.

13. Governing Law

This Agreement shall be construed and enforced in accordance with, and governed by, the laws and decisions of the State of Michigan.

14. Waiver

One or more waivers of any term, covenant, conditions or provision of this Agreement by any of the parties hereto shall not be construed as a waiver of a subsequent breach or of other terms, covenants, conditions or provisions. No breach of any such term, covenant, condition or provision shall be deemed to have been waived by DMC unless such waiver be in writing signed by the President of DMC or his or her designee.

15. Notices

Any notice, offer, demand or communication required or permitted to be given under any provision of this Agreement shall be deemed to have been sufficiently given or served for all purposes if delivered personally to the party to whom the same is directed, or if sent by registered or certified mail, postage and charges prepaid, to the address of the respective party set forth on the first page of this Agreement. Except as otherwise expressly provided in this Agreement, any such notice shall be deemed to be given on the date on which the same is deposited in a regularly maintained receptacle for the deposit of United States mail.

16. Nondiscrimination

In fulfilling their respective duties and other responsibilities hereunder, neither party shall discriminate in any manner against any person in violation of applicable law.

17. Miscellaneous

Whenever the singular is used herein, the same shall include the plural. All references to the masculine, feminine and neuter genders shall be deemed to include the others. If any language is stricken or deleted from this Agreement, such language shall be deemed never to have appeared herein and no connotations or inferences shall be drawn therefrom. The paragraph headings used herein are for convenience only and shall not be used in the construction or interpretation of this Agreement.

I ____ (Resident) acknowledge that I have read and agree to be bound by the terms and conditions in this agreement.

XI. RESIDENT BENEFITS AS AN EMPLOYEE

All of the benefits listed below are provided to postgraduate trainees who are on the Detroit Medical Center payroll. DMC reserves the right to add, delete or otherwise change benefits without advance notice at DMC's discretion and as DMC deems appropriate.

HEALTH INSURANCE

The Detroit Medical Center offers trainees the choice between two health insurance providers: (Coverage is effective on the date of your appointment)

DMC CARE

This benefit is available to you and your dependents at no cost.

BLUE CROSS/BLUE SHIELD MASTER MEDICAL

This benefit is available to you and your dependents with a premium participation cost.

PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR REPORTING ANY CHANGE IN YOUR FAMILY'S STATUS (E.G. MARRIAGE, BIRTH OF A CHILD, ETC.) TO THE GME OFFICE IN PERSON WITHIN 30 DAYS OF THE OCCURRENCE. If you do not report such changes within the required period of time, it will not be possible to obtain coverage for that individual until open enrollment which takes place during the month of November each year, with coverage taking effect January 1.

SPONSORED DEPENDENTS (E.G. PARENTS) who are claimed as dependents on your income tax can be enrolled at premium participation cost as long as benefit requirements are met (Contact the Benefits Office for requirements).

DENTAL INSURANCE

Dental insurance is provided through Prudential Insurance Company. *YOU ARE RESPONSIBLE FOR REPORTING ANY CHANGE IN THE STATUS OF YOU OR YOUR FAMILY TO THE G.M.E. OFFICE IN PERSON WITHIN 30 DAYS OF THE OCCURRENCE.* Sponsored dependents are not eligible for coverage under dental insurance.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE

A \$30,000 term life insurance policy and \$30,000 accidental death and dismemberment coverage is available to you and is effective on your date of appointment. There is no option to purchase additional life insurance. *AFTER INITIAL ENROLLMENT, ANY CHANGE IN BENEFICIARY MUST BE REPORTED TO THE G.M.E. OFFICE IN PERSON.*

SHORT-TERM ILLNESS

Trainees who started on or after 7/1/97 (including Sinai trainees who transferred to DMC payroll effective 5/11/97) will receive payment of stipend for verifiable illness for up to 180 days as follows: 1-90 days at 100%; 91-180 days at 75%. Trainees who started prior to 7/1/97 will receive full payment of stipend for verifiable illness for up to 90 days.

Program Directors will notify the GME office when a trainee is out ill for more than 3 calendar days. For absences in excess of 3 calendar days, physician verification may be required. Illness time does not accumulate.

The DMC Graduate Medical Education Program does not have a separate policy for maternity leave; time off for pregnancy and delivery is provided for under Short Term Illness.

LONG-TERM DISABILITY

A long-term disability plan underwritten by Provident Life & Accident Insurance Company is provided to all trainees on the DMC payroll. The plan provides 60% of salary to a maximum benefit of \$2,000 per month. For trainees who started on or after 7/1/97 (including Sinai trainees who transferred to DMC payroll effective 5/11/97), long-term disability benefits are payable after 180 consecutive days of disability and are payable as long as the disability continues (maximum to age 65 benefit period). For trainees who started before 7/1/97, long-term disability benefits are payable after 90 consecutive days of disability and are payable as long as the disability continues (maximum to age 65 benefit period).

An optional supplemental policy is available, at your own expense, up to a maximum of \$2,000 per month. For a supplemental application contact a Provident representative at (810) 827-2570.

EMPLOYEE ASSISTANCE PROGRAM

The Detroit Medical Center offers an Employee Assistance Program (EAP) to all Postgraduate Trainees. The EAP is designed to help you with personal problems or work situations that affect your work and home life such as anxiety or depression, alcohol or substance abuse, marital or family problems, legal or financial matters. To contact an EAP counselor, call 313-745-1900 or 877-789-3271.

PERSONAL LEAVES OF ABSENCE

Approval of personal leaves of absence may be granted at the discretion of the DMC Program Director for up to 90 calendar days. Personal leaves of absence shall be unpaid. The Detroit Medical Center will continue to provide insurance premium payment for 30 days; after 30 days, the postgraduate trainee will be provided the opportunity to continue insurance coverage in accordance with the provisions of current law (COBRA). A family leave of absence is a conditional privilege of postgraduate training. Such time off will be provided in accord with DMC policy in order to accommodate specific family care needs.

Depending on the length of the leave and individual board requirements, training time may need to be extended as determined by your Program Director.

PROFESSIONAL LIABILITY COVERAGE

Your professional liability coverage is through the DMC Insurance Company, Limited. Your policy is a limited claims made policy with extended reporting endorsement (tail coverage); coverage limit is \$2.5 million per claim. This coverage does not extend outside of the training program.

TAX SHELTERED ANNUITY (TSA) PROGRAM

This Program can help you reduce your current taxes and increase your retirement savings by saving pre-tax dollars. You have a choice of fixed annuity contracts, as well as variable annuity (mutual fund) investment options within an annuity contract(s).

VACATION

First year trainees are eligible for two weeks of vacation per contract year. All other residents and fellows are eligible for three weeks of vacation per year. All vacation time must be approved in advance by your Program Director. Vacation time does not accumulate.

XII. American Board of Orthopædic Surgery Rules and Procedures, Part I and Part II Examinations

Previous versions of this handbook included the text of the American Board of Orthopædic Surgeons' Rules and Procedures for the certifying Examinations. The Rules and Procedures are available at <abos.org>.

XIII. The DMC / Providence Orthopaedic Residency Program Corrective Action Procedures

This document describes the procedures to be followed when a resident (“Resident”) is subject to corrective action, as provided by the Residency Agreement between the DMC Orthopaedic Residency Program and the Resident.

1. GENERAL PROVISIONS

1.1. **Corrective Action.** As used in this document, “corrective action” includes the following actions:

1.1.1. **Suspension.** This action involves the temporary removal from the residency program (“Program”) for a definite period of time. It does not include a summary suspension, as discussed in Paragraph 3 below.

1.1.2. **Reappointment Without Advancement.** This action involves reappointment to the Program without advancement to the next training level.

1.1.3. **Decision Not To Reappoint.** This action involves a decision not to reappoint a Resident following the expiration of the term of his or her current contract.

1.1.4. **Termination.** This action involves immediate and permanent dismissal from the Program.

1.1.5. **Other.** Other corrective action includes, but is not limited to, the following:

(a) Placing the Resident on probationary status.

(1) Probation status shall not exceed one year. If the probation exceeds six months, the probation shall include at least one interim review at the approximate midpoint of the probation.

(2) Probation is imposed in accordance with 2.13 and 2.14.

(b) Issuing the Resident a letter of warning, admonition or reprimand which documents the cause for concern and becomes part of the Resident’s permanent record.

1.2. **Criteria for Initiation.** Corrective action may be based upon the following criteria:

1.2.1. Failure of the Resident to fulfill each and every obligation imposed by the Residency Agreement.

1.2.2. Any action, conduct or health status of the Resident that is adverse to the best interests of patient care or the institutions to which the Resident is assigned.

1.3. **Examples.** The criteria described in Paragraph 1.2 include, but are not limited to, the following examples:

1.3.1. Breach of professional ethics;

1.3.2. Misrepresentation of research results;

1.3.3. Violation of the rules of the Program, of the institution to which the Resident is assigned or of the law; and

1.3.4. Inadequate medical knowledge, deficient application of medical knowledge to either patient care or research, deficient technical skills or any other deficiency that adversely affects the Resident's performance.

1.4. **Parties Who May Initiate Corrective Action.** Any of the following parties may initiate corrective action:

1.4.1. Any DMC Hospital or other hospital to which the Resident is or has been assigned, or in which duties under the Residency Agreement are otherwise performed;

1.4.2. The DMC Orthopaedic Residency Program ;

1.4.3. The Department or Section Chief to which the Resident is assigned;
or

1.4.4. The Program Director.

1.5. **Separate Action by DMC Hospitals or Other Hospitals.** In addition to the corrective actions described in this document, any DMC Hospital or other hospital to which the Resident is assigned may, in accordance with the policies of such hospital, limit, restrict or suspend, summarily or otherwise, the Resident's participation in the Program at such hospital. The Hospital shall first consult with the Department Chairman, the DMC Academic Council or appropriate Program Director regarding such action. Such action by a Hospital shall not require the initiation of corrective action under this policy.

1.6. **Notice.** Any notice required by this document shall be deemed sufficient if the notice provisions of the Residency Agreement are satisfied.

2. CORRECTIVE ACTION PROCEDURE

2.1. All requests for the corrective actions described above in Paragraphs 1.1.1. through 1.1.4. shall be in writing, submitted to the Coordinator of the DMC Orthopaedic Residency Program, and supported by reference to the specific

activity, conduct, deficiency or other basis constituting the grounds for the request. The procedures described below in Paragraphs 2.2. through 2.12. shall be followed for such corrective actions, and the procedure described below in Paragraph 2.13. and 2.14. shall be followed for all other corrective actions.

- 2.2. The DMC Orthopaedic Residency Program shall investigate the request for corrective action in the manner and to the extent it deems appropriate. The investigative procedure may include consultation with the Resident and/or other parties, as determined in the sole discretion of the DMC Orthopaedic Residency Program, and shall be completed no later than thirty days following receipt of the request.
- 2.3. The Chair of the DMC Orthopaedic Residency Program (“DMC Academic Council”) shall appoint a Committee of not less than three members of the DMC Academic Council. The Chair of the DMC Academic Council shall not serve as a member of the Committee, nor shall the Department or Section Chief of the Department to which the Resident is assigned or the individual initiating the corrective action.
- 2.4. Upon completion of the investigation, the DMC Orthopaedic Residency Program shall forward the request and a written report of its investigation and recommendations to the members of the Committee. A copy of the request shall also be sent to the Resident, along with a copy of the Corrective Action Procedures then in effect, and a notice that he or she may request an appearance before the Committee.
- 2.5. The Resident shall have ten days following the date of the notice described in Paragraph 2.4. above to file a written request for an appearance before the Committee. This request may include the Resident’s written response to the request for corrective action. The request is to be made to the Chair of the DMC Academic Council. The request for an appearance shall specify:
 - 2.5.1. The name of the single physician, if any, who will accompany and represent the Resident;
 - 2.5.2. The Resident’s request to be represented by an attorney (although such a request shall be denied in such circumstances as may be determined solely by the Committee). The Chair of the DMC Academic Council shall notify the Resident within ten days of the request for appearance if the request to be represented by an attorney will be granted; and
 - 2.5.3. The names of any witnesses the Resident intends to call.
 - 2.5.4. The rights to representation by a physician, to request representation by an attorney, and/or to call witnesses shall be deemed waived if the request for an appearance fails to specify the information described in Paragraphs 2.5.1. through 2.5.3.

2.6. If the Resident fails to request an appearance within the applicable time period:

2.6.1. He or she waives any right to such appearance and to any further appellate procedures to which he or she might otherwise have been entitled; and

2.6.2. He or she will be deemed to have accepted an adverse decision by the Committee, which decision shall thereupon become the final decision and shall be implemented.

2.7. The Committee shall consider and decide upon the request for corrective action at its next meeting or as soon thereafter as may be practicable. The following procedures shall be applicable if the Resident has requested an appearance in accordance with the provisions of Paragraph 2.5. above.

2.7.1. The Resident shall be provided fifteen days notice of the time, place and date of the meeting;

2.7.2. The Resident may present witnesses named pursuant to Paragraph 2.5.3.;

2.7.3. The DMC Orthopaedic Residency Program may present witnesses;

2.7.4. Either party may cross-examine any witness appearing in-person;

2.7.5. Any party may present evidence of a type on which reasonable persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law; and

2.7.6. The Committee shall record its evidentiary proceedings. Deliberations of the Committee shall not be recorded.

2.8. The Resident shall be deemed to have waived his or her rights to appear as well as any appeal rights if, having requested an appearance, he or she fails without good cause to attend the meeting.

2.9. Following the appearance of the Resident and the presentation and examination of all witnesses and evidence, the Committee shall deliberate to determine appropriate action. The Committee may take either the action sought in the initial request for corrective action or such other action that the Committee determines to be warranted.

2.10. The Committee shall notify the Resident and the DMC Academic Council of its findings and corrective action decision no later than fifteen days following the meeting.

2.11. The Resident may submit a written request for reconsideration by the Department Chairman of the decision of the Committee within ten days of the

date of notice of such decision. The Chairman, in his or her sole discretion, may affirm, modify or reverse the decision of the Committee, or return the case for consideration by the full DMC Academic Council. The Chairman shall notify the Resident of his or her decision within fifteen days of the receipt of such request for consideration. The Chairman's decision shall be final and binding except as described below in Paragraph 2.12.

- 2.12. To the extent there are procedures established by the DMC Orthopaedic Residency Program for appeal of an adverse reconsideration decision by the Chairman to the DMC Orthopaedic Residency Program, the Resident may appeal to the DMC Orthopaedic Residency Program in accordance with such procedures.
- 2.13. The procedures described in Paragraphs 2.1. through 2.12. above shall not apply to the other corrective action that is provided for above by Paragraph 1.1.5. The Resident shall have the opportunity, however, to informally discuss the pertinent circumstances with his or her Program Director in the event that the Resident is subjected to such other corrective action. The Resident shall be entitled to present such information or provide such explanation that may be relevant, but the Program Director's determination of the action to be taken, if any, shall be final and binding.
- 2.14. If the Program Director determines that the Resident should be placed on probation, the Program Director shall provide the Resident with the following information in writing:
- (a) The length of the probationary period, which shall not exceed one year.
 - (b) The academic or professional deficiency or conduct, or other basis giving rise to the probation.
 - (c) The criteria which the Resident must meet in order to satisfy the terms of the probation.
 - (d) The approximate date or dates on which the Resident's probationary status will be reviewed.

A copy of such written probation notice, including the information provided to the Resident, shall be submitted to the DMC Orthopaedic Residency Program. If the Program Director fails to provide such information, the Resident may request review by the Committee as set forth in paragraphs 2.1 through 2.12.

3. SUMMARY SUSPENSION

- 3.1. **Description.** The Resident may be summarily suspended from the Program, based on the criteria listed about in Paragraph 1.2., and such suspension shall become effective immediately upon imposition. In the event any corrective action described in Paragraphs 1.1.1. through 1.1.4. is also recommended, summary suspension shall continue pending completion of the corrective action

proceedings described in Paragraph 2 above. If no such corrective action is recommended within ten days, or if any corrective action described in Paragraph 1.1.5. is taken, the summary suspension shall terminate upon expiration of the ten-day period or upon the taking of such corrective action.

3.2. Parties Who May Initiate. Summary suspension, as described above in Paragraph 3.1., may be initiated by any of the parties described in Paragraph 1.4.2. through 1.4.4. above.

3.3. Action by DMC Hospitals or Other Hospitals. As provided in Paragraph 1.5. above, a DMC Hospital or other hospital to which the Resident is assigned may summarily suspend the Resident from participating in the Program at such hospital, in accordance with that hospital's procedures. Such action may be taken independent of, and in addition to, any action taken pursuant to in Paragraph 3.1.

XIV. Detroit Medical Center Guidelines For The Appointment Of Orthopaedic Residents

DMC Programs must obtain the following from ALL APPLICANTS:

Application Form:

ALL APPOINTMENT PAPERWORK MUST BE ACCOMPANIED BY A DMC GRADUATE MEDICAL EDUCATION APPLICATION OR ERAS (Electronic Residency Application System) FORM

Letters Of Recommendation:

A minimum of three letters of recommendation. Letters of recommendation are to be maintained in the applicant's program file; not the GME Office.

The three letters of recommendation must include a letter from Dean of applicant's medical school

If applicant is currently in a training program or has completed a training program, there must be a letter of recommendation from current/previous Program Director

Eligibility:

Applicants must be one of the following in order to be eligible for appointment:

Graduate of medical school in U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME).

Graduate of college of osteopathic medicine in the U.S. accredited by the American Osteopathic Association (AOA).

Graduates of medical schools outside of the U.S. and Canada must possess a currently valid certificate from the Educational Commission for Foreign Medical Graduates.

Original certified transcript - to be maintained in the applicant's program file; not the GME Office.

Personal Interview:

Personal interviews will be arranged by the residency program office.

Examinations:

The applicant must have taken and passed the USMLE Part-I examination prior to being granted an interview. Exceptions may be authorized by the Program Director in extraordinary circumstances. (The same criteria are applied to U.S. medical school graduates as are applied to international medical school graduates.)

A resident cannot be promoted in the Orthopædic Residency Education Program from Year 3 to Year 4 without having passed USMLE Part-III. If the situation occurs that a resident may need to repeat Year 3 more than once for reason of failure to pass USMLE Part-III, or for any other reason, the Orthopædic Department, at its sole discretion, may refuse to renew that resident's appointment.

For those international medical graduate applicants who have taken FMGEMS, ECFMG or VQE, verification of *one* of the following must be obtained:

Average score of 82 or above on FMGEMS

Score of 82 or above on ECFMG

Passing score on VQE

NON-U.S. CITIZEN INTERNATIONAL MEDICAL GRADUATES - ALL OF THE ABOVE, PLUS THE FOLLOWING:

Proof of current permanent resident visa (Green Card)

XV. Detroit Medical Center, Housestaff Supervision And On-site Hours Guidelines

The following policy provides guidelines which were adapted from Association of American Medical Colleges recommendations for resident physician assignments and supervision. The objectives of these guidelines are quality education and patient care.

- A. Each training program shall have a statement that resident education is preeminent over service responsibilities and that the service experience for each resident will in all cases be determined by the educational requirements of the training program. Within this defined service experience, residents will be required to provide care appropriate to level of training. Service to patients on a non-teaching service will be provided by residents in the case of medical emergencies and will be provided as a humane act appropriate to any physician.
- B. There shall be close supervision by an identifiable, more experienced physician (including a more senior resident physician), who is reachable and available in person if needed.
 1. Each program shall comply with special requirements of the Residency Review Committee.
 2. The extent of supervision shall allow for progressively greater independence in decision making and performance of procedures, consistent with quality patient care.
- C. There shall be provisions for allowing time for special interests of the resident physician during the course of the training program.
- D. To ensure that the resident physician's ability to learn, to make decisions about care of patients and to perform with technical competence is not impaired by fatigue resulting from excessive assigned hours, or from the intensity of assigned responsibilities:
 1. Resident hours actually worked (defined as on-call hours during which the resident physician continuously participates in the care of patients and/or is repeatedly required to return to on-site duty) should not exceed 80 hours per week when averaged over four weeks.
 2. Residents should not be scheduled to work as a matter of course for more than 30 consecutive hours. If on-site patient care activities have lasted 30 hours, there must be an 18-hour break before resuming any patient care activity during which the resident is required to make critical decisions about patient care or perform technically demanding procedures. During a 30-hour period, residents should not be required to admit new patients for more than the initial 24 hours of the period. The number of admissions must adhere to ACGME established guidelines for any specialty. During

the 30-hour period, residents should have a minimum 4 hour rest period. For residents assigned to emergency medicine rooms for 12 hours, there must be an 8-hour break before resuming any patient care activity of similar intensity. Exceptions shall be determined by the primary supervising attending physician/surgeon, in consultation with the residency training director.

3. There should be at least one 24-hour period each week that is free of on-site patient care responsibility.
4. All moonlighting activity must be specifically authorized by the program director and identified by frequency and duration. This moonlighting activity must be included in the 80 hours per week when averaged over four weeks.*
5. Each program director is responsible for maintaining a record of resident assignments and hours worked to demonstrate compliance with this policy.

*In the Program, at this time, moonlighting is not allowed.

1. Forms to Request Resident Time Off

A form is presented below to request resident time off. For all periods of time off, each resident must submit this form. These forms are to be used for all periods of time off—vacation or non-vacation.

For his/her own safety, the resident should retain a copy of the signed form (Remember, these forms mean near to nothing until every signature is filled in, including the faculty signature.

FORM TO REQUEST TIME OFF FOR AN ORTHOPÆDIC RESIDENT

(circle one): Providence, Receiving, Childrens, DMC Surg Hosp, Other (specify)

(name of resident asking for time off)

(first date requested off)

(last date requested off)

1. (Chief resident's approval) By signing this, I affirm that I am scheduled to be the chief resident of this service at the time in question. I certify that I am aware of all other periods of time off that I have signed approval for, and I warrant that there will be enough personnel remaining to do the necessary work without undue hardship befalling anyone.

(legible name)

(signature)

(date signed)

2. (Faculty's approval) By signing this, I affirm that I am in charge of this rotation. I certify that I am aware of all other periods of time off that I have signed approval for, and I approve this request.

(legible name)

(signature)

(date signed)

The requesting resident must fax the completed form to Barbara Calati (313)-966-8400.

**ACGME Procedures for Dealing with Complaints Against Residency Programs
(Effective 2/9/99)**

Previous versions of this handbook included the text of the ACGME Procedures for Dealing with Complaints Against Residency Programs, which became effective February 9, 1999. These procedures are available at <acgme.org>.

XX. Orthopædic Resident Work Hours Audit Protocol

- (1) Prior to commencing training, all entering residents will complete a Resident Work Hours Attestation form indicating they are aware of and agree to abide by the Resident Work Hours policy.
- (2) Residents will be required to sign an attestation at the beginning of every academic year and, if rotating from another Program, prior to commencing a rotation.
- (3) The Program Directors will complete a Program Director's Resident Work Hours Attestation form annually. The Program Director's attestation indicates the Program Director is:
 - aware of and understands the purpose of the policy pertaining to resident work hours
 - will insure that all program schedules are designed to comply with the policy pertaining to resident work hours
 - is aware of his responsibility to monitor working hours of graduate medical education trainees enrolled in or rotating through his/her program to ensure the residents remain compliant with the policy pertaining to resident work hours
- (4) Work hours will be recorded on-line via "New Innovations."

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Cable, Matthew G	7887
Jove, Nathaniel A	7891
Karek, Matthew R	7892
Pytiak, Andrew V	7893

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Benuck, Russell G	7905
Kesto, William K	7907
Nasr, Kerellos A	7909
Sami, Syed A	7910

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Herzog, Darren T	8956
Liston, Michael J	8972
Mulder, Andrew	8976
Vigdorchik, Jonathon M	8992

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Gheraibeh, Petra J	8836
Khoury, John I	8215
Lancaster, Gerard	4537
Raaii, Farhang	8878