Frequently Asked Questions: Orthopaedic Surgery
Review Committee for Orthopaedic Surgery
ACGME

Question	Answer
Oversight	
If the Sponsoring Institution does not sponsor a program in general surgery, internal medicine, and/or pediatrics, is there an alternative the Review Committee would accept? *[Program Requirement: I.B.1.a)]*	If the Sponsoring Institution does not sponsor one or more of these programs, the program director must submit a formal request for an exception to this requirement to the Review Committee that includes an educational rationale for the lack of these programs, and detailing how experiences and exposures to these specialty areas will be provided to the residents. In general, the Committee expects that at least a third of the total education and training time will take place at sites with a significant presence of internal medicine, surgery, and pediatrics residents from ACGME-accredited programs, however this is not a specific requirement, and other considerations, such as distance from the primary clinical site and pattern of educational experience, are important factors in reviewing proposals for compliance.
What would the Review Committee consider a justifiable educational rationale for rotating to distant sites? *[Program Requirement: I.B.5.a)]*	There must be an educationally necessary benefit available exclusively at the distant site to justify a rotation there. For example, one rationale for choosing a distant site rather than a more geographically proximate site would be that the availability of a specific *required* resident experience is not available locally.

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Can videoconferencing be used for the required four hours of didactics per week when residents are rotating to distant sites? *[Program Requirement: I.B.5.b)]*	In order to achieve the educational benefits of any form of didactics, it needs to be an interactive and not a passive learning experience. Interactive learning is achieved through discussion facilitated by faculty members and by sustaining the lecture topic after the conference through follow-up in the operating room/clinic. When residents cannot attend didactic education at the primary clinic site and there is not an acceptable didactic program at the distant site providing similar education in which the rotating residents and faculty members from that site participate or when the didactic education at the primary clinical site is clearly better, teleconferencing is an acceptable alternative, with the following considerations: • there is a clear rationale to support the need for videoconferencing; • the videoconference is interactive (i.e., live, two-way interaction involving the residents/faculty members at the primary clinical site didactic session and residents/faculty members at the distant site); and, • residents at the distant site are provided with protected time for didactics (whether in person or videoconferencing).
Resources	
What are the anatomic areas reviewed by the Committee as part of the annual program review? *[Program Requirements: I.D.1.b)-I.D.1.b).(1)]*	The ACGME generates several Case Log statistical reports for each year's program graduates. These include the following program-specific reports: Minimums Report; Minimums Ratio Report; Resident Report; and Program Report. In addition, a National Report is generated each year showing the aggregated data for all orthopaedic surgery graduates that year. As part of the annual accreditation review for each program, the Committee reviews the Minimums Report and the Program Report. The Program Report contains statistical information (program average, program minimum, program median, program maximum, program percentile, and national percentile) organized into anatomic areas (shoulder, humerus/elbow, forearm/wrist, hand/fingers, pelvis/hip, femur/knee, leg/ankle, foot toes, other musculoskeletal, spine, integumentary system, nervous system), as well as oncology cases, microsurgeries, reductions, and total procedures. The program percentiles are also shown in a summary graph that the Committee reviews to gain insight into the breadth and depth of surgical experiences the program provides for its residents.
Personnel	

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What types of evidence of periodic updates of knowledge and skills would the Review Committee consider for complying with the requirement for additional program director qualifications? *[Program Requirement: II.A.3.d)]*	Examples of acceptable evidence include: • Peer-reviewed publications and book chapters related specifically to teaching, supervision, and assessment of residents • Participation in education courses/workshops, such as those offered through the ACGME, American Academy of Orthopaedic Surgeons, American Orthopaedic Association, or AOA • Active participation in the Council of Orthopaedic Residency Directors (CORD) • Development of educational materials, such as simulations, video-taped lectures, or items for examination question banks • Participation in or leadership of department and/or institutional committees related to resident education, such as the Clinical Competency Committee, Program Evaluation Committee, Patient Quality/Safety Committee, Graduate Medical Education Committee, Institutional Review Board
What types of faculty development activities to enhance skills as educators are acceptable to the Review Committee? *[Program Requirement: II.B.2.f).(1)]*	The Review Committee will accept a wide variety of activities specifically designed to improve faculty members' skills as educators. Examples of national opportunities include participation in the annual AOAssn/CORD meetings, AAOS Orthopaedic Educators Course, AOAssn webinars devoted to topics related to evaluation, feedback, mentoring, supervision, and teaching, and ACGME faculty development workshops. Offerings at a regional or local level that seek to improve faculty skills in these areas are also acceptable. For example, discussions of the Milestones at a faculty meeting could involve an exercise in helping faculty members achieve a common understanding of review criteria. Activities specifically related to improving faculty members' specialty-specific knowledge – while important – are not acceptable.
How should programs document faculty members' participation in faculty development activities related to resident education? *[Program Requirement: II.B.2.g)]*	Faculty members should include this information as part of their CV, which is already updated annually by most faculty members as part of their departmental annual performance review. At the time of the 10-Year Accreditation Site Visit, faculty members' CVs will be reviewed by the Accreditation Field Representative. In the interim, the Review Committee might request copies of core faculty members' CVs if a concern arises regarding faculty member commitment to resident education. Additionally, minutes from a faculty meeting detailing such faculty development activities/discussions during the meeting, along with an attendance roster, would constitute appropriate documentation.

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Educational Program	
Can elective or non-clinical rotations be less than six weeks in length? *[Program Requirement: IV.C.1.c)]*	Yes. Shorter periods can be used for elective clinical or research rotations.
Are PGY-1 residents permitted to complete an intern year in a general surgery program and enter the orthopaedic surgery program at the PGY-2 level? *[Program Requirement: IV.C.3.]*	The Review Committee expects that all residents will begin orthopaedic surgery education in the PG-1 year. Programs are specifically prohibited from double-matching (i.e., matching a resident who intends to complete a preliminary general surgery year prior to entering the orthopaedic surgery program). PGY-1 residents must have six months of orthopaedic surgery rotations, as well as six months of non-orthopaedic surgery rotations. The goals for PGY-1 education are specified in the Program Requirements. In rare instances, a resident who has completed an intern year in a general surgery program may apply for admission into an orthopaedic surgery program at the PGY-2 level. For such an application to be considered, the general surgery program director must provide documentation, acceptable to the orthopaedic surgery program director, the Review Committee, and the American Board of Orthopaedic Surgery (ABOS), that all orthopaedic surgery requirements for the PGY-1 have been met.
Does the Review Committee allow rotations to international sites to count toward the residents' required education? *[Program Requirements: IV.C.5. and IV.C.8.]*	Cases performed during an international rotation may not be entered into the Case Log System. Programs should inform the Review Committee by emailing the Executive Director prior to the start of any international rotation, and are advised to consult the ABOS or AOBOS regarding any plans for such rotations in order to ensure the continued certification eligibility for residents who participate.
What resources are available to help programs provide education and experience in disaster and mass casualty preparedness? *[Program Requirement: IV.C.5.c)]*	A variety of resources currently exist to assist programs to provide mass casualty education, including formal courses through governmental agencies and surgical societies. There are also many articles available that could be incorporated into the program's journal club or other educational venue. Experience might be gained by having residents actively participate in institutional mass casualty exercise(s) that most hospitals now regularly conduct. Contact the Executive Director for additional resource suggestions.

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How many faculty members, or what percentage of the program faculty, should demonstrate scholarly activity? *[Program Requirement: IV.D.1.b).(1)]*	At least half of the physician faculty should demonstrate scholarly activity.
The Learning and Working Environment	
What are the Review Committee's expectations for indirect supervision with direct supervision available? *[Program Requirements: VI.A.2.b).(2).]*	A supervising physician or licensed independent practitioner who is not present within the hospital but is present at another site may provide indirect supervision by phone or properly encrypted or de-identified electronic communication. Direct supervision should be available within 15 minutes.
Who may provide direct supervision to PGY-1 residents? *[Program Requirement: VI.A.2.b).(1.(a)]*	Each program is responsible for having clear policies for supervision. Direct supervision requires the supervising individual to be physically present. Supervising individuals must have been credentialed by the program to do a particular procedure or to manage a particular clinical scenario, and may be more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task), fellows, and attending orthopaedic surgeons. Appropriately credentialed and privileged non-orthopaedic attending physicians, as well as licensed independent practitioners (this may include non-physician faculty members working in conjunction with the orthopaedic surgery department) with whom the program has a clearly defined relationship outlined in the supervision policy, may directly supervise PGY-1 residents. The clinical care supervised by a non-physician must be within the scope of practice of that non-physician professional.
For which tasks may PGY-1 residents be supervised indirectly, and for which tasks should PGY-1 residents have direct supervision until competence is demonstrated? *[Program Requirement: VI.A.2.b).(1).(a).(i)]*	1. Examples of patient management competencies for which indirect supervision is allowed: a) evaluation and management patients admitted to the hospital, including initial history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan b) pre-operative evaluation and management, including history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan c) evaluation and management of post-operative patients, including monitoring patients and ordering medications, tests, and other indicated treatments d) transfer of patients between hospital units or hospitals

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	e) discharge of patients from the hospital f) interpretation of laboratory results g) interpretation of radiographs h) consultation of appropriate inpatient services 2. Examples of procedural competencies for which indirect supervision is allowed: a) performance of basic venous access procedures, including establishing intravenous access b) placement and removal of nasogastric tubes and Foley catheters c) arterial puncture for blood gases d) removal of surgical drains e) application of dressings and prefabricated splints f) placement of splints for non-displaced fractures g) removal of non-absorbable sutures or skin staples 3. Examples of patient management competencies for which direct supervision is required until competency is demonstrated: a) initial evaluation and management of patients in urgent or emergent situations, including: urgent consultations, trauma, and emergency department consultations; and evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria b) evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments c) management of patients in cardiac or respiratory arrest d) management of patients with major fractures that are displaced e) evaluation and management of patients with infections of the spine, pelvis, or extremities 4. Examples of procedural competencies for which direct supervision is required until competency is demonstrated: a) repair of surgical incisions of the skin and soft tissues b) repair of lacerations of the skin and soft tissues

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	c) excision of lesions of the skin and subcutaneous tissues d) repair of nail bed lacerations or distal digit amputation injuries that do not require management in an operating room setting e) incision and drainage of paronychias, felons, or other abscesses of the hand and forearm that do not require management in an operating room setting f) endotracheal intubation g) bedside wound debridement h) insertion of skeletal traction pins i) arthrocentesis j) closed reduction of fractures and dislocations k) placement of casts l) placement of splints for displaced fractures m) administration of local anesthetic n) measurement of compartment pressure
How does the Review Committee determine program compliance with respect to optimal clinical workload? *[Program Requirement: VI.E.1.]*	The program should incorporate graded clinical responsibility for residents. The expectation is that the program will assign cases and procedures that are appropriate to each resident's PGY and current level of credentialing.

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