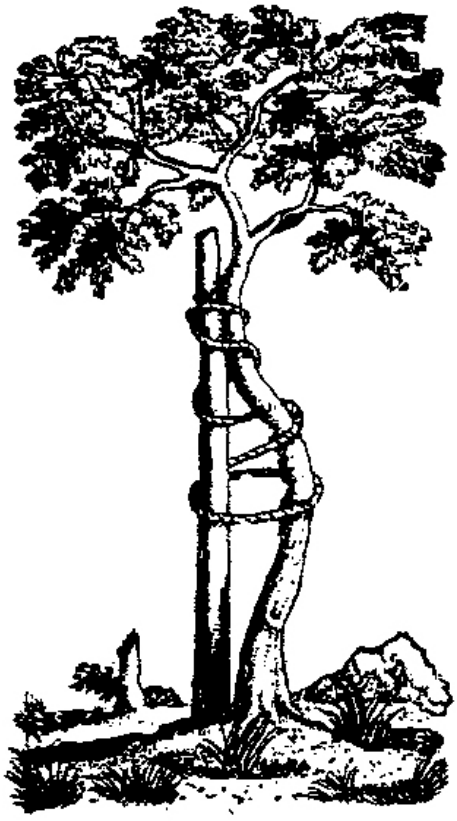
Cleveland Clinic
Akron General

# Department of Orthopaedic Surgery Residency

***A Culture of Education***



**Orthopaedic Surgery - Resident Handbook**

**2024-2025**

## Specialty Definition

Orthopaedic Surgery includes the study and prevention of musculoskeletal diseases, disorders, and injuries, and their treatment by medical, surgical, and physical methods.

**Sponsoring Institution:** Cleveland Clinic Akron General (ACGME-accredited)

**Primary Clinical Site:** Cleveland Clinic Akron General, Department of Orthopaedics
**Participating Site:** Akron Children's Hospital

**Length of Educational Program:** 60 months

The Cleveland Clinic Akron General Orthopaedic Surgery Residency is an accredited, five-year program offering prospective resident candidates a broad orthopaedic training experience. The PGY-1 intern year includes surgical and non-surgical rotation requirements, followed by PGY 2-5 years that incorporate all orthopaedic subspecialties, research, and leadership administrative duties. The overall breakdown is generally 51 months adult patient care, seven months pediatric patient care and two months of research. The program works diligently to recruit and retain a diverse workforce of residents and faculty in addition to ensuring appropriate resources and a highly reliable, safe work environment for successful patient care and the promotion of resident well-being. As a teaching institution, we provide education for many outside learners including medical students, support staff, and advanced care practitioners without a negative impact on the development of the resident. The Orthopaedic Department does not currently support or train subspecialty fellows.

## Mission Statement

The mission of the Orthopaedic Surgery Residency Program at Cleveland Clinic Akron General is to train proficient, aware, and ethical surgeons capable of providing safe care for a diverse patient population in a hybrid academic- and historically community-based Level 1 Trauma Center. We emphasize education during a combined longitudinal and rotation-based 60-month experience and teach research principles with a focus on achievable goals. Our graduates will be competitive candidates for entry into general orthopaedic practice or application for subspecialty fellowship training.

**Orthopaedic Surgery Teaching Faculty: Cleveland Clinic Akron General**

**Nicholas J DiNicola MD**
Program Director, Orthopaedic Surgery Residency
Specialty: Orthopaedic Trauma

**Andrew Esterle MD**
Associate Program Director, Orthopaedic Surgery Residency
Specialty: Hand and Elbow Surgery

**William B Kurtz MD**
Chairman, Department of Orthopaedic Surgery
Specialty: Orthopaedic Trauma

**Stephen B Lippitt MD**
Research Director, Orthopaedic Surgery Residency
Specialty: Shoulder and Elbow Surgery

**Timothy Marks MD**
Education Coordinator, Orthopaedic Surgery Residency
Specialty: Orthopaedic Oncology

**John L Pinkowski MD**
Musculoskeletal Service Line Director
Specialty: Arthroscopy and Sports Medicine Surgery

**Gregory A Vrabec MD**
Specialty: Adult Reconstruction/Orthopaedic Trauma

**Anthony T Kantaras MD**
Specialty: Arthroscopy and Sports Medicine Surgery

**Jordan P Grossman DPM FACFAS**
Specialty: Podiatry/Surgery of the Foot and Ankle

**John Elias PhD**
Senior Research Scientist

**William Lanzinger MD**
Specialty: Hand Surgery

**Paul Wilkie MD**
Specialty: Adult Reconstruction

**Jeffrey Yang MD**
Specialty: Arthroscopy and Sports Medicine Surgery

**Lauren Kishman DPM**
Specialty: Podiatry/Surgery of the Foot and Ankle

**Jonathan Streit MD**
Specialty: Shoulder and Elbow Surgery

**Carol Armstrong MD**
Specialty: Hand and Elbow Surgery

**Jacob Hoffman MD**
Chief of Orthopaedic Spine Surgery
Specialty: Orthopaedic Spine Surgery

**Samantha Figas DPM**
Specialty: Podiatry/Surgery of the Foot and Ankle

**Gordon Preston DO**
Specialty: Orthopaedic Spine Surgery

**Heather Preston DO**
Specialty: Arthroscopy and Sports Medicine Surgery

**Nicholas Satariano MD**
Specialty: Hand Surgery

**Patrick Kane MD**
Specialty: Arthroscopy and Sports Medicine Surgery

**Michael Makowski MD**
Specialty: Orthopaedic Trauma

**Keegan Conry MD**
Specialty: Orthopaedic Spine Surgery

**Orthopaedic Surgery Teaching Faculty: Akron Children's**

**Patrick Riley Sr MD**
Education Director for Orthopaedic Pediatric Surgery

**Todd F Ritzman MD**
Chairman of the Department of Pediatric Orthopaedic Surgery

**Mark J Adamczyk MD**
Research Director for Pediatric Orthoapedic Surgery

**William C Schrader MD**
Specialty: Pediatric Orthopaedic Surgery

**Paul Fleissner MD**
Specialty: Pediatric Orthopaedic Surgery

**Drew Engles MD**
Specialty: Pediatric Hand and Microvascular Surgery

**Kenneth Bono MD**
Specialty: Pediatric Orthopaedic Surgery

**Patrick Riley Jr MD**
Specialty: Pediatric Orthopaedic Surgery

**Orthopaedic Surgery Program Administration: Cleveland Clinic Akron General**

**Holly Gordon BS**
Program Manager

**Kendall Goodman BA**
Undergraduate Medical Education Coordinator

## EDUCATIONAL PROGRAM

The Educational Program for the orthopaedic resident is designed to facilitate exposure and expertise within the discipline in a manner consistent with graduated responsibility and a focus on teamwork and teaming. The ultimate goal is to provide a trajectory to independent, safe, and excellent patient care. Additionally, the ACGME has identified six core competencies vital to resident training:

### ACGME Core Competencies

**Patient Care and Procedural Skills** – Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the practice of orthopaedics.

**Medical Knowledge** – Residents must demonstrate medical knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.

**Practice-based Learning and Improvement** – Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on self-evaluation and lifelong learning.

**Interpersonal and Communication Skills** – Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

**Professionalism** – Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. This includes competence in: compassion, integrity, and respect for others; responsiveness to patient needs that supersedes self-interest; cultural humility; respect for patient privacy and autonomy; accountability to patients, society, and the profession; respect and responsiveness to diverse patient populations, including diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; the ability to recognize and develop a plan for one's own personal and professional well-being; appropriately disclosing and addressing conflict or duality of interest.

**Systems-Based Practice** – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals.

## CURRICULUM COMPONENTS

## DIDACTIC EXPERIENCE

Weekday morning conference with assigned reading
Skills month
Anatomy experience
Health Sciences quarterly conference
Annual Orthopaedic Research Day
Cleveland Clinic Akron General Scientific Session
Annual Pediatric Resident Review course
Other local courses (Summa, CCF main campus)
Other local research conferences (Akron Children's, CCF main campus)
Industry sponsored lab events (variable)
Industry sponsored journal clubs (variable)
Visiting professors (variable)
Educational and research conference travel

### Weekday conference

A monthly conference schedule is designed to address orthopaedic topics during 0700-0800 protected weekday time (five hours per week, on average). The majority of conferences are attending led, although body site-specific fracture conferences are generally given by a PGY-3 (pre-made presentations available for all topics) and weekly fracture conferences are generally case discussions overseen by a PGY-4 with heavy attending input. Some intermittent conferences that also may be resident led include travel conference updates (such as AAOS annual meeting and CCJR) and clinical rotation specific presentation requirements. This time may also be used for Institution needs such as health-system updates from administration and a variety of leader-guided discussions. Additionally, Orthopaedic Morbidity and Mortality, Orthopaedic Journal Club and Trauma Grand Rounds will take place on this schedule. Virtual access is available through Outlook invitations to Program and Department members. The ROCK (Resident Orthopaedic Core Knowledge) reading curriculum is assigned to include both topics on the schedule and topics that may not have individual hour-long didactics; alternate and more extensive reading resources are abundantly available. Weekday conference is protected educational time, with the following rules:

- Location: Orthopaedic Department conference room 0700-0800, virtual access
- Alternate similar events may have differing time schedule and higher or lower level of expected protection per event: HSS lecture series, trauma or other service grand rounds, off campus specific labs, skills month afternoon labs, evening journal clubs
- Mandatory protected attendance for all orthopaedic residents, except:
    - Resident on vacation or other approved leave, in-house health-related self-care (medication needs, lactation management, acute illness etc.) and interviews.
    - Resident scheduled off-campus rotation or site (includes Akron Children's, Health and Wellness Surgery Center, Medina or Mercy Hospital surgical lineup).
    - Resident travel related to educational conference or research presentation conference
    - Resident off service (PGY-1 rotation dependent, some may allow attendance).

- Chief resident committee meeting attendance (Patient Safety, Trauma QI, Orthopaedic Department Peer Review).
- On-call resident responding to emergency patient care, including rapid response team, trauma with sub-30-minute response requirement condition (orthopaedic – mangled extremity, compartment syndrome and open pelvic fracture), condition dependent consultation (such as necrotizing fasciitis).
    - Resident not to leave conference for routine floor and ED consults or inpatient floor questions during protected time, which can be staffed afterwards or passed to orthopaedic APP.
- On-call resident providing patient care in emergency surgical case that began prior to 0700.
    - Resident not to leave protected conference for surgical cases scheduled to begin 0700-0800.

### Skills Month

A basic surgical skills schedule is created each July to address several topics to prepare PGY-1 interns for common clinical encounters in the operating room and when taking orthopaedic call. This typically includes a morning conference followed by an afternoon lab. Attendance is mandatory for all PGY-1s and will vary for older residents based on availability during other assignments. We have also been fortunate to have our PGY-1 class attend OrthoCamp which is a similar two-day preparatory June conference in Houston (or virtual) since 2022; this has been a valuable addition but is not a mandatory requirement.

### Anatomy Experience

During the 2022 academic year, we partnered with the University of Akron Department of Biology to use their lab and storage for limb, pelvis and spine cadaveric dissection and surgical approaches. As the scheduling is refined and we are caught up from pandemic delays, this opportunity is historically intended for the PGY-2 class. Each May a new cadaver will be available, with expected lab time early in the summer when the students are not in class. The Program Manager and Director will help coordinate timing with the Anatomy Professor.

### HSS Quarterly Conference

Medical Education hosts a required quarterly conference series for all residents, addressing several components of support, wellness, and health system requirements. There are usually three dates available each quarter to ensure all residents can attend.

### Regional and National Conferences

It is a privilege to have the opportunity to travel to paid educational conferences for residents. There are two allotted conferences per resident year, funded by Medical Education or the Orthopaedic Department, or sponsored by Industry. Resident must be compliant with all required documentation (duty hours, case logs, research logs, employee modules, etc.) and in good standing with the Clinical Competency Committee to qualify for paid travel. Frequently, research presentations can afford the opportunity for additional conference travel.

**Regional and National Conferences (continued)**

- **PGY-1** – ATLS (local); OrthoCamp (Houston)
- **PGY-2** – OTA Fracture Course (varies), AO Basic Fracture Course (varies)
- **PGY-3** – AANA Knee/Shoulder Arthroscopy Course (Rosemont), Elective
- **PGY-4** – Current Concepts in Joint Replacement/CCJR (Orlando), Elective
- **PGY-5** – AAOS Annual Meeting (varies), Miller Board Review (Denver)

**CLINICAL EXPERIENCE**

Rotation blocks (procedural and office)
Weekday and weekend morning check-out
Overnight call assignment

**Clinical Rotations**

Rotation assignments are designed within ACGME requirements to provide an organizational structure to daily surgical scheduling and weekly office scheduling. They also provide more short-term continuity of care for following patients within a subspecialty. Based on the size of the department, the overall responsibility for patient care is overlapping between all residents, regardless of rotation assignment or PGY level. For example, at no time is a junior resident on a rotation expected to be the sole provider patient care for that service. As the rotation schedule is refined, goals and expectations for those assigned will continue to be delineated. At the onset, the goal for any rotation is for the resident to spend 4/5 days per work week within the subspecialty (surgical lineups and office). This affords some flexibility for further case coverage outside the rotation depending on the surgeries scheduled and residents on leave or post-call.

The duty of the Administrative Chief is to provide a highly organized weekly schedule; if unable to perform the duty it will be provided by the Associate Program Director or the Program Director. The Administrative Chief is also responsible for ensuring another chief resident can cover scheduling when they are on leave, or on some occasions allow a PGY-4 to gain experience scheduling. This task requires the resident to take many factors into account in building a smooth yet flexible schedule; it is a showcase of leadership ability that emphasizes communication, anticipation, fairness, and compromise.

## Clinical Rotations (continued)

**PGY-1**

- BASIC SURGICAL SKILLS 1 month
- GENERAL SURGERY – TRAUMA 1 month
- SICU 1 month
- VASCULAR SURGERY 1 month
- PLASTIC SURGERY 1 month
- ANESTHESIOLOGY 1 month
- INFECTIOUS DISEASE 1 month
- HAND SURGERY 1 month
- SPINE SURGERY 1 month
- FOOT & ANKLE SURGERY 1 month
- PEDIATRIC ORTHOPAEDIC SURGERY 1 month
- ADULT ORTHOPAEDIC SURGERY 1 month

**PGY-2**

- ORTHOPAEDIC TRAUMA 2 months
- SPINE SURGERY 2 months
- HAND SURGERY 2 months
- FOOT & ANKLE SURGERY 2 months
- PEDIATRIC ORTHOPAEDIC SURGERY 2 months
- ADULT ORTHOPAEDIC SURGERY 2 months

**PGY-3**

- ADULT RECONSTRUCTION 2 months
- SPORTS ORTHOPAEDIC SURGERY 2 months
- ORTHOPAEDIC ONCOLOGY 2 months
- ORTHOPAEDIC TRAUMA 3 months
- RESEARCH 1 month
- PEDIATRIC ORTHOPAEDIC SURGERY 2 months

**PGY-4**

- ADULT RECONSTRUCTION 2 months
- SPORTS ORTHOPAEDIC SURGERY 2 months
- HAND SURGERY 2 months
- RESEARCH 1 month
- ADULT ORTHOPAEDIC SURGERY 5 months

**PGY-5**

- ORTHOPAEDIC TRAUMA 2 months
- PEDIATRIC ORTHOPAEDIC SURGERY 2 months
- ADULT ORTHOPAEDIC SURGERY 4 months
- ADMIN/ADULT ORTHOPAEDIC SURGERY 4 months

## Morning Check-Out/Transitions-Of-Care

Weekday morning check-out occurs prior to the didactic in the POB Orthopaedic Department conference room at 0645; all local residents on-service participate with the Orthopaedic NP and any attendings present. Updates for all patient care are reviewed and the daily needs are assigned. Direct communication with associated attendings that aren't present should occur after conference. Weekend transitions occur between the rounding call teams and with direct communication with the associated attending physicians.

## Orthopaedic Call

The monthly resident call schedule is divided into 24-hour First Call (intern/junior resident) and Second Call (senior resident) for each day. There are several monthly attending call schedules, including Orthopaedic Trauma/Service, Orthopaedic Spine, Hand Surgery, and a separate Orthopaedic Group call (typically weekends for those attendings not assigned to any other call service). This is designed to provide timely appropriate patient care in a graduated manner of responsibility with layers of supervision.

The First Call resident is initially responsible for fielding floor phone calls, organizing and initiating new orthopaedic consults, and assisting with floor patient care needs. The First Call resident is practicing organization and communication skills throughout their shift. The First Call resident maintains an accurate consult log that includes CPT coding for non-surgical care (fracture and dislocation care including reductions, splinting and casting, and other floor procedures including joint aspirations/injections and incision and drainage procedures).

The Second Call resident is the immediate back-up for direct and indirect supervision of the First Call resident. They provide a higher level of experience and management skills. The Second Call resident is responsible for reviewing every consult, directly communicating with the patient and attending when necessary, and ensuring that the consult log is accurate. If the First Call resident is at the level of PGY 2.5, the Second Call resident may leave the hospital on a slower night, but is still responsible for all oversight as listed.

The monthly call schedule is created by the Administrative Chief, whose goal should be to design a fair and viable schedule given the availability of the resident staff. Any individual call schedule may not be perfectly equal, but will be inherently fair over time. The call schedule will abide by all ACGME duty hour rules. If the Administrative Chief (or substitute chief resident) is unable to manage the call schedule, they will be created by the Associate Program Director or Program Director.

**Maximum in-house on-call frequency is no more than every-third-night (when averaged over a four-week period).**

## Duty Hours

- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. **Reading done in preparation for conference or the following day's cases, studying, and research done from home do not count toward the 80 hours.**
- Residents should have eight hours off between scheduled clinical work and educational periods.
    - The schedules will be structured in this manner; there is flexibility for occasional patient care or education events that a resident may choose return, providing still working within the context of the 80-hour rule.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks).
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. **Up to four hours of additional time may be used for activities related to patient safety (such as providing effective transitions of care), and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.**
- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. These additional hours of care or education must be counted toward the 80-hour weekly limit.

## Duty Hour Log

It is an ACGME and Med Ed requirement that work hours are logged accurately and routinely. Beginning May 1, 2024, the orthopaedic program will have the same protocol as used at main campus:

- Residents must enter their own work hours in New Innovations (phone app available).
- Work hours can only be entered for the previous two-week period.
- Residents will be locked from entering hours outside of the previous two weeks to ensure timely completion and to address delinquent work hour reporting.
- Residents will need to contact Med Ed to have access turned back on if not entered on time.
- Repeated issues will be referred to the Program Director (refer to Discipline Protocol for documentation).

## Procedural Case Log

Similarly, case log documentation is an ACGME requirement for graduation (1000 – 3000 entries needed over 60-month period; does not mean when you hit the minimum you are finished). The logs are routinely monitored by the program; HOWEVER beginning January 2025 the ABOS Knowledge, Skills and Behavior (KSB) program will have a new strict entry protocol that will determine your board eligibility.

## Resident Evaluation

Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- Residents identify their strengths and weaknesses and target areas that need work.
- Program directors and faculty members recognize where residents are struggling and address problems immediately.

Examples of this type of collected evaluation include surgical surveys completed by faculty and routine discussion with the resident regarding procedural, call, or clinic performance.

- Surveys are currently collected in New Innovations. Beginning January 2025, the ABOS is implementing the KSB for all programs which **require** the resident to log procedural cases withing 48 hours of completion; they **must request** a written evaluation from faculty eight times per month and average 80 evaluations per year to be eligible for the written board exam.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively. It is utilized to make decisions about promotion to the next level of training, or program completion.

- Milestone surveys are completed by faculty and averaged twice yearly per resident class and submitted to the ACGME. The Clinical Competency Committee uses this indicator to devise ongoing summative evaluation. Summative feedback meetings are scheduled with each individual resident twice yearly.
- A final evaluation utilizing Milestones and orthopaedic case-logs is provided at program completion to verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

Additionally, resident and faculty staff participate in annual program retreats (typically scheduled in August) to provide program and individual evaluations in a closed-door setting.

## Scholarly Activity

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching. **Residents must participate in scholarship, and demonstrate through at least one of the following activities:**

- Participation in sponsored research
- Preparation of an article for a peer-reviewed publication
- Presentation of research at a regional or national meeting
- Participation in a structured literature review of an important topic

**RESIDENT DOCUMENTATION AND REQUIRED PARTICIPATION:**

There are numerous accreditation and employment requirements for physicians that demand a high level of organization and responsiveness for success. Residents must take individual responsibility for their completion and participation of:

- DUTY HOUR LOGS – CCF and Med Ed requires honest accurate logs submitted every 2 weeks
- CASE LOGS – (procedural and non-surgical call logs) between 1000 – 3000 ACGME graduation requirement
- RESEARCH TIME LOG & SCHOLARLY ACTIVITY LOG – research rotation and yearly update
- SURGICAL EVALUATION REQUESTS – 80 per year, beginning January 2025 (ABOS/ACGME requirement)
- MANDATORY EMPLOYEE MODULES – CCF/HR requirement – yearly and intermittent
- HSS QUARTERLY CONFERENCE – Med Ed requirement
- ACGME YEARLY PROGRAM SURVEY

It is imperative that residents ensure they are timely with documentation. It is an employee requirement to check work e-mail routinely for any notification of additional needs. It is an employee requirement to adhere to all standards for Epic documentation. The orthopaedic resident mailboxes should be routinely checked and emptied in the department. All documentation logs are subject to the Academic Integrity Policy (see House Officer Manual and attached to this handbook).

**DISCIPLINE PROTOCOL:**

- 1st offense – verbal warning from Program Director/Associate Program Director/Program Manager
- 2nd offense – written warning
- 3rd offense – mandatory meeting with the Clinical Competency Committee; review of circumstance can result in loss of next unscheduled paid travel conference
- 4th offense – mandatory meeting with Dr. Sheers DIO – Medical Education and permanent letter as part of resident file; this gets reported to outside hospital employment applications (including as required for fellowships) and state licensing applications. Note this is highly undesirable, as your next employers will demand a response from you regarding documentation behavior when determining job status.

- Anything further will be reviewed by the Clinical Competency Committee for probation, remediation, or dismissal.

- Additional discipline may be required as outlined in the Academic Integrity Policy.

## Travel

Residents must complete an Application for Meeting Attendance and submit it to the Program Manager for approval by the Department Chair and Medical Education DIO prior to registering for a course or making any travel arrangements. Residents are responsible for scheduling and attending conferences. A missed conference will be forfeited and must not be made up during another PGY year.

Upon approval of the travel request, residents will be responsible for registering for educational conferences and research presentations. Many courses have a limited number of seats, and it will be the resident's responsibility to register before the course fills. After confirmation of registration is received, the resident is also responsible for booking a hotel for the duration of the conference. Following completion of the conference, the cost of registration and the hotel will be reimbursed to the resident.

All airfare must be booked through the Cleveland Clinic Travel Agency, and is not permitted to be purchased independently by the resident, or through third party sites (for expected reimbursement). No less than 30 days before the conference, the resident must inform the Program Manager of their intended flight information, so the manager can purchase tickets on behalf of the resident.

When traveling for educational conferences or research presentations, the following expenses are reimbursed to the resident after returning and submitting all receipts and folios to the Program Manager. All receipts must be submitted within 14 days of return. Any missing receipts will be exempt from reimbursement.

**Reimbursable expenses:**

**Meals** - up to $100 per day total amount including tips. Receipts must only reflect meals eaten by the resident and must not include any purchase of alcohol. An itemized receipt must be submitted for reimbursement. It is highly frowned upon by Medical Education to submit receipts for meals that cost several hundred dollars and demand $100 for the day (if this occurs they have suggested meal reimbursement be removed from this pool); choose your receipts wisely.

**Tuition/Registration fees** - To be purchased in advance by the resident. An invoice or receipt must be submitted for reimbursement.

**Hotel room** - If circumstances allow, residents should share a hotel room. If offered, residents must book hotel rooms through the conference group rate or room block. If unavailable, residents are required to book the lowest cost, most practical option to suit conference needs. Residents are only permitted to book standard rooms. The purchase of suites or non-hotel housing is not permitted and will not be reimbursed. A full hotel folio, including an itemized description of all charges, must be submitted for reimbursement.

**Baggage Fees** - Residents will be permitted to purchase one checked bag. A receipt or ticket stub containing the amount paid must be submitted for reimbursement.

## Vacation and Leave

All residents are allotted three weeks of PTO per academic year (refer to employee contract) and another vacation period during the Christmas/New Year's holidays. Additionally, there is an extensive leave policy as provided by Medical Education that should be reviewed. Residents must utilize an entire week of PTO at a time and will only be allowed to split one week of PTO to use as needed (typically broken into two days/three days). An example of what is not allowed is to use five days of PTO to take five distinct Fridays or Mondays off. PTO requests must only include one weekend before or after the requested time off, but many times both bookend weekends can be accommodated providing the resident is available for call the other weekends of the month.

PTO requests must be submitted at least 30 days in advance through New Innovations to be approved by the Program Manager and the Administrative Chief Resident for that month. All PTO requests will be approved on a first-come, first-served basis. PTO requests will be accommodated as best possible, but patient care and educational requirements come first. Careful attention should be given to how many additional residents may be out at the same time (for example, paid educational conference travel for an entire class greatly affects vacation requests).

PGY-4 residents will receive an additional eight days to be used for fellowship or job interviews, as well as travel days required for interviews. If a resident need exceeds those eight days, additional time may be deducted from one week of PTO. Further time requirements must be discussed with the Administrative Chief Resident and Program Director/Associate Program Director.

PGY-5 residents will receive an additional five days to be used for relocation needs prior to graduation. PGY-5 residents must be in the hospital until the third Friday of June, otherwise they must utilize PTO.

**VACATION NOT ALLOWED DURING: June 1 – June 10 or December 15 - January 3**

It is expected that residents will attend graduation events; it is a professional courtesy to our graduating seniors and Orthopaedic Program, as well as the Department of Medication Education. Occasionally there will be conflicting events (such as weddings during this season); these will be handled on an individual basis. Every attempt should be made to support the Program in which you are enrolled.

In addition to graduation events, pay attention to other routine yearly events such as Orthopaedic Research Day, Akron General Scientific Session, the Annual State of the Residency Dinner, resident retreats, the oncology/pediatric OITE review sessions, and the OITE when considering vacation time.

Evenly distributed vacation time is encouraged to avoid resident burnout. Be mindful of the impact on your fellow residents when planning time away; the Administrative Chief Resident has to navigate a complex scheduling process to ensure a smooth workflow for everyone.

Remember that REQUESTS ARE NOT A GUARANTEE OF TIME OFF. You will receive confirmation of your request via New Innovations, and should not make any travel arrangements until confirmed. It is your responsibility to follow-up on your vacation or leave request.

## Illness/Sick Leave/FMLA

- If a resident will be absent from work, they must notify the Administrative Chief Resident AND the Program Manager by 7:00 AM of the day in question. The voicemail for the Program Manager will take messages 24 hours a day; the phone number is 330-344-6269. The Program must be able to report the location of every orthopaedic resident to administration and Medical Education at all times.
- Residents are not encouraged to work while ill. If the resident misses a call day due to illness, they are expected to switch on-call dates with another resident. Every opportunity should be made to exchange call shifts with another resident of the same PGY level.
- If a resident is out sick for two or more days, a doctor's excuse must be submitted (from an appropriate treating physician) and an appointment scheduled to be seen by Employee Health for clearance before the resident can return to work.
- If required, FMLA forms are available in the Human Resources department or from the Program Manager. The FMLA policy is located in the AGMC House Staff officer manual.

## Leave of Absence/Maternity/Paternity Leave

Refer to the extensive Leave Policy as provided by Medical Education. Proper timely documentation is essential to access the Leave Policy.

## Resident Attire

Resident staff are expected to have a clean professional appearance when facing patients. Refer to the most recent House Officer Manual for guidelines administered by Medical Education.

Specifically for the program, all patient-facing office interaction is performed in business casual (or higher) attire. Employee badge is to be worn above the waist, so patients have easy access to view your identification. Surgical scrubs are **NEVER** to be worn in the office setting, regardless of what the faculty or other rotating students may be wearing.

There are very specific attire rules inside the Operating Room that are required for hospital Joint Commission accreditation. This includes blue scrubs, covered forearms with a scrub jacket until the procedure to begin, no masks hanging around the neck at any point in the hospital, a clean surgical cap and appropriate eye coverage when the patient enters the room. Soiled or bloodied scrubs are to be changed immediately upon safe completion of patient care; residents should not be in public areas with soiled attire or wearing surgical scrub caps. Cover, clean, or replace soiled shoes. Joint Commission performs both scheduled and surprise visits every year.

Hospital administration will specifically identify residents that are dressed inappropriately, and particularly watch if staff is wearing blue scrubs to and from their vehicle or wearing jackets that are not branded appropriately. It is always safest to wear a while coat over scrubs or business casual (or higher) attire when in public areas.

Repeated attire violations will result in individual meetings being scheduled with hospital administration and the Clinical Competency Committee with loss of the next unscheduled paid conference travel. Lack of attentiveness to professional appearance and hygiene is a behavioral red flag, and will actually be recorded as part of the KSB beginning January 2025.

## Fatigue and Resident Wellness

Strategies for resident and faculty wellbeing are paramount for efficient and safe patient care as well as care of the individual. There are numerous non-clinical team events throughout the year that promote resident wellness, both at the Program and House Staff level. There are also many resources available from the Cleveland Clinic to promote caregiver wellness.

****Refer to the Caregiver Central menu or the Medical Education Department tab on the www.agmc.org intranet for an extensive list of resources.****

**The historic fatigue policy for the orthopaedic residency program is outlined below; it is anticipated that this will be updated in context of resources that continue to become available:**

Symptoms of fatigue and/or stress are normal and expected to occur periodically with the resident population, just as it would in other professional settings. Not unexpectedly, residents may on occasion, experience some effects of inadequate sleep and/or stress. The Orthopaedic Surgery Residency Program of Akron General Medical Center has adopted the following policy to address resident fatigue and/or stress (2018):

**Recognition of Resident Excess Fatigue and/or Stress**

Signs and symptoms of resident fatigue and/or stress may include but are not limited to the following:

- Inattentiveness to details
- Forgetfulness
- Emotional liability
- Mood swings
- Increased conflicts with others
- Lack of attention to proper attire or hygiene
- Difficulty with novel tasks and multitasking
- Awareness is impaired (fall back on rote memory)

**Response**

The demonstration of resident excess fatigue and/or stress may occur in patient care settings or in non-patient care settings such as lectures and conferences. In patient care settings, patient safety, as well as the personal safety and well-being of the resident, mandates implementation of an immediate and a proper response sequence. In non-patient care settings, responses may vary depending on the severity of and the demeanor of the resident's appearance and perceived condition. The following is intended as a general guideline for those recognizing or observing excessive resident fatigue and/or stress in either setting.

**Patient Care Settings and Non-Clinical Settings**

- **Attending Clinician:**

1. In the interest of patient and resident safety, the recognition that a resident is demonstrating evidence for excess fatigue and/or stress requires the attending or supervising resident to consider immediate release of the resident from any further patient care responsibilities at the time of recognition.

2. The attending clinician or supervising resident should privately discuss his/her opinion with the resident, attempt to identify the reason for excess fatigue and/or stress, and estimate the amount of rest that will be required to alleviate the situation.
3. The attending clinician must attempt, in all circumstances without exception, to notify the chief/supervising resident on-call, Program Director or Department Chair, respectively, depending on the ability to contact one of these individuals of the decision to release the resident from further patient care responsibilities at that time.
4. If excess fatigue is the issue, the attending clinician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle. This may mean that the resident should first go to the on-call room for a sleep interval no less than 30 minutes. The resident may also be advised to consider calling someone to provide transportation home.
5. The attending should notify the on-call hospital administrator for further documentation of advice given to the resident removed from duty.
6. If stress is the issue, the attending upon privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity; notification of program administrative personnel shall include the chief/supervising resident on-call, Program Director or Department Chair, respectively, depending on the ability to contact one of these individuals.
7. A resident who has been released from further immediate patient care because of excess fatigue and/or stress cannot appeal the decision to the responding attending.
8. A resident who has been released from patient care cannot resume patient care duties without permission of the Program Director or chair when applicable.

- **Allied Health Care Personnel:**
  Allied health care professionals in patient service areas will be permitted to report observations of apparent resident excess fatigue and/or stress to the observer's immediate supervisor who will then be responsible for reporting the observation to the respective Program Director.

- **Residents:**
  1. Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, and the Program Director without fear of reprisal.
  2. Residents recognizing resident fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, and/or the Program Director.

  **Program Director:**
  1. Following removal of a resident from duty, in association with the chief resident, determine the need for an immediate adjustment in duty assignments for remaining residents in the program.
  2. Subsequently, the Program Director will review the resident's call schedules, duty hour logs, extent of patient care responsibilities, any known personal problems, and stresses contributing to this for the resident.
  3. The Program Director will notify the Department Chair of the rotation in question to discuss methods to reduce resident fatigue.

4. In matters of resident stress, the Program Director will meet with the resident personally as soon as can be arranged. If counseling by the Program Director is judged to be insufficient, the Program Director will refer the resident to the Employee Assistance Program within CCAG.
5. If the problem is recurrent or not resolved in a timely manner, the Program Director will have the authority to release the resident indefinitely from patient care duties pending evaluation from an individual designated by the Employee Assistance Program.
6. The Program Director will release the resident to resume patient care duties only after advisement from the EAP and will be responsible for informing the resident as well as the attending physician of the resident's current rotation.
7. If the EAP feels the resident should undergo continued counseling, the Program Director will be notified and should receive periodic updates from the EAP representative.
8. Extended periods of release from duty assignments that exceed requirements for completion of training must be made up to meet ACGME/ABOS training guidelines.