



**POLICIES AND PROCEDURES
for Residents/Fellows**

Rev. October 8, 2008

The American Academy of Orthopaedic Surgery has published a *Guide to the Ethical Practice of Orthopaedic Surgery (3rd Edition)*, which the Department of Orthopaedic Surgery at the University of Louisville has adopted as a guideline for physicians and residents. The literature is available in the Department for review, however, the basic tenets of this *Guide* are listed below.

PRINCIPLES OF MEDICAL ETHICS IN ORTHOPAEDIC SURGERY

The following Principles of Medical Ethics have been adopted by the Board of Directors of the American Academy of Orthopaedic Surgeons. They are not laws, but rather standards of conduct that define the essentials of honorable behavior for the orthopaedic surgeon.

- I. **Physician-Patient Relationship:** The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns. The orthopaedic surgeon should be dedicated to providing competent medical service with compassion and respect.
- II. **Integrity:** The orthopaedic surgeon should maintain a reputation for truth and honesty with patients and colleagues, and should strive to expose through the appropriate review process those physicians who are deficient in character or competence or who engage in fraud or deception.
- III. **Legalities and Honor:** The orthopaedic surgeon must obey the law, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The orthopaedic surgeon also has a responsibility to seek changes in legal requirements that are contrary to the best interest of the patient.
- IV. **Conflicts of Interest:** The practice of medicine inherently presents potential conflicts of interest. Wherever a conflict of interest arises, it must be resolved in the best interest of the patient. The orthopaedic surgeon should exercise all reasonable alternatives to ensure that the most appropriate care is provided to the patient. If a conflict of interest cannot be resolved, the orthopaedic surgeon should notify the patient of his or her intention to withdraw from the care of the patient.
- V. **Confidentiality:** The orthopaedic surgeon should respect the rights of patients, of colleagues, and other health professionals and must safeguard patient confidence within the constraints of the law.
- VI. **Medical Knowledge:** The orthopaedic surgeon continually must strive to maintain and improve medical knowledge and to make relevant information available to patients, colleagues, and the public.
- VII. **Cooperation:** Good relationships among physicians, nurses, and health care professionals are essential for good patient care. The orthopaedic surgeon should promote the development of an expert health care team that will work together harmoniously to provide optimal patient care.

- VIII. Remuneration: Remuneration for orthopaedic services should be commensurate with the services rendered. Orthopaedic surgeons should deliver high quality, cost-effective care without discrimination.**
- IX. Publicity: The orthopaedic surgeon should not publicize himself or herself through any medium or form of public communication in an untruthful, misleading, or deceptive manner.**
- X. Societal Responsibility: The orthopaedic surgeon has a responsibility not only to individual patient, to colleagues and orthopaedic surgeons-in-training, but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the orthopaedic surgeon.**

CODE OF ETHICS FOR ORTHOPAEDIC SURGEONS

American Academy of Orthopaedic Surgeons

Adopted October, 1988

Amended October, 1991

Amended December, 1995

PREAMBLE

Concerns for the patient's welfare and the appropriate behavior of the physician are a part of the heritage of medicine originating with the Code of Hammurabi, a code of ethics dating from 2000 BC. Guidelines for ethical behavior must address the demands of contemporary orthopaedic practice. The American Academy of Orthopaedic Surgeons (Academy) developed the *Principles of Medical Ethics in Orthopaedic Surgery* and the *Code of Ethics for Orthopaedic Surgeons* primarily for the benefit of our patients and to serve as a guide to conduct in the physician-patient relationship. These documents are, in part, derived from the *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (AMA)*. The Academy documents are directed to concerns of specific interest to orthopaedic surgeons. Orthopaedic surgeons are encouraged to refer to the *Current Opinions of the Council on Ethical and Judicial Affairs of the AMA* for guidance if the particular ethical matter at issue is not addressed in the Academy's *Principles of Medical Ethics in Orthopaedic Surgery* or *Code of Ethics*.

The Academy's *Principles of Medical Ethics in Orthopaedic Surgery* and *Code of Ethics for Orthopaedic Surgeons* provide standards of conduct that define the essentials of honorable behavior for the orthopaedic surgeon. *The Principles of Medical Ethics in Orthopaedic Surgery* and *Code of Ethics*, while taking into account the legal requirements of medical practice, call for and espouse a standard of behavior that is higher than that required by the law.

Orthopaedic Surgeons should recognize that they are role models for orthopaedic surgeons-in-training and other health care professionals and should by their deeds and actions comply with the Academy's *Principles of Medical Ethics in Orthopaedic Surgery* and *Code of Ethics*.

I. The Physician-Patient Relationship

- A. The orthopaedic profession exists for the purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns.
- B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust, and honesty. Both the patient and the orthopaedic surgeon are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. An orthopaedist has an obligation to render care only for those conditions that he or she is competent to treat. The orthopaedist shall not decline to accept patients solely on the basis of race, color, gender, sexual

orientation, religion, or national origin or on any basis that would constitute illegal discrimination.

- C. The orthopaedic surgeon may choose whom he or she will serve. An orthopaedic surgeon should render services to the best of his or her ability. Having undertaken the care of a patient, the orthopaedic surgeon may not neglect that person. Unless discharged by the patient, the orthopaedic surgeon may discontinue services only after giving adequate notice to the patient so that the patient can secure alternative care. Managed care agreements may contain provisions which alter the method by which patients are discharged. If the enrollment of a physician or patient is discontinued in a managed care plan, the physician will have an ethical responsibility to assist the patient in obtaining follow-up care. In this instance, the physician will be responsible to provide medically necessary care for the patient until appropriate referrals can be arranged.
- D. When obtaining informed consent for treatment, the orthopaedic surgeon is obligated to present to the patient or to the person responsible for the patient, in understandable terms, pertinent medical facts and recommendations consistent with good medical practice. Such information should include alternative modes of treatment, the objectives, risks and possible complications of such treatment, and the complications and consequences of no treatment.

II Personal Conduct

- A. The orthopaedic surgeon should maintain a reputation for truth and honesty. In all professional conduct, the orthopaedic surgeon is expected to provide competent and compassionate patient care, exercise appropriate respect for other health care professionals, and maintain the patient's best interests as paramount.
- B. The orthopaedic surgeon should conduct himself or herself morally and ethically, so as to merit the confidence of patients entrusted to the orthopaedic surgeon's care, rendering to each a full measure of service and devotion.
- C. The orthopaedic surgeon should obey all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. Within legal and other constraints, if the orthopaedic surgeon has a reasonable basis for believing that a physician or other health care provider has been involved in any unethical or illegal activity, he or she should attempt to prevent the continuation of this activity by communicating with that person and/or identifying that person to a duly-constituted peer review authority or the appropriate regulatory agency. In addition, the orthopaedic surgeon should cooperate with peer review and other authorities in their professional and legal efforts to prevent the continuation of unethical or illegal conduct.
- D. Because of the orthopaedic surgeon's responsibility for the patient's life and future welfare, substance abuse is a special threat that must be recognized and stopped. The orthopaedic surgeon must avoid substance abuse and, when necessary, seek rehabilitation. It is ethical for an orthopaedic surgeon to take

actions to encourage colleagues who are chemically dependent to seek rehabilitation.

III. Conflicts of Interest

- A. The practice of medicine inherently presents potential conflicts of interest. Whenever a conflict of interest arises, it must be resolved in the best interest of the patient. The orthopaedic surgeon should exercise all reasonable alternatives to ensure that the most appropriate care is provided to the patient. If the conflict of interest cannot be resolved, the orthopaedic surgeon should notify the patient of his or her intention to withdraw from the relationship.**
- B. If the orthopaedic surgeon has a financial or ownership interest in a durable medical goods provider, imaging center, surgery center or other health care facility where the orthopaedic surgeon's financial interest is not immediately obvious, the orthopaedic surgeon must disclose this interest to the patient. The orthopaedic surgeon has an obligation to know the applicable laws regarding physician ownership, compensation and control of these services and facilities.**
- C. When an orthopaedic surgeon receives anything of value, including royalties, from a manufacturer, the orthopaedic surgeon must disclose this fact to the patient. It is unethical for an orthopaedic surgeon to receive compensation (excluding royalties) from a manufacturer for using a particular device or medication. Reimbursement for administrative costs in conducting or participating in a scientifically sound research trial is acceptable.**
- D. An orthopaedic surgeon reporting on clinical research or experience with a given procedure or device must disclose any financial interest in that procedure or device if the orthopaedic surgeon or any institution with which that orthopaedic surgeon is connected has received anything of value from its inventor or manufacturer.**
- E. Except when inconsistent with applicable law, orthopaedic surgeons have a right to dispense medication, assistive devices, orthopaedic appliances, and similar related patient-care items, and to provide facilities and render services as long as their doing so provides a convenience or an accommodation to the patient without taking financial advantage of the patient. Ultimately, the patient must have the choice of accepting the dispensed medication or patient-care items or obtaining them outside the physician's office.**

IV. Maintenance of Competence

- A. The orthopaedic surgeon must continually strive to maintain and improve medical knowledge and skill, and should make available to patients and colleagues the benefits of his or her professional attainments. Each orthopaedic surgeon should participate in continuing relevant medical educational activities.**

V. Relationships with Orthopaedic Surgeons, Nurses, and Allied Health Personnel

- A. Good relationships among physicians, nurses, and other health care professionals are essential for good patient care. The orthopaedic surgeon should promote the development of an expert health care team that will work together harmoniously to provide optimal patient care.**
- B. The professional conduct of the orthopaedic surgeon will be scrutinized by local professional associations, hospital(s), managed care organization(s), peer review committees, and state medical and/or licensing boards. These groups deserve the participation and cooperation of orthopaedic surgeons.**
- C. Orthopaedic surgeons are frequently called upon to provide expert medical testimony in courts of law. In providing testimony, the orthopaedic surgeon should exercise extreme caution to ensure that the testimony provided is nonpartisan, scientifically correct, and clinically accurate. The orthopaedic surgeon should not testify concerning matters about which the orthopaedic surgeon is not knowledgeable. It is unethical for an orthopaedic surgeon to accept compensation that is contingent upon the outcome of litigation.**

VI. Relationship to the Public

- A. The orthopaedic surgeon should not publicize himself or herself through any medium or form of public communication in an untruthful, misleading, or deceptive manner. Competition between and among surgeons and other health care practitioners is ethical and acceptable.**
- B. Professional fees should be commensurate with the services provided. It is unethical for orthopaedic surgeons to bill individually for services that are properly considered a part of the “global service” package where defined, i.e., services that are a necessary part of the surgical procedure. It is unethical for orthopaedic surgeons to submit billing codes that reflect higher levels of service or complexity than those that were actually required. It is unethical for orthopaedic surgeons to charge for services not provided.**
- C. Physicians should be encouraged to devote some time and work to provide care for individuals who have no means of paying.**
- D. The orthopaedic surgeon may enter into a contractual relationship with a group, a prepaid practice plan, or a hospital. The physician has an obligation to serve as the patient’s advocate and to ensure that the patient’s welfare remains the paramount concern.**

VII. General Principles of Care

- A. An orthopaedic surgeon should practice only within the scope of his or her personal education, training, and experience. If an orthopaedic surgeon contracts to provide comprehensive musculoskeletal care, then he or she has the obligation to ensure that appropriate care is provided in areas outside of his or her personal expertise.**

- B. It is unethical to prescribe, provide, or seek compensation for unnecessary services or not to provide services that are medically necessary. It is unethical to prescribe controlled substances when they are not medically indicated. It is also unethical to prescribe substances for the sole purpose of enhancing athletic performance.**
- C. The orthopaedic surgeon should not perform a surgical operation under circumstances in which the responsibility for diagnosis or care of the patient is delegated to another who is not qualified to undertake it.**
- D. When a patient submits a proper request for records, the patient is entitled to a copy of such records as they pertain to that patient individually. Charges should be commensurate with the services provided to reproduce the medical records. Certain correspondence from insurance carriers or attorneys may call for conclusions on the part of the orthopaedic surgeon. As such, a reasonable fee for professional services is permissible.**

VIII. Research and Academic Responsibilities

- A. All research and academic activities must be conducted under conditions of full compliance with ethical, institutional, and government guidelines. Patients participating in research programs must have given full informed consent and retain the right to withdraw from the research protocol at any time.**
- B. Orthopaedic surgeons should not claim as their own intellectual property that which is not theirs. Plagiarism or the use of others' work without attribution is unethical.**
- C. The principal investigator of a scientific research project is responsible for proposing, designing, and reporting the research. The principal investigator may delegate portions of the work to other individuals, but this does not relieve the principal investigator of the responsibility for work conducted by the other individuals.**
- D. The principal investigator or senior author of a scientific report is responsible for ensuring that appropriate credit is given for contributions to the research described.**

IX. Community Responsibility

- A. The honored ideals of the medical profession imply that the responsibility of the orthopaedic surgeon extends not only to the individual but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the orthopaedic surgeon.**

TABLE OF CONTENTS

1.0	GENERAL INFORMATION
1.1	PURPOSE
1.2	MAIL
1.3	EMERGENCY NOTIFICATION.....
2.0	NATIONAL POLICIES (ACGME) GENERAL AND SPECIAL REQUIREMENTS FOR GRADUATE TRAINING IN ORTHOPAEDIC SURGERY
3.0	SUMMARY OF KENTUCKY STATE LAWS (KENTUCKY BOARD OF MEDICAL LICENSURE)
3.1	LICENSURE LAWS.....
3.2	REPORTING LAWS.....
3.2.1	CHILD ABUSE
3.2.2	SPOUSE ABUSE.....
3.2.3	DISEASES.....
3.2.4	IMPAIRED PHYSICIANS
3.3	ALLEGATIONS OF SEXUAL MISCONDUCT.....
4.0	UNIVERSITY HOUSE STAFF POLICIES AND BENEFITS
4.1	REQUIREMENTS FOR INCOMING TRAINEES
4.1.1	HSC SERVICES OFFICE
4.1.2	MALPRACTICE APPLICATIONS.....
4.1.3	COMPLETION OF ACLS PROVIDER COURSE.....
4.1.4	HEALTH STATUS/IMMUNIZATION DOCUMENTATION.....
4.1.5	PROCEDURE FOR NEEDLE STICKS OR OTHER ACCIDENTAL EXPOSURES TO BLOODBORNE PATHOGENS
4.1.6	MEDICAL LICENSURE
4.1.7	DEA NUMBER.....
4.2	UNIVERSITY BENEFITS.....
4.2.1	UNIVERSITY PERSONNEL.....
4.2.2	SICK LEAVE/SHORT TERM DISABILITY FAMILY & MEDICAL LEAVE ACT OF 1993.....
4.2.3	LONG TERM DISABILITY.....
4.2.4	HEALTH INSURANCE.....
4.2.5	LIFE INSURANCE.....
4.2.6	UNIVERSITY OF LOUISVILLE ID CARDS
4.2.7	UNIVERSITY PARKING PERMITS
4.2.8	WORKER'S COMPENSATION.....
4.2.9	LIBRARY PRIVILEGES
4.2.10	UNIVERSITY DISCOUNTS
4.2.11	GROUPWISE ACCOUNTS.....

	4.2.12	RECREATIONAL FEATURES.....
	4.2.13	MISCELLANEOUS.....
4.3		MEDICAL RECORDS
4.4		MISCELLANEOUS UNIVERSITY POLICIES
	4.4.1	DRUG FREE SCHOOLS NOTICE
	4.4.2	POLICY ON RESIDENT RECRUITMENT
	4.4.3	POLICY ON RESIDENT SUPERVISION
	4.4.4	POLICY ON STRESS AND FATIGUE
	4.4.5	POLICY ON RESIDENT DUTY HOURS.....
	4.4.6	MOONLIGHTING
5.0		DEPARTMENTAL RESIDENCY PROGRAM POLICIES AND BENEFITS
5.1		PROMOTION CRITERIA.....
	5.1.1	POLICY ON COMPLIANCE WITH TEACHING PHYSICIAN REGULATIONS
5.2		ACADEMIC WARNING, PROBATION, DISMISSAL AND APPEALS
	5.2.1	UNSATISFACTORY EVALUATION.....
	5.2.2	REMEDIATION.....
	5.2.3	DEPARTMENT ACADEMIC WARNING.....
	5.2.4	ACADEMIC PROBATION AND DUE PROCESS POLICY FOR RESIDENTS.....
	5.2.5	DISMISSAL.....
	5.2.6	GRIEVANCE PROCEDURE.....
	5.2.7	PROCEDURE FOR LEAVING THE PROGRAM.....
	5.2.8	GRADUATE MEDICAL EDUCATION POLICY ON RESIDENCY CLOSURE/REDUCTION
	5.2.9	DEPARTMENT MOONLIGHTING POLICY
	5.2.10	DEPARTMENT POLICY ON RESIDENT DUTY HOURS
5.3		LEAVE TIME
	5.3.1	DEFINITIONS
	5.3.2	VACATIONS/HOLIDAYS
	5.3.3	EDUCATIONAL LEAVE
	5.3.4	LEAVES OF ABSENCE
5.4		BENEFITS
	5.4.1	PROFESSIONAL COATS
	5.4.2	REIMBURSEMENT FOR EXAMINATIONS
	5.4.3	BEEPERS
5.5		CHIEF RESIDENTS.....
	5.5.1	HOW SELECTED
	5.5.2	TERM
	5.5.3	DUTIES
6.0		CURRICULUM INFORMATION
6.1		DEPARTMENT OF ORTHOPAEDIC SURGERY CLINIC RESPONSIBILITIES.....

6.1.1	CHANGES IN CLINIC SCHEDULE
6.2	ON-CALL AND HOSPITAL RESPONSIBILITIES.....
6.2.1	ON-CALL SCHEDULES
6.2.2	EMERGENCY DEPARTMENT ADMISSIONS
6.2.3	HOSPITAL ADMISSIONS
6.2.4	PATIENT CARE RESPONSIBILITIES
6.2.5	JEWISH HOSPITAL/NORTON'S HOSPITAL/KOSAIR'S... ..
6.2.6	OTHER HOSPITALS
6.2.7	NON-ORTHOAEDIC PATIENTS
6.2.8	HOSPITAL STATISTICS
6.2.9	PEER REVIEW ACTIONS
6.3	CONFERENCE AND GRAND ROUNDS ATTENDANCE REQUIREMENTS
7.0	AMERICAN BOARD OF ORTHOPAEDIC SURGERY
7.1	IN-TRAINING EXAM

1.0 GENERAL INFORMATION

1.1 PURPOSE

The purpose of this document is to provide faculty, residents, and staff with easy access to the policies of the University of Louisville Orthopaedic Surgery Residency Program.

1.2 MAIL

Every resident is provided with a mailbox in the Resident's Office. All information concerning the resident's rotations, schedules of Orthopaedic Surgery Office responsibilities and call schedules will be distributed via these mailboxes. Any mail posted through the University of Louisville postal system will also be distributed to the resident via this mailbox. This will include but is not limited to licensing matters and house staff policies and procedures.

1.3 EMERGENCY NOTIFICATION

It is important that the Department of Orthopaedic Surgery Residency Program (852-5319) be notified of any changes in the resident's home address or telephone number as soon as possible. Each resident is requested to give the residency office an address or telephone number where program staff can reach them while on off site rotations, at medical conferences, or during vacations. While the program is not trying to invade the resident's privacy, there have been times when it is vitally important to be able to contact the resident. In the past, relatives have called with family emergencies and it was not possible for the program to assist them.

2.0 NATIONAL POLICIES (ACGME) GENERAL AND SPECIAL REQUIREMENTS FOR GRADUATE TRAINING IN ORTHOPAEDIC SURGERY.

Program Requirements for Graduate Medical Education in Orthopaedic Surgery

Common Program Requirements Appear in Bold
Sections of text that are not bolded are specialty-specific requirements.

I. Introduction

RESIDENCIES IN GRADUATE MEDICAL EDUCATION: INSTITUTIONAL AND PROGRAM REQUIREMENTS

A. Definition and Scope of the Specialty

Orthopaedic surgery is the medical specialty that includes the study and prevention of musculoskeletal diseases, disorders, and injuries and their treatment of medical, surgical and physical methods.

B. Duration and Scope of Education

1. Orthopaedic residencies will be accredited to offer 5 years of graduate medical education. The orthopaedic residency director is responsible for the design, implementation, and oversight of a PGY-1 year that will prepare residents for specialty education in orthopaedic surgery. This year must include resident participation in clinical and didactic activities that will give them the opportunity to
 - a. develop the knowledge, attitudes and skills needed to formulate principles and assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;

- b. Be involved in the care of patients with surgical and/or medical emergencies, multiple organ system trauma, soft tissue wounds, nervous system injuries and disease, peripheral vascular injuries and diseases, and rheumatologic and other medical diseases;
 - c. gain experience in the care of critically ill surgical and medical patients;
 - d. participate in the pre-, intra- and post-operative care of surgical patients; and
 - e. develop an understanding of surgical anesthesia, including anesthetic risks and the management of intra-operative anesthetic complications.
2. In order to meet these goals the PGY-1 year must include:
 - a. a minimum of six months of structured education in surgery to include multi-system trauma, plastic surgery/burn care, intensive care, and vascular surgery;
 - b. a minimum of one month of structured education in at least three of the following: emergency medicine, neurology, neurological surgery, pediatric surgery or pediatrics, rheumatology, anesthesiology, musculoskeletal imaging, and rehabilitation; and
 - c. a maximum of three months of orthopaedic surgery.
3. The program director is also responsible for the design, implementation and oversight of PGY-2 through PGY-5 years that
 - a. must include at least 3 years of rotations on orthopaedic services; and
 - b. may include rotations on related services such as plastic surgery, physical medicine and rehabilitation, rheumatology, or neurological surgery.

II. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

1. One primary site must provide most of the residents' basic science and research education.
 - a. Residents' clinical education at the primary site should include extensive experience in patient care. Preoperative evaluation and postoperative follow-up, as well as valuation and treatment of patients not requiring surgery, must be included.
 - b. Basic science education and the principal clinical conferences should be provided at

the primary site.

Supplemental conferences may also be provided at other locations, but the program's didactic activities should be provided at the program's primary site.

2. The governing body of the sponsoring institution must provide support for the program director in teaching, recruiting staff, selecting residents, assigning residents to an appropriate workload, and dismissing residents whose performance is unsatisfactory and must encourage continuity in the program directorship.
3. In communities where the didactic programs of several residencies are combined, the staff of each accredited program must actively and consistently participate in the combined effort.
4. To provide an adequate interdisciplinary educational experience, the institution that sponsors the orthopaedic program should also participate in ACGME-accredited programs in general surgery, internal medicine, and pediatrics.

B. Participating Institutions

- 1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of continuity of the educational experience.**
- 2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
 - a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
 - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
 - c) specify the duration and content of the educational experience; and
 - d) state the policies and procedures that will govern resident education during the assignment.
- 3. Affiliations should be avoided with institutions that are at such a distance from the sponsoring institution as to make resident participation in program conferences and rounds difficult, unless the participating institution provides comparable activities.**
- 4. The program director must have the responsibility and authority to coordinate**

program activities at all participating institutions and must maintain a file of written descriptions of the educational activities provided at each institution involved in the program.

III. Program Personnel and Resources

A. Program Director

1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data system of the ACGME.
2. The Program Director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership. Programs that have acting directors for more than one year will be subject to review, which may include a site visit.
- 3. Qualifications of the program director are as follows:**
 - a) The program director must possess the requisite expertise, as well as documented educational and administrative abilities.
 - b) The program director must be certified in the specialty by the American Board of Orthopaedic Surgery, or possess qualifications judged to be acceptable by the RRC
 - c) The program director must be appointed in good standing and based at the primary teaching site.
- 4. Responsibilities of the program director are as follows:**
 - a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.
 - b) The program director is responsible for preparing an accurate statistical and narrative description of the program as

requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.

- C) The program director must ensure the implementation of fair policies, grievance Procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional requirements.
- d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:
 - (1) The addition or deletion of a participating institution;
 - (2) a change in the format of the education program;
 - (3) a change in the approved resident complement for those specialties that approve resident complement.On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.
- e) Ensuring the provision of adequate facilities teaching staff, resident staff, teaching beds, educational resource materials, outpatient facilities, and research facilities.
- f) Maintaining a file of current, written institutional and inter-institutional agreements, resident agreements, patient care statistics, the operative experience of individual residents, policies on duty hours and supervision, and regular assessments of resident performance. These documents must be provided on request to the RRC or to the site visitor.

B. Faculty

1. **At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**
 - a) All programs must have at least three faculty who devote at least 20 hours each week to the program.
 - b) There must be at least one full-time faculty equivalent (one FTE equals 45 hours per week devoted to the residency) for every four residents in the program (excluding residents in nonorthopaedic education).
 - c) It is the responsibility of the teaching staff to ensure that the structure and content of the residency reflect an education-to-service ratio that identifies residents as

students and provide adequate experience in preoperative and postoperative, as well as intraoperative, patient care.

- d) The teaching staff must provide direct supervision appropriate to a resident's competence and level of training in all patient care settings, including operative, inpatient, outpatient, and emergency
2. **The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**
 3. **Qualifications of the physician faculty are as follows:**
 - a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.
 - b) The physician faculty must be certified in the specialty by the American Board of Orthopaedic Surgery, or possess qualifications judged to be acceptable by the RRC.
 - c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.
 4. **The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**
 - a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or publication of original research in a peer-reviewed journal;
 - b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
 - c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.Complimentary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and

technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

5. Qualifications of the nonphysician faculty are as follows:

- a) Nonphysician faculty must be appropriately qualified in their field;
- b) Nonphysician faculty must possess appropriate institutional appointments.

C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. Resources

1. The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.
2. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions.
3. Library resources must include current and past periodicals and reference books that are readily available accessible to all orthopaedic residents in the program.
4. Library services should include the electronic retrieval of information from medical databases.
5. There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

IV. Resident Appointments

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. Programs are encouraged to recognize the value and importance of recruiting qualified women and minority students.

B. Number of Residents

The RRC will approve the number of residents to be educated in the program and at each level of the program based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching. It is important that the

resident complement be sufficient in number to sustain an educational environment.

C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

D. Appointment of Fellows and Other Students
The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

V. Program Curriculum

A. Program Design

1. Format
The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.
2. Goals and Objectives
The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior their assignments.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

1. Didactic Components
 - a. Basic Medical Sciences
Basic science education must include substantial instruction in anatomy, biomechanics, pathology, and physiology. The basic science program must also include resident education in embryology, immunology, pharmacology, biochemistry, and microbiology.
 - (1) Instruction in anatomy must include study and dissection of anatomic specimens by the residents and

- lectures or other formal sessions.
- (2) Instruction in pathology must include organized instruction in correlative pathology in which gross and microscopic pathology are related to clinical and roentgenographic findings.
 - (3) Instruction in biomechanics should be presented in seminars or conferences emphasizing principles, terminology, and application to orthopaedics.
 - (4) Organized instruction in the basic medical sciences must be integrated into the daily clinical activities by clearly linking the pathophysiologic process and findings to the diagnosis, treatment, and management of clinical disorders.
 - (5) Organized instruction in the appropriate use and interpretation of radiographic and other imaging techniques must be provided for all residents.
- b. Related Areas of Instruction
Resident education must include Orthopaedic Oncology, rehabilitation of neurologic injury and disease, spinal cord injury rehabilitation, orthotics and prosthetics, and the ethics of medical practice.
 - c. Teaching Rounds
Faculty and residents must attend And participate in regularly scheduled And held teaching rounds, lectures, And conferences. Treatment indications, Clinical outcomes, complications, Morbidity, and mortality must be Critically reviewed and discussed on a Regular basis. Subjects of mutual Interest and the changing practice of Medicine should be discussed at inter-Disciplinary conferences. On average, There must be at least 4 hours of formal teaching activities each week.
2. Clinical Components
 - a. Clinical Resources
Clinical problems must be of sufficient Variety and volume to afford the residents Adequate experience in the diagnosis And management of adult and pediatric Orthopaedic disorders. The residents' clinical experience must include adult orthopaedics, including joint reconstruction; Pediatric orthopaedics, including pediatric trauma; trauma, including multisystem trauma, surgery of the spine, including disk surgery, spinal trauma, and spinal deformities, hand surgery; foot surgery in adults and children; athletic injuries, including arthroscopy; metastatic disease; and orthopaedic rehabilitation, including amputations and postamputation care.
 - b. Continuity of care
All residents must have the opportunity to develop competence in the preadmission care, hospital care, operative care, and follow-up care (including rehabilitation) of patients. Opportunities for resident involvement in all aspects of care of the same patient should be maximized.
 - c. Nonoperative Outpatient Experience
Residents must have adequate experience in nonoperative outpatient diagnosis and care, including all orthopaedic anatomic areas and patients of all age groups. Each week residents must have at least one-half day and should have two-half days of outpatient clinical experience in physician offices or hospital clinics with a minimum of 10 patients per session on all clinical rotations. Residents must be directly supervised by faculty and instructed in pre-and post-operative assessment as well as the operative and non-operative care of general and subspecialty orthopaedic patients. Opportunities for resident involvement in all aspects of outpatient care of the same patient should be maximized.
 - d. Progressive Responsibility
Residents must have the opportunity to assume increasing responsibility for patient care, under direct faculty supervision (as appropriate for each resident's ability and experience), as they progress through a program. Inpatient and outpatient experience with all age group is necessary.
 - e. Basic Motor Skills
Instruction in basic motor skills must Include experience in the proper use of Surgical instruments and operative Techniques. Evaluation of new or Experimental techniques and/or materials should be emphasized. The application of basic motor skills must be integrated into daily clinical activities, especially in the operating room.
- C. Residents Scholarly Activities**
Each program must provide an opportunity for residents to participate in research or other scholarly activities.
1. Resources for scholarly activity by residents

must include laboratory space and equipment, computer and data analysis services, statistical consultation services, research conferences, faculty expertise and supervision, support personnel, time, and funding.

2. To develop the abilities to critically evaluate medical literature, research, and other scholarly activity, resident education must include instruction in experimental design, hypothesis testing, and other current research methods, as well as participation in clinical or basic research.

3. Program directors must maintain a current record of research activity by residents and faculty.

D. ACGME Competencies

The residency program must require its Residents To obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following

1. *Patient care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health.*

Residents are expected to:

- a. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
- b. gather essential and accurate information about their patients;
- c. make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgement;
- d. develop and carry out patient management plans;
- e. counsel and educate patients and their families;
- f. demonstrate the ability to practice culturally competent medicine;
- g. use information technology to support patient care decisions and patient education;
- h. perform competently all medical and invasive procedures considered essential for the area of practice;
- i. provide health care services aimed at preventing health problems or maintaining health; and
- j. work with health care professionals, including those from other disciplines, to provide patient-focused care.

2. *Medical Knowledge about established and evolving biomedical, clinical, and cognate*

sciences, as well as the application of this knowledge to patient care. Residents are expected to:

- a. demonstrate an investigatory and analytic thinking approach to clinical situations; and
- b. know and apply the basic and clinically supportive sciences which are appropriate to orthopaedic surgery.

3. *Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care. Residents are expected to:*

- a. analyze practice experience and perform practice-based improvement activities using a systematic methodology;
- b. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- c. obtain and use information about their own population of patients and the larger population from which their patients' are drawn;
- d. apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness;
- e. use information technology to manage information, access on-line medical information, and support their own education; and
- f. facilitate the learning of students and other health care professionals.

4. *Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals. Residents are expected to:*

- a. create and sustain a therapeutic and ethically relationship with patients;
- b. use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills; and
- c. work effectively with others as a member or leader of a healthcare team or other professional group.

5. *Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. Residents are expected to:*

- a. demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients,

- society and the profession; and a commitment to excellence and ongoing professional development;
- b. demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices;
- c. demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities; and
- d. demonstrate sensitivity and responsiveness to fellow health care professionals' culture, age, gender, and disabilities.

6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:

- a. understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements of the system affect their own practice;
- b. know how types of medical practice and delivery systems differ from one another, including methods of controller healthcare costs and allocation resources;
- c. practice cost-effective health care and resources allocation that does not compromise quality of care;
- d. advocate for quality patient care and assist patients in dealing with system complexities; and
- e. know how to partner with health care managers and healthcare procedures to assess, coordinate, and improve health care and know how these activities can affect system performance.

VI. Resident Duty Hours and the Working Environment

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

A. Supervision of Residents

1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

B. Duty Hours

1. Duty hours are defined as clinical and academic activities related to the residency program; i.e., patient care (both in-patient and out-patient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

C. On-Call Activities

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

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.

Residents may remain on duty for up to 6 additional hours to participate in didactic

activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

3. No new patients may be accepted after 24 hours of continuous duty.

4. *At-home call* (or *pager call*) is defined as a call taken from outside the assigned institution.

- a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 7-week period.
- b) When residents are called into the hospital from home, the hours residents spend in-hours are counted toward the 80-hour limit.
- c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.

3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

E. Oversight

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

2. Back-up support systems must be

provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
- b) Assessment should include the regular and timely performance feedback to residents that includes at least semi-annual written evaluations. Such evaluations are to be maintained in a record that is accessible to each resident.
- c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

2. Final Evaluation

The program director must provide a final Evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by the residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMCEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan for action, which should be approved by the faculty and documented in the minutes of the meeting.

2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. Program graduates should take both Part I and Part II of the American Board of Orthopaedic Surgery examinations and at least 75% of those who take the exams for the first time should pass.

3. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in

advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

IX. Certification

Residents who plan to seek certification by the American Board of Orthopaedic Surgery should communicate with the office of the board regarding the full requirements for certification

*ACGME: June 2001 Effective: July 2002
Editorial Revision: June 2004*

**3.0 MEDICAL LICENSURE POLICY FOR THE RESIDENTS OF ORTHOPAEDIC SURGERY
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE**

3.1 Licensure Law

1. The current University of Louisville School of Medicine Resident Agreement states in Item #1, "Physician represents that he/she is familiar with the requirements for medical licensure in Kentucky and now possesses the valid Kentucky license listed after his/her signature below or will be eligible for a Kentucky license at the end of his/her PGY-1 year." The physician will not be appointed as a resident beyond postgraduate level one without possession of a valid license to practice medicine in the Commonwealth of Kentucky."
2. Acceptance of any individuals above the PGY-1 level is contingent upon eligibility for licensure. It will be the responsibility of each Program Director to insure that individuals accepted are eligible for licensure. The Program Director should be aware of the current state licensure board requirements for all individuals. If there is any question in individual cases, the Graduate Medical Education Office will furnish assistance.
3. PGY-2's or above entering from other programs will not be permitted to begin training until proof of Kentucky licensure, (Institutional Practice, Residency Training, Fellowship Training, temporary, or regular) is furnished. Proof shall consist of confirmation of licensure number and a photocopy of the license. This requirement applies to all trainees entering above PGY-1 status, including residents, fellows, gratis or visiting residents, or international fellows.
4. For residents in U of L programs advancement from PGY-1 to PGY-2 level will not be permitted until licensure is actually attained. Again, it is incumbent upon each Program Director to make sure that PGY-1's who intend to continue as PGY-2's meet basic eligibility criteria.
5. The USMLE Step 3 exam is administered by the Federation of State Medical Boards (FSMB). Applications are available from FSMB (817-571-2949 phone or www.fsmb.org web site) or from individual Training Program offices.
6. Residents who successfully complete one year of training in an ACGME-accredited program are eligible for a training license, either the Institutional Permit (IP) or the Residency Training (RT) license.
7. The IP license requires passing USMLE Steps I and II, and restricts practice to the parameters of the residency program (no moonlighting).
8. The RT license requires passing USMLE Steps I, II, and III, permits moonlighting in locations approved by the Program Director, and permits the holder to obtain a DEA number. The RT license can be issued only with written approval of the Program Director. Both the IP and RT licenses are renewable annually for the duration of training, or until the resident is issued a regular license or leaves the program.

9. Residents who successfully complete two (2) years of training and pass USMLE Steps I, II, and III are eligible to apply for a regular license.
10. The Graduate Medical Education office will pay for the cost of the initial license only for current PG-1 residents who intend to remain at University of Louisville for the PG-2 year. PG-2's and above, who are entering from outside the University are responsible for initial licensure costs. Fees for annual renewal of licenses are paid by either the resident or the resident's program office.
11. Temporary Fellowship Training (FT) licensure is available to international physicians who enter the U.S. for up to one year of advanced training. The FT license limits the practice to the parameters of the training program and is non-renewable.
12. All physicians applying for medical licensure in Kentucky must provide documentation of having completed a 2-hour state-approved AIDS education course. This requirement is explained in detail in the application materials from the Licensure Board, and must be satisfied prior to approval for medical licensure. This requirement is applicable to all types of licenses: full, institutional, resident, or special fellowship licenses.

In addition, primary care physicians (Medicine, Pediatrics, Medicine-Pediatrics, Emergency Medicine, Family Practice and Obstetrics-Gynecology) must complete a 3-hour state approved course in Domestic Violence. This is a one-time requirement and must be completed within three years of initial licensure.

KRS 311.595 – Causes for Denial, Probation, Suspension or Revocation of Medical License

There are several reasons why an individual might lose their license to practice in the state of Kentucky. Generally these reasons relate to criminal activity and other types of dishonorable or unethical conduct. Acts that involve moral turpitude are considered serious grounds for disciplinary actions and these acts might include but are not limited to providing false statements, fraud, or forgery. Individuals may also lose their license if they become addicted to a controlled substance or become a chronic or persistent alcoholic. Physicians should not willingly violate a confidential communication.

KRS 311.597 – Acts Declared to Constitute Dishonorable, Unethical or Unprofessional Conduct.

There are five parts to this section that regulate physician behavior. They include:

1. Physicians are prohibited from prescribing or dispensing controlled substances except for an accepted therapeutic purpose.
2. Physicians may not represent themselves in an extravagant way. For instance, a physician cannot claim to cure cancer in all cases.
3. Physicians may lose their license if they are found grossly incompetent or negligent.
4. Physicians should not engage in activities calculated to bring disrepute to the profession.
5. Any licensed physician is required to report any known or observed violation of

the licensure law by another licensee. This is known as the “snitch law”. It requires a physician in the state of Kentucky to report violations of the licensure law to the KBML.

3.2 REPORTING LAWS

Kentucky state law requires physicians to report specific situations to the appropriate State agency. Residents must follow these procedures.

3.2.1 Child Abuse

From time to time a resident will be called to see a child in the office or the emergency room who may have been battered. Kentucky State Law requires physicians to report any cases of SUSPECTED abuse to the Child Abuse Hotline (595-4550)

3.2.2 Spouse Abuse

Kentucky State Law requires that any assault on a woman, either physical or sexual, be reported to Adult Protective Services (595-4803). After 5:00 p.m. the Resident should report these cases to the Crisis and Information Center (589-4313)

The Domestic Violence Program or the Center for Women and Families Spouse Abuse Center is available to help any battered or abused woman, but is self-referral. The resident should recommend to a woman who is not admitted to the hospital that she seek help from the Center. The resident should give them the number and if possible take them to a phone in the office or ER and help them make the call. The number is 581-7222. When in doubt, call the Jefferson County Board of Health

A resident must notify Adult Protective Services of any adult patient who has been subjected to abuse or neglect by the family or any other care giver.

3.2.3 Diseases

State and local health departments require physicians to report all cases of certain diseases. Generally these are:

1. Any sexually transmitted diseases
2. Diseases spread through water or food (giardia, Hepatitis A)
3. Diseases that occur in epidemics (measles)

3.2.4 Impaired Resident/Substance Abuse University of Louisville School of Medicine

Residents who exhibit signs of impairment due to substance abuse are referred to the Kentucky Physicians Health Foundation (KPHF) for evaluation in accordance with Kentucky medical licensure laws. KPHF evaluates and monitors impaired physicians for the Kentucky Board of Medical Licensure (KBML) under a formal contractual arrangement. The University follows the recommendations of this organization for the treatment and monitoring of impaired residents as well as the written policies of the University of Louisville Hospital. As residents begin training in University programs, they are required to complete a Hospital Privileges Application, which requires information about their personal health status and includes questions related to impairment due to alcohol and other drugs. These applications are reviewed by the hospital Physicians Health Committee (PHC), which in turn makes recommendations to the hospital Credentials Committee. Residents who are in recovery are reviewed

at quarterly meetings of the PHC. There is formal written exchange of information about the status of the resident's recovery between the PHC and the KPHF quarterly. Residents who are found to be impaired because of known and untreated substance abuse, or who violate the Kentucky licensure law are referred to the KBML as required by law.

Residents needing assistance or who have questions should contact their Program Director, the Medical Director of the Kentucky Physicians Health Foundation (Dr. Burns Brady at 425-7761), or the chairman of the University of Louisville Hospital's Physicians Health committee (Dr. Christopher Stewart at 336-5239).

3.3 POLICY AND PROCEDURES ON SEXUAL HARASSMENT UNIVERSITY OF LOUISVILLE OFFICE OF THE PRESIDENT

Policy

The University of Louisville strives to maintain the campus free of all forms of illegal discrimination as a place of work and study for faculty, staff, and students.

Sexual harassment is unacceptable and unlawful conduct and will not be tolerated in the workplace and the educational environment.

Unwelcome sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or participation in a university sponsored education program or activity; (2) submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual; or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's employment or academic performance or creating an intimidating, hostile, or offensive working or educational environment. Faculty, staff, students, and administrators must adhere to this anti-harassment policy. The Provost, Vice Presidents, Dean, Directors, and heads of departments, divisions, and offices are specifically responsible within their particular organizations for publicizing, implementing, and enforcing this policy.

Retaliation

Discrimination in any university employment or academic decision against person who seek redress under the procedures outlined below is prohibited.

Disciplinary Action

If an individual is shown to have violated the sexual harassment policy, the individual will be subject, depending upon the seriousness of the violation, to disciplinary action up to and including termination of employment or expulsion from the University.

The Provost, Vice Presidents, Deans, Directors, and head of departments, divisions, and offices are required to enforce this policy. Failure to do so constitutes a violation subject to separate disciplinary action.

PROCEDURES

Seeking Assistance

If you believe you have been a victim of sexual harassment, there are two ways to seek assistance

1. Informal Approach

- A. You may immediately voice your concern to the person whose actions you find offensive or to the administrative head of the department in which you are an employee or a student.**
- B. If you wish to discuss the incident on a confidential basis with someone outside the department in which you are employed or a student, the people listed below are willing to talk to you informally. These people will listen to you, will provide information, and will provide other assistance if deemed appropriate. They will also report to responsible administrative officers contacts by persons concerned about conduct perceived to be a form of sexual harassment, without identifying the individual, for periodic analysis.**

2. Formal Approach

- A. You should contact the Affirmative Action Office if you wish to initiate a formal complaint, which must be in writing. A formal complaint is the vehicle to use if you want an official University investigation and disciplinary action against University personnel.**
- B. You should file formal complaints against students in writing with the Assistant Vice President for Student Life.**
- C. You may file a grievance as provided for in The Redbook or Staff Handbook.**

4.0 UNIVERSITY HOUSE STAFF POLICIES AND BENEFITS

4.1 REQUIREMENTS FOR INCOMING TRAINEES

4.1.1 HSC HEALTH SERVICES OFFICE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE HSC

HSC Health Services Office
(502) 852-6446 (Answered 24 hours/day)
Phillip F. Bressoud, M.D., Director

The Health Services Office, located in the Ambulatory Care Building, provides medical care and immunizations, including boosters and TB testing to all HSC students, residents and staff. The HSO also serves as an on-site treatment facility for workers compensation related injuries and exposures including needle sticks. The office is staffed by board certified faculty physicians and faculty nurse practitioners. All providers have extensive primary care and occupational exposure experience. On-site laboratory and X-ray facilities are located adjacent to the office.

The office is open daily from 8:30 to 4:30. Please call ahead to arrange an appointment if possible, but walk-ins will be accommodated as allowed.

Exposures involving HIV, Hepatitis B and C positive patients can be referred 24 hours a day to the attending physician on call. After post-exposure counseling, treatment is arranged after considering the source and antibody status of the resident. In the case of HIV positive exposures, access to antiviral drugs should be started within one hour of the exposure. **Only the on-call physician for the HSO can release the antiviral drugs from the University of Louisville in-patient pharmacy to U of L employees, residents, and students. Please do not ask other house staff or attending physicians to write for HIV post-exposure prophylactic drugs.** Follow up testing and reporting of the exposure to Workers Compensation can usually be completed the next working day.

While employed by the University of Louisville, any work related injuries or occupational exposures such as Tuberculosis, including PPD conversions, needle sticks or HIV exposures must be treated by a gatekeeper physician credentialed with the State of Kentucky Workers Compensation insurance carrier. Although you may choose any approved facility, the HSO is prepared to minimize the time it takes for you to be seen and return you to your clinical duties as soon as possible. Failure to use an approved facility can result in denial of payment on your claim to Workers Compensation for treatment. The HSO works with the U of L Risk Management Office to assist you in completing the necessary paperwork to process your claim. **Please note that failure to report an injury or exposure will result in non-payment of any future claims. For example, if you have a needle stick from a HIV positive patient and eventually convert to HIV positive but never reported the original needle stick from the source patient, Workers Compensation would not pay for any HIV treatments or services even though it was work related.**

The HSO also serves as the repository of your immunization records and exposure data while you are in your residency. If you attended medical school at U of L, your student data will be carried forward when you begin your U of L residency. If requested, the HSO will provide you with one free copy of your immunization and PPD documentation when you leave the University. Additional copies may be obtained at a charge of \$1 per page.

4.1.2

RESIDENT MALPRACTICE COVERAGE

Residents on rotation at University of Louisville Hospital and other approved sites in Kentucky are covered by malpractice insurance purchased by the University with annual limits of \$200,000 per claim/\$600,000 aggregate claims per resident. In order to qualify for this coverage the resident must complete the required application, be accepted by the company, and comply with the terms of the policy issued by the company. This coverage does not apply to moonlighting activities.

Affiliated teaching hospitals (Veterans Affairs Medical Center, Norton Healthcare (Norton Hospital, Kosair Children's Hospital, Norton Healthcare Pavilion, Norton Audubon Hospital, Norton Southwest Hospital, and Norton Suburban Hospital), Jewish Hospital, and Frazier Rehabilitation Center) provide insurance coverage for Physicians rotating there.

Physicians may also purchase additional liability insurance at their own expense.

NOTE: The coverage provided is occurrence coverage, therefore, graduating or other residents who leave a program do not need tail coverage

4.1.3 COMPLETION OF ACLS PROVIDER COURSE

ACLS POLICY FOR RESIDENTS UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

1. All residents/fellows in U of L postgraduate training programs must have Advanced Cardiac Life Support (ACLS) certification prior to beginning training in U of L medical and dental programs. Pediatric residents may have PALS instead of ACLS. Documentation and record keeping will be the responsibility of each program. Programs must submit data on ACLS certification annually for all residents/fellows to the Graduate Medical Education Office.
2. A 30-day grace period may be permitted, but must be requested in advance from the Graduate Medical Education Office.
3. Recertification of current residents is not a requirement and will be the option of each program/department. Departments may require recertification, but should provide a mechanism for recertification if they do require it for continuation in the program.
4. BLS is no longer part of ACLS certification training, therefore, all residents will be required to obtain BLS certification prior to ACLS training. It is recommended that both BLS and ACLS be obtained by new residents prior to their arrival in Louisville if they have not been certified at their schools.

Revised 05-26-00

4.1.4 HEALTH STATUS/IMMUNIZATION DOCUMENTATION

POLICY ON IMMUNIZATION AND SKIN TEST REQUIREMENTS FOR RESIDENTS UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

These requirements have been established by the School of Medicine in recognition of our responsibility to provide for your safety, and for the safety of patients whom you will encounter in the course of your training. In addition, they reflect the standards established by the CDC and by the hospitals in which you will be working. It is the expectation of the administration of the School of Medicine that you will accept the value of these conditions, and that you will accept the responsibility for providing full documentation of your status as stipulated under each heading. You may not begin your training unless the basic requirements are met, and your continuation as a resident will depend upon your remaining in compliance. Residents not in total compliance with this policy (except for the 3rd dose of Hepatitis B vaccine) within 30 days of their employment date will be suspended until they are in compliance.

Each resident is responsible for supplying the required information and documentation to his/her Program Director. Immunization, TB skin tests and lab work are provided at no cost to residents through the HSC Health Services office on the 1st Floor of the Ambulatory Care Building.

The following are requirements for all Residents:

1. Tetanus-Diphtheria: (1) dose of Td within the past 10 years.

2. Varicella (Chicken Pox):

- a. History of disease reported by patient (use reporting form), or
- b. Serological proof of immunity, or
- c. (2) two doses of vaccine followed by serological titer

3. Hepatitis B:

- a. (3) doses of vaccine followed by a titer 4-8 weeks following third dose, or
- b. Serological proof of immunity, or
- c. Documentation of chronic active Hepatitis

4. Tuberculosis Skin Test:

- a. Negative Report (in millimeters) of PPD (Manovac/tine not accepted) within the past 12 months unless history of positive skin test
- b. BCG recipients and/or persons 45 years of age and older: (2) negative PPDs (reported in millimeters) within 12 months separated by at least 1 week.
- c. If history of (+) PPD or active tuberculosis, please provide documentation of treatment, if any and latest CXR report.

NOTE: BCG recipients are still required to obtain 2 step PPD testing as recommended by the Centers for Disease Control (CDC).

5. Measles (Rubeola): For those born after 1957

- a. (2) doses of vaccine given at least 30 days apart
- b. Serological proof of immunity

6. Mumps: For those born after 1957

- a. (1) dose of vaccine
- b. Serological proof of immunity

7. Rubella:

- a. (1) dose of vaccine
- b. Serological proof of immunity

8. Influenza

- a. Strongly recommended but not required

You MUST provide documentation of all immunizations and tests to meet the immunization requirements. The Physician Director of the HSC Health Services Office will review individual cases as needed.

4.1.5 PROCEDURE FOR NEEDLE STICKS OR OTHER ACCIDENTAL EXPOSURES TO BLOODBORNE PATHOGENS

If you experience a needle stick or other occupational blood exposure please do the following:

- 1. Obtain consent from the patient involved for HIV testing if necessary and contact nursing supervisor at facility where the incident occurred.**
- 2. Complete incident report at facility where injury occurred.**
- 3. If you have a needle stick from a high risk patient, i.e. patient who is HIV positive or exhibits high risk behavior, please call 852-6446 immediately and ask to speak to the physician on call. HIV post exposure prophylaxis should be started within one hour of the exposure.**

4. During working hours go to the Health Services Office on the first floor of the ACB for assistance. We strive to keep your visit as short as possible and have all of the appropriate worker's compensation forms available if necessary.
5. You will be counseled at your visit and appropriate long term follow-up testing determined. It is your responsibility to complete any follow-up testing.
6. Failure to follow the above procedures could result in nonpayment by worker's compensation insurance or non-contract prices for labs, which will be substantially higher than negotiated pricing.

Occupational Exposure & Needle Stick Evaluation Program
HSC Health Services Office
First Floor Ambulatory Care Building
University of Louisville
Louisville, KY 40292
(502) 852-6446 (answered 24 hours)
Office hours: 8:30 - 4:30 Monday - Friday

4.1.6 MEDICAL LICENSURE

MEDICAL LICENSURE POLICY FOR RESIDENTS

1. The current University of Louisville School of Medicine Resident Agreement states in Item #1, "Physician represents that he/she is familiar with the requirements for medical licensure in Kentucky and now possesses the valid Kentucky license listed after his/her signature below or will be eligible for a Kentucky license at the end of his/her PGY-1 year." The physician will not be appointed as a resident beyond postgraduate level one without possession of a valid license to practice medicine in the Commonwealth of Kentucky."
2. Acceptance of any individuals above the PGY-1 level is contingent upon eligibility for licensure. It will be the responsibility of each Program Director to insure that individuals accepted are eligible for licensure. The Program Director should be aware of the current state licensure board requirements for all individuals. If there is any question in individual cases, the Graduate Medical Education Office will furnish assistance.
3. PGY-2's or above entering from other programs will not be permitted to begin training until proof of Kentucky licensure, (Institutional Practice, Residency Training, Fellowship Training, temporary, or regular) is furnished. Proof shall consist of confirmation of licensure number and a photocopy of the license. This requirement applies to all trainees entering above PGY-1 status, including residents, fellows, gratis or visiting residents, or international fellows.
4. For residents in U of L programs advancement from PGY-1 to PGY-2 level will not be permitted until licensure is actually attained. Again, it is incumbent upon each Program Director to make sure that PGY-1's who intend to continue as PGY-2's meet basic eligibility criteria.

5. The USMLE Step 3 exam is administered by the Federation of State Medical Boards (FSMB). Applications are available from FSMB (817-571-2949 phone or www.fsmb.org web site) or from individual Training Program offices.
6. Residents who successfully complete one year of training in an ACGME-accredited program are eligible for a training license, either the Institutional Permit (IP) or the Residency Training (RT) license.
7. The IP license requires passing USMLE Steps I and II, and restricts practice to the parameters of the residency program (no moonlighting).
8. The RT license requires passing USMLE Steps I, II, and III, permits moonlighting in locations approved by the Program Director, and permits the holder to obtain a DEA number. The RT license can be issued only with written approval of the Program Director. Both the IP and RT licenses are renewable annually for the duration of training, or if the resident is issued a regular license or leaves the program.
9. Residents who successfully complete two (2) years of training and pass USMLE Steps I, II, and III are eligible to apply for a regular license.
10. The Graduate Medical Education office will pay for the cost of the initial license only for current PG-1 residents who intend to remain at University of Louisville for the PG-2 year. PG-2's and above, who are entering from outside the University are responsible for initial licensure costs. Fees for annual renewal of licenses are paid by either the resident or the resident's program office.
11. Temporary Fellowship Training (FT) licensure is available to international physicians who enter the U.S. for up to one year of advanced training. The FT license limits the practice to the parameters of the training program and is non-renewable.
12. All physicians applying for medical licensure in Kentucky must provide documentation of having completed a 2-hour state-approved AIDS education course. This requirement is explained in detail in the application materials from the Licensure Board, and must be satisfied prior to approval for medical licensure. This requirement is applicable to all types of licenses: full, institutional, resident, or special fellowship licenses.

In addition, primary care physicians (Medicine, Pediatrics, Medicine-Pediatrics, Emergency Medicine, Family Practice and Obstetrics-Gynecology) must complete a 3-hour state approved course in Domestic Violence. This is a one-time requirement and must be completed within three years of initial licensure.

4.1.7 DEA NUMBER

It is imperative that residents with unrestricted Kentucky licenses apply for a DEA number (residents with institutional licenses are not eligible for a DEA). The residency program reimburses the resident for this expense, if the resident does not do any "moonlighting". *The residency program will not reimburse residents holding unrestricted licenses in states other than Kentucky for a DEA number.* Applications are available in the residency program office. The resident should state in

the application that licensure is pending and will be issued July 1 (or actual effective date). The approval process takes several months; the resident should expect delays.

4.2 UNIVERSITY BENEFITS

4.2.1 UNIVERSITY PERSONNEL

To receive University benefits, incoming residents **MUST** register with The University of Louisville Personnel Office. The House Staff Office mails all of the necessary paperwork to a new resident before House Staff Orientation. The University of Louisville Personnel Office is represented during House Staff Orientation (normally held during The last week of June). At this time, an original social security card must be presented, and one other form of identification (usually a driver's license).

4.2.2 SICK LEAVE/SHORT TERM DISABILITY SICK LEAVE POLICY FOR RESIDENTS

- 1. Sick leave shall be defined as any medical condition, which necessitates an absence from work, including complications of pregnancy up to time of delivery.**
- 2. All paid sick leave, beginning with the first day of leave, shall utilize unused Program Director's discretionary personal/educational leave (maximum 14 calendar days) and vacation days (maximum 28 calendar days).**
- 3. Residents on sick leave for more than seven consecutive calendar days must furnish a physician's statement to the Program Director that he/she cannot work for medical reasons. The resident may be requested to provide additional statements at any time during the leave and upon return should furnish a physician's statement that he/she is medically fit to resume residency training. The Program Director must inform the Associate Dean for Graduate Medical Education in writing of any medical leave of more than seven (7) calendar days. This notification must include an explanation and a completed "Request for Maternity Leave/Sick Leave" worksheet (available from the Graduate Medical Education Office).**
- 4. An additional period of paid sick leave for any prolonged injury or illness may be requested in writing by the Program Director and Department Chair and submitted for approval by the Associate Dean for Graduate Medical Education.**
- 5. After 90 calendar days total sick leave, leave of absence without pay will begin. The Resident Disability Program begins its coverage 90 calendar days from the date of initial disability. Residents who require more than 90 calendar days for sick leave should apply for disability coverage as soon as they become aware that they will need more than 90 days. Applications for resident disability coverage should be requested from the Graduate Medical Education Office. If disability is denied or the individual requests leave of absence without pay, the University is not responsible for reimbursement while in this status.**

6. **Should the Resident Sick Leave Policy be in conflict with the respective ACGME or Board requirements, the ACGME or Board requirements will take precedence. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. If residents are required to make-up time missed, that time must be covered by a Resident Agreement, with the resident being paid at the appropriate level.**

7. **Any modifications of duty assignment related to a medical condition or returning to duty after illness, will be at the discretion of the Program Director and Department Chairman.**

**YOUR RIGHTS UNDER THE
FAMILY & MEDICAL LEAVE ACT OF 1993**

Fmlar requires covered employers to provide up to 12 weeks of unpaid, job-protected leave To “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

REASONS FOR TAKING LEAVE: Unpaid leave must be granted for any of the following reasons:

- to care for the employee’s child after birth, or placement for adoption or foster care;
- to care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- a serious health condition that makes the employee unable to perform the employee’s job.

At the employee’s or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable”.
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION

- For the duration of FMAL leave, the employer must maintain the employee’s health coverage under any “group” health plan;
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms;
- The sue of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

UNLAWFUL ACTS BY EMPLOYERS: FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA

ENFORCEMENT:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring civil action against an employer for violations

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor

U.S. Department of Labor, Employment Standards Administration
Wage and Hour Division; Washington, D.C. 202210
WH Publication 1420
June, 1993

4.2.4 HEALTH INSURANCE

Single coverage is provided at no cost to residents, and family coverage is available at group rates. Several different plans at varying costs are available to choose from. Residents who elect family coverage may choose premium conversion which permits payment of premiums with pre-tax dollars.

4.2.5 TERM LIFE INSURANCE

Term life insurance is provided for all residents, in the amount of \$2000 of life insurance for every \$1000 of annual stipend. Accidental death and dismemberment coverage is also included.

4.2.6 UNIVERSITY OF LOUISVILLE ID CARDS

All residents registering with the University of Louisville Personnel Office will be issued a University of Louisville picture ID card. The resident must hold a valid ID to receive a parking permit, bookstore discounts, athletic discounts, library discounts, and other privileges.

4.2.7 UNIVERSITY PARKING PERMITS

University of Louisville parking permits are issued to all residents free of charge. These permits are valid for U of L parking lots on the HSC campus. In addition, the affiliated hospitals all provide free parking to residents when they are assigned to these hospitals

4.2.8 WORKER'S COMPENSATION

All residents are covered by worker's compensation for medical expenses and lost work time due to job-related illness or injury.

4.2.9 LIBRARY PRIVILEGES

Residents have library privileges at the medical school library and at all the affiliated hospitals. Available services include electronic literature searches and interlibrary loan service. Audiovisual equipment, as well as computers and computer software are made available to residents through the library. A valid ID card is required to use the facilities. The resident can also perform MedLine searches on their computer in the residents office.

4.2.10 UNIVERSITY DISCOUNTS

A valid University of Louisville ID will entitle house staff members and staff a variety of discounts. A complete list of vendors and services offered at University discount can be found at :
<http://php.louisville.edu/admin/humanr/staffdev/discounts/>

4.2.11 GROUPWISE ACCOUNTS

All residents will receive a Groupwise account. This is the University of Louisville's e-mail and access to the internet (including MedLine). Program Staff are on-line and can assist the resident.

4.2.12 RECREATIONAL FACILITIES

The Health Sciences Campus contains a fitness center which includes weight machines, free weights and 20 pieces of aerobic equipment. In addition, use of swimming pool and recreational facilities on Belknap Campus are available to residents through the Intramural and Recreational Sports Office, the Student Activities Center, and Crawford Gymnasium.

4.2.13 MISCELLANEOUS

Dental Care and Coverage

The Dental Clinic in the Ambulatory Care Building will provide annual examination, including cleaning and x-rays, to residents free of charge. Residents may also purchase, at group rates, dental insurance in both single and family plans

Maternity Leave

Maternity leave shall be defined as leave following the birth or adoption of a child. A request for Resident Maternity Leave/Sick Leave worksheet must be completed and signed by the Program Director and resident.

1. Maternity Leave may be paid, unpaid or a combination of paid and unpaid.
2. A resident may be paid during the maternity leave by utilizing any unused vacation days (up to 28 calendar days per contract year). Additionally, residency Program Directors may allow up to two additional weeks (14 calendar days) of paid leave per contract year (Program Director's Discretionary Time). By utilizing the entire annual vacation leave and being granted two weeks of discretionary time by the Program Director the resident can achieve a six-week (42 calendar days) paid maternity leave.
3. Maternity leave extending beyond the available vacation days and the Program Director's Discretionary Time (if granted) will be unpaid leave, in accordance with the Graduate Medical Student Leave Policy (p.5). Residents should check with UofL Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence, and make arrangements for continuity of health insurance benefit coverage.
4. Maternity leave may require additional training time to fulfill Board Certification Requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, the amount of time that must be made up. If residents are required to make up time missed, that time must be covered by a House Staff Agreement, with the resident being paid at the appropriate level.
5. Residents requiring additional leave due to complications of pregnancy or delivery should refer to the Sick Leave Policy (p.3). In cases of extended sick leave (90 days or greater) residents should contact the resident disability insurance carrier.
6. Should this policy be in conflict with the respective ACGME or Board requirements, those requirements will take precedence.

Paternity Leave

1. Paternity leave is available either from unused paid vacation leave and Program Director's discretionary personal/educational days, or as unpaid leave as outlined in the "Graduate Medical Student Leave Policy" (p.5).
2. All leaves of absence must be authorized and taken in accordance with established policies mentioned above and with individual program policies. Should these policies be in conflict with ACGME or Board requirements, the ACGME or Board requirements will take precedence

Flexible Spending Account

The university offers flexible spending account (FSA) options: health care and dependent care. A Health Care FSA is an alternate way of paying your share of your health care costs. In the same manner, a Dependent/Child Care FSA reimburses you for expenses for dependents and childcare which are necessary to allow you and your spouse to work. A concise explanation of FSA's is located at: www.louisville.edu/admin/humanr/currentemployee/benefits/125broc

An FSA is a benefit option designed to increase your disposable income by reducing the amount of taxes you pay. An FSA enables you to use pre-tax dollars to pay for qualified dependent care and health care expenses. These qualified expenses must be for service rendered AFTER the start date of your FSA and on or before the December 31 following your start date. The maximum annual contribution limit of the Health Care account is \$3,000 and \$5,000 for the Dependent/Child Care.

FSA's have a "spend-it-or-lose-it" provision. Any money deposited in FSA's and not used in the same calendar year is forfeited. You don't get back any unspent balances. However, your account for the plan year will remain open until the following March 31 to allow you to be reimbursed for expenses incurred in the plan year but not billed until after the year ended.

The university's flexible spending account (FSA) administrator is Chard, Snyder & Associates (Chard, Snyder). The Chard, Snyder website is located at: www.chard-snyder.com

Counseling Services

Confidential psychiatric consultation is provided at no charge to the resident. Residents desiring or in need of personal counseling, psychiatric consultation and/or treatment should contact the HSC Health Services Office, located on the 1st floor of the Ambulatory Care Building; phone 852-6446

Vacation (Annual Leave)

PGY-1.....3 weeks annually
PGY-2/above....4 weeks annually

At the discretion of the Program Director, an additional 2 weeks may be permitted for personal or educational leave. In addition, Program Directors may grant one additional week vacation to PG-1's.

Lab Coats and Name Tags

Lab coats and name tags are provided by departments for residents at the beginning of their training.

Physician Placement Service

The University of Louisville Physician Placement Service Office provides assistance to residents and others seeking practice opportunities in Kentucky. This is a free service to residents.

Athletic Tickets

Residents are eligible for the purchase of student athletic tickets, which are offered at reduced rates to students through the Athletics Department.

Medical and Personal Leave

Paid medical leave up to 60 days is available in cases of personal illness or pregnancy. Residents are covered under the Graduate Medical Student Leave Policy, which provides up to 12 weeks unpaid leave for personal or family illness. Personal leave is available at

Other Benefits

Most departments provide additional benefits to their residents, such as textbooks, professional dues, or funds for travel to educational meetings.

4.3 MEDICAL RECORDS

1. A resident who is identified as having incomplete medical records (any record greater than 15 days past hospital discharge) by any of the Record Departments of the affiliated hospitals will be notified by the respective Medical Records department and given 15 days to complete the records in question. At that time, the resident will also be notified that if he/she does not complete the medical records within 15 days that he/she will be recommended to be placed on probation.
2. If at the end of the 15-day period the records (now a "delinquent" record over 30 days post discharge) have not been completed, the Director of Medical Records will notify the Associate Dean for Graduate Medical Education, who will recommend to the Dean that the resident be placed on probation. The resident will be notified in writing by the Dean of the probationary status.
3. Once placed on probation, the resident will be given 15 additional days to complete all additional records at all affiliated hospitals and notified that if records are not completed at the end of 15 days, the resident will then be recommended to be suspended.

4. The Medical Records Department of the appropriate hospitals will notify the Vice Dean for Clinical Affairs if the medical records in question have not been completed at the end of 15 days probationary period. The Vice Dean in turn will recommend to the Dean that the individual be suspended. The Dean will notify the individual resident of the suspension in writing. The Dean will notify the resident's Program Director and the Chairman of the Department.
5. Suspension will include the following conditions:
 - A. Resident will be relieved of all clinical duties.
 - B. The resident will receive no credit for training while in suspended status.
 - C. The resident will receive no pay while in suspended status.
 - D. The suspension will continue until all delinquent medical records are completed.
6. If at the end of 30 days suspension period the resident has failed to comply, a recommendation will be made to the Dean from the Associate Dean that the resident be terminated/dismissed from the training program.
7. All available medical records should be completed prior to a resident departing for a vacation, leave of absence, or any out-of-town or out-of-state rotation since the above probation, suspension, and dismissal process will apply in these cases.
8. Prior to a resident departing from a program and receiving any credit or certification for the period of training, all medical records must be completed at all affiliated hospitals.

4/00

4.4 MISCELLANEOUS UNIVERSITY POLICIES

4.4.1 DRUG FREE SCHOOLS NOTICE

As required by the Federal Drug-Free Schools and Communities Act Amendments of 1989, you are hereby notified by the University of Louisville (University) that on University premises or at University-sponsored activities the following acts are prohibited:

(i) distribution, possession, or use of any illegal drug or controlled substance without legal authorization;

(ii) providing alcoholic beverages to individuals under 21 years of age, or possession of alcoholic beverages by individuals under 21 years of age; or

(iii) illegal possession of an open container of an alcoholic beverage, public intoxication, driving while intoxicated, and drinking alcoholic beverages in an unlicensed public place.

In addition to imposition of disciplinary sanctions under University procedures including suspension or separation from the University for such acts, students or employees may face prosecution and imprisonment under Federal and Kentucky laws which make such acts felony and misdemeanor crimes.

The Code of Student Conduct lists details of offenses and disciplines for students. Staff may be disciplined under Section 11.1 of the Staff Handbook. Faculty may be disciplined by Deans per Redbook Sections 4.5.3 or 3.2.2 with review per 4.4 for sanctions less than dismissal or suspension for one year. The health risks associated with the misuse and abuse of mind-altering drugs, including controlled substances and alcohol, include but are not limited to: physical and psychological dependence; damage to the brain, pancreas, kidneys and lungs; high blood pressure, heart attacks, and strokes; ulcers; birth defects; a diminished immune system, and, death. See Appendix B for further listing of health affects.

The Counseling Center and Student Health Services provide assessment and referral services to University students, as well as an alcohol and other drug information/education resources. For further information, call 852-6585. Service for faculty and staff are available through the Faculty/Staff Assistance Program. For further information call 852-6543.

Physicians who require assistance may call the Kentucky Physician Health Foundation at 425-7761.

4.4.2 POLICY ON RESIDENT RECRUITMENT

The sponsored resident training program of the University of Louisville School of Medicine exist for the purpose of training the highest quality physician possible in each program's respective discipline. The following is the official policy for the selection of candidates for training. This policy is consistent with the Accreditation Council on Graduate Medical Education (ACGME) Institutional Requirements and the Commonwealth of Kentucky Medical and Osteopathic Practice Act Regulations and Statutes. Program Directors and coordinators should also be familiar with the "Medical Licensure Policy for House Staff" published in the House Staff Policies and Procedures manual. Program Directors and Coordinators are strongly encouraged' to call the Office of Graduate Medical Education if questions, problems or uncertainties arise.

1. Resident Eligibility

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs at the University of Louisville School of Medicine:

- a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME)
- b. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).
- c. Graduates of medical schools outside the United States and Canada who have current, valid certificates from the Educational Commission For Foreign Medical Graduates (ECFMG).
- d. Graduates from accredited dental schools who are enrolled in oral-maxillofacial surgery and general practice dentistry (GPR) programs. These programs are accredited by the Council on Dental Accreditation of the American Dental Association but are under the general auspices of the University of Louisville School of Medicine Graduate Medical Education Programs. Candidates must Obtain dental licensure through the Kentucky Board of Dentistry.

2. Resident Selection

- a. Programs should select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to

Communicate should be considered in the selection. Personal interviews prior to Selection are strongly encouraged.

- b. In selecting from among qualified applicants for first year positions, sponsored programs must participate in the National Resident Matching Program (NRMP) when it is available.
- c. In selecting from among eligible applicants for positions other than the first-year positions, programs should select the most qualified candidate as listed in 2.a above. Appointment of PGY2 (and above) positions is contingent upon candidate being issued a Kentucky medical license prior to beginning of training year.

All resident selection must be made without unlawful discrimination in terms of age, color, disabled status, national origin, race, religion or sex, in keeping with University of Louisville standards as an Affirmative Action/Equal Opportunity employer.

The enrollment of noneligible residents may be cause for withdrawal of accreditation of the involved program and/or the Institution.

4.4.3 POLICY ON RESIDENT SUPERVISION

Individual residency training programs are responsible for establishing written guidelines for resident training and supervision, which are consistent with the program's Residency Review Committee (RRC) requirements. The Office of Graduate Medical Education of the University of Louisville, School of Medicine is, in turn, required by the Accreditation Council of Graduate Medical Education (ACGME) to ensure that the individual training program's policy, and practice, are in compliance with both the RRC and ACGME requirements. Failure to adhere to these requirements may result in loss of accreditation of the training program and/or institution. General guidelines for resident supervision are listed below:

1. It is the responsibility of the program directors and coordinators of resident training programs to know, and to adhere to, the training program's specific RRC requirements for resident supervision.
2. Residents must be appropriately supervised by teaching staff at all times and in such a way that the individual resident is allowed to assume progressively increasing responsibilities according to their level of education, ability, and experience. However, at no time should the resident not have access to a supervisory attending. The teaching staff of the respective program is responsible for determining the level of responsibility accorded each resident.
3. Residency programs are responsible for creating a periodic call schedule, which clearly identifies the primary on-call resident and the appropriate chain of supervision, including the name of the supervisory attending physician. The schedule should contain pertinent information (telephone number, beeper number, etc.) necessary to quickly and efficiently contact the embers in the chain of command. Copies of the call schedule should be available to the residents and the key personnel at the training sites (clinics, hospital operators, etc.). It is the responsibility of the residency program to keep the call schedule current and accurate.
4. Residents should be informed that if they are at anytime concerned about the availability or level of supervision, the should contact their residency program

director, the departmental chairperson, or the office of Graduate Medical Education of the University of Louisville School of Medicine.

5. Compliance with the RRC's requirements for resident supervision must be attested to in the periodic internal review. (See Policy on Internal Review of Residency Programs). In addition, all programs must submit a copy of their written policy on Resident Supervision to the Office of Graduate Education. The office of GME must receive copies of any changes to this document.

4.4.4 POLICY ON STRESS AND FATIGUE

Stress and fatigue is inherent in physician training. Fatigue and its role in medical errors are regarded as a challenge to providing quality medical training and care. As such, prevention of fatigue, its recognition, and the early recognition of professional and personal stress reactions are regarded as critical to the safe and effective practice of orthopaedic surgery. Faculty and residents must be educated to recognize the signs of fatigue and adopt & apply policies to prevent and counteract their negative effects.

Strategies to Prevent Fatigue and Alleviate Stress

- 1. Work hour limitations – The 80 hour work week will be strictly adhered to.**
- 2. Moonlighting will be monitored to ensure that residents are not adversely affected by any moonlighting activities. The Department reserves the right to deny the right to moonlight to any resident showing signs of stress, fatigue, poor work performance, or signs that moonlighting in any way disrupts or interferes with his/her educational experience.**
- 3. Didactic education on the signs and symptoms of substance abuse is provided**
- 4. Didactic education on the related topics of the effective regulation of wakefulness; the neurocognitive performance consequences of a disrupted circadian timing system, a disrupted sleep-wake homeostasis with sleep debt; and sleep inertia will be provided. Fatigue management strategies and countermeasures are included. Workplace harassment policies and procedures are reviewed.**
- 5. Orthopaedic surgery faculty promotes the culture of healthy lifestyle strategy and shared responsibility.**
- 6. Department of Orthopaedic Surgery will facilitate residents access to appropriate, confidential counseling, medical and psychological support services.**
- 7. Recognize basic signs of fatigue and/or stress:
Physiological vs. subjective sleepiness
Falling asleep in conferences or rounds**

Feeling restless and irritable with staff, colleagues, family, friends
Having to check work repeatedly
Having difficulty focusing on care of patients
Feeling like you just don't care

8. If a resident has had a busy night on call or illness or other condition and feels that he/she is suffering from fatigue and/or sleep deprivation, he/she must contact his/her head of the rotation (rotation leader) and either Dr. Craig Roberts (Program Director) or Dr. John Johnson (Chairman) to arrange release from clinical responsibilities and to facilitate back-up resident coverage. A back-up plan will then be initiated.

Monitoring Strategies:

1. Program Director will review planned work schedules and moonlighting schedules to assure duty hour requirements are met and circadian scheduling principles are demonstrated.
2. Residents have a responsibility to communicate off-service rotation schedules believed to be out of compliance with the ACGME eight-hour workweek over four weeks on average
3. Faculty or Resident direct observation of the signs and symptoms of fatigue, stress, substance abuse, or mental health disorder are discussed and confidentially addressed individually by the Program Director.
4. Direct resident feedback regarding resident stressors is sought via monthly evaluations of rotations, at the semi-performance review, and review of the program's ACGME resident survey results. The Program Director, Dr. Roberts, will refer/cooperate with resident involvement in the Kentucky Physician Health Foundation, the Counseling Center, University Hospital's Physician Health Committee and other health services as needed.

4.4.5 POLICY ON RESIDENT DUTY HOURS

The educational goals of residency training programs and the learning objectives of residents must not be compromised by excessive clinical service obligations. The Accreditation Council on Graduate Medical Education (ACGME) has charged sponsoring institutions, in this case the University of Louisville School of Medicine, with ensuring that formal written policies governing resident duty hours be established at both the institutional and program level.

1. Each sponsored training program at the U of L School of Medicine must have a formal, written policy on resident duty hours. The written policy must be provided to all residents and faculty. The policy must foster resident education, facilitate patient care, and be consistent with the current published institutional and program requirements of the specialties and subspecialties that apply to each program. The policy must cover all institutions to which residents rotate. In the event an individual RRC publishes standards which differ from those stated in this policy, the program should follow its published RRC standards.

- 2. Resident duty hours must not exceed 80 hours per week averaged over four weeks. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.**
- 3. Residents should be given 10 hours off for rest and personal activities between duty periods and after call.**
- 4. In-house call must occur no more frequently than every third night, averaged over a four-week period.**
- 5. Resident assignments must not exceed 24 hours maximum continuous on-site duty with up to 6 additional hours permitted for patient transfer and other activities defined in RRC requirements. There must be no new patients assigned after 24 hours of continuous duty.**
- 6. Resident time spent in the hospital during at-home call must be counted toward the 80 hours. At-home call, defined as call taken from outside the assigned institution by pager or phone, is not subject to the every 3rd night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for residents.**
- 7. Program Directors must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Programs must implement mechanisms to monitor resident moonlighting to ensure compliance with both program and institutional policies. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.**
- 8. All residents, including those assigned at-home call, must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.**
- 9. Duty hours must be monitored by the program. Programs must have a process to monitor resident duty hours by rotation. Institutional mechanisms for monitoring duty hours will include the internal review process and quarterly time studies completed by the residents.**
- 10. Program Directors must develop and implement policies to prevent and counteract effects of resident fatigue.**
- 11. Programs must ensure that residents are provided appropriate back-up support when patient care responsibilities are particularly difficult or prolonged.**
- 12. Residents must at all times have appropriate support and supervision in accordance with current published ACGME institutional and program requirements and with the School of Medicine GME Policy on Resident Supervision.**

13. Resident moonlighting must be approved in advance and monitored by the program director.

14. The Graduate Medical Education Committee is responsible for establishing procedures for reviewing requests for exceptions to the weekly duty hours limits of up to 10 percent or a maximum of 88 hours. Requests must be justified on educational grounds and must be approved by the GMEC before consideration by the appropriate Residency Review Committee.

4.4.6. MOONLIGHTING

1. Programs must not require residents to participate in outside employment
2. Resident physicians who hold either a Regular or a Residency Training (RT) license in Kentucky shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities, so long as the resident obtains the prior written approval of the Department Chair or Program Director for such outside employment activities, and so long as such activities do not interfere with the resident's obligations to the University, impair the effectiveness of the educational program engaged in, or cause detriment to the service and reputation of the hospital to which the resident is assigned.
3. Each program must develop a moonlighting policy that is consistent with the Resident Moonlighting Policy of the University of Louisville. The policy must give guidelines for outside employment activities of residents, including defining the hours and rotations when such outside employment activities may be permitted, and under what circumstances permission may be denied for outside employment activities. Residents are required to comply with individual program policies.
4. The University does not provide professional liability insurance or any other insurance or coverage for resident off-duty activities or employment, and assumes no liability or responsibility for such activities or employment. Confirmation of professional liability insurance for resident off-duty activities or employment will be the responsibility of the moonlighting employer.
5. Residents who wish to moonlight must hold either a Regular or Residency Training license in Kentucky. Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the University training program for which these licenses are issued, and do not cover outside employment activities. Resident Training (RT) licenses permit moonlighting only in locations authorized and approved by the resident's Program Director.
6. Resident physicians who hold J-1 or H-1B visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019 (J-1 holders) or I-797C (H-1B holders). Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas. Employment of H-1B holders is limited to the petitioner (employer) and activities listed on the I-797C.
7. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Resident Agreement.

8. **Programs are required to monitor and approve all moonlighting hours and locations for residents.**
9. **Programs are encouraged to monitor all individual resident moonlighting hours each month to assure outside activity does not contribute to excess fatigue or detrimental educational performance.**

Approved by GMEC: 4/17/2000

Revised: 2/21/01 Revision approved by GMEC: 3/21/01 Revised: 4/29/03

Revision approved by GMEC: 5/21/03

5.0 DEPARTMENTAL RESIDENCY PROGRAM POLICIES AND BENEFITS

5.1 PROMOTION CRITERIA.

PGY1 Interns will be promoted to the second level of orthopaedic training based upon successful completion of the intern's transitional year in general surgery. The PGY1 transitional year will be designed by the Dept. of Orthopaedics in cooperation with the Dept. of Surgery to ensure that the intern year will comply with the requirements of the ACGME.

PGY2's, 3's, 4's will be considered for promotion to the next level of training pursuant to the following guidelines:

1. The resident must satisfactorily complete four "block" rotations (4 blocks = 12 month long rotation)
2. Attendance rate of 75% at approved educational activities
3. Acceptable results on the resident's orthopaedic in-training examination
4. Maintenance of operative logsheets and duty hour sheets
5. Acceptable work as determined by the Department of Orthopaedic Surgery and review of faculty evaluations for the year.
6. Proper documentation from ECFMG for foreign medical school graduates
7. The resident must possess a valid Kentucky medical license

A resident will not be promoted to the next level if any of the following is in evidence:

1. Performance on any of the block rotations is deemed unsatisfactory*
2. Failure to meet the required conference attendance or to pass required examinations.
3. Failure to obtain a valid license to practice medicine in the State of Kentucky
4. Unacceptable care rendered to patients of the Orthopaedic Surgery Department
5. Failure to submit documentation of operative procedures

**those rotations in which performance was deemed unsatisfactory must be successfully repeated with a satisfactory performance.*

Residents who fail to meet the promotion criteria will be placed on probation and kept at the present PGY level until skills are commensurate with those expected of Residents at each level. Failure at the end of the probationary period will be grounds for dismissal or a continuation of probationary status.

For PGY5 residents to receive Departmental recommendation for the American Board of Orthopaedic Surgeons Certification Examination:

- a) The resident must fulfill the requirements set forth in the ACGME "Essentials of Accredited Residencies", (General), and the "Special Requirements for Residency Training in Orthopaedic Surgery" as well as the "Minimal Educational Requirements for Board Certification" by the American Board of Orthopaedic Surgeons
- b) Satisfactory completion of block rotations. Unsatisfactory evaluations may cause an extension beyond 60 months to successfully complete all block rotations.
- c) Satisfactory completion of the longitudinal experience which will include:
 1. acceptable work determined by the Orthopaedic Surgery faculty in applicable offices
 2. acceptable attendance hours at Orthopaedic Surgery core conferences and departmental Grand Rounds

3. fulfillment of research requirements
4. acceptable performance on the orthopaedic in-training examinations
5. documentation of operative procedures and completion of logsheets. Compliance with resident duty hour regulations.

Those PGY5's who fail to meet the above criteria may have their residency extended in order to meet the requirements to sit for the certification examination of the American Board of Orthopaedic surgery. PLEASE NOTE: a resident may complete all requirements for the residency program and yet fail to gain the Department's recommendation to sit for the Certification Examination. No residents shall be denied this recommendation without being placed on probation and given written notice that eligibility to sit for the certification examination is in jeopardy.

5.1.1 Policy on Compliance with Teaching Physician Regulations

1. The Health Care Financing Administration's (HCFA) Medicare's Final Rule for Teaching Physicians was effective July 1, 1996.. This rule outlines the documentation criteria for physicians (including residents) in teaching institutions.
2. Representatives of HCFA indicate that audit and enforcement activities will continue relative to teaching institutions. Failure to comply with the applicable rules can lead to serious civil penalties, criminal prosecution and decertification of a provider. It is our sincere desire that neither any UofL Physician nor the University suffer the possible serious consequences that could result from either not understanding or not following the rules.
3. Accordingly, the UofL School of Medicine is seeking to be pro-active in implementing these new rules by providing faculty, residents and staff educational sessions and reference materials. It is mandatory that all residents attend a session on documentation since compliance involves efforts by you and the School of Medicine. Training is provided by the School of Medicine Office of Compliance.
4. Residents are required to attend and complete an educational session on the HCFA Teaching Physician Regulations within 30 days of hire. Failure to Comply with this requirement within 30 days of hire will result in the resident being placed on academic probation for fifteen days by the Dean of the School of Medicine. If, after fifteen days of academic probation the resident still has not completed the required training, the resident will be suspended from his/her training program. Suspension will include cessation of clinical training duties and removal from payroll status. If the training has not been completed after 15 days of suspension, the resident's contract will be terminated.
5. Compliance training will be an annual requirement for all residents. Failure to comply with this annual requirement within 30 days of notification to schedule such training will result in the sanctions as noted in #4.

5.2 ACADEMIC WARNING, PROBATION, DISMISSAL AND APPEALS

5.2.1 UNSATISFACTORY EVALUATION

If a resident receives an adverse evaluation from outside the Department of Orthopaedic Surgery, the Program Director will discuss the evaluation with the outside rotation and the resident in question. This information will be presented at the Department of Orthopaedic Surgery monthly Business Meeting for a recommendation of action. The

faculty may take any one of the following actions:

1. The issue may be decided in favor of the resident.
2. The resident may be advised that an unfavorable evaluation will be included in his/her personnel file;
3. The resident training for that rotation may be extended and/or repeated;
4. The resident may receive a written reprimand to be included in his/her personnel file;
5. The resident may be placed on probation;
6. The resident may face dismissal from the program.

The Residency Director may recommend that the resident be placed on academic warning. The resident has the ability to appeal the decision by the process outlined in section 5.2.5 below.

5.2.2 Remediation

A resident is allowed to use elective time to remediate deficiencies noted during the course of the core curricular rotations, as long as no more than 50% of the elective time is used for remediation. When more than 50% of the elective time would be used for remediation the residency will be extended beyond the usual 60 months.

5.2.3 Department Academic Warning

A resident whose performance is below standard may be given an “academic warning”. This time frame may be up to three (3) months at the discretion of the faculty. At the time the academic warning is issued, (a) faculty member(s) will meet with the resident to discuss the resident’s weaknesses. The resident will be given in writing a list of the perceived problems. This document will contain a list of actions to be taken by the Department to help correct these weaknesses or problems. It will also clearly define how the resident will be evaluated at the end of the warning period. The options available to the Department and resident at the end of the warning period will be given to the resident in writing. Failure to fulfill the requirements of the academic warning period may be grounds for the issuance of University probationary status. The resident has a right to appeal the issuance of warning status, by submitting a written request to the Program Director.

5.2.4 Academic Probation and Due Process Policy for Residents

Residents in University of Louisville School of Medicine residency programs are classified as students (see item #7 in the House Staff Agreement) and as such, are covered by the Student Academic Grievance Policy and Procedures outlined in the *RedBook* Chapter 6, Articles 6.6 through 6.8.14. (The *RedBook* is available on line at www.louisville.edu/provost) Articles 6.6.3 grants each academic unit the responsibility and authority to make decisions in accordance with standards determined by the unit. Academic units are also responsible for seeing that the standards determined are in Compliance with their respective RRC and Board requirements.

The procedure to be followed when academic probation is recommended by a unit is:

1. Program Director (or Residency Evaluation Committee) makes recommendation to the Department Chairman.
2. Department Chairman makes written recommendation to the Dean (copy to the Associate Dean for Graduate Medical Education). The written recommendation should include the reasons for the recommendation, the length of the recommended probation (usually three months, at the discretion of the Residency Director), and the expected resolutions to the problems.
3. The Dean reviews the recommendation and informs the resident of the

- problems.
4. At the end of the probationary period, the Department Chairman informs the Dean (copy to the Associate Dean for Graduate Medical Education) in writing of the resident's progress, advising the Dean if the problem is resolved, if an additional period of probation is necessary, or if dismissal is recommended. The Dean takes the appropriate action.

At the time the probationary status is issued, faculty members will meet with the resident to discuss the resident's weaknesses. The resident will be given in writing a list of the perceived weaknesses. This document will also be placed in the resident's files. It will contain a list of actions to be taken by the Department to help correct these weaknesses or problems. It will also define how the resident will be evaluated at the end of the probationary period. The options available to the Department and the resident at the end of the probationary period will be given to the resident in writing. Failure to fulfill the requirements of the academic probationary period may be grounds for dismissal from the residency program. The resident has the right to appeal being placed on academic probation. The Student Academic Grievance Procedure provides residents a fair means of dealing with actions or decisions which the resident may feel to be unfair or unjust. The School of Medicine Student Academic Grievance Committee includes resident representatives.

5.2.5 DISMISSAL.

Grounds for immediate dismissal of a resident from the residency program include the Following:

- 1) criminal activity (suspension may occur pending the outcome of due process)
- 2) unethical behavior
- 3) impairment due to substance abuse (suspension may occur while the resident undergoes treatment)
- 4) contract violations

Dismissal may also occur because of unsatisfactory performance at the end of a Probationary period outlined above. The resident has a right to appeal dismissal.

5.2.6 GRIEVANCE PROCEDURES FOR RESIDENTS

To pursue a grievance concerning academic matters within the academic unit, the following steps of the grievance procedure should be observed:

1. The resident should first discuss the matter with the person involved and attempt to resolve the grievance through informal discussion.
2. If there is no resolution, the resident should discuss the matter with that person's supervisor or the person to whom such person reports, who should attempt to mediate a resolution.
3. If the resident still has not been able to obtain a resolution, he or she may request the Student Grievance Officer (S.G.O.) (Joseph Steffen, 852-7209) to attempt informal mediation of the problem.

Grievance Procedures

4. If the matter has not been satisfactorily resolved through the informal process, the resident shall submit a written statement of the grievance to the School of Medicine Grievance Committee through the Office of the Dean. The statement shall contain:
 - (1) A brief narrative of the condition giving rise to the grievance;
 - (2) A designation of parties involved; and

(3) A statement of the remedy requested.

5.2.7 PROCEDURE FOR LEAVING THE PROGRAM

Residents may leave the program by resignation, termination, non-renewal of contract or upon graduation. If a resident feels it is necessary to leave before completing the five years of training, the resident should request a meeting with the Program Director to discuss their departure and the rationale for such. At that time, if the resident still feels it is necessary to leave, the resident should submit to the Program Director a written resignation at least 30 days prior to departure. Beyond the moral obligation of honoring a written contract, courtesy to the program and the resident's peers would dictate at least 30 days advance notice to accommodate for coverage of the resident's previously assigned duties.

When a resident leaves the program, he/she should return all departmental office keys, return beeper and educational materials that may have been borrowed from the program. A Payroll Action Form (PAF) will be completed to end the status with the University. The ABOS will be notified of the separation from the program. An exit interview will be conducted with the Chairman of the Department.

5.2.8 GRADUATE MEDICAL EDUCATION POLICY ON RESIDENCY CLOSURE/REDUCTION

1. In the event that a training program must be closed or reduce the number of positions in the program, the School of Medicine (institution) must notify the residents enrolled in the program as soon as possible.
2. In the event the program closure or reduction of positions for reasons other than loss of accreditation, residents already in the program will be permitted to complete their training, or may elect to transfer to another program. Residents who wish to transfer will be assisted by the institution in enrolling in other programs.
3. In the event accreditation is withdrawn from a training program, residents will be permitted to continue in the program until the effective date of the withdrawal of accreditation. The institution will assist residents in enrolling in other ACGME-accredited programs in order to continue their training.
4. This policy applies to all graduate medical education training programs sponsored by the institution.

5.2.9 DEPARTMENT POLICY ON MOONLIGHTING

MOONLIGHTING

1. The Department of Orthopaedic Surgery does not require residents to moonlight.
2. All moonlighting activities must be declared and cleared in advance of any moonlighting with Dr. Johnson and Dr. Craig Roberts. The Department of Orthopaedic Surgery reserves the right to not permit moonlighting when such activities are adversely affecting the resident's education performance. Residents who wish to moonlight must hold either a Regular or Residency training license in Kentucky. Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the University training program for which these licenses are issued, and do not cover outside

employment activities. Resident Training (RT) licenses permit moonlighting only in locations authorized and approved by the resident's Program Director.

3. Moonlighting activities are monitored very closely. Moonlighting days are routinely reported by the resident at their semi-annual evaluations by the Program and Residency Director.
4. Residents are encouraged to not let any moonlighting cause their work week to exceed 80 hours per week.
5. Residents are allowed a maximum of two moonlighting sessions each month, only one that may involve a weekday overnight on call.
6. Moonlighting activity must not in any way interfere with scheduled and required activities of the Residency program.
7. The Department does not provide malpractice insurance coverage for moonlighting activities.
8. Resident physicians who hold J-1 or H-1B visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019 (J-1 holders) or I-797C (H-1B holders). Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas. Employment of H-1B holders is limited to the petitioner (employer) and activities listed on the I-797C.
9. Residents are not to represent themselves to moonlighting employers as being fully trained in their specialty. Further, residents who moonlight are not to present themselves as agents of the University of Louisville during moonlighting activities. University lab coats, name badges, and identification cards are not to be worn outside of the resident's training program activities. It is the resident's responsibility to assure the billing procedures of the moonlighting employer are conducted in an ethical and legal manner.
10. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Agreement.

5.2.10 DEPARTMENT POLICY ON RESIDENT DUTY HOURS

The educational goals of residency training programs and the learning objectives of residents must not be compromised by excessive clinical service obligations.

1. This is the formal written policy of the Department of Orthopaedic Surgery governing resident duty hours established at both the institutional and program level. This policy covers all institutions to which residents rotate.
2. Resident duty hours must not exceed 80 hours per week averaged over a four week period. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to

patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.

3. Residents will be given 10 hours off for rest and personal activities between duty periods and after call.
4. In-house call must occur no more frequently than every third night, averaged over a four week period.
5. Resident assignments will not exceed 24 hours maximum continuous on-site duty with up to 6 additional hours permitted for patient transfer and other activities defined in RRC requirements. There must be no new patient assigned after 24 hours of continuous duty.
6. Resident time spent in the hospital during at-home call must be counted toward the 80 hours. At-home call, defined as call taken from outside the assigned institution by pager or phone, is not subject to the every 3rd night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for residents.
7. Every resident post-call will be paged by a staff member in the Department of Orthopaedics. He/she will be asked specifically, how many hours they have been on-call and how many consecutive hours they have been on duty. Any resident found to have worked 24 hours or in danger of violating the 24 rule, he/she will be sent home. If a resident has not had 1 day off in seven, that resident will be sent home.

In the course of monitoring the resident duty activity, if we find that a resident has “shaved” his/her hours, they will receive a written letter of reprimand and a copy placed in the resident’s file.

8. D. John Johnson, Chair of the Dept. of Orthopaedic Surgery, and Dr. Craig Roberts, Residency Director, will ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Residents are required to report any moonlighting they are involved with at the beginning of each rotation. Resident performance will be monitored. If it is deemed by either Dr. Johnson or Dr. Roberts that the moonlighting activity is interfering in any way with the educational objectives or the clinical responsibilities of the resident, the resident will be required to discontinue the moonlighting activity. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor’s primary clinic site (s) i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.
9. All residents, including those assigned at-home call, will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. One day is defined as one continuous 24 hour period free from all clinical, educational, and administrative activities.
10. Duty hours will be monitored by the program. Weekly time studies will be conducted and residents will be required to document actual hours worked on the on-line system, New Innovations, implemented by the Graduate Medical Education Office.

11. Attending faculty are required to monitor and prevent or counteract effects of resident fatigue.
12. Residents will have appropriate back-up support when patient care responsibilities are particularly difficult or prolonged.
13. Residents will at all times have appropriate support and supervision in accordance with current published ACGME institutional and program requirements and with the School of Medicine GME Policy on Resident Supervision.
14. Resident moonlighting must be approved in advance and monitored by the program administration.
15. Duty hours and case logs will be reviewed each month at the departmental business meeting.

5.3 LEAVE TIME

5.3.1 DEFINITIONS

For purposes of call and leave:

DAY = 24 hour period (begins 7:00 a.m. one day to 7:00 a.m. the next day)

WEEK = 7:00 a.m. Sunday to following Sunday 7:00 a.m.

MONTH = 7:00 a.m. on the 1st of month to 7:00 a.m. on the 1st day of the next month as Defined by the University "Universal Change of Service" schedule per year.

The American Board of Orthopaedic Surgeons allows 42 days maximum leave per year Including: vacation, sick leave, and educational leave. If the resident is away from the Program for more than 42 days in any year then the resident must discuss possible Extension of the residency with the Residency Director.

Residents are required to call the Residency Coordinator's Office during illness. The Program Office will notify the medical office and the rotation of the resident's illness. As a rule, each level is expected to cover illness occurring within their ranks; however, It is hoped other house staff will demonstrate mutual concern for their colleagues by helping out, especially in exceptional cases (not excluding Chief Residents). The Chief Resident will attempt to arbitrate what is equitable to all concerned. If an illness is serious, prolonged, or requires hospitalization, the Chief Resident will arrange for other House Officers to substitute. (See section 4.4 for further discussion of sick leave and section 4.5 for disability benefits).

5.3.2 VACATIONS/HOLIDAYS

All Orthopaedic residents shall be entitled to 1 week of vacation per rotation.

Vacations do not accrue from one year to another. Vacations usually occur during a calendar week (e.g.; 9 days – Saturday through Sunday inclusive). Weekends are counted as days of leave. A PGY2, 3 or 4 resident may take 2 weeks vacation concurrently only between rotations(e.g.; last week of one rotation and first week of the next). A PGY5 resident may not take vacation during his Chief Resident's Trauma Service rotation. He/She may, therefore, take an extra week's vacation during any of the other three rotations during the PGY5 year. PGY5 Residents rotating with the Hand Service are entitled to an elective month of rotation. The PGY5 vacation must occur during the resident's elective month of rotation.

A PGY3 or PGY4 resident who elects to attend a meeting, course or conference of any kind during his/her trauma rotation may attend but must forego any vacation for that rotation.

Vacation requests must be submitted no later than the 15th of the month prior to beginning the rotation on which the vacation is to be used. Whenever possible, schedulers try to accommodate a week's vacation by not placing the resident on call the night before a vacation starts and the night after a vacation ends. Please be aware that this is done as a courtesy only. It is not a requirement and the rotation is under no obligation to change their schedule for your.

If the request for vacation has not been received before the 15th of the month prior to beginning the rotation in question, then the availability of the vacation will be up to the attending who controls the rotation. If we are unable to make suitable accommodations, this may lead to that vacation being forfeited by the resident who was unable to submit the request on time. Saving vacation time till the end of the year does not guarantee that a resident will be able to take vacation at that time. In the event that a requested vacation time creates disruption in the service, more than one resident has requested the same time span for vacation, or presents other conflicts with training quality, the final decision will be made by the Residency Director, Dr. Craig Roberts. The residents have the right to appeal any decision to the Program Director and Chair, Dr. John Johnson.

5.3.3 Educational Leave

The Department, through Fischer Owen, will fund two (2) courses/conferences per residency and one (1) review course. The Department Education Committee determined that the two courses recommended for resident attendance, the OTA trauma course for PGY2s and the Boston Pathology course for PGY3s would remain the same. In the resident's PGY4 or PGY5 year of training, the department will fund one additional course. The resident may elect to not attend a course and ask the department to fund his/her attendance at the American Academy of Orthopaedic Surgeons annual meeting.

Residents who attend courses or conferences funded by pharmaceutical or equipment manufacturers must use their vacation time. Reimbursement for expenses will be limited to the amount of grant provided by the pharmaceutical or equipment manufacturers. Attendance by residents at courses/conferences funded by outside entities will have to meet strict criteria.

1. Educational value
2. Resident conference attendance
3. Academic status
4. Compliance with duty hour and log sheet requirements
5. Resident absence must not cause undue hardship on any rotation
6. Course must be approved by Program Director
7. Resident must use vacation time to attend courses sponsored by pharmaceutical and/or manufacturer's representatives.

Requests for travel compensation must be submitted 30 days prior to the meeting . All requests for travel funds must be approved by the faculty at the departmental business meeting. Residents will have to pay out of pocket for all expenses and submit receipts for reimbursement. Note that per diem is \$40.00 per day, but all receipts must be submitted for reimbursement, including meals.

Educational leave includes conferences that have been approved by the Resident Travel Committee. Only residents in good standing are eligible for educational leave. Good standing is defined as 1) not on probation, 2) having acceptable attendance at Core conferences during the previous postgraduate training year (75%), 3) logsheets, duty hours, and medical records are current. Residents must make sure that any

administrative responsibilities are covered while he/she is gone (e.g.; conference attendance sheets, etc.)

Residents must seek approval to attend conferences/seminars in writing at least six weeks in advance. This must be submitted to the Residency Director and the Chairman for signature with a copy of the conference announcement.

NOTE: NO TRAVEL FORM SHOULD BE SUBMITTED TO THE STAFF OF THE ORTHOPAEDIC DEPARTMENT IF THE RESIDENT HAS NOT CONSULTED WITH HIS/HER ATTENDING BEFOREHAND. IF THERE IS EVER A CONFLICT ARISING BECAUSE THE RESIDENT HAS NOT CONSULTED WITH HI/HER ATTENDING, THE TRAVEL WILL BE AUTOMATICALLY DENIED.

5.3.4 Graduate Medical Student Leave Policy

Residents who have been enrolled in a training program for one year and have worked 1,250 hours in the 12 months prior to leave are eligible for graduate medical student leave. If the resident (male or female) takes any time off for the birth of a child or the care of the newborn, or because he/she has adopted or taken a state-approved foster child into his/her home, that time must be counted as graduate medical student leave. Time off to care for a child under 18, a parent or spouse with a serious health condition, defined within the policy, also must be counted as such.

The policy allows for the care of children who are older than 18 if they are unable to care for themselves, either because of mental or physical reasons. It will not, however, allow graduate medical student leave time for the care of parents-in-law, or other relatives.

If both spouses are enrolled in U of L training programs, they are entitled to only 12 weeks of graduate medical student leave combined for the birth and care of a newborn or the placement of a child in their home. Otherwise, they are entitled to 12 weeks each.

Residents must use all vacation days or education/personal leave he/she has available at the same time he/she is on graduate medical student leave so during this time he/she will continue to have an income. Only when he/she has used all of his paid time off will he/she go on leave-without-pay status.

Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck.

A resident may take intermittent leave or work on a reduced leave schedule where he/she works fewer hours a day or week than normally scheduled. The schedule should be designed to cause the minimum amount of disruption to the training program as is possible.

Graduate medical student leave cannot exceed 12 weeks, but the university may also provide for situations that go beyond the 12 weeks. Additional information about extended leave is available from the University Human Resource Office.

Graduate medical student leave covers time taken off for:

- The birth of a child and care of a newborn;
- Adoption of a child or placement of a state-approved foster child within the Resident's home;

- Care of a child (under 18), parent, or spouse with a serious health condition (defined in the policy);
- A resident's own serious health condition.

Graduate medical student leave does not cover time off for, among other things:

- The care of a parent-in-law;
- Death in the family;
- Cold, flu, earaches, upset stomach, minor ulcers, headaches other than migraine, routine dental and orthodontia problems, periodontal disease or cosmetic treatments.

Approved by GMEC 1/16/02

MATERNITY LEAVE POLICY FOR RESIDENTS UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

1. Maternity leave shall be defined as leave following the birth or adoption of a child. A Request for Resident Maternity Leave/Sick Leave worksheet must be completed and signed by the Program Director and resident.
2. Maternity Leave may be paid, unpaid or a combination of paid and unpaid.
3. A resident may be paid during the maternity leave by utilizing any unused vacation days (up to 28 calendar days per contract year). Additionally, residency Program Directors may allow up to two additional weeks (14 calendar days) of paid leave per contract year (Program Director's Discretionary Time). By utilizing the entire annual vacation leave and being granted two weeks of discretionary time by the Program Director the resident can achieve a six-week (42 calendar days) paid maternity leave.
4. Maternity leave extending beyond the available vacation days and the Program Director's Discretionary Time (if granted) will be unpaid leave, in accordance with the Graduate Medical Student Leave Policy (p.5). Residents should check with UofL Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence, and make arrangements for continuity of health insurance benefit coverage.
5. Maternity leave may require additional training time to fulfill Board Certification Requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, the amount of time that must be made up. If residents are required to make up time missed, that time must be covered by a House Staff Agreement, with the resident being paid at the appropriate level.
6. Residents requiring additional leave due to complications of pregnancy or delivery should refer to the Sick Leave Policy (p.3). In cases of extended sick leave (90 days or greater) residents should contact the resident disability insurance carrier.
7. Should this policy be in conflict with the respective ACGME or Board requirements, those requirements will take precedence.

Revised 08/08/01 Approved by GMEC:

08/15/01 Revised and approved 1/16/02 Revised: 11/18/02, 01/15/03

PATERNITY LEAVE POLICY FOR RESIDENTS UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

- 1. Paternity leave is available either from unused paid vacation leave and Program Director's discretionary personal/educational days, or as unpaid leave as outlined in the "Graduate Medical Student Leave Policy" (p.5).**
- 2. All leaves of absence must be authorized and taken in accordance with established policies mentioned above and with individual program policies. Should these policies be in conflict with ACGME or Board requirements, the ACGME or Board requirements will take precedence.**

5.4 BENEFITS

5.4.1 PROFESSIONAL COATS

The Department will provide two monogrammed lab coats for each new PGY2 resident upon entering the program. It is the resident's responsibility to purchase new lab coats, as needed, for the remaining three years. It is also the resident's responsibility to maintain a professional appearance at all times. Cleaning and pressing lab coats should be routine.

5.4.2 Reimbursement for Medical License and DEA Number

The Department will reimburse the resident for the expense of renewing his/her medical license each year. The DEA number renewal expense, however, will only be reimbursed after the resident has signed a statement attesting to the fact that he/she will not do any "moonlighting" during the year.

5.4.3 BEEPERS

The Department will provide beepers for all residents upon entering the Residency program. It is important that the resident respond to a page as soon as possible when the Department is trying to get in touch with the resident. The Department will replace any beeper that is damaged or broken, but if a beeper is lost, the resident must replace it at his/her own expense.

5.5 CHIEF RESIDENTS

The Chief Residents are to function as role models for residents and students in exemplifying the mission and goals of the Department and the training program. They will participate in setting the program goals to achieve the mission and assist the program director to carry them out with dynamic and effective leadership. Chief residents are also in the position to identify resident problems and concerns to improve their well being during their training years. The residency training program shall have one Administrative Chief Resident.

5.5.1 How Selected

The administrative chief will be nominated by a faculty member at the monthly

departmental business meeting. Any faculty member, full-time or clinical, may nominate a PGY4 resident to be administrative chief for the coming academic year. The administrative chief is selected by a majority vote of the faculty.

5.5.2 Term

The administrative chief will generally serve 12 months. The administrative Chief will receive \$200 per month for reimbursement of their services.

5.5.3 Duties

The administrative chief resident will be responsible for preparing the annual rotation schedule for residents. He/She shall attend monthly departmental business meetings, serve as liaison between the residents and other department members, coordinate resident duties during core conferences, (M&M, Resident Education Forum, Grand Rounds, Spine Conference, Hand Conference, etc.). The administrative chief will also coordinate resident social events. The administrative chief will be assisted by the administrative assistant in the department. He/She will also review vacation requests and arbitrate any conflicts.

6.0 CURRICULUM INFORMATION

6.1 DEPARTMENT OF ORTHOPAEDIC SURGERY CLINIC RESPONSIBILITIES

It is the resident's responsibility to come to the Clinic when scheduled, on time and dressed appropriately.

Individual Clinics might have alternative start and stop times, and it is the resident's responsibility to ensure they are aware of the correct Clinic hours.

Each resident is expected to comply with the policies and procedures of each facilities medical director and clinical staff.

6.1.1 Changes in Clinic Schedules

Any changes in clinic hours need to be forwarded to the Clinic Administrator for implementation. All rationales for alterations in Clinic hours are subject to denial and appropriate clinic personnel will be notified of any approved or unapproved changes in schedules. Orthopaedic Surgery Clinic responsibilities are a major portion of the resident's core curriculum and are not to be treated lightly.

6.2 ON-CALL AND HOSPITAL RESPONSIBILITIES

ALL RESIDENTS, REGARDLESS OF PGY LEVEL, ARE RESPONSIBLE FOR ON-CALL DUTIES. Adequate coverage for hospitalized patients drives call

responsibilities and not the residents PG level. Adequate medical coverage for hospitalized patients of the Orthopaedic Surgery Offices is the ultimate priority and it will not be compromised.

6.2.1 ON-CALL SCHEDULES

UNIVERSITY HOSPITAL – ULH chief Resident ON-Call Schedule:

Coverage of University of Louisville Hospital call schedule will consist of one PGY5 resident either the PGY5 on Chief's Trauma Service or the PGY5 on the Elective Service and a PGY2, 3 or 4 resident on the Chief's Trauma Service or the Fracture Service. NOTE: The PGY2 junior resident at the VA Hospital will help with the Trauma team night call and will take four (4) nights of call per month during weekdays only. The call will be for week nights, any weeknight, and no weekend days. The PGY5 on Trauma and the PGY5 on Elective Service will be responsible for submitting the night call schedule to the Orthopaedic Surgery Department at least one month in advance. The PGY5 Residents on Trauma Service and Fracture Service will be responsible for submitting the completed night call schedule for ULH junior resident coverage to the Orthopaedic Surgery Department one month in advance.

There is no in-house call for residents at University of Louisville Hospital. All call is taken from the resident's home to try to remain in compliance with the mandated 80 hour work week.

CHILDREN'S HOSPITAL (KOSAIR) PGY2, PGY3 and PGY4

Coverage of Kosair Children's Hospital call schedule consists of the PGY4 and PGY2 resident on Children's Service and the PGY3 Resident on Alliant Service. The PGY4 Resident on Children's service will be responsible for submitting the night call schedule for Children's Hospital to the Orthopaedic Surgery Department at least one month in advance.

HAND SERVICE – The preceptor for the Kleinert-Kutz Hand Service will be responsible for assigning call responsibilities for this rotation.

Duties of the call resident include but are not limited to:

- a) on site care of hospitalized patients
- b) admitting patients to the hospital (this includes writing or dictating history and physical)
- c) evaluating patients in the emergency rooms of participating hospitals.

Residents are assigned to take call on patients of the attending physicians. The resident should respond to these calls, document these conversations, and include this information in the patient's medical record. If the resident advises the patient to visit the office or clinic the next day, the resident must call the voice mail for the respective office and inform office personnel that the patient has been advised to come in.

The senior resident on each rotation will make resident assignments for on-call duties. Faculty assignments will be submitted and the call schedule will be released. Once the call schedule has been published, individual residents are

responsible for finding their own replacements, if necessary. These changes should be reported to hospital personnel as necessary. **NO CHANGES WILL BE MADE TO THE MASTER CALL SCHEDULE AFTER IT HAS BEEN RELEASED. IF CHANGES NEED TO BE MADE, IT IS UP TO THE PHYSICIANS INVOLVED TO ASSUME THE RESPONSIBILITY OF NOTIFYING THE APPROPRIATE PARTIES (answering services, hospitals, other residents, etc.)** Final schedules are posted in:

- Resident's Office
- Orthopaedic Office Common Area
- University Hospital Switchboard
- Jewish Hospital Switchboard
- Kosair Hospital Switchboard
- Alliant Hospital Switchboard
- Norton Hospital Switchboard
- Each Resident's Mailbox
- Each Faculty Member's Mailbox
- All Staff Members

6.2.2 EMERGENCY DEPARTMENT ADMISSIONS

Sometimes a patient calls in after office hours and needs to be referred to an emergency room. Once it has been established that the patient needs to go to the emergency room, the on-call resident must decide which emergency room to use. Usually, adult and pediatric patients are handled differently.

ADULTS:

Five emergency rooms are used: University Hospital, Jewish Hospital, Children's Hospital, Norton's Hospital. Usually, a patient will be sent to the emergency room at the discretion of the Resident and particulars of the patient's insurance policy. Whenever possible, admitting the patient to University Hospital is in the best interest of the resident.

UNIVERSITY HOSPITAL

Indigent patients should be sent to University Hospital. Patient's with Commercial insurance plans may be sent to the specific participating hospital in the plan's network of hospitals.

The resident should call ahead to the Emergency Room and let the staff know that a patient has been sent to be seen. That way, the Emergency Room resident will know who to call for follow-up.

JEWISH HOSPITAL

A Dept. of Orthopaedic Surgery faculty member or resident who refers a patient To the Jewish Hospital Emergency Room for evaluation by an emergency room physician must always call the emergency room and inform the emergency room of the referral and provide any pertinent information about the patient that may be helpful to the emergency room physician.

A referring faculty member will always be the physician with whom the Emergency room should communicate following evaluation of the patient unless they instruct the emergency room to communicate with another faculty at the time of the referral.

A referring resident will always inform the emergency room which faculty member should be informed after the emergency room has evaluated the patient. Unless provided with instructions to the contrary, this physician will always be the physician who is the designated hospital attending for a particular period of time.

The emergency room physician should always communicate with the appropriate hospital attending whenever necessary about any Department of Orthopaedic Surgery patient evaluated in the Jewish Hospital Emergency Department without prior referral from a Department of Orthopaedic Surgery physician.

If a Department of Orthopaedic Surgery faculty or resident desires to evaluate a patient in the Jewish Hospital Emergency Room, they will inform the emergency department of the patient's arrival and stipulate that they will come to the emergency room promptly and that there is no need for the emergency room physician to see the patient.

PEDIATRIC PATIENTS

The resident can send pediatric patients to Kosair Children's Hospital, but the Resident should call ahead to the emergency room and inform them that they have sent a patient. The patient should be sent in under the name of a faculty physician. If the patient does not have a faculty physician, the name of the follow-up rather than back, to the Department of Orthopaedic Surgery.

6.2.3 HOSPITAL ADMISSIONS

Patients needing hospitalization will use the following hospitals:

UNIVERSITY HOSPITAL: Patients admitted to University Hospital will be admitted under the care of the faculty physician who is attending at the time of admission.

JEWISH HOSPITAL: Patients admitted to Jewish Hospital will be admitted under the care of the faculty physician attending at the time of admission

NORTON'S HOSPITAL: Patients admitted to Norton's Hospital will be admitted under the care of the faculty physician attending at the time of admission.

KOSAIR CHILDREN'S HOSPITAL: Patients admitted to Kosair Children's Hospital will be admitted under the name of the faculty physician attending at the time of admission. The University Pediatric residents will provide day to day care for our patients. The faculty attending will round on the patient daily and make a note for the chart. The faculty attending may choose to have the

entire Pediatric Orthopaedic Surgery team round on pediatric patients.

6.2.4 PATIENT CARE RESPONSIBILITIES

Care of hospitalized patients must be documented with extreme accuracy. Detailed documentation is required for reimbursement purposes, peer review purposes, and good patient care. This is a serious responsibility and it should not be taken lightly. All entries into the medical record should be entered with the correct date and time and under no circumstances should an entry be post or pre-dated or altered after the fact. Residents are responsible for checking results of all laboratory, x-ray, or other diagnostic tests that he/she has ordered.

University Hospital – Adult Patients

Residents should follow these procedures in caring for patients admitted to University Hospital:

At the time of admission, the resident will;

- 1) Write admitting note and dictate history and physical
- 2) Make an admission problem list and affix the problem list to the front of the chart.

SAMPLE ORDERS:

Admit to:	Regular bed/23 hour bed
Admit to:	UofL Orthopaedic Surgery Service
	Attending: Faculty Name
	Resident: Resident Name
	P.C.P.: Patient's Primary Care Physician

Please notify the Primary Care Physician of admission and room number

The Orthopaedic Surgery team will assume responsibility for writing the progress notes. Progress notes need to be written on a daily basis by the Orthopaedic Surgery team. A progress note should be made in each of the following instances:

- 1) Any change in the patient's status;
- 2) Any time a procedure is performed on a patient;
- 3) Any time a major change in the treatment plan for the patient is implemented;
- 4) Any time there is a significant abnormal laboratory or diagnostic test

UNIVERSITY HOSPITAL – CONSULTS

Orthopaedic Surgery may be asked to provide a consultation on a patient admitted to another service. The most senior resident on the Orthopaedic Service should perform consults. The senior resident should consult with the Orthopaedic Surgery attending as soon as possible. Usually, this is by the end of the working day. It may be possible to wait until the first thing in the morning to have the faculty attending assess the patient for consults obtained during the evening or nighttime hours.

Reports for medical consultations should be written on the appropriate form provided by the hospital. Consults should be written in ARSO format. The

assessment should be written first, followed by the recommendations. The subjective and objective information should be written.

6.2.5 JEWISH HOSPITAL/NORTON'S HOSPITAL/KOSAIR'S

The procedures for caring for a patient at Jewish Hospital and other hospitals are similar to those in caring for an adult hospitalized at University of Louisville Hospital. However, the resident must understand that they are acting as an agent of the attending physician in that instance. All work performed by the resident at Jewish Hospital, which includes admitting notes and orders, must be countersigned by the faculty attending as soon as possible.

6.2.6 OTHER HOSPITALS

The resident should not do negotiations and discussions with outside hospitals. This is a faculty responsibility. There has been some concern about rotations at hospitals where residents are normally not scheduled and privileged to do cases, such as Clark County Hospital with the Hand Service and Baptist East and Suburban Hospital with some attendings on the Orthopaedic Service. The policy on this remains that, in general, residents are not credentialed or privileged by the program to rotate and do cases at hospitals not affiliated with the University of Louisville. Therefore, should a circumstance where an attending is requesting help at a location where residents are not credentialed to go, that request needs to be dealt with on a case by case basis with prior approval by Dr. Johnson, Chairman of the Department of Orthopaedic Surgery.

6.2.9 HOSPITAL STATISTICS

Resident logsheets must be kept current and accurate. These logsheets are used to tally hospital statistics and prepare reports for the American Board of Orthopaedic Surgeons and the Accreditation Council for Graduate Medical Education. Residents are to make every effort to assure that his/her logsheets are submitted accurately and in a timely manner. Logsheets are due no later than the tenth (10th) day of the following month after completion of a full month on a service.

In addition to logsheets, residents are responsible for submitting duty hour reports each month. These reports are used to monitor the required 80 hour work week and ensure compliance with ACGME requirements. Duty hour reports are to be as accurate as possible. Residents found to be filing false work hour reports will be required to meet with the Chair to explain.

6.2.9 PEER REVIEW ACTIONS

If a resident receives written notice from a Peer Review Organization (PRO) Regarding patient care, they should report this immediately to the Program Director.

6.3 CONFERENCE AND GRAND ROUNDS ATTENDANCE REQUIREMENTS

Every resident is required to accumulate number of lecture/conference hours to qualify for promotion to the next PGY level. Program staff will maintain

attendance records on the resident's attendance at Resident Education Forum, Grand Rounds, Spine Conference and Hand Conference. Resident's are required to maintain a 75% attendance rate at these conferences. In addition, each service is required to have 50% representation at each conference/Grand Rounds presentation.

7.0 AMERICAN BOARD OF ORTHOPAEDIC SURGERY

7.1 IN-TRAINING EXAM

The American Board of Orthopaedic Surgery Orthopaedic In-Training Examination is a standardized group test of cognitive development in Orthopaedic Surgery. All residents will sit for the examination on the second Saturday in November and will receive a test profile stating overall performance as well as individual scores upon receipt of the results.

Performance on this examination is emphasized and is used as an educational tool. This examination is used to improve our educational programs and is not used as the sole criteria for determining resident promotion. However, examination performance is considered in conjunction with many other parameters of resident performance. The Chairman and Residency Director will meet with each resident to discuss the results of his/her examination. Areas of concern will be addressed and any remedial action will be taken at that time.