# How Can Orthopaedic Educational Programs Most Effectively Prepare Residents For General Orthopaedic Practice?

*A Resolution by Attendees of the 2005 AOA-OREF-Zimmer Resident Leadership Forum*

**What We Know - Background**

- Whereas there appears to be no clear definition of general orthopedics. Is it community orthopedic? A community based experience? A private practice, or a little bit of everything? In a five year program, residents should come out as a competent general orthopedist. In most experiences, residents pick a subspecialty, and in this age of subspecialty, is general orthopedics an obsolete term? What truly defines general practice?
- Whereas there is no clear data on how many orthopedists across the country practice “general orthopedics," and on what that practice is. Do we all have to have certain basic fundamentals? Without a broad database of general practice, although residents can articulate what they want, they can only speculate about what they need. There needs to be a broad effort to need to poll orthopedists out in the community, to find out what kinds of cases they’re doing, and to have that data drive decisions about the definition of orthopedic practice. Perhaps the six month case list can be an aid to a clearer definition of what general orthopedic practice is.
- Whereas there is no clear picture of who is or will or who should be defining general orthopedic practice; what the benchmarks are, how will that impact who does what, and who will be reimbursed for what. If we as a profession don't define it, it may be defined for us by others who do not have either our best interests or the patient's.
- Whereas in most residency programs, faculty are based in more subspecialty areas and may not be providing residents with a broad enough perspective of general orthopedic practice.
- Whereas there is general consensus among the RLF 2005 class that there is a need to interact with other specialties in internship like radiology and anesthesia in a meaningful way– not just tagging along with an unstructured experience.
- Whereas there seems to be significant variability in the clinic experience in residency programs, and based on our survey data, a majority of orthopedists currently in practice wish they had had more clinic time during their residency programs. The issue of gaining important perspectives on continuity of care was also a concern.
- Whereas the six core competencies, while stressed in some programs, are not the central focus of others. Measurement tools are now being developed to more clearly document learned capacity against these competencies.
- The line between these competencies as guidelines and a more bureaucratic perspective that proscribes too closely each program's use of them is a thin one, and there is no clear consensus among the RLF 2005 class on where that line should be drawn. We don’t want a system that micromanages, but we do need clearer guidelines. A better sense of what's expected is needed; a clearer definition of what residents need to know in order to evaluate our progress and capabilities.
- Whereas there is no consensus yet on whether residency curriculums will need to be redefined based on the 80 hour work week; it is still be too early to gauge the impact. The requirement appears to be affecting different classes in different ways, and different programs in different ways, and there is no clear consensus on its long term impact, except that it will have a significant impact in some way and will need to be considered in any future modifications to the residency curriculum.

**What Should Be Done - Actions**

- Be it resolved that the RLF Class of 2005 recommends to the AOA Board the creation and definition of a core set of orthopedics knowledge, within the framework of the six general competencies.
- Be it further resolved that once the above has been accomplished, a review of the length of training and quality of time spent be reevaluated.

**How It Should Be Done - Guiding Principles and Considerations**

- In whatever changes occur in residency programs, the journal club and the M and M should be preserved, and the continued confidentiality of the M and M process is essential to its success as a learning experience.
- There should be a way to reward faculty to make education a priority. Today in many programs, there is no real incentive for attending physicians to stop and teach; they are assessed on the volume of cases they do, and this often creates too much of a business model. In order to ensure the continued quality of the resident educational experience, faculty teaching must be strongly encouraged, and institutions need to help with this.
- If a more specific set of requirements is created, residents must have a curriculum and program that allows them to be able to achieve them. If learning experiences directly related to some requirements are not available in a particular program, institutions must allow residents to go out into the community to gain the needed experience. Institutions must abandon the 'not invented here' syndrome and allow residents to gain knowledge elsewhere in order to meet needed requirements.
- Whatever changes are made to orthopedic education, we must respect and embrace the diversity of each program and of each individual - reflecting the reality that programs and individuals must be able to have the maximum flexibility to reach a common goal.
- Ensure that the assessment tool of the orthopedic credentialing body truly reflects and i.e. linked to whatever is defined as core orthopedic knowledge, and that there are appropriate and transparent evaluation methods relative to the core orthopedic knowledge.
- Ensure that the intern year is governed by the department of orthopedics so that it facilitates orthopedic education consistent with our goals; that interaction with other specialties is pertinent to orthopedic training, such as general trauma, plastics, radiology and anesthesia is accomplished in a meaningful way– not just tagging along with an unstructured experience.