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About the
Philippine Board of Orthopaedics

The Philippine Board of Orthopaedics, Inc. (PBO) is the official accrediting and examining arm of the Philippine Orthopaedic Association (POA), and is administratively independent of the latter.

Duly registered with the Philippine Securities and Exchange Commission, it is tasked with accreditation and supervision of residency training programs (graduate medical education) in Orthopaedic Surgery in the Philippines. It is also tasked with the administration of the Orthopaedic In-Training and Qualifying Examinations to resident physician trainees, and the Diplomate Examinations to qualified graduates of accredited training programs.

Vision
The Philippine Board of Orthopaedics will be a model of excellence and integrity as a regulatory specialty board with competent and principled members.

Mission
The Philippine Board of Orthopaedics (PBO) functions to serve the best interest of the public and of the medical profession by continuously enhancing the standards of Orthopaedic Training and Education in the Philippines.

Functions

GENERAL: The PBO regulates Orthopaedic Residency Training programs in the Philippines.

SPECIFIC:
• Monitors training programs by accreditation and inspection.
• Administers annual In-Training Examination of trainees of accredited institutions.
• Administers Qualifying Examination of graduating trainees of accredited institutions.
• Administers Diplomate Examination of graduates of accredited institutions.
• Implements measures to continuously improve the quality of Orthopaedic Residency Training and Education in the Philippines
• Recognizes and awards outstanding residents.
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Preface to the Fourth Edition

This *Manual of Policies and Procedures for Orthopaedic Residency Education*, also commonly referred to as the “Greenbook”, is the fourth iteration of the Manual that first appeared in 1994. In 1998, incorporation of the various board resolutions and new guidelines into the existing Manual resulted in the second edition of the Greenbook. The 2009 and 2010 PBO Board of Trustees came out with the third edition of the Greenbook in order to keep abreast with developments in technology, treatment concepts, and manner of training residents. The aim was to offer accredited residency programs a more structured training system.

The fourth edition of the Greenbook continues with the objectives specified in the previous editions. The present manual defines the curriculum and the conduct of training of orthopaedic residents in the Philippines, identifies the requirements needed to graduate, and describes the accreditation process of training programs.

It is incumbent on the Philippine Board of Orthopaedics to ensure that our training institutions graduate competent orthopaedic surgeons. With the increasing number of orthopaedic cases in the country, the temptation to use orthopaedic residents as surgical assists or physician assistants (e.g., to cover a doctor’s practice when he is away) in the guise of providing training is very great. This is a very sensitive topic that has to be addressed by the Board, sooner or later. This is probably why it took four years and several meetings with the various chairs and training officers before we could come up with the present edition.

In time, we will have a fifth edition to supplant this present edition. Until that time comes, we sincerely hope that this edition will continue what all the previous editions have done – to provide policies and procedures that would improve orthopaedic residency training in our country.

The Philippine Board of Orthopaedics  
Manila 2017
Acknowledgements

This edition of the *Manual of Policies and Procedures for Orthopaedic Residency Education* would not have been possible without the efforts of the authors of the previous editions of this Manual, from which this edition is based. We thank them for their contributions. We also thank the chairmen and training officers of the various training programs who have taken the time to review the drafts of this Manual and offer their suggestions. Finally, we acknowledge the officers and trustees of the 2014, 2015, 2016, and 2017 Philippine Board of Orthopaedics who have worked together for the past years to come up with this edition.
A. THE RESIDENCY PROGRAM

1. Selection Process
   a. New Entrants
      i. A selection Board/Committee/Panel prescribed by the institution must appoint the residents following a formal selection process.
      ii. This selection process must be documented and subject to review by the PBO. It may include appropriate forms as necessary.
      iii. The number of residents accepted into a program must be in compliance with the guidelines set forth by the PBO. This will be determined based on the following:
          1. Census of cases
          2. Minimum required number of cases per resident prior to graduation (please see sections: “Curriculum – Skills” and “Minimum Requirements for Accreditation”).
   b. Lateral Entrants
      i. In some circumstances, trainees find it necessary to transfer from one accredited training program to another. This is considered as lateral entry into a training program. Regardless of their reasons, the PBO allows this. The Board gives the accepting institution the prerogative to decide what particular year level the transferee will be considered to be in on entry. However, it can never be more senior that the applicant’s present level unless the applicant had already completed his present level in the previous accredited institution. A lateral entrant will have to take the ITE of his re-entry level, regardless of whether he took it previously or not. The current score will supersede his score from the previous ITE.
      ii. The total number of residents or the number of residents in any specific year level, inclusive of the lateral entrant/s, should never be more than the number of resident slots approved by the PBO for the training program.
   c. Foreign Medical Professionals (FMPs)
      i. Increasing numbers of Foreign Medical Professionals are participating in various graduate medical education programs in the Philippines. Orthopaedic Residency programs are no exception.
         1. The 1987 Philippine Constitution (Section 14, Article XII) provides that the practice of all professions in the Philippines shall be limited to Filipino citizens, except in cases prescribed by law.
         2. In 2015, the PRC and the Department of Health (DOH) issued Joint Administrative Order No. 2015-01 “Policies and Guidelines on the Conduct of Medical Residency and Fellowship Training Program for Foreign Medical
Professionals in the Philippines”. Training programs should note the following salient points:

a. A Committee on Training Programs for Foreign Medical Professionals (CTPFMP) will be formed by the PRC and DOH that will be responsible for the planning and monitoring of the training programs for the FMPs.

b. FMPs shall comprise no more than 40% of the total number of training residents in a program.

c. A foreign medical professional will need a temporary training permit in order to undergo residency training. This permit is issued by the Professional Regulatory Board of Medicine (PRBOM) and is valid for a period co-terminus with the residency training, unless revoked sooner.

d. The CTPFMP is responsible for setting guidelines in the accreditation of participating hospitals that can accept FMPs.
   i. Non-accredited hospitals will have to apply for accreditation with their respective specialty boards.
   ii. Accredited training hospitals are included in the roster of participating accredited training hospitals of the CTPFMP.

e. Upon completion of an accredited residency-training program, the FMP will be issued a Certificate of Completion signed by the Training Officer, Chairperson of the Department, and Medical Director/Chief of Hospital.

f. Upon passing the certifying specialty board examination administered by the pertinent specialty board, the FMP will be issued a Certificate of Specialization signed by the Chairperson of the PRC, Secretary of the DOH, Chairperson of the PBROM, and Chairperson of the Specialty Board.
   i. Only FMPs from accredited residency training programs may take the certifying examinations.
   ii. The FMP can then be conferred the title “Diplomate”.

ii. FMPs who have temporary training permits and who have been accepted in an accredited training program will be treated by the PBO as being in the same footing as local medical graduates. They are required to take all examinations given by the PBO and their scores will be included in the calculation of the assessment score.
when accrediting a training program (please see section: “Assessment of Training Program”).

iii. When considering the number of residents that a training program may have, FMPs will be included in the computation since they will be treated as regular residents.

iv. As stated in the Joint Administrative Order No. 2015-01 “Policies and Guidelines on the Conduct of Medical Residency and Fellowship Training Program for Foreign Medical Professionals in the Philippines”, FMPs are eligible to take the diplomate examinations as long as the necessary prerequisites have been accomplished (please see section: “The Diplomate Board Examination”).

1. In lieu of a valid physician’s license, the FMP should have a valid temporary training permit that has not expired.
2. Since the validity of the temporary training permit is co-terminus with the residency training, the FMP should take the practical examination prior to finishing his/her training, unless the permit is extended by the PRBOM for the purpose of taking the practical examination.
3. FMPs who pass parts 1, 2, and 3 of the diplomate examination shall be awarded the title “Diplomate of the Philippine Board of Orthopaedics”.

v. Whether an FMP who has been awarded the title “Diplomate of the Philippine Board of Orthopaedics” will be allowed to become a Fellow of the Philippine Orthopaedic Association is beyond the decision of the Philippine Board of Orthopaedics.

1. The Philippine Orthopaedic Association will decide on this matter.
2. The temporary training permit expires with the completion of training of the FMP. The FMP cannot therefore practice medicine in the Philippines upon graduation from the training program.

vi. All FMPs trainees are expected to comply with all requirements of Filipino residents in training.

2. Number of Residents
   a. The minimum number of residents for an accredited training program is one resident per year of training.
   
   b. Changes in the Number of Residency Positions
      i. Changes in the total number of residents or the number of residents in any specific year level beyond the number of existing slots approved by the PBO for the training program in question must receive prior written approval from the Accreditation Committee of the PBO.
1. The rationale for such changes must be explicitly stated by the program chairman in a letter addressed to the Accreditation Committee of the PBO. Consideration will be given to the individual and specific needs of each accredited training institution.

2. If an increase in the number of residents is requested, it must be demonstrated that this increase will not adversely affect the minimum case load required per resident prior to graduation.

   ii. The Board should be notified of the entry of new residents to existing slots approved by the PBO or the reduction of residents from the program, either through completion or termination. The Board should be updated on the number of residents in the training program and informed as soon as that number changes for whatever reason (e.g., resignation, transfers).

   iii. If residents cannot fulfill the required minimum caseload prior to graduation (please see section: “Curriculum – Skills”), the PBO will require that the program concerned take remedial measures, which would include:

       1. Increasing the duration of the residency program, or
       2. Decreasing the number of residents.

   iii. In the event that the above two remedial measures are not adequate, external rotations will have to be developed by the training program (please see section: “Partnerships”).

3. Duration of Residency

   a. The duration of residency training is at least four years, provided that all requirements necessary for graduation can be accomplished in that time frame.

   b. The duration of residency training of any particular program may be lengthened by yearly increments if this is necessary in order to fulfill the requirements for graduation.

      i. The duration may be increased if the training program deems it necessary. In this case, a letter must be written to the PBO explaining the reason for such extension. Only after approval by the PBO can such an extension be implemented.

      ii. The duration may be increased if the PBO deems it necessary. In this case, the PBO will furnish the training program with its recommendation for the extension and why it is needed.

      iii. Note that this applies to the duration of the entire program, NOT to the duration of training of any particular resident or group of residents in a training program.

      iv. Training programs that have a 5-year program at the time of issue of this guideline need not apply for an extension over the 4-
year minimum requirement, unless they wish to extend their training over their existing duration of training.

4. **Conduct of Training and Learning Opportunities**
   
a. **Rotations**
   
i. The following table depicts the minimum time that a resident should spend in each service.

<table>
<thead>
<tr>
<th>ROTATION</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAUMA</td>
<td>Twelve (12) Months</td>
</tr>
<tr>
<td>ADULT</td>
<td>Twelve (12) Months</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>Six (6) Months</td>
</tr>
<tr>
<td>HAND</td>
<td>Six (6) Months</td>
</tr>
<tr>
<td>SPINE</td>
<td>Six (6) Months</td>
</tr>
<tr>
<td>ELECTIVE</td>
<td>Six (6) Months</td>
</tr>
</tbody>
</table>

   ii. Subspecialties of Arthroplasty, Tumor, Sports Medicine, and Methods of Ilizarov shall be covered accordingly under the Adult and Pediatric rotations.
   
   iii. First year residents are not allowed to rotate in affiliate institutions.
   
   iv. First year residents are not allowed to rotate in the Emergency Room, unless accompanied by a more senior resident or consultant.

b. **Curriculum**
   
i. Theoretical knowledge is discussed in the section on “Curriculum – Basic and Clinical Knowledge”.
   
   ii. Practical knowledge is discussed in the section on “Curriculum - Skills”.

c. **Duties of Residents**
   
i. Duties as part of the hospital staff
   1. Attend the outpatient clinics
   2. Attend supervised elective and emergency surgical cases
   3. Undertake rotations in the Emergency Department for assessment and acute care of trauma cases. A first year resident may rotate in the emergency room only if accompanied by a more senior resident or consultant.
   4. Undertake the care of admitted patients

   ii. Duties as a learner
   1. Participate in relevant conferences and teaching sessions organized by their respective departments
   2. Participate in Journal Clubs
3. Undertake clinical reviews and research
4. Attend appropriately organized and instructed external courses, particularly the Annual and Midyear scientific meetings of the Philippine Orthopaedic Association
5. Produce poster presentations, oral presentations and publications
6. Undertake internet-based learning
7. Personal study using the educational resources provided by the training program

iii. Duties in relation to the PBO
1. Each resident must take the annual Orthopaedics In-Training Examination (ITE) for four years, the last of which shall serve as the Qualifying Examination for the PBO Diplomate Examination.
2. Each resident must keep an updated and complete PBO logbook of operations and summary of operations (digital and/or printed). These logbooks/ summaries of operations are subject to inspection by the PBO anytime and are to be reviewed and certified by the Training Officer every quarter.
3. Upon completion of residency training and prior to taking the diplomate examinations, each resident must have performed the minimum number of specific cases as determined by the PBO Committee on Accreditation, and other special operative procedures that are required by the Board. Graduates of a residency-training program who have not met the minimum case requirements will not be eligible to take the diplomate examinations.
4. Each resident must have completed at least one research project approved by an institutional review board, be it departmental or for the entire hospital. This must have been published or presented orally or in poster format in a national or international forum.

d. External Courses
   i. External organizations (e.g. the POA, its chapters and subspecialty societies, the AO Group, other training institutions) regularly promote and organize continuing medical/surgical education meetings. The Training Officers must encourage participation of their residents in these sessions.
   ii. Participation in these meetings must be documented and reported as required in the PBO Annual Report.
The Residency Program

e. Educational Resources
   i. Protected time (that is, time in which a resident may not be called
      upon to perform any duty) of at least one hour per week must be
      established in order to provide residents the opportunity to study.
   ii. As there is now a wealth of internet-based instructional materials
      and medical resources, an Internet connection for each training
      program is highly recommended.

g. Professionalism
   i. Residents must demonstrate a commitment to carrying out
      professional responsibilities, adherence to ethical principles, and
      sensitivity to a diverse patient population. Residents are expected
      to:
         1. 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.
         2. Demonstrate a commitment to ethical principles pertaining
            to provision or withholding of clinical care, confidentiality
            of patient information, informed consent, and business
            practice.
         3. Demonstrate sensitivity and responsiveness to patients'
            culture, age, gender, and disabilities.
   ii. To achieve the goal of inculcating the sense of Professionalism
      among trainees, the faculty/trainers of each training program
      must strive to develop modules that discuss ethical issues in
      orthopaedic surgery. To be implemented successfully, these
      modules must include substantial focused discussion and
      incorporate background information in the literature with
      appropriate moderators leading the discussion. In addition, as
      ethical issues arise that relate to the orthopaedic community,
      open dialogue with the residents must be undertaken to provide
      them with the perspective on these issues. Lastly, as ethical role
      models continue to be at the core of teaching ethics and
      professionalism effectively, the faculty and trainers themselves
      are expected to exhibit strong adherence to sound practices and
      professional behavior.

5. Assessment
   a. The assessment of a trainee’s performance and skill by the Training
      Officer is fundamental to their continuing satisfactory progression through
      the residency-training program.
i. Although members of the training staff should take an active role in the training of residents, it is the Training Officer who is ultimately responsible for education, training, and assessment of residents.

ii. Assessment of residents should take place in the workplace where possible.

iii. Where appropriate, knowledge and its application will be assessed by formal examinations prepared by the training faculty.

iv. It is recommended that in a setup where trainees progress from one rotation to another, a post-rotation examination be carried out.

b. Assessment of Resident Performance during Clinical Training

i. An assessment report must be completed for each resident:
   1. At least on a semi-annual basis, or quarterly following the completion of a quarterly rotation through the different subspecialties.
   2. As soon as practical any time after the identification of unsatisfactory or marginal performance as determined by the Training Officer.

ii. The Training Officer, or another designated Consultant (e.g. a designated Consultant of a subspecialty service), must have a performance assessment meeting to discuss the assessment report. Where unsatisfactory or marginal performance is identified the assessment report must be accompanied by a remedial plan.

iii. The completed assessment report should be signed and dated by both the trainee and the assessing officer and should reflect the discussions held during the applicable performance assessment meeting. Signing the report confirms the assessment report has been discussed, but does not signify agreement with the assessment.

iv. The completed assessment is then filed by the Training Officer in the resident’s training portfolio. Residents are required to keep a copy of the assessment report for their personal records.

c. Assessment of Resident Surgical Experience during Training

i. Accurate reporting of the surgical experience by each resident is required. The logbook of operations (digital and/or printed) will provide details about the resident’s level of supervised and independent surgical operative experience.

ii. The logbook (digital and/or printed) must be completed by the resident at regular intervals and will be subject to review by the Board during the annual visit of the training institution.
iii. The logbook (digital and/or printed) must be reviewed and signed by the Training Officer, or an appropriate designee, at least on a quarterly basis.

iv. Inaccurate or malicious recording of procedures, including falsification of data, in the operative logbook (digital and/or printed) is considered a serious misconduct by the resident and may form grounds for the Board to recommend dismissal from the training program.

d. Probationary Status for Unsatisfactory or Marginal Performance
   i. Where an assessment report identifies unsatisfactory or marginal performance, the Training Officer must notify the trainee. A copy of the notification must be attached in the training portfolio of the resident. Such a notification should include:
      1. Identification of the areas of unsatisfactory or marginal performance
      2. Confirmation of the remedial action plan
      3. Identification of the required standard of performance to be achieved
      4. Notification of the duration of the probationary period
      5. The time at which reassessment will be carried out
      6. Possible implications if the required standard of performance is not achieved

   ii. The probationary period should be no less than three months and no more than six months.

   iii. During the probationary period, the resident’s performance should be regularly reviewed by the Training Officer and the resident should be offered constructive feedback and support.

   iv. If performance has improved to the satisfaction of the training officer at the conclusion of the probationary period, the probationary status must be removed.

   v. If performance has not improved to the required standard at the conclusion of the probationary period, the Training Officer may proceed with dismissal in accordance with administrative procedures of the respective training institutions. The Training Officer must notify the Board of such an action.

e. Instruments of Assessment – the following are suggested for use by the Training Officer/Committee and may be revised if necessary:
   i. Peer Assessment Tool (see Form AT-01 in Appendix - PBO Forms). This is a type of 360-degree appraisal strategy that measures many aspects of the performance of a resident. Raters should include consultant staff, co-residents, nurses, anesthetists and allied health professionals as deemed appropriate by the training officer. The aggregate ratings are used to provide feedback on behaviors and skills.
ii. Clinical Evaluation Exercise (see Form AT-02 in Appendix - PBO Forms). This is the direct observation of the clinical skills in the ward or in outpatient clinics of the trainee: e.g. history taking, physical examination, and discharge work up. Preferably one such assessment is carried out for each rotation throughout a particular year level of training.

iii. Case Based Discussion (see Form AT-03 in Appendix - PBO Forms). This is a focused discussion of the resident’s recent entries in a patient’s clinical record to explore clinical thinking and management.

iv. Direct Observation of Practical Skills (see Form AT-04 in Appendix A - PBO Forms). The instrument allows assessment of commonly performed straightforward procedures in the operating room and clinic or ward settings. This would include for example suturing, applying a cast, or injecting a joint.

v. Logbook (digital and/or printed) Monitoring. The logbook allows the residents the opportunity to document the details of all operations in which they are considered the primary surgeon.
   1. It provides external auditors such as the PBO a tangible evidence of the surgical experience of the trainees. The data available in the logbook allows scrutiny not only of an individual trainee’s experience, but training patterns by trainers.
   2. If residents wish to keep a detailed logbook of all other surgeries in which they were not the primary surgeon, they may do so in another logbook. However, for purposes of evaluating a training program, only the logbook listing those cases in which residents were the primary surgeon will be thoroughly inspected.

3. If a digital logbook is required by the PBO:
   a. Data entered by graduating residents in Form AC-03 (Evaluation Sheet of Surgical Case Variety and Number) will be confirmed with data entered into their digital logbooks.
   b. Calculation of the “surgical case load” and the “variety of cases” components of Form AC-02 (Evaluation Sheet for Orthopaedic Training Programs) will be based on the submitted digital data.
B. CURRICULUM

Orthopaedics is a specialty that encompasses the management of musculoskeletal injuries. It also deals with congenital, developmental, and acquired disorders of the bones, joints, and their associated soft tissues, including vascular structures, nerves, muscles, tendons, ligaments, and the integument.

The curriculum provides guidelines for the core competencies and learning standards by which graduates of orthopaedic residency training programs in the Philippines are evaluated. The curriculum is presented to guide orthopaedic graduate medical education by providing accessible information to the trainees and trainers, its primary end users, and other stakeholders.

This syllabus is presented in three parts that capture the attitudes, knowledge, and skills expected of orthopaedic residents in training. These three parts consist of:

- Basic and Clinical Knowledge that form the foundation over which more advanced learning and education may be built upon.

- Applied Clinical Skills that are needed to manage the more common orthopaedic conditions seen in general practice. These are the skills that a surgeon may use as building blocks when performing more complicated cases.

- Attitudes that outline general aspects of behavior that trainees are expected to demonstrate while in training and which they will hopefully carry on into their practice.

Each training program should have a curriculum based on the recommendations of the PBO and should, at the minimum, include the following:

- Objectives of the program (vision, mission)
- Intended outcomes after graduation
- Core competencies to be developed
- Syllabus on content of the curriculum
- Intended learning outcomes per year level and per rotation
- Method of assessment
- Quality assurance
B1. CURRICULUM – BASIC AND CLINICAL KNOWLEDGE

1. Topics
   The following topics are the minimum requirements that a resident should know upon graduation from an accredited training program:
   
   i. Basic Science in Orthopaedics
      1. Anatomy, histology, and physiology of the musculoskeletal system
      2. Biomechanics and Biomaterials
      3. Fracture healing
      4. Management of shock and the multiply injured patient
      5. Orthopaedic imaging
      6. Orthopaedic infections

   ii. Research
      1. Developing a research protocol
      2. Writing and presenting a research paper
      3. Critical appraisal of research papers
      4. Evidence-based practice

   iii. Orthopaedic Trauma
      1. Classification of fractures
      2. Principles of fracture management
      3. Open fractures
      4. Fractures of long bones
      5. Joint dislocations and fracture dislocations
      6. Periarticular fractures and dislocations
      7. Fractures of the pelvis and acetabulum
      8. Fractures of the foot
      9. Complications of internal fixation

   iv. Pediatric Orthopaedics
      1. Development of the musculoskeletal system
      2. Normal developmental milestones and patterns of gait
      3. Congenital disorders
      4. Developmental disorders
      5. Metabolic and endocrine disorders
      6. Rheumatologic disorders
      7. Infectious arthritis and osteomyelitis
      8. Circulatory disorders
      9. Afflictions of the neuromuscular system (e.g., polio, CP)
     10. Orthopedic disorders of neglect (e.g., cubitus varus)
     11. Musculoskeletal tumors in children
     12. Sports injuries
     13. Fractures and dislocations in children

   v. Hand Surgery
      1. Anatomy and biomechanics of the wrist and hand
      2. Orthopaedic imaging of the wrist and hand
      3. Tendon and nerve injury, healing, repair
4. Stenosing tenosynovitis
5. Tendon transfers
6. Principles of rehabilitation of hand injuries
7. Congenital disorders of the wrist and hand
8. Compressive neuropathy
9. Rheumatoid wrist and hand
10. Arthritis of the wrist and hand
11. Fractures and dislocations of the wrist and hand
12. Amputation and reconstruction
13. Infections
14. Tumors of the wrist and hand

vi. Adult Orthopaedics
1. Osteoporosis
2. Pathologic fractures
3. Metabolic disorders involving bone
4. Rheumatologic disorders
5. Degenerative disorders of joints
6. Infectious arthritis and osteomyelitis
7. Peripheral vascular disease (e.g., DVT, Buerger’s disease)
8. Afflictions of the neuromuscular system (e.g., CP, Polio)
9. Orthopedic disorders of neglect (e.g., malunion)
10. Musculoskeletal tumors
11. Sports injuries
12. Periprosthetic fractures
13. Postoperative infection

vii. Spine surgery
1. Anatomy, development, and biomechanics of the spine
2. Orthopaedic imaging of the spine
3. Spinal cord injuries
4. Surgical approaches to the spine
5. Low back pain
6. Spinal deformities
7. Herniated nucleus pulposus
8. Metabolic disorders of the spine
9. Degenerative disorders of the spine
10. Infection
11. Pediatric spine problems
12. Scoliosis
13. Tumors of the spine

2. Textbooks
   a. The Philippine Board of Orthopaedics has approved the following textbooks as the standard textbooks for training. Majority, if not all, of the questions in the in-service training examinations, qualifying examinations, and diplomate board examinations will be from these books.
i. Basic Orthopaedic Sciences – The Stanmore Guide by Ramachandran
ii. Campbell’s Operative Orthopaedics by Canale, et. al.
iii. Rockwood and Green’s Fractures in Adults by Bucholz
iv. Rockwood and Wilkin’s Fractures in Children by Beaty
v. AO Principles of Fracture Management by Ruedi
vi. Surgical Exposures in Orthopaedics – The Anatomic Approach by Hoppenfeld
vii. Tachjian’s Pediatric Orthopaedics by Hering
viii. Rothman-Simone The Spine by Herkowitz
ix. Green’s Operative Hand Surgery by Wolfe
x. Orthopedic research manual published and distributed by the PBO

b. The PBO will inform the training programs from what editions of the standard textbooks the questions for the board examinations will come from.
   i. Questions will always come from the latest editions of the textbooks, unless a newer edition appears at the beginning of the year and the PBO feels that the training programs would not have sufficient time to update their libraries.
   ii. The Examination Committee of the Philippine Board of Orthopaedics will determine what particular topics will be covered during the In-Training Examinations per year level. The training programs will be duly notified.

c. The training programs will be duly notified if additional textbooks will be used or if any of the aforementioned textbooks will be changed or removed.

d. It is envisioned by the PBO that information acquired by studying these textbooks would serve as the foundation for more advanced learning experiences.

e. The PBO encourages the use of other textbooks and journals to augment knowledge gained by reading the standard textbooks.

3. Other sources of learning:
   a. Journals
   b. Didactic lectures
   c. Clinical presentations
   d. Journal discussions
   e. Courses offered by the POA, subspecialty societies, AO, etc.
B2. CURRICULUM – SKILLS

1. Description  
a. Residents should adequately handle a minimum volume and variety of cases in order to develop competency in the **pre-operative, intra-operative, and post-operative management** of patients.

b. Since the competencies to be developed include not only the surgical exercise itself but also pre-operative and post-operative care, majority of cases should therefore be residents’ cases for the purpose of evaluation (see definition of “resident’s case” below).

2. Core Competencies to be Developed  
a. Consent  
   i. Demonstrates sound knowledge of indications and contraindications including alternatives to surgery  
   ii. Demonstrates awareness of sequelae of non-operative and surgical management  
   iii. Demonstrates sound knowledge of complications of surgery  
   iv. Explains the perioperative process to the patient and/or next of kin and verifies their understanding  
   v. Explains likely outcome and time to recovery and verifies understanding  

b. Pre-operative Planning  
   i. Recognizes anatomical and pathological abnormalities and selects appropriate surgical strategies/techniques to deal with these  
   ii. Demonstrates ability to make sound choice of appropriate equipment, materials or devices taking into account appropriate investigations  
   iii. Exhibits ability to properly template preoperative radiographs in those cases that require templating  
   iv. Checks materials, equipment, and device requirements with the operating room personnel  
   v. Ensures the operation site is marked, where applicable  
   vi. Checks patient’s records and personally reviews results of preoperative investigations  

c. Pre-operative Preparation  
   i. Checks in the operating room that the consent has been obtained  
   ii. Gives effective briefing to the operating room team  
   iii. Ensures proper and safe positioning of the patient on the operating table  
   iv. Demonstrates careful skin preparation
v. Demonstrates careful draping of the patient’s operative field
vi. Ensures general equipment and materials are positioned safely
   (e.g., cautery tip and cords, catheters)

d. Exposure and Closure
   i. Demonstrates knowledge of optimum skin incision
   ii. Achieves an adequate exposure through planned dissection in the
       correct tissue planes and identifies all structures correctly
   iii. Completes a sound wound repair where appropriate
   iv. Protects the wound with dressings, splints and drains, as
       appropriate

e. Intra-operative Technique
   i. Follows an agreed, logical sequence or protocol for the procedure
   ii. Consistently handles tissue well with minimal damage
   iii. Controls bleeding promptly by an appropriate method
   iv. Demonstrates a sound technique of knots, sutures and/or staples
   v. Uses instruments appropriately and safely
   vi. Proceeds at an appropriate pace with economy of movement
   vii. Anticipates and responds appropriately to variation in anatomy
   viii. Deals calmly and effectively with unexpected events/complications
   ix. Able to direct surgical assists to efficiently carry out the procedure
   x. Communicates clearly and consistently with the scrub team
   xi. Communicates clearly and consistently with the anesthetic team

f. Post-operative Management
   i. Ensures the patient is transferred safely from the operating table to
      the recovery room bed
   ii. Completes an accurate operative report
   iii. Records clear and appropriate post-operative instructions
   iv. Deals with specimen appropriately, including labeling and storage
   v. Explains result of surgery, prognosis, and possible outcome to
      relatives and patient

3. Resident’s Case
   a. A resident’s case is a case in which the resident is considered as the
      primary surgeon who performed the case. The resident is considered as the
      primary surgeon when:
      i. The resident does the surgery independently, or
      ii. The resident performs the major and more important parts of the
          case, if there is a consultant who is scrubbed with the resident.

   b. Independent performance of a case is not similar to unsupervised
      performance of a case.
      i. Independent performance – the resident is allowed to perform the
         case without a scrubbed consultant. However, the consultant is
readily available within the operating room or the hospital, should assistance be required.

ii. Unsupervised performance – the resident performs the case without a scrubbed consultant. The responsible consultant is not within the vicinity of the hospital and/or is not readily available to assist or instruct the resident, should the need arise.

c. For the case to be considered as part of a resident’s caseload, the case should be done under a qualified training staff. The consultant need not scrub for the case and may not even be in the operating room. However, the consultant should be readily available should the resident require assistance.

d. Charity or service cases
   i. Charity or service cases are patients who are admitted in the charity or service ward of a hospital. These patients are handled completely by resident physicians under the supervision of consultants.
   ii. All charity or service cases operated upon by a resident are considered resident’s cases, as long as the following criteria are fulfilled:
      1. The resident does the surgery independently, or
      2. The resident performs the major and more important parts of the case, if there is a consultant who is scrubbed with the resident.
   iii. There are instances in which “private patients ” are managed and operated upon by residents (for example, patients in the Philhealth ward of a government hospital may actually be handled by residents). That is, the resident-in-charge admits the patient, indicates the patient for surgery, prepares the patient for surgery, performs the surgery, and cares for the patient after surgery and during the follow-up period. In such circumstances in which the resident is responsible for the full management of the patient, such a case may be considered a “charity or service case” for purposes of determining a resident’s caseload with the approval of the training officer.

e. Private cases
   i. Private cases are patients who are admitted in the private ward of a hospital. These patients are handled by consultants. Resident physicians may assist the consultant in the management of these patients.
   ii. For private cases that are given by a consultant to a resident to operate on, only a maximum of 50% per category can be considered as residents’ cases.
      1. The following criteria must also be fulfilled:
a. The resident does the surgery independently, or
b. The resident performs the major and more important parts of the case, if there is a consultant who is scrubbed with the resident.

2. Examples:
   a. If ten femoral nailings are required and the resident performs ten cases given to him by his/her consultants, only five will be credited as resident’s cases.
   b. If ten femoral nailings are required and the resident performs seven charity cases, he will be credited with seven resident’s cases. The remaining three cases may be accomplished by performing three private cases.

3. Rationale for this rule: Since the goal of surgery is not only to develop the technical skill of the surgeon but to develop competency in the pre-operative, intra-operative, and post-operative management of patients, it is imperative that residents have adequate time to handle the patients before and after the surgery. For private patients, it is almost always the case that the resident is not responsible for the total care of the patient. Furthermore, follow-up care for private patients is ethically the responsibility of the consultant and not the resident.

f. For cases performed during surgical outreach programs, only 20% will be credited as residents’ cases. The reason for this rule is that by the very nature of medical/surgical missions or surgical outreach programs, there is often inadequate pre-operative and post-operative follow-up and care.

g. Each graduating resident should have been able to perform the minimum required number of resident’s cases as determined by the PBO.

4. Minimum Required Number of Resident’s Cases – Total Cases
   a. The minimum required number of cases was developed by looking into the census of all orthopedic training programs in the Philippines in 2014.
      i. Cases were grouped based on anatomical structure (e.g., arm, thigh, etc.) or functional type (e.g., tumor, pediatric orthopaedics, casting). Cases from POC and PGH were purposely not included to avoid skewing the results.
      ii. The “minimum required number of cases” was based on the mean number of procedures done by the residents of the accredited training programs nationwide in 2014.
      iii. At the present time, the minimum required number of cases that a graduating resident must accomplish is 243, excluding closed reduction and casting.
b. It is important to realize that these numbers represent the minimum that residents are expected to perform prior to graduation.
   i. It does not mean that residents should confine themselves to these procedures.
   ii. There are many other cases that are not listed from which residents could learn.
   iii. The PBO encourages residents to perform more cases than the minimum, if possible, and to perform other cases that are not listed, when possible. Surgery is a technical skill that requires constant practice under adequate supervision in order to improve.

c. However, it is also important to realize that a resident who does not perform the minimum required number of cases will not be eligible to take the diplomate examinations.

d. The minimum required number of cases may be adjusted by the PBO in the future, depending on the yearly census of all training programs.

5. **Minimum Required Number of Resident’s Cases – Specific Cases**
   a. The following rules apply when recording “Minimum Case Requirements”:
      i. For pediatric cases, the cut-off is 18 years old.
         1. Any procedure in patients equal to or younger than 18 years old will be considered a pediatric case.
         2. Any procedure in patients older than 18 years will be considered an adult case.
      ii. Deep (for removal of implant or removal of foreign body)
         1. The structure to be removed is deeper than the deep fascia
         2. No part of the structure is accessible superficial to the deep fascia. Hence, removal of pins after supracondylar pinning, in which the pins are protruding out of the skin, cannot be counted for cases that require removal of “deep” structures.
      iii. Internal fixation may involve open reduction (ORIF) or closed reduction (CRIF).

b. Graduating residents should submit Form AC-03 (Evaluation of Surgical Case Variety and Number for Graduating Residents) to the PBO as a prerequisite to take the diplomate board examination.
   i. The PBO reserves the right to verify the authenticity of the data submitted.
   ii. It is recommended that the details of each case performed be accurately entered in the surgery logbook (digital and/or printed) and that copies of the operative technique and patient data sheet be kept by the resident.
c. Table of Minimum Case Requirements

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Minimum Case Requirements*</th>
<th>Inclusions/Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed reduction and casting</td>
<td>50</td>
<td>Does not include procedures in which reduction was not performed. Excludes procedures done in patients less than 18 years old.</td>
</tr>
<tr>
<td>Debridement of open fractures (must have at least 12 of external fixation)</td>
<td>30</td>
<td>Excludes wrist and hand</td>
</tr>
<tr>
<td>Surgery shoulder, humerus, clavicle, scapula (must have at least 2 internal fixations, any method)</td>
<td>8</td>
<td>Includes amputation, delayed fixation, disarticulation, soft tissue repair or reconstruction, surgery for malunion/nonunion, internal fixation, release of structures, revision of fixation, stumps revision, removal of implant (deep)</td>
</tr>
<tr>
<td>Surgery elbow (must have at least 3 internal fixations, any method)</td>
<td>12</td>
<td>Includes arthrotomy, delayed fixation, soft tissue repair or reconstruction, surgery for malunion/nonunion, surgery for dislocation, internal fixation, release of structures, removal of foreign body (deep), removal of implant (deep), revision of fixation</td>
</tr>
<tr>
<td>Surgery forearm (must have at least 3 ORIFs)</td>
<td>8</td>
<td>Includes amputation, delayed fixation, surgery for malunion/nonunion, internal fixation, release of structures, removal of implant (deep), revision of fixation, stumps revision</td>
</tr>
<tr>
<td>Surgery of wrist and hand (must have at least 8 internal or external fixations, any method)</td>
<td>40</td>
<td>Includes amputation/disarticulation, debridement, external fixation, reduction and internal fixation, release of structures, repair/reconstruction of structures, biopsy, excision of mass such as tumors or cysts, tumor surgery of the hand, flaps, fusion, correction of malunion or nonunion, removal of implants (deep), stumps revision. Excludes splint, cast, and traction.</td>
</tr>
<tr>
<td>Surgery hip (must have at least 3 internal fixations, any method)</td>
<td>10</td>
<td>Includes disarticulation, arthroplasty, fusion, reduction and internal fixation, revision hip surgery, surgery for dislocation, revision of implants, reconstruction, arthroplasty</td>
</tr>
<tr>
<td>Surgery femur (must have at least 5 internal fixations, any method)</td>
<td>25</td>
<td>Includes amputation, delayed fixation, surgery for malunion/nonunion, internal fixation, removal of foreign body (deep), removal of implant (deep), revision of fixation, revision of stumps</td>
</tr>
<tr>
<td>Surgery knee (must have at least 3 internal fixations, any method)</td>
<td>10</td>
<td>Includes arthroplasty, disarticulation, fusion, soft tissue repair, surgery for malunion/nonunion, surgery for dislocation, internal fixation, removal of foreign body (deep), removal of implants (deep), revision of fixation</td>
</tr>
<tr>
<td>Surgery tibia (must have at least 5 internal fixations, any method)</td>
<td>20</td>
<td>Includes amputation, delayed fixation, flaps, surgery for malunion/nonunion, internal fixation, removal of implant (deep), revision of fixation, stumps revision</td>
</tr>
<tr>
<td>Surgery ankle (must have at least 4 internal fixations, any method)</td>
<td>10</td>
<td>Includes delayed fixation, disarticulation, fusion, soft tissue repair or reconstruction, surgery for malunion/nonunion, surgery for dislocation, internal fixation, release of structures, revision of fixation, removal of implant (deep)</td>
</tr>
<tr>
<td>Surgery foot (must have at least 4 internal or external fixations, any method)</td>
<td>16</td>
<td>Includes amputation, disarticulation, fusion, surgery for malunion/nonunion, internal fixation, release of structures, soft tissue repair/reconstruction, skin graft, stumps revision, ungentectomy, removal of implants (deep)</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td>10</td>
<td>Includes any knee or shoulder arthroscopy</td>
</tr>
<tr>
<td>Tumor surgery</td>
<td>20</td>
<td>Includes biopsy, curettage with or without additional procedures, excision/resection of benign or malignant lesions. Excludes region of the wrist or hand.</td>
</tr>
<tr>
<td>Spine surgery</td>
<td>4</td>
<td>Includes decompression, disc procedures, fusion, stabilization, scoliosis, removal of implants (deep), release of structures, revision of fixation</td>
</tr>
<tr>
<td>Pediatric Orthopaedics (must have at least 5 pinning of supracondylar fractures)</td>
<td>20</td>
<td>Includes Ponsetti casting (maximum of 6 procedures will be counted for this category), closed or open reduction with fixation (splint, cast, or internal fixation) of children, release of structures in children, surgery for malunion/nonunion in children, reconstructive procedures in children. Excludes any tumor surgery.</td>
</tr>
</tbody>
</table>

*There are 243 cases, excluding the 50 cases for closed reduction and casting*
B3. CURRICULUM – ATTITUDES

1. The orthopaedic resident is expected to behave in a manner that is nothing less than exemplary at all times. This portion of the syllabus outlines general aspects of behavior that trainees are expected to demonstrate while in training and which they hopefully carry on into their practice.

2. Relationship with patients
   a. Keep the best interest of the patient through adherence to ethical codes in all aspects of assessment, treatment and management.
   b. Show respect to all patients and their caregivers.
   c. Demonstrate an emphatic approach to all patients under their care.
   d. Adhere to contemporary frameworks of confidentiality.
   e. Be honest about outcomes, complications and consequences of care.
   f. Work with patients and their caregivers to develop collaborative management plans.
   g. Encourage participation in the choice of care and treatment.

3. Maintaining and improving competence and performance
   a. Demonstrate a commitment to continuing professional development by keeping up-to-date with clinical advances throughout their career.
   b. Be open to new ideas and developments that will improve patient care.
   c. Routinely practice critical self-awareness and review personal clinical practice and compare with accepted standards.

4. Relationship with Colleagues
   a. Actively engage in maintaining a healthy, safe and productive working environment among medical and allied medical staff.
   b. Demonstrate clinical leadership skills and seek to foster and encourage junior residents to develop their own skills.
   c. Be aware of and work within one’s own competence level, seeking advice as is necessary from others.

5. Teaching and Training
   a. Exhibit commitment to learning and teaching.
   b. Demonstrate willingness to supervise the work of less experienced colleagues.
   c. Demonstrate sensitivity to the needs of students and junior residents.
C. THE DIPLOMATE BOARD EXAMINATION

1. Description:
   a. The PBO Diplomate Examination is the Certifying Examination in Orthopaedics required for eligibility to become a Fellow of the Philippine Orthopaedic Association.

   b. Training will be deemed complete when the trainee has satisfactorily achieved the learning objectives recommended in the curriculum. At this stage, the trainee should be able to join and lead a multidisciplinary team that would receive, assess and go on to definitively manage the majority of patients who need emergency treatment. He would be able to provide a similar service for a range of common non-urgent conditions.

2. Requirements:
   a. Board Eligibility - The minimum requirements to take the Diplomate Examination are the following:
      i. A valid physician's license (issued by the Professional Regulation Commission) to practice in the Philippines. For Foreign Medical Professionals (FMPs), a valid temporary training permit that has not expired is required in lieu of the physician's license.
      ii. Completion of residency training in an institution or program accredited by the PBO.
      iii. The candidate must have passed the Qualifying Examination given by the PBO the previous year.
      iv. The candidate must have performed the minimum number of required cases as delineated in the section on “Minimum Case Requirements”.
      v. The candidate must have completed a research paper. The paper must have been presented in a national or an international forum (poster or podium), or it must have been published in a national or an international journal.

   b. Documentary Requirements
      i. A written application to take the written and oral parts of the examination must be submitted to the Board through the Secretary at least 60 days before the scheduled date of examination. The date of the examination for the current year is set by the PBO at the start of the fiscal year.
      ii. The applicant should submit a completed form AC-03 (Evaluation of Surgical Case Variety and Number for Graduating Residents) to the PBO one month after graduation from the training program.
      iii. The applicant shall also submit to the Board not later than 30 days prior to the examination the following:
1. A properly filled-up PBO Information sheet for Diplomate Examination (PBO Form EC-01)
2. Two passport-size and one ID size pictures, current within the last six months
3. Current Curriculum Vitae
4. List of surgeries done for the past 12 months, inclusive of surgeries done during fellowship, if any. The list of cases performed by the graduate should be authenticated by his immediate superior – the fellowship director for a fellowship program or the department chairman in other cases.
5. A research paper that the applicant had done during or after his residency training. This paper must have been presented in a local or an international forum, or it must have been published in a national or an international journal.
6. A photocopy of Diploma or Certificate of Completion of Training from the Institution he graduated from.

iv. Payment of the Application/Examination Fee, the amount of which is to be determined by the Board. The current fee is published in the PBO website (www.pbortho.org).

3. Review of Applications
The Committee on Examination shall review the applications and requirements submitted. The Secretary will inform the applicants who are approved and are qualified to take the Diplomate Examination. They will also be issued examination permits to enable them to take the examination at the specified time and venue.

4. Schedule of Examinations
a. The Board, through the Examination Committee, shall administer and schedule the Diplomate Examination not later than October 31 of each year. The specific date and place of the examination as determined by the Board will be announced before the date of the examination.

b. The Diplomate Examination shall be administered in three parts:
   i. Part 1: Written Examination
   ii. Part 2: Oral Examination
   iii. Part 3: Practical Examination

c. A candidate must take all three parts of the examination.
   i. Passing Part 1 (Written Examination) is a prerequisite to taking Part 2 (Oral Examination).
   ii. Part 3 (Practical Examination) should be scheduled during the last 12 months of residency training.
5. **Failure to Pass the Board Examinations**
   a. A board-eligible candidate who fails any part of the Diplomate Examination is allowed to retake that part during the next year’s Diplomate Examination.

   b. A board-eligible candidate is allowed three attempts to pass any part of the examination. After that, the candidate is required to take a six-month refresher course in an accredited training program as designated by the PBO *every time* the candidate takes that part of the board examination that was not passed.

   c. A certification of attendance to the refresher course by the Program Chairman will be required before the candidate is allowed to retake the Diplomate Examination.

6. **Guidelines for Taking a Refresher Course**
   a. A candidate who requires a refresher course should write a formal letter to the PBO requesting for the opportunity to undertake such a course for the purpose of taking the diplomate examinations.

   b. The PBO will determine in which institution the candidate will have to take the refresher course, taking into account the areas where the candidate is deficient. The PBO will then inform the candidate and the institution.

   c. The refresher course will last for 6 months. During the refresher course, the candidate will be involved in conferences, lectures, rounds, self-directed learning, and other educational opportunities in the fields of trauma, adult orthopaedics, spine, pediatric orthopaedics, and hand. The chairman is given the freedom to choose how the candidate’s attendance is monitored.

   d. In addition, depending on the institution in which he/she is assigned, the candidate may assist in surgeries, PROVIDED that it affords him/her the opportunity to learn AND it does not detract from time needed for any other educational activities.

   e. A candidate is not allowed to go on duty.

   f. After the six-month refresher course, the candidate will have to present to the PBO a certificate of completion signed by the chairman of the program in which the refresher course was taken.

7. Candidates who have passed Parts 1, 2 and 3 as determined by the Board of Trustees are notified by mail. A certificate/diploma to this effect will be issued with all the rights and privileges thereunto appertaining to the title “Diplomate of the Philippine Board of Orthopaedics”.

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D. MINIMUM REQUIREMENTS FOR ACCREDITATION

1. Hospital Requirements
   a. The program should be in a specialty hospital (as defined in the Department of Health Classification of 2015) that is devoted to the treatment of musculoskeletal disorders (e.g., Philippine Orthopedic Center) or a Level 3 general hospital (as defined in the Department of Health Classification of 2015) with at least 100-bed capacity.

   b. There should be an emergency room or emergency department.

   c. There should be a service/charity division that would be handled by training residents.

   d. There must be a separate and adequately equipped Orthopaedic Outpatient Clinic.

   e. Operating room facilities must be adequate for performing minor and major orthopaedic procedures in Trauma, Adult Orthopaedics, Pediatrics, Spine and Hand. These facilities should include a C-arm (fluoroscope), orthopedic table (C-arm compatible) and arthroscope.

   f. Rehabilitation facilities and a brace shop must be available within the vicinity of the Hospital.

   g. There must be a Radiology Unit with a board certified Radiologist in attendance. There must be easy access to CT-scan and MRI in the locality.

   h. There must be a Pathology Unit with a board certified Pathologist capable of doing clinical and anatomic pathology.

   i. An orthopaedic library with current, standard textbooks, journals and other references including electronic resources must be available.

2. Training Program Requirements
   a. Training Staff
      i. Minimum Qualifications of a Trainer
         1. Currently a Fellow in good standing of the POA.
         2. Be familiar with and understand the Curriculum in the PBO Manual.
         3. Commitment to devote time to training of residents.
         4. Commitment to undertake continuing professional development endeavors.
a. Members of the training staff are encouraged to undertake subspecialty training and to continually update their skills and knowledge.

b. It is highly recommended that those participating in training undergo some courses to enhance their role as trainers. Noteworthy are the programs offered by the National Teacher Training Center for Health Professionals at the University of the Philippines Manila.

5. Commitment to maintain their good standing with the POA

ii. Responsibilities of the Training Staff

1. To coordinate the management, education and training of residents.

2. To conduct performance assessment meetings and complete assessment reports as required.

3. To monitor resident’s surgical experience and regularly review the operative logbooks (digital and/or printed).

4. To identify, document and advised the trainee of any unsatisfactory or marginal performance at the earliest possible opportunity.

iii. Positions

1. Chairperson

   a. Must be a Fellow of the Philippine Orthopaedic Association (POA) and an active staff member of the hospital.

   b. At any given time, the chairperson should head only one residency training program, whether accredited or non-accredited.

   c. The chairman must not be an incumbent Trustee of the Philippine Board of Orthopaedics.

2. Training Officer

   a. Must be a Fellow of the POA and an active staff member of the hospital.

   b. At any given time, the training officer should be the training officer in only one residency training program, whether accredited or non-accredited.

   c. The training officer must not be an incumbent Trustee of the Philippine Board of Orthopaedics.

3. Consultant Staff

   a. At least three other Fellows of the POA with subspecialty expertise who are credentialed by the hospital and actively involved in the training of residents.

   b. A minimum of 5 consultants (chairman, training officer, three additional consultant staff) who actively participate in the training of residents is
Minimum Requirements for Accreditation

required per 5 residents. An additional POA Fellow with subspecialty expertise who is credentialed by the hospital and actively involved in the training of residents is required for every additional resident accepted into the program.

b. Resident Staff
   i. The minimum number of residents for an accredited training program is one resident per year of training.
   ii. Each resident should take the annual orthopaedic in-training examinations (ITE) every year for three years. For programs with a duration of 4 years, residents will have to take the ITE starting on their first year. For programs with a duration of 5 years, residents will have to take the ITE starting on their second year. For programs with a duration of 6 years, residents will have to take the ITE starting on their third year. And so on.
   iii. Residents will have to take the ITE for their year level, regardless of whether they took it previously or not (e.g., a resident who repeats a year level). Their present score will supersede any previous score that they had.
   iv. Any resident who does not take the ITE for whatever reason will not be allowed to advance to the next year of training.
   v. Each resident on his/her last year of training is required to take the qualifying examination. The Training Officer/Committee should furnish the PBO with the list of qualified residents who will take the qualifying examination.
   vi. Each resident must complete the minimum number of case requirements prior to graduation as determined by the PBO Committee on Accreditation, and other special operative procedures that are required by the Board.
   vii. Each graduating resident must have completed at least one research project. This must have been published or presented orally or in poster format in a national or international forum.

c. Case Requirements
   i. The minimum case requirements may be adjusted by the board in the future, depending on the total number and variety of cases performed by residents in all accredited training programs at that time.
   ii. The minimum case requirements should be fulfilled by every resident graduating from an accredited training program.
   iii. The chapter on “Curriculum Skills” lists the minimum case requirements (see “Minimum Required Number of Resident’s Cases – Total Cases” and “Minimum Required Number of Resident’s Cases – Specific Cases”).
iv. Based on the minimum case requirements, the minimum number of charity/service patients needed to be operated on in a year per program can be calculated.

1. The assumption is that the resident will perform all his requirements on the last year of training. More junior residents will not perform any procedure until their last year (NOTE: THIS IS ONLY AN ASSUMPTION FOR THE CALCULATION).

2. From the total number of cases needed per resident, half should be charity cases since the rule requires that per category, at least 50% should be charity patients.

3. The minimum number of charity/service patients operated in one year, per program would be: \( \frac{1}{2} \) total number of cases required multiplied by the number of graduating residents.

4. Based on the present table of “Minimum Case Requirements” (see the chapter on “Curriculum Skills”):
   a. A graduating resident needs to perform 243 procedures prior to graduation (excludes the required 50 open/closed reduction with case/splint/traction);
   b. Half of this number is approximately 121;
   c. Therefore, at the time of this writing, a training program would require \( (121 \times \text{number of graduating residents}) \) to meet the minimum number of charity patients operated upon in a year.
E. PARTNERSHIPS AND OUTSIDE ROTATIONS

1. Purpose of forming partnerships/outside rotations:
   a. To meet the required minimum number and variety of cases for a training program to maintain its accreditation status
   
   b. To meet the required minimum case requirements necessary for a training resident to graduate from a program
   
   c. To foster exchange of knowledge
   
   d. To expose a resident to different treatment scenarios
   
   e. For graduates who have failed the diplomate examination three (3) times, the board will require these graduates to take a refresher course in any of the accredited programs as a prerequisite to retake the diplomate examination (see chapter on “The Diplomate Board Examination”

2. Guidelines for Partnerships/Outside Rotations
   a. A partnership between hospitals or training programs is formed so that residents may benefit from the outside rotation (external rotation) that such a partnership offers.
   
   b. A training program that can independently meet the requirements for accreditation is not required to form a partnership.
   
   c. If institutions, programs, or hospitals enter into a partnership, a notarized Memorandum of Agreement between the involved parties is required.
   
   d. An existing training program whose residents cannot meet the minimum case requirements for graduation should initially increase the length of the residency program and/or decrease its complement of residents until the minimum number of one resident per year is reached.
      i. If this is not enough, consideration may be given to forming a partnership with another hospital.
      ii. The PBO does not allow a program that has entered into a partnership with another hospital to increase its complement of residents and use such partnership to address any resulting deficiencies.
   
   e. Partnerships may only involve accredited training programs or satellite hospitals and must be approved by the PBO. The PBO may suggest or recommend which hospitals or programs may form partnerships.
      i. The PBO will determine the duration of external rotations and the specialties in which residents will have to rotate in.
Partnerships and Outside Rotations

ii. External rotations will have a fixed length of three (3) months per period/block per specialty (trauma, hand, spine, pediatrics, and adult) and can be increased in 3-month periods, as needed.

f. An existing training program that can independently meet the requirements for accreditation is not allowed to initiate a partnership with a satellite hospital (see definition below). This is to avoid the possibility of using residents as manpower for a satellite hospital.

g. First year residents are not allowed to rotate outside their base hospital. The exception is in a Consortium in which residents, although rotating in different hospitals, are under one administrative body only.
   i. Definition of base hospital – This is the hospital that hosts the residency program or where the training program is based. A base hospital does not include any satellite clinic/hospital or sister hospital. There can only be one medical director per base hospital.
   ii. Strictly speaking, a consortium has no base hospital (see definition of consortium below). A consortium, therefore, is not allowed to increase its complement of residents beyond what the hospitals in the consortium can provide in terms of the minimum case requirements per resident.

h. Graduating residents are allowed to rotate outside the hospital where their training program is based, except when they happen to hold the position of chief resident.

i. Rotating residents will be excused from all activities/duties of their base hospital. They are not allowed to be pulled-out to another institution for purposes of assisting surgeries or manning the OPD. Resident allocation for these purposes should have been planned prior to starting a partnership.

j. Rotating residents will be under the direct supervision of the training officer of the receiving program throughout the duration of his/her rotation, during which he/she will be expected to perform the duties and responsibilities (ER, Ward, OR, OPD, conferences, rounds and other teaching activities) of a regular resident. For satellite programs, residents will be under the supervision of an assigned POA fellow from the satellite program who should also be a consultant of the base hospital.

k. Rotating residents will be evaluated and graded based on their performance by the host program. A copy of this evaluation will be forwarded to the home program and to the PBO.

l. The types of partnerships are:
   i. Consortium
   ii. Linkage
iii. Affiliation
iv. Satellite

m. Any questions/clarifications will be directed to the PBO and will be answered accordingly.

3. Types of Partnerships
   a. Consortium
      i. Definition: A consortium is composed of several hospitals whose training programs cannot individually be accredited, but as a group can establish a residency training program with its pooled resources and with only one administrative body, i.e. one training committee with one department chairman and training officer.
         1. In a Consortium, each member-hospital has no accredited training program in orthopedics.
         2. It is the program itself, within the context of the Consortium, which is evaluated for accreditation or reaccreditation.
      ii. Requirements:
         1. There must be a Notarized Memorandum of Agreement signed by the responsible officers of the institutions desiring to form, sustain and maintain a Consortium.
            a. This will contain the scope of the involvement, functions and responsibilities of the member-hospitals.
            b. The duration of such an agreement should not be less than the length of the Residency Training Program.
            c. The participating institutions should come from a local area where there is no accredited training program.
            d. The participating hospitals should be level 3 hospitals per the Department of Health guidelines with at least a 100-bed capacity per hospital.
         2. The member-hospitals in a Consortium do not have the capability to be independently accredited due to certain deficiencies that cannot be corrected on their own.
         3. The training of orthopedic residents from the participating hospitals shall be under the supervision and control of one set of Consortium officers, i.e., one Chairman, one Training Officer and one set of Training Staff. These officers shall be selected from among the consultant staff of the hospitals forming the consortium.
         4. There must be only one set of Residents who will rotate among the member-hospitals. The number of residents in training will depend upon the capacity of the consortium.
5. There must be only one Residency Training Program to be followed by all participating member-hospitals.
6. The approval of the PBO must be secured before any consortium can be formed.

iii. Accreditation:
1. The accreditation of the training program will apply only to the Consortium and not to each member-hospital.
2. The initial period of accreditation of the Consortium will be for one year (Provisional Accreditation) with provisions for regular visits.
3. A Consortium may eventually be granted full accreditation status if it fulfills the requirements for such a status.
4. Should any of the participating hospitals wish to apply for their own accredited training program, the Consortium will have to be formally dissolved before any application can be considered.
   a. The Consortium cannot be formally dissolved until the present group of residents graduate from the program.
   b. The PBO will have to be informed of the dissolution of the Consortium.
   c. A participating hospital applying for its own accredited training program will be considered as a first-time applicant and will have to follow the procedures for first-time applicants as set forth in this handbook.

iv. Monitoring:
1. The Consortium must submit an Annual Report to the PBO Committee on Accreditation and other reports required by the PBO.
2. The Committee on Accreditation will conduct a regular evaluation of the Consortium during the period of its Provisional Accreditation and thereafter as mandated by events.
3. Members of the Resident Staff of the Consortium must take the Annual PBO In-Training Examination.

b. Linkage
i. Definition: A Linkage consists of the mutual exchange of residents coming from accredited residency training programs whose training programs cannot individually fulfill the requirements for reaccreditation because of some deficiencies and shortcomings in terms of patient population and other needed resources. Each institution has its own department Chairman and Training Officer. Each program can retain its individual accreditation through this scheme.
1. In a Linkage, each member-hospital has an accredited training program in orthopedics.
2. However, each member-hospital cannot fulfill the requirements for reaccreditation on its own and that is the reason why the Linkage was formed.

ii. Requirements:
1. There must be a Notarized Memorandum of Agreement signed by the responsible officers of the institutions desiring to form, sustain and maintain a Linkage.
   a. This will contain the scope of the involvement, functions and responsibilities of the member-hospitals.
   b. The duration of such an agreement should not be less than the length of the Residency Training Program.
   c. Each participating institution should have an existing accredited orthopedic training program.
2. Each participating institution on its own should not be able to meet the requirements for an independent reaccreditation. It would need the facilities of the other institution to fully meet the requirements. The same is true with the other participating institutions.
3. The Orthopaedic Department of each participating institution shall be under the supervision of its own Chairman and Training Officer. Each training institution will have its own roster of residents.
4. The residents of all the participating institutions involved in the linkage shall rotate among the different member-institutions.
   a. They shall have regular conferences and common activities among themselves.
   b. The resident/s will be governed by the rules and regulations of the host hospital where they are rotating.
   c. A resident who is rotating outside his/her base hospital cannot be called back into the base hospital for the purpose of assisting in surgery until the rotation is completed.
5. The Orthopaedic Departments of the participating hospitals shall retain their own identity as an accredited training program for as long as they participate in the Linkage.
6. The approval of the PBO Board must be secured before any formal Linkage can be formed and started.

iii. Accreditation:
1. The accreditation of the training program will apply to each member-hospital of the Linkage. In other words, the result
for all member-hospitals will be the same. Thus, should a member-hospital receive a warning, all member-hospitals will receive a warning since each member-hospital is dependent on the others for their accreditation.

2. The initial period of accreditation of the Linkage will be for one year (provisional accreditation) with provisions for regular visits.

3. A Linkage can never be granted full accreditation. The highest status each member-hospital can achieve is Qualified Accreditation.
   a. Accreditation is granted to each member-hospital. However, as a prerequisite to forming a linkage, each hospital should not be able to meet the requirements for accreditation on its own. That is why the linkage was formed.
   b. Unlike a Linkage, a Consortium can be granted full accreditation since it is the consortium itself, and not the individual member-hospitals, that is evaluated.

4. Should any of the participating hospitals in a Linkage feel that they can satisfy the requirements for reaccreditation on their own and therefore wish to become independent, the Linkage will have to be formally dissolved and the PBO notified of this.
   a. The Linkage cannot be formally dissolved until the present group of residents graduate from the program.
   b. It is important to realize that once the Linkage is dissolved, participating hospitals that cannot satisfy the requirements for reaccreditation on their own risk losing their accreditation status.

iv. Monitoring:
   1. The member-hospitals of the Linkage must individually submit an Annual Report and other reports required by the PBO to the Committee on Accreditation.
   2. The Committee on Accreditation will conduct a regular evaluation of each member-hospital of the Linkage during the period of its Provisional Accreditation and thereafter as mandated by events.
   3. Resident physicians of the member-hospitals of the Linkage must take the Annual PBO In-Training Examination.

c. Affiliation
   i. Definition: An Affiliation exists when a residency-training program sends residents to one or more accredited residency-
training programs and does not receive residents from them in return for reaccreditation purposes.

1. In an Affiliation, each member-hospital has an accredited training program in orthopedics.

2. However, there are certain member-hospitals that cannot fulfill the requirements for reaccreditation on its own and that is the reason why they have to send residents to the receiving member-hospital/s. On the other hand, the recipient member-hospital/s have an orthopedic program that can independently fulfill the requirements for reaccreditation.

3. Although it does not have to do so, a receiving hospital (which should be able to independently fulfill the requirements for accreditation) may send its residents to the other member-hospitals if it feels that it would be advantageous to do so. But this would still constitute an Affiliation and not a Linkage, since in a Linkage, the member-hospitals cannot independently fulfill the requirements for accreditation.

ii. Requirements:

1. There must be a Notarized Memorandum of Agreement signed by the responsible officers of the institutions agreeing to form, sustain and maintain an Affiliation.
   a. This will contain the scope of the involvement, functions and responsibilities of the member-hospitals.
   b. The duration of such an agreement should at least be one year.
   c. Each participating institution should have an existing accredited orthopedic training program.

2. The program sending residents to another program should not be able to meet the requirements for an independent reaccreditation. On the other hand, the receiving institution should be able to independently meet the requirements for reaccreditation.

3. The rules and regulations of the receiving hospital will govern the affiliating resident.

4. Before any Affiliation can be done, the approval of the Board of Trustees must be obtained upon recommendation of the PBO Committee on Accreditation.

iii. Accreditation:

1. Each member-hospital will be individually and independently evaluated for reaccreditation.

2. The initial period of accreditation for the member-hospital sending residents to another program will be for one year
(provisional accreditation) with provisions for regular visits.

3. A member-hospital that sends residents to another program for the purpose of meeting the requirements for reaccreditation can never be granted full accreditation. The highest status that it can achieve is Qualified Accreditation.

4. A member-hospital that receives residents from another program and that can independently fulfill the requirements for reaccreditation may eventually be granted full accreditation status if it fulfills the requirements for such a status.

iv. Monitoring:

1. The member-hospitals of the Affiliation must individually submit an Annual Report and other reports required by the PBO to the Committee on Accreditation.

2. The Committee on Accreditation will conduct a regular evaluation of each member-hospital of the Affiliation.

3. Resident physicians of the member-hospitals of the Affiliation must take the Annual PBO In-Training Examination.

d. Satellite

i. Definition: A Satellite partnership exists when an accredited training program sends residents to one or more hospitals that do not have an existing accredited residency-training program in orthopedics.

1. A Satellite institution is not by itself a training institution, but is a general or specialty hospital catering to cases that may satisfy the service and training needs of an accredited training institution. These institutions must be staffed by Fellows of the POA in order to qualify under this category.

2. In a Satellite partnership, a member-hospital has an accredited training program in orthopedics. However, the receiving Satellite hospital or institution does not have an accredited training program in orthopedics.

3. The member-hospital with an accredited training program cannot fulfill the requirements for reaccreditation on its own and needs to send their residents to another hospital, even if there is no accredited orthopedic training program in place, in order to address its deficiencies.

ii. Requirements:

1. There must be a Notarized Memorandum of Agreement signed by the responsible officers of the institutions agreeing to form, sustain and maintain a Satellite institution.
a. This will contain the scope of the involvement, functions and responsibilities of the two hospitals involved.
b. The duration of such an agreement should at least be one year.

2. The program sending residents to another hospital should not be able to meet the requirements for an independent reaccreditation.

3. The receiving hospital has no accredited training program in orthopedics.

4. The receiving hospital must have bonafide fellows of the POA in good standing who are also staff members of the accredited training institution from where the residents are based.

5. The rules and regulations of the receiving hospital will govern the affiliating resident physicians.

6. Before a Satellite Institution can be established, the approval of the Board of Trustees must be obtained upon recommendation of the PBO Committee on Accreditation.

iii. Accreditation:

1. The member-hospital with an accredited training program in orthopedics will be individually and independently evaluated for reaccreditation.

2. The initial period of accreditation for the member-hospital sending residents to a satellite hospital will be for one year (provisional accreditation) with provisions for regular visits.

3. A member-hospital that sends residents to a satellite hospital for the purpose of meeting the requirements for reaccreditation can never be granted full accreditation. The highest status that it can achieve is Qualified Accreditation.

iv. Monitoring:

1. The member-hospitals with an accredited training program in orthopedics must submit an Annual Report and other reports required by the PBO to the Committee on Accreditation.

2. The Committee on Accreditation will conduct a regular evaluation the hospital sending residents to the Satellite hospital.

3. Resident physicians in the accredited training institution must take the Annual PBO In-Training Examination.
F. ACCREDITATION PROCESS

1. Accreditation Procedures
   a. Procedure for Initial (First-time) Accreditation
      i. The hospital through the department chair and with prior approval
         of the Medical Director/Chief of Hospital must submit a letter of
         application addressed to the Chairman of the Philippine Board of
         Orthopaedics.
      ii. The Philippine Board of Orthopaedics will in turn provide the
          following: Application for Accreditation Sheet (Form AC-01), and
          Annual Report Sheet (Form AC-04). Alternatively, these forms
          may be downloaded from the PBO Website (www.pbortho.org).
      iii. The applicant will submit the accomplished forms (AC-01 and
           AC-04) and the application fee. The current fees are made
           available on the PBO Website. The Annual Report shall contain
           statistics of the full year prior to application.
      iv. The PBO Committee on Accreditation will evaluate the
          application information and statistics submitted. Form AC-05 will
          be used as the evaluation tool. Applicants who cannot show
          evidence of fulfilling the minimum case requirements for
          accreditation (see chapter on curriculum skills) will be notified
          accordingly.
      v. Applicants whose data indicate compliance with the minimum
         case requirements will be visited by a team composed of
         members of the Committee on Accreditation.
   vi. Expectations of the visiting team:
      1. Presence of the following is mandatory:
         a. Department chairman
         b. Resident training officer
         c. All residents in the program, if there are any
      2. The following should be ready for presentation:
         a. Residents’ logbook (digital and/or printed), if any
         b. All other relevant records
         c. Pictures of cases done by the residents (pre-op, post-
            op, etc.), if any
      3. Presentation of any census, case, or document relevant to
         the accreditation process should be done by the chairman or
         training officer. He/she may be assisted by the residents, if
         necessary.
      4. Form to be used: PBO AC-05
   vii. The Committee on Accreditation will meet, deliberate, evaluate
       and make reports and recommendations to the Board of Trustees.
   viii. The Board of Trustees will notify the applicant about the result of
        the evaluation.
b. Procedure for Reaccreditation of Accredited, Provisional, and Conditional Programs

i. Each accredited training institution (or the common training program, in the case of consortiums) must submit the following to the Board:

1. An Annual Report to be submitted on or before February 15 of each year. The report should conform to PBO Form AC-06 (see Appendix - PBO Forms).
2. Completed PBO Form AC-03 per graduate to be submitted one month after graduation of their senior residents.

ii. Annual Accreditation Fee. All accredited training institutions (or the common training program, in the case of consortiums) are subject to payment of an Annual Accreditation Fee as determined by the Board. The current fees are made available in the PBO Website.

iii. Accreditation visit:

1. Institutions will be informed of when they will be visited after submission of the Annual Report.
   a. Institutions with full accreditation will be visited every third year.
   b. Institutions with full accreditation may be visited more frequently if:
      i. more than 1/3 of all their training residents rank below the 70% percentile of their respective year level in the in-service training examination;
      ii. more than 1/3 of all their graduating residents rank below the 70% percentile in the qualifying examination;
      iii. only 50% or less of their qualified residents pass the diplomate board examination;
      iv. there is a question as to whether minimum case requirements are being met; and/or
      v. there are problems noted in the annual report.
2. The following will be presented/inspected:
   a. Annual Report
   b. Hospital facilities
   c. Residents’ log book and individual annual report

3. Expectations of the visiting team:
   a. Presence of the following is mandatory:
      i. Department chairman
      ii. Resident training officer
      iii. All residents in the training program
   b. The following should be ready for presentation:
      i. Residents’ logbook (digital and/or printed)
ii. All other relevant records
iii. Pictures of cases done by the residents (pre-op, post-op, etc.)

4. Interview:
   a. All residents should prepare to be interviewed to verify the data in their Logbooks (digital and/or printed) and to discuss other important information regarding their training program.
   b. The Chairman and/or Training Officer may be interviewed separately.

5. Form to be used: PBO AC-02
   iv. The Committee on Accreditation will meet, deliberate, evaluate and make reports and recommendations to the Board of Trustees.
   v. The Board of Trustees will notify the training program about the result of the evaluation.

c. Procedure for Reaccreditation after Suspension of a Previously Accredited Orthopedic Training Program
   i. For programs that have been SUSPENDED, application for reaccreditation must be made within two years of the suspension.
   ii. The hospital through the department chair and with prior approval of the Medical Director/Chief of Hospital must submit a letter requesting for reaccreditation addressed to the Chairman of the Philippine Board of Orthopaedics.
   iii. A copy of the letter sent by the PBO to the training program outlining the deficiencies and explaining why the program was suspended should be included in the request for reaccreditation.
   iv. A report indicating how the deficiencies in the training program have been corrected should likewise be included in the request for reaccreditation.
   v. The training program must submit to the Board an Annual Report of the year/s that it was under suspension. The report should conform to PBO Form AC-06 (see Appendix A: PBO Forms). Furthermore, the training program should submit to the Board the completed Form AC-03 of each graduate during the same period.
   vi. Reaccreditation Fee. A reaccreditation fee as determined by the Board will be charged. The current fees are made available on the PBO Website.
   vii. The PBO Committee on Accreditation will evaluate the reaccreditation information and statistics submitted by the training program.
   viii. If the data show that deficiencies have been corrected, a team composed of members of the Committee on Accreditation will visit the training program.
   ix. The reaccreditation visit:
1. The institution will be informed when the visit will take place.
2. The following will be presented/inspected:
   a. Annual Report
   b. Hospital facilities
   c. Residents’ log book and individual annual report
3. Expectations of the visiting team:
   a. Presence of the following is mandatory:
      i. Department chairman
      ii. Resident training officer
      iii. All residents in the training program
   b. The following should be ready for presentation:
      i. Residents’ logbook (digital and/or printed)
      ii. All other relevant records
      iii. Pictures of cases done by the residents (pre-op, post-op, etc.)
4. Interview:
   a. All residents should prepare to be interviewed to verify the data in their logbooks (digital and/or printed) and to discuss other important information regarding their training program.
   b. The Chairman and/or Training Officer may be interviewed separately.
5. Form to be used: PBO AC-02
   x. The Committee on Accreditation will meet, deliberate, evaluate and make reports and recommendations to the Board of Trustees.
   xi. The Board of Trustees will notify the training program about the result of the evaluation.

d. Procedure for Application after Termination of a Previously Accredited Orthopedic Training Program
i. For programs that have been TERMINATED, application for accreditation may only be done after a minimum of two years from the date of termination.
   1. All rules and regulations affecting first-time applicants for accreditation will apply to applications from programs that have been terminated and are now applying for accreditation.
   2. Thus, for example, if a regulation now exists that only hospitals attached to a medical school may have a training program, a program that once existed in a hospital without a medical school cannot apply for accreditation after it has been terminated unless the hospital is now attached to a medical school.
ii. The hospital through the department chair and with prior approval of the Medical Director/Chief of Hospital must submit a letter of
application addressed to the Chairman of the Philippine Board of Orthopaedics.

iii. The Philippine Board of Orthopaedics will in turn provide the following: Application for Accreditation Sheet (Form AC-01), and Annual Report Sheet (Form AC-04). Alternatively, these forms may be downloaded from the PBO Website (www.pbortho.org).

iv. The applicant will submit the accomplished forms and the application fee. The current fees are made available on the PBO Website. The Annual Report shall contain statistics of the full year prior to application. In addition, the following should also be submitted:

1. A copy of the letter sent by the PBO to the training program outlining the deficiencies and explaining why the program was terminated.

2. A report indicating how the deficiencies have been corrected.

v. The PBO Committee on Accreditation will evaluate the application information and statistics submitted. Form AC-05 will be used as the evaluation tool. Applicants who cannot show evidence of fulfilling the minimum case requirements for accreditation (see chapter on curriculum skills) or who cannot demonstrate that deficiencies have been adequately addressed will be notified accordingly.

vi. Applicants whose data indicate compliance with the minimum requirements or whose data indicate that deficiencies have been corrected will be visited by a team composed of members of the Committee on Accreditation.

vii. Expectations of the visiting team:

1. Presence of the following is mandatory:
   a. Department chairman
   b. Resident training officer
   c. All residents in the program, if there are any

2. The following should be ready for presentation:
   a. Residents’ logbook (digital and/or printed), if any
   b. All other relevant records
   c. Pictures of cases done by the residents (pre-op, post-op, etc.), if any

3. Presentation of any census, case, or document relevant to the accreditation process should be done by the chairman or training officer. He/she may be assisted by the residents, if necessary.

4. Form to be used: PBO AC-05

viii. The Committee on Accreditation will meet, deliberate, evaluate and make reports and recommendations to the Board of Trustees.

ix. The Board of Trustees will notify the applicant about the result of the evaluation.
2. Verification
The Board reserves the right to verify the authenticity and veracity of all documents submitted to it during the accreditation process. In the event that falsification or misrepresentation of any document is noted, appropriate sanctions will be imposed by the Board after due deliberation.

3. Assessment of Training Programs (Form AC-02)
   a. Form AC-02 (Evaluation Sheet for Orthopaedic Training Programs) will be used in the assessment of training programs, excluding initial (first-time) applicants and terminated programs applying for accreditation. This form may be modified or updated as the need arises.

   b. The following will be assessed when accrediting a training program:
      i. Surgical skills
         1. Surgical charity case load (refer to the section of “Minimum Case Requirement” in the chapter “Minimum Requirements for Accreditation”)
         2. Variety of cases performed by the residents who graduated in the year immediately preceding the present accreditation visit. This will be based on Form AC-03.
         3. Logbook Monitoring (digital and/or printed)
            a. The Residents’ logbook (logbook of operations, digital and/or printed) allows the training residents an opportunity to document all operations that they attended and the extent of their involvement in the operation.
            b. Such a scheme allows for a better assessment of the trainees level of experience relative to other trainees and in the future will allow the creation of “normalized” data allowing the Board to create definitive standards for required experience. Comparison of numbers of operations attended, the extent of surgical exposure and the level of supervision can now be made and this can be scientifically analyzed by the Board.
            c. The data that can be harnessed from this system will allow Training Officers of each institution better scrutiny of each resident’s experience at varying stages of their training. It will also provide the Board with vital “hard data” in understanding satisfactory and unsatisfactory progress on the part of the resident or even demonstrating an unsatisfactory training environment and an uncommitted trainer.
            d. If a digital logbook is required by the PBO, data entered will be used to calculate the scores in the
Accreditation Process

“Surgical Charity Case Load” and “Variety of Cases” components of Form AC-02.

4. Score/s of board-eligible graduate/s in the Diplomate Examination Part 3 (Practical Examination)

ii. Theoretical knowledge

1. In-training Examination (ITE). The ITE is a formal test of knowledge relevant to the training of the residents conducted by the PBO. This assessment specifically tests knowledge and, to a limited degree, the application of that knowledge. The format is multiple-choice questions. It is conducted annually for the last three levels immediately prior to the final year of residency (e.g., year level I to level III for a 4-year program or year level II to level IV for a 5-year program).

2. Qualifying Examination. Each graduating resident of an accredited training program must pass this examination before he can be qualified to take the Diplomate Examination.

   a. Passing of the Qualifying Examination is a prerequisite to taking of the Diplomate Examination.

   b. The Qualifying Exam can only be taken a maximum of three times before a graduate is allowed to take the Diplomate Examination. After three unsuccessful attempts, the examinee is required to take a refresher course of at least six months every time the examinee plans to retake the Qualifying Exam. The refresher course should be handled by the training program of the examinee. A certificate of completion of the refresher course should be submitted to the PBO before the candidate is allowed to retake the exam.

3. Results of the Diplomate Examination Part 1 (Written Examination).

4. Results of interviews with the residents by the Board members during the visitation.

iii. Research

1. Points are given based on the research output of the training program.

2. Only research output for the year being evaluated will be considered.

3. For ongoing researches, points will be given if it can be demonstrated that meaningful interval progress was accomplished during the year being evaluated. The Board may require that an interval report be submitted highlighting the progress of the ongoing research.
4. For papers that win a research contest, only national or international competitions or presentations will be given points.

5. For papers that have been published, only national or international journals will be given points.

iv. Teaching and Learning Activities
v. Physical Plant
vi. Annual Report
vii. Staffing and Staff Development

c. Scores are calculated as detailed in Form AC-02.

4. Categories of Accreditation
   
a. Full Accreditation
      i. Requirements (all criteria should be fulfilled):
         1. Evaluation grade of 85% and above
         2. Less than 1/3 of all their training residents rank below the 70% percentile of their respective year level in the in-service training examination
         3. Less than 1/3 of all their graduating residents rank below the 70% percentile in the qualifying examination
         4. More than 50% of their qualified residents pass the diplomate board examination
         5. Meets minimum case requirements for residents
      ii. Accreditation is good for three years. Reaccreditation on the third year.

b. Qualified Accreditation
   i. Requirements (all criteria should be fulfilled):
      1. Evaluation grade between 70% and 84.99%
      2. Meets minimum case requirements for residents
   ii. Accreditation is good for one year. Yearly accreditation.

c. Provisional Accreditation
   i. Applicability:
      1. This applies to a new program accredited to train residents in orthopedic surgery after having satisfied the requirements of the PBO.
      2. This applies to a program that was previously terminated but has presently satisfied the requirements of the PBO to train orthopedic residents.
   ii. Accreditation is good for one year. Yearly accreditation.

d. Conditional Accreditation
   i. Requirements:
      1. Evaluation grade between 55% and 69.99%; AND/OR
2. Does not meet minimum case requirements for residents; AND/OR
3. Computed score for the “Surgical Skills” portion of the assessment score (see Form AC-02) is less than 17; AND/OR
4. Computed score for the “Theoretical Knowledge” portion of the assessment score (see Form AC-02) is less than 17; AND/OR
5. Computed score for the “Department Research Activity” portion of the assessment score (see Form AC-02) is less than 14

ii. A program in this category may be suspended if the rating cannot be improved within one year from the time that this status is given.

iii. This status is effective for a period of one (1) year. The PBO may opt to re-inspect the program within six months after this status has been given pending a request for re-accreditation. The program Chairman must notify all current residents and applicants to the program of this status in writing.

iv. Accreditation is good for one year. Yearly accreditation.

e. Suspended Accreditation

i. Requirements:
   1. Evaluation grade below 55%; AND/OR
   2. Program cannot improve its rating within one year from the time that the status of “Conditional Accreditation” was given; AND/OR
   3. Does not meet minimum case requirements for residents for 2 years in a row

ii. Suspension of a residency training program shall be for a minimum of twelve months and shall take effect upon deliberation by the Board and due notification of the involved program. The Board will allow the current residents to continue their training. However, the Board will not recognize new residents. Application for reaccreditation must be made in writing within two years once the deficiencies have been corrected and other requirements fulfilled as determined in a revisit.

iii. Accreditation status is lost. Application for reaccreditation must be made within two years of the suspension.

f. Terminated Accreditation

i. If a suspended program is unable to comply with the requirements imposed by the PBO after two years from the time a status of “suspended accreditation” is given, the program will finally be denied accreditation.

ii. Termination shall take effect upon decision by the PBO and the program duly notified. The Board will no longer recognize the
training of residents following the termination. Affected residents may transfer to other accredited programs by lateral entry to carry on with their training.

iii. Accreditation status is lost. Application for accreditation may only be done after a minimum of two years from the date of termination.

g. Disapproved

i. Applicability:
   1. This applies to a new program applying for accreditation but has not satisfied the requirements of the PBO.
   2. This applies to a program that was previously terminated and is presently applying for accreditation but has not satisfied the requirements of the PBO to train orthopedic residents.

ii. Application for an orthopedic training program is denied. Reaplication may be done after a minimum of one year from the time of disapproval.

5. Appeals

a. A program chairman may appeal any unfavorable ruling made by the Accreditation Committee. This must be done in writing and addressed to the PBO Chairman.

b. An appeals ad-hoc committee is formed by the PBO Chairman from the members of the Board of Trustees to be headed by the Accreditation Committee Chairman. A hearing is held, following which the appeals committee transmits its decision to the PBO Chairman.

c. Final action is then taken and the program Chairman appealing the decision is notified of this action in writing.
## APPENDIX – PBO FORMS

<table>
<thead>
<tr>
<th>PBO COMMITTEE</th>
<th>FORM</th>
<th>FORM NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>AC-01</td>
<td>Application for Accreditation</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AC-02</td>
<td>Annual Inspection Evaluation Sheet</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AC-03</td>
<td>Evaluation Sheet for Case Variety and Number</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AC-04</td>
<td>Annual Report for New Applicants</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AC-05</td>
<td>Evaluation Sheet for New Applicants</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AC-06</td>
<td>Annual Report for Current Training Programs</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AT-01</td>
<td>Peer Assessment Tool</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AT-02</td>
<td>Clinical Evaluation Exercise</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AT-03</td>
<td>Case-Based Discussion</td>
</tr>
<tr>
<td>Accreditation</td>
<td>AT-04</td>
<td>Direct Observation of Procedural Skills in Surgery</td>
</tr>
<tr>
<td>Awards</td>
<td>AW-01</td>
<td>Outstanding Residents Award: CV of Applicants</td>
</tr>
<tr>
<td>Awards</td>
<td>AW-02</td>
<td>Outstanding Residents Award: Criteria for Judging</td>
</tr>
<tr>
<td>Examination</td>
<td>EC-01</td>
<td>Information Sheet: OITE/Qualifying Examination Candidates</td>
</tr>
<tr>
<td>Examination</td>
<td>EC-02</td>
<td>Information Sheet: Diplomate Examination Candidates</td>
</tr>
<tr>
<td>Examination</td>
<td>EC-03</td>
<td>Evaluation Sheet: Diplomate Examination: Part 3</td>
</tr>
</tbody>
</table>

**Note:**

The complete and current version of the forms are available for download from the PBO website (www.pbortho.org). Please check the download page.
LETTER OF INTENT TO APPLY FOR ACCREDITATION

I, ____________________________________________, by the authority vested in me by the Governing Body / Medical Director / Chief of Hospital of ________________________ (Name of Hospital) hereby voluntarily apply for the accreditation of our Residency Training Program in

ORTHOPAEDIC SURGERY

We are fully aware that this application is on a voluntary basis, that the hospital authorities submit unconditionally for the inspection, review and survey of items pertinent to accreditation including physical plant, facilities and working staff of the hospital and that the hospital authorities are committed to abide by the decision of the Committee on Accreditation.

__________________________
Printed Name
Chairman/Section Head
Section/Department of Orthopedics

__________________________
Printed Name
Chairman, Department of Surgery
(if applicable)

__________________________
(Signature)

__________________________
(Signature)

NOTED AND APPROVED:

__________________________
Printed Name
Chairman, Governing Board or Chief of Hospital or Medical Director

__________________________
(Signature)

DATE: ______________________
(mm-dd-yyyy)
Institution: ________________________________ Date: __________

Passing Grade: 70% but must have passed MPL of criteria 1,2,3

Must Pass Criteria:

<table>
<thead>
<tr>
<th>1. Surgical Skills (25 points/MPL is 17)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Surgical Charity Case Load</td>
<td>7</td>
</tr>
<tr>
<td>Calculation: (Actual number of charity cases done by graduating residents of the previous year x 7) / (Number of graduating residents of the previous year x minimum charity case requirement per resident)</td>
<td></td>
</tr>
<tr>
<td>b) Variety of Cases</td>
<td>7</td>
</tr>
<tr>
<td>Calculation: (Average score from Form AC-03 of graduating residents of the previous year x 7) / 100</td>
<td></td>
</tr>
<tr>
<td>c) Log book</td>
<td>4</td>
</tr>
<tr>
<td>d) Score of Diplomate Exam Part 3 (practicals)</td>
<td>7</td>
</tr>
<tr>
<td>Calculation: (Average score of diplomate practical exam takers of the previous year x 7) / 100</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Theoretical Knowledge: (25 PTS/MPL is 17)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ITE scores</td>
<td>6</td>
</tr>
<tr>
<td>Calculation: (Transmuted average score of all residents who took the ITE the previous year x 6) / 100</td>
<td></td>
</tr>
<tr>
<td>b) Qualifying Exam Scores</td>
<td>7</td>
</tr>
<tr>
<td>Calculation: (Transmuted average score of all residents who took the qualifying exams the previous year x 7) / 100</td>
<td></td>
</tr>
</tbody>
</table>
c) Score of Diplomate Examinations
Calculation: (Transmuted average score of all residents who took the Diplomate Exams the previous year x 8) / 100

NB: The score of each resident is calculated as follows:
(Exam score / Number of items) x 100

e) Resident’s Interview with PBO

TOTAL 25

NB: For criteria 1 and 2 above: If there is a missing item, cross-multiplication will be applied. For example, for criteria 2 (theoretical knowledge), if no one took the diplomate exams, calculation will be: total institution score for criteria 2 /(25-8) : converted score / 25. Converted score will be the recorded score.

3. Department Research Activity (20 PTS/MPL is 14) *

<table>
<thead>
<tr>
<th>Research protocol</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papers presented as poster (national or international)</td>
<td>8</td>
</tr>
<tr>
<td>Papers presented in podium (national or international)</td>
<td>12</td>
</tr>
<tr>
<td>Papers published in an institutional journal</td>
<td>15</td>
</tr>
<tr>
<td>Papers that won a research contest</td>
<td>20</td>
</tr>
<tr>
<td>Papers published in a national (not institutional) journal</td>
<td>25</td>
</tr>
<tr>
<td>Papers published in an international journal</td>
<td>30</td>
</tr>
</tbody>
</table>

Calculation: Score for each research paper or activity / total number of research papers for the previous year

TOTAL 20

* includes only output for the year being evaluated

4. Teaching and Learning Activities (10 PTS)

<table>
<thead>
<tr>
<th>Teaching and Learning Activities</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre op and post op conference attendance</td>
<td>2</td>
</tr>
<tr>
<td>Mortality and Morbidity conference attendance</td>
<td>2</td>
</tr>
<tr>
<td>Subspecialty conference</td>
<td>1</td>
</tr>
<tr>
<td>Residents ’ protected Hour</td>
<td>1</td>
</tr>
<tr>
<td>Resident /Consultant Echo lectures</td>
<td>1</td>
</tr>
<tr>
<td>POA Annual Convention attendance</td>
<td>1</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Local workshops attendance</td>
<td>1</td>
</tr>
<tr>
<td>International Convention attendance</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

### 5. Physical Plant (10 PTS)

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated orthopaedic beds</td>
<td>2</td>
</tr>
<tr>
<td>Functional Xrays ( portable and fix )</td>
<td>2</td>
</tr>
<tr>
<td>Working C-Arm</td>
<td>1</td>
</tr>
<tr>
<td>Working Fracture Table</td>
<td>1</td>
</tr>
<tr>
<td>Working Operative Microscope</td>
<td>1</td>
</tr>
<tr>
<td>Spica table</td>
<td>1</td>
</tr>
<tr>
<td>Complete Ortho required textbook and on line access</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

### 6. Annual Report (5 PTS)

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted on time</td>
<td>1</td>
</tr>
<tr>
<td>Complied with prescribed format</td>
<td>1</td>
</tr>
<tr>
<td>Properly documented Mortalities / Morbidities</td>
<td>1</td>
</tr>
<tr>
<td>Presented well ( oral and powerpoint )</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

### 7. Staffing and Staff Development

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete line of consultants ( Trauma/Adult/Hand/Spine/Pedia )</td>
<td>2</td>
</tr>
<tr>
<td>With superspecialist Consultants ( sports/foot &amp; ankle/infectious/ arthroplasty/ Ilizarov &amp; reconstruction)</td>
<td>1</td>
</tr>
<tr>
<td>Residents and Consultants with award citations</td>
<td>1</td>
</tr>
<tr>
<td>Consultants attending short term fellowships</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>
Name of Graduating Resident: ____________________________________________
Institution: ___________________________________________________________ Date: ________

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Minimum</th>
<th>Total Done</th>
<th>Fixation</th>
<th>Charity</th>
<th>Private</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debridement of open fractures (must have at least 12 of external fixation)</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery shoulder, humerus, clavicle, scapula (must have at least 2 internal fixations)</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery elbow (must have at least 4 internal fixations, any method)</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery forearm (must have at least 3 ORIFs)</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery of wrist and hand (must have at least 8 internal or external fixations, any method)</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery hip (must have at least 3 internal fixations, any method)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery femur (must have at least 5 internal fixations, any method)</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery knee (must have at least 4 internal fixations, any method)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery tibia (must have at least 5 internal fixations, any method)</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery ankle (must have at least 4 internal fixations, any method)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery foot (must have at least 4 internal or external fixations, any method)</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthroscopy</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor surgery</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine surgery</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Orthopaedics (must have at least 5 pinning of supracondylar fractures)</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:** 243                                                Ave: ________

**NOTES:**
1. For more details, please see the chapter “Curriculum –Skills” in the Manual of Policies and Procedures (“Greenbook”).
2. For each procedure, at least 50% should be charity or service patients.
3. For each procedure, the minimum number of surgeries requiring fixation (where indicated) should be complied with.

Minimum – minimum number of cases that must have been performed prior to graduation, **Total Done – total** number of cases done as surgeon, **Fixation** – number of performed cases where internal fixation or external fixation was done, **Charity** – charity or service patients, **Private** – private patients, **Score** – to be filled up by PBO examiner, **Ave:** average score

**Scoring:** Procedures in which the minimum number of charity/service cases were performed and in which the minimum number of fixations were done will be evaluated. Those not meeting the minimum requirements will be graded as “0”. Score is calculated as: (Total done/minimum requirements) x 100. Scores over “100” will be scored as “100”.
I. HOSPITAL DATA:

A. Hospital : ________________________________
   Date : ________________________________

Section Head : ________________________________

Signature : ________________________________

Department Chairman: ________________________________

Signature : ________________________________

Hospital Director : ________________________________

Signature : ________________________________

B. Total Bed Capacity
   1. Private Beds : ____________
   2. Charity Beds : ____________
   3. Orthopedic Beds: ____________ (Charity/Service)

C. Directory
   Address : _______________________________________________________
   Tel. No. : _____________________________________________________
   Fax No. : _____________________________________________________
   E-Mail : _____________________________________________________
II. BREAKDOWN OF OPERATIONS (previous year):

<table>
<thead>
<tr>
<th>I. Nature of Operations</th>
<th>Residents (Charity/Service Cases)</th>
<th>Residents (Private Cases)</th>
<th>Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Major Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Minor Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ER</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. OPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td></td>
</tr>
</tbody>
</table>

II. Classification (By Specialty)

<table>
<thead>
<tr>
<th>A. Trauma: Major Operation</th>
<th>No.(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>B. Adult : Major Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>Minor Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>C. Pedia : Major Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>Minor Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>D. Hand : Major Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>Minor Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>E. Spine : Major Operation</td>
<td>No.(%)</td>
</tr>
<tr>
<td>Minor Operation (if any)</td>
<td>No.(%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

III. Comparative Data

<table>
<thead>
<tr>
<th>III. Comparative Data</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Nature of Operations (Graph/Table)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Major Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Minor Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Type of Operation (Graph/Table)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Elective Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Emergency Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:
1. **Major Operation**: done in OR, with regional/general anesthesia, major joint/bone, longer than 1 hour; wide dissection
2. **Major Emergency**: urgent surgery (excludes repeat debridement of bone/joint)
3. **Major Elective**: definitive procedures, non-urgent
4. **Minor Operation**: local anesthesia, done in OPD/OR/ER, about 1 hour, Superficial or no dissection (includes casting after reduction, pin removals, aspiration, etc. Application of casts or splints without prior reduction in not included.)

III. STAFFING:

A. Consultant’s Staff

a. Active

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Specialty Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Chairman/Section Head)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Training Officer)</td>
<td></td>
</tr>
</tbody>
</table>

b. Visiting/Voluntary Consultant

| 1.   |                           |               |
| 2.   |                           |               |
|      | Total                      |               |

IV. RESEARCH OUTPUT:

A. On-Going

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Year of Completion</th>
</tr>
</thead>
</table>
B. Completed (unpublished)

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Year Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Completed (presented/published)

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Venue/Publication/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V. DEPARTMENT MATERIALS AND RESOURCES:

A. Orthopedic Ward/No. of Beds

B. Library
1. Journals
2. Textbooks
3. CD-ROM
4. Others

C. Equipment
1. X-ray, mobile
2. Arthroscope
3. C-Arm
4. Orthopedic table
5. Others

D. Teaching Aids
1. Projectors, screen, LCD/carousel
2. Skeleton model
3. Others

E. NEWLY ACQUIRED
1. Internet Access
2. E-mail address
3. Web page server

VI. LIST OF OPERATIONS (previous year)

IN-PATIENTS

<table>
<thead>
<tr>
<th>I. TRAUMA</th>
<th>Resident</th>
<th>Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Joints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Shoulder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ ORIF, plating, body of scapula,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ IM pinning AC; Multiple pinning glenoid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Arthrotomy, Debridement and Irrigation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Elbow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ ORIF Pinning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Cross-pinning, supracondylar area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cross-pinning, lateral condyle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ ORIF multiple pinning, olecranon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td></td>
<td></td>
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<tr>
<td>------------------------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ORIF Buttress plating, radius, Transcapitello-radial pinning</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Debridement and Irrigation and Arthrotomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIF TBW of Olecranon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR with application of External fixator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Hip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hip Replacement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femoral capital epiphyseal separation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement, irrigation and arthrotomy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ORIF, Compression Hip Screw Fixation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Multiple Screw Fixation, femoral neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed Reduction (Allis Method)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Knee</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ORIF, Patella, TBW</td>
<td></td>
<td></td>
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<tr>
<td>Arthrotomy with mosaic plasty, Tibial plateau</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee Arthrotomy and Irrigation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial patellectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of Spanning External Fixator</td>
<td></td>
<td></td>
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<tr>
<td>Percutaneous Screw Fixation</td>
<td></td>
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<tr>
<td>Partial Patellectomy w/ neutralization</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cable fixation</td>
<td></td>
<td></td>
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<tr>
<td>Lateral Retinacular Release</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sacro-iliac joint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screw Fixation, open reduction and Plating of pelvis</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Ankle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIF, Plating lateral malleolus, screw Fixation medial malleolus w/syndesmotic Screw fixation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIF pinning lateral malleolus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIF multiple pinning medial malleolus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement and Irrigation with Tendon of Achilles repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headl avulsion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achilles Tendon Repair (Primary)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement and Irrigation &amp; Arthrotomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement &amp; Irrigation &amp; Arthrotomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With talus pinning</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subtotal

| Subtotal                                                                 |  |

B. Long Bones

1. Humerus

- ORIF, Plating, humeral shaft
- OR, Pinning
- Debridement and Irrigation
- Debridement & Irrigation, External Fixation
- Iliac Bone grafting secondary to nonunion
- Debridement & Irrigation humeral shortening

2. Radius-Ulna

- ORIF, Plating Radius
- ORIF, Plating Radius-Ulna
- OR with External Fixator
- Buttress Plating, Distal Radius
- Close reduction, Monteggia fracture
- IM Pinning, Ulna
- Opening Reduction, Pinning, Distal Radius
- IM Pinning Radius
- Percutaneous pinning, distal radius
- Open osteoclasis, open reduction, IM Pinning, Radius-Ulna
- Close reduction, external fixation, radius
- Debridement and Irrigation
- Close Reduction, distal radius, LACC
- Close Reduction. Distal radius,
<table>
<thead>
<tr>
<th>Application of External Fixation</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Fixation, wrist with percutaneous Cross-pinning, distal radius</td>
</tr>
<tr>
<td>Debridement and Irrigation, External Fixation</td>
</tr>
<tr>
<td>Open reduction, wedge osteotomy, Distal radius</td>
</tr>
</tbody>
</table>

3. Femur
- ORIF, Interlocked IM Nailing
- ORIF, Interlocked IM Nailing with IBG
- ORIF plain nailing
- ORIF, IM Nailing Dynamic Locking
- Open reduction, supracondylar nailing
- Closed IM Nailing
- Debridement, Irrigation, Fasciotomy
  - Application of Quad Frame
  - ORIF, Angle-Blade Plating
  - Ilizarov Fixation
- Debridement and Irrigation
- Skeletal traction
- Above knee Amputation

4. Tibia and Fibula
- Closed IM Nailing, Plain
- Closed IM Nailing, Static Locking
- Open plain IM Nailing
- ORIF, Interlocked Tibial Nailing, Static
- ORIF, Interlocked Tibial Nailing w/IBG
- ORIF, IM Nailing, Dynamic
- Debridement & Irrigation, External Fixation
- Ilizarov Fixation
- Debridement, Irrigation, Tenorrhaphy
  - myorrhaphy
- Debridement and Irrigation
- Extensor Hallucis Longus Muscle Flap
- Buttress Plating, tibial plateau
- Tibial Open Corticotomy
- Closed reduction, application of LLCC
- Fasciotomy (Compartment Syndrome)
- ORIF with screw fixation
- Below knee Amputation
- Application of Tibial traction pin (OR)
  - ORIF screw fixation, Tibial tubercle

C. Flat Bones
1. Clavicle
- IM Pinning
- IM Pinning (revision)
- Debridement and Irrigation

2. Foot
- IM pinning, phalanges
- Traumatic amputation/disarticulation
- Debridement & Irrigation w/pinning
- Debridement and Irrigation
- Pinning Metatarsal
- Pin Fixation, Calcaneus

3. Pelvis.
- ORIF, Plating, symphysis pubis & superior ramus
- ORIF, Plating, superior pubic ramus
- Screw fixation, St. Joint
- ORIF, Plating, acetabulum

Subtotal

II. WRIST & HAND
A. TRAUMA

<table>
<thead>
<tr>
<th>II. WRIST &amp; HAND</th>
<th>Resident</th>
<th>Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed Reduction, application of external Fixator, metacarpal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement and Irrigation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debridement &amp; Irrigation with STSG</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Debridement & Irrigation with application
  Of spacer
- Debridement & Irrigation, disarticulation phalanges
- Debridement & Irrigation, disarticulation thumb
- Debridement & Irrigation Radial
  Arteriirhaphy, ulnar epineurorrhaphy, Multiple tenorrhaphy
- Debridement, Irrigation, fasciotomy of Left forearm; MCP disarticulation of index And middle fingers
- ORIF IM pinning, metacarpals, phalanges
- Cross pinning, phalanges, metacarpals
- Debridement and Irrigation, cross pinning phalanges
- Debridement & Irrigation, transmetacarpal pinning
- Debridement & Irrigation w/tenorrhaphy
- External Fixation MCP Joint
- ORIF metacarpal plating
- Wrist fusion
- Corrective osteotomy, open reduction PIP joint fusion, index finger

**B. NON-TRAUMA**
- Release of trigger thumb (OR)
- Release of Carpal tunnel

---

### III. ADULT ORTHOPEDICS

<table>
<thead>
<tr>
<th>Resident</th>
<th>Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Amputation/Disarticulation
- Below Knee Amputation, DM Foot
- Ray amputation, DM Foot
- Debridement and Irrigation, DM Foot
- Above Knee Amputation
- Below Knee Amputation
- Ray amputation

#### B. Infections (Bones/Joints)
- Debridement, Curettage, removal of Infected kunchter nail
- Incision and Drainage, psoas abscess
- Debridement, irrigation
- Debridement and Irrigation, removal of External fixator
- Debridement – Arthroscopy, synovectomy

2. Infections
3. Tumors
4. Joint Reconstructive Procedures
5. Post Trauma Reconstructive Procedures
6. Wound Coverage Procedures
7. Others

---

### IV. SPINE SURGERY (List down)

<table>
<thead>
<tr>
<th>Resident</th>
<th>Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

1. Trauma
2. Non-Trauma
3. Others

---

### V. PEDIATRIC ORTHOPEDICS (List down)

<table>
<thead>
<tr>
<th>Resident</th>
<th>Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Post Trauma Reconstructive Surgery
2. Congenital/Developmental Disorders
3. Infections
4. Tumors
## OUT PATIENT DEPARTMENT PROCEDURES (previous year)

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Residents</th>
<th>Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Hand (List down)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Upper Extremity (List down)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Lower Extremity (List down)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## EMERGENCY ROOM PROCEDURES (previous year)

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Residents</th>
<th>Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. JOINTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Shoulder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Acromio-clavicular joint</td>
<td></td>
<td></td>
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<tr>
<td>3. Elbow</td>
<td></td>
<td></td>
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<tr>
<td>4. Wrist</td>
<td></td>
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<td></td>
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<tr>
<td>5. Hand</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Hip</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Pelvic diastasis, pelvic hammock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Sacro-iliac joint disruption, pelvic hammock</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. Knee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Ankle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Foot</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. SCAPULA (list down)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Fracture (closed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Fracture (open)</td>
<td></td>
<td></td>
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<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. CLAVICLE (list down)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Fracture (closed)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Fracture (open)</td>
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<tr>
<td>Subtotal</td>
<td></td>
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</tr>
<tr>
<td>D. HUMERUS (List down)</td>
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<td>Subtotal</td>
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<tr>
<td>E. RADIUS-ULNA (list down)</td>
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<td>Subtotal</td>
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<tr>
<td>F. PELVIS (list down)</td>
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<td>Subtotal</td>
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<tr>
<td>G. ACETABULUM (list down)</td>
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<tr>
<td>Subtotal</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>H. FEMUR (list down)</td>
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<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. TIBIA-FIBULA (list down)

| Subtotal |

J. HAND (list down)

| Subtotal |

K. FOOT (list down)

| Subtotal |

L. SPINE (list down)

| Subtotal |

M. SOFT TISSUE (list down)

| Subtotal |

### MORBIDITY AND MORTALITY (previous year)

<table>
<thead>
<tr>
<th>A. Morbidities</th>
<th>B. Mortalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Peri-operative complications (e.g. bleeding malreduction, poor fixation, etc)</td>
<td>(within 30 days)</td>
</tr>
<tr>
<td>2. Infections (early and late) (specify nature severity/site)</td>
<td>1. Perioperative (within 24 hours)</td>
</tr>
<tr>
<td>3. Fracture complications (exert infection) (specify delayed delayed union/non-union/malunion)</td>
<td>2. Late (within 30 days) including medical causes)</td>
</tr>
<tr>
<td>4. Medical Complications</td>
<td>3. Others</td>
</tr>
<tr>
<td>5. Others (e.g. misdiagnosis, iatrogenic complications)</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

### VII. TEACHING ACTIVITIES (previous year)*

<table>
<thead>
<tr>
<th>A. Conferences</th>
<th>TIME</th>
<th>DATE</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admitting/Endorsement Rounds</td>
<td></td>
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<tr>
<td>2. Pre-op/Post-op Conferences</td>
<td></td>
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</tr>
<tr>
<td>3. Morbidity and Mortality Conferences</td>
<td></td>
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<tr>
<td>4. Journal Club</td>
<td></td>
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<tr>
<td>5. Staff/Business Meetings</td>
<td></td>
<td></td>
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<tr>
<td>6. Special Conferences</td>
<td></td>
<td></td>
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<tr>
<td>7. Others (Interhospital/Interdepartment conferences)</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Service Rounds/Consultant Rounds</th>
<th>TIME</th>
<th>DATE</th>
<th>REMARKS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>C. Weekly Schedule (In Calendar Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM (Time)</td>
</tr>
<tr>
<td>PM (Time)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Rotation of Residents (by specialty/period)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E. Schedule of Lectures</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ List of Topics/ Dates/ Lecturer (Consultant or Resident) / Venue / No. of Attendees (logbook verifiable) ]</td>
</tr>
</tbody>
</table>

*Indicated whether accomplished or unaccomplished
VIII. GRADUATES (if any)

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Graduation</th>
<th>Certification and Year (Diplomate/Fellow)</th>
<th>Place of Practice or Post Residency Training Institution</th>
</tr>
</thead>
</table>

IX. REPORT ON TRAINING PROGRAM CURRICULUM

A. Syllabus per year level

B. Core competencies to be developed per year level (knowledge, skills, attitude)
   1. Curriculum mapping per year level
   2. Methods of assessment if core competencies have been achieved
   3. Corrective measures if core competencies not achieved

X. PUBLICATIONS (Books/Manuals/Monographs)

NOTE: Publication report will be needed only for reaccreditation and not for new applicants

XI. STAFF DEVELOPMENT PROGRAMS (previous year only)

A. Workshops/Seminars/Symposia/Congresses/Date and Venue/Participation (Lecturer/Presentor/Attendee)
   1. Consultants
   2. Residents

XII. HOSPITAL EQUIPMENT AND FACILITIES

1. Radiology (X-rays, CT scan, MRI. Ultrasound) {Specify}
2. Pathology/Laboratory/Special Procedures
3. Rehabilitation
4. Orthotics/Prosthetics/Brace Shop
5. Others

XIII. OPERATING ROOM FACILITIES

1. Fracture Table {Specify}
2. Image Intensifier/C-arm {Specify}
3. Arthroscopic Set {Specify}
4. Others {Specify}

XIV. LIBRARY AND AUDIO-VISUAL FACILITIES

1. Books (list) – Title, author, edition, year of publication
2. Journals
3. Old
4. New Acquisitions
5. CD Rom {Specify}
6. Online Subscriptions to Medical Database {Specify}
7. Others (e.g. video cassettes, etc.)
### CRITERIA | POINTS
---|---
INSTITUTIONAL REQUIREMENT | 30
CLINICAL MATERIAL | 20
TRAINING PROGRAM | 30
STAFFING | 15
REPORTING | 5

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>REQUIREMENTS</th>
<th>SCORE</th>
<th>INSTITUTION’S FEATURES</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. INSTITUTIONAL REQUIREMENTS</strong></td>
<td>BASIC STANDARDS – Program providers <strong>MUST</strong> have the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOSPITAL SET-UP</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Must be a Level 3 / Tertiary Hospital, or an Orthopaedic Specialty Hospital</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic ward / rooms</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic beds with Balkan Frames</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic ready - Emergency Room &amp; OPD, Casting &amp; Treatment rooms, ICU / RR</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiology Dept. (CT Scan, x-ray, MRI) with a certified Radiologist, portable x-ray</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehab Unit &amp; Brace shop within hospital vicinity</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPERATING ROOM REQUIREMENTS</td>
<td><strong>10</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Large and small fragment instruments, etc.</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-Arm &amp; adequate protective apparels</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fracture table or transparent table</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arthroscope set (instruments)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Microsurgical scope</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEACHING / LEARNING RESOURCES</td>
<td><strong>5</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic Office / computer /</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic library - with complete required textbooks and electronic resources</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conference room /projector</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II. CLINICAL MATERIAL</strong></td>
<td>BASIC STANDARDS – Program providers <strong>MUST</strong> have the following (<strong>with correct indication for any surgery</strong>):</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report procedures of <strong>PREVIOUS</strong> year. Report must reflect the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Minimum total resident’s case of <strong>243/resident</strong></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Minimum Charity / Service patients (<strong>121/resident</strong>)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Minimum Closed Reduction + casting (50 cases/res)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. TRAINING PROGRAM</td>
<td>BASIC STANDARDS – Program providers <strong>MUST</strong> have the following:</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Program</td>
<td>Definition of Vision, Mission, Values, Roles</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Goals or Core competencies</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Curriculum / Syllabus</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intended Learning Outcomes (ILO)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Instructional Design (ILO Mapping /year level)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professionalism</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment and Feedback</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. STAFFING REQUIREMENTS</th>
<th>BASIC STANDARDS – Program providers <strong>MUST</strong> have the following:</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINERS</td>
<td>Must be qualified (see Manual for qualifications)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Must be actively involved in only one training program or committee to avoid conflict.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>With training in medical education (e.g., short courses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must have protected / dedicated scheduled time for training activities, operating room supervision, didactics, patient care supervision (ER/OPD/Ward), and attendance in weekly scheduled activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quantity: 5 consultants in active participation per 5 residents and an additional one per additional resident.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRAINEEES (RESIDENTS)</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Must have a <strong>minimum</strong> number of one (1) resident per year level</td>
</tr>
<tr>
<td></td>
<td>For those having more than one resident per year level, program requirements on number of cases and active faculty must be followed</td>
</tr>
<tr>
<td></td>
<td>Trainee must have been admitted through a pre-screening evaluation by the training committee</td>
</tr>
<tr>
<td></td>
<td>Observance of protected time for didactics, physical and mental rest / study time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADMINISTRATIVE / OFFICE STAFF</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support system for administrative operations, recorded archiving, research, encoding registries</td>
</tr>
</tbody>
</table>
## REQUIRED SPECIFIC PROCEDURES

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>SPECIALTY</th>
<th>ADDED REQUIREMENTS</th>
<th>MINIMUM NO. OF CASES REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed reduction + casting</td>
<td>TRAUMA</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>Debridement of Open Fractures</td>
<td>TRAUMA</td>
<td>12 EX. FIXATION</td>
<td>30</td>
</tr>
<tr>
<td>Shoulder surgery (2IF)</td>
<td>AO TRAUMA</td>
<td>2 INT. FIXATION</td>
<td>8</td>
</tr>
<tr>
<td>Elbow surgery (3IF)</td>
<td>AO/TRAUMA</td>
<td>3 INT. FIXATION</td>
<td>12</td>
</tr>
<tr>
<td>Forearm surgery (3IF)</td>
<td>TRAUMA</td>
<td>3 INT. FIXATION</td>
<td>8</td>
</tr>
<tr>
<td>Surgery of wrist and hand</td>
<td>HAND</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Surgery hip (3IF)</td>
<td>AO/TRAUMA</td>
<td>3 INT. FIXATION</td>
<td>10</td>
</tr>
<tr>
<td>Surgery Femur (5IF)</td>
<td>TRAUMA</td>
<td>5 INT. FIXATION</td>
<td>25</td>
</tr>
<tr>
<td>Surgery Knee (3IF)</td>
<td>AO/TRAUMA</td>
<td>3 INT. FIXATION</td>
<td>10</td>
</tr>
<tr>
<td>Surgery Tibia (5IF)</td>
<td>AO/TRAUMA</td>
<td>5 INT. FIXATION</td>
<td>20</td>
</tr>
<tr>
<td>Surgery of Ankle (4IF)</td>
<td>AO/TRAUMA</td>
<td>4 INT. FIXATION</td>
<td>10</td>
</tr>
<tr>
<td>Surgery of Foot (4IF)</td>
<td>AO/TRAUMA</td>
<td>4 INT. FIXATION</td>
<td>16</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td>AO</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Tumor</td>
<td>AO</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Spine surgery</td>
<td>SPINE</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Pediatric Orthopedics (SPSFX)</td>
<td>CO/PEDIA</td>
<td>5 PINNING SUPRACONDYLAR FRACTURE</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>293</strong></td>
</tr>
</tbody>
</table>
I. **HOSPITAL DATA:**

A. Hospital: _________________________________
   Date: _________________________________

   Section Head: _________________________________

   Signature: _________________________________

   Department Chairman: _________________________________

   Signature: _________________________________

   Hospital Director: _________________________________

   Signature: _________________________________

B. Total Bed Capacity
   1. Private Beds: __________
   2. Charity Beds: __________
   3. Orthopedic Beds: __________ (Charity/Service)

C. Directory
   Address: ______________________________________
   Tel. No.: ______________________________________
   Fax No.: ______________________________________
   E-Mail: ______________________________________
II. BREAKDOWN OF OPERATIONS (previous year):

<table>
<thead>
<tr>
<th>I. Nature of Operations</th>
<th>Residents (Charity/Service Cases)</th>
<th>Residents (Private Cases)</th>
<th>Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Major Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Minor Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. OPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. Classification (By Specialty)

<table>
<thead>
<tr>
<th>II. Classification (By Specialty)</th>
<th>No.(%)</th>
<th>No.(%)</th>
<th>No.(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Trauma: Major Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Adult: Major Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Pedia: Major Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Hand: Major Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Spine: Major Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Operation (if any)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Comparative Data

<table>
<thead>
<tr>
<th>III. Comparative Data</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Nature of Operations (Graph/Table)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Major Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Minor Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Type of Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Elective Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Emergency Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:
1. **Major Operation**: done in OR, with regional/general anesthesia, major joint/bone, longer than 1 hour; wide dissection
2. **Major Emergency**: urgent surgery (excludes repeat debridement of bone/joint)
3. **Major Elective**: definitive procedures, non-urgent
4. **Minor Operation**: local anesthesia, done in OPD/OR/ER, about 1 hour, Superficial or no dissection (includes casting after reduction, pin removals, aspiration, etc. *Application of casts or splints without prior reduction in not included.*)

III. STAFFING:

A. Consultant’s Staff
   a. Active

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Specialty Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Chairman/Section Head)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Training Officer)</td>
<td></td>
</tr>
</tbody>
</table>

b. Visiting/Voluntary Consultant

1.  
2.  
Total  

IV. RESEARCH OUTPUT (previous year):

A. On-Going

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Year of Completion</th>
</tr>
</thead>
</table>
B. Completed (unpublished)

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Year Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Completed (presented/published)

<table>
<thead>
<tr>
<th>Title</th>
<th>Proponents</th>
<th>Venue/Publication/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V. DEPARTMENT MATERIALS AND RESOURCES:

A. Orthopedic Ward/No. of Beds

B. Library
   1. Journals
   2. Textbooks
   3. CD-ROM
   4. Others

C. Equipment
   1. X-ray, mobile
   2. Arthroscope
   3. C-Arm
   4. Orthopedic table
   5. Others

D. Teaching Aids
   1. Projectors, screen, LCD/carousel
   2. Skeleton model
   3. Others

E. NEWLY ACQUIRED
   1. Internet Access
   2. E-mail address
   3. Web page server

VI. LIST OF MORBIDITIES AND MORTALITIES (previous year)

A. Morbidities
   1. Peri-operative complications (e.g. bleeding malreduction,
      Poor fixation, etc)
   2. Infections (early and late) (specify nature severity/site)
   3. Fracture complications (exert infection) (specify delayed
      Delayed union/non-union/malunion)
   4. Medical Complications
   5. Others (e.g. misdiagnosis, iatrogenic complications)

   TOTAL

B. Mortalities (within 30 days)
   1. Perioperative (within 24 hours)
   2. Late (within 30 days) including medical causes
   3. Others

   TOTAL
VII. TEACHING ACTIVITIES (previous year)*

<table>
<thead>
<tr>
<th>A. Conferences</th>
<th>TIME</th>
<th>DATE</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admitting/Endorsement Rounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Pre-op/Post-op Conferences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Morbidity and Mortality Conferences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Journal Club</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Staff/Business Meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Special Conferences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Others (Interhospital/Interdepartment conferences)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Service Rounds/Consultant Rounds</th>
<th>TIME</th>
<th>DATE</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Weekly Schedule (In Calendar Form)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM (Time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM (Time)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

D. Rotation of Residents (by specialty/period)

E. Schedule of Lectures

[ List of Topics/Dates/Lecturer (Consultant or Resident) / Venue / No. of Attendees (logbook verifiable) ]

*Indicated whether accomplished or unaccomplished

VIII. GRADUATES

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Graduation</th>
<th>Certification and Year (Diplomate/Fellow)</th>
<th>Place of Practice or Post Residency Training Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IX. REPORT ON TRAINING PROGRAM CURRICULUM

A. Objectives of the program

B. Curriculum per year level and per rotation

C. Core competencies to be developed per year level and per rotation (knowledge, skills, attitude)
   1. Curriculum mapping per year level and per rotation
   2. Methods of assessment if core competencies have been achieved
   3. Corrective measures if core competencies not achieved

X. PUBLICATIONS (Books/Manuals/Monographs)

NOTE: Publication report will be needed only for reaccreditation and not for new applicants

XI. STAFF DEVELOPMENT PROGRAMS (previous year only)

A. Workshops/Seminars/Symposia/Congresses/Date and Venue/Participation (Lecturer/Presentor/Attendee)
   1. Consultants
   2. Residents
XII. HOSPITAL EQUIPMENT AND FACILITIES
1. Radiology (X-rays, CT scan, MRI. Ultrasound) {Specify}
2. Pathology/Laboratory/Special Procedures
3. Rehabilitation
4. Orthotics/Prosthetics/Brace Shop
5. Others

XIII. OPERATING ROOM FACILITIES
1. Fracture Table {Specify}
2. Image Intensifier/C-arm {Specify}
3. Arthroscope Set {Specify}
4. Others {Specify}

XIV. LIBRARY AND AUDIO-VISUAL FACILITIES
1. Books (list) – Title, author, edition, year of publication
2. Journals
3. Old
4. New Acquisitions
5. CD Rom {Specify}
6. Online Subscriptions to Medical Database {Specify}
7. Others (e.g. video cassettes, etc.)
PEER ASSESSMENT TOOL
ASSESSMENT AND FEEDBACK DURING TRAINING

Resident’s Name ▶
Institution ▶
Year Level ▶ Date of Assessment ▶

<table>
<thead>
<tr>
<th>How do you rate this Resident in their:</th>
<th>Standard: The assessment be judged against the standard expected at completion of this level of training. Levels of training are defined by respective training programs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below expectations</td>
<td>Borderline</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Good Clinical Care**

1. Ability to diagnose patient problems
2. Ability to formulate appropriate management plans
3. Awareness of own limitations.
4. Ability to respond to psychosocial aspects of illness.
5. Appropriate utilization of resources e.g ordering investigations.

**Maintaining good medical practice**

6. Ability to manage time effectively priorities.
7. Technical skills (appropriate to Current practice).

**Teaching and Training, Appraising and Assessing**

8. Willingness and effectiveness when Teaching / Training colleagues.

**Relationship with Patients**

9. Communication with patients
10. Communication with careers and/or family
11. Respect for patients and their rights To confidentiality

**Working with colleagues**

12. Verbal communication with Colleagues.
13. Written communication with Colleagues
14. Ability to recognize and value the Contributions of others.
15. Accessibility / Reliability
16. Overall, how do you rate this doctor compared to a doctor ready to complete this level of Training?

---

1 Please mark this if you have not observed the behavior and therefore feel unable to comment
Resident’s Name ▶
Institution ▶
Year Level ▶ Date of Assessment ▶

Clinical setting
e.g. Outpatients, Inpatients, ER

Clinical problem
e.g. fracture, dislocation

Focus of clinical encounter:
☐ Medical record keeping  ☐ Clinical Assessment  ☐ Management  ☐ Professionalism

Complexity of case:  ☐ Low  ☐ Average  ☐ High  Assessor’s position:

<table>
<thead>
<tr>
<th>Please grade the areas below using the scale 1-6:</th>
<th>Below expectations</th>
<th>Borderline</th>
<th>Meets expectations</th>
<th>Above expectations</th>
<th>U/C ¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History taking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Physical Examination Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Communication Skills</td>
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<tr>
<td>4. Clinical Judgement</td>
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<tr>
<td>5. Professionalism</td>
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<tr>
<td>6. Organization/ Efficiency</td>
<td></td>
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<tr>
<td>7. Overall Clinical Care</td>
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</tbody>
</table>

¹ U/C Please mark this if you have not observed the behavior and therefore feel unable to comment.

Anything especially good?  Suggestions for development: Include an explanation of any rating below “Meets Expectations”

Agreed action:

Evaluator’s Name and Signature ▶
Date ▶
PHILIPPINE BOARD OF ORTHOPAEDICS, INC.

CASE-BASED DISCUSSION (CBD)
ASSESSMENT AND FEEDBACK DURING TRAINING

Resident's Name ▶
Institution ▶
Year Level ▶ Date of Assessment ▶

**Clinical setting**
e.g. Outpatients, Inpatients, ER

**Clinical problem**
e.g. fracture, dislocation

**Focus of clinical encounter:**
☐ Medical record keeping  ☐ Clinical Assessment  ☐ Management  ☐ Professionalism

**Complexity of case:**
☐ Low  ☐ Average  ☐ High  Assessor’s position: 

Please grade the areas below using the scale 1-6:

<table>
<thead>
<tr>
<th></th>
<th>Below expectations</th>
<th>Borderline</th>
<th>Meets expectations</th>
<th>Above expectations</th>
<th>U/C (^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Recording</td>
<td></td>
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<tr>
<td>2. Clinical Assessment</td>
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<tr>
<td>3. Investigation &amp; Repair</td>
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<td>4. Treatment</td>
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<td>5. Follow-up and Future Planning</td>
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<tr>
<td>6. Professionalism</td>
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<td>7. Overall Clinical Judgment</td>
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</tbody>
</table>

\(^1\) U/C Please mark this if you have not observed the behavior and therefore feel unable to comment.

**Anything especially good?**

**Suggestions for development:** Include an explanation of any rating below “Meets Expectations”

**Agreed action:**

Evaluator’s Name and Signature ▶
Date ▶
# Direct Observation of Procedural Skills in Surgery

**Resident's Name**: 

**Institution**: 

**Year Level**: 

**Date of Assessment**: 

**Name of Procedure**: 

**Number of times Resident has performed this procedure**: 

**Complexity of procedure**:  

- [ ] Low  
- [ ] Average  
- [ ] High  

**Assessor's position**: 

---

## Please grade the areas below using the scale 1-6:

<table>
<thead>
<tr>
<th>Area</th>
<th>Below expectations</th>
<th>Borderline</th>
<th>Meets expectations</th>
<th>Above expectations</th>
<th>U/C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describes indications, relevant anatomy &amp; details of procedure</td>
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<td>2. Obtains informed consent, after explaining procedure &amp; consents</td>
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<td>3. Prepares for procedure according to an agreed protocol</td>
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<td>4. Administers effective local anaesthesia (if no anaesthetist)</td>
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<td>5. Demonstrates good asepsis and safe use of instruments/sharp tools</td>
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<td>6. Performs the technical aspects in line with the guidance notes</td>
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<td>7. Deals with any unexpected event or seeks help when appropriate</td>
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<td>8. Completes required documents (operative record)</td>
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<td>9. Issues clear post-procedure instructions to patient/staff</td>
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<td>10. Communicates with patient &amp; staff professionally</td>
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</table>

**Overall ability to perform the whole operation**

---

**Suggestions for development/Agreed Action**

---

**Evaluator's Name and Signature**

**Date**
I. PERSONAL DATA:

Name: ____________________________ Civil Status: ________________
Age/Sex: ________________ Birth date: ________________ Telephone number: ________________
Citizenship: ________________ Nickname: ____________________________

II. EDUCATIONAL BACKGROUND:

<table>
<thead>
<tr>
<th>School/Address</th>
<th>Dates of Attendance</th>
<th>Degrees</th>
<th>Academic Distinctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary</td>
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<td>Post-Graduate</td>
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</tbody>
</table>

III. LICENSURE/SPECIAL EXAMINATIONS TAKEN: (Local and Foreign)

<table>
<thead>
<tr>
<th>Examination</th>
<th>Date Taken</th>
<th>Rating/Rank</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Name: ___________________________  Civil Status: ____________
Age/Sex: ________________  Birth date: ________________  Telephone number: ________________
Citizenship: ________________  Nickname: __________________________

I. ITE (40%)  
Score: ______________________

II. Research Paper (30%)  
Score: ______________________

III. Interview (30%)  
Score: ______________________

A.) Achievements

* International  -  Points
* National  -  Points
* Local  -  Points

B.) Leadership

* International  -  Points
* National  -  Points
* Local  -  Points

C.) Social Civic Consciousness

* International  -  Points
* National  -  Points
* Local  -  Points

D.) Development

* International  -  Points
* National  -  Points
* Local  -  Points

Total: ______________________

PBO EVALUATOR: __________________________
(Name and Signature)
(Please Print)

**Surname:**

**First name:**

**Middle name:**

**Birth date:** (mmddyyyy)

**Birth place:**

**Gender:**

☐ Male  ☐ Female

**Home Address:**

**Home phone no.:**

**Office Address:**

**Mobile phone no.:**

(Photo here)

**Preferred Mailing Address** (Please Tick One)  
☐ Home  ☐ Office

**Medical School Graduated from:**

**Year graduated:**

**Internship:**

**Year graduated:**

**PRC Licensed no.:**

**Date Issued:**

**Valid until:**

---

**ORTHOPAEDIC RESIDENCY TRAINING**

1. **Institution**

   ▼ **Dates of attendance:**

   1. Year Level 1

   2. Year Level 2

   3. Year Level 3

   4. Year Level 4

   5. Year Level 5

---

*** This portion for PBO use only. ***

**ORTHOPAEDIC IN TRAINING EXAM RESULT**

<table>
<thead>
<tr>
<th>Year Level</th>
<th>Date taken</th>
<th>Result/Comments</th>
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<tbody>
<tr>
<td>Level 1</td>
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<td>Level 2</td>
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<td>Level 3</td>
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<tr>
<td>Level 4</td>
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</table>
## INFORMATION SHEET
### DIPLOMATE EXAMINATION CANDIDATES

(Please Print)

<table>
<thead>
<tr>
<th>▼ Surname:</th>
<th>▼ First name:</th>
<th>▼ Middle name:</th>
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<table>
<thead>
<tr>
<th>▼ Birth date: (mmdyy)</th>
<th>▼ Birth place:</th>
<th>▼ Gender:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Male □ Female</td>
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</table>

<table>
<thead>
<tr>
<th>▼ Home Address:</th>
<th>▼ Home phone no.:</th>
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</table>

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<thead>
<tr>
<th>▼ Primary Clinic Address:</th>
<th>▼ Mobile phone no.:</th>
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</tbody>
</table>

**Preferred Mailing Address** (Please Tick One) ▶: □ Home □ Clinic □ Clinic Phone ▶:

**Place(s) of Practice** ▶:

**Medical School Graduated from** ▶: Year graduated ▶:

**Internship** ▶: Year attended ▶:

**PRC License no.** ▶: **Date Issued** ▶: **Valid Until** ▶:

<table>
<thead>
<tr>
<th>▼ Orthopaedic Residency Training:</th>
<th>▼ Inclusive dates of attendance:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>▼ Fellowship or Post Graduate Training:</th>
<th>▼ Inclusive dates of attendance:</th>
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<tbody>
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<td>1.</td>
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<td>2.</td>
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</table>

<table>
<thead>
<tr>
<th>▼ Academic Appointments: (Institution)</th>
<th>▼ Rank/Position:</th>
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<td>1.</td>
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<td>2.</td>
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<table>
<thead>
<tr>
<th>▼ Medical Society Membership(s):</th>
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<tbody>
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<td>1.</td>
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<td>2.</td>
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<tr>
<td>3.</td>
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</table>

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<thead>
<tr>
<th>▼ Hospital Affiliations (Credentialled, if applicable):</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>▼ Research Papers (Titles and where published, if applicable; Attach papers separately):</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</tbody>
</table>
DIPLOMATE EXAMINATION: PART 3
PRACTICAL EXAM

(Please Print)

Surname:       First name:       Middle name:

Date of Examination:       Place of Examination:
Residency Training:       Year completed:

PATIENT DETAILS

Patients Initials:       Hospital Case No:
Pre-operative Diagnosis:

Part One: PROCESS

PRE-OP:
Proposed Procedure/PLAN: 20%

INTRA-OP: (Subtotal = 50%)
Positioning; Asepsis/Antisepsis; Draping: 5%
Approaches & Dissection: 15%
Soft tissue handling / Hemostasis: 5%
Use of instruments / implants: 10%
Intra-op decision-making: 15%

POST-OP:
Immediate Post-Op Management: 20%

OPERATING ROOM DECORUM:
Total Score for Part One: 100%

Part Two: OUTCOME

(X-rays, Complication, etc.):
Total Score for Part Two: 100%

FINAL SCORE: (MPL = 75%)
(Score of Part One x .80) + (Score of Part Two x .20)

REMARKS:

PBO EXAMINER:

(Name and Signature)