T he title of my presidential address at The American Orthopaedic Association/Canadian Orthopaedic Association Combined Meeting in Montreal last June was “Tipping Points in Surgical Education.” In the last AOA News I discussed issues related to orthopaedic workforce, the IOM report on Graduate Medical Education (GME), and the need for an orthopaedic curriculum. These topics reflect my ongoing interest in the current and future status of GME. The future is threatened by many pressures which include poor basic skills of incoming residents, faculty compensation based on productivity, expansion of subspecialized surgical techniques, threats to funding of GME, and decreased resident responsibilities during training.

I have asked the Carousel Presidents to describe the most important issue in resident education in each of their countries. This article will present my opinion of the issues in US resident education that we can and should be able to improve:

1. Lack of a curriculum
2. Poor assessment of competence
3. Procedural competency at the end of residency
4. Time vs. competency based training

These four seemingly separate issues all weave together and interrelate. For instance, you cannot have competency-based training without a curriculum and good assessments of the competencies defined within that curriculum. Better assessment will determine the degree to which competence is achieved at the end of training and could be used to determine when training should be complete.

Lack of a curriculum

Previously developed orthopaedic curricula have not been widely adopted because they were not required. Now is the time to require a curriculum. The American Board of Orthopaedic Surgery (ABOS) has engaged a group from the Residency Review Committee in Orthopaedic Surgery (RRC) and AOA and its CORD program to develop a plan for an orthopaedic residency curriculum. There have been introductory talks with ACGME since using existing Milestones and procedural logging will be desirable. A curriculum will define the appropriate knowledge and skills and assessments of levels of competence necessary to finish residency training. Many of the highly-specialized surgical cases that currently occupy resident time while they provide clinical service may not be part of this curriculum.

Poor assessment of competence

Assessment is an inherent part of a curriculum. The ACGME and the ABOS have defined 41 educational Milestones for residency training in orthopaedic surgery, and these milestones can form the basis of an assessment program. Across all the competencies some strategically developed additional milestones may be necessary. Initial data from the current milestones is being evaluated by the ACGME.

continued on page 2
President’s Message (from page 1)

Procedural competency at the end of residency

This has not been a big issue for orthopaedics since we rely on the one year fellowship system, which provides additional training and experience and encourages many young surgeons to specialize their practice. In general surgery there are concerns that residency graduates are not prepared for surgical practice. A 2009 article identified a lack of procedural experience by residents in key general surgery procedures and a 2013 survey of Program Directors found that program graduates often could not be left alone for major procedures. Recommendation in general surgery has included both an accelerating preparation for surgical residency and a plan for practice transition at the end of training. If fellowship funding in the US continues to decrease we may need to consider these issues in orthopaedic surgery.

Time vs. Competency-based Training

Competency is an important endpoint of training. It is not logical to train for five years and then be declared fully competent. Trainees learn at different rates; some requiring more time and some less. The Toronto competency-based program—where the end of training is defined as completing a curriculum—should open our eyes that alternatives are possible. The ABOS and RRC are currently considering a pilot competency program in orthopaedics at Duke University.

In my opinion, developing a curriculum is a starting point to make progress in all of these areas. A curriculum will require assessments of competence and will engage the resident in the assessment process. A curriculum will define the procedural areas that must be mastered and the methods to assess that necessary mastery is obtained. Once we have competencies defined in a curriculum with required assessments, we will have moved toward competency-based training—an important step in improving orthopaedic GME.

As a parting word, I hope you are not only making plans to attend the Annual Meeting in Providence, Rhode Island, but that you will consider inviting a colleague who is not a member. It will be a great meeting and we should show it off to non-member colleagues and, in so doing, introduce them to the AOA.
A Change in Residency Complement

By John Glaser, MD

This issue of the CORD Corner will discuss some of the nuts and bolts of the new system for applying for a change in residency complement. Having now been a Program Director long enough to have applied in both the old and new systems, I wanted to impart some of the details of how the newer system works.

In the previous system an application was much more tedious. It required submission of the program information form (PIF) and a formal site visit by a member of the RRC. Paper documents were a requirement. In the current system, the PIF is gone and there is no routine site visit. Much of the information regarding the program is already in the ACGME accreditation data system and does not need to be repeated. If information regarding the core clinical faculty and information regarding educational sites have been kept up-to-date, it is a great timesaver at the time of application. Case logs from the prior year’s graduating residents are reviewed, as well as case minimums and annual program surveys. Pass rates for first-time takers of ABOS exams are available and reviewed. There is a lag, though, in the transmission of the information. We applied in the fall of 2013 for the RRC meeting in January of 2014, but the results from the 2013 exams were not available. This is something to consider if the most recent results help or hurt your application.

This automation allows the program director to spend more time and effort discussing the educational rationale for an increase. This will need to include an explanation of how an increase will be funded. This is limited to 8,000 characters which includes punctuation. I’m not sure why, but the character count on the website does not correlate exactly with the character count in some of the standard word processing programs. One of the frustrating parts of the application was cutting out information because the character count was exceeded on the website.

There is also a section where the current block diagram of resident rotations will need to be uploaded and the following section requests the proposed new block diagram of rotations. This will need to be in PDF format.

One of the more tedious tasks in the application process is to enter information regarding number of cases performed at all institutions where the residents work. It generally follows the format used by residents entering their case logs. This cannot be taken from the resident case log, though, as the request is for all cases and not just those cases with resident staffing. None of our hospital systems use the same programming as the ACGME, so this task required the manual entering of information as well as some judgment as to what category the cases should be entered in. Cases that involve multiple CPT codes also should only be entered once.

In summary, although it is definitely not a painless process, application for a change in resident complement has been streamlined and made easier than it had been.

Full Speed Ahead to the AOA’s Annual Meeting & Affiliated Events

June 24-27, 2015, Rhode Island Convention Center, Providence, Rhode Island

Join your colleagues for the AOA’s unique meeting and affiliated events where we connect with other orthopaedic leaders across subspecialties to consider and discuss the larger issues confronting the profession.

While the scientific content is incomparable, the meeting’s highlight is the opportunity for members to meet face-to-face with peers across subspecialties.

You should have received an e-mail containing the electronic preliminary program. If you have not, please contact the AOA Headquarters at info@aoassn.org or (847) 318-7330. Registration is now open. Visit www.aoassn.org for details.

Spring 2015
The Resident Leadership Forum was first held in 2003, with an inaugural class of 53. Since then, the yearly activity has evolved into a successful and highly-regarded event—not only by the attendees and institutions that send them, but also by the AOA’s membership.

About the AOA’s Resident Leadership Forum (RLF)
Each year, the AOA invites Department Chairs and Program Directors from ACGME-accredited institutions to nominate up to two PGY4 residents to attend. In 2014, a record 123 institutions sent 174 residents to Montreal, Canada. The goal is to host sessions that introduce the attendees to leadership topics not addressed while in clinical training. These topics include Leading as a Chief Resident, Orthopaedic Mythbusters, Residents as Teachers, Work-Life Balance, Considerations for Setting Up a Practice, and a leadership education topic such as Negotiations or Decision-Making.

How the RLF Supports the AOA’s Mission
The Resident Leadership Forum is widely regarded by the AOA membership as a valuable activity. The goals of this leadership event are in direct alignment with, and support of, the AOA’s mission to engage the orthopaedic community in developing leaders, strategies, and resources to guide the future of musculoskeletal care.

One can see this in the following ways:

• Program Directors at all ACGME-accredited institutions have come to recognize the AOA as a strong source of learning within their educational landscape—with each resident nominated, the reach of the quality programming put on by the RLF extends. Attendees of the RLF gain exposure to leadership concepts, communication skills, and critical issues facing orthopaedics—empowering them not only to encounter the challenges ahead within their own career, but initiating them into professional engagement.

• Attendees of the RLF come to see the AOA as a home for leadership development and strategic thinking.

• The AOA has the ability to learn from the up-and-coming leaders through survey questions on important topics—a fact that supports resource development to guide the future of musculoskeletal care.

• AOA members, with their insights into strategic thinking that directly and profoundly impact the orthopaedic community, often are tapped to lead some of the RLF’s diverse sessions. Resident attendees directly benefit from this connection, and hearing the wisdom provided by the AOA member panelists.

• Following the Resident Leadership Forum, attendees are invited to connect themselves to the AOA through the Emerging Leaders Program. Over the course of time, these individuals are connected to the AOA’s continuum of learning and leadership development which is mutually beneficial to themselves and the AOA.


2015 Resident Leadership Forum
As in year’s past, 2015 Resident Leadership Forum attendees will benefit from the leadership skills and topics important to orthopaedics for which they typically do not receive any formal education. This year’s Resident Leadership Forum will offer 11 interactive sessions including a collaboration with the AOA’s Council of Orthopaedic Residency Directors (CORD) program.

One 2014 Forum attendee put it this way, “I appreciated that this meeting was focused on being thoughtful. Every session contributed to the meeting’s purpose in a meaningful way.” Resident leaders also enjoy the opportunity to connect with other “hard-driven” residents from across the country.

Currently 121 institutions have nominated 179 PGY4 residents to attend this year’s Forum in Providence. Of those institutions, 56 have nominated two residents and 63 institutions have nominated one resident.
Emerging Leaders | Program

Identifying Young Leaders to Engage our Orthopaedic Community

By Keith Kenter, MD, Young Leaders Committee, 2016 Chair, Emerging Leaders Forum

In 2014, the AOA celebrated the 10 year anniversary of its Emerging Leaders Program. As a member of the Young Leaders Committee and appointed Chair of the 2016 Emerging Leaders Forum to be held in Seattle, I have the privilege of working with the AOA to develop opportunities for young orthopaedic leaders who are members of this successful program. The Emerging Leaders Program has recently expanded from the once-a-year forum to further assist our members throughout the year. This expansion includes webinars, podcasts, and year round innovation projects.

Who is in the Emerging Leaders Program?
Currently, the membership in the AOA’s Emerging Leaders Program is almost 600 individuals ranging from PGY5 residents to those in their 13th year of clinical practice. These members have been recognized as individuals that are raising leaders poised to impact the specialty and their community. Many of the Emerging Leaders serve at academic centers but they also represent traditional private practice models, hospital-employed settings, and are actively serving in the military. Most have learned about the Emerging Leaders Program through attendance at the AOA’s Resident Leadership Forum, having been identified by their Residency Program’s leadership. Yet others have been tapped by AOA members and nominated to join the AOA.

Highlights
The highlight of being an Emerging Leader is eligibility to attend the Emerging Leaders Forum held in conjunction with the AOA’s Annual Meeting each June.

Over the years, the Young Leaders Committee has put together successful and highly-rated forums emphasizing leadership development, critical thinking, professionalism, and communication skills. These forums have increased the attendees’ potential to further develop their practice setting and motivate them to interact, share challenges, and help each other develop strategies to bring these challenges to a successful solution.

Each year, the AOA’s Emerging Leaders Forum attendance draws larger numbers of participants. The AOA’s reputation for delivering thought-provoking content relevant to orthopaedic surgeons continues to grow with every forum meeting. This can help draw young leaders to pursue active membership into the AOA. With almost 600 Emerging Leaders, the AOA is seeing the value of these efforts as more young leaders look for opportunities to connect with the AOA and its numerous educational opportunities.

Beyond the Emerging Leaders Forum
The Young Leaders Committee recognizes the challenges for these individuals to attend this annual forum in June. Last year only 12.9% of the Emerging Leader Program members were able to attend. Consequently, the Young Leaders Committee has expanded the opportunities for Emerging Leaders to benefit from the AOA’s leadership. Yearly, Emerging Leaders Program members have an opportunity to apply to serve as an ex-officio on the AOA’s Young Leaders Committee. The selected individual participates in all committee conversations, providing insights and perspectives. A monthly e-newsletter delivers leadership content and updates on AOA activities and opportunities. Webinars and podcasts specifically developed for Emerging Leaders provides insights and perspectives from AOA members on key topics relevant to the Emerging Leaders career stage. Further, Emerging Leader Program members may attend AOA events—creating more moments for young and established leaders to intersect and potentially learn from one another. There is hope to further reestablish a mentorship for these young leaders with established AOA members. More recently, an Innovation Project has been developed to continuously engage Emerging Leaders throughout the year and in a real-time setting.

Call to Action
It remains important for the AOA to identify individuals early in their career and encourage them toward the AOA, its membership, and its resources. Membership in the Emerging Leaders Program gives Emerging Leaders an opportunity to develop a sound foundation to help them succeed in their career and reach their professional goals. This program also allows AOA members to be placed in a position to mentor Emerging Leader Program members. Emerging Leaders Program educational offerings help to accomplish the AOA’s mission of “Engaging the orthopaedic community to develop leaders, strategies, and resources to guide the future of musculoskeletal care.”

1. Look for leaders in unusual places. The Emerging Leaders Program draws many of its members from the Resident Leadership Forum and younger partners from our own academic centers. We forget that many leaders are within our own community hospitals or in private practice.
2. Encourage your partners and senior residents to consider the AOA. Identify senior residents and young partners and challenge them in becoming established leaders in their orthopaedic community.

continued on page 15
In this issue, we examine the concerns regarding the disruptive physician from the legal, medical, and leadership vantage point. Disruptive physician behavior refers to a style of interaction physicians have with others including other medical staff, patients, and family members of patients. This problematic, toxic behavior adversely affects the entire health care team by contributing to low morale, lack of focus and concentration, and substandard communication. All of these negatively impact patient care and outcomes.

From overt verbal anger or physical threats to the more passive refusal to complete tasks or work cooperatively with other hospital personnel, behavior of the disruptive physician, according to a 2012 study by the Joint Commission, can contribute to “behaviors that undermine the culture of safety.” The statistics are alarming. More than 800 physician leaders and staff physicians—representing a variety of health care settings—completed a 2011 questionnaire by O. MacDonald on the QuantiaMD website. In this survey 71% of the respondents indicated they had personally witnessed such behaviors as degrading comments, insults, and yelling in the previous month, with the incidents occurring most frequently in the operating room, intensive care units, and in the emergency departments of health facilities. And, while hospitals have been mandated to develop a code of conduct that defines acceptable and unacceptable behavior, some may be unaware of the policy and/or observe no consequences being handed down when they observe antagonistic behavior in others.

As increasing emphasis is placed on productivity and documentation, stress levels increase. With this, the potential for behavioral outbursts and negative actions also increases. Yet, disruptive behaviors cannot be ignored. It is essential that orthopaedic leaders develop strategies to ameliorate these problems and prevent difficult behaviors from escalating or report these disruptions to the proper channels. By addressing issues and fostering an atmosphere of respect and collegiality, orthopaedic leaders will be able to more effectively work within and across teams to better treat and serve patients.
The goal of all effective institutions is to create a highly supportive, functional organizational work culture. Physicians are key elements of health care delivery systems and their behavior is a prime determinant of the effectiveness of the interdisciplinary work environment. Unfortunately, disruptive physician behavior often undermines practice morale, can detract from productive activities, and creates a feeling of intimidation and unnecessary stress in the workplace. Personal, physical, or verbal conduct can negatively impact co-workers with a resultant interference in effective patient care.1

Dr. Clohisy described the phenomena of disruptive orthopaedic physician behavior in the summer 2014 issue of AOA News. In it, he outlined the ways in which disruptive behavior can affect orthopaedic surgeons throughout their career. From the perspective of an Emerging Leader, disruptive behavior can take many forms. Three examples are:

1. The disruptive behavior in a flawed mentor;
2. The Emerging Leaders' own personal conduct; and
3. The Emerging Leader administratively dealing with disruptive behavior in a subordinate.

Emerging Leaders can be exposed to role models with many positive traits but who demonstrate disruptive behavior intermittently. As an Emerging Leader, one must take the best and leave the rest; emulating good behavior and understanding when the behavior is inappropriate. Poor role models are role models nonetheless and the Emerging Leader must be attentive to recognizing the good as well as the bad, distinguishing between them, and emulating the good while avoiding the less productive. Disruptive behaviors often provide a sense of power or accomplishment and the perpetrators fail to recognize the negative consequences of their actions.

In some situations, Emerging Leaders themselves may fall into patterns of conduct that are similar to disruptive behaviors. This is a crucial mistake that should be recognized, corrected, and in reality avoided at all costs. Stressful situations often reveal underlying character weaknesses. Emerging Leaders with limited experience and judgment may find themselves unconsciously expressing disruptive behavior in stressful situations. They may not recognize that they are contributing to the problem rather than helping to arrive at a successful resolution of the situation. They are fanning the flames rather than putting out the fire.

Emerging Leaders will have to effectively deal with managing problems that result from disruptive behavior by fellow physicians in their area of administrative control. When this occurs, the first step is to determine what truly happened. Rarely is the story as originally presented and it is important to have all the facts before acting.

The next step is to categorize the nature of the event and Bolton has a classification that we have found useful. He breaks down disruptive behavior into three groups; the ‘Can’ts, the Won’ts and the ‘Oops’.2 The group of ‘can’ts’ are unable to change behavior and can carry a diagnosis such as autism-spectrum. The ‘won’ts’ are able to change behavior but choose not to. This group can have problems related to anger, addiction, burnout or personality disorders. This group can have an ‘I’m right and you are wrong” attitude. The ‘oops’ group consists of individuals who ordinarily live up to expectations but on rare occasion (due to stress, fatigue, anger, etc.) they don’t. This group demonstrates remorse and regret, unlike the ‘won’ts’ and some of the ‘can’ts,’ and their behaviors can be corrected with three components of an apology:

1. A sincere apology
2. Explaining that the offender will work to make things right
3. Understanding that the person offended doesn’t have to accept the apology

The effectiveness of intervention depends on identifying the type of problem that the disruptive physician represents. This review should include a determination of the true existence of disruptive physician behavior.3 If this is the case, and disruptive behavior occurred, then the next step is to set up a formal meeting with the physician involved in a timely fashion. Unpleasant tasks tend to be delayed, yet this is something that needs prompt attention in order to achieve an effective solution for all parties. The focus of the meeting should be to gather an additional perspective. There are at least two sides to every story. If the original determination is confirmed, then corrective action is appropriate.4

A global recognition of the disruptive behavior may be curative.

Critical Issue

Disruptive Physician Behavior from an Emerging Leader Perspective

By Deana Mercer, MD; Jonathan W. Bolton, MD; Robert C. Schenck, MD

AOA News

continued on page 18
Disruptive physician conduct is a challenge that periodically faces every hospital, clinic, surgery center, and physician group. While the nature of the conduct may differ, there are common themes presented by behavior that is disruptive or abusive in nature. This article identifies common questions that arise when dealing with physician behavior issues.

What is disruptive physician conduct?
There are numerous definitions of disruptive conduct. Perhaps it is best summarized as behavior that unreasonably interferes with the ability of other members of the health care team to focus on providing quality patient care. It can be obvious – yelling, throwing objects, threats, profanity, physical assault or degrading or insulting comments. It can also be more subtle – refusal to follow established protocols, lack of availability when on call, inappropriate medical record entries, violation of patient or peer review confidentiality obligations, etc. It can be part of a pattern of conduct or, if sufficiently egregious, a single event.

Does disruptive physician conduct impact patient care?
Staff subjected to disruptive conduct begin to avoid the subject physician. They are less willing to speak to him/her when they are on the floor or call them after-hours for fear of the physician’s response. The impact compromises communication, whether it’s checking a medication order, reporting a change in patient status, or reporting lab results. In the study referenced above, 99% of respondents believed disruptive behavior adversely affects patient care. Courts that have considered the element of personal differences as a factor. In independent assessments, they reach their own conclusions about the underlying issues. In turn, that objectivity removes the element of personal differences as a factor.

How does disruptive physician conduct otherwise impact the organization?
Not only can patient care be affected such that it creates professional liability risk, disruptive conduct leads to increased employee absences and turnover. If unaddressed, staff complaints can evolve into lawsuits. Disruptive physician conduct can monopolize the attention of the CMO, VPMA, and other leadership, impeding their ability to focus on other issues. Finally, where behavior has been tolerated for years, staff confidence in leadership is eroded. Reporting of issues becomes infrequent or stops altogether, creating an environment where issues fester.

Is an informal, collegial conversation with a physician about his/her conduct an effective response?
Many organizations have adopted informal means to address physician conduct issues. It is a viable response provided that “collegial” is not confused with “friendly.” To be effective, the discussion must be taken seriously by the subject physician. It’s unlikely a two-minute hallway conversation will satisfy that requirement. The discussion should be held in the VPMA, CMO, or other leader’s office. In this setting, the issue can be identified and the physician given an opportunity to respond. Expectations for behavior should be made clear. The discussion should be confirmed in writing and the expectations summarized once again.

We’ve overlooked a physician’s behavior issues for years. What do we do?
This is a common scenario. Behavior issues are tolerated for years, but a change in leadership or an egregious event prompts a decision to act. The challenges presented by inaction include little documentation of issues and an inability to demonstrate that the subject physician was informed of the concerns. Absent that support, it is often challenging to demonstrate a trend of behavior relying solely on memories necessary to justify the preferred course of action.

The organization can start from “square one,” meeting with the physician, explaining the concerns and identifying expectations. That meeting may or may not reference his/her history. If a single event triggered the need for action, that incident may be sufficient in and of itself to warrant some form of action.

Should physicians who engage in disruptive behavior be referred to a Physician Assistance Committee or similar program?
The Physician Wellness or assistance committee is often a useful means to work through disruptive conduct issues. If this approach is used, the physician should be referred to a program that conducts detailed assessments of the physician, including psychological testing. There are well-respected programs across the country that deal with physician disruptive conduct, anger management, and related issues. Because they perform independent assessments, they reach their own conclusions about the underlying issues. In turn, that objectivity removes the element of personal differences as a factor.

Can we promise staff and employees who report disruptive physician conduct that they will remain anonymous?
Anonymity is a difficult promise to make. Complaints need to be documented, including the date and time of the incident,
Disruptive Physicians: Can We Try a Little Prevention?

By Ronald E. Campbell, PhD, Principal, Leadership Research Institute

Very few industries could match the due diligence and scientific research the medical community demonstrates to ascertain the impact of a disruptive physician: compromised patient safety/care, turnover, stress, frustration, quality care, mortality, impaired communication and information transfer, and less engaged employees, etc. Reputable studies and common sense tell us the toll on the organization is great. These very same studies would indicate that the truly disruptive physician is a small percentage of the population. Small in numbers but very high in terms of negative impact. (Compound that by throwing in a few disruptive administrators, nurses, and staff and you have a real losing team.)

Disruption occurs in varying degrees. A rude comment in a moment of stress on one end of the spectrum to an established well-documented pattern of abuse. I can’t think of a single facility that does not have a policy, procedure, boards, and reporting systems to address the more flagrant transgressions. So there are ways in place to address the chronic slow learners and those resisting the sweeping changes in care delivery. It really has come down to folks using the fine rules and well-designed procedures that have been put in place—and all that gets trumped by whether people believe the leaders in the organization will stand by those fine rules and do something appropriate about the infractions. Systemic solutions are needed for the egregious transgressions, but be clear that systemic solutions are not a replacement for individual leadership responsibilities.

Bear with me a moment while I zoom out to a higher level and talk about an industry’s or organization’s culture. Culture is a delicate blend of the values, mores, traditions, and behaviors that contribute to the unique social and psychological environment that people function within. How one picks up and learns those values, mores, etc. has more to do with socialization than stated rules, policies, and vision statements. At the risk of over simplification, if the stated policy is to treat people with dignity and respect—do you? If the answer is yes, and everyone around me models that dignity and respect, then that is what I learn to do. If I am having a little trouble “learning,” what type of coaching and teaching will I receive? The better the coaching and teaching, the less resistance to adaptation and the faster to skill acquisition.

Herein lies the Disruptive Physician Prevention model; insist that others with any role of authority to model the appropriate behaviors do so. Easy to say, hard to do. Please don’t underestimate the skills required to initially shape or later correct behavior. The better my skills for having the conversation the more likely that I will have it, have it sooner (in real time), and have a successful outcome. Skill level also determines if it comes across like a caring coaching conversation or an intervention to place blame, fault, and guilt. The better my skill level for the conversation the less relevant position or authority becomes. Recall that I am not referring to a habitual egregious pattern here.

Let’s start with you, your motives, or what is in your heart. What do you want for the other person? What do you want for their relationship with others in the organization? What is the big compelling purpose you are trying to help them to get on board with? The good news is this is not a protracted diagnostic exercise. It is a very powerful quick step that gets your head (and heart) in the right place before you speak. What shared or common purpose do you have with this person? The stronger the shared purpose the better chance for a productive conversation.

Be really clear on your expectations. What does good behavior look like? What is important here? What are we trying to accomplish? What do we want? A simple eloquent answer to any of those questions is far better than a Power Point slide with 20 bullets. Share, or hopefully reiterate the expectation. Do a quick acceptance or alignment check that the person you are addressing has the same expectations. Alignment of expectations is really important to keep this conversation on track. It extends to ensuring that you and the person you’re talking with are also aligned, on the same team, and have each other’s best interest at heart.

Communicate the gap. Just the facts, as briefly as possible describe the behaviors you saw or experienced that are different than what is expected. Keep the emotional level in check; yours and theirs. If you are addressing the transgression in the moment it is reasonable to expect a bit of defensiveness. If you don’t join the argument the defensiveness will quickly subside.

Caution(s):

- Avoid interpreting their motives or intentions: “I know you didn’t mean to”; “you were probably feeling stressed”; “easy to lose your composure under pressure,” etc. At this point try not to enter into conversations about why or how this happened.

- Don’t sell past the close. The goal here is for the person to hear and/or agree with the observation. The person might even own the gap. If so, don’t pile it on.

- If you are in a formal teacher or coach role be sure you are describing and not debating.

- If you are not in a formal teacher or coach role and the person is just not open to feedback or discussion don’t be a right fighter; don’t argue. If the disruption to patient care and staff is significant, be certain to document and follow procedures through official channels.

If appropriate, explore what caused the gap. In this step, you do much more listening than talking. Your questioning skills and emotional intelligence, particularly empathy, are your best tools. Demonstrating
Frequently Asked Questions: ... (from page 8)

the persons present, and the name of the individual making the report. Physicians subject to complaints understandably want to see the reports supporting the allegations. Even if the name of the reporter is removed, the description is frequently sufficient for the physician to have a fairly clear idea of who filed the complaint. If the situation escalates into a disciplinary proceeding (i.e., a medical staff fair hearing), individuals may be called as witnesses to appropriately support the recommended discipline or other action.

Rather than commit to anonymity, it is more practical to commit to enforcing a retaliation-free workplace. That is, when the physician is informed of the complaint(s), he/she is instructed that the organization has a zero tolerance for retaliation against persons who make good faith reports about behavior issues. Any such retaliation should result in immediate action, whether by the medical staff or the employer, depending on the situation. A failure to enforce this commitment will not only chill future reports but could result in a lawsuit by the reporting employee.

When dealing with disruptive physician conduct, which governs – medical staff bylaws, fair hearing plan, code of conduct, employment agreement?

Depending on the situation, potentially all of them. In a hospital, the bylaws, applicable policies, a code of conduct, etc. are all relevant when dealing with disruptive physician conduct. If he/she is employed, his/her contract is also a consideration. In a physician practice setting, there are likely no bylaws. However, there are policies, possibly a code of conduct, an employment agreement and potentially a shareholder agreement to be taken into consideration when deciding how to proceed.

To the extent the relevant documents address disruptive conduct, it is not uncommon for them to outline differing processes, which can create significant difficulties for the organization. When considering implementing a code of conduct or changes to another of these documents, they should be examined side by side to ensure consistency and appropriately reference one another.

References

2 Id.

This article is educational in nature and is not intended as legal advice. Always consult your legal counsel with specific legal matters. If you have any questions or would like additional information about this topic, please contact Jim Hogan at (317) 977-1439 or jhogan@hallrender.com.

...Can We Try a Little Prevention.. (from page 9)

empathy does not mean agreement, it means understanding. And the other person believes you understand them. Understanding does not mean accepting excuses. Should the disruptive behavior you observed or experienced is not a pattern, they own the unfortunate behavior, and there is minimal negative impact, cause may not even need to be explored.

On the opposite end of the spectrum cut short pity parties, woe is me, and not my fault (but I’ll tell you whose fault it is). Unfortunately some people don’t take feedback very well and arguing or throwing others under the bus has become pretty much a conditioned response. If so, keep it short and move on to the next step as quickly as possible.

Close the gap. Much of what it takes to close the gap is driven by the size of the gap and the complexity of the skill set. Closing the gap may be as simple as a one-time follow up all the way to a series of coaching events. This is the execution or actionable part of the program. Specific behaviors and all of the: who, what, when, where, and how’s come into play—as does follow up and follow through. Once you initiate the conversation you have an obligation to check in on progress to praise or help with possible challenges.

When one is in the midst of change the size and scope of what is happening in the medical community, you’re part of the problem or part of the solution. There is no in between. Preventing future disruptive physician behavior is an investment. As busy people you need to make that investment wisely, but you do need to make it.

I am a huge fan of Dr. Ken Blanchard's mantra of catching people doing something right and telling them about it. This is especially true when closing gaps.

Catching people doing something right and telling them so is a powerful way to shape future behavior. Don’t wait for or just look for the disruptive behavior to correct. One of your best preventative tools is to look for and acknowledge behavior that is aligned with the expectations of a high performing teams.

Do you have thoughts to share about the disruptive physician? Please e-mail info@aaoassn.org and we will be glad to run your comments in the monthly e-newsletter, Community of Leaders.
What sets star leaders apart from the rest of the pack? Why do great orthopaedic leaders ignite passion and inspire the best? More than three decades of research point to Emotional Intelligence as the critical factor that shows great leadership works through the emotions and sets star performers apart from their peers.

Understanding the powerful role of emotions in the workplace sets the best leaders apart from the rest—not just in tangibles such as superior health care results, but also in the all-important intangibles such as higher morale, motivation, and commitment within multidisciplinary teams in the orthopaedic landscape.

Emotional Intelligence is an elusive element. This intangible is responsible for how we manage behavior, navigate through social situations, and make personal decisions that achieve positive results.

The idea of Emotional Intelligence was first established in 1983 and attributed to Howard Gardner’s Frames of Mind: The Theory of Multiple Intelligences. Gardner suggests that traditional types of intelligence such as IQ, do not truly explain cognitive ability and introduced the idea that multiple types of intelligence including interpersonal intelligence (comprising the ability to understand the intentions, motivations, and desires of others) with intrapersonal intelligence (the ability to understand oneself and appreciate one’s feelings, fears, and motivations) are at play. In today’s fast-paced, ever-changing world including increased accountability, we look for effective tools that can help us manage and adapt.

Learnable Capabilities that Result in Outstanding Performance

Just as clinical care has scientific research to back up its efficacy, so does Emotional Intelligence. More than 30 years of scientific evidence substantiates the effectiveness that developing and practicing Emotional Intelligence has on successful leadership. The notion that components of Emotional Intelligence may be essential to success in life has been around since the 1940s.

There are several models for developing emotional and social intelligence. The model developed by Daniel Goleman and Richard Boyatzis in their book Primal Leadership: Learning to Lead with Emotional Intelligence, are organized into four clusters of competencies that can contribute to stellar management, outstanding performance, and innovation.

Emotional Intelligence is made up of four core skills that pair up under two primary competencies: personal and social.

PERSONAL COMPETENCE is made up of self-awareness and self-management skills. These skills are internally focused and rely on the ability to stay aware of emotions and the ability to manage both emotions and behavioral tendencies.

- **Self-Awareness**: the capacity to accurately perceive your emotions and stay aware of them as they happen.
- **Self-Management**: is the capacity to effectively manage or control emotions and behavior and the ability to use awareness of your emotions to stay flexible and positively direct your behavior.

SOCIAL COMPETENCE is made up of social awareness and relationship management skills. It encompasses the ability to understand and be attuned to other people’s moods, behavior and motives in order to improve the quality of your relationships.

- **Social Awareness** is the ability to accurately pick up on emotions in other people and understand what is really going on.
- **Relationship Management** is ability to induce desirable responses in others.

Developing Emotional Intelligence

Richard Boyatzis, an American organizational theorist and professor of Organizational Behavior at Case Western Reserve University, is widely considered an expert in the field of Emotional Intelligence, behavior change, and competence. He believes that Emotional Intelligence can be developed and those that are looking to intentionally develop this behavior should seek input and support from trusted friends and peers to facilitate its development.

Following are five steps that have been culled from Boyatzis’ International Change Theory:

1. **Decide what type of leader you want to be.** Envision what leadership characteristics you would like to display consistently. The discovery and articulation of the type of leader you would like to become may be facilitated by input from peers and other professionals.

2. **Self-Assessment.** Be honest about your strengths and shortcomings when it comes to leadership and seek feedback from others.

3. **Develop a focused plan for change.** Target areas of improvement and leverage your strengths to close any gaps that exist between the leader you are currently and the leader you wish to become.

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Continued on page 17
he Institute of Medicine (IOM) has criticized Graduate Medical Education (GME) in the US and recommended profound changes. The report specifically highlighted insufficient ethnic and geographic diversity resulting in regional workforce disparity, no control of specialization with workforce expansion in the wrong specialties, and program graduates with inadequate skills and knowledge for effective practice. Intervention was recommended along the whole continuum of training. Funding based on performance should encourage innovation directed toward meaningful change.

With these recommendations on the table where are surgical specialties in adapting to change? For decades GME in orthopaedic surgery has produced competent surgeons through a time-based training system. Five years in general orthopaedics is followed with one year of subspecialty fellowship training. This system is now under significant stress from outside forces that have hampered educational experiences including work hour restrictions, productivity based pressures on academic faculty, and the need for enhanced patient safety. These pressures are coupled with the increased technical demands of the procedurally-based orthopaedic subspecialties. Few surgeons can master skills across a wide range of orthopaedics leading to practices with a strong subspecialty focus. Two studies in the general surgery literature provide evidence that questions whether the current training system is producing competent surgeons, suggesting inadequate procedural exposure and lack of preparation for independent practice. These concerns are compounded by the fact that funding for fellowship training is threatened as industry support is decreased. Who will pay for that extra year? These external pressures may force us to reconsider our 5 + 1 training paradigm in orthopaedic surgery. Training is expensive and time is spent on tasks which are not pertinent to future practice. Trainees provide service in areas that are irrelevant to a career in a subspecialty such as spine surgery or pediatric orthopaedics.

With this background, one view recognizes that other surgical specialties allow more flexible training options with earlier subspecialty tracking. Starting residents in subspecialty training during their fourth or fifth year could shorten training and allow graduates to be better prepared to enter subspecialty practice independently following fellowship. The alternative view recognizes that some program graduates still enter general practice directly from residency and most enter practice that includes some general orthopaedic care. These facts argue that all graduating residents need to have a strong background in the full scope of orthopaedic practice.

Similar issues are faced by our colleagues in the orthopaedic carousel. This June, at the Annual Meeting in Providence, James E. Carpenter, MD will moderate Symposium 7: Subspecialty Tracking in Residency Training: Progress or Problematic? Following the symposium, the Carousel Presidents will be invited to opine on this topic. Following is a preview of their thoughts.

The Canadian Perspective
By Bas Masri, MD, FRCSC
President, Canadian Orthopaedic Association
Surgical training in Canada, like its equivalent in the US, has been based on the time-honored surgical training principles first introduced by Dr. William Stewart Halsted, who initiated a surgical residency at Johns Hopkins University in the late 1880’s. Over the years, the basic premise has changed little; however, the implementation has changed. Internships have disappeared, most residency programs are five years in duration, and most orthopaedic graduates in Canada now pursue one to two years of fellowship training.

Certainly, emphasis on education has increased over the years, and over the decades, discipline-specific educational requirements have been added, as have non-medical expert roles of proficiency. These roles include areas of knowledge as a scholar, professional, communicator, collaborator, manager, and health advocate. The Royal College of Physicians and Surgeons in Canada has paid a lot of attention to these domains, and program accreditation depends on fulfilling the needs for competency in all of these spheres, known as the CanMEDS roles.

Reflecting on Current Training Paradigms
By J. Lawrence Marsh, MD and Presidents of the English-Speaking Orthopaedic Societies

Determining competency is an iterative process that requires continued measurement and documentation.
examinations at the completion of training. It is an iterative process that requires continued measurement and documentation during the trainee’s entire program.

A novel curriculum was devised and organized training into 21 specific modules that were based into three phases of training.

**Phase 1** focused on the teaching and assessment of basic orthopaedic skills and knowledge. Modules in Phase 1 included introduction to surgery (otherwise known as Orthopaedic Boot Camp), emergency orthopaedics, hip and basic fractures, basic arthroplasty, basic sports, ICU medicine, medicine consults, and two online modules teaching and assessing the CanMEDS roles.

**Phase 2** focused on the teaching and assessment of subspecialty-specific skills and knowledge. Modules in Phase 2 included spine, foot and ankle, hand and upper extremity, pediatric fractures, and MSK medicine, an off-service based module focused on specialties directly related to orthopaedic surgery (i.e. rheumatology, physical medicine and rehabilitation, infectious diseases, neurology; and medical genetics).

**Phase 3** focused on the teaching and assessment of more advanced skills and knowledge. Modules in Phase 3 included oncology, complex trauma, advanced arthroplasty, advanced sports, and pediatrics. A research module was designed to run throughout all academic years of training. A resident does not progress from one module to the next until competence in that module has been carefully documented. As such, the residency-training program is no longer time-based, and competency may be established in as many years as is deemed necessary for each resident.

Since its implementation, the CBC has shown, through numerous outcome measures, that its trainees have done as well or better than their peers in the regular stream of training. As a consequence, the Division decided to make the CBC stream its standard stream of training as of the 2013-2014 academic year.

The Royal College of Physicians and Surgeons of Canada has reviewed the CBC training program at multiple times. Based on very positive reviews, as well as based on the new strategic plan of the College (Competence by Design), all programs in Canada will be competency-based in the near future, perhaps as early as 2017-2018.

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**The British Perspective**

By Colin R. Howie, MB, ChB; FRCS (Ed, Glas) Orth

President, British Orthopaedic Association

The T&O curriculum has been refined a number of times over the last decade and is now based fully online.

The T&O curriculum includes common procedures and compulsory case-based discussion assessments, defined to cover the breadth of T&O practice, with the aim of producing a general T&O surgeon by the end of training. We can monitor the progress of our trainees, across the country, in real time by training program. Our final exam is nationally set, based on the curriculum; the standards of written, oral, and clinical questions are rigorously checked and standardized before the results are issued. Our trainees, trainers, and regulators are satisfied with the current program on the whole. It is fair and comprehensive.

Elsewhere in the UK, mainly in medicine and general surgery, superspecialization has created problems for service delivery which mainly requires generalists in the major specialties to run our hospital on-call rotas. The government “Shape of Training Report” (ShOT), published last year, proposes to shorten and generalize training across the board, and train doctors to match the needs of the population: creating a training system whereby the endpoint would be as a generalist T&O surgeon. Once appointed as a consultant, the surgeon could develop their specialist interest as their career progresses; this would allow for careers to change over time as long as employing hospitals could accommodate.

The T&O curriculum, and our methods of formative workplace-based assessment, will continue to develop under our professional leadership. We hope that the impact on T&O will be less significant than those of some of our sister specialties, but vigilance is required.

All this against a background of increasing harmonization of curricula, assessment and training programs across Europe with pan European Hand and Foot surgery exams developing to allow cross-border flow of surgeons. Ironically, the prospect of European agreement on a general orthopaedic curriculum, with so many significant differences in practice, looks more remote than ever. There is a committee, though…

**The Australian Perspective**

By John C. Tuffley, MBBS, FRACS, FAOrthA

President, Australian Orthopaedic Association

Three decades ago, a fresh graduate from the Australian four-year orthopaedic residency program was by world standards, a quality general orthopaedic surgeon, able to go into practice, metropolitan or rural, either public or private. Most had spent two or three years working in “non-accredited” posts prior to being formally accepted into an orthopaedic residency program. These “pre-residency” posts afforded similar experience to those posts occupied by trainees. So in essence, most graduating residents had about six years orthopaedic training and some exposure to other surgical specialties.

To an outside observer, the training program would not have looked overly impressive. The orthopaedic surgeons for whom the residents continued on page 14
worked were not trained teachers. There was no structured curriculum. Learning was driven by filtered down knowledge of what might have been asked in the final exam taken in the last year of training.

So why did this haphazard training produce good orthopaedic surgeons? Trainee selection. If a prospective orthopaedic resident "got the nod" from senior surgeons, he was selected for training. There was no complex multifaceted selection system designed to withstand legal challenges. When a prospective trainee had worked closely with a well respected senior surgeon experienced in assessing people, a recommendation from that surgeon to the local training committee, a couple of other good references, and good performance at an unstructured single station interview generally saw that person selected for orthopaedic training. Without being undertaken formally, this method of selection would have serendipitously taken into account whether that person had the technical and non-technical qualities proposed by the Royal College of Physicians and Surgeons Canada in the CanMEDS competency framework.

Scrutiny by legislators and lawyers, changing societal demands, and an altered environment in which the residents train has led to a vastly different Australian training system than existed 20-30 years ago, and to a system that continues to have challenges. Currently, the training system for Australian orthopaedic residents is undergoing a major review which hinges on what qualities are expected of an orthopaedic surgeon on his/her first day of independent practice."

Discussed below are the challenges faced.

Resident selection. Orthopaedic surgeons who, in practice, are considered problematic are rarely considered due to a lack of technical ability or orthopaedic knowledge, but instead due to personality issues such as how they interact with health practitioners and patients, and their honesty. The current Australian selection process involves scoring a submitted CV, scoring a multistation interview process, and scoring referee reports chosen by the selection panel. This is undergoing annual refinement in an effort to select persons for the program who possess not only the appropriate technical skills, but who have the non-technical skills that will make them decent orthopaedic surgeons.

Training. Safe hours of work legislated by the government plus an ever-increasing body of orthopaedic knowledge has led to the training program being increased from four years to five years. Increased use of competency-based assessment methods and the possibility of four years of general training with the fifth year being in the subspecialty of the resident’s choosing is being explored.

A major initiative currently underway is the formulation of a new curriculum that categorizes operative procedures into one of three groups:

1. Be able to perform independently
2. Have observed, assisted with, or performed with supervision
3. Be able to discuss how the procedure would be performed

The proposed new curriculum is also placing greater emphasis on the formal teaching and assessment of the non-technical skills, or "foundation" competencies.

There is considerable discussion around the level of research in which a resident should be involved. Some consider being able to critique a paper and understand the statistics is all that should be required. Others feel research with the results being presented at a national meeting or being published should be required. Currently, research work is required to complete training. A research assistant is soon to be employed by the Australian Orthopaedic Association to assist the residents with research.

Assessment. In training, assessment has been increased with three monthly reports obtained relating to medical expertise, technical expertise, judgment, communication, collaboration, management and leadership, health advocacy, scholar and teacher, and professionalism.

An objectively scored DOPS [direct observation of procedural skill] is also required every three months. For those that do not meet a specific standard, a remedial plan is formulated and instituted. It is only after several suboptimal performances that a trainee will be removed from the training program. An enormous amount of documentation is required so that removal from the training program will withstand legal challenge.

These three monthly assessments are part of the move to make greater use of competency-based assessments. However, they require increased input and effort by the consultants who currently provide training pro bono.

Current discussions are exploring a more formal breakdown of the training program into stages with progression from one stage to the next being partially competency-based and partially based on a summative assessment.

Additional criticism is for the current final seven part exam that residents take in their fifth year of training. Some consider that the exam doesn’t assess the higher levels of Bloom’s Taxonomy [Analysis, Synthesis, and Evaluation of knowledge], tending
more to assess the lower levels [Knowledge, Comprehension, and Application].

Gazing Backwards. We need to consider the end product sought by society to guide the selection, training, curriculum, and assessment of our orthopaedic residents.

The good news must be that advances in orthopaedics, along with the concerted efforts of those who train orthopaedic surgeons to produce “a better product” is providing society with a high and responsible standard which also addresses sustainability of such services.

To read the preceding article about the Australian perspective in its entirety, please login to www.aoassn.org

The South African Perspective

By Mac Lukhele, MD
President, South African Orthopaedic Association

In South Africa, orthopaedic training is the competency of the country’s public universities which are funded by the department of education while the training platforms (hospitals) are funded by the department of health. More than 70% of the population utilizes public health facilities while only 30% of the orthopaedic surgeons in the country work in the public hospitals. The high work load and the low number of posts available for orthopaedic surgeons in the public sector is a push factor in attracting orthopaedic educators in the system. This lands itself with a high turnover and less junior colleagues involved in the education. The burden of trauma and infection is beginning to significantly compromise the exposure of trainees to elective orthopaedic procedure. Most training centers utilize some established private practices for exposure to elective surgery. The limited exposure to elective procedure is further compromised by the escalating costs of the new technology interventions which are becoming unaffordable in both public and private services.

The assessment of orthopaedic surgeons is the competency of the South African Colleges of Medicine and certification of orthopaedics is done by the South African Health Professional Council of South Africa. The SAOA only has an indirect influence with those structures.

The SAOA has an established an education standard committee that includes the heads of orthopaedic departments of all the universities through which it provides input, support, and resources for the education of orthopaedic surgeons. The challenge is to make this education committee of the SAOA a recognized structure for updating and adapting the orthopaedic curriculum to the ever changing environment.

Find out more about the South African Orthopaedic Association at http://www.saoa.org.za/

Another US Perspective

By Joshua J. Jacobs, MD
President, American Academy of Orthopaedic Surgeons

Education is the cornerstone of the AAOS mission. With the expanding knowledge base, increasing specialization of the profession, innovations in non-surgical and surgical clinical care, and advances in information technology the demand and need for educational products and programs has never been greater. Our organization has responded with new initiatives, products, and programs adapted to the shifting needs of busy professionals. One such new initiative is the incorporation of social and professional networking into our educational programs enabling increased sharing of images and ideas while ensuring that the Academy’s high standards of quality and accuracy are maintained.

AAOS members are also faced with the challenges of new practice paradigms and payment options such as accountable care organizations, bundled payments, changing employment models, meaningful use requirements, and ICD-10 transition. In each of these areas, the AAOS has provided significant support, through webinars, primers, CODE-X, online information, articles in our periodicals, live and digital programming, and staff resources committed to excellence.

The Presidents of the English-Speaking Orthopaedic Societies will be attending the AOA’s Annual Meeting in June and will be taking part in Symposium 7 on Saturday, June 27.

Advocate the value of leadership training and understanding the importance of critical communications and professionalism—building blocks for successful leaders, in my opinion. The Emerging Leaders Program and the AOA have great resources to help in developing these skills.

The AOA’s Emerging Leaders Program is a strong and vital part of the AOA and the organization’s mission. Please join me in the efforts to engage newly identified leaders into the AOA’s network of personal growth and professional opportunities.

If you would like to nominate a developing leader for the Emerging Leaders Program, please visit www.aoassn.org/programs and navigate to the Emerging Leaders Program for details.
In May 2014, the AOA-JOA Traveling Fellows embarked on a three-week journey through the Land of the Rising Sun. This year's fellows were:

- Leo T. Kroonen, MD, Hand Surgery, Naval Medical Center San Diego
- Hassan R. Mir, MD, MBA, Orthopaedic Traumatology, Vanderbilt University
- Wakenda K. Tyler, MD, Orthopaedic Oncology, University of Rochester
- Dan A. Zlotolow, MD, Pediatric Hand Surgery, Shriners Hospital Philadelphia

Our hosts treated us extremely kindly. Every location included hospital and facility tours, surgical observation, academic sessions, discussions with all of the faculty and residents, and multiple regional and cultural highlights.

The first stop was Hokkaido University in Sapporo. The northern island of Japan, known for its beautiful mountainous scenery, was home to the 1972 Winter Olympics. We toured the Olympic ski jump facility, and our stay ended with a chance to say “Kanpai” with the residents and staff at the Sapporo Beer Garden.

The next stop was Tokyo, where we made our way to St. Marianna University. Here we learned about several differences in orthopaedic surgery training between Japan and the US, mainly with the number of trainees who become non-operative orthopaedists. Our tour included stops at Tokyo Tower, the Imperial Palace, and Asakusa shrine. We also visited the Japanese Institute for Sports Science, which is their Olympic Training Center, and got to see some of Japan’s elite athletes in action. We also had academic sessions with the orthopaedic departments at Jikei University and Jutendo University.

We traveled west to the seaside city of Kanazawa where we were taken to Kanazawa Castle, Kenroku-en Garden, and the shops of gold-painted lacquerware. Kanazawa University has the busiest orthopaedic oncology center in Japan, and we were lucky to observe their pioneering work with liquid nitrogen treatment and re-implantation of bony tumors, and their work on iodine-coated implants. We also went to the World Heritage designated historical city of Shirakawa.

We went by bullet train to the 79th Meeting of the Japanese Orthopaedic Association in Kobe, where we had the opportunity to meet with several JOA dignitaries and with several US orthopaedic surgeons who were distinguished guests. We were privileged to each present our own work in a special session dedicated to Traveling Fellows. The keynote speech was delivered by Professor Shinya Yamanaka, the 2012 Nobel Prize winner for his work on the development of induced pluripotent stem cells (iPS).

We traveled to the historic city of Kyoto where we visited Kyoto University. We enjoyed seeing hospital rounds in the traditional style with the
Chairman leading and the entire department following throughout the wards. We also toured the iPS lab. Our sightseeing included Kiyomizu temple, a bamboo forest, a train along the Huzogawa River, and back down the river rapids by boat. This was followed by a visit to the Golden Pavilion (Kinkakuji) and a traditional dinner hosted by geishas.

Our final destination was Nagasaki. We had the somber experience of visiting the Atomic Bomb Museum. From roaming along the river through the town, to exploring Mount Unzen (the local active volcano) and dipping our feet in the natural hot springs, the cultural experience was as memorable as the academic experience.

On May 30, we parted ways, each returning to our normal lives in the United States. Each and every day of the three-week journey was an amazing adventure. The warm and welcoming reception we had at every stop was beyond what we could have ever expected. The experience as a whole expanded our views to a much more global perspective on orthopaedic surgery and the delivery of health care, and created lifelong professional and personal relationships.

For a more detailed account of the 2014 JOA Traveling Fellows, please visit aoatravelingfellowships.wordpress.com

Applications Now Open for JOA and ASG Traveling Fellowships

Deadline: May 1, 2015

The American Orthopaedic Association is seeking qualified candidates to apply for the 2016 Austria-Switzerland-Germany and 2016 Japanese Orthopaedic Association Traveling Fellowships. We ask that you encourage your colleagues, juniors, and friends to apply for these life-changing fellowship tours.

For details, visit www.aoassn.org/programs and navigate to Traveling Fellowships.

Emotional Intelligence... (from page 11)

4. **Experiment with and practice new behaviors.** To make impactful change toward becoming a more emotionally intelligent leader you must develop new behaviors. Utilize input from mentors, peers, colleagues and trusted team members and practice this changed behavior until you become comfortable.

5. **Enlist the support of others in your Emotional Intelligence development.** Behavioral change is difficult, but creating a network of trusted and supportive individuals will aid in your growth.

For strong and effective leaders, self-awareness is crucial to developing Emotional Intelligence. Simply knowing our own values, attitudes, beliefs and motivators goes a long way in helping us to understand our own behavior and, in particular, how we respond when these values feel compromised. Recognizing what triggers our stress response and pre-empting this before we’re in the grip helps us to maintain composure and control.

With clear evidence linking high Emotional Intelligence to high performance in leaders, and regular illustrations of high-profile leaders derailing due to the lack of Emotional Intelligence, there is a compelling case for leaders to focus attention on developing Emotional Intelligence in order to sustain leadership success.

References

**Professionally and Personally, Inspiring Excellence**

*By Todd J. Albert, MD*

The AOA’s network of orthopaedic leaders is key for our professional and personal successes. Individually, we struggle with the changing health care landscape and shrinking funding. Collectively, as members of the larger AOA community, we benefit from the education, leadership skills, and resources we develop and share with one another.

**Engaging the Orthopaedic Community**

Together, as a Community of Leaders, our strength is that we are a small organization of orthopaedic leaders from across the specialty and North America. We each are tied to our particular subspecialty through clinical interests. Many of us are involved with training residents and/or fellows, and are able to influence issues at the institutional, local, and regional levels as well. Jointly, we identify and analyze critical issues facing our specialty. Not that other associations don’t do this; however, as a community of leaders, the AOA leverages influence differently.

**Standing on the Shoulders of Giants**

AOA’s founding members brought orthopaedics out of general surgery into the separate specialty it is today. From its beginning in 1887, AOA members have led the advancement of the specialty — treatment, research, and teaching. Standing shoulder to shoulder, as members of the AOA, we’ve led the profession throughout the many decades of ongoing change. To this day, the AOA remains a leader in taking on critical issues that resonate no matter the subspecialty or practice setting.

**Providing Thought Leadership Today**

As leaders across the specialty, we have the opportunity and responsibility to guide the orthopaedic community as it navigates the challenges of this quickly-shifting health care environment. Each member of our small organization has the opportunity to weigh in on critical issues at our Annual Meeting, write opinion pieces for the AOA News, or take an active role in helping to select and review new members. Our online Membership Directory makes it easy for us to reach out and connect with one another.

**Looking Forward**

The AOA is no stranger to one of the issues we’re all familiar with: decreased mission-based funding from device, pharmaceutical, and biotechnology companies. OREF’s change in focus made it necessary for the AOA to seek donations directly from its members. Our dues alone are not enough to take action in all the areas in which the AOA is active. You may wish to honor a mentor or colleague, support a particular AOA program, or remember the AOA in your will. As members of this unique Community of Leaders, our ability to inspire excellence in those around us will help the musculoskeletal community generate effective answers to new situations and problems.

We have a responsibility in upholding our mission, “engaging the orthopaedic community to develop leaders, strategies, and resources to guide the future of musculoskeletal care.”

For more information about how you can invest in the AOA’s future, please visit “Ways to Give” at www.aoassn.org.

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**Disruptive Physician Behavior... (from page 7)**

Offentimes, the offender is so focused on the event that they fail to recognize the disruptive behavior component. The next step is to improve future performance in crisis resolution techniques. Everyone recognizes that as a desirable goal. Most people do not consciously try to make problems worse and may not recognize that the behavior triggered undesirable consequences. Recognition may be sufficient to fix the problem entirely however there are other interventional techniques that can be utilized.1,2

In conclusion, from the Emerging Leader perspective, disruptive physician behavior can interfere with effective organizational work culture. When a mentor’s behavior is troublesome, the effective leader needs to recognize it and abandon this behavior. When it affects the Emerging Leader, the behavior pattern needs to be recognized and avoided. When the disruptive behavior is expressed in subordinates, it is important to follow a process that includes the "can’t, won’t, oops" model and use interventional techniques appropriate for each situation.

**References**

Donor Recognition

Thank you to the following individuals for their 2014 contributions, which directly benefit their designated programs. These contributions help advance the AOA’s mission, “engaging the orthopaedic community to develop leaders, strategies, and resources to guide the future of musculoskeletal care.”

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The AOA is pleased to recognize tribute gifts made in honor of and in memory of colleagues and friends.

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## Important AOA Dates & Deadlines

For details and the most current information, visit www.aoassn.org.

### 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1</td>
<td>Application Deadline for the Austria-Switzerland-Germany and the Japanese Orthopaedic Association Traveling Fellowships</td>
</tr>
<tr>
<td>May 12</td>
<td>Annual Meeting Registration Closes; Late Registration with fees begins</td>
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<tr>
<td>June 24-27</td>
<td>128th Annual Meeting - Providence, RI</td>
</tr>
<tr>
<td>June 26-27</td>
<td>CORD Conference - Providence, RI</td>
</tr>
<tr>
<td>June 27</td>
<td>Own the Bone Symposium - Providence, RI</td>
</tr>
<tr>
<td>July 6</td>
<td>Nominations for the Membership Class of 2016 Open</td>
</tr>
<tr>
<td>July 31</td>
<td>2016 Annual Meeting Call for Submissions Opens</td>
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<tr>
<td></td>
<td>Applications Open for the 2016 American-British-Canadian Traveling Fellowship</td>
</tr>
<tr>
<td>August 21</td>
<td>Nominations for the 2016 Resident Leadership Forum Open</td>
</tr>
<tr>
<td>September 18</td>
<td>2016 Annual Meeting Call for Submissions Closes</td>
</tr>
<tr>
<td>November 2</td>
<td>Nominations Open for AOA Awards: Distinguished Contributions to Orthopaedics and Distinguished Clinician Educator</td>
</tr>
<tr>
<td>December 7</td>
<td>Nominations Close for AOA Awards: Distinguished Contributions to Orthopaedics and Distinguished Clinician Educator</td>
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</tbody>
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### 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>June 22-25</td>
<td>129th Annual Meeting &amp; Affiliated Events - Seattle, WA</td>
</tr>
</tbody>
</table>