Away Rotation Evaluation Form

1. Specialty: Orthopaedic Surgery

2. Medical School / Hospital: Harbor-UCLA

3. How would you rate your overall experience? (check one)
[ ] Poor [ ] Fair [ ] Good [x] Very Good [ ] Excellent

4. How many hours per week were you on duty? 80

5. How many hours per week did you spend with:
a. Interns: 10
b. Residents: 80
c. Fellows: 0
d. Attendings: 5

6. Did you meet with or work with the Residency Program Director or the Department Chair?
Yes – rounds with PD every Tuesday
7. Which attendings had the greatest influence on your experience?
PD
8. What were your daily duties?
OR and clinic, no floor patients
9. Did this rotation (check one):
[x] Create new interest in the specialty
[x] Reinforce existing interest
[ ] Decrease interest
[ ] Have no effect

10. Any tips on how to get the most out of this rotation?
Be pro-active
11. Any warnings or tips on what NOT to do?

12. Did you get a letter of recommendation?
No, did not ask
13. Did this rotation help you get an interview?
Yes
14. Is housing provided? If not, any recommendations on where to stay?
Yes
15. Is parking provided? If not, any recommendations on where to park?
Yes
16. Who did you contact to set up this rotation?
See UCLA website
17. When did you apply for the rotation and when did they inform you that you got the rotation?
April, informed late July
18. Where there any special requirements for the rotation (i.e. BLS re-certification, LOR, etc.)?
No

19. Would you recommend this rotation to future JMC 4th years?
Yes
20. Please add additional comments (strengths, weaknesses, miscellaneous tips…)

My first day there – I got into LA early afternoon and was at the hospital around 7pm… My housing was not set-up so I just brought my luggage to 2nd floor where the ortho clinic is. Ran into a couple residents who said I could hang out with them. The next thing I know – the second year goes to surgery and leaves me with the 1mo old intern to amputate an gangrenous finger in the cast room… We did it with a scalpel, ronjeurs, and some nylon sutures without supervision or without knowing exactly what to do (both of us looked it up in the textbook – however, we did not do advancement flaps as are recommended for fingertips, but instead informed the patient that he may need plastic surgery down the road). A couple hours later we get a severe multi-trauma, pelvic fracture – I get a Black and Decker drill and a pin set and walk up to the SICU to put a femoral traction pin. The second year instructs me of the necessary anatomy while running to the ER to see another incoming trauma. And this all happened in the first night…

Harbor is a county hospital where most patients are indigent with no coverage. Level I trauma with really high volume and complexity – lots of high speed car accidents and gun shot trauma. The service is run by one chief from Harbor, one chief from UCLA, and one junior chief (a 4th year) from Harbor. Each of them has a second year and an intern. The attendings communicate only with the chiefs and usually do not show up unless the case is overly complex or the chief is not familiar with the case (e.g. pelvic fractures, complex distal humerus fractures, non-union requiring a taylor spatial frame for bone transport). This was the most intense trauma experience I've seen compared to all other institutions I've rotated with, known about, or shadowed at. As a result the chiefs are extraordinarily skilled – they do all the pilons, tibial plateaus, etc… The chiefs are on call q3, and operate only on their call days. Depending on the chief, they may be in the OR 7 am to 2-3 am the next day. The rest of the days they typically schedule their cases, follow up on administrative stuff, and supervise the trauma clinic.

The trauma clinic has about 160 patients daily – it's run by 1 to 2 second years, a couple pa-s and the med students. It's really busy so as a student I made decisions on follow up, did all the paperwork, and necessary procedures, and usually just ran the x-ray by the 2nd year for 10 sec confirmation. The interns run the cast room under the supervision of the 2nd years who run the clinic – they do all the reductions and casting – you can also do as much as you want as a student. There's a mini C-arm that I used quite a bit to confirm my work before sending the patients for x-ray, and sometimes I put the cast 4 times before the second year would be happy… Great learning experience – you get good fast at short arm and short leg casts or sugar tongues… Most of what they see are ankle fractures and metacarpal fractures sent up from the ER.

I usually tried to follow a chief mainly, also jumping into the OR with other chiefs if they needed coverage. As a result, I operated at least every 3rd day, typically running as second assist or perhaps first assist – in multi trauma I usually closed the other sites while the residents moved to the new site. I would typically stay till the OR day finished. Call was up to us – typically I did one to two calls a week and typically got an hour or two of sleep. Once the OR would finish we would finish the patients waiting in the cast room to be reduced and splinted or casted, see the ER consults and then maybe help the intern (as a med student, we were not responsible of the

floors at all, which was great). The intern runs the floor completely independently (basically like a second year at most places). They are welcome to scrub whenever they want if the floor work is done.

The place is not academic at all – this is an operate all day place. The residents have done tons of cases and they did them all by themselves, so they all had very good surgical skills in my opinion. Even on electives, the chiefs would do their own joints or hand work with attendings only supervising (for electives – they typically did have an attending in the or) without really touching anything, unless they would mess up. However, they had good clinical teaching – Tuesdays was actual rounds with the program director who would spend about 40 minutes by each patients room going over basic science, classifications, etc. Almost every noon there was a conference. Wednesday morning was the trauma conference where the chiefs presented the cases they did that week and like 4 faculty would tear them up – educationally though…

Harbor provides students with free housing and one meal a day on the id (sometimes I did not slide my id, and with the noon conferences that would often have food – food was not really an issue). The housing is dorm style with shared bathroom, but the room was quite large and the floor only had like 5 other medical students - right across from the hospital.

Important: bring scrubs – the hospital will not provide you with scrubs. They do have paper scrubs if you want, but you are on your own. Do not bring any other clothes for work – scrubs only morning to night. No white coat either… I even wore the scrub pants to the beach…Buses run quite well – 20 minutes to Redondo Beach.

The residents are frustrated but happy – frustrated with the volume and absence of resources at Harbor. They are a really good bunch who enjoy surfing and the beach – all of them rented apartments with ocean views. The morale was very high, they supported each other, helped each other a lot, and typically partied together. This was probably one of the more friendly places. They don't do well on the OITE but evidently all of them passed the boards last year and almost all of them went into fellowships.

This is the place to go if you are thinking of going in a low key high trauma private practice. You will be a trauma ace and feel comfortable with most joints. This is not the place to be if you are interested in an academic career.