



UAEU

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NATIONAL INSTITUTE FOR HEALTH SPECIALTIES

NIHS Entrustable Professional Activities (EPAs) for Specialty Education in Hand Surgery

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Hand Surgery

EPA 1: Evaluate and manage a new hand/upper-extremity referral

Key Features: This EPA focuses on the ability to assess a new patient referred to with a hand or upper-extremity problem and develop an appropriate initial management plan.

- The fellow is expected to obtain a focused history, perform a structured upper-extremity examination, interpret relevant imaging, formulate a differential diagnosis, identify urgent or time-sensitive conditions, and propose an initial plan in collaboration with the patient and supervising surgeon.
- The fellow must recognize common traumatic, degenerative, inflammatory, compressive, congenital, infectious, vascular, and tumor-related presentations, distinguish conditions requiring urgent intervention from those suitable for elective management, and communicate the diagnosis, options, risks, and next steps using shared decision-making.
- The EPA includes accurate documentation.

Assessment Plan:

Direct observation, case discussion, and/or review of clinical documentation/imaging by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; other approved supervisor).

Assessment form collects information on:

- Setting: outpatient clinic; emergency department; inpatient consultation; fracture clinic; multidisciplinary clinic
- Case mix: acute trauma; fracture/dislocation; tendon injury; nerve compression; infection; arthritis/degenerative condition; congenital/pediatric condition; tumor/mass; vascular problem; postoperative or complication referral; other (write in)
- Patient age: pediatric; adult; older adult
- Urgency: routine; urgent; emergency

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 acute or urgent referral
- At least 1 non-traumatic/elective referral
- At least 1 case involving imaging interpretation
- At least 1 pediatric or older adult patient
- At least 2 different case-mix categories
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 1.4 Perform appropriately timed clinical assessments with organized recommendations

2. ME 2.1 Prioritize issues in the patient encounter
3. ME 2.2 Elicit history, perform physical examination, select investigations and interpret results
4. ME 2.4 Establish patient-centered management plans
5. COM 3.1 Share information and support shared decision-making
6. COL 1.3 Communicate effectively with other clinicians and team members
7. P 1.1 Demonstrate appropriate professional behaviors

Hand Surgery

EPA 2: Assess and triage acute hand trauma in ED/urgent settings

Key Features: This EPA focuses on the ability to assess and triage patients presenting with acute hand or upper-extremity trauma in emergency department or urgent care settings.

- The fellow is expected to perform a rapid but complete assessment, identify injuries requiring urgent intervention, determine neurovascular status, recognize compartment concerns, assess open injuries, initiate appropriate immediate management, and decide whether the patient requires local treatment, urgent operative care, specialist review, admission, or transfer.
- The fellow must recognize time-sensitive traumatic conditions, communicate effectively with the emergency team and supervising surgeon, and ensure that early decisions protect limb function, tissue viability, infection control, and patient safety.
- The EPA includes accurate documentation of neurovascular and soft tissue findings, imaging interpretation, initiating safe early management, communication with the relevant teams, and appropriate decisions regarding escalation, admission, operative intervention, or transfer

Assessment Plan:

Direct observation, case discussion, and/or review of clinical documentation (photographs, imaging, transfer/referral decisions) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, emergency physician with hand trauma expertise, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent care; fracture clinic; inpatient consultation; regional referral/transfer discussion
- Case mix: open injury; fracture/dislocation; tendon injury; nerve injury; vascular injury; fingertip injury; crush injury; infection/contaminated wound; compartment concern; amputation or near-amputation; other (write in)
- Patient age: pediatric; adult; older adult
- Urgency: urgent; emergency; requires transfer

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 2 cases must be assessed in an ED or urgent setting
- At least 1 case must involve neurovascular assessment
- At least 1 case must involve an open or contaminated injury
- At least 1 case must involve fracture/dislocation, tendon, nerve, or vascular injury
- At least 1 case must include a decision regarding transfer, admission, or urgent operative management
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components

1. ME 2.2 Obtain a focused trauma history, including mechanism, timing, hand dominance, occupation, contamination, tetanus status, comorbidities, anticoagulation, previous injury, and functional demands.
2. ME 2.2 Perform a structured hand and upper-extremity examination, including inspection, wounds, swelling, deformity, tendon function, sensation, motor function, vascular status, range of motion, and pain response.
3. ME 2.1 Identify and prioritize urgent or limb-threatening problems, including vascular compromise, compartment syndrome, open fracture, major contamination, crush injury, amputation, tendon injury, nerve injury, infection, and unstable fracture or dislocation.
4. ME 2.2 Interpret relevant imaging and correlate radiographic findings with the mechanism of injury and clinical examination.
5. ME 3.1 Determine the appropriate initial intervention, taking into account urgency, risk of deterioration, tissue viability, contamination, available resources, and need for operative management.
6. ME 2.4 Develop and implement an initial management plan, including analgesia, hemostasis, wound dressing, antibiotics where indicated, tetanus prophylaxis, immobilization, reduction where appropriate, elevation, follow-up, admission, or urgent operative review.
7. ME 3.4 Perform initial emergency procedures safely within scope, such as dressing, splinting, reduction, irrigation, or temporary stabilization, and adapt when findings change.
8. COL 1.3 Communicate effectively with emergency physicians, nurses, therapists, radiology, anesthesia, operating room staff, and the supervising hand surgeon, including clear handover when urgent care or transfer is required.
9. L 2.1 Use available local and regional resources appropriately when deciding whether the patient can be managed locally or requires transfer to a specialized hand trauma service.
10. COM 3.1 Explain the injury, urgency, initial treatment plan, possible need for surgery or transfer, risks, expected recovery, and next steps to the patient and family.
11. P 1.1 Recognize personal limits, seek timely senior assistance, and maintain professional accountability in complex, unstable, or high-risk trauma cases.
12. COM 5.1 Document the assessment, neurovascular findings, imaging interpretation, initial treatment, senior advice, transfer decision, patient discussion, and follow-up plan accurately, promptly, and in accordance with professional and medicolegal standards.

Hand Surgery

EPA 3: Definitive management of fingertip injuries and nailbed trauma

Key Features: This EPA focuses on the ability to provide definitive management for common fingertip injuries and nailbed trauma.

- The fellow is expected to assess the injury pattern, identify associated fracture, tendon, neurovascular, soft tissue, nailbed, and germinal matrix involvement, and select an appropriate treatment approach based on tissue loss, contamination, viability, patient age, functional needs, and expected outcome.
- The fellow must be able to perform appropriate nailbed repair, fingertip wound management, fracture stabilization where indicated, and soft tissue coverage using simple closure, secondary intention, local flap, graft, or referral for more complex reconstruction.
- The fellow is also expected to provide aftercare instructions, arrange follow-up, recognize complications, and coordinate hand therapy where required.

Assessment Plan:

Direct observation of clinical care and/or operative management, with case discussion and review of documentation (photographs, imaging) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; procedure room; operating room; fracture clinic; outpatient clinic
- Case mix: nailbed laceration; subungual hematoma; fingertip laceration; pulp loss; crush injury; fingertip amputation; distal phalanx fracture; open injury; pediatric fingertip injury; other (write in)
- Patient age: pediatric; adult; older adult
- Management: nail plate removal/replacement; nailbed repair; wound debridement; primary closure; dressing/secondary intention; fracture stabilization; local flap; skin graft; referral/escalation for reconstruction; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 2 cases must involve nailbed repair or nail complex management
- At least 1 case must involve pulp loss, fingertip amputation, or soft tissue coverage decision-making
- At least 1 case must involve associated distal phalanx fracture or crush injury
- At least 1 case must involve aftercare and follow-up assessment
- At least 1 pediatric or older adult patient
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including mechanism of injury, timing, contamination, hand dominance, occupation, tetanus status, comorbidities, anticoagulation, symptoms, and functional needs.
2. ME 2.2 Perform a structured fingertip and nail complex examination, including wound pattern, tissue viability, pulp loss, nail plate position, nailbed injury, germinal matrix involvement, sensation, perfusion, tendon function, and range of motion.
3. ME 2.2 Identify associated injuries, including distal phalanx fracture, open fracture, tendon injury, neurovascular injury, foreign body, contamination, crush injury, or amputation.
4. ME 2.2 Interpret appropriate imaging and correlate radiographic findings with the injury pattern and management plan.
5. ME 2.1 Determine urgency and priorities management according to tissue viability, contamination, exposed bone, neurovascular compromise, fracture stability, patient age, and available resources.
6. ME 3.1 Select the appropriate treatment approach, including trephination, nail plate removal or replacement, nailbed repair, irrigation and debridement, primary closure, dressing and secondary intention, fracture stabilization, flap, graft, or referral.
7. ME 3.4 Perform nailbed and fingertip repair safely and skillfully, using appropriate anesthesia, magnification where available, tissue handling, hemostasis, suture selection, nail fold protection, and dressing technique.
8. ME 3.4 Recognize when injury complexity exceeds current competence, including major tissue loss, exposed tendon or joint, complex pediatric injury, unstable fracture, replantation consideration, severe contamination, or need for advanced flap reconstruction.
9. ME 4.1 Provide appropriate postoperative and aftercare planning, including dressings, splinting, antibiotics where indicated, analgesia, wound care, elevation, therapy referral, activity restriction, and follow-up.
10. COM 3.1 Explain the injury, treatment options, expected healing, nail deformity risk, sensory change, stiffness, recovery time, and possible need for further procedures to the patient and family.
11. COL 1.3 Coordinate care with emergency staff, nurses, hand therapists, radiology, operating room staff, and supervising surgeons where required.
12. ME 5.1 Recognize and respond to early complications, including infection, wound breakdown, flap or graft compromise, fracture displacement, persistent pain, hypersensitivity, nail deformity, stiffness, or delayed healing.
13. COM 5.1 Document the assessment, imaging findings, procedure, repair technique, materials used, complications, patient discussion, aftercare instructions, and follow-up plan accurately and promptly.

Hand Surgery

EPA 4: Manage hand infections

Key Features: This EPA focuses on the ability to assess and manage common and urgent hand infections, including felon, paronychia, deep space infections, flexor tenosynovitis, bite wounds, infected wounds, infection associated with trauma or foreign body, cellulitis, and necrotizing fasciitis.

- The fellow is expected to recognize the severity and anatomical extent of infection, identify features requiring urgent operative management, and provide appropriate non-operative or operative treatment pathways.
- The fellow must assess systemic risk factors, recognize red flags such as spreading infection, neurovascular compromise, abscess, tendon sheath involvement, deep space infection, sepsis, or immunocompromise, and coordinate timely surgical, antimicrobial, imaging, admission, and follow-up decisions.

Assessment Plan

Direct observation, case discussion, and/or review of clinical documentation (imaging, operative notes, microbiology results, follow-up outcomes) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, infectious diseases physician, emergency physician with hand expertise, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; inpatient ward; operating room; outpatient clinic
- Case mix: felon; paronychia; deep space infection; flexor tenosynovitis; bite wound; infected traumatic wound; abscess; foreign body-related infection; infection in immunocompromised patient; hand cellulitis, and necrotizing fasciitis; other (write in).
- Patient age: pediatric; adult; older adult
- Management (select all that apply): non-operative; bedside drainage; operative drainage/debridement; admission/IV antibiotics; referral/escalation; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 felon or paronychia
- At least 1 bite wound or contaminated traumatic wound
- At least 1 deep infection, suspected flexor tenosynovitis, or deep space infection
- At least 1 case requiring operative drainage, debridement, or urgent surgical care
- At least 1 follow-up case assessing response to treatment
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including onset, progression, mechanism, wound or

bite exposure, contamination, foreign body risk, hand dominance, occupation, comorbidities, diabetes, immunosuppression, medications, allergies, tetanus status, antibiotic use, and systemic symptoms.

2. ME 2.2 Perform a structured hand examination, including wound location, swelling, erythema, fluctuance, tenderness, pulp space involvement, nail fold involvement, tendon sheath signs, deep space involvement, range of motion, pain with passive stretch, neurovascular status, lymphangitis, and signs of systemic illness.
3. ME 2.1 Identify urgent or high-risk infections, including flexor tenosynovitis, deep space infection, rapidly spreading cellulitis, abscess, necrotizing infection, septic arthritis, osteomyelitis, infected open fracture, bite-related infection, sepsis, and infection in an immunocompromised patient.
4. ME 2.2 Select and interpret appropriate investigations, including radiographs for foreign body, fracture, gas, or bony involvement; ultrasound or advanced imaging where indicated; blood tests; blood cultures; wound cultures; and microbiology results.
5. ME 2.4 Develop an initial management plan that addresses analgesia, elevation, splinting, wound care, antibiotics, tetanus prophylaxis, drainage, debridement, admission, operative intervention, and follow-up.
6. ME 3.3 Determine whether infection can be managed non-operatively, with bedside drainage, or requires urgent operative management, considering severity, anatomical site, risk of deterioration, available resources, and timing of surgery.
7. ME 3.4 Perform appropriate initial procedures within scope, such as incision and drainage of superficial abscess, paronychia drainage, felon drainage, irrigation, dressing, splinting, and wound care, using safe technique and appropriate infection control.
8. ME 3.4 Recognize when operative drainage, tendon sheath washout, deep space decompression, repeat debridement, specialist consultation, or transfer is required.
9. ME 4.1 Reassess clinical response to treatment, including pain, swelling, range of motion, wound appearance, neurovascular status, systemic signs, microbiology results, and need for further intervention.
10. COL 1.3 Coordinate care with emergency staff, nursing staff, microbiology or infectious diseases, radiology, anesthesia, operating room staff, hand therapists, and supervising surgeons.
11. COM 3.1 Explain the diagnosis, severity, treatment options, antibiotic plan, need for surgery or admission, risks of stiffness or tissue damage, warning signs, and follow-up requirements to the patient and family.
12. HA 1.1 Address prevention and risk reduction, including wound care, bite precautions, occupational risk, diabetes control, smoking cessation, hygiene advice, and early return if symptoms worsen.
13. COM 5.1 Document the assessment, anatomical extent of infection, neurovascular findings, investigations, antimicrobial plan, procedure performed, operative decision-

making, patient discussion, reassessment, and follow-up plan accurately and promptly.

Hand Surgery

EPA 5: Manage and operate on common tendon disorders

Key Features: This EPA focuses on the ability to assess, manage, and provide procedural or operative treatment for common tendon disorders of the hand and wrist.

- This includes trigger finger, De Quervain tenosynovitis, extensor carpi ulnaris (ECU) and flexor carpi ulnaris (FCU) tendinopathy or instability where applicable, and other common stenosing or inflammatory tendon conditions.
- The fellow is expected to establish the diagnosis, assess severity and functional impact, identify contributing factors, select appropriate non-operative treatment, perform injections safely where indicated, determine when surgery is required, and perform common tendon release procedures within scope.
- The fellow must also recognize atypical, recurrent, inflammatory, traumatic, or complex tendon conditions requiring further investigation, senior input, or alternative management.

Assessment Plan:

Direct observation, procedure observation, operative observation, case discussion, and/or review of clinical documentation (imaging, injection records, operative notes, postoperative follow-up) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, rheumatologist, other approved supervisor)

Assessment form collects information on:

- Setting: outpatient hand clinic; procedure room; operating room; hand therapy clinic; postoperative follow-up
- Case mix: trigger finger; De Quervain tenosynovitis; ECU tendinopathy or instability; FCU tendinopathy; intersection syndrome; recurrent tendon disorder; inflammatory tendon condition; tennis elbow; golfer elbow; other (write in)
- Patient age: adult; older adult
- Management: non-operative; corticosteroid injection; splinting/therapy; operative release; tendon stabilization or reconstruction planning; postoperative management; complication management; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 trigger finger case
- At least 1 De Quervain case
- At least 1 case involving injection decision-making or injection performance
- At least 1 operative tendon release case
- At least 1 case involving postoperative follow-up or complication assessment
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including symptom onset, pain location, triggering or locking, functional limitation, occupation, repetitive activity, hand dominance, prior injections or surgery, inflammatory disease, diabetes, pregnancy or postpartum status, trauma, and patient goals.
2. ME 2.2 Perform a structured examination, including tenderness, swelling, triggering, crepitus, tendon excursion, range of motion, joint stiffness, neurovascular status, provocative tests, tendon stability, and comparison with adjacent or contralateral structures.
3. ME 2.1 Identify atypical or complex features, including recurrent disease, multiple digit involvement, inflammatory tenosynovitis, infection concern, traumatic tendon injury, tendon rupture, nerve symptoms, severe stiffness, or uncertain diagnosis.
4. ME 2.2 Select and interpret investigations where indicated, including radiographs, ultrasound, MRI, inflammatory markers, or specialist assessment when diagnosis or surgical planning is uncertain.
5. ME 2.4 Determine the appropriate management pathway, including observation, activity modification, splinting, hand therapy, corticosteroid injection, operative release, tendon stabilization, reconstruction planning, or referral for senior input.
6. ME 3.1 Weigh injection versus surgery based on diagnosis, severity, recurrence, prior treatment response, comorbidities, patient preference, functional demands, complication risk, and expected outcome.
7. ME 3.4 Perform tendon sheath or first dorsal compartment injection safely where indicated, using appropriate consent, anatomical landmarks, aseptic technique, medication selection, needle placement, patient comfort measures, and post-injection advice.
8. ME 3.4 Perform common tendon release procedures safely, including appropriate anesthesia, positioning, incision placement, identification and protection of neurovascular structures, complete release, tendon gliding assessment, hemostasis, wound closure, and dressing.
9. ME 3.4 Recognize when the case exceeds current competence, including revision surgery, complex ECU instability, tendon subluxation requiring reconstruction, inflammatory tendon disease, severe scarring, nerve risk, infection, or uncertain anatomy.
10. ME 4.1 Provide postoperative and follow-up management, including wound care, pain control, mobilization, scar management, therapy referral, return-to-work advice, and assessment of symptom resolution.
11. ME 5.1 Recognize and respond to complications, including infection, stiffness, scar sensitivity, nerve irritation or injury, incomplete release, recurrence, tendon bowstringing, persistent pain, tendon instability, and delayed functional recovery.
12. COM 3.1 Explain the diagnosis, natural history, non-operative options, injection

benefits and risks, surgical indications, expected recovery, recurrence risk, and possible complications to the patient.

13. COL 1.3 Communicate effectively with hand therapists, rheumatologists, primary care physicians, nursing staff, operating room staff, and supervising surgeons when coordinating care.
14. COM 5.1 Document the assessment, diagnosis, treatment decision, consent discussion, injection or operative details, complications, patient instructions, and follow-up plan accurately and promptly.

Hand Surgery

EPA 6: Evaluate and manage hand tumors and mass lesions

Key Features: This EPA focuses on the ability to evaluate and manage patients presenting with tumors or mass lesions of the hand and wrist.

- This includes common benign lesions such as ganglion cysts, giant cell tumor of tendon sheath, epidermoid inclusion cysts, lipomas, vascular lesions, enchondromas, glomus tumors, and other soft tissue or bony masses, as well as recognition of suspicious or malignant lesions requiring urgent referral.
- The fellow is expected to obtain a focused history, perform a structured examination, interpret appropriate imaging, distinguish benign-appearing lesions from concerning presentations, and select appropriate management.
- This may include observation, aspiration where appropriate, biopsy planning, excision within scope, or referral to a tumor, sarcoma, dermatology, oncology, or specialist hand service.
- The fellow must understand biopsy and excision principles, including avoiding poorly planned excisions of suspicious lesions that may compromise definitive oncologic management.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (imaging, pathology results, operative notes, follow-up outcomes) by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; musculoskeletal tumor surgeon; other approved supervisor).

Assessment form collects information on:

- Setting: outpatient hand clinic; urgent hand clinic; operating room; procedure room; multidisciplinary tumor clinic; postoperative follow-up
- Case mix: ganglion cyst; benign soft tissue tumor; benign bone lesion; vascular lesion; glomus tumor; recurrent mass; suspicious lesion; malignant or potentially malignant lesion; post-excision follow-up; other (write in)
- Patient age: pediatric; adult; older adult
- Management: observation; aspiration; imaging and surveillance; biopsy planning; excision; reconstruction post excision; referral/escalation; postoperative management; recurrence strategy; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 ganglion or common benign soft tissue mass
- At least 1 solid mass or lesion requiring imaging interpretation
- At least 1 case involving biopsy, excision, or operative decision-making
- At least 1 suspicious, atypical, recurrent, or referral-level lesion
- At least 1 postoperative or pathology follow-up case

- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including duration, growth rate, pain, tenderness, trauma, functional limitation, neurological symptoms, skin change, previous treatment, recurrence, systemic symptoms, cancer history, hand dominance, occupation, and patient concerns.
2. ME 2.2 Perform a structured examination of the mass, including site, size, depth, consistency, mobility, tenderness, transillumination where relevant, skin involvement, attachment to tendon or joint, neurovascular status, range of motion, and impact on hand function.
3. ME 2.1 Identify concerning features, including rapid growth, increasing pain, deep location, fixation, skin ulceration, neurovascular symptoms, recurrent lesion, atypical imaging, bone destruction, systemic symptoms, or suspicion of malignancy.
4. ME 2.2 Select and interpret appropriate investigations, including plain radiographs, ultrasound, magnetic resonance imaging, computed tomography, vascular imaging, or laboratory tests where indicated.
5. ME 2.4 Formulate a differential diagnosis and determine whether the lesion is likely benign, uncertain, inflammatory, infectious, vascular, bony, recurrent, or suspicious for malignancy.
6. ME 3.1 Determine the appropriate management pathway, including reassurance, observation, aspiration, surveillance imaging, biopsy planning, excision, pathology review, or referral to a specialist tumor or oncology service.
7. ME 3.1 Apply safe biopsy and excision principles, including avoiding unplanned excision of suspicious lesions, preserving tissue planes, protecting neurovascular structures, ensuring appropriate specimen handling, and seeking senior or specialist input when malignancy is possible.
8. ME 3.4 Perform excision of selected benign lesions safely within scope, using appropriate consent, anesthesia, incision planning, exposure, tissue handling, hemostasis, protection of tendons and neurovascular structures, specimen labelling, wound closure, and dressing.
9. ME 3.4 Recognize when the case exceeds current competence, including suspected sarcoma, aggressive bone lesion, complex vascular lesion, deep or poorly defined mass, recurrent lesion with scarring, lesion involving major neurovascular structures, or uncertain diagnosis.
10. ME 4.1 Follow up pathology and imaging results, correlate them with the clinical findings, and revise the management plan where required.
11. ME 5.1 Recognize and respond to complications, including wound infection, hematoma, nerve irritation or injury, stiffness, recurrence, incomplete excision,

unexpected pathology, delayed healing, and functional limitation.

12. COM 3.1 Explain the likely diagnosis, uncertainty, investigation plan, treatment options, biopsy or excision risks, possible recurrence, pathology follow-up, and need for referral to the patient and family.
13. COL 1.3 Communicate effectively with radiology, pathology, oncology, dermatology, musculoskeletal tumor teams, hand therapists, nursing staff, operating room staff, and supervising surgeons.
14. HA 1.1 Consider the patient's function, occupation, anxiety about malignancy, access to specialist care, and ability to attend surveillance or follow-up.
15. COM 5.1 Document the history, examination findings, lesion characteristics, imaging interpretation, differential diagnosis, management plan, consent discussion, procedure performed, specimen handling, pathology follow-up, referral decision, and follow-up plan accurately and promptly.

Hand Surgery

EPA 7: Provide postoperative care and coordinate rehabilitation

Key Features: This EPA focuses on the ability to provide postoperative care for patients following hand and upper-extremity procedures, and to coordinate rehabilitation in partnership with hand therapists and the wider care team.

- The fellow is expected to monitor recovery, prescribe appropriate therapy and splinting protocols, identify complications early, guide functional progression, and support return-to-work and return-to-activity planning.
- The fellow must understand the postoperative priorities for common hand surgery procedures, including wound healing, oedema control, pain management, scar care, tendon glide, joint motion, fracture protection, nerve recovery, implant or fixation stability, flap or graft monitoring, and prevention of stiffness.
- The fellow is expected to individualize rehabilitation according to the diagnosis, procedure performed, patient risk factors, functional goals, and expected healing timeline.

Assessment Plan:

Direct observation, case discussion, and/or review of clinical documentation (therapy prescriptions, splinting instructions, postoperative plans, follow-up outcomes) by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; hand therapist; other approved supervisor)

Assessment form collects information on:

- Setting: postoperative clinic; hand therapy clinic; inpatient ward; fracture clinic; multidisciplinary hand review; virtual or telephone follow-up
- Case mix: fracture fixation; tendon repair; nerve repair; soft tissue reconstruction; infection; arthritis procedure; compression neuropathy surgery; Dupuytren surgery; tumor or mass excision; complex trauma; other (write in)
- Patient age: pediatric; adult; older adult
- Rehabilitation focus: therapy prescription; splinting protocol; wound care; motion protocol; return-to-work planning; complication surveillance; functional recovery review.

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 case involving tendon repair or tendon reconstruction rehabilitation
- At least 1 case involving fracture, dislocation, or fixation follow-up
- At least 1 case involving nerve recovery, soft tissue reconstruction, or complex trauma
- At least 1 case involving a hand therapy prescription or splinting protocol
- At least 1 case involving return-to-work or return-to-activity planning
- At least 2 observers, including at least 1 hand surgeon or approved surgical supervisor

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Review the operative diagnosis, procedure performed, intraoperative findings, fixation or repair stability, postoperative restrictions, expected healing timeline, and patient-specific risk factors.
2. ME 2.2 Perform a structured postoperative assessment, including wound status, swelling, pain, range of motion, tendon function, neurovascular status, sensation, strength, scar quality, splint fit, and functional progress.
3. ME 2.1 Identify postoperative concerns requiring urgent review, including infection, vascular compromise, tendon rupture, loss of fixation, compartment concern, flap or graft compromise, uncontrolled pain, neurological deterioration, or complex regional pain syndrome.
4. ME 2.4 Develop and update a postoperative care plan that addresses wound care, analgesia, oedema control, splinting, mobilization, therapy, activity restriction, follow-up imaging, and timing of return to function.
5. ME 4.1 Prescribe appropriate hand therapy, including goals, precautions, range-of-motion parameters, strengthening restrictions, scar management, desensitization, sensory re-education, oedema control, and expected progression.
6. ME 3.1 Select or confirm appropriate splinting protocols based on the procedure, tissue healing, fixation stability, tendon repair strength, joint position, soft tissue condition, and rehabilitation goals.
7. ME 4.1 Monitor healing and functional recovery over time, including wound healing, fracture union, tendon glide, joint mobility, nerve recovery, pain control, grip and pinch function, and ability to perform daily activities.
8. ME 5.1 Recognize and respond to complications, including stiffness, infection, delayed wound healing, tendon adhesion or rupture, nerve symptoms, hardware problems, non-union, malunion, hypersensitivity, scar contracture, recurrence, and delayed rehabilitation progress.
9. COM 3.1 Explain postoperative expectations, restrictions, rehabilitation requirements, warning signs, recovery timeline, likely functional outcome, and the importance of adherence to therapy and splinting.
10. COL 1.3 Communicate effectively with hand therapists, nurses, primary care physicians, occupational health, employers where appropriate, and supervising surgeons to coordinate safe recovery and rehabilitation.
11. L 2.1 Use available rehabilitation, imaging, clinic, and community resources appropriately when arranging follow-up, therapy access, splint modification, and escalation of care.
12. HA 1.1 Consider patient-specific barriers to recovery, including occupation, caregiving responsibilities, transport, access to therapy, health literacy, psychosocial factors, financial impact, and ability to comply with restrictions.
13. ME 4.1 Develop a realistic return-to-work or return-to-activity plan that considers

healing stage, job demands, hand dominance, safety, driving, modified duties, therapy progress, and risk of reinjury.

14. P 1.1 Recognize personal limits, seek timely senior input when recovery is abnormal or complications are suspected, and demonstrate accountability for continuity of postoperative care.
15. COM 5.1 Document the postoperative assessment, therapy prescription, splinting instructions, restrictions, complications, patient counselling, return-to-work plan, and follow-up arrangements accurately and promptly.

Hand Surgery

EPA 8: Provide operative leadership, safety, and systems practice in hand surgery

Key Features: This EPA focuses on the ability to provide safe, organized, and professional leadership during hand surgery care, particularly in the operative and perioperative environment.

- The fellow is expected to support patient safety, informed consent, surgical planning, team communication, time-outs, implant and equipment stewardship, accurate documentation, basic coding or claims requirements, and multidisciplinary coordination.
- The fellow must demonstrate awareness of systems-based practice, including efficient use of operating room time, appropriate selection and use of implants or consumables, communication with the surgical team, coordination with hand therapy and follow-up services, and completion of documentation that supports continuity of care, medicolegal standards, billing, coding, and quality assurance.

Assessment Plan:

Direct observation, case discussion, multisource feedback, and/or review of documentation (operative documentation, consent forms, implant records, coding or claims documentation, and postoperative coordination) by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; anesthetist; operating room nurse; hand therapist; other approved supervisor)

- Setting: operating room; procedure room; preoperative clinic; postoperative clinic; inpatient ward; multidisciplinary hand service
- Case complexity: low; medium; high
- Leadership focus (select all that apply): consent; surgical time-out; implant/equipment stewardship; operative documentation; coding/claims basics; multidisciplinary coordination; postoperative planning; patient safety event or near miss

Basis for formal entrustment decision:

Collect 4 observations of achievement.

- At least 2 observations must occur in the operating room or procedure room
- At least 1 observation must include consent and surgical safety processes
- At least 1 observation must include implant, equipment, or resource stewardship
- At least 1 observation must include documentation, coding, claims, or administrative completion
- At least 1 observation must include multidisciplinary coordination
- At least 2 observers, including at least 1 surgeon and 1 non-surgeon team member

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 3.2 Confirm that the planned procedure is appropriate, the indication is clear, and

the consent discussion includes the diagnosis, options, benefits, risks, alternatives, expected recovery, and consequences of no treatment.

2. P 3.1 Ensure that consent documentation is accurate, procedure-specific, complete, and consistent with institutional, legal, professional, and ethical requirements.
3. L 1.2 Lead surgical safety processes, including patient identity confirmation, procedure and site verification, laterality marking, allergy review, antibiotic planning, imaging availability, implant availability, and anticipated operative concerns.
4. COL 1.3 Communicate clearly with anesthesia, nursing staff, operating room personnel, therapists, radiology, ward staff, and supervising surgeons to coordinate safe and efficient perioperative care.
5. ME 3.1 Prepare for the procedure by confirming required imaging, instruments, implants, sutures, graft materials, splints, dressings, and postoperative rehabilitation requirements.
6. L 2.1 Use implants, consumables, operating room time, imaging, and specialist resources responsibly, balancing patient need, safety, cost-effectiveness, and stewardship.
7. ME 3.3 Anticipate procedural risks, equipment needs, positioning concerns, tourniquet considerations, implant requirements, and postoperative care needs before the operation begins.
8. P 1.1 Maintain professional behavior, situational awareness, composure, and accountability in the operating room, including during unexpected findings, delays, complications, or team pressure.
9. COL 2.1 Delegate tasks appropriately and respectfully, ensuring that responsibilities are clear and that patient safety is maintained throughout the perioperative pathway.
10. ME 5.1 Recognize and respond to patient safety risks, including wrong-site risk, equipment problems, missing imaging, implant mismatch, infection prevention concerns, communication breakdown, documentation gaps, or near misses.
11. COM 5.1 Complete operative documentation accurately and promptly, including diagnosis, procedure performed, findings, implants or materials used, tourniquet time where applicable, complications, postoperative instructions, and follow-up plan.
12. COM 5.1 Complete or support basic coding, billing, claims, or administrative documentation where required, ensuring that the recorded diagnosis, procedure, laterality, implants, and complexity are accurate and consistent with institutional processes.
13. ME 4.1 Coordinate postoperative plans with hand therapists and the clinical team, including splinting, wound care, imaging, antibiotics, activity restrictions, therapy timing, and return-to-work guidance.
14. L 1.1 Participate in quality improvement, morbidity and mortality review, audit, incident reporting, or feedback processes when safety events, complications, documentation issues, or system problems occur.

15. HA 1.1 Consider patient-specific barriers to safe perioperative care and rehabilitation, including language, health literacy, transport, work demands, financial impact, access to therapy, and ability to comply with postoperative instructions.
16. P 1.2 Seek feedback from supervisors and team members, recognize personal limits, and use feedback to improve operative leadership, safety practice, communication, documentation, and systems awareness.

Hand Surgery

EPA 9: Perform hand and wrist fracture/dislocation care

Key Features: This EPA focuses on the ability to assess and manage hand and wrist fractures and dislocations, including initial reduction and splinting, selection of operative versus non-operative treatment, performance of operative fixation within scope, and postoperative management.

- The fellow is expected to interpret injury patterns, assess stability, identify associated soft tissue or neurovascular injury, and develop a management plan that protects alignment, healing, function, and rehabilitation.
- The fellow must recognize injuries requiring urgent reduction, operative fixation, specialist input, or transfer, and perform the appropriate procedure.
- The fellow must also provide safe postoperative care, including immobilization, wound care, radiographic follow-up, therapy referral, complication recognition, and patient counselling.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (imaging, operative notes, postoperative follow-up) by supervisor (hand surgeon; orthopedic surgeon; plastic surgeon; other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; fracture clinic; urgent hand clinic; operating room; inpatient ward; outpatient follow-up
- Case mix: metacarpal fracture; phalangeal fracture; distal radius fracture; carpal fracture; fracture-dislocation involving hand, wrist of forearm; joint dislocation involving hand or wrist joints; open fracture; pediatric fracture; postoperative fixation follow-up; other (write in)
- Patient age: pediatric; adult; older adult
- Management: non-operative; reduction and splinting; operative fixation; postoperative management; complication management; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 2 cases must involve reduction and/or splinting
- At least 2 cases must involve operative fixation or operative care
- At least 1 wrist or carpal injury
- At least 1 metacarpal or phalangeal injury
- At least 1 postoperative follow-up case
- At least 1 pediatric or older adult patient
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 1

Relevant Task Components:

1. ME 2.2 Obtain a focused injury history, including mechanism, timing, hand dominance, occupation, functional demands, open injury risk, previous injury, comorbidities, medications, anticoagulation, and patient goals.
2. ME 2.2 Perform a structured examination of the hand and wrist, including deformity, swelling, wounds, rotation, alignment, tenderness, range of motion, tendon function, neurovascular status, and associated soft tissue injury.
3. ME 2.1 Identify urgent injuries requiring immediate intervention, including open fracture, vascular compromise, compartment concern, irreducible dislocation, fracture-dislocation, unstable alignment, nerve injury, tendon injury, or threatened skin.
4. ME 2.2 Interpret plain radiographs and advanced imaging where indicated, assessing fracture pattern, joint involvement, displacement, rotation, angulation, shortening, comminution, carpal alignment, and stability.
5. ME 2.4 Determine whether the injury is suitable for non-operative treatment, closed reduction, splinting, percutaneous fixation, open reduction and internal fixation, external fixation, or specialist referral.
6. ME 3.3 Prioritize timing of reduction, surgery, imaging, transfer, and follow-up according to urgency, risk of deterioration, soft tissue condition, available resources, and functional consequences.
7. ME 3.4 Perform closed reduction and immobilization safely where appropriate, including adequate analgesia or anesthesia, reduction technique, splint selection, post-reduction assessment, and post-reduction imaging.
8. ME 3.4 Perform operative fixation within scope, using appropriate surgical exposure, fracture handling, fracture stabilization with external, internal fixation or percutaneous fixation, implant selection, fixation principles, fluoroscopy, soft tissue protection, and wound closure.
9. ME 3.4 Recognize when operative complexity exceeds current competence, including complex intra-articular injury, severe comminution, unstable carpal injury, open contaminated fracture, pediatric physeal injury, bone loss, or combined tendon, nerve, or vascular injury.
10. ME 4.1 Provide postoperative management, including pain control, wound care, immobilization, radiographic review, infection prevention, suture or pin care, activity restrictions, and follow-up planning.
11. ME 4.1 Coordinate rehabilitation with hand therapists, including range-of-motion timing, splint modification, oedema control, strengthening, return-to-work planning, and prevention of stiffness.
12. ME 5.1 Recognize and respond to complications, including loss of reduction, malrotation, stiffness, non-union, malunion, infection, tendon adhesion or rupture, nerve symptoms, complex regional pain syndrome, implant failure, and post-traumatic arthritis.

13. COM 3.1 Explain the injury, treatment options, risks, expected healing, rehabilitation needs, functional limitations, possible complications, and expected recovery to the patient and family.
14. COL 1.3 Communicate effectively with emergency physicians, nurses, radiology, anesthesia, operating room staff, hand therapists, and supervising surgeons.
15. COM 5.1 Document the assessment, imaging interpretation, reduction or operative procedure, implants or splint used, neurovascular findings, postoperative plan, patient discussion, and follow-up arrangements accurately and promptly.

Hand Surgery

EPA10: Perform tendon repair and reconstruction

Key Features: This EPA focuses on the fellow's ability to assess, plan, perform, and coordinate care for patients requiring tendon repair or reconstruction of the hand and wrist.

- This includes acute flexor and extensor tendon injuries, delayed presentations, tendon loss, adhesions, rupture, and cases requiring staged reconstruction planning.
- The fellow is expected to recognize tendon injury patterns, assess associated neurovascular, bony, joint, skin, and soft tissue injuries, determine the appropriate operative approach, perform tendon repair within scope, and coordinate postoperative rehabilitation with hand therapists.
- The fellow must also recognize cases requiring staged reconstruction, grafting, tendon transfer, pulley reconstruction, or senior-led management.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (imaging, operative notes, rehabilitation plans) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; operating room; inpatient ward; hand therapy clinic; outpatient clinic
- Case mix: acute flexor tendon injury; acute extensor tendon injury; delayed tendon injury; tendon rupture; tendon adhesion; staged reconstruction planning; tendon graft or transfer planning; combined tendon and neurovascular injury; other (write in)
- Patient age: pediatric; adult; older adult
- Management: non-operative; acute repair; delayed repair; staged reconstruction planning; rehabilitation coordination; complication management; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 2 flexor tendon cases
- At least 2 extensor tendon cases
- At least 2 operative observations
- At least 1 case involving delayed presentation, reconstruction planning, or complex associated injury
- At least 1 case involving postoperative rehabilitation coordination
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including mechanism of injury, timing, wound

location, hand dominance, occupation, functional demands, contamination, previous injury or surgery, comorbidities, medications, and patient goals.

2. ME 2.2 Perform a structured tendon examination, including wound assessment, active and passive range of motion, isolated tendon testing, cascade, tenodesis effect, joint stability, sensation, vascular status, and assessment for associated nerve, vessel, fracture, or joint injury.
3. ME 2.1 Identify urgent or complex tendon injuries, including open tendon laceration, combined neurovascular injury, contaminated wound, fracture-dislocation, pulley injury, tendon loss, delayed presentation, rupture, or failed previous repair.
4. ME 2.2 Interpret relevant imaging where indicated, including radiographs for fracture, foreign body, joint involvement, or associated bony injury, and advanced imaging where tendon continuity is uncertain.
5. ME 2.4 Determine the appropriate management pathway, including non-operative treatment, primary repair, delayed repair, staged reconstruction, tendon grafting, tendon transfer, tenolysis, or referral for senior-led reconstruction.
6. ME 3.1 Plan the procedure according to tendon zone, injury pattern, timing, soft tissue condition, contamination, pulley integrity, associated injuries, rehabilitation requirements, and available resources.
7. ME 3.4 Perform tendon repair safely within scope, using appropriate anesthesia, exposure, tissue handling, identification of tendon ends, repair technique, suture selection, tensioning, gliding assessment, hemostasis, and wound closure.
8. ME 3.4 Recognize when the injury exceeds current competence, including complex flexor zone injuries, tendon loss, multiple digit injuries, pediatric injuries, failed repair, severe scarring, infection, or need for staged reconstruction.
9. ME 4.1 Identify the appropriate rehabilitation protocols and coordinate postoperative rehabilitation with hand therapists, including splinting, protected motion protocol, restrictions, oedema control, wound care, therapy timing, and patient adherence.
10. COM 3.1 Explain the diagnosis, operative and non-operative options, risks, rehabilitation commitment, expected recovery, stiffness risk, rupture risk, adhesions, possible need for further surgery, and functional prognosis to the patient and family.
11. COL 1.3 Communicate effectively with emergency physicians, nurses, anesthesia, operating room staff, hand therapists, and supervising surgeons to ensure coordinated perioperative and rehabilitation care.
12. ME 5.1 Recognize and respond to complications, including tendon rupture, adhesions, stiffness, infection, wound breakdown, pulley problems, contracture, poor tendon glide, complex regional pain syndrome, and delayed functional recovery.
13. COM 5.1 Document the assessment, tendon findings, associated injuries, operative plan, repair technique, postoperative protocol, therapy instructions, patient counselling, complications, and follow-up arrangements accurately and promptly.

Hand Surgery

EPA11: Manage complex soft tissue and microsurgical reconstruction of the hand

Key Features: This EPA focuses on the ability to assess, plan, perform, and coordinate care for patients requiring complex soft tissue reconstruction of the hand and upper extremity.

- This includes local and regional flap coverage, skin grafting, soft tissue reconstruction after trauma, infection, tumor excision, or wound complications, and microsurgical reconstruction where applicable to the training setting.
- The fellow is expected to assess tissue loss, exposure of critical structures, vascularity, contamination, fracture or tendon involvement, reconstructive timing, donor-site options, and the need for local, regional, or free tissue transfer.
- The fellow must also demonstrate readiness principles for replantation and microsurgical reconstruction, including patient selection, ischemia considerations, preservation of amputated parts, transfer decisions, perioperative planning, postoperative monitoring, and timely escalation for threatened reconstruction.

Assessment Plan

Direct observation, operative observation, case discussion, and/or review of clinical documentation (photographs, imaging, operative notes, reconstruction plans, postoperative monitoring records) by supervisor (hand surgeon, plastic surgeon, microsurgeon, orthopedic surgeon with hand reconstruction expertise, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; operating room; inpatient ward; microsurgery service; outpatient follow-up
- Case mix: fingertip, digital soft tissue loss or more proximal soft tissue loss at wrist forearm or arm level; exposed tendon, bone, joint, implant, or neurovascular structure; traumatic soft tissue defect; infected or contaminated wound; tumor-related defect; local flap; regional flap; skin graft; free tissue transfer; replantation or revascularization readiness; other (write in)
- Patient age: pediatric; adult; older adult
- Management: non-operative wound care; skin grafting; local flap; regional flap; free tissue transfer planning or performance; use of dermal substitute or negative pressure wound therapy (NPWT); replantation/revascularization assessment; postoperative monitoring; complication management; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 2 operative reconstruction cases
- At least 1 local or regional flap case
- At least 1 case involving exposed tendon, bone, joint, implant, or neurovascular structure

- At least 1 case involving microsurgical reconstruction, free tissue transfer, revascularization, replantation, or transfer/readiness decision-making
- At least 1 case involving postoperative monitoring or management of a threatened reconstruction
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including mechanism of injury, timing, contamination, ischemia time where relevant, hand dominance, occupation, functional demands, comorbidities, smoking status, medications, previous surgery, and patient goals.
2. ME 2.2 Perform a structured assessment of the soft tissue defect, including wound size, location, depth, contamination, vascularity, exposed tendon, bone, joint, implant or neurovascular structures, skin quality, donor-site options, and associated skeletal, tendon, nerve, or vascular injury.
3. ME 2.1 Identify urgent or limb-threatening reconstructive problems, including devascularized tissue, exposed critical structures, threatened flap or graft, major contamination, compartment concern, amputation, revascularization need, or replantation candidate.
4. ME 2.2 Select and interpret appropriate investigations, including radiographs, vascular assessment, Doppler evaluation, CT angiography where indicated, and review of photographs or imaging to support reconstructive planning.
5. ME 2.4 Develop a reconstructive plan that considers wound bed preparation, timing of coverage, debridement, skeletal stability, tendon and nerve needs, infection control, donor-site morbidity, rehabilitation, and expected functional outcome.
6. ME 3.1 Select an appropriate reconstructive option, including secondary intention, delayed closure, NPWT, skin substitute, skin graft, local flap, regional flap, free tissue transfer, revascularization, replantation, or referral/transfer for specialized microsurgical management.
7. ME 3.4 Perform soft tissue reconstruction safely within scope, using appropriate anesthesia, exposure, debridement, tissue handling, hemostasis, flap design, graft or flap inset, donor-site management, dressing, splinting, and wound closure.
8. ME 3.4 Recognize when the case exceeds current competence, including complex free flap reconstruction, major replantation, multilevel injury, prolonged ischemia, severe contamination, mangled extremity, failed reconstruction, or need for specialized microsurgical resources.
9. ME 4.1 Coordinate postoperative care with nursing staff, hand therapists, anesthesia, pain service, infectious diseases, radiology and supervising reconstructive or microsurgical team.
10. ME 4.1 Choose appropriate method of flap monitoring, monitor reconstruction

viability through flap color, temperature, capillary refill, turgor, bleeding, Doppler signal, swelling, pain, venous congestion, arterial insufficiency, graft take, wound breakdown, infection, and need for urgent re-exploration.

11. COM 3.1 Explain the reconstructive options, risks, expected recovery, donor-site implications, possible need for staged procedures, microsurgical uncertainty, functional limitations, rehabilitation requirements, and prognosis to the patient and family.
12. L 2.1 Use local and regional resources appropriately, including decisions about timing of surgery, operating room access, microsurgical availability, transfer to a specialized center, and safe coordination of urgent reconstruction.
13. COL 1.3 Communicate effectively with emergency physicians, nurses, therapists, anesthesia, operating room staff, radiology, microsurgical colleagues, and referring teams to ensure timely and coordinated care.
14. P 1.1 Demonstrate professional judgement, accountability, and awareness of personal limits when managing high-risk reconstructive cases, including timely escalation and seeking senior input.
15. COM 5.1 Document the assessment, defect characteristics, vascular status, imaging interpretation, reconstructive plan, procedure performed, flap or graft details, donor site, postoperative monitoring instructions, patient counselling, complications, and follow-up plan accurately and promptly.

Hand Surgery

EPA 12: Perform peripheral nerve and brachial plexus–related procedures within hand surgery scope

Key Features: This EPA focuses on the ability to assess, plan, perform, and coordinate care for patients requiring peripheral nerve procedures relevant to hand surgery practice.

- This includes acute nerve repair, delayed nerve reconstruction, nerve grafting, neurolysis, selected nerve transfers where applicable, and postoperative sensory and motor recovery planning.
- The fellow is expected to identify the level and severity of nerve injury, assess associated tendon, vascular, skeletal, and soft tissue injuries, select appropriate investigations, determine timing of intervention, and perform nerve procedures safely within scope.
- The fellow must also recognize complex brachial plexus or proximal nerve injuries requiring senior-led care, multidisciplinary planning, or referral to a specialized peripheral nerve or brachial plexus service.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (electrodiagnostic studies, imaging, operative notes, postoperative recovery plans) by supervisor (hand surgeon, peripheral nerve surgeon, plastic surgeon, orthopedic surgeon, other approved supervisor)

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; operating room; peripheral nerve clinic; brachial plexus clinic; hand therapy clinic; outpatient follow-up
- Case mix: acute digital nerve injury; median nerve injury; ulnar nerve injury; radial nerve injury; mixed nerve injury; compressive neuropathy requiring neurolysis; nerve grafting; nerve transfer planning; brachial plexus-related assessment; combined nerve and tendon/vascular injury; other (write in)
- Patient age: pediatric; adult; older adult
- Management: primary nerve repair; delayed repair; neurolysis; nerve grafting; nerve transfer planning or performance; referral/escalation; postoperative sensory/motor recovery planning; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 2 operative peripheral nerve cases
- At least 1 acute nerve repair
- At least 1 case involving nerve grafting, neurolysis, nerve transfer planning, or complex reconstruction
- At least 1 case involving brachial plexus-related assessment
- At least 1 case involving postoperative sensory or motor recovery planning

- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including mechanism of injury, timing, wound location, sensory or motor deficit, pain, hand dominance, occupation, functional demands, previous injury or surgery, comorbidities, and patient goals.
2. ME 2.2 Perform a structured nerve examination, including sensory mapping, two-point discrimination where appropriate, motor testing, intrinsic and extrinsic muscle function, Tinel's sign, autonomic changes, pain features, vascular status, and associated tendon, bone, joint, or soft tissue injury.
3. ME 2.1 Identify urgent or complex nerve-related presentations, including open nerve laceration, combined nerve and vascular injury, progressive motor deficit, severe neuropathic pain, brachial plexus injury, crush or avulsion injury, and nerve injury associated with fracture or dislocation.
4. ME 2.2 Select and interpret appropriate investigations, including radiographs, ultrasound or MRI where indicated, and electrodiagnostic studies when relevant to localization, severity, chronicity, prognosis, or operative planning.
5. ME 2.4 Determine the appropriate management pathway, including observation, splinting, therapy, exploration, primary repair, delayed repair, neurolysis, nerve grafting, nerve transfer, tendon transfer consideration, or referral to a specialized nerve or brachial plexus service.
6. ME 3.1 Plan the procedure according to nerve involved, level of injury, timing, gap length, tissue condition, contamination, associated injuries, expected recovery, donor nerve or graft options, and available resources.
7. ME 3.4 Perform peripheral nerve procedures safely within scope, using appropriate exposure, magnification, atraumatic tissue handling, nerve identification, debridement of non-viable nerve ends, tension-free repair principles, fascicular alignment where appropriate, graft preparation, hemostasis, and wound closure.
8. ME 3.4 Recognize when the case exceeds current competence, including proximal major nerve injury, brachial plexus injury, nerve avulsion, complex nerve gap, failed reconstruction, severe scarring, combined vascular injury, or need for advanced nerve transfer planning.
9. ME 4.1 Develop and coordinate a postoperative recovery plan, including wound care, immobilization, splinting, therapy referral, sensory re-education, motor retraining, pain management, scar management, and serial assessment of recovery.
10. COM 3.1 Explain the diagnosis, treatment options, timing, risks, expected sensory and motor recovery, uncertainty of nerve regeneration, prolonged rehabilitation, possible incomplete recovery, and potential need for further procedures to the patient and family.

11. COL 1.3 Communicate effectively with emergency physicians, therapists, neurologists, electrodiagnostic specialists, radiologists, anesthesia, operating room staff, and supervising or specialized peripheral nerve surgeons.
12. ME 5.1 Recognize and respond to complications, including neuroma, persistent numbness, neuropathic pain, poor motor recovery, stiffness, infection, wound breakdown, tendon imbalance, cold intolerance, and delayed functional recovery.
13. COM 5.1 Document the assessment, sensory and motor findings, investigations, operative plan, repair or reconstruction technique, intraoperative findings, postoperative restrictions, rehabilitation plan, patient counselling, and follow-up arrangements accurately and promptly.

Hand Surgery

EPA 13: Perform carpal tunnel and common compression neuropathy surgery

Key Features: This EPA focuses on the ability to assess, plan, perform appropriate procedure, and provide postoperative care for common compression neuropathies of the hand and upper extremity.

- This includes carpal tunnel syndrome, cubital tunnel syndrome, and ulnar nerve compression at the wrist where applicable.
- The fellow is expected to confirm the diagnosis, assess severity, identify contributing factors, interpret relevant investigations, select appropriate non-operative or operative management, perform carpal tunnel release (CTR) and selected decompression procedures within scope, and recognize cases requiring senior input, including recurrent symptoms, failed previous surgery, severe nerve dysfunction, complex anatomy, or revision surgery.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (electrodiagnostic studies, imaging where relevant, operative notes, postoperative follow-up) by supervisor (hand surgeon, plastic surgeon, orthopedic surgeon, peripheral nerve surgeon, other approved supervisor)

Assessment form collects information on:

- Setting: outpatient clinic; nerve compression clinic; operating room; procedure room; hand therapy clinic; postoperative follow-up
- Case mix: carpal tunnel syndrome; cubital tunnel syndrome; Guyon's canal syndrome; Pronator teres syndrome; anterior interosseous nerve syndrome; Radial tunnel syndrome; Posterior interosseous nerve syndrome; double crush or multifocal compression; recurrent or persistent symptoms; revision consideration; other (write in)
- Patient age: adult; older adult
- Management: non-operative with immobilization, corticosteroid injection, and rehabilitation therapy; primary carpal tunnel release; cubital tunnel decompression; ulnar nerve decompression at wrist; revision assessment; postoperative management; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 2 operative carpal tunnel release cases
- At least 1 cubital tunnel, ulnar nerve compression, or radial nerve compression case
- At least 1 case involving electrodiagnostic interpretation
- At least 1 case involving recurrent, persistent, severe, or revision-related symptoms
- At least 1 postoperative follow-up case
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including sensory symptoms, nocturnal symptoms, weakness, clumsiness, pain distribution, duration, functional impact, occupation, hand dominance, previous treatment, previous surgery, comorbidities, medications, and patient goals.
2. ME 2.2 Perform a structured examination, including sensory testing, motor testing, thenar and intrinsic muscle assessment, provocative tests, nerve distribution, cervical or proximal nerve screening, and assessment for multifocal compression where relevant.
3. ME 2.1 Identify severe or urgent features, including progressive weakness, thenar or intrinsic wasting, severe sensory loss, acute compression, recurrent symptoms, failed previous surgery, or findings inconsistent with a simple compression neuropathy.
4. ME 2.2 Select and interpret relevant investigations, including electrodiagnostic studies and imaging where indicated, and correlate findings with the clinical presentation.
5. ME 2.4 Determine the appropriate management pathway, including observation, splinting, activity modification, steroid injections where applicable, therapy, primary decompression, revision assessment, or referral for senior-led management.
6. ME 3.1 Plan the procedure according to the site of compression, severity of nerve dysfunction, previous surgery, anatomical risk, patient comorbidities, expected benefit, and available resources.
7. ME 3.4 Perform carpal tunnel release safely within scope, including appropriate anesthesia, positioning, incision placement, soft tissue handling, identification and protection of neurovascular structures, complete release, hemostasis, wound closure, and dressing.
8. ME 3.4 Perform selected cubital tunnel or ulnar nerve decompression procedures within scope, recognizing the indications for simple decompression, transposition, Guyon's canal release, or senior-led operative planning.
9. ME 3.4 Recognize when the case exceeds current competence, including revision carpal tunnel surgery, recurrent or persistent symptoms, severe scarring, suspected nerve injury, complex cubital tunnel instability, tumor or mass effect, or uncertain diagnosis.
10. ME 4.1 Provide postoperative management, including wound care, pain control, activity advice, splinting where indicated, therapy referral, return-to-work guidance, and follow-up of sensory and motor recovery.
11. ME 5.1 Recognize and respond to complications, including incomplete release, nerve injury, pillar pain, scar sensitivity, wound infection, hematoma, stiffness, persistent symptoms, recurrent symptoms, complex regional pain syndrome, and delayed functional recovery.
12. COM 3.1 Explain the diagnosis, non-operative and operative options, expected recovery, risks, limitations, recurrence risk, possibility of incomplete symptom

resolution, and revision considerations to the patient and family.

13. COL 1.3 Communicate effectively with therapists, neurologists, electrodiagnostic specialists, anesthesia, nursing staff, operating room staff, and supervising surgeons.
14. COM 5.1 Document the clinical findings, investigation interpretation, diagnosis, treatment decision, consent discussion, operative details, complications, postoperative instructions, and follow-up plan accurately and promptly.

Hand Surgery

EPA 14: Manage arthritis and degenerative wrist/hand disorders

Key Features: This EPA focuses on the ability to assess, plan, and manage common arthritis and degenerative disorders of the hand and wrist.

- This includes thumb carpometacarpal (CMC) osteoarthritis, metacarpophalangeal (MCP) and interphalangeal (IP) joint arthritis, distal radioulnar joint (DRUJ) degeneration or instability, scapholunate advanced collapse (SLAC) and scaphoid non-union advanced collapse (SNAC) wrist, post-traumatic arthritis, inflammatory arthropathy affecting the hand, and degenerative conditions requiring reconstructive or salvage decision-making.
- The fellow is expected to establish the diagnosis, assess pain, deformity, stability, function, occupation, patient goals, and disease severity, interpret appropriate imaging, and perform appropriately either non-operative or operative management.
- The fellow must understand indications, limitations, risks, and expected outcomes of injections, splinting, therapy, arthrodesis, arthroplasty, excision arthroplasty, proximal row carpectomy, partial wrist fusion, total wrist fusion, DRUJ procedures, and referral for complex reconstruction where required.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (imaging, operative notes, postoperative follow-up) by supervisor (hand surgeon; orthopedic surgeon; plastic surgeon; rheumatologist where appropriate; other approved supervisor)

Assessment form collects information on:

- Setting: outpatient hand clinic; arthritis clinic; fracture/post-traumatic clinic; operating room; hand therapy clinic; postoperative follow-up
- Case mix: thumb CMC osteoarthritis; MCP/IP arthritis; DRUJ arthritis or instability; SLAC wrist; SNAC wrist; post-traumatic arthritis; inflammatory arthritis; failed previous treatment or revision consideration; other (write in)
- Patient age: adult; older adult
- Management (select all that apply): non-operative; injection; splinting/therapy; arthrodesis planning or performance; arthroplasty planning or performance; partial wrist fusion; proximal row carpectomy; total wrist fusion; DRUJ procedure; postoperative management; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 1 thumb CMC osteoarthritis case
- At least 1 wrist arthritis case, such as SLAC, SNAC, post-traumatic arthritis, or pan carpal arthritis
- At least 1 DRUJ or ulnar-sided degenerative wrist case

- At least 1 case involving operative decision-making for arthrodesis, arthroplasty, proximal row carpectomy, or partial wrist fusion
- At least 1 postoperative follow-up case
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including pain location, duration, stiffness, weakness, instability, previous injury, prior treatment, inflammatory disease, occupation, hand dominance, functional limitations, patient expectations, and treatment goals.
2. ME 2.2 Perform a structured hand and wrist examination, including alignment, deformity, swelling, tenderness, range of motion, grip and pinch strength, joint stability, crepitus, provocative tests, neurovascular status, and adjacent joint function.
3. ME 2.2 Select and interpret appropriate imaging, including plain radiographs, stress views, CT, MRI, or inflammatory disease investigations where indicated.
4. ME 2.1 Identify factors that affect urgency, treatment selection, and prognosis, including severe pain, progressive deformity, instability, loss of function, inflammatory disease activity, previous surgery, bone loss, poor soft tissue envelope, and patient comorbidities.
5. ME 2.4 Develop a patient-centered management plan that considers observation, analgesia, activity modification, splinting, hand therapy, corticosteroid injection, disease-modifying treatment referral, or operative intervention.
6. ME 3.1 Select appropriate operative options based on diagnosis, disease stage, joint involved, functional demand, bone stock, alignment, adjacent joint disease, patient age, occupation, expectations, and available resources.
7. ME 3.1 Compare procedure options and limitations, including thumb CMC procedures, MCP or IP arthrodesis or arthroplasty, DRUJ procedures, proximal row carpectomy, partial wrist fusion, total wrist fusion, and wrist arthroplasty where applicable.
8. ME 3.4 Perform injections or selected operative procedures safely within scope, using appropriate consent, anesthesia, exposure, tissue handling, implant or fixation principles, protection of neurovascular structures, hemostasis, closure, and immobilization.
9. ME 3.4 Recognize when the case exceeds current competence, including complex deformity, inflammatory joint destruction, failed previous reconstruction, revision arthroplasty, severe bone loss, pan carpal disease, complex DRUJ instability, or need for specialized reconstructive planning.
10. ME 4.1 Coordinate postoperative care and rehabilitation, including wound care, immobilization, therapy timing, oedema control, range-of-motion plan, strengthening, activity restrictions, and return-to-work planning.
11. ME 5.1 Recognize and respond to complications, including infection, stiffness,

persistent pain, implant failure, non-union, malunion, instability, tendon irritation or rupture, nerve symptoms, complex regional pain syndrome, and delayed functional recovery.

12. COM 3.1 Explain the diagnosis, natural history, non-operative options, surgical choices, risks, benefits, limitations, recovery time, rehabilitation needs, durability, and likelihood of residual symptoms to the patient and family.
13. COL 1.3 Communicate effectively with hand therapists, rheumatologists, primary care physicians, radiology, anesthesia, operating room staff, and supervising surgeons.
14. HA 1.1 Consider the patient's occupational needs, independence, access to therapy, ability to comply with rehabilitation, and broader impact of hand function on quality of life.
15. COM 5.1 Document the assessment, imaging interpretation, diagnosis, treatment options, shared decision-making, operative plan, procedure performed, postoperative instructions, and follow-up plan accurately and promptly.

Hand Surgery

EPA 15: Manage ligament injuries and wrist instability

Key Features: This EPA focuses on the fellow's ability to assess, diagnose, and manage ligament injuries and instability of the hand and wrist.

- This includes scapholunate ligament injuries, lunotriquetral ligament injuries, triangular fibrocartilage complex (TFCC) injuries, distal radioulnar joint (DRUJ) instability, peri lunate injury patterns, and other causes of acute or chronic carpal instability. There are included also collateral ligament injuries of metacarpophalangeal and interphalangeal joints; volar plate injuries and instabilities of finger joints.
- The fellow is expected to obtain a focused history, perform a structured hand and wrist examination, interpret appropriate imaging, identify instability patterns, and determine whether the injury is suitable for non-operative treatment, immobilization, therapy, arthroscopy-assisted care, ligament repair, reconstruction, salvage procedure, or referral for senior-led management.
- The fellow must recognize time-sensitive instability patterns, especially acute scapholunate injury, peri lunate instability, and DRUJ instability associated with trauma.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (imaging, arthroscopy findings, operative notes, follow-up outcomes) by supervisor (hand surgeon, orthopedic surgeon, plastic surgeon, wrist arthroscopy surgeon, or other approved supervisor).

Assessment form collects information on:

- Setting: emergency department; urgent hand clinic; outpatient wrist clinic; fracture clinic; operating room; hand therapy clinic; postoperative follow-up
- Case mix: scapholunate ligament injury; lunotriquetral ligament injury; triangular fibrocartilage complex injury; distal radioulnar joint instability; peri lunate injury pattern; chronic carpal instability; post-traumatic wrist pain/ instability; collateral ligament injuries of metacarpophalangeal and interphalangeal joints; volar plate injuries; other (write in)
- Patient age: adult; older adult
- Management: non-operative; immobilization; therapy; injection; arthroscopy-assisted assessment or treatment; ligament repair; ligament reconstruction; salvage procedure planning; postoperative management; other (write in)

Basis for formal entrustment decision:

Collect 6 observations of achievement.

- At least 1 collateral ligament injury of finger joints
- At least 1 scapholunate ligament injury
- At least 1 triangular fibrocartilage complex injury or distal radioulnar joint instability

case

- At least 1 acute or urgent instability case
- At least 1 chronic or delayed presentation
- At least 1 case involving arthroscopy-assisted assessment or operative decision-making where applicable
- At least 1 postoperative follow-up case
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including mechanism of injury, timing, pain location, clicking, weakness, instability symptoms, swelling, previous trauma, occupation, sport or activity demands, hand dominance, comorbidities, and patient goals.
2. ME 2.2 Perform a structured wrist examination, including inspection, swelling, tenderness, range of motion, grip strength, carpal alignment, provocative tests, distal radioulnar joint stability, ulnar-sided wrist assessment, neurovascular status, and comparison with the contralateral wrist.
3. ME 2.1 Identify urgent or time-sensitive injuries, including peri lunate instability, acute scapholunate ligament injury, unstable carpal dissociation, distal radioulnar joint instability, fracture-dislocation, open injury, and neurovascular compromise.
4. ME 2.2 Select and interpret appropriate investigations, including plain radiographs, clenched fist or stress views, computed tomography, magnetic resonance imaging, magnetic resonance arthrography, ultrasound where appropriate, and arthroscopic findings where applicable.
5. ME 2.4 Formulate a diagnosis and classify the instability pattern, including scapholunate instability, lunotriquetral instability, triangular fibrocartilage complex injury, distal radioulnar joint instability, peri lunate injury, dynamic instability, static instability, or chronic degenerative instability.
6. ME 3.1 Determine the appropriate management pathway, including immobilization, analgesia, activity modification, hand therapy, injection where appropriate, arthroscopy-assisted assessment or treatment, ligament repair, reconstruction, salvage procedure, or referral.
7. ME 3.4 Perform or assist with procedures within scope, including closed reduction and immobilization, diagnostic wrist arthroscopy, arthroscopy-assisted debridement or repair where applicable, ligament repair, pinning, reconstruction, or postoperative immobilization.
8. ME 3.4 Recognize when the case exceeds current competence, including complex peri lunate injury, chronic static instability, failed previous reconstruction, advanced degenerative collapse, combined ligament and fracture injury, complex triangular fibrocartilage complex tear, or need for specialized wrist arthroscopy or

reconstruction.

9. ME 4.1 Coordinate postoperative and rehabilitation care, including splinting, immobilization duration, therapy timing, range-of-motion progression, strengthening, activity restriction, return-to-work guidance, and follow-up imaging where indicated.
10. ME 5.1 Recognize and respond to complications, including persistent instability, stiffness, chronic pain, loss of reduction, pin complications, recurrent symptoms, non-healing ligament repair, distal radioulnar joint dysfunction, complex regional pain syndrome, and progression to arthritis.
11. COM 3.1 Explain the diagnosis, uncertainty, treatment options, operative and non-operative risks, expected recovery, rehabilitation requirements, possible residual pain or stiffness, risk of arthritis, and need for staged or salvage procedures to the patient and family.
12. COL 1.3 Communicate effectively with emergency physicians, radiologists, hand therapists, anesthesia, operating room staff, and supervising surgeons to ensure coordinated assessment, operative planning, and rehabilitation.
13. HA 1.1 Consider occupational, sporting, functional, and access-to-therapy factors when planning treatment and recovery.
14. COM 5.1 Document the history, examination findings, instability tests, imaging interpretation, diagnosis, management plan, operative or arthroscopy findings, rehabilitation instructions, patient counselling, and follow-up plan accurately and promptly.

Hand Surgery

EPA 16: Manage Dupuytren disease

Key Features: This EPA focuses on the ability to assess, plan, and manage patients with Dupuytren disease affecting the hand.

- The fellow is expected to assess disease severity, functional impact, pattern of contracture, skin involvement, neurovascular risk, previous treatment, recurrence, and patient goals.
- The fellow must select appropriate non-operative or procedural management, including observation, splinting or therapy where appropriate, needle aponeurotomy or percutaneous needle fasciotomy, collagenase injection pathways where used, limited fasciectomy, dermo fasciectomy, and revision strategies for recurrent disease.
- The fellow is expected to counsel patients regarding recurrence, complications, rehabilitation, and realistic functional outcomes.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (photographs, operative notes, postoperative follow-up) by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; other approved supervisor).

Assessment form collects information on:

- Setting: outpatient hand clinic; procedure room; operating room; hand therapy clinic; postoperative follow-up
- Case mix: primary Dupuytren disease; recurrent Dupuytren disease; metacarpophalangeal joint contracture; proximal interphalangeal joint contracture; multi-digit disease; skin involvement; revision case; other (write in)
- Patient age: adult; older adult
- Management: observation; therapy or splinting; needle aponeurotomy/percutaneous needle fasciotomy; collagenase pathway where used; limited fasciectomy; dermo fasciectomy; revision strategy; postoperative rehabilitation; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 primary Dupuytren disease case
- At least 1 recurrent or previously treated case
- At least 1 proximal interphalangeal joint contracture case
- At least 1 case involving procedural or operative decision-making
- At least 1 postoperative follow-up or rehabilitation review
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including disease duration, progression, hand

- dominance, occupation, functional limitation, family history, previous treatment, recurrence, comorbidities, anticoagulation, smoking status, and patient goals.
2. ME 2.2 Perform a structured hand examination, including nodules, cords, skin pitting, skin quality, joint contracture, range of motion, tabletop test, neurovascular status, grip function, and involvement of adjacent digits.
 3. ME 2.2 Measure and document contracture severity at the metacarpophalangeal joint, proximal interphalangeal joint, and distal interphalangeal joint where relevant.
 4. ME 2.1 Identify features associated with complex disease, including severe proximal interphalangeal joint contracture, recurrent disease, multi-digit involvement, skin deficiency, neurovascular displacement, previous fasciectomy, young age at onset, aggressive progression, or significant functional impairment.
 5. ME 2.4 Determine the appropriate management pathway, including observation, patient education, therapy, needle aponeurotomy, percutaneous needle fasciotomy, collagenase injection where used, limited fasciectomy, dermo fasciectomy, revision surgery, or referral for senior-led management.
 6. ME 3.1 Select treatment based on disease pattern, degree of contracture, joint involved, skin quality, recurrence risk, patient age, functional demands, comorbidities, rehabilitation capacity, and available resources.
 7. ME 3.4 Perform or assist with procedural or operative treatment within scope, using appropriate consent, anesthesia, incision or needle placement, tissue handling, identification and protection of neurovascular structures, correction of contracture, hemostasis, wound closure, dressing, and splinting.
 8. ME 3.4 Recognize when the case exceeds current competence, including revision fasciectomy, severe recurrent contracture, major skin deficiency, complex proximal interphalangeal joint deformity, neurovascular risk, or need for dermo fasciectomy or staged reconstruction.
 9. ME 4.1 Coordinate postoperative rehabilitation with hand therapists, including wound care, edema control, scar management, splinting, range-of-motion exercises, recurrence monitoring, and return-to-function planning.
 10. ME 5.1 Recognize and respond to complications, including wound breakdown, hematoma, infection, skin necrosis, nerve injury, vascular compromise, stiffness, complex regional pain syndrome, incomplete correction, recurrence, and delayed functional recovery.
 11. COM 3.1 Explain the diagnosis, natural history, treatment options, expected benefit, recurrence risk, complications, rehabilitation requirements, and possibility of further treatment to the patient.
 12. COL 1.3 Communicate effectively with hand therapists, nursing staff, anesthesia, operating room staff, primary care physicians, and supervising surgeons to ensure coordinated care.
 13. HA 1.1 Consider the impact of contracture on work, independence, daily activities,

access to therapy, and patient ability to comply with postoperative rehabilitation.

14. COM 5.1 Document disease severity, joint measurements, functional impact, treatment options, shared decision-making, consent discussion, procedure performed, complications, rehabilitation plan, and recurrence strategy accurately and promptly.

Hand Surgery

EPA 17: Recognize and manage complications and adverse outcomes

Key Features: This EPA focuses on the ability to recognize, assess, manage, and appropriately escalate complications and adverse outcomes following hand and upper-extremity injury or surgery.

- This includes infection, stiffness, complex regional pain syndrome, nonunion, malunion, tendon rupture, tendon adhesion, nerve pain, neuroma, implant problems, wound complications, flap or graft compromise, persistent instability, and recurrent or persistent symptoms.
- The fellow is expected to distinguish expected postoperative recovery from abnormal or concerning findings, identify complications requiring urgent intervention, initiate appropriate first-line management, and contribute to reoperation or revision planning where required.
- The fellow must communicate clearly with patients and the care team, document adverse outcomes accurately, and demonstrate professional accountability, transparency, and timely escalation.

Assessment Plan:

Direct observation, case discussion, and/or review of clinical documentation (imaging, therapy reports, operative notes, complication management plans, reoperation planning) by supervisor (hand surgeon; plastic surgeon; orthopedic surgeon; hand therapist; other approved supervisor)

Assessment form collects information on:

- Setting: postoperative clinic; emergency department; inpatient ward; hand therapy clinic; operating room; multidisciplinary review
- Case mix: infection; stiffness; complex regional pain syndrome; nonunion or malunion; tendon rupture or adhesion; nerve pain or neuroma; wound complication; implant or hardware complication; flap or graft compromise; recurrent or persistent symptoms; other (write in)
- Patient age: pediatric; adult; older adult
- Management: non-operative; therapy escalation; antimicrobial treatment; pain management; imaging and surveillance; urgent surgical review; reoperation or revision planning; referral/escalation; conduct a multidisciplinary meeting with different stakeholders to establish a treatment plan; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 infection or wound complication
- At least 1 stiffness, tendon adhesion, or complex regional pain syndrome case
- At least 1 structural complication, such as nonunion, malunion, tendon rupture, implant failure, or recurrent instability

- At least 1 nerve-related complication, such as nerve pain, neuroma, persistent numbness, or motor deficit
- At least 1 case involving reoperation, revision planning, or senior escalation
- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history of the complication, including timing, symptom progression, pain pattern, wound concerns, fever or systemic symptoms, functional loss, sensory or motor change, therapy progress, adherence, previous treatment, and patient concerns.
2. ME 2.2 Perform a structured complication-focused examination, including wound status, swelling, erythema, drainage, tenderness, range of motion, tendon function, neurovascular status, sensation, strength, scar quality, implant prominence, splint fit, and functional limitation.
3. ME 2.1 Identify complications requiring urgent review, including deep infection, sepsis, vascular compromise, flap or graft failure, compartment concern, tendon rupture, fixation failure, progressive neurological deficit, uncontrolled pain, or rapidly worsening function.
4. ME 2.2 Select and interpret appropriate investigations, including radiographs, ultrasound, computed tomography, magnetic resonance imaging, blood tests, cultures, electrodiagnostic studies, or therapy assessments where indicated.
5. ME 2.4 Develop an initial management plan that addresses pain control, wound care, antibiotics where indicated, splinting, therapy modification, imaging follow-up, activity restriction, referral, or urgent surgical review.
6. ME 3.1 Determine whether the complication can be managed non-operatively or requires operative intervention, taking into account severity, timing, functional impact, tissue viability, infection risk, fixation or repair stability, and available resources.
7. ME 3.4 Perform procedures within scope, such as wound care, drainage of superficial infection, dressing changes, splint adjustment, suture or pin removal, manipulation planning, or operative assistance, while recognizing personal limits.
8. ME 3.1 Contribute to reoperation or revision planning, including defining the problem, reviewing prior treatment, assessing imaging and operative findings, identifying surgical options, anticipating risks, and planning postoperative rehabilitation.
9. ME 4.1 Coordinate multidisciplinary care with hand therapists, nurses, infectious diseases, pain specialists, radiology, anesthesia, occupational health, and supervising surgeons.
10. ME 5.1 Monitor response to treatment and adjust the plan according to wound healing, infection control, pain, motion, tendon function, nerve recovery, fracture union, patient adherence, and functional progress.

11. COM 3.1 Communicate complications and adverse outcomes to the patient and family clearly, honestly, and compassionately, including uncertainty, treatment options, expected recovery, risks, and possible need for further surgery.
12. P 1.1 Demonstrate professional accountability, transparency, respect, and timely escalation when complications or adverse outcomes occur.
13. S 1.2 Reflect on complications, seek feedback, identify learning needs, and use evidence or supervisor guidance to improve future practice.
14. L 1.1 Use institutional pathways, safety reporting processes, clinic resources, operating room access, and rehabilitation services appropriately when managing adverse outcomes.
15. HA 1.1 Consider patient-specific barriers to recovery, including access to therapy, work demands, transport, psychosocial distress, financial impact, health literacy, and ability to comply with treatment.
16. COM 5.1 Document the complication, assessment findings, investigations, management plan, patient discussion, senior input, reoperation plan, safety considerations, and follow-up arrangements accurately and promptly.

Hand Surgery

EPA 18: Evaluate and manage common congenital hand differences (Syndactyly, Polydactyly)

Key Features: This EPA focuses on the fellow's ability to evaluate and manage common congenital hand differences, including syndactyly and polydactyly.

- The fellow is expected to assess the anatomical pattern, functional impact, associated limb or systemic findings, family concerns, timing of intervention, and need for imaging, genetic assessment, therapy, or multidisciplinary referral.
- The fellow must distinguish simple from complex presentations, counsel families sensitively, select appropriate operative or non-operative management, and perform procedures within scope.
- This includes planning for syndactyly release, skin flap and graft requirements, correction of web-space involvement, excision or reconstruction of duplicated digits, and postoperative care that supports growth, function, cosmesis, and family-centered outcomes.

Assessment Plan:

Direct observation, operative observation, case discussion, and/or review of clinical documentation (photographs, imaging, operative notes, postoperative follow-up) by supervisor (hand surgeon; pediatric hand surgeon; plastic surgeon; orthopedic surgeon; other approved supervisor)

Assessment form collects information on:

- Setting: pediatric hand clinic; outpatient hand clinic; multidisciplinary clinic; operating room; hand therapy review; postoperative follow-up
- Case mix: simple syndactyly; complex syndactyly; preaxial polydactyly; postaxial polydactyly; central polydactyly; thumb duplication; multiple congenital differences; suspected syndromic presentation; congenital trigger finger, camptodactyly, clinodactyly; other (write in)
- Patient age: infant; child; adolescent; adult with untreated/recurrent congenital hand difference
- Management: observation; imaging and surveillance; operative planning; syndactyly release; polydactyly excision or reconstruction; postoperative splinting or therapy; recurrence or revision planning; other (write in)

Basis for formal entrustment decision:

Collect 5 observations of achievement.

- At least 1 syndactyly case
- At least 1 polydactyly or thumb duplication case
- At least 1 case involving operative planning or operative management
- At least 1 case involving family counselling about timing, risks, and expected outcomes
- At least 1 postoperative follow-up or rehabilitation review

- At least 2 observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant Task Components:

1. ME 2.2 Obtain a focused history, including prenatal history, birth history, developmental history, family history, associated anomalies, previous treatment, functional concerns, parental expectations, and psychosocial impact.
2. ME 2.2 Perform a structured examination of both upper limbs, including digit number, web-space involvement, digit alignment, motion, nail development, skeletal stability, neurovascular status, skin quality, grasp, pinch, and functional use.
3. ME 2.1 Identify complex features requiring senior or multidisciplinary input, including syndromic features, bilateral or multiple limb differences, complex syndactyly, bony fusion, thumb duplication, central polydactyly, unstable joints, absent structures, or significant functional limitation.
4. ME 2.2 Select and interpret appropriate investigations, including plain radiographs, photographs, and additional imaging or genetic assessment where indicated.
5. ME 2.4 Develop a management plan that considers age, growth, function, cosmesis, family goals, surgical timing, anesthetic risk, need for staged procedures, and expected rehabilitation.
6. ME 3.1 Plan syndactyly management, including timing of release, web-space reconstruction, zig-zag incision planning, need for skin grafting or local flaps, protection of neurovascular structures, and avoidance of web creep.
7. ME 3.1 Plan polydactyly management, including classification of duplication, selection of the digit or elements to preserve, reconstruction of soft tissue, tendon, ligament, joint, nail, and skeletal structures where required.
8. ME 3.4 Perform or assist with congenital hand procedures within scope, using appropriate consent, pediatric surgical principles, atraumatic tissue handling, neurovascular protection, flap design, graft placement, skeletal correction, wound closure, dressing, and splinting.
9. ME 3.4 Recognize when the case exceeds current competence, including complex thumb duplication, central polydactyly, syndromic hand differences, revision surgery, severe contracture, growth-related deformity, or need for staged reconstruction.
10. ME 4.1 Coordinate postoperative care with hand therapists, pediatric teams, nursing staff, and the supervising surgeon, including dressing changes, splinting, scar care, motion plan, and follow-up through growth.
11. ME 5.1 Recognize and respond to complications, including wound problems, graft loss, infection, stiffness, scar contracture, web creep, angular deformity, nail deformity, recurrence, growth disturbance, and delayed functional recovery.
12. COM 3.1 Communicate sensitively with parents, caregivers, and the patient where appropriate, explaining the diagnosis, natural history, treatment options, timing, risks,

expected appearance, functional outcomes, and possibility of further procedures.

13. COL 1.3 Communicate effectively with pediatricians, geneticists, anesthesiologists, hand therapists, nurses, operating room staff, and supervising surgeons when coordinating care.
14. HA 1.1 Consider the child's development, family preferences, cultural concerns, access to therapy, school or activity needs, psychosocial impact, and long-term function when planning treatment.
15. COM 5.1 Document the congenital hand difference, classification where applicable, examination findings, imaging interpretation, family discussion, treatment plan, consent, operative details, postoperative instructions, and follow-up plan accurately and promptly.

