

NEW YORK  
DOWNTOWN  
HOSPITAL

DEPARTMENT OF PODIATRIC MEDICAL EDUCATION  
Department of Orthopaedic Surgery/ Podiatry Section

**Podiatric Medicine and Surgery Residency**  
with added credential for reconstructive rearfoot/ ankle surgery

**RESIDENCY MANUAL**

**2012/2013**

170 WILLIAM STREET  
NEW YORK, NEW YORK 10038

(212)312-5000

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## **INTRODUCTION**

This manual is designed to be a resource to assist you in maneuvering through your Podiatric Medicine and surgery (PMSR) residency training program. It includes policies procedures, schedules, expected competencies and a myriad of other material which we hope will be useful to you. In addition to this document, you are also expected to be familiar with, and adhere to the “NEW YORK DOWNTOWN HOSPITAL GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES MANUAL”. A copy is available on the Hospital intranet under the GME tab, and a digital and/or paper copy can be made available to you on request.

### **Role and Responsibility**

*Welcome to NY Downtown Hospital. The goal of the residency program is to provide effective, quality patient care and a stimulating academic environment to support your further educational growth and development. Your primary responsibility is to your patients. To that end, all of the resources of the Hospital are committed and available to assist you.*

*To assure the availability of adequate teaching and supervision, health care providers are directly and immediately available to assist in-patient care, technical and operational issues, and manage all of the teaching services. In addition, all patients have an assigned Attending of Record who is available at all times for the discussion of patient management and care.*

*We are sure you will find this 36 month academic program challenging and satisfying.*

### **New York Downtown Hospital: Historical Timeline**

1853

Elizabeth Blackwell, M.D., the first licensed woman physician in the United States, founds the New York Dispensary for Poor Women and Children.

**1857**

Dr. Blackwell opens a hospital, The New York Infirmary for Indigent Women and Children, near present-day Tompkins Square Park on the Lower East Side of Manhattan. The following year, The Infirmary moves to large quarters on Stuyvesant Square.

**1905**

St. Gregory's Free Emergency Accident Hospital and Ambulance Station is founded by the Volunteers of America, and later named Volunteer Hospital.

**1922**

After the September 1920 bombing of JP Morgan Company, Wall Street financiers create Broad Street Hospital, taking over Volunteer Hospital.

**1932**

The Kate Depew Strang Clinic is founded by Dr. Elise Strang L'Esperance, one of Dr. Blackwell's first students. The Strang Clinic is the world's first specialized cancer treatment clinic and the site of the world's first cancer prevention program.

**1937**

The Strang Cancer Prevention Clinic at The New York Infirmary opens.

**1945**

St. Gregory's Free Emergency Accident Hospital and Ambulance Station merges with Broad Street Hospital to form Beekman Downtown Hospital.

**1969**

New York Infirmary forms an affiliation with NYU Medical Center to strengthen teaching programs at both institutions.

**1975**

FALN, a Puerto Rican nationalist group, bombs Fraunces Tavern, a meeting place for financiers and government officials for over 150 years. Four people were killed and 50 were wounded, many of whom came to the Hospital's emergency department for life-saving treatment.

**1979**

New York Infirmary merges with Beekman Downtown Hospital and in 1981 relocates from Stuyvesant Square to its present location at 170 William Street in Lower Manhattan.

**1991**

New York Infirmary-Beekman Downtown Hospital affiliates with The New York Hospital and is renamed New York Downtown Hospital.

**1993**

Within minutes of the explosion at the World Trade Center Towers, New York Downtown Hospital begins to receive hundreds of injured victims. The explosion kills 6, injures over 1,000, and forces more than 50,000 people to evacuate.

**1994**

New York Downtown Hospital begins an affiliation with NYU Medical Center. In 1997, New York Downtown Hospital is renamed NYU Downtown Hospital.

**2001**

NYU Downtown Hospital gains international recognition for its extraordinary response during the tragedy of September 11, 2001. The Hospital treats over 1,000 victims; offers refuge to an additional 450 people; provides care, prescriptions and over 350 meals to seniors in the community – all despite the loss of water, electrical power, telephones/faxes, computers, steam and gas.

**2002**

New York City Mayor Michael Bloomberg proclaims March 11 as "NYU Downtown Hospital Day."

**2003**

NYU Downtown Hospital breaks ground for the full reconstruction and expansion of its emergency center. The renovation will create a state-of-the-art emergency facility designed to meet the unique needs of Lower Manhattan. The new facility will be named The Lehman Brothers Emergency Center in recognition of a generous gift of \$5 million from The Lehman Brothers Foundation.

**2005**

NYU Downtown Hospital severs its ties to NYU Medical Center and shortly thereafter becomes a member of the prestigious NewYork-Presbyterian Healthcare System. The Hospital reverts to its traditional name: New York Downtown Hospital.

**2006**

New York Downtown Hospital opens The Lehman Brothers Emergency Center. This new state-of-the-art emergency facility is double the size of the previous emergency room and can handle more than triple the capacity. Every patient area has been upgraded, including those for women, children, asthma and chest pain patients, and people in need of routine care. The new facility includes the largest decontamination unit in the city for responding to bio-terrorism, as well as other improvements to enhance the Hospital's ability to respond to both individual and community-wide emergencies. The Lehman Brothers Emergency Center serves as a cornerstone of New York Downtown Hospital's efforts to ensure the health and safety of every employee, resident and visitor in Lower Manhattan, 24 hours a day, 365 days a year.

**2010**

New York Downtown Hospital acquires sponsorship of a 36 month Podiatric Medical & Surgical Residency program from St. Vincent's Manhattan Hospital due to bankruptcy. The podiatric residency training program has been in existence since 1989 when it began at St. Clare's Hospital in NYC. St. Clare's was acquired by St. Vincent's in 2004.

**2012**

The 36 month Podiatric Medical & Surgical Residency program converts to a 36 month Podiatric Medicine and surgery Residency with added credential for reconstructive rearfoot and ankle surgery.

## Mission Statement of the Program

The Podiatric Medicine and surgery Residency (PMSR) is a 36 month podiatric residency program at NYDH. In keeping with the mission of our sponsoring institution, it is designed to provide the academic and clinical foundations for the Doctor of Podiatric Medicine. Our mission is to train individuals who will provide high quality, cost-effective, compassionate and accessible care to all patients.

### The Program seeks to:

- Sensitize students to the diversity of health care needs and the impact of socioeconomic factors on health care. We believe that tolerance, understanding, and cultural sensitivity are vital attributes needed by health care professionals practicing in a vibrant and highly diverse urban environment.
- Encourage and motivate our students to return to their communities and improve the access to quality health care.
- Foster the development of the interpersonal skills, attitudes and behavior that are needed to function competently, confidently, and compassionately as health care professionals
- Develop an understanding of the role of the podiatrist within the health care system, the provision of health care services, health promotion and disease prevention.
- Integrate the basic sciences, social sciences, medical education and clinical training to provide a comprehensive introduction to the practice of podiatric medicine and surgery.
- Provide the competencies necessary to allow the graduate to ultimately achieve Board Certification status by the American Board of Podiatric Medicine and The American Board of Podiatric Surgery for both Foot Surgery and the added credential for Reconstructive Rearfoot/ Ankle Surgery.
- Develop competencies in written and oral communication skills. We believe that clinicians must be able to communicate clearly with their peers and with their patients.
- Develop learning strategies for life-long learning.
- Encourage collaboration in learning and working.
- Encourage the students to empower their patients and advocate for their needs.
- Serve as role models in the medical community.

## Program Goals:

The Program is designed to provide residents with the necessary academic, clinical, professional and interpersonal skills to allow them, as newly graduated podiatrists, to function competently, confidently, compassionately, and efficiently.

Through a critical, continuous and dynamic self-assessment, the program will identify and implement changes necessary to maintain the highest possible standards as outlined in Document 320 of the Council on Podiatric Medical Education.

The Program seeks to sensitize residents to the diversity of the patient population and their health care needs. The impact of socioeconomic factors on health care will be continual focus, with a hope of promoting non-discrimination and inspiring graduates to work in communities that have been traditionally underserved.

It is a goal of the Program to provide the student with the desire and strategies to pursue learning as a lifelong process and to maintain the highest level of knowledge and commitment

*Values central to our mission:*

*Respect  
Integrity  
Compassion  
Excellence  
Education*

Our program is accredited by the American Podiatric Medical Association through the Council on Podiatric Medical Education. During 36 months of training we hope to produce podiatric medical doctors that are competent and confident in their abilities to treat lower extremity pathology. We encourage all of our graduates to follow the path of certification by the American Board of Podiatric Surgery as well as the American Board of Podiatric Medicine. Our program meets the criteria of both ABPS for diplomate status in reconstructive rear foot/ ankle surgery, and ABPM certification as a diplomate.

Our program is designed to meet the competencies and performance indicators as required by the Council on Podiatric Medical Education, and outlined in Document CPME-320.

A complete list of the competencies and performance indicators they may be found at [http://www.abpoppm.org/residency/res\\_PDFs/CompPerformIndicator2.pdf](http://www.abpoppm.org/residency/res_PDFs/CompPerformIndicator2.pdf)

## GENERAL HOUSESTAFF POLICIES

### **ABSENCES**

It is the resident's responsibility to inform the page operator, his/her immediate Clinical Supervisor, as well as the Podiatric Medical Education Office when he/she will be absent. All absences from assigned clinical responsibility (both on and off site) must be communicated to and documented by the **Podiatric Medical Education Office (646 926-5578)**. This includes nights, weekends, and holidays. Leave a message on the answering service. There are no exceptions and unexcused absences are not acceptable.

Any house staff member's absence from all or any part of an assigned shift which is not documented by a direct telephone call to the rotation supervisor and a direct call to the Podiatric Medical Education Office before the shift begins is an unexcused absence. Any absence from work that is reported to the Medical Education Office, directly or indirectly, after the fact is an unexcused absence. Unexcused absences from work are not reimbursable. Unexcused absence from an assigned shift will result in the house officer's loss of a day's pay. Any number of unexcused absences beyond one will be considered grounds for further disciplinary action, to be arbitrated by the Medical Education Committee.

Anytime a resident on duty must be out of the hospital for any period of time, he/she must inform the page operator and give the name of the covering resident.

The post-call Residents must inform the page operator when he/she is leaving the hospital for the day. They must also give the name of the covering resident.

### **APMA MEMBERSHIP**

All residents are encouraged to maintain membership of the American Podiatric Medical Association. For specific information regarding membership, contact the NYS Podiatric Medical Association directly. (212) 996-4400

### **ATTENDANCE**

Timely attendance on a daily basis, as well as at all scheduled conferences and teaching sessions is mandatory. Attendance records will be maintained on an on-going basis. Resident participation will be reflected in final evaluations and letters of reference.

## **GRIEVANCES & REMEDIATION**

The graduate trainee may be subject to probation or remediation upon receipt of one or more unsatisfactory evaluations. As noted in the **New York Downtown Hospital Graduate Education Policies and Procedure Manual; Section VIII Grievances and Due Process**, “it is the policy of New York Downtown Hospital (NYDH) that all adverse actions will be handled in a manner consistent with the guidelines described in **CPME Document 320 Section 3.10**, and all applicable rules and regulations of the NYDH Medical Staff, New York State, and other authorities. Nonacademic, non-patient related disciplinary actions may be appealed through the contractual grievance procedure in the collective bargaining agreement between the Hospital and the Residents collective bargaining representative.”

Should a resident receive an unsatisfactory evaluation from an evaluator in any rotation, steps must be taken to remediate in order to develop the competencies necessary in that area of practice. The rotation director will develop a remediation program consistent with **Section VII of the New York Downtown Hospital Graduate Education Policies and Procedure Manual**.

Residents who encounter a problem during a rotation pertaining to the educational program, should confer with the following individuals in sequence:

1. Assigned Clinical Supervisor of Service
2. Chief of relevant Service
3. Director of Podiatric Medical Education

Residents have the right to submit a written objection/personal statement to any performance evaluation in their file. Such Residents addendums will be maintained in the Residents ship files of the Department of Medical Education and will be considered a component of the Evaluation Form.

**The Director of Podiatric Medical Education will privately and verbally counsel residents if significant performance insufficiencies are perceived through the monthly review of Logs and Evaluation Forms.**

## **CARDIAC/RESPIRATORY ARREST**

To initiate a Code for a cardiac or respiratory arrest, dial **4444**, state that you are calling **CODE 99**, and give the location of the Unit/Department where the event occurred.

## **CONSULTATIONS**

**When the podiatry service receives a request for consultation you must follow the following protocol:**

Notify the Chief Resident of each/every/any requests for consultations immediately.

The Chief Resident will determine which resident and which attending podiatry staff member will perform the consult.

- If the consult requests a specific attending podiatrist, then that podiatrist ONLY must be notified in a reasonable period of time.
- If the consult is for “House” or is not specified, then the Chief resident will determine who the attending will be.

When you are assigned to perform the consultation follow the following steps in order:  
(This should be within 6 hours of receiving the assignment)

1. Review the chart
2. Review ancillary information (imaging studies, other consults, etc.)
3. Examine the patient but do NOT initiate treatment
4. Form a treatment plan
5. Call the attending assigned to the case and discuss your treatment plan.

CMS requirements demand that all consultations/treatments be performed by the attending podiatrist, or by the resident under direct supervision.

Residents cannot sign consultation forms. You should place a note in the chart, but the consultation must be signed by the attending within 24 hrs of your notifying him/her.

The patient should be followed daily, and seen at least twice a day by the PGY III residents.

If the patient is to go to the OR the resident assigned to the case must pre-op the patient, be certain that all is in order and contact the attending of specifics.

## **EVALUATIONS**

Evaluations are an essential means of both providing you with recognition of your ability and for identifying areas for improvement. You should ask each rotational supervisor for an interim verbal assessment two weeks into the rotation and a final exit interview.

At the completion of each monthly rotation, the Clinical Supervisor, Attending Physician or Rotation Supervisor will evaluate all residents. These written evaluations will be signed by the resident, reviewed and signed by the Director of Podiatric Medical Education and maintained in the performance files in the Department of Medical Education.

The Director of Podiatric Medical Education will meet with each resident, as necessary, to review and discuss the evaluations. Every attempt will be made to hold these meetings on a monthly basis. On a quarterly basis, each resident will be counseled regarding his/her overall performance, including an assessment of fund of medical knowledge, technical and interpersonal skills. A written quarterly evaluation will be filed in the residents performance file. Throughout the year, the resident will have the opportunity to respond to issues and conflicts both verbally and in writing.

Each resident is expected to complete an Evaluation of Rotation Form for each completed rotation. The Podiatric Medical Education Committee, as a means of continuing program self-evaluation and performance improvement, will periodically review evaluation of Rotation Forms. Evaluation of Rotation Forms may be reviewed and discussed with the appropriate rotation supervisor when necessary, in an effort to strengthen perceived areas of weakness in the educational program.

Evaluation forms are to be received by the Medical Education Office within two weeks of any rotation's completion. It is the resident's responsibility to insure that all paperwork is completed in a timely fashion.

A Rotation Evaluation Form can be found in this manual. It should be reproduced, completed and submitted on a monthly basis, regardless of the length of the rotation.

## **NOTE WRITING**

A PGYIII in the podiatric medicine and surgery residency training program is obligated to make rounds, and place appropriate notes in the chart, on EVERY patient on the podiatry service TWICE a day. That is **EVERY** day, seven days a week.

Morning rounds must be completed before morning lecture. Evening rounds should be performed sometime between 4pm and 8pm.

If a PGYI and/or II is assigned to the podiatry service, it is the Chief resident who determines what days they round with the PGY III, but they are NOT to round alone.

You are required to write a daily progress note on all your hospitalized patients. If your signature is not easily legibly, your name must be clearly printed as well. Your Hospital ID# must also be noted.

## PERSONAL HEALTH EMERGENCIES

If a resident has an emergent medical/surgical problem while on duty, he/she should immediately notify his/her Clinical Supervisor and be seen in the Emergency Room.

## ACTIVITY LOGS/SURGICAL LOGS

The podiatric residency program offered at NY Downtown Hospital participates in the Podiatric Residency Resource Program ®. Each resident will be assigned a unique password for logging in to this internet based program. All patient care and educational activities must be documented on line no later than two weeks after the end of each rotation. The program and manual can be found at [www.podiatryrr.com](http://www.podiatryrr.com)

These logs will be necessary for you to document your activity during your residency training. At some point, the American Board of Podiatric Medicine and/or the American Board of Podiatric Surgery will require submission of documentation through the Podiatry Residency Resource Log System for credentialing by those organizations. It is imperative that these logs be maintained on a regular basis, and it is your advantage to ensure that this is performed. These logs will be reviewed regularly by The Director of Podiatric Medical Education and be signed off on a regular basis.

It is suggested that logs be updated daily. Logs MUST be current, within one week, at all times.

## MEDICAL RECORDS

The Medical Record Department is located in the basement of the Hospital. Their contact numbers are: Chart Requests 312-5171, Operations Supervisor 312 5153, Dictation Chart Completion 646 588-2655 Tumor Registry 646 588-2650 and Director 646 588-2653. Timely completion of medical records (discharge summaries, etc.) is mandatory. Failure to do so will result in a verbal warning. If the delinquent records are not completed in a timely fashion, further corrective action will be considered.

## *EMPLOYMENT BENEFITS*

### **HEALTH INSURANCE**

Hospital, medicine and surgery coverage is provided to residents. Specific information regarding this coverage, deductibles and policy numbers may be obtained from the Human Resources Department, located on the first floor of the Hospital at the Lobby entrance.

### **HOLIDAYS**

Residents are entitled to the following paid holidays, as observed by the institution:

- New Years Day
- Martin Luther King's Birthday
- Presidents Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Residents who are scheduled to work on a hospital holiday shall be entitled to an alternate day off with pay. Such holiday alternatives must be scheduled in advance with the approval of the Resident's Clinical Supervisor. The Resident is responsible for directly informing the Medical Education Office of any day off within 30 days of the scheduled holiday. Lack of such notification will result in the Resident's loss of a day's pay for an unexcused absence.

### **MALPRACTICE INSURANCE**

The hospital's insurance carrier for malpractice automatically covers all residents during the term of their employment. If any problems or questions arise regarding coverage or lawsuits, contact the Legal Department in Administration.

## SICK DAYS

Residents are entitled to no more than ten paid sick days during a twelve-month Residency. Sick days must be documented by a telephone call to the rotation supervisor and the Medical Education Office before the missed shift begins (see policy regarding ABSENCES). If in the opinion of the rotation supervisor and/or the Program Director a resident is abusing the sick day privilege, medical documentation of an illness may be requested of a house officer before being reimbursed for any or all shifts missed. If three sick days are taken consecutively, a physician's note may be requested before returning to work at NY Downtown Hospital.

## UNIFORMS

At all times, residents are expected to maintain professional standards in personal grooming, hygiene and appearance.

Residents are expected to maintain professional standards in personal grooming, hygiene and appearance. Scrubs should not be worn outside of the operating room area. If you must leave the OR area in scrubs, you must wear a physician jacket with proper identification.

**Residents will be charged for any uniform pieces not returned at the end of their employment at the hospital's current replacement cost.**

## VACATION TIME

Residents receive a total of twenty paid vacation days per year. Vacation days may be scheduled one to five days at a time at the Resident's discretion, in advance, with the Director of Podiatric Medical Education and the Clinical Supervisor's approval, throughout the training year. Requests will not be approved by the DPME until the request form has been signed off FIRST by the Clinical Supervisor of the rotation you are scheduled to be on at the time of requested vacation.

Vacation time may be scheduled only during selective rotations (i.e., Anesthesiology, ER, Medical Imaging, Pathology, Podiatry, Podiatric Surgery). A Resident may not schedule more than one week of vacation time (five weekdays) within any monthly rotation. Residents may not schedule more than one vacation day at a time while on rotation in the Departments of Medicine Orthopaedic Surgery and General Surgery.

Hospital policy mandates that no vacation be taken within the first three months of employment

## **GENERAL INFORMATION**

### **BCLS/ACLS CERTIFICATION**

Certification in Basic Cardiac Life Support and Advanced Cardiac Life Support is a requirement of your Residency. Residents are financially responsible for acquiring BCLS and ACLS certification whether acquired at NY Downtown Manhattan Hospital or at another institution.

### **BEEPERS**

Beepers are issued by the IT department, located in the basement level. The hospital's replacement cost is borne by the resident.

### **DRESS CODE**

All residents are required to wear clean, pressed white physician jackets at all times while on duty. A professional appearance and manner are expected. Residents are expected to maintain professional standards in personal grooming, hygiene and appearance. Scrubs should not be worn outside of the operating room area. If you must leave the OR area in scrubs, you must wear a physician jacket with proper identification.

### **ID BADGES**

Identification badges are available from the Security Department, located on the ground floor of the Hospital near the Emergency Department. ID badges must be worn at all times while on duty at NY Downtown Hospital. Lost ID badges should be reported immediately to the Security Department and a replacement procured. A replacement fee may be required to reissue an ID badge.

## **TIMECLOCK PROCEDURES**

You will also be issued a payroll time sheet. It is imperative that you sign in and out on a daily basis in order that we may monitor your hours and assure that you are NOT working more than 80 hours per week. You are to sign your time sheet daily at the Podiatric Medical Education Coordinators office. This is necessary in order to generate the appropriate paycheck for you on a bi-weekly basis. If you do not sign in and out as required, the Hospital may be deemed in non-compliance of IPRO regulations. This is a serious offense that can penalize the hospital and the program. If you are found NOT to have obeyed the “sign- in” regulation, you will be notified and placed on notice. The second offense will generate a letter to be placed in your personnel file. Subsequent infractions may be grounds for suspension, repetition of rotations, or the inability of NY Downtown Manhattan to grant you a completion certificate. It is therefore personally advantageous for residents to document any excused absence from work, including any variations in the printed on-call schedule, by a direct phone call to the Department of Medical Education.

## IPRO REGULATIONS



**NYS – ACGME Post-Graduate Trainee Work-Hour Regulations  
Comparison Guide**



Regulation Area	NYS 405 Regulations	ACGME Policy (effective July 01, 2011)	NYS 405 regulations compared to ACGME	What rule needs to be followed to be in compliance with both the NYS 405 regulations & ACGME Policy
<b>Maximum Duty Hours per Work Week</b>	A maximum of 80 hours per week averaged over 4 weeks, inclusive of all in-house activities, clinic assignments, and moonlighting activities.	80 hours per week averaged over a 4-week period, inclusive of all in-house call activities and all moonlighting.	Same	A maximum of 80 hours per week averaged over 4 weeks, inclusive of all in-house activities, clinic assignments, and moonlighting activities.
<b>Duty Hours- Work Week Exception</b>	Surgical Exemption	An RRC may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.	Distinct	Surgical Exemption- please refer to Specialty Programs exemptions.
<b>Moonlighting</b>	Hospitals shall adopt and enforce specific policies governing dual employment.  All moonlighting hours worked are included in total weekly work hours.	Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour maximum weekly limit. PGY-1 residents are not permitted to moonlight.	Comparable	All moonlighting hours worked are included in the total weekly work hours.
<b>Mandatory Weekly Time Off Duty</b>	24 hours off per week	Residents must be scheduled for a minimum of one day free of duty every week when averaged over 4 weeks. At-home call cannot be assigned on these free days.	Distinct	24 hours off per week
<b>Mandatory Rest / Time Off Between Duty Periods</b>	8 hours between scheduled duty assignments	PGY-1 residents should have 10 hours and must have 8 hours free of duty between scheduled duty periods. Intermediate-level residents should have 10 hours free of duty and must have 8 hours between scheduled duty periods; and they must have at least 14 hours free of duty after 24 hours of in-house duty	Comparable	All residents must have 8 hours, should have 10 hours free between scheduled duty periods. Intermediate level residents must have at least 14 hours free of duty after 24 hours of in-house duty.

## MAIL

All mail will be distributed to residents through the Podiatric Medical Education Office in the Orthopaedic Surgery Department. Residents are responsible for checking their mailboxes at least once a day. All personal mail, departmental or inter-office memorandums, phone messages, schedules, journals, etc. will be distributed to residents via the House staff mailboxes. Any communication delivered to a resident's mailbox is considered "hand delivered" and is expected to be picked up and read by the resident within 24 hours.

Each resident is issued a hospital Email account. All correspondence will be through that account. Personal accounts should not be used for hospital related activity. Please check your E-mail account regularly.

## PAGING

To page: dial 76. After the prompt dial your beeper number and the extension at which you can be called back. Your call will be returned momentarily.

## PAYCHECKS

Paychecks are issued bi-weekly, on Thursday, and are available from the Podiatric Medical Education Office. Direct deposit is available and can be arranged through the payroll department

## **RESIDENT SELECTION: POLICY AND PROCEDURE**

The process of resident selection is objective and fair, resulting in the recruitment of the finest, most capable house staff for training. All applicants are given equal consideration without bias toward age, race, religion, gender or sexual preference.

All applicants are to complete the official Application for Residency form through the Central Application Service for Podiatric Residencies (CASPR). In addition to all CASPR requirements, NY Downtown Manhattan

requires an application fee. All fees collected will be used wholly for the purpose of administering the residency selection process.

Interviews are scheduled through the Centralized Regional Interview Program (CRIP) conducted by the AACPM, or at a mutually convenient time at the Hospital.

The Director of Podiatric Medical Education, along with interested attending members of the podiatric and medical staff and the current Podiatric House staff, conducts interviews at a Central Regional Interview Process. Other arrangements can be made under special circumstances.

Applicants' credentials and evaluations are presented to and reviewed by the Medical Education Committee. They are prioritized on the basis of:

- a) Academic standing
- b) Letters of recommendation
- c) Personal attributes (willingness, initiative, commitment, and personality) as determined through interview.

Applicants are ranked in sequential order of preference as per regulations of the Central Application Service for Podiatric Residencies (CASPR) conducted by the AACPM. NY Downtown is bound by the results of the CASPR match to offer each matched candidate a contract for residency.

All Residents are required to have successfully completed Part I and Part II of the National Board of Podiatric Medical Examiners (NBPME) before beginning the PMSR training program. Residents must possess New York State licensure as outlined in a memorandum from the New York State Department of Education.

Further information can be found in ***Section VI of the New York Downtown Hospital Graduate Education Policies and Procedure Manual.***

NY Downtown Manhattan Hospital is an equal opportunity employer.

## **RESIDENT RESCUE FUND**

An issue of great concern in postgraduate podiatric medical education involves the sudden or unexpected discontinuance of podiatric residency programs. When this occurs in the midst of a resident training year, it is not only tragic for the profession, but it is a personal tragedy for the individuals involved. In an effort to be of assistance to podiatric residents, The Council of Teaching Hospitals (COTH) of the American Association of Colleges of Podiatric Medicine (AACPM) sets aside a portion of the annual dues paid by COTH member institutions to a fund to known as the **Resident Rescue Fund**. This fund is used exclusively for the assistance of residents who find themselves displaced and unable to continue their education through no action of theirs, but rather because of institutional default. This fund is maintained by COTH of AACPM and held separate and apart from any other monies utilized by the organization. It is utilized for the costs associated with relocating a resident, allowing a living allowance for a predetermined period of time, and assisting in placement in another training program. This fund is available only to residents accepted by, or enrolled in COTH participating institutions. NY Downtown Manhattan Hospital is a member of the Council of Teaching Hospitals (COTH). For further information, please contact Ms. Nancy Chioraud Director of Graduate Services of AACPM at (301) 948-9764.

# RESIDENT CONTACT INFORMATION

## PGY III

Heather Jones  
606 599-4962  
[heather.jonesi@downtownhospital.org](mailto:heather.jonesi@downtownhospital.org)

Ashish Mishra  
609 468-0687  
[asish.mishra@downtownhospital.org](mailto:asish.mishra@downtownhospital.org)

Ari Rubinstein  
917 328-1165  
[ari.rubinstein@downtownhospital.org](mailto:ari.rubinstein@downtownhospital.org)

Greg Tamagnin  
201 317-1038  
[greg.tamagnini@downtownhospital.org](mailto:greg.tamagnini@downtownhospital.org)

## PGY II

Yekatarina Gurnevitch  
(917) 637-9940  
[yekatarina.gurnevich@downtownhospital.org](mailto:yekatarina.gurnevich@downtownhospital.org)

Harley Kantor  
(917) 282-3370  
[harleykantor@downtownhospital.org](mailto:harleykantor@downtownhospital.org)

Jason Levy  
(732) 580-3158  
[Jason.levy@downtownhospital.org](mailto:Jason.levy@downtownhospital.org)

Nelya Lobkova  
(718)753-9523  
[Nelya.lobkova@downtownhospital.org](mailto:Nelya.lobkova@downtownhospital.org)

## PGY I

Yitzchak Cohen  
(917) 837- 2284  
[Yitzchak.cohen@downtownhospital.org](mailto:Yitzchak.cohen@downtownhospital.org)

Ilana Ocher  
[Liana.ocher@downtownhospital.org](mailto:Liana.ocher@downtownhospital.org)  
(718) 644-8181

Adam Rammacher  
(314) 306 6366  
[adamrammacher@downtownhospital.org](mailto:adamrammacher@downtownhospital.org)

Kartherine Wood  
(845) 987 6747  
[Katherine.wood@downtownhospital.org](mailto:Katherine.wood@downtownhospital.org)

**ATTENDING CONTACT INFORMATION**

Steve Abraham, DPM  
425 Grand Street  
New York, NY 10002  
(212) 475-5540  
(646) 514-8260 - fax  
[sabrahamdpm@gmail.com](mailto:sabrahamdpm@gmail.com)

Robert Adelman, DPM  
(212) 254-2772  
(212) 254-6336 – fax  
[luckyfeet@aol.com](mailto:luckyfeet@aol.com)

Theodore Antonetz, DPM  
240 West End Avenue  
New York, NY 10024  
(212)877-3062  
(212) 873-9521 – fax  
[drantonetz@verizon.net](mailto:drantonetz@verizon.net)

Inna Blakeman, DPM  
225 Broadway  
New York, NY 10007  
(212) 285-8083  
(212) 693-40114 – fax  
[innablakeman@hotmail.com](mailto:innablakeman@hotmail.com)

Raymond Cavalliere, DPM  
201 East 28<sup>th</sup> Street  
New York, NY  
(212) 481-0064  
[draycav@aol.com](mailto:draycav@aol.com)

Herbert Shuo-Chien DPM  
254 Canal Street Suite 2005  
New York, NY 10013  
(212) 925-8805  
[herbiec@aol.com](mailto:herbiec@aol.com)

Gary Evans, DPM  
One Penn Plaza- Suite 1707  
New York, NY 10119  
(212) 279-0086  
(212) 279-6401  
[nycpodiatry@gmail.com](mailto:nycpodiatry@gmail.com)

Joseph S. Fox, DPM  
33 Fifth Avenue – Grd Flr  
New York, NY 10003  
(212) 473-3049  
(212) 777-3347  
[drjfox@verizon.net](mailto:drjfox@verizon.net)

Richard H. Frankel, DPM  
120 East 56 Street - Suite 940  
New York, NY 10022  
(212) 980-6487  
(212) 980-8685-fax  
[rfrankel@chpnet.org](mailto:rfrankel@chpnet.org)

Arnold Gershman, DPM  
137 East 36<sup>th</sup> Street  
New York, NY 10016  
(212) 684-0500  
(212) 686-3068 – fax  
[agershman@aol.com](mailto:agershman@aol.com)

Scott E. Herbert, DPM  
33 5th Avenue  
New York, NY 10003  
212-473-3049  
212-777-3347 F  
[Seherbert11746@yahoo.com](mailto:Seherbert11746@yahoo.com)

Ivan Herstik, DPM  
36 7<sup>th</sup> Avenue  
New York, NY 10011  
(212) 366-1718  
(212) 366-4830 – fax  
[ivanherstik@footdrx.com](mailto:ivanherstik@footdrx.com)

Chester Lo, DPM  
198 Canal Street – Suite 302  
New York, NY 10013  
(212) 233-9400  
(212) 608-1828  
[clo2888@gmail.com](mailto:clo2888@gmail.com)

Kenneth Meisler, DPM  
210 East 86<sup>th</sup> St – Suite 402  
New York, NY 10028  
(212) 628-4444  
(212) 570-6120  
[kenmeisler@aol.com](mailto:kenmeisler@aol.com)

Steven Menna, DPM  
52 Duane Street  
New York, NY 10007  
(212) 349-7676  
(212) 349-1382  
[manfootcare@aol.com](mailto:manfootcare@aol.com)

Chris Minacopelli, DPM  
210 East 86<sup>th</sup> Street Suite 402  
New York, NY 10028  
(212) 628-4444  
(212) 570-6120  
[drpiede72@aol.com](mailto:drpiede72@aol.com)

George Pace, DPM  
52 Duane Street  
New York, NY 10007  
(212) 349-7676  
(212) 349-1382  
[manfootcare@aol.com](mailto:manfootcare@aol.com)

Fabienne Rottenberg, DPM  
285 W End Ave # 4  
New York, NY 10023-6511  
(212) 724-4457  
[fabienne.rottenberg@gmail.com](mailto:fabienne.rottenberg@gmail.com)

Keith R. Springer, DPM  
220 East 63<sup>rd</sup> Street  
New York, NY 10065  
(212) 751-2069  
(212) 752-4930  
[Krspr174@aol.com](mailto:Krspr174@aol.com)

Alan Teitelbaum, DPM  
315 E. 86<sup>th</sup> Street  
New York, NY 10028  
(212) 369-9494  
[tbaum5@aol.com](mailto:tbaum5@aol.com)

Rosanna Troia, DPM  
One West 85<sup>th</sup> Street  
Suite 1C  
New York, NY 10024  
(212) 874-0564  
(212) 496-8548 – fax  
[rtroidpm@yahoo.com](mailto:rtroidpm@yahoo.com)

Christina Ellock Tsim, DPM  
8 Chatham Square –Ste 502  
New York, NY 10038  
(212) 267-8988  
[Rambo77594@msn.com](mailto:Rambo77594@msn.com)

Edwin Wolf, DPM  
One West 85<sup>th</sup> Street  
Suite 1C  
New York, NY 10024  
(212) 874-0564  
(212) 496-8548 – fax  
[edwin.wolf@downtownhospital.org](mailto:edwin.wolf@downtownhospital.org)

John Zboinski, DPM  
Seaport Orthopedic Associat  
19 Beekman Street  
New York, NY  
(212) 513-7711  
(212) 513-1035  
[nysurgn@aol.com](mailto:nysurgn@aol.com)

## COMPREHENSIVE PROGRAM OVERVIEW

NY Downtown Hospital sponsors a PMSR with added credential for reconstructive rearfoot and ankle surgery. This is a 36 month program which is accredited by the Council of Podiatric Medical Education (CPME). We are fully accredited through 2017. We are members of the Council of Teaching Hospitals (COH) of the American Association of Colleges of Podiatric Medicine (AACPM). We adhere to the guidelines of the Council of Podiatric Medical Education (CPME) as published in CPME 320 (attached).

The Podiatric Residency Program at NY DOWNTOWN Hospital is designed to provide education and hands on experience for the resident in a hospital setting. The teaching program will demonstrate to the podiatric resident a more effective method of improving foot health and better prepare him/her for a position in the total health care delivery system.

The Podiatric Residency Program at NY DOWNTOWN is designed to provide education and instruction in all phases of podiatric medicine and surgery in order to meet graduate training program requirements for board admissibility in the American Board of Podiatric Surgery- Foot Surgery and added credential for Reconstructive Rearfoot and Ankle Surgery and the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. This program provides an intensive period of multi-disciplinary graduate training for the podiatric resident.

Upon successful completion of the program, the graduate of this program will be eligible to sit for the Board Qualification examinations as offered by both the American Board of Podiatric Surgery (the reconstructive rearfoot and ankle section, as well as the foot section) as well as by the American Board of Podiatric Medicine.

### Components of Podiatric Competencies for the **PMSR PROGRAM**

The PMSR program provides the resident with experiences in first contact care, continuous care, long term care and comprehensive care. During the thirty six months of the Program, the resident will rotate through, and achieve competencies in the major clinical areas of the hospital by spending time in Medicine, Surgery, Anesthesia, Pathology, Medical Imaging, Emergency Services, Orthopaedic Surgery, Behavioral Health, Wound Care and Out-Patient Clinics. An outside rotation at the Center for Specialty Care Surgery Center also is part of the training. These rotations will enable the resident to gain a broad knowledge of a variety of diseases that affect the human body and to relate other disease processes and manifestations to the diagnosis, management and treatment of foot problems. Education will be provided through scheduled lectures, seminars, and conferences with emphasis on the integration of the basic sciences with clinical treatment of patients. The value and importance of a close working relationship between podiatry and medicine will be stressed to the podiatric resident. To further this end, lectures and demonstrations will be given by personnel in the other departments at the hospital.

During the first year it is expected that the resident will gain knowledge experience and a level of competency in the following:

1. Hospital charting and protocol.
2. Indications for hospital admission.
3. Detailed history and physical taking.
4. Drawing of routine and pre-operative blood work.
5. Interpretation of laboratory results.
6. Performance and observation of specialized radiographic techniques such as angiography, venography, doppler, etc..
7. Indications and assisting in general surgical procedures.
8. Knowledge of anesthetic inducing and maintenance medications for the surgical patient.
9. Interpretation of standard radiographs of the entire body.
10. Participation in out-patient community podiatry clinics.
11. Attend lectures and seminars given by the podiatry staff as well as other specialties.
12. Understand the indications for emergency surgery.
13. Participate and manage medicine and surgery emergencies including CVA, MI, diabetic crises, seizures.

14. Develop an understanding of pathological states of the human body.
15. Participate in the staining and mounting of specimens for histological analysis.
16. Evaluate medical literature. A journal club is instituted and is designed to provide the resident with experience in evaluating literature related to any discipline in medicine.
17. Develop an understanding of methods of diagnosis and management of a variety of individuals with emotional, behavioral and learning problems and recognize the implications of life changes on health and disease.

The second and third years the Podiatric Medicine and surgery Resident will spend the major portion of the rotation in Surgery, concentrating on Orthopedic and Podiatric cases. This will enhance the residency experience and allow larger number of hands-on care of patients. The resident will follow patients from admission, pre-operative work-up, surgery, including scrubbing and assisting at all Orthopedic and Podiatric surgeries, and through the post-operative period until discharge. The resident will review medical imaging studies and will develop competency in evaluating the total status of the patient in relationship to the specific Orthopedic/Podiatric procedures that are planned. The second year and third year residents will perform podiatric procedures under the supervision of a licensed and qualified Podiatrist.

The PGY II and III resident of the PMSR program will gain competencies in the following:

1. Concise and detailed podiatric and general history and physical examination.
2. The ability to recognize and treatment of pathological states of the foot including benign and malignant neoplasms.
3. Experience in the evaluation of the podiatric surgical patient's ability to undergo anesthesia for surgical procedures.
4. Develop the ability to understand the indications for hospitalization of podiatric patients.
5. Develop experience in all phases of foot surgery.
6. Develop experience in the management of the postoperative surgical patient with emphasis on fluid management as well as postoperative pain relief.

7. Develop experience in hospital charting and documentation.
8. Improvement in his/her skills of antibiotic management of pedal infections both postoperatively and in the emergency situation.
9. Attend didactic seminars provided by the attending podiatry staff as well as other specialties.
10. Improvement in rehabilitative skills postoperatively.
11. Perform out-patient procedures in the podiatry clinic such as total nail avulsions, partial nail avulsions, phenol and alcohol procedures, etc..
12. Attend to the medically and surgically compromised podiatric patient in the emergency setting.
13. Develop experience in the performance and interpretation of pedal radiographs, CT scan and MRI.
14. Develop experience in the prevention and treatment of diabetic emergencies, shock, cardiopulmonary emergencies and seizures.
15. Resident will be able to act as first assistant.
16. Resident will be able to perform soft tissue surgery.
17. Resident will be able to perform digital surgery.
18. Resident will be able to perform lesser metatarsal surgery.
19. Resident will be able to perform first metatarsal surgery.
20. Resident will be able to perform midfoot (Cuneiform, cuboid, navicular) surgery.
21. Resident will be able to perform rearfoot and ankle surgery.
22. Resident will be able to apply fixation techniques in the foot and ankle.
23. Resident will be able to apply casts to the foot and ankle.
25. Resident will be able to recognize and manage perioperative complications

Our program is designed to meet the competencies and performance indicators as required by the Council on Podiatric Medical Education, and outlined in Document CPME-320 (July 2011).

A complete list of the competencies and performance indicators they may be found at [http://www.abpoppm.org/residency/res\\_PDFs/CompPerformIndicator2.pdf](http://www.abpoppm.org/residency/res_PDFs/CompPerformIndicator2.pdf)

	Yitz Cohen	Katherine Wilana Ocher	Adam Ramir	Kathy Gumi	Jason Levy	Nelya Lobbk	Harley Kant	Asish Mishr An	Rubinst	Greg Tamaç	Heather Jones	
July	EM	Ortho	GenSurg	Med Clinics	Ortho Floors	Ortho Sands	SurgiCenter	Podiatry	Vascular	Podiatry	Podiatry	Ortho Sands
Aug	Rad/Path	Ortho	GenSurg	Med Clinics	Ortho Floors	Ortho Sands	Podiatry	SurgiCenter	Vascular	Podiatry	Podiatry	Ortho Sands
Sept	Anes	EM	Podiatry	Med Floor	SurgiCenter	Ortho Sands	Podiatry	Ortho Floors	Vascular	Podiatry	Podiatry	Ortho Sands
Oct	EM	Med Floor	Ortho	Podiatry	Ortho Sands	SurgiCenter	Podiatry	Ortho Floors	Ortho Sands	Vascular	Podiatry	Podiatry
Nov	Podiatry	Med Clinics	EM	GenSurg	Ortho Sands	Podiatry	SurgiCenter	Ortho Floors	Ortho Sands	Vascular	Podiatry	Podiatry
Dec	Ortho	Med Clinics	Anes	GenSurg	Ortho Sands	Podiatry	Ortho Floors	SurgiCenter	Ortho Sands	Vascular	Podiatry	Podiatry
Jan	Ortho	EM	Med Clinics	Anes	SurgiCenter	Podiatry	Ortho Floors	Ortho Sands	Podiatry	Ortho Sands	Vascular	Podiatry
Feb	GenSurg	Anes	Med Clinics	Ortho	Podiatry	SurgiCenter	Ortho Floors	Ortho Sands	Podiatry	Ortho Sands	Vascular	Podiatry
March	GenSurg	Rad/Path	Med Floor	Ortho	Podiatry	Ortho Floors	SurgiCenter	Ortho Sands	Podiatry	Ortho Sands	Vascular	Podiatry
April	Med Clinics	GenSurg	EM	Rad/Path	Pod/OF	Ortho Floors	Ortho Sands	SurgiCenter	Podiatry	Podiatry	Ortho Sands	Vascular
May	Med Clinics	GenSurg	Rad/Path	EM	SurgiCenter	Ortho Floors	Ortho Sands	Podiatry	Podiatry	Podiatry	Ortho Sands	Vascular
June	Med Floor	Podiatry	Ortho	EM	Ortho Floors	SurgiCenter	Ortho Sands	Podiatry	Podiatry	Podiatry	Ortho Sands	Vascular



170 William Street  
New York, NY 10038-2649  
Phone: (212) 312-5990  
Fax: (212) 312-5988  
[www.downtownhospital.org](http://www.downtownhospital.org)

Section of Podiatric Medical Education  
Dept. of Orthopaedic Surgery; Division of Podiatry

**PGY III – Daily Schedule**

	“A” *	“B”	“C”
Monday			
am	OR/Floor (Dr. Zboinski)	Clinic (Sands)	Elective
pm	OR /Floor	House consults/floor/OR	Elective
Tuesday			
am	OR	Clinic (Sands)	Elective
pm	OR/Floor/Consults	House consults/floor/OR	Elective
Wednesday			
am	Resident Clinic (Wolf)	Clinic (Sands)	Elective
pm	OR/Floor (Dr. Zboinski) Podiatry Meeting	Clinic (Sands) Podiatry Meeting	Elective
Thursday			
am	House consults/floor/OR	OR with Dr. Sands	Elective
pm	House consults/floor/OR	OR with Dr. Sands	Elective
Friday			
am	OR/ House consults/floor	Clinic (Sands)	Elective
pm	OR/ House consults/floor	OR with Dr. Phillips	Elective
Saturday (if needed)			
am	OR/ House consults/floor	OR/ House consults/floor	Elective
pm	OR/ House consults/floor	OR/ House consults/floor	Elective

**\* Chief Resident – Covers all NYDH cases with PGY II; Oversees all consults; carries podiatry pager when PGY II not available. ROUNDS ON ALL IN-HOUSE PATIENTS 2X/DAY WITH OTHER HOUSE STAFF ON SERVICE.**

# NEW YORK DOWNTOWN HOSPITAL

Section of Podiatric Medical Education  
Dept. of Orthopaedic Surgery; Division of Podiatry

## PGY I AND II on Podiatry Service– Daily Schedule

“A” \*

Monday

am

Podiatry Clinic (Dr. Rottenberg)

pm

OR /Floor (Meissler/Zboinski)

Tuesday

am

OR(Troia)

pm

Podiatry clinic (Fox)

Wednesday

am

Resident Clinic (Wolf)

pm

OR/Floor

Podiatry Meeting

Thursday

am

House consults/floor/OR

pm

House consults/floor/OR (Meissler)

Friday

am

Ortho Foot Clinic (Phillips)

pm

OR/ House consults/floor

Saturday (if needed)

am

OR/ House consults/floor

pm

OR/ House consults/floor

Round on any in-house Podiatry service patients every morning at 7am and communicate patient updates to attendings

Pre-op Podiatry patients (h&p, consent, orders)

Carry the Podiatry Consult Pager (1819), answer consults and present to the PGY III on rotation

'A'

Cover ALL podiatry cases at NYDH

## MEDICINE ROTATION – CLINIC MONTH SCHEDULE

	M	T	W	Th	Fr
AM	MEDICINE	MEDICINE	Infectious Disease	MEDICINE	ENDOCRINE
PM	MEDICINE (DERM)	MEDICINE	Infectious Disease (NEUROLOGY)	Rheumatology (REHAB)	MEDICINE

revised 6/12

## VASCULAR SURGERY ROTATION –SCHEDULE

	M	T	W	Th	Fr
AM	Dr. Wun Clinic		Vascular Lab	OR	Dr. Wun Clinic
PM OR	Dr. Wun OR		Dr. Friedman clinic	OR	Dr. Wun

revised 06/2011

## **LECTURE SCHEDULE**

The Orthopedics Department offers academic lectures each morning of the week in the conference room on the 3rd floor. Every PMSR resident is expected to be in attendance daily unless immediate demands to clinical responsibilities or outside rotations preclude attendance. Most of the lectures involve topics of importance to the podiatric medical/surgical residents. Even those that are not specialty specific (eg: trauma to the spine) offer value in teaching principles, logic patterns and educational material that can be interpolated to areas of podiatric medicine and surgery. All lectures attended are to be logged in the Activity Log section of Podiatric Residency Resource/

A specific lecture series for the Podiatric Medical Education Program is scheduled for Thursday from 4:00 PM- 6:00PM. This program is coordinated by Dr. Steve Abraham, a member of the podiatry section clinical faculty. All podiatric residents are required to attend. While it is understood that clinical responsibilities may occasionally interfere with attendance, every effort should be made to be present by scheduling one's time appropriately. Although clinical responsibilities may interfere, lecture attendance is still encouraged. Please prioritize your responsibilities and make every effort to attend. Attendance records will be kept to allow documentation of our academic training. Three unexcused absences are allowed for the year after which the remediation process will be initiated.

While the lectures presented are specifically geared for the Podiatric Medical Education Program, all members of the Podiatry section of the surgery department are encouraged to attend. Other interested parties are invited to attend as well. All present at the lecture series are expected to be prepared and attentive.

A portion of the lecture schedule is devoted to a review of cases for that month and will be in the format of Chart Rounds or Mortality and Morbidity Rounds. A review of difficult cases, interesting pathology, or cases that went awry will be discussed. Any interested party may bring cases to this forum regardless of whether these patients have been or will be treated at NY DOWNTOWN Hospital. Residents in particular are expected to bring ED and clinic cases to these meetings.

# SIGN IN PLEASE:

DATE: \_\_\_\_\_ LECTURER: \_\_\_\_\_

TOPIC \_\_\_\_\_ SPONSOR \_\_\_\_\_

H. Jones, DPM \_\_\_\_\_

A. Mishra, DPM \_\_\_\_\_

G. Tamagnini, DPM \_\_\_\_\_

A. Rubinstein, DPM \_\_\_\_\_

K. Gurnevitch, DPM \_\_\_\_\_

H. Kantor, DPM \_\_\_\_\_

J. Levy, DPM \_\_\_\_\_

N. Lobkova, DPM \_\_\_\_\_

Y. Cohen, DPM \_\_\_\_\_

I Ocher, DPM \_\_\_\_\_

A. Rammacher, DPM \_\_\_\_\_

K. Wood, DPM \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Director Podiatric Medical Education

\_\_\_\_\_

Date

**PODIATRIC LECTURE SERIES 2011-2012 - Wednesday @ 5:30 pm*****JULY***

July 5, 2012 TOPIC: WELCOME & ORIENTATION TO LECTURES

SPEAKER: Drs. Abraham/ Wolf

July 12, 2012 TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

July 19, 2012 TOPIC: Evaluation Hallux Valgus

SPEAKER Keith Springer, DPM

July 26, 2012 TOPIC: Suture Workshop

SPEAKER Ray Cavaliere, DPM

***AUGUST***

August 2,2012 TOPIC Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

August 9, 2012 TOPIC: Biomechanical Examination

SPEAKER R. Troia, DPM

August 16, 2012 TOPIC: Suture selection/anchoring devices

SPEAKER

August 23, 2012 TOPIC: Principles of Internal Fixation

SPEAKER

August 30, 2012 TOPIC: Dermatologica Examination

SPEAKER I. Herstik, DPM

***SEPTEMBER***

September 6, 2012 TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

September 13, 2012 TOPIC: Chronic Regional Pain Syndrome

SPEAKER R. Troia, DPM

September 20, 2012 TOPIC: Charcot Foot

SPEAKER

September 27., 2012 TOPIC: Neurological Examination

SPEAKER

***OCTOBER***

4: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

11: TOPIC: Evaluating Heel Pain

SPEAKER:

18: TOPIC: PVD and Wound Care

SPEAKER:

25: TOPIC: Juvenile Hallux Valgus

SPEAKER: Dr. Herbert

### ***NOVEMBER 2012***

1: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

8: TOPIC: Posterior Tendon Dysfunction

SPEAKER:

15: TOPIC: Venous Insufficiency

SPEAKER:

29: TOPIC: Thanksgiving Holiday

SPEAKER: **No Lecture**

### ***DECEMBER 2012***

6: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

13 TOPIC: Complications of Bunionectomy

SPEAKER:

20: **Holiday - No Lecture**

27: **Holiday - No Lecture**

### ***JANUARY 2013***

3: **Holiday - No Lecture**

17: TOPIC: The Complete Medical Examination

SPEAKER:

24: TOPIC: Medical Evaluation of Lower Extremity Disease

SPEAKER:

31: TOPIC: Gout

SPEAKER:

**FEBRUARY 2013**

7 TOPIC: Digital and Sesamoid Fractures

SPEAKER:

14: TOPIC: Metatarsal Fractures

SPEAKER:

21: TOPIC: Lisfrancs Injuries

SPEAKER:

28: TOPIC: Broken Heels & Broken Hearts

SPEAKER: Sadie Hawkins, DPM

***MARCH 2013***

7: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

14: TOPIC: Ankle Injuries

SPEAKER:

21: TOPIC: Antibiotic prophylaxis

SPEAKER:

28: TOPIC: Rheumatoid and Psoriatic Arthritis

SPEAKER:

***APRIL 2013***

4: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

11: TOPIC: Osteomyelitis

SPEAKER:

18 TOPIC: Postoperative Edema and Hematoma

SPEAKER:

25: TOPIC: Tarsal Tunnel Syndrome

SPEAKER:

***MAY 2013***

2: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

9: TOPIC: Achilles Tendon Injuries

SPEAKER:

16: TOPIC: Flaps and Grafts

SPEAKER:

23 TOPIC : Fusions of the foot

SPEAKER:

30 **HOLIDAY: NO LECTURE**

***JUNE 2012***

6: TOPIC: Case Presentations – Chief Resident

SPEAKER Drs. Abraham/Wolf

13: TOPIC: Implant selection

SPEAKER:

20: TOPIC: Cavus Deformity

SPEAKER:

27: TOPIC: Cirrhosis/Hepatitis and Jaundice

SPEAKER: Jack Daniels (location TBA)

## **COMPETENCIES FOR ANESTHESIOLOGY**

During your rotation in the Anesthesia Department, you will gain experience in the initial work-up, management and care of patients preoperatively, intraoperatively and post-operatively. You will learn how to recognize and manage anesthesia related problems and complications and you will become familiar with a variety of anesthetic agents and techniques of administration.

At the conclusion of this rotation, you should be able to:

1. Document a clear and accurate patient anesthesia history.
2. Determine a patient's anesthesia risk group.
3. Become familiar with the methodology used to select the type of anesthesia to be administered.
4. Gain experience in the manual aspects of IV therapy, regional blocks, and intubations.
5. Recognize anesthesia related emergencies and complications and proper methods of prevention and treatment.
6. Monitor patients appropriately in the immediate post-operative period.
7. Evaluate patients' medical problems which have a direct impact on the use of anesthesia for surgical procedures.
8. Gain knowledge in the proper use of a variety of anesthetic agents and techniques.
9. Demonstrate knowledge of various modes of anesthesia as well as various monitoring systems.

NY DOWNTOWN HOSPITAL  
PODIATRIC RESIDENT EVALUATION FORM

**ANESTHESIOLOGY**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5** EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. DOCUMENT A CLEAR AND ACCURATE PATIENT ANESTHESIA HISTORY.						
2. DETERMINE A PATIENT'S ANESTHESIA RISK GROUP.						
3. BECOME FAMILIAR WITH THE METHODOLOGY USED TO SELECT THE TYPE OF ANESTHESIA TO BE ADMINISTERED.						
4. GAIN EXPERIENCE IN MANUAL ASPECTS OF IV THERAPY, REGIONAL BLOCKS AND INTUBATION.						
5. RECOGNIZE ANESTHESIA RELATED EMERGENCIES AND COMPLICATIONS AND PROPER METHODS OF PREVENTION AND TREATMENT.						
6. MONITOR PATIENTS APPROPRIATELY IN THE IMMEDIATE POST-OPERATIVE PERIOD.						
7. EVALUATE PATIENTS' MEDICAL PROBLEMS WHICH HAVE A DIRECT IMPACT ON THE USE OF ANESTHESIA FOR SURGICAL PROCEDURES.						
8. GAIN KNOWLEDGE IN THE PROPER USE OF A VARIETY OF ANESTHETIC AGENTS AND TECHNIQUES.						
9. DEMONSTRATE KNOWLEDGE OF VARIOUS MODES OF ANESTHESIA AS WELL AS VARIOUS MONITORING SYSTEMS.						
10. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: \_\_\_\_\_  
(Signature)

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_  
(Signature)

DATE \_\_\_\_\_

Revised 6/2012

## **COMMUNITY MEDICINE / BEHAVIORAL HEALTH**

NY Downtown Hospital is committed to providing care to the poor, disadvantaged, homeless, and all persons in need of health care without regard to their ability to pay. The practice of community podiatry is therefore consistent with the mission of the hospital itself.

To enhance this experience a specific rotation in the Department of Community medicine is included in your education. The rotation centers around the Community Medicine out-patient practice. This primary care clinic will include your direct participation in training experiences that include exposure to and treatment of a variety of patient populations

During the course of your PMSR you will be exposed to a variety of learning experiences with patients of all ages with diagnoses such as emotional problems, behavioral problems, learning disabilities, adolescent reactive disorders, neuroses and organic psychoses and mental retardation. Behavioral Science is an ongoing, concomitant rotation. Such training is obtained on a case by case basis in both the inpatient and outpatient settings. This one month rotation will give you the direction in which you will learn to approach these issues.

At the start of your rotation you are to report to Dr. Wu. who will be your supervisor for that rotation, and will assign you your work schedule.

During all of your inpatient and outpatient rotations throughout the training year, you will be exposed to:

1. Patients from extended care facilities.
2. Patients with psychosocial disorders limiting their ability to function in society.
3. Homeless.
4. Under-served minorities
5. Medically disenfranchised
6. Participate in the medical management of a variety of individuals with emotional, behavioral, psychiatric, and learning problems
7. Participate in the discharge planning of disadvantaged patients.
8. Provide podiatric treatment to psychiatric patients.
9. Educate and instruct patients on their self-care management.
10. Recognize the implications of life changes on health and disease.

NY DOWNTOWN HOSPITAL  
 PODIATRIC MEDICINE RESIDENT EVALUATION FORM

**COMMUNITY MEDICINE/ BEHAVIORAL HEALTH**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR:

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. MANAGEMENT OF PATIENTS FROM EXTENDED CARE FACILITIES.						
2. MANAGEMENT OF PATIENTS WITH PSYCHOSOCIAL DISORDERS.						
3. TREATMENT AND MANAGEMENT OF HOMELESS PATIENTS.						
4. TREATMENT AND MANAGEMENT OF UNDER-SERVED MINORITY PATIENTS.						
5. TREATMENT AND MANAGEMENT OF MEDICALLY DISENFRANCHISED PATIENTS.						
6. MEDICAL MANAGEMENT OF EMOTIONAL, BEHAVIORAL, PSYCHIATRIC, AND LEARNING PROBLEMS.						
7. DISCHARGE PLANNING OF DISADVANTAGED PATIENTS.						
8. PODIATRIC TREATMENT TO PSYCHIATRIC PATIENTS						
9. ABILITY TO EDUCATE & INSTRUCT PATIENTS ON SELF CARE MANAGEMENT.						
10. RECOGNIZE THE IMPLICATIONS OF LIFE CHANGES ON HEALTH AND DISEASE.						
11 OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_  
 (signature)

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_  
 (signature)

DATE \_\_\_\_\_

Revised 4/2010

Revised 6/2012

## **EDUCATIONAL OBJECTIVES FOR EMERGENCY SERVICES**

In the course of your interactions in the Emergency Department, you will be exposed to patients presenting with a wide variety of acute medicine and surgery conditions. You will learn how to evaluate, diagnose, and manage patients requiring immediate interventions.

At the conclusion of the program rotation, you should be able to:

1. Elicit an accurate history of patients presenting complaints and symptoms.
2. Perform a physical exam and diagnostic work-up to reach a diagnosis in patients presenting with acute problems.
3. Use ancillary services (Lab, Radiology, etc.) appropriately in confirming or ruling out a specific diagnosis.
4. Determine what clinical manifestations warrant immediate surgical intervention.
5. Distinguish how to prioritize appropriately when triaging patients according to severity of condition.
6. Become familiar with a variety of illnesses and symptoms requiring immediate assessment and intervention.
7. Gain knowledge in the management of the acutely ill diabetic patient.
8. Gain knowledge in the management of sepsis and septic shock.
9. Gain knowledge in the insertion of chest tubes and central lines.
10. Have a better understanding of EMS field activity and EMS techniques for immobilization and pre-hospital care interventions.
11. Apply your technical abilities with a greater degree of confidence, e.g. cast applications, suture techniques, acute trauma care, hemorrhage control, trephination, venous access techniques, etc..

NY DOWNTOWN HOSPITAL  
PODIATRIC RESIDENT EVALUATION FORM

**EMERGENCY SERVICES**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. ELICIT AN ACCURATE HISTORY OF PATIENTS PRESENTING COMPLAINTS AND SYMPTOMS.						
2. PERFORM A PHYSICAL EXAM AND DIAGNOSTIC WORK-UP TO REACH A DIAGNOSIS IN PATIENTS PRESENTING WITH ACUTE PROBLEMS.						
3. USE ANCILLARY SERVICES APPROPRIATELY IN CONFIRMING OR RULING OUT A SPECIFIC DIAGNOSIS.						
4. DETERMINE WHAT CLINICAL MANIFESTATIONS WARRANT IMMEDIATE SURGICAL INTERVENTION.						
5. DISTINGUISH HOW TO PRIORITIZE APPROPRIATELY WHEN TRIAGING PATIENTS ACCORDING TO SEVERITY OF CONDITION.						
6. BECOME FAMILIAR WITH A VARIETY OF ILLNESSES AND SYMPTOMS REQUIRING IMMEDIATE ASSESSMENT AND INTERVENTION.						
7. GAIN KNOWLEDGE/SKILL IN THE MANAGEMENT OF ACUTELY ILL PATIENTS						
8. GAIN KNOWLEDGE/SKILL IN THE MANAGEMENT OF SEPSIS AND SEPTIC SHOCK.						
9. GAIN KNOWLEDGE/SKILL IN THE INSERTION OF CHEST TUBES & CENTRAL LINES.						
10. UNDERSTANDING OF EMS FIELD ACTIVITY AND EMS TECHNIQUES FOR IMMOBILIZATION AND PRE-HOSPITAL CARE INTERVENTIONS.						
11. GAIN TECHNICAL ABILITIES (CAST APPLICATIONS, SUTURE TECHNIQUES, ETC)						
12. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

Revised 4/2012

## **COMPETENCIES FOR PODIATRY CLINIC ROTATION**

The resident will be expected to gain an understanding of the various pathologies encountered in an outpatient comprehensive podiatric medical/surgical. This rotation will take place at the NY Downtown Clinic on the fifth and seventh floors and will include participation in podiatric outpatient clinics. The specific objectives of each discipline are delineated individually. At the end of the total rotation the Podiatric Medical Director of the podiatry clinic will complete the evaluation form.

At the end of this rotation, you should be able to:

1. Perform the assigned charting and documentation in a timely manner.
2. Properly obtain record and complete history and physical examination including neurological, vascular, dermatological, musculoskeletal, biomechanical, systems, and treat appropriately
3. Perform, order and interpret medical imaging, hematological, microbiological and histological studies
4. Organize and present cases.
5. Formulate a plan of diagnosis and therapy.
6. Understand the various common concepts and techniques utilized in a variety of medical/surgical sub-specialties.
7. Understand the common drugs and their dosages.
8. Detail proper procedures in managing common emergencies.
9. Order and interpret laboratory data and correlate it with clinical findings to develop a more definitive diagnosis.

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**PODIATRY CLINIC**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5** EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. PROPERLY OBTAIN RECORD AND COMPLETE HISTORY AND PHYSICAL EXAMINATION INCLUDING NEUROLOGICAL, VASCULAR, DERMATOLOGICAL, MUSCULOSKELETAL, BIOMECHANICAL, SYSTEMS, AND TREAT APPROPRIATELY						
2. PERFORM THE ASSIGNED CHARTING AND DOCUMENTATION IN A TIMELY MANNER.						
3. COMMUNICATE EASILY AND EFFECTIVELY WITH ALL PATIENTS.						
4. ORGANIZE AND PRESENT CASES.						
5. FORMULATE A PLAN OF DIAGNOSIS AND THERAPY.						
6. PROPERLY OBTAIN AND RECORD A COMPLETE HISTORY AND PHYSICAL EXAM.						
7. UNDERSTAND THE COMMON DRUGS AND THEIR DOSAGES.						
8. DETAIL PROPER PROCEDURES IN MANAGING COMMON EMERGENCIES.						
9. ORDER AND INTERPRET LAB DATA AND CORRELATE WITH CLINICAL FINDINGS TO DEVELOP A MORE DEFINITIVE DIAGNOSIS.						
10. UNDERSTANDING OF VARIOUS COMMON CONCEPTS AND TECHNIQUES UTILIZED.						
11. TECHNICAL ABILITIES.						
12. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

## **COMEPETENCIES FOR DERMATOLOGY**

In the course of your Medicine rotation you will spend time in the in the dermatology clinic You will be exposed to patients presenting with a wide variety of skin conditions. You will learn how to evaluate, diagnose, and manage patients requiring dermatologic interventions.

At the conclusion of this rotation, you should be able to:

1. Perform a dermatological history and physical examination.
2. Understand the diagnosis and treatment of general dermatological conditions.
3. Diagnose skin conditions related to the lower extremity and medical conditions associated with some of these skin manifestations.
4. Be familiar with topical and oral medications used for treatment of dermatological conditions.
5. Perform basic dermatological procedures.
6. Identify fungal cultures and biopsy slides.

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**DERMATOLOGY**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. ABILITY TO PERFORM A DERMATOLOGIC HISTORY AND PHYSICAL EXAM.						
2. UNDERSTANDING THE DIAGNOSIS AND TREATMENT OF GENERAL DERMATOLOGICAL CONDITIONS.						
3. ABILITY TO DIAGNOSE SKIN CONDITIONS RELATED TO THE LOWER EXTREMITY AND MEDICAL CONDITIONS ASSOCIATED WITH SOME OF THESE SKIN MANIFESTATIONS.						
4. FAMILIARITY WITH TOPICAL AND ORAL MEDICATIONS USED FOR TREATMENT OF DERMATOLOGICAL CONDITIONS.						
5. ABILITY TO PERFORM BASIC DERMATOLOGICAL PROCEDURES.						
6. ABILITY TO IDENTIFY FUNGAL CULTURES AND BIOPSY SLIDES.						
7. OVERALL RATING OF RESIDENT'S GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

**EDUCATIONAL OBJECTIVES FOR PODIATRIC SURGERY (PGY II)at the  
CENTER FOR SPECIALTY CARE**

The purpose of the PGY II year is to provide the resident additional practical experience in the areas of podiatric surgical technique and general outpatient surgical care patient care. To this end we have established a rotation at an outpatient surgical facility - The Center for Specialty Care, a unique facility located at 50 East 69<sup>th</sup> Street. The Center's highly specialized facilities include three Operating Suites. They have more than 15 podiatrists on staff as well as many other specialties.

The mission at the Center for Specialty Care, Inc. is to create a superior surgical environment, blending cutting-edge technology and skill with personalized attention to detail, in a setting dedicated to making the patients feel comfortable and calm.

The fundamental goal of this rotation is to provide the resident with a well-rounded exposure to an outpatient surgical environment in preparation for management of podiatric conditions and diseases as they are related to surgical conditions in the lower extremities.

At the conclusion of this second year rotation, you should be able to:

1. Comprehend and complete preoperative history and physical examination.
2. Develop a differential diagnosis for foot and ankle pathology.
3. Interpret preoperative lab values and tests.
4. Complete preoperative charting and dictation techniques.
5. Act as first assistant.
6. Assist/Perform soft tissue surgery.
7. Assist/Perform digital surgery.
8. Assist/Perform lesser metatarsal surgery.
9. Assist/Perform first metatarsal surgery.
10. Assist/Perform midfoot surgery.
11. Assist/Perform rearfoot and ankle surgery.
12. Assist/Perform Internal fixation.
13. Assist/Perform application of casts.
14. Recognize and manage podiatric complications.

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**PODIATRIC SURGERY (PGY II) at the  
 CENTER for SPECIALTY CARE**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL  
 IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. COMPREHEND\COMPLETE PREOPERATIVE HISTORY AND PHYSICAL EXAM.						
2. DEVELOP A DIFFERENTIAL DIAGNOSIS FOR FOOT AND ANKLE PATHOLOGY.						
3. INTERPRET PREOPERATIVE LAB VALUES AND TEST.						
4. COMPLETE PREOPERATIVE CHARTING AND DICTATION TECHNIQUES.						
5. ACT AS FIRST ASSISTANT.						
6. PERFORM SOFT TISSUE SURGERY.						
7. PERFORM DIGITAL SURGERY.						
8. PERFORM LESSER METATARSAL SURGERY.						
9. PERFORM FIRST METATARSAL SURGERY.						
10. PERFORM MIDFOOT SURGERY.						
11. PERFORM REARFOOT AND ANKLE SURGERY.						
12. PERFORM RESIDENTSAL FIXATION.						
13. PERFORM APPLICATION OF CASTS.						
14. RECOGNIZE AND MANAGE COMPLICATIONS.						
15. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

Rev. 6/2012

## RESIDENCY ROTATION AGREEMENT

This Agreement is made this 1<sup>st</sup> day of July 2010 by and between **New York Downtown Hospital**, a New York not-for-profit corporation (“Hospital”) and **The Center For Specialty Care, Inc.** located at 50 East 69<sup>th</sup> Street, New York, NY 10021 (“Participating Institution”).

WHEREAS, Hospital has developed a postgraduate program, and as part of such program, sends post graduate trainees (“Residents”) to other non-hospital facilities for various Hospital sponsored rotations, (the “Program”);

WHEREAS, Participating Institution wishes to contribute to the post graduate education of Residents by accepting Residents from Hospital to participate in residency training rotations at Participating Institution; and

WHEREAS, Hospital and Participating Institution intend to cooperate in the postgraduate education and training of Residents of the Program.

NOW, THEREFORE, the parties agree as follows:

1. Schedule. Beginning on or after August 1, 2010, Hospital shall provide 1 (one) Resident-for rotation at Participating Institution at such times as are mutually agreed to by the parties. Each Resident shall be scheduled for rotation at Participating Institution for up to three (3) months.
2. Employment. Residents who rotate at Participating Institution from Hospital shall remain employees of Hospital, and Hospital shall be exclusively responsible for payment of their wages, benefits, and all other incidents of employment.
3. Compliance with Policies and Procedures; Training and Orientation. Hospital shall require all Residents who rotate at Participating Institution to comply with all applicable Participating Institution policies and procedures, including, but not limited to, those relating to the maintenance of confidentiality of patient information. Hospital shall provide HIV confidentiality and comprehensive infection control training to each resident prior to commencement of the rotation and shall provide documentation of such training to Participating Institution upon its request. Participating Institution shall be responsible for distributing copies of its rules and regulations and for providing an orientation to residents.
4. Health Status. Hospital shall, upon request, provide to Participating Institution documentation that each Resident meets all applicable federal, state, and local health requirements including evidence that each Resident is free from communicable disease and health impairment, which might interfere with the performance of his/her duties.

5. Curriculum; Supervision. Hospital Residents rotating at Participating Institution pursuant to this Agreement shall have the opportunity to assist attending surgeons for purposes of receiving training in accordance with the terms of Exhibit A. Daniel Geller, DPM, shall assume administrative, educational and supervisory responsibility for the Residents while they are at Participating Institution. Dr. Geller shall consult with the applicable Department Chair/Program Director at Hospital regarding the content and structure of the training program for the Residents and regarding any problems with the performance of a Resident. Supervising physicians of the Participating Institution shall also provide verbal feedback to the Residents on an ongoing basis and shall provide written evaluation of each Resident twice annually. Dr. Geller shall evaluate each Resident's performance during the rotation and shall provide a written evaluation.
6. Removal of Residents. Hospital shall promptly remove a Resident from the Participating Institution, upon Participating Institution's request, if the Resident (i) is unacceptable by reason of health; (ii) fails to abide by the Participating Institution's policies, procedures, rules, regulations or medical staff bylaws; (iii) poses a threat to patient, staff or visitor health, safety or welfare; (iv) fails to perform his/her assignments properly; or (v) for any other reasonable cause. In the event of an issue of disciplinary action, Hospital policies regarding due process will be followed.
7. Program Coordinator. Each party shall appoint a coordinator who shall confer at regular intervals on all matters arising under this Agreement. See Section 5.
8. Medical Services. Participating Institution shall arrange for emergency care to Residents who may become ill or injured while at Participating Institution. Such emergency care and any other care rendered to Residents shall be the financial responsibility of the Resident.
9. Compensation. Teaching by physicians at Participating Institution is voluntary. There is no payment to the Participating Institution for supervisory activities because the Participating Institution does not incur these costs.
10. Insurance. At all times while this Agreement is in effect, Participating Institution shall maintain professional liability insurance covering (i) itself with limits of not less than \$1 million per incident and \$3 million in the aggregate and general liability insurance of \$1 million per occurrence and \$3 million in the aggregate, and (ii) each professional person providing services to implement this Agreement, with limits not less than \$1 million per incident and \$3 million in the aggregate. Hospital shall maintain professional liability insurance covering the activities of the Residents while performing services at Participating Institution with limits of not less than \$1 million per incident and \$3 million in the aggregate. The parties shall exchange certificates of insurance, upon request, evidencing such coverage and other terms and shall notify one another prior to any material change in insurance terms.

11. Confidentiality. All information and records relating to the residents at Participating Institution are and shall remain the property of Participating Institution. The parties shall cooperate in ensuring appropriate access to such records by Hospital and Residents to the extent permitted by law and as required to fulfill the purposes of this Agreement.
12. Waiver. The failure of either party to insist in any instance upon performance of any term, covenant or condition of this Agreement shall not be construed as a waiver of future performance of any such term, covenant or condition, and the obligations of the parties with respect thereto shall continue in full force and effect.
13. Compliance with Laws. Both parties agree that notwithstanding any other provision in this Agreement, each party shall remain responsible for ensuring that any services it provides pursuant to this Agreement shall comply with all pertinent provisions of federal, state and local statutes, rules and regulations.
14. Non-Discrimination. The parties shall not unlawfully discriminate on the basis of race, color, sex, sexual orientation, age, religion, disability, national origin, or any other grounds prohibited by law.
15. Indemnification. Each party shall indemnify, defend and hold harmless the other party, its agents, trustees, directors, officers and employees from any and all loss, damage, injury, demands, lawsuits, judgments, causes of action or liability of any kind whatsoever, including defense costs and reasonable legal fees, that are caused by or arise out of any act, omission, fault, negligence or other misconduct by said party, its officers, employees or agents in connection with this Agreement.
16. Term and Termination. This Agreement shall be effective from July 1, 2010 until June 30, 2011 unless terminated as provided in this Agreement. This agreement shall automatically renew annually. This Agreement may be terminated at any time by either party upon thirty (30) days written notice. Notwithstanding such notice, any Residents rotating at the time of such notice shall be allowed to complete their rotation.
17. Entire Agreement. This Agreement constitutes the entire understanding and Agreement between the parties with regard to all matters referred to herein. There are no other agreements, conditions or representations, oral or written, express or implied, with regard thereto. This Agreement may be modified or amended only by a writing signed by both parties.
18. Applicable Law. This Agreement shall be governed by the laws of the State of New York, and jurisdiction and venue shall lie in a court in the County of New York, State of New York.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year so indicated.

**New York Downtown Hospital**

By: \_\_\_\_\_  
Warren B. Licht, M.D.  
Senior Vice President  
Director of Graduate Medical Education

By: \_\_\_\_\_  
Edwin W. Wolf, DPM  
Director; Podiatric Medical Education

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**Center For Specialty Care**

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## **GOALS AND OBJECTIVES OF THE PODIATRIC SURGERY ROTATION (PGY III)**

The rotation will provide the resident with experiences in first contact care, continuous care, long term care and comprehensive care. During the three months of the rotation as a PGY III, the resident will rotate through clinical areas of the podiatry and will spend time in the operating room. This rotation will enable the resident to gain a broad knowledge of a variety of diseases that affect the human body and to relate other disease processes and manifestations to the diagnosis, management and treatment of foot problems. Education will be enhanced through daily scheduled lectures, and conferences through the orthopedics department to integrate the basic sciences with clinical treatment of patients. The resident will review x-ray findings and will develop competency in evaluating the total status of the patient in relationship to the specific procedures that are planned. The resident will perform procedures under the supervision of a licensed and qualified individual.

The resident will gain knowledge and experience in the following:

1. Outpatient charting and protocol.
2. Detailed history and physical taking.
3. Interpretation of laboratory results.
4. Performance and observation of specialized radiographic techniques such as angiography, venography, doppler, etc.
5. Interpretation of standard radiographs of the entire body.
6. Attend lectures and seminars given by the staff as well as other specialties.
7. Understand the indications for ambulatory surgery.
8. Develop an understanding of pathological states of the human body.
9. Develop experience in the performance and interpretation of pedal radiographs, CT scan, MRI
10. Develop experience in the prevention and treatment of diabetic emergencies, shock, cardiopulmonary emergencies as well as seizures.
11. Resident will be able to act as first assistant.
12. Resident will be able to perform soft tissue surgery.
13. Resident will be able to perform digital surgery.
14. Resident will be able to perform lesser metatarsal surgery.
15. Resident will be able to perform first metatarsal surgery.
16. Resident will be able to perform midfoot (Cuneiform, cuboid, navicular) surgery.
17. Resident will be able to perform rearfoot and ankle surgery.
18. Resident will be able to apply internal fixation techniques in the foot and ankle.
19. Resident will be able to apply casts to the foot and ankle.
20. Resident will be able to recognize and manage perioperative complications.

NY DOWNTOWN Hospital  
 PODIATRIC SURGERY PGY III Evaluation Form

Resident: \_\_\_\_\_ Date: \_\_\_\_\_ Evaluator & Title: \_\_\_\_\_

**Using the following scale, please rate the Resident's performance level in meeting each of the COMPETENCIES as listed below:**

5 Exceptional    4 Very Good    3 Average    2 Below Average    1 Unsatisfactory    0 Not Observed

	5	4	3	2	1	0
UNDERSTAND THE PRINCIPLES OF CASTING, TRACTION AND IMMOBILIZATION.						
APPLY CASTS TO SIMPLE FRACTURES OF EXTREMITIES.						
GAIN KNOWLEDGE ON THE PROPER USE OF A VARIETY OF ORTHOPEDIC EQUIPMENT.						
REVIEW CLINICAL SYMPTOMS AND RADIOLOGY FINDINGS WITH ATTENDINGS TO DETERMINE THE APPROPRIATE TREATMENT REGIMEN FOR PATIENTS.						
EVALUATE PATIENTS IN THE POST-OPERATIVE PERIOD AND RECOGNIZE ANY POTENTIAL COMPLICATIONS.						
DOCUMENT A CLEAR AND CONCISE TRAUMA HISTORY.						
UNDERSTANDING OF OPEN AND CLOSED FRACTION REDUCTION.						
UNDERSTANDING INTERNAAL FIXATION PRINCIPLES.						
Understand basic orthopedic prosthesis and instrumentation						
Elicit an accurate history of patients' complaints and symptoms and perform a preoperative physical exam in patients presenting for elective podiatric surgery						
Correlate radiographs with diagnosis and procedure						
Determine what clinical presentations warrant surgical intervention						
Work-up patients and develop and implement appropriate treatment plans						
Act as an appropriate assistant intraoperatively.						
Technical abilities intraoperatively						
Able to perform forefoot surgery						
OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

Rev. 6/2012

## **COMPETENCIES FOR ORTHOPAEDIC SURGERY**

During this rotation, you will work closely with the Orthopaedic surgeons and follow patients from admission through discharge. You will have the opportunity to assist in the operating room as well as to learn to diagnose and manage emergency Orthopaedic problems in a variety of situations.

At the conclusion of this rotation, you will be able to:

1. Understand the principles of casting, traction and immobilization.
2. Apply casts to simple fractures of extremities.
3. Gain knowledge on the proper use of a variety of Orthopedic equipment.
4. Review clinical symptoms and radiology findings with Attending to determine the appropriate treatment regimen for patients.
5. Evaluate the patients in the post-operative period and recognize any potential complications.
6. Document a clear and concise trauma history.
7. Understand open and closed fraction reduction.
8. Understand Residentsal fixation principles.
9. Understand basic orthopedic prosthetic devices and instrumentation.

Revised 3/2012

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**ORTHOPAEDIC SURGERY**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED**

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. UNDERSTAND THE PRINCIPLES OF CASTING, TRACTION AND IMMOBILIZATION.						
2. APPLY CASTS TO SIMPLE FRACTURES OF EXTREMITIES.						
3. GAIN KNOWLEDGE ON THE PROPER USE OF A VARIETY OF ORTHOPEDIC EQUIPMENT.						
4. REVIEW CLINICAL SYMPTOMS AND RADIOLOGY FINDINGS WITH ATTENDING TO DETERMINE THE APPROPRIATE TREATMENT REGIMEN FOR PATIENTS.						
5. EVALUATE PATIENTS IN THE POST-OPERATIVE PERIOD AND RECOGNIZE ANY POTENTIAL COMPLICATIONS.						
6. DOCUMENT A CLEAR AND CONCISE TRAUMA HISTORY.						
7. UNDERSTANDING OF OPEN AND CLOSED FRACTION REDUCTION.						
8. UNDERSTANDING RESIDENTSAL FIXATION PRINCIPLES.						
9. UNDERSTANDING OF BASIC ORTHOPEDIC PROSTHETIC DEVICES AND INSTRUMENTATION.						
10. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

Revised 3/2012

## **COMPETENCIES FOR PEDIATRICS**

The resident will be expected to gain an understanding of the normal ontogeny of the lower extremity and the various developmental stages of newborns, infants, and children. The resident should also gain knowledge of the treatment modalities available for use in pediatrics and when it is appropriate to seek consultation.

At the conclusion of this rotation, you will be able to:

1. Perform an examination of newborns, infants and children.
2. Be familiar with common pediatric medications and their dosage.
3. Perform pediatric CPR.
4. Understand and recognize common pediatric neurologic and orthopedic diseases.
5. Understand the management of pediatric emergencies.

Rev. 6/2012

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**PEDIATRICS**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5** EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. ABILITY TO PERFORM AN EXAMINATION OF NEWBORNS, INFANT, AND CHILDREN.						
2. FAMILIARITY WITH COMMON PEDIATRIC MEDICATIONS AND THEIR DOSAGE.						
3. ABILITY TO PERFORM PEDIATRIC CPR.						
4. UNDERSTANDING THE MANAGEMENT OF PEDIATRIC EMERGENCIES.						
5. UNDERSTANDING AND RECOGNITION OF COMMON PEDIATRIC NEUROLOGIC AND ORTHOPEDIC DISEASES.						
6. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

Rev. 6/2012

## ***COMPETENCIES FOR PMSR FOR INTERNAL MEDICINE***

Your involvement in Internal Medicine is designed to provide you with exposure to a variety of disease processes in a varied group of patients. It is designed to improve the body of knowledge developed during your podiatric medical school education. You will be presented with the pathophysiologic, diagnostic and therapeutic aspects of an assortment of medical conditions, during the course of your rotation. You will also follow selected outpatients on an ongoing, primary care basis through the medical clinic under the aegis of a Clinical Supervisor.

At the conclusion of this rotation, you should be able to:

1. Elicit a detailed and accurate patient history and perform a complete physical examination in a timely fashion.
2. Discuss the differential diagnosis and use ancillary services appropriately in confirming or ruling out a diagnosis for a variety of common medical conditions.
3. Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of Internal medicine and establishing a differential diagnosis before assigned attendings.
4. Discuss management plans for a variety of common medical conditions.
5. Establish safe and effective discharge planning for a variety of patient situations and medical problems.
6. Actively participate in the daily medical management and in the discharge planning for all in-house podiatric patients.
7. Discuss the management of podiatric in-house patients with attending in various aspects of Internal medicine (infectious disease, endocrinology, cardiology, etc.).

## MEDICINE ROTATION – CLINIC MONTH SCHEDULE

	M	T	W	Th	Fr
AM	Endocrine (Derm)	Medicine (Derm)	Infectious Disease	Medicine	Wound Care
PM	Endocrine	Medicine	Infectious Disease (Neurology)	Rheumatology	Endocrinology

revised 11/10

NY DOWNTOWN Hospital  
Podiatric Resident (PMSR) Evaluation Form

**INTERNAL MEDICINE/General Medicine**

Resident: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluator Name & Title: \_\_\_\_\_

Using the following scale, please rate the Resident's performance level in meeting each of the COMPETENCIES as listed below:  
**5** Exceptional    **4** Very Good    **3** Average    **2** Below Average    **1** Unsatisfactory    **0** Not Observed

Elicit a detailed and accurate Patient History and perform a complete physical examination in a timely fashion					
Discuss the differential diagnosis, diagnostic evaluation, medical management and discharge planning for a variety of medical conditions.					
Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of internall medicine and establishing a differential diagnosis.					
Discuss management plans for a variety of common medical conditions.					
Establish safe and effective discharge planning for a variety of patient situations and medical problems					
Actively participate in the daily medical management and in the discharge planning for all in-house patients.					
Overall rating of resident's professional growth					

COMMENTS:

Evaluator \_\_\_\_\_

DATE \_\_\_\_\_

Resident \_\_\_\_\_

DATE \_\_\_\_\_

Director \_\_\_\_\_

DATE \_\_\_\_\_

NY DOWNTOWN Hospital  
Podiatric Resident (PMSR) Evaluation Form

**INTERNAL MEDICINE/ENDOCRINE**

Resident: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluator Name & Title: \_\_\_\_\_

Using the following scale, please rate the Resident's performance level in meeting each of the COMPETENCIES as listed below:  
**5** Exceptional    **4** Very Good    **3** Average    **2** Below Average    **1** Unsatisfactory    **0** Not Observed

Elicit a detailed and accurate Patient History and perform a complete physical examination in a timely fashion					
Discuss the differential diagnosis, diagnostic evaluation, medical management and discharge planning for patients with endocrine disorders.					
Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of endocrine disorders and establishing a differential diagnosis.					
Discuss management plans for a variety of common endocrine disorders.					
Establish safe and effective outpatient regimines for a variety of patient situations with endocrinological problems					
Actively participate in the daily medical management and in the discharge planning for all in-house patients on the endocrine service.					
Overall rating of resident's professional growth					

COMMENTS:

Evaluator \_\_\_\_\_

DATE \_\_\_\_\_

Resident \_\_\_\_\_

DATE \_\_\_\_\_

Director \_\_\_\_\_

DATE \_\_\_\_\_

NY DOWNTOWN Hospital  
Podiatric Resident (PMSR) Evaluation Form

**INTERNAL MEDICINE/RHEUMATOLOGY**

Resident: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluator Name & Title: \_\_\_\_\_

Using the following scale, please rate the Resident's performance level in meeting each of the COMPETENCIES as listed below:  
**5** Exceptional    **4** Very Good    **3** Average    **2** Below Average    **1** Unsatisfactory    **0** Not Observed

Elicit a detailed and accurate Patient History and perform a complete physical examination in a timely fashion both inpatient and outpatient					
Discuss the differential diagnosis, diagnostic evaluation, medical management and discharge planning for a variety of arthritic conditions.					
Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of internal medicine and establishing a differential diagnosis for patients with rheumatological disease.					
Discuss management plans for a variety of common arthritic conditions.					
Establish safe and effective discharge planning for a variety of patient situations and arthritic problems					
Actively participate in the daily medical management and in the discharge planning for all in-house patients on the rheumatology service.					
Overall rating of resident's professional growth					

COMMENTS:

Evaluator \_\_\_\_\_

DATE \_\_\_\_\_

Resident \_\_\_\_\_

DATE \_\_\_\_\_

Director \_\_\_\_\_

DATE \_\_\_\_\_

NY DOWNTOWN Hospital  
Podiatric Resident (PMSR) Evaluation Form

**INTERNAL MEDICINE/NEUROLOGY**

Resident: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluator Name & Title: \_\_\_\_\_

Using the following scale, please rate the Resident's performance level in meeting each of the COMPETENCIES as listed below:  
**5** Exceptional    **4** Very Good    **3** Average    **2** Below Average    **1** Unsatisfactory    **0** Not Observed

Elicit a detailed and accurate Patient History and perform a complete physical examination in a timely fashion for inpatients and outpatients					
Discuss the differential diagnosis, diagnostic evaluation, medical management and discharge planning for a variety of medical conditions.					
Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of neurological disorders and establishing a differential diagnosis.					
Discuss management plans for a variety of common medical conditions with neurological implications.					
Establish safe and effective discharge planning for a variety of patient situations and neurological problems					
Actively participate in the daily medical management and in the discharge planning for all in-house patients on the neurology service.					
Overall rating of resident's professional growth					

COMMENTS:

Evaluator \_\_\_\_\_

DATE \_\_\_\_\_

Resident \_\_\_\_\_

DATE \_\_\_\_\_

Director \_\_\_\_\_

DATE \_\_\_\_\_

## INFECTIOUS DISEASE/ MEDICINE

NY DOWNTOWN Hospital sees large numbers of patients whose problems include problems of an infectious disease nature. As such the hospital maintains an active infectious disease service through the Department of Medicine.

As part of the PMSR the resident rotates through three months on the Medicine Service. To enhance this experience significant interaction with the Infectious Disease Service is included in your education.

During the course of your PMSR you will be exposed to a variety of learning experiences with patients of all ages with infections. This will be on an inpatient basis as well as an outpatient basis.

The resident will participate in the infectious disease service which will include, but is not limited to the following experiences:

1. Recognizing and diagnosing common infectious processes in the pediatric and adult patient.
2. Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring.
3. Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring
4. Exposure to local and systemic infected wound care.
5. You will learn to prevent, diagnose and manage diseases, disorders and injuries of the pediatric and adult lower extremity which involve infectious processes, by surgical and non-surgical means.
6. Demonstrate the ability to interact with, and communicate effectively in a multi-disciplinary setting.

As in all of your other experiences at New York Downtown Hospital, you will be expected to practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion, and be lifelong inquisitive learners and teachers.

NY DOWNTOWN HOSPITAL  
 PODIATRIC MEDICINE RESIDENT EVALUATION FORM

**INFECTIOUS DISEASE**

RESIDENT: \_\_\_\_\_ ROTATION DATE: \_\_\_\_\_

EVALUATOR:

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
Recognizing and diagnosing common infectious processes in the pediatric and adult patient						
Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring						
Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring						
Exposure to local and systemic infected wound care.						
You will learn to prevent, diagnose and manage diseases, disorders and injuries of the pediatric and adult lower extremity which involve infectious processes, by surgical and non-surgical means.						
Demonstrate the ability to interact with, and communicate effectively in a multi-disciplinary setting.						
OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_ DATE \_\_\_\_\_  
 (signature)

RESIDENT \_\_\_\_\_ DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_ DATE \_\_\_\_\_  
 (signature)

Revised6/2012

## **COMPETENCIES FOR PATHOLOGY**

Your rotation in Pathology is designed to familiarize you with proper techniques used in a variety of laboratory procedures. You will be exposed to the processing of various types of pathological specimens and will learn how to interpret microscopic specimens as they relate to the disease process.

At the conclusion of this rotation, you will be able to:

1. Process and fix a variety of specimens.
2. Interpret abnormal and normal tissue specimens microscopically in a variety of diseases.
3. Relate abnormal pathology findings to the disease process and develop an appropriate treatment plan.
4. Become familiar with a variety of laboratory techniques and the proper use of lab equipment.
5. Make a presentation on a specific disease entity that includes the use of pathologic diagnosis to develop a treatment plan and prognosis.
6. Gain experience in handling, processing, and interpreting blood samples for a variety of tests, including chemistry, hematology, serology and blood typing and cross matching.

NY DOWNTOWN HOSPITAL  
 PODIATRIC MEDICINE RESIDENT EVALUATION FORM

**PATHOLOGY**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5** EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. PROCESS AND FIX A VARIETY OF SPECIMENS.						
2. INTERPRET ABNORMAL AND NORMAL TISSUE SPECIMENS MICROSCOPICALLY IN A VARIETY OF DISEASES.						
3. RELATE ABNORMAL PATHOLOGY FINDINGS TO THE DISEASE PROCESS AND DEVELOP AN APPROPRIATE TREATMENT PLAN.						
4. BECOME FAMILIAR WITH A VARIETY OF LABORATORY TECHNIQUES AND THE PROPER USE OF LAB EQUIPMENT.						
5. MAKE A PRESENTATION ON A SPECIFIC DISEASE ENTITY THAT INCLUDES THE USE OF PATHOLOGIC DIAGNOSIS TO DEVELOP A TREATMENT PLAN AND PROGNOSIS.						
6. GAIN EXPERIENCE IN HANDLING, PROCESSING, AND INTERPRETING BLOOD SAMPLES FOR A VARIETY OF TESTS, INCLUDING CHEMISTRY, HEMATOLOGY, SEROLOGY AND BLOOD TYPING AND CROSSMATCHING.						
7. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

### **COMPETENCIES FOR PODIATRIC MEDICINE**

This rotation provides didactic as well as clinical training in the evaluation of patients with foot and ankle problems. You will participate in the diagnosis and treatment of an acceptable volume and diversity of cases identified with podiatric pathology. Training will emphasize nonsurgical intervention, preventative medicine and patient education.

At the conclusion of this rotation, you will be able to:

1. Work-up patients with foot and ankle problems.
2. Interpret foot and ankle x-rays for podiatric pathology.
3. Develop an understanding of abnormal pathology.
4. Gain technical skills in performing a variety of podiatric procedures.
5. Discuss the diagnostic work-up, diagnosis and treatment plan with Podiatrists on patients with a variety of foot and ankle problems.
6. Become familiar with a variety of complex podiatric pathologies.
7. Manage newborn through geriatric patients, with emphasis on treatment of patients.
8. Develop effective patient-physician communication skills.

## **GUIDELINES FOR QUALITY ASSURANCE**

### **Outpatient Clinic – Podiatry Section**

#### **Antibiotics**

All patients that are begun on parenteral antibiotics, either intravenous or oral, should have a culture & sensitivity harvesting before initiation of medication. While the infection should certainly be treated empirically, a baseline must be done with a culture & sensitivity before initiation of antibiotics.

#### **Bone surgery**

All patients who have bone surgery done at NY Downtown Hospital must have postoperative x-rays taken before discharge from the facility. There should be some notation somewhere by the house staff and/or attending staff that these x-rays were reviewed and are of appropriate quality.

#### **Charting**

All patient charts must be completed and signed by the resident and the attending before a clinic session is to be considered complete. This must be done before the end of business of the day of the clinic. All attendings and house staff must sign legibly or print their names along with the signature. All attendings must sign the attestation which states that the chart has been reviewed and that they agree with the evaluation and treatment as noted.

#### **Consent Forms**

All patient undergoing surgical procedures should have appropriately filled out consent forms. The witness of this form must be different from the surgeon. Please note that any changes in the consent form must be clearly legible and must be initialed by the patient and a witness as well as dated.

#### **Hallux Valgus**

Documentation of a painful deformity must be noted in the record before surgical intervention should be considered.

- Preoperatively, all patients must have:
  - weight bearing AP and lateral x-rays. These radiographs must be reviewed and an evaluation form filled out by the resident and the attending podiatrist. This form should include the decision making logic for selection of criteria.

## **HIV + Patients**

To be considered for elective surgery, the CD-4 counts should be greater than 200 or the viral load should be insignificant. This can be overridden by the Medicine Department during time of evaluation for preoperative clearance. This, however, must be clearly noted and identified in the record.

## **Nail Surgery**

Clear documentation of pathology is necessary. A consent form should be in the chart, signed and witnessed before the procedure is performed. Appropriate follow-up care should be identified in the record.

## **Onychomycosis**

Diagnosis to be confirmed by KOH culture if a patient is to be started on oral antifungal medication. Oral medication should be followed up with liver function *tests if there is medical necessity as determined by history and physical examination.*

In cases where onychomycosis is to be treated on the basis of topical medication only, there is no indication or need for objective laboratory testing to confirm the diagnosis

## **Orthotics**

All patients being considered for orthotics should have a biomechanical evaluation form completed in the chart before casting.

## **PREOPERATIVE EVALUATIONS**

All patients who are scheduled for elective surgery through the Family Health Center must be seen in the facility within two weeks of the surgery. The attending of record, the resident on the case and the patient must ALL be present. A consent form should be signed at that time, outlining the elective surgical procedures. If this procedure is not followed anyone has the right to summarily cancel the case.

## **PRIMARY CARE PHYSICIANS**

All patients seen in the podiatry clinics must have a documented primary care physician whose name is identified in the chart. It need not be a NY Downtown Physician, but it must be noted that a PCP exists and has evaluated the patient within a reasonable previous interval.

## SIGNATURES

All signatures should be legible, and should identify the degree of the provider. Dr. John Smith is NOT an acceptable signature. John Smith DPM is. A preprinted stamp is provided by the hospital for your use, and should be used in conjunction with your signature, each and every time.

## VASCULAR

**ALL RESIDENTS ARE RQUIRED TO HAVE A HANDHELD DOPPLER WITH THEM AT ALL TIMES.** Patients who have less than normal findings of arterial inflow to the feet ( as measured by palpation) must have an ABI documented in the record. At all times the noted ABI must be less than 3 months old. All patients with ABI of less than 1.0 should be referred to the vascular clinic

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**PODIATRIC MEDICINE**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

<b>ROTATION'S EDUCATIONAL OBJECTIVES</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. WORK-UP PATIENTS WITH FOOT AND ANKLE PROBLEMS.						
2. INTERPRET FOOT AND ANKLE X-RAYS FOR PODIATRIC PATHOLOGY.						
3. DEVELOP AN UNDERSTANDING OF ABNORMAL PATHOLOGY.						
4. GAIN TECHNICAL SKILLS IN PERFORMING A VARIETY OF PODIATRIC PROCEDURES.						
5. DISCUSS THE DIAGNOSTIC WORK-UP, DIAGNOSIS AND TREATMENT PLAN ON PATIENTS WITH A VARIETY OF FOOT AND ANKLE PROBLEMS.						
6. BECOME FAMILIAR WITH A VARIETY OF COMPLEX PODIATRIC PATHOLOGIES.						
7. MANAGEMENT AND TREATMENT OF PATIENTS.						
8. PATIENT-PHYSICIAN COMMUNICATION SKILLS.						
9. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

## **COMPETENCIES FOR MEDICAL IMAGING**

Your rotation in Medical Imaging will enable you to become familiar with the various techniques and procedures used to enable the Clinician to accurately diagnose a variety of disease processes.

At the conclusion of this rotation, you should be able to:

1. Evaluate and interpret films for the abnormal and normal in a variety of body systems.
2. Develop an interesting case file of various pathology identified on x-ray.
3. Determine which x-ray procedure to use based on standard criteria.
4. Gain an understanding of the techniques employed in performing a wide variety of procedures including CAT scans and ultrasound.
5. Use x-ray findings to develop a course of treatment for a variety of conditions.
6. Gain an understanding of various radiological studies and evaluate the results toward the establishment of diagnoses relative to structural, traumatic, infectious, metabolic, neoplastic, or neurovascular disease of the body.

Revised 2/2011

## MEDICAL IMAGING

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

**5** EXCEPTIONAL   **4** VERY GOOD   **3** AVERAGE   **2** BELOW AVERAGE   **1** UNSATISFACTORY   **0** NOT OBSERVED

	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. EVALUATE AND INTERPRET FILMS FOR THE ABNORMAL AND NORMAL IN A VARIETY OF BODY SYSTEMS.						
2. DEVELOP AN INTERESTING CASE FILE OF VARIOUS PATHOLOGY IDENTIFIED ON X-RAY.						
3. DETERMINE WHICH X-RAY PROCEDURE TO USE BASED ON STANDARD CRITERIA.						
4. UNDERSTAND TECHNIQUES EMPLOYED IN PERFORMING A WIDE VARIETY OF PROCEDURES INCLUDING CAT SCANS AND ULTRASOUND.						
5. USE X-RAY FINDINGS TO DEVELOP A COURSE OF TREATMENT FOR A VARIETY OF CONDITIONS.						
6. UNDERSTAND VARIOUS RADIOLOGICAL STUDIES AND EVALUATE THE RESULTS TOWARD THE ESTABLISHMENT OF DIAGNOSES RELATIVE TO STRUCTURAL, TRAUMATIC, INFECTIOUS, METABOLIC, NEOPLASTIC, OR NEUROVASCULAR DISEASE OF THE BODY.						
7. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

## EDUCATIONAL OBJECTIVES FOR GENERAL SURGERY

Your rotation in General Surgery is planned to continue to provide you with the opportunity to evaluate and manage patients with conditions requiring elective surgical intervention as well as emergency patients presenting with acute conditions requiring surgery.

At the conclusion of this rotation, the resident should be able to:

1. Obtain a good surgical history from patients and generate a differential surgical diagnosis.
2. Determine which clinical presentations warrant surgical intervention.
3. Be able to appropriately prepare patients with significant medical histories (diabetes, renal disease, steroid dependencies, ect.) for surgery.
4. Provide and document routine post-operative care and manage post-operative complications appropriately.
5. Assist at a variety of operative procedures particularly with the subspecialties of orthopedics, plastics and vascular surgery.
6. Become familiar, through lectures and personal reading, with a variety of complex surgical procedures.
7. Work with subspecialties such as vascular and plastics on complex podiatric surgical cases.

NY DOWNTOWN HOSPITAL  
 PODIATRIC RESIDENT EVALUATION FORM

**GENERAL SURGERY**

RESIDENT: \_\_\_\_\_

ROTATION DATE: \_\_\_\_\_

EVALUATOR NAME & TITLE: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. OBTAIN A GOOD SURGICAL HISTORY FROM PATIENTS.						
2. GENERATE A DIFFERENTIAL SURGICAL DIAGNOSIS.						
3. DETERMINE WHAT CLINICAL PRESENTATION WARRANTS SURGICAL INTERVENTION.						
4. ASSIST AT A VARIETY OF OPERATIVE PROCEDURES IN BOTH GENERAL SURGERY AND SUBSPECIALTIES.						
5. PROVIDE AND DOCUMENT ROUTINE POST-OPERATIVE CARE.						
6. BECOME FAMILIAR, THROUGH LECTURES AND PERSONAL READING, WITH A VARIETY OF COMPLEX SURGICAL PROCEDURES.						
7. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_

DATE \_\_\_\_\_

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

## **COMPETENCIES FOR VASCULAR SURGERY ROTATION**

During this rotation, you will work closely with the vascular surgeons and follow patients from admission through discharge. You will have the opportunity work ion the vascular lab and clinic, as well as to assist in the operating room. You will learn to diagnose and manage vascular problems in a variety of situations.

At the conclusion of this rotation, you will be able to:

Prevent, diagnose, and manage vascular diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means.

Perform and interpret the findings of a thorough problem-focused history and physical exam, including: vascular examination, vascular imaging., hematology, blood chemistries, coagulation studies

Perform (and/or order) and interpret appropriate diagnostic studies, including: other diagnostic studies, including non-invasive vascular studies.

Appropriate non-surgical management when indicated, including: pharmacologic management, including the use of: antibiotics, peripheral vascular agents, anticoagulants

Formulate and implement an appropriate plan of management, including: appropriate medical/surgical management when indicated, including: debridement of superficial ulcer or wound.

Assess and manage the patient's general vascular status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination). Formulate an appropriate differential diagnosis of the patient's problem

Recognize the need for (and/or orders) additional diagnostic studies, when indicated

Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic and/or surgical intervention.

Practice with professionalism, compassion, and concern, in a legal, ethical, and moral fashion. Practices and abides by the principles of informed consent. Understand and respects the ethical boundaries of interactions with patients, colleagues and employees. Demonstrate professional humanistic qualities

Demonstrate the ability to communicate effectively in oral and written form with patients, colleagues, payers and the public.

Partner with health care managers and health care providers to assess, coordinate and improve health care.

Maintain appropriate medical records and understands medical-legal considerations involving health care delivery.

Have the capacity to manage individuals and populations in a variety of socioeconomic and health care settings.

Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature.

revised 6/01/2011

## VASCULAR SURGERY SCHEDULE

	M	T	W	Th	Fr
AM	CLINIC (Dr. Wun0	Operating Room	VASCULAR LAB or CLINIC	Operating Room	CLINIC (Elizabeth Street)
PM	Office procedures or Operating Room	Operating ROOM	CLINIC (Elizabeth Street)	Operating ROOM	Office procedures or Operating Room

revised June 2011

**NEW YORK DOWNTOWN HOSPITAL  
PODIATRIC RESIDENT EVALUATION FORM  
Vascular Surgery**

RESIDENT: \_\_\_\_\_ DATE: \_\_\_\_\_ EVALUATOR: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:  
5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
Prevent, diagnose, and manage vascular diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means						
Perform and interpret the findings of a thorough problem-focused history and physical exam, including: vascular examination, vascular imaging., hematology, blood chemistries, coagulation studies, non-invasive vascular studies						
Appropriate non-surgical management when indicated, including: pharmacologic management, including the use of: antibiotics, peripheral vascular agents, anticoagulants and formulates and implement an appropriate plan of management, including: appropriate medical/surgical management when indicated, including: debridement of superficial ulcer or wound.						
Assess and manage the patient's general vascular status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination). Formulate an appropriate differential diagnosis of the patient's problem orders) additional diagnostic studies, when indicated..						
Practice with professionalism, compassion, and concern						
Demonstrate the ability to communicate effectively in oral and written form.						
Maintains appropriate medical records and understands medical-legal considerations involving health care delivery.						
Be professionally inquisitive to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature.						

Comments:

EVALUATOR \_\_\_\_\_ DATE \_\_\_\_\_  
(signature)

RESIDENT \_\_\_\_\_ DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_ DATE \_\_\_\_\_

## COMPETENCIES FOR WOUND CARE ROTATION

Your rotation through the wound care service is designed to provide you with a broad exposure to a variety of wounds of differing etiologies in patients with all types of disease entities and risk factors. You will be presented with the pathophysiologic, diagnostic and therapeutic aspects of an assortment of wound care problems, during the course of your rotation. You will also follow selected outpatients on an ongoing, basis through the wound care clinic under the aegis of various specialists. The wound care outpatient facility is located on the 8th Floor of the Spellman building.

The core of the rotation involves attendance at the clinics. The clinic sessions are mornings and afternoons five days a week. The resident will be present at all of these clinic sessions.

The rotation will allow the resident to experience wound care from various different perspectives. Treatment of foot wounds are seen by the podiatrist in the clinic. Other wound care specialties that attend clinic sessions include general surgery, plastic surgery, vascular surgery, and cardiothoracic surgery. Additionally, there are regular consultations on a daily basis from infectious disease, physical therapist, and an orthotist. This will allow the resident to experience the totality of wound care from various perspectives and allow them to integrate the body of knowledge gained from all of the different specialties into their ability to evaluate, diagnose, and manage wound care wounds which affect the foot.

The resident will be responsible for performing an admitting history and physical on patients who need hospital admission, and will follow those patients while admitted at NY Downtown Hospital. Rounds will be conducted at least twice daily during the week and at least daily on the weekends.

At the conclusion of this rotation, you should be able to:

1. Evaluate the etiology of a lower extremity wound.
2. Identify the risk factors which have allowed this wound to develop and/or progress.
3. Manage various aspects of lower extremity wounds.
4. Determine which patients need immediate hospitalization or can be treated as outpatients.
5. Determine which patients need bracing and/or shoe modification.
6. Determine which patients need urgent surgical intervention.
7. Determine which patients need elective surgical intervention and determine whether or not they are good candidates for these procedures.
8. Determine which procedures are appropriate for the pathology
9. Determine the mechanics of the foot as they affect the etiology of wounds
10. Evaluate the associated medical conditions and risk factors of patients with wounds
11. Determine when patients to safely be taken to the operating theater and formulate an appropriate surgical plan.
12. Gain knowledge in the use of VAC therapy and hyperbaric options

PODIATRIC RESIDENT EVALUATION FORM

**WOUND CARE**

RESIDENT: \_\_\_\_\_

DATE: \_\_\_\_\_

EVALUATOR: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

	5	4	3	2	1	0
1. UNDERSTANDS THE ETIOLOGIC CHARACTERISTICS OF WOUNDS (pathophysiology, epidemiology, etc.)						
2. HAS ABILITY TO MANAGE SUPERFICIAL WOUND AS AN OUTPATIENT						
3. HAS ABILITY TO MANAGE COMPLEX WOUND AS AN OUTPATIENT						
4. HAS ABILITY TO MANAGE WOUNDS AS AN INPATIENT AND DEVELOPS AND IMPLEMENTS AN APPROPRIATE TREATMENT PLAN.						
5. IS ABLE TO DIFFERENTIATE AN IWOUND WHICH REPRESENTS A LOCAL PROBLEM FROM ONE WHICH IS INDICATIVE OF A COMPLEX PROBLEM.						
6. DEMONSTRATE PROFICIENCY IN THE THE USE OF DIFFERT WOUND CARE AGENTS AND DRESSINGS.						
7. UNDERSTANDS THE PRINCIPLES OF WOUND REPAIR.						

COMMENTS:

SIGNATURES:

EVALUATOR \_\_\_\_\_ DATE \_\_\_\_\_  
(signature)

RESIDENT \_\_\_\_\_ DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_ DATE \_\_\_\_\_  
Edwin W. Wolf, DPM

NEW YORK  
DOWNTOWN  
HOSPITAL

**PMSR QUARTERLY EVALUATION FORM**

RESIDENT: \_\_\_\_\_

PGY I II III

QUARTER: 1 2 3 4

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT OBSERVED

<b>CLINICAL PERFORMANCE &amp; CASE MANAGEMENT</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
1. MANAGEMENT OF ROUTINE CASES.						
2. MANAGEMENT OF DIFFICULT CASES.						
3. DETECTION AND DIAGNOSIS OF PATHOLOGY.						
4. UNDERSTANDING OF SYSTEMIC PHARMACOLOGY.						
5. MAKING APPROPRIATE REFERRALS WHEN INDICATED.						
6. WRITING REPORTS/NOTES AND RECORD KEEPING.						
7. APPROACH AND ATTITUDE TOWARDS PATIENTS.						
8. INDEPENDENCE AND FOLLOW THROUGH IN CASE MANAGEMENT.						
9. TECHNICAL APTITUDES.						
<b>INTERPERSONAL SKILLS</b>						
1. COMMUNICATION AND INTERACTION WITH PATIENTS.						
2. COMMUNICATION AND INTERACTION WITH PEERS AND STAFF.						
3. PROFESSIONALISM.						
<b>LEARNING SKILLS</b>						
1. INTEREST AND INDUSTRY; ENTHUSIASM FOR LEARNING.						
2. INTELLECTUAL CURIOSITY; GROWTH IN KNOWLEDGE AND SKILLS.						
3. PARTICIPATION IN EDUCATIONAL ACTIVITIES.						
4. CRITICAL AND ANALYTICAL REASONING.						
5. APPLICATION OF GENERAL FUND OF KNOWLEDGE.						
<b>CORRELATING THE RESIDENT'S EVALUATIONS TO DATE, HOW WOULD YOU RATE THE OVERALL PERFORMANCE OF THE RESIDENT THIS QUARTER COMPARED TO THE PREVIOUS ONE:</b>						
<input type="checkbox"/> SAME AS BEFORE <input type="checkbox"/> BETTER THAN BEFORE <input type="checkbox"/> NOT AS GOOD <input type="checkbox"/> UNSATISFACTORY <input type="checkbox"/> FIRST QUARTER						

COMMENTS:

RESIDENT \_\_\_\_\_

DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

# NEW YORK DOWNTOWN HOSPITAL

## PODIATRIC MEDICAL & SURGICAL RESIDENCY

### EVALUATION OF ROTATION FORM

RESIDENT: \_\_\_\_\_ ROTATION DATE: \_\_\_\_\_

ROTATION: \_\_\_\_\_

USING THE FOLLOWING SCALE, PLEASE RATE THE ROTATION IN TERMS OF THE CRITERIA AS LISTED BELOW:

5 EXCEPTIONAL 4 VERY GOOD 3 AVERAGE 2 BELOW AVERAGE 1 UNSATISFACTORY 0 NOT APPLICABLE

CRITERIA	5	4	3	2	1	0
1. ROTATION MET ITS STATED OBJECTIVES.						
2. ADEQUATE NUMBER AND VARIETY OF PROCEDURES.						
3. ABLE TO ACTIVELY PARTICIPATE IN PROCEDURES.						
4. PROVIDED POSITIVE FEEDBACK AND CONSTRUCTIVE SUGGESTIONS.						
5. WAS GIVEN SUGGESTIONS FOR APPROPRIATE AND CURRENT READING ASSIGNMENTS.						
6. OVERALL RATING OF ROTATION.						

COMMENTS:

SIGNATURES:

RESIDENT \_\_\_\_\_ DATE \_\_\_\_\_

DIRECTOR \_\_\_\_\_ DATE \_\_\_\_\_

# SAMPLE CONTRACT

## **RESIDENT AGREEMENT FOR**

### **PODIATRIC MEDICINE & SURGERY RESIDENCY**

#### **with added credential - reconstructive rearfoot/ankle surgery**

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**AGREEMENT** made as of the 1st day of July, 2012 between New York Downtown Hospital, having its principal location at 170 William Street, New York, New York, 10038-2649 (The "Hospital") and \_\_\_\_\_, DPM. (the "Resident") residing at \_\_\_\_\_

### **IT IS HEREBY AGREED AS FOLLOWS:**

**1. Residency Training Program.**

The Hospital sponsors a 36 month Podiatric Medicine & Surgery Residency (PMSR) with added credential for reconstructive rearfoot/ankle surgery approved by the Council on Medical Education ("CPME").

**2. Resident Appointment.**

(a) The Hospital offers, and the Resident accepts, appointment as a PGY-I Resident in the podiatric medicine & surgery residency (PMSR), for the duration of the academic year: July 1, 2012 through June 30, 2013 at an annual salary of \$\_\_\_\_\_, pursuant to the collective bargaining agreement between New York Downtown Hospital and the New York Downtown Hospital – Committee on Interns and Residents ("the Housestaff Agreement"). There will be a salary adjustment effect April 1, 2013 that will raise the annual salary of a PGY-I resident to \$\_\_\_\_\_ pursuant to the Housestaff Agreement.

(b) The appointment of the Resident is subject to the Resident's successful completion and graduation from a medical school meeting the eligibility criteria established by the CPME as outlined in Section VI. of the New York Downtown Hospital ("NYDH") GME Policies and Procedures Manual, as well as having completed any previous residency training satisfactorily. In addition, the appointment of the

Resident is contingent upon the successful completion of a health assessment, toxicology screening, background investigation and verification of identity and eligibility to be employed in the United States in accordance with the Federal Immigration and Naturalization requirements.

- (c) Resident appointment is dependent on the Resident fulfilling the Program's selection criteria that requires that the Resident has displayed preparedness, ability, aptitude, academic credentials, communications skills, motivation, and integrity.
  
- (d) To the extent not set forth specifically herein, the provisions of the NYDH Administrative Policies and Procedures Manual, the NYDH Graduate Medical Education Policies and Procedures Manual and the Human Resources Policies and Procedures Manual, as then in effect, as well as the Housestaff Agreement, are incorporated by reference herein, as set forth in full in connection with the following matters:
  - 1. Financial support;
  - 2. Vacation policies;
  - 3. Professional liability insurance and coverage for claims filed after completion of program related to residency training at NYDH;
  - 4. Health insurance benefits for the Resident and his/her family to commence on the first date of appointment;
  - 5. The Resident will be provided access to disability insurance coverage for disabilities which may result from activities performed during the residency program training;
  - 6. Leave of absence policies (covering professional, parental and sick leave) and the possible effects on satisfying criteria for program completion and eligibility for the Board Exam;

**3. Resident Responsibilities.**

The Resident is responsible for the satisfactory performance of all duties and responsibilities assigned by the Director of the Residency Program in the podiatric medicine & surgery residency (PMSR) or by any member of the teaching faculty, including the proper discharge of clinical responsibilities, attendance at conferences, and other educational requirements of the teaching program. The Resident shall be required to demonstrate technical aptitude and the requisite degree of knowledge

commensurate with the capabilities generally expected of a PGY-I resident in the field of podiatric medicine & surgery and of those put forth in general competencies outlined by the CPME. The Resident shall comply with all rules, regulations, policies and procedures of the Hospital. In the event that the Program Director determines that the Resident has not performed satisfactorily during the term of this agreement, the Hospital may terminate the Resident's appointment, or to decline to reappoint the Resident for subsequent year(s) of training, consistent with the Housestaff Agreement and CPME guidelines.

**4. Conditions for Reappointment.**

In the event that the Program Director determines that the Resident has not performed satisfactorily during the term of this agreement, same shall permit the Hospital to terminate the Resident's appointment, or to decline to reappoint or promote the Resident for subsequent year(s) of training. If circumstances permit, a letter of intent will be issued by NYDH at least four (4) months prior to the end of the current agreement. However, if a severe occurrence occurs during the last 4 months of the Resident's agreement, a letter of intent may be issued within a reasonable time frame. Upon receipt of written notice or intent of non-renewal or non-promotion, the Resident may implement the Institution's Grievance Procedure and due process as set forth in Section VI of the GME Policies and Procedures Manual.

**5. Professional Activities Outside the Residency Training Program.**

The Resident shall not be permitted to engage in any professional activities (i.e., moonlighting) outside of the Residency Program.

**6. Counseling and Support Services.**

The Hospital will facilitate access to counseling, medical, psychological, and other support services, on a confidential basis, including matters relative to physician impairment. The foregoing are covered in the following policies and procedures of the Hospital: Section IX of the GME Policies and Procedures Manual and the Housestaff Agreement, which are incorporated herein by reference as if fully set forth.

**7. Sexual (or other forms of ) Harassment.**

In addition to those remedies available through Human Resources, any complaints or concerns may be brought to the attention of the Chairman of the Department and/or the Chief Medical Officer ("CMO") for investigation and action, as indicated. In all cases, the Chairman and CMO will ensure that residents are able to raise such issues and have them fairly resolved without fear of intimidation or retaliation. The foregoing are covered in the

policies and procedures of the Hospital: Section IX of the GME Policies and Procedures Manual.

**8. Duty Hours Policies and Procedures.**

The resident agrees to comply with Hospital, CPME and New York State resident duty hours regulations. The foregoing are covered in the policies and procedures of the Hospital: Section XI of the GME Policies and Procedures Manual.

**9. Physical Impairment and Substance Abuse.**

Residents, as employees of New York Downtown Hospital, shall be subject to the rules and regulations regarding employee impairment and substance abuse as put forth in the New York Downtown Hospital Human Resources Policies and Procedures Manual, as then in effect.

**10. Accommodations for Disabilities.**

All reasonable accommodations will be made for persons with disclosed disabilities as put forth in Section IX of the GME Policies and Procedures Manual.

**11. Closure and/or Reduction.**

In the event of Institutional or Residency Program closure and/or reduction, the Hospital will inform the Resident in a timely manner, make every effort to allow the Resident to complete his/her education, and assist the Resident in identifying a Program in which he/she can continue his/her education as put forth in Section XI of the GME Policies and Procedures Manual.

**12. Miscellaneous.**

This Agreement, together with any materials incorporated by reference herein, constitutes the entire understanding between the Hospital and the Resident. This Agreement can be amended only by writing signed by both parties. The Resident shall not withdraw from the residency program without having received prior approval of the Program Director. NYDH nor its GME Programs require Residents to sign a non-competition guarantee.

*Date:* \_\_\_\_\_

\_\_\_\_\_ *DPM*  
Resident

\_\_\_\_\_

**Eli Bryk, M.D.**  
Chairman of Orthopaedic Surgery

\_\_\_\_\_

**Edwin Wolf, DPM.**  
Program Director

\_\_\_\_\_

**Jeffery Menkes**  
President and Chief Executive Officer  
Chief Medical Officer

\_\_\_\_\_

**Steven Friedman, M.D.**  
Senior Vice President for Medical Affairs

**SAMPLE DELINIATION OF PRIVILEGES**

**NEW YORK DOWNTOWN HOSPITAL  
DEPARTMENT OF ORTHOPAEDIC SURGERY  
DIVISION OF PODIATRY-PMSR**

**CREDENTIALING FORM**

**July 1, 2011- June 30, 2012**

**Name** \_\_\_\_\_

**The resident named above is authorized to perform procedures listed on the attached page under the general supervision of the responsible attending.**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Chairman  
Department of Orthopaedic Surgery**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Chief of Podiatry**

**I have hereby reviewed the procedures listed.**

\_\_\_\_\_  
**Resident's signature**

\_\_\_\_\_  
**Date**

Name DPM, PG 2

<b>Procedure</b>	<b>Authorized</b>	<b>Authorized only after consultation with attending</b>	<b>Not authorized</b>
<b>I. EMERGENCY ROOM</b>			
<b>1. Paronychia</b>			
<b>2. Diabetic foot infection</b>			
<b>3. Lacerations/foot trauma</b>			
<b>4. Fracture care</b>			
<b>5. Non-operative management of sprains foot/ankle</b>			
<b>6. Gout/arthritis of foot</b>			
<b>7. Application of casts</b>			
<b>8. Incision and drainage of Abscess</b>			
<b>9. Removal of subcutaneous foreign body</b>			

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**Signature of Chairman  
Department of Orthopaedic Surgery**

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**Signature of Chief of Podiatry**

Name           , D.P.M. PG 2

Procedure	Authorized	Authorized only after consultation with attending	Not Authorized
<b>II. Out-Patient Clinic</b>			
<b>1. Non-operative management of acute and chronic arthritis, bursitis, tendonitis</b>			
<b>2. Steroid injection of trigger points</b>			
<b>3. Application of casts</b>			
<b>4. Suture removal</b>			
<b>5. Cast removal</b>			

\_\_\_\_\_  
**Signature of Chairman**  
**Department of Orthopaedic Surgery**

\_\_\_\_\_  
**Signature of Chief of Podiatry**

Name           , D.P.M., PG 2

Procedure	Authorized	Authorized only after consultation with attending	Not authorized
<b>III. OPERATING ROOM</b>			
<b>1. First assist surgical attending</b>			
<b>2. Perform surgery under direct supervision of surgical attending</b>			

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**Signature of Chairman  
Department of Orthopaedic Surgery**

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**Signature of Chief of Podiatry**

NEW YORK  
DOWNTOWN  
HOSPITAL

**MEMORANDUM**

DATE: June 10, 2012  
TO: All Residents, Podiatry Division; Orthopedics Dept.  
FROM: Edwin Wolf, DPM Director of Podiatric Medical Education  
RE: Biomechanical Exams

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One of the competencies you must become proficient in as a resident involves the performance of a biomechanical exam. The Council on Podiatric Medical education is very specific about what constitutes a biomechanical examination, and it is outlined in Document CPME 320. In short noting that a patient has pes planus and referring them to an orthotist for an orthotic is not sufficient.

Whenever you log a biomechanical exam ( and you need 75 during your PMSR) you must complete the attached Biomechanical Exam form and place it in the patients chart.

It is also a good idea to keep a copy of all your biomechanical exams in a folder (similar to your evaluation folder) in the podiatric medical education office.

Revised 6/12

# NEW YORK DOWNTOWN HOSPITAL

## BIOMECHANICAL EXAM SHEET

PT NAME: \_\_\_\_\_ MR # \_\_\_\_\_ DATE: \_\_\_\_\_ AGE \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HANDED: R L SHOE SIZE/TYPE: \_\_\_\_\_ / \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

LIMB LENGTH:	L	R
ASIS - MM	_____ cm	_____ cm
Umb - MM	_____ cm	_____ cm

HIP ROM: (if appropriate)	L	R
Internal Rotation	_____	_____
External Rotation	_____	_____
Abduction	_____	_____
Adduction	_____	_____
Flexion	_____	_____
Extension	_____	_____
HAMSTRINGS:	_____	_____

MUSCLE TESTING:		Strength
Hip flexors	/5	/5
Hip extensors	/5	/5
Anterior thigh	/5	/5
Posterior thigh	/5	/5
Anterior leg	/5	/5
Posterior leg	/5	/5
Extensors foot	/5	/5
IT Band Syndrome	+ -	+ -

All muscle groups tested and are equal and symmetrical

Spinal assessment:      Straight              Kyphosis              Lordosis              Scoliosis

+ Back hx ? : \_\_\_\_\_

KNEE:			
Genu Varum	B	L	R
Genu Valgum	B	L	R
Genu Recurvatum	B	L	R
Ligaments			
WNL			
Weak			
Chondromalacia	+ -		+ -
Crepitus	+ -		+

TIBIA: R L  
 Varum \_\_\_\_\_  
 Valgum \_\_\_\_\_

ANKLE:  
 Dorsiflexion \_\_\_\_\_  
     Knee extended \_\_\_\_\_  
     Knee flexed \_\_\_\_\_  
 Plantar flexion \_\_\_\_\_

STJ:  
 Inversion \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
 Eversion \_\_\_\_\_ ( ) \_\_\_\_\_ ( )

FOREFOOT:  
 Varus \_\_\_\_\_  
 Supinatus \_\_\_\_\_  
 Valgus \_\_\_\_\_  
 Varus with plantar flexed 1st ray in valgus \_\_\_\_\_  
 Metatarsal primus elevatus \_\_\_\_\_  
 Plantar flexed first ray \_\_\_\_\_

MPJ:	ROM		L			R						
		Dorsiflexion	1	2	3	4	5	1	2	3	4	5
		Plantar flexion	1	2	3	4	5	1	2	3	4	5

GAIT ANALYSIS:  
 Shoulders square WNL \_\_\_\_\_  
 Shoulder tilt + - \_\_\_\_\_  
 Shoulder rotated + - \_\_\_\_\_  
 Arm swing WNL \_\_\_\_\_  
 Back Straight & WNL \_\_\_\_\_  
 Hips WNL  
     + Trendelenburg R L  
     Outflare R L  
     Intoe R L

In toe gait	Out toe gait	Waddle gait	Scissors gait
Knees forward on frontal plane _____			
Abnormal _____			
ANKLE / STJ		WNL _____	
Early H.O.	L	R	
Other _____			

DIAGNOSIS: \_\_\_\_\_

TREATMENT PLAN: \_\_\_\_\_

\_\_\_\_\_  
 Resident

\_\_\_\_\_  
 Attending

**MEMORANDUM**

To: All PMSR Residents  
From: Edwin W. Wolf, DPM – Director of Podiatric Medical Education  
Subject: Consultations  
Date: August 16, 2010

**When the podiatry service receives a request for consultation you must follow the following protocol:**  
Notify the Chief Resident of each/every/any requests for consultations immediately.

The Chief Resident will determine which resident and which attending podiatry staff member will perform the consult.

- If the consult requests a specific attending podiatrist, then that podiatrist **ONLY** must be notified in a reasonable period of time.
- If the consult is for “House” or is not specified, then the Chief resident will determine who the attending will be.

When you are assigned to perform the consultation follow the following steps in order: (This should be within 6 hours of receiving the assignment)

1. Review the chart
2. Review ancillary information (imaging studies, other consults, etc.)
3. Examine the patient but do NOT initiate treatment
4. Form a treatment plan
5. Call the attending assigned to the case and discuss your treatment plan.

CMS requirements demand that all consultations/treatments be performed by the attending podiatrist, or by the resident under direct supervision.

Residents cannot sign consultation forms. You should place a note in the chart, but the consultation must be signed by the attending within 24 hrs of your notifying him/her.

The patient should be followed daily, and seen at least twice a day by the residents.

If the patient is to go to the OR the resident assigned to the case must pre-op the patient, be certain that all is in order and contact the attending of specifics.

*Following this protocol will result in better patient care, a better educational process for you as a resident, and a busier podiatry service at New York Downtown Hospital.*



## MEMORANDUM

To: All PMSR Residents  
From: Edwin W. Wolf, DPM – Director of Podiatric Medical Education  
Subject: Perioperative evaluations  
Date: February 7, 2011

---

One of the reasons you each spend 3 months and medicine and significant amount of time in non-podiatric rotations in the early part of your residency is so that you will be confident and competent to evaluate whether your patients need "medical clearance" before surgery. As an example: It is NOT appropriate to send otherwise healthy 25 y.o. patients scheduled for elective bunionectomies for extensive expensive preoperative workups.

Attached please find the NYD criteria to determine what, if any, tests need be done preoperatively. I expect each of you to do H&P's on your patients preoperatively, and then decide which, if any, preop labs, consultations, or other tests are necessary before taking the patient to the OR. Please review all three of these forms and use them appropriately. They are in Word format so you can add YOUR name and contact numbers as well, so you can be contacted by patients, scheduling, anesthesia, etc. should there be any questions regarding house cases.

**PREOPERATIVE TEST ORDER SHEET**

<b>Patient Name:</b>	<b>Last,</b>	<b>First,</b>	<b>Age</b>	<b>Scheduled Date of Procedure</b>
<b>Patient Address:</b>	<b>Pt. Home Phone:</b>		<b>Pt. Work Phone:</b>	<b>Pt. Cell Phone</b>
<b>City and State</b>	<b>Zip Code</b>	<b>Physicians Name:</b>		<b>Physicians Phone #:</b>
			<b>Edwin Wolf, DPM</b>	<b>(212) 874-0564</b>

**INSTRUCTIONS:**

Preoperative testing is required on all patients scheduled for general, regional, or monitored anesthesia care. The hospital requires the following tests to be completed and reports submitted at least 48 hrs in advance of the procedure. (Fax #: (212) 312-5242). Please check the appropriate test.

<b>Type of Anesthesia</b>	<b>Test</b>	<input checked="" type="checkbox"/> <b>If requested</b>	<b>Initial when completed</b>
Nerve Block or IV sedation (M.A.C.)  (within 6 months)	CBC age > 65	_____	_____
	EKG age > 65	_____	_____
	Chem -7 age > 74	_____	_____
General or Regional (ie: spinal/epidural/axillary)  (within 1 month)	CBC all women , males age > 50	_____	_____
	EKG age > 40	_____	_____
	Chem -7 age > 65	_____	_____
	CXR age > 74	_____	_____

**Additional tests requested by attending physician**

<b>Test</b>	<b>Suggested for</b>	<input checked="" type="checkbox"/> <b>If requested</b>	<b>Initial when completed</b>
CBC	Procedures with blood loss, cardiac or renal disease, anemia malignancy, smoking > 20 pack years, bleeding disorder		
Chem - 7	Renal disease, diabetes, CNS disease, use of diuretics, digoxin or steroids		
PT/PTT	Hepatic disease, bleeding disorder, use of anticoagulants, history of malignancy		
Liver Function tests	Hepatic disease, exposure to hepatitis, alcohol abuse, history of malignancy		
Chest X Ray	Smoking > 20 pack years, cardiac disease, COPD, history of malignancy		
EKG	Cardiovascular disease, COPD		
Pregnancy Test	Woman who could be pregnant		
Rh status	Woman who are pregnant		
Type and screen/Cross	Procedures with the potential for blood loss or transfusion		
Other Tests			

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

COMMENTS \_\_\_\_\_

Blood Drawn By: \_\_\_\_\_ Date/Time \_\_\_\_\_ Preoperative patient

Instructions Initiated By: \_\_\_\_\_

NEW YORK  
DOWNTOWN  
HOSPITAL

**Instructions for Out-patient Surgery**

**Failure to comply with the below instructions could result in cancellation of your procedure**

- Due to last minute changes, you must be available all day the day of your procedure should there be a need to contact you to arrive early for your procedure.
- Please arrive at the hospital 2 hours before time of surgery. Please report to the 1<sup>st</sup> floor admitting for registration—then you will be escorted to the 2<sup>nd</sup> floor pre-op waiting area (Room 207)

- Your surgery is scheduled for: Date \_\_\_\_\_; Time \_\_\_\_\_

- The procedure(s) scheduled is (are): \_\_\_\_\_

---

- Notify our office immediately of any changes in your physical condition such as fever, a cold, an infection, or exposure to a contagious disease.
- Stop taking the following medications 5 days before surgery unless you specifically instructed to continue: Plavix, aspirin, or anti-inflammatory medications (NO ibuprofen, NO herbs, and NO Vitamin E). Tylenol is OK.
- Please take the following medications with one sip of water on the morning of procedure:  
\_\_\_\_\_
- Eat a light meal the evening prior to your procedure
- **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE EVENING BEFORE YOUR PROCEDURE** (except for the sip of water needed to take the above approved medications)
- NY Downtown Hospital is not responsible for jewelry, money or other valuables. Please leave them at home. Please remove all body piercing jewelry and leave them at home.
- You will not be able to wear your contact lenses during your procedure. If contact lenses, eyeglasses, or dentures are brought to the hospital, please bring a container to protect them during the procedure.
- You must be accompanied by a responsible adult when you leave the hospital.
- Please bring a list of all medications and their dosages on the day of surgery.
- If you have further questions, please call our office (212)874-0564.

**Again, please arrive 2 hours prior to surgery**

NEW YORK

DOWNTOWN

HOSPITAL

**PREOPERATIVE ANESTHESIA QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Surgeon's Name: Edwin Wolf, DPM Date of Procedure: \_\_\_\_\_

- 1 What kind of operation are you going to have?  
\_\_\_\_\_
- 2 What kind of anesthesia was discussed with your surgeon?  
\_\_\_\_\_ General \_\_\_\_\_ Local anesthesia with sedation  
\_\_\_\_\_ Spinal or Epidural \_\_\_\_\_ Don't know  
\_\_\_\_\_ Nerve Block
- 3 What medications, if any, are you allergic to? \_\_\_\_\_
- 4 What medications and dosages are you currently taking? \_\_\_\_\_  
\_\_\_\_\_
- 5 Have you ever been hospitalized? If so, for what? \_\_\_\_\_

*Please answer YES or NO to the following questions:* **YES** **NO**

- 6 Is there any possibility that you can be pregnant? \_\_\_\_\_
- Do you have a history of: \_\_\_\_\_
- 7 Heart disease, heart failure, angina or chest pain? \_\_\_\_\_
- 8 Heart attack or myocardial infarction? \_\_\_\_\_
- 9 Palpitations, irregular heart rhythm or a heart murmur? \_\_\_\_\_
- 10 Mitral valve prolapsed or valvular heart disease? \_\_\_\_\_
- 11 Shortness of breath? \_\_\_\_\_
- 12 Asthma, emphysema, or bronchitis? \_\_\_\_\_
- 13 Cigarette smoking? If yes; how much? \_\_\_\_\_
- 14 Pneumonia? \_\_\_\_\_
- 15 Coughing? \_\_\_\_\_
- 16 Coughing up blood or sputum? \_\_\_\_\_
- 17 Recent cold, fever or chills? \_\_\_\_\_
- 18 Excessive bleeding of gums with tooth brushing? \_\_\_\_\_
- 19 Abnormal bleeding in yourself or in a family member? \_\_\_\_\_
- 20 High blood pressure? \_\_\_\_\_
- 21 High blood sugar or Diabetes? \_\_\_\_\_
- 22 Epilepsy or seizures? \_\_\_\_\_
- 23 Hepatitis, jaundice or liver disease? \_\_\_\_\_
- 24 Blood transfusion? \_\_\_\_\_
- 25 Kidney disease? \_\_\_\_\_
- 26 A reaction to anesthesia in yourself or in a family member? \_\_\_\_\_
- 27 Problems moving the jaw or the neck? \_\_\_\_\_
- 28 Stomach ulcer, gastrointestinal bleeding? \_\_\_\_\_
- 29 Thyroid disease? \_\_\_\_\_
- 30 Other illness? If yes; please explain \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# **PODIATRIC MEDICAL & SURGICAL –36 / 36 MONTH ORIENTATION MANUAL**

(Last Revision Date: 6/2011)

Approved by:

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Edwin W. Wolf, D.P.M.  
Director of Podiatric Medical Education

I have read the Podiatric Medicine & Surgical Resident Orientation Manual. My signature below verifies that I am familiar and compliant with the rules, regulations, policies and procedures of the Department of Podiatric Medical Education.

---

Resident Signature

---

Date

Please sign, date and return this page to the Office of Medical Education.

# CPME 320

## Council on Podiatric Medical Education

### CPME.320 - 2011

Council on Podiatric Medical Education  
9312 Old Georgetown Road  
Bethesda, Maryland 20814-1621  
(301) 581-9200FAX  
(301) 571-4903

[www.APMA.ORG/CPME](http://www.APMA.ORG/CPME)

# **STANDARDS AND REQUIREMENTS FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES**

## **COUNCIL ON PODIATRIC MEDICAL EDUCATION**

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# INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency programs that are conducted under the sponsorship of healthcare institutions. Residencies afford these individuals structured learning experiences in patient management along with training in the diagnosis and care of podiatric pathology. The individuals involved in these training programs are referred to as “residents” and are recognized as such by the institutions sponsoring the programs.

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council’s approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of doctoral education, postdoctoral education, certification, and continuing education. By confirming that these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council has been authorized by the APMA to approve institutions that sponsor residency programs that demonstrate and maintain compliance with the standards and requirements in this publication. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council.

Standards and requirements in this publication are divided into institutional standards and requirements and program standards and requirements. Standard 6.0 and the associated requirements were developed as a collaborative effort of the Council on Podiatric Medical Education, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), and the American Board of Podiatric Surgery (ABPS).

Under no circumstances may the standards and requirements for approval by the Council supersede federal or state law.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council’s community of interest may be affected.

The Council formulates and adopts its own approval procedures. These procedures are stated in CPME 330, *Procedures for Approval of Podiatric Residencies*. This document, as well as CPME 320, may be obtained on the Council’s website at [www.cpme.org](http://www.cpme.org) or by contacting the Council office.

## ABOUT THIS DOCUMENT

This publication describes the standards and requirements for approval of podiatric residency programs. The standards and requirements, along with the procedures for approval, serve as the basis for evaluating the quality of the educational program offered by a sponsoring institution and holding the institution and program accountable to the educational community, podiatric medical profession, and the public.

The **standards** for approval of residency programs serve to evaluate the quality of education. These standards are broad statements that embrace areas of expected performance on the part of the sponsoring institution and the residency program. Compliance with the standards ensures good educational practice in the field of podiatric medicine and thus enables the Council to grant or extend approval.

Related to each standard is a series of specific **requirements**. Compliance with the requirements provides an indication of whether the broader educational standard has been satisfied. During an on-site evaluation of a residency program, the evaluation team gathers detailed information about whether these requirements have been satisfied. Based upon the extent to which the requirements have been satisfied, the Council determines the compliance of the sponsoring institution and the residency program with each standard. In the requirements, the verb “shall” is used to indicate conditions that are imperative to demonstrate compliance.

The **guidelines** are explanatory materials for the requirements. Guidelines are used to indicate how the requirements either must be interpreted or may be interpreted to allow for flexibility, yet remain within a consistent framework. The following terms are used within the guidelines:

- The verbs “must” and “is” indicate how a requirement is to be interpreted, without fail. The approval status of a residency program is at risk if noncompliance with a “must” or an “is” is identified. The verb “should” indicates a desirable, but not mandatory, condition.
- The verb “may” is used to express freedom or liberty to follow an alternative.

Throughout this publication, the use of the terms “institution” and “program” is premised on the idea that the program exists within and is sponsored by an institution.

The terms “college” and “school” are used interchangeably throughout this document.

# GLOSSARY

**The Council strongly encourages sponsoring institutions and program directors to become familiar with the following definitions to ensure complete understanding of this publication.**

## **Academic Health Center**

Academic health centers bring together programs of instruction and research in the health sciences and the delivery of health services. The Association of Academic Health Centers (AAHC) defines an academic health center as consisting of an allopathic or osteopathic school of medicine, at least one other health professions school or program, and one or more teaching hospitals, health systems, or other organized health care services. The AAHC also notes that the organization and structure of these institutions may vary. Academic health centers function either as component units of public or private universities, of state university systems, or as free-standing institutions.

## **Accreditation**

Accreditation is the recognition of institutional or program compliance with standards established by the Council on Podiatric Medical Education, based on evaluation of the institution's own stated objectives. Accreditation is a voluntary process of peer review. The Council is responsible for accrediting colleges of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

## **Affiliated Training Site**

An affiliated training site is an institution or facility that provides a rotation(s) for residents. Examples of sites include: a college of podiatric medicine, a teaching hospital including its ambulatory clinics and related facilities, a private medical practice or group practice, a skilled nursing facility, a federally qualified health center, a public health agency, an organized health care delivery system, or a health maintenance organization (clinical facility).

## **American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)**

ABPOPPM is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric medicine and orthopedics. ABPOPPM maintains one certification pathway leading to certification in podiatric orthopedics and primary podiatric medicine.

## **American Board of Podiatric Surgery (ABPS)**

ABPS is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric surgery. ABPS maintains two certification pathways: foot surgery and reconstructive rearfoot/ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot/ankle status.

### **Approval**

Approval is the recognition of a podiatric residency program, podiatric fellowship program, or sponsor of continuing education that has attained compliance with standards established by the Council on Podiatric Medical Education. Approval is a program-specific form of accreditation.

## **Centralized Application Service for Podiatric Residencies (CASPR)**

CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to podiatric residency programs approved by the Council. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

### **Certification**

Certification is a process to provide assurance to the public that a podiatric physician has successfully completed an approved residency and an evaluation, including an examination process designed to assess the knowledge, experience, and skills requisite to the provision of high quality care in a particular specialty.

## **Collaborative Residency Evaluator Committee (CREC)**

CREC is an effort of ABPOPPM, ABPS, and the Council to improve the methods by which residency evaluators and team chairs are selected, trained, assessed, remediated, and dismissed. The composition of the Committee includes three individuals from each organization, one of whom must be the executive director or that individual's designee, who must be an employee of the organization represented.

### **Competencies**

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. ABPOPPM and ABPS have identified competencies related to certification pathways.

## **Council of Teaching Hospitals (COTH)**

COTH is a membership organization comprised of institutions sponsoring Council-approved podiatric residency programs (including programs holding provisional and probationary approval). The goals of COTH include fostering excellence in residency training, promoting a code of ethics, developing policy, and serving as a forum for the exchange of ideas on residency education. COTH is a component of the American Association of Colleges of Podiatric Medicine (AACPM). The Council on Podiatric Medical Education and the RRC encourage sponsoring institutions to participate in COTH.

## **Curriculum**

The curriculum is the residency program's unique organization and utilization of its clinical and didactic training resources to assure that the resident achieves the competencies identified by the Council and is prepared to enter clinical practice upon completion of the residency.

## **Due Process**

Due process is a defined procedure established by the sponsoring institution that is utilized whenever any adverse action is proposed or taken against a resident. All parties to a residency program are protected when there is a reasonable opportunity provided to present pertinent facts.

## **External Assessments**

External assessments are standardized evaluations of residents that are monitored and/or delivered by organizations external to the residency program for the purpose of validating the resident's experiences and development. An example is an annual in-training examination conducted by a specialty board.

## **Healthcare Institution**

A healthcare institution is an organization or corporation (such as a hospital or academic health center) established under the control and direction of a governing board. The mission of such an institution includes the evaluation, diagnosis, and treatment of disease and injury. Private individuals and/or groups of private individuals are not viewed to be healthcare institutions.

## **Hospital**

A hospital is an institution that provides diagnosis and treatment of a variety of medical conditions in inpatient and outpatient settings. The institution may provide training in the many special professional, technical, and economic fields essential to the discharge of its proper functions.

## **Internal Assessments**

Internal assessments are those evaluations of residents that are conducted within the residency program by faculty, staff, peers, and patients for the purpose of validating the serial acquisition of necessary knowledge, attitudes, and skills by the residents. Knowledge, attitudes, and skills should be evaluated separately. Knowledge may be assessed with internal modular testlets. Attitudes may be assessed with an attitudinal assessment form. Skills may be assessed by utilizing a standardized technical skills assessment form and observing a particular skill set.

## **In-training Examination**

Administered by the specialty board, the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification by the specialty board.

## **Joint Committee on the Recognition of Specialty Boards (JCRSB)**

The JCRSB is a committee established by the Council on Podiatric Medical Education on behalf of the podiatric medical profession to recognize specialty boards. The recognition of a specialty board by the JCRSB serves to provide important information to the podiatric medical profession, healthcare institutions, and the public about the sound operations and fair conduct of the board's certification process. The Council and JCRSB are committed to a process that assures the public that those podiatric physicians who are certified have successfully completed the requirements for certification in an area of specialization. The Council's authority for the recognition of specialty boards through the JCRSB is derived solely from the House of Delegates of the American Podiatric Medical Association. The JCRSB recognizes the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and the American Board of Podiatric Surgery.

## **Podiatric Medicine and Surgery**

Podiatric medicine and surgery is the profession and medical specialty that includes the study, prevention, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.

## **Residency**

A residency is a postgraduate educational program conducted under the sponsorship of a hospital or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges of podiatric medicine through clinical and didactic experiences.

A residency program is based on the resource-based, competency-driven, assessment-validated model of training:

- Resource-based implies that the program director constructs the residency program based upon the resources that are available. While the Council recognizes that available

resources may differ among institutions, the program director is responsible for determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.

- Competency-driven implies that the program director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the sponsoring institution as having successfully completed the residency program.
- Assessment-validated implies that the serial acquisition and final achievement of the competencies are validated by assessments of the resident's knowledge, attitudes, and skills. To provide the most effective validation, assessment is conducted both internally (within the Residency Review Committee (RRC) organizations).

The RRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in and reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

Composition of the RRC includes two representatives each from ABPOPPM and ABPS, one representative from COTH, one representative from residency programs at large (selected by the Council), and at least two Council members.

Although the RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of the RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the RRC.

## **Training Resources**

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medicine and surgery subspecialties.

## **STANDARDS FOR APPROVAL OF PODIATRIC RESIDENCY PROGRAMS**

The following standards pertain to all residency programs for which initial or continuing approval is sought. The standards encompass essential elements including sponsorship, administration, program development, clinical expectations, and assessment.

### **INSTITUTIONAL STANDARDS:**

*1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a healthcare institution that develops, implements, and monitors the residency program.*

*2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.*

*3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.*

*4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.*

### **PROGRAM STANDARDS:**

*5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.*

*6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medicine and surgery management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.*

*7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.*

# INSTITUTIONAL STANDARDS AND REQUIREMENTS

***1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a healthcare institution that develops, implements, and monitors the residency program.***

**1.1 The sponsor shall be a hospital or academic health center. Hospital facilities shall be provided under the auspices of the sponsoring institution or through an affiliation with an accredited institution(s) where the affiliation is specific to residency training.**

A college of podiatric medicine may co-sponsor a residency with a hospital and/or academic health center but cannot be the sole sponsor of the program. A surgery center may co-sponsor a residency with a hospital and/or academic health center but cannot be the sole sponsor of the program.

Institutions that co-sponsor a residency program must define their relationship to each other to delineate the extent to which financial, administrative, and teaching resources are to be shared. The document defining the relationship between the co-sponsoring institutions and the resident contracts must describe arrangements established for the residency program and the resident in the event of dissolution of the co-sponsorship.

**1.2 The healthcare institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission, the American Osteopathic Association, or a healthcare agency approved by the Centers for Medicare and Medicaid Services.**

**1.3 The sponsoring institution shall formalize arrangements with each training site by means of a written agreement that defines clearly the roles and responsibilities of each institution and/or facility involved.**

When training is provided at an affiliated training site, the participating institutions must:

- Indicate their respective training commitments through an affiliation agreement that is reaffirmed at least once every five years.

This document must:

- Acknowledge the affiliation and delineate financial support (including resident liability) and educational contributions of each training site.
- Be signed and dated by the chief administrative officer or designee of each participating institution or facility.

- Be forwarded to the program director.

If the program director does not participate actively at the affiliated institution or facility, or if a significant portion of the program is conducted at the affiliated institution or facility, a site coordinator must be designated formally to ensure appropriate conduct of the program at this training site. The site coordinator must hold a staff appointment at the affiliated site and be a faculty member actively involved in the program at the affiliated institution or facility. Written confirmation of this appointment must include the signatures of the program director and the site coordinator.

The entirety of training experiences provided at sites located beyond daily commuting distance from the sponsoring institution and/or co-sponsor must not exceed one-sixth of the residency. Training provided abroad may not be counted toward the requirements of any training resource.

## ***2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.***

### **2.1 The sponsoring institution shall ensure that the physical facilities, equipment, and resources of the primary and affiliated training site(s) are sufficient to permit achievement of the stated competencies of the residency program.**

The physical plant must be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources, and a health information management system must be available for resident training.

The sponsoring institution must have been in operation for at least 12 months before submitting an application for approval to assure that sufficient resources are available for the residency program. The institution should have had an active podiatric service for at least 12 months prior to submitting an application for approval.

### **2.2 The sponsoring institution shall afford the resident ready access to adequate library resources, including a diverse collection of current podiatric and non-podiatric medical texts and other pertinent reference resources (i.e., journals and audiovisual materials/instructional media).**

Library resources should be located on site or within close geographic proximity to the institution(s) at which the resident is afforded training. Library services must include the electronic retrieval of information from medical databases.

### **2.3 The sponsoring institution shall afford the resident ready access to adequate information technologies and resources.**

**2.4 The sponsoring institution shall afford the resident ready access to adequate office and study spaces at the institution(s) in which residency training is primarily conducted.**

**2.5 The sponsoring institution shall provide designated support staff to ensure efficient administration of the residency program.**

The institution must ensure that neither the program director nor the resident assumes the responsibility of clerical personnel. The institution must ensure that the resident does not assume the responsibilities of nurses, podiatric medical assistants, or operating room or laboratory technicians.

***3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.***

**3.1 The sponsoring institution shall utilize a residency selection committee to interview and select prospective resident(s). The committee shall include the program director and individuals who are active in the residency program.**

**3.2 The sponsoring institution shall conduct its process of interviewing and selecting residents equitably and in an ethical manner.**

The sponsoring institution must inform the prospective resident in writing of the selection process and conditions of appointment established for the program.

Interviews must not occur prior to, or be in conflict with, interview dates established by the national resident application matching service with which the residency program participates. The sponsoring institution must make the residency curriculum available to the prospective resident.

**3.3 The sponsoring institution shall participate in a national resident application matching service. The sponsoring institution shall not obtain a binding commitment from the prospective resident prior to the date established by the national resident matching service in which the institution participates.**

**3.4 Application fees, if required, shall be paid to the sponsoring institution and shall be used only to recover costs associated with processing the application and conducting the interview process.**

The sponsoring institution must publish its policies regarding application fees (i.e., amount, due date, uses, and refunds).

**3.5 The sponsoring institution shall inform all applicants as to the completeness of the application as well as the final disposition of the application (acceptance or denial).**

**3.6 The sponsoring institution shall accept only graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed the Parts I and II examinations of the National Board of Podiatric Medical Examiners.**

**3.7 The sponsoring institution shall ensure that the resident is compensated equitably with and enjoys the same rights and privileges as other residents at the institution.**

If the sponsoring institution does not offer other residency programs, then the resident must be compensated equitably with other residents in the geographic area.

The stipend offered by the institution is determined as an annual salary. The amount of resident compensation must not be contingent on the productivity of the individual resident.

The resident cannot be hired as an independent contractor; rather, the resident must be an employee of the institution.

The sponsoring institution should disclose annually to the program director the current amounts of direct and indirect graduate medical education reimbursement received by the sponsoring institution.

**3.8 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall state whether the reconstructive rearfoot/ankle credential is being offered and the amount of the resident stipend. The contract or letter shall be signed and dated by the chief administrative officer of the institution or appropriate senior administrative officer, the program director, and the resident.**

When a letter of appointment is utilized, a written confirmation of acceptance must be executed by the prospective resident and forwarded to the chief administrative officer or appropriate senior administrative officer. In the case of a co-sponsored program, the contract or letter of appointment must be signed and dated by the chief administrative officer of each co-sponsoring institution, the program director, and the resident.

Programs that exceed 36 months of training must state the extended program length in the contract.

**3.9 The sponsoring institution shall include or reference the following items in the contract or letter of appointment:**

- of work.

The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident's ability to function in the training program.

**b. duration of the agreement.**

**c. health insurance benefits.**

The sponsoring institution must provide health insurance for the resident for the duration of the training program. The resident's health insurance must be at least equivalent to that afforded other entry-level professional employees at the sponsoring institution.

**d. professional, family, and sick leave benefits.**

The resident's leave benefits must be at least equivalent to those afforded other entry-level professional employees at the sponsoring institution.

**e. leave of absence.**

The sponsoring institution must establish a policy pertaining to leave of absence or other interruption of the resident's designated training period. In accordance with applicable laws, the policy must address continuation of pay and benefits and the effect of the leave of absence on meeting the requirements for completion of the residency program.

**f. professional liability insurance coverage.**

The sponsoring institution must provide professional liability insurance for the resident that is effective when training commences and continues for the duration of the training program. This insurance must cover all rotations at all training sites and must provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution must provide the resident with proof of coverage upon request.

**g. other benefits if provided (e.g., meals, uniforms, vacation policy, housing provisions, payment of dues for membership in national, state, and local professional organizations, and disability insurance benefits).**

**3.10 The sponsoring institution shall develop a residency manual to include, but not be limited to the policies and mechanisms affecting the resident, rules and regulations, curriculum, training schedule, assessments, didactic activities schedule, and journal review schedule.**

The sponsoring institution must ensure that the residency manual is distributed to and acknowledged in writing by the resident at the beginning of the program and following any revisions. The manual must be distributed at the beginning of the training year to the faculty and administrative staff involved in the residency.

The manual may be in written or electronic format. The manual must include CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies* and 330, *Procedures for Approval of Podiatric Medicine and Surgery Residencies*.

**3.11 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements. The certificate shall identify the program as a Podiatric Medicine and Surgery Residency and shall state the date of completion of the resident's training.**

The certificate must include the statement "Approved by the Council on Podiatric Medical Education." The certificate must, at minimum, be signed and dated by the program director and the chief administrative officer, or designee. In the case of a co-sponsored program, the certificate must be signed and dated by the chief administrative officer of each co-sponsoring institution and the program director.

If applicable, the certificate also verifies successful completion of training requirements for the added reconstructive rearfoot/ankle credential. The certificate would identify the added credential as "Reconstructive Rearfoot/Ankle Surgery." At its discretion, the sponsoring institution may instead issue an additional certificate verifying successful completion of training requirements for the added credential. The second certificate must include the signatures of the program director and the chief administrative officer, or designee and the date of completion, and identify the added credential as "Reconstructive Rearfoot/Ankle Surgery." The additional certificate also must include the statement "Approved by the Council on Podiatric Medical Education."

**3.12 The sponsoring institution shall ensure that the residency program is established and conducted in an ethical manner.**

The conduct of the residency program must focus upon the educational development of the resident rather than on service responsibility to individual faculty members.

**3.13 The sponsoring institution shall ensure that the following written policies and mechanisms are included in the residency manual:**

**a. the mechanism of appeal.**

The sponsoring institution must establish a written mechanism of appeal that ensures due process for the resident and the sponsoring institution, should there

be a dispute between the parties. Any individual possessing a conflict of interest related to the dispute, including the program director, must be excluded from all levels of the appeal process.

- b. the remediation methods established to address instances of unsatisfactory resident performance.** The sponsoring institution must establish and delineate remediation methods to address instances of unsatisfactory resident performance (academic and/or attitudinal) and that identify the time frame allowed for remediation. Remediation methods may include, but not be limited to, requiring that the resident repeat particular training experiences, spend additional hours in a clinic, or complete additional assigned reading to facilitate achievement of the stated competencies of the curriculum. Remediation should be completed no later than three months beyond the normal length of the residency program.
- c. the rules and regulations for the conduct of the resident.**

***4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.***

**4.1 The sponsoring institution shall report annually to the Council office on institutional data, residents completing training, residents selected for training, changes in the curriculum, and other information requested by the Council and/or the Residency Review Committee.**

**4.2 The sponsoring institution shall inform the Council office in writing within 30 calendar days of substantive changes in the program.**

The sponsoring institution must inform the Council of changes in areas including, but not limited to, sponsorship, affiliated training sites, appointment of a new program director, curriculum, a significant increase or decrease in faculty, and resident transfer.

**4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, and current and incoming residents informing them of adverse actions or voluntary termination of the program. Program applicants shall be notified prior to the interview.**

The institution must submit either the program applicants' and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicants' and the current and incoming residents' receipt of the institution's letter (i.e., signed copies of return receipts for certified mail). These materials must be received in the Council office within 50

calendar days of the program director's receipt of the letter informing the institution of the action taken by the Review Committee or the Council.

Adverse actions include denial of eligibility for initial on-site evaluation, probation, administrative probation, withholding of provisional approval, withdrawal of approval, and denial of an increase in positions. Programs are strongly encouraged to notify program applicants and/or incoming residents of denial of eligibility for initial on-site evaluation.

# PROGRAM STANDARDS AND REQUIREMENTS

## ***5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.***

**5.1 The sponsoring institution shall designate one podiatric physician as program director to serve as administrator of the residency program. The program director shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.**

The sponsoring institution must provide compensation to the program director. This compensation must be commensurate with that provided other residency directors at the institution. If the sponsoring institution does not offer other residency programs, then the program director must be compensated equitably with other program directors in the geographic area.

The program director must be a member of the medical staff of the sponsoring institution, or in the case of a co-sponsorship, at one of the sponsoring institutions. The program director must be a member of the graduate medical education committee or equivalent within the institution. The program director should be a member of national, state and/or local professional organization(s).

Because of the potential of creating confusion in the leadership and direction of the program, co-directorship is specifically prohibited; however, the program director may appoint an assistant director to assist in administration of the residency program. A residency training committee also may be established to assist the program director in the administration of the residency program.

The sponsoring institution must provide an orientation when the program director is new to this position. A consultant may be utilized to present or participate in this orientation.

Co-sponsoring institutions must designate one program director responsible for the entire co-sponsored residency. This individual must be provided the authority and have the ability to oversee resident training at all sites.

**5.2 The program director shall possess appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and achieving the stated competencies of the residency.**

The program director should be certified in the specialty area(s) by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and/or the American Board of Podiatric Surgery.

**5.3 The program director shall be responsible for the administration of the residency in all participating institutions. The program director shall be able to devote sufficient time to fulfill the responsibilities required of the position. The program director shall ensure that each resident receives equitable training experiences.**

The director is responsible for maintenance of records related to the educational program, communication with the Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. In a co-sponsored program, the director is responsible for ensuring that the Council is provided requested information for all residents at all training sites, not just at one of the co-sponsoring sites (e.g., the institution at which the director is based).

The director must not delegate to the resident maintenance of records related to the educational program, communication with the Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

The director must ensure resident participation in training resources and didactic experiences (e.g., lectures, journal review sessions, conferences, and seminars).

**5.4 The program director shall participate at least annually in faculty development activities (i.e., administrative, organizational, teaching, and/or research skills for residency programs).**

The faculty development activities should be approved as continuing education programs by the Council on Podiatric Medical Education or another appropriate agency. Formal faculty development programs provided by teaching hospitals and colleges that do not offer continuing education activities also will be acceptable if appropriate documentation is provided of the program's nature, duration, and attendance.

**5.5 The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident.**

The complement of faculty relates to the number of residents, institutional type and size, organization and capabilities of the services through which the resident rotates, and training experiences offered outside the sponsoring institution.

Faculty members must take an active role in the presentation of lectures, conferences, journal review sessions, and other didactic activities. Faculty members must supervise and evaluate the resident in clinical sessions and assume

responsibility for the quality of care provided by the resident during the clinical sessions that they supervise. Faculty members must discuss patient evaluation, treatment planning, patient management, complications, and outcomes with the resident and review records of patients assigned to the resident to ensure the accuracy and completeness of these records.

**5.6 Podiatric and non-podiatric medical faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible.**

The active podiatric faculty must include sufficient representation by individuals certified by each board recognized by the Joint Committee on the Recognition of Specialty Boards, or by individuals possessing other specialized qualifications acceptable to the Residency Review Committee.

Podiatric faculty should participate in faculty development activities to improve teaching, research, and evaluation skills.

***6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medicine and surgery management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.***

The resident must be afforded training in the breadth of podiatric healthcare. Completion of a podiatric residency leads to the following certification pathways -- the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and foot surgery of the American Board of Podiatric Surgery (ABPS).

Completion of a podiatric residency with the added credential in Reconstructive Rearfoot/Ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of the ABPS.

All required curricular elements must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. Programs that extend the residency beyond 36 months must present a clear educational rationale consistent with program requirements. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee prior to implementation and at each subsequent approval review of the program.

The Council and the RRC view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

▪ Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.

▪ Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medicine and surgery evaluation and management.

▪ Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medicine and surgery evaluation and management.

**6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.**

The curriculum must be distributed at the beginning of the training year to all individuals involved in the training program including residents and faculty.

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

**A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.**

1. Perform and interpret the findings of a thorough problem-focused history and physical exam, including problem-focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis.

2. Formulate an appropriate diagnosis and/or differential diagnosis.

3. Perform (and/or order) and interpret appropriate diagnostic studies, including:

- Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and microbiology include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis.

- Pathology, including anatomic and cellular pathology.
- Other diagnostic studies, including electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies.

4. Formulate and implement an appropriate plan of management, including:

- Direct participation of the resident in the evaluation and management of patients in a clinic/office setting.
  - Perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
- Management when indicated, including
  - dermatologic conditions.
  - manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
  - closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation.
  - cast management.
  - tape immobilization.
  - orthotic, brace, prosthetic, and custom shoe management.
  - footwear and padding.
  - injections and aspirations.
  - physical therapy.
  - pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications.
  - evaluating, diagnosing, selecting appropriate treatment and avoiding complications.
- Surgical management when indicated, including
  - progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, the following: Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, Reconstructive Rearfoot/Ankle Surgery (added credential only), Other Procedures (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
- Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia.
- Consultation and/or referrals.
- Lower extremity health promotion and education.

5. Assess the treatment plan and revise it as necessary.
  - Direct participation of the resident in urgent and emergent evaluation and management of podiatric and non-podiatric patients.

**B. Assess and manage the patient's general medicine and surgery status.**

1. Perform and interpret the findings of comprehensive medical history and physical examinations (including pre-operative history and physical examination), including (see Appendix A):
  - Comprehensive medical history.
  - Comprehensive physical examination.
    - vital signs.
    - physical examination including head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination.
2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).
3. Recognize the need for (and/or order) additional diagnostic studies, when indicated, including (see also section A.3 for diagnostic studies not repeated in this section).
  - EKG.
  - Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound.
  - Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis.
  - Other diagnostic studies.
4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.
5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.
6. Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to:
  - Understanding management of preoperative and postoperative surgical patients with emphasis on complications.

- Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
- Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.

7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:

- Local anesthesia.
- General, spinal, epidural, regional, and conscious sedation anesthesia.

8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.

9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training opportunities:

- Recognizing and diagnosing common infective organisms.
- Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring.
- Exposure to local and systemic infected wound care.

10. Participate actively in a behavioral science rotation that includes, but is not limited to:

- Understanding of psychosocial aspects of health care delivery.
- Knowledge of and experience in effective patient-physician communication skills.
- Understanding cultural, ethnic and socioeconomic diversity of patients.
- Knowledge of the implications of prevention and wellness.

**C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion**

1. Understand and abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

2. Practice and abide by the principles of informed consent.

3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

4. Demonstrate professional humanistic qualities.

5. Demonstrate ability to formulate a methodical and comprehensive treatment plan

**D. Communicate effectively and function in a multi-disciplinary setting.**

1. Communicate in oral and written form with patients, colleagues, payors, and the public.
2. Maintain appropriate medical records.

**E. Manage individuals and populations in a variety of socioeconomic and healthcare settings.**

1. Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

**F. Understand podiatric practice management in a multitude of healthcare delivery settings.**

1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand healthcare reimbursement.
3. Understand insurance issues including professional and general liability, disability, and Medical Malpractice considerations involving healthcare delivery.
5. Demonstrate understanding of common business practices.

**G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.**

1. Read, interpret, and critically examine and present medical and scientific literature.

2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.

3. Demonstrate information technology skills in learning, teaching, and clinical practice. Participate in continuing education activities.

**6.2 The sponsoring institution shall require that the resident maintain web-based logs in formats approved by the RRC documenting all experiences related to the residency.**

**6.3 The program shall establish a formal schedule for clinical training. The schedule shall be distributed at the beginning of the training year to all individuals involved in the training program including residents, faculty, and administrative staff.**

The schedule must reflect the experiences provided the resident at all training sites.

The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

The residency must be continuous and uninterrupted unless extenuating circumstances are present.

Twenty percent is the maximum proportion of residency education that is acceptable to be conducted in a podiatric private practice office-based setting.

**6.4 The residency program shall provide rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include: medical imaging; pathology; behavioral sciences; internal medicine and/or family practice; medical subspecialties; infectious disease; general surgery; surgical subspecialties; anesthesiology; emergency medicine; podiatric surgery; and podiatric medicine. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.**

The program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources.

In developing the curriculum, the program director must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

In addition to podiatric medicine and podiatric surgery, the following rotations are required:

- a. Medical imaging.
- b. Pathology.
- c. Behavioral sciences.
- d. Infectious disease.
- e. Internal medicine and/or family practice.
- f. Medical subspecialties. Rotations that satisfy the medical subspecialty requirement include at least two of the following: dermatology, endocrinology, neurology, pain management, physical medicine and rehabilitation, rheumatology, or wound care.
- g. General surgery.
- h. Surgical subspecialties: Training resources that satisfy the surgical subspecialty requirement must include at least one of the following: orthopedic, plastic, or vascular surgery.
- i. Anesthesiology.
- j. Emergency medicine. Training resources may include emergency room service, urgent care center, trauma service, and critical care unit service.

The time spent in infectious disease (d) plus the time spent in internal medicine and/or family practice (e) plus the time spent in medical subspecialties (f) must be equivalent to a minimum of three full-time months of training.

**6.5 The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of training.**

Resident certification must be obtained as early as possible during the training year but no later than six months after the resident's starting date.

**6.6 The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.**

The program director must assure that patient records accurately document the resident's participation in performing history and physical examinations and recording of operative reports, discharge summaries, and progress notes. The resident should participate in quality assurance and utilization review activities.

**6.7 Didactic activities that complement and supplement the curriculum shall be available at least weekly.**

Didactic activities must be provided in a variety of formats. These formats may include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

The program of didactic activities should include participating by faculty as prescribed by JCRSB-recognized specialty boards. If the resident is required to take an in-training examination(s), the sponsoring institution must pay any fees associated with the examination(s). The residency curriculum must include instruction in research methodology. The resident should participate in research activities to broaden the scope of training. Examinator results are used as a guide for resident remediation and as part of the annual self-assessment of the program. The program director may appoint a faculty member to coordinate didactic activities.

**6.8 A journal review session, consisting of faculty and residents, shall be scheduled at least monthly to facilitate reading, analyzing, and presenting medical and scientific literature.**

The curriculum must afford the resident instruction in the critical analysis of scientific literature. The resident should present current articles and analyze the content and validity of the research.

**6.9 The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.**

***7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.***

**7.1 The program director shall review, evaluate, and verify resident logs on a monthly basis.**

The program director must review the logs for accuracy to ensure that there is no duplication, miscategorization, and/or fragmentation of procedures into their component parts. Procedure notes must support the selected experience.

**7.2 The faculty and program director shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.**

The program director must conduct a formal semi-annual meeting with the resident to review the extent to which the resident is achieving the competencies. Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

The assessments must be written or completed in an electronic format. The assessment instrument must identify the dates covered and the name of the faculty member. The assessment must be signed (signature and printed name) and dated by the faculty member, the resident, and the program director. The instrument must include assessment of the resident in areas such as communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency must allow sufficient opportunity for remediation.

**7.3 The program director, faculty, and resident(s) shall conduct an annual self-assessment of the program's resources and curriculum. Information resulting from this review shall be used in improving the program.**

The review must include evaluation of the program's compliance with the current standards and requirements of the Council, the resident's formal evaluation of the program, and the director's formal evaluation of the faculty.

The curriculum must be assessed to determine if it is relevant to the competencies. The review must determine the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved. The review also must determine the extent to which didactic activities complement and supplement the curriculum. The review must use performance data such as resident performance on external exams and attainment of board certification and state licensure to support the program's goal of assuring resident achievement of the competencies.

The review should include measures of program outcomes such as success of previous residents in private practice and teaching environments, hospital appointments, and publications.

# APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

## A. Patient Care Activity Requirements MAV

(Abbreviations are defined in section B.)

### Case Activities

Podiatric clinic/office encounters 1000

Podiatric surgical cases 300

Trauma cases 50

Podopediatric cases 25

Biomechanical cases 75

Comprehensive medical histories and physical examinations 50

### Procedure Activities

First and second assistant procedures (total) 400

First assistant procedures, including:

Digital 80

First Ray 60

Other Soft Tissue Foot Surgery 45

Other Osseous Foot Surgery 40

Reconstructive Rearfoot/Ankle (added credential only) 50

## B. Definitions

### 1. Levels of Resident Activity for Each Logged Procedure

First assistant: The resident participates actively in the procedure **under direct supervision of the attending.**

Second assistant: The resident participates in the procedure. Participation may include retracting and assisting, or performing limited portions of the procedure **under direct supervision of the attending.**

### 2. Minimum Activity Volume (MAV)

MAVs are patient care activity requirements that assure that the resident has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. For some residents, the minimum repetitions may be higher or lower than the MAVs. It is incumbent upon the program director and the faculty to assure that the resident has achieved a competency, regardless of the number of repetitions.

### 3. Required Case Activities

A case is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

- a. Podiatric clinic/office encounters. This activity includes direct participation of the resident in the clinical evaluation and management of patients with foot and ankle complaints. The sponsoring institution must document the availability of at least 1,000 encounters per resident
- b. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.
- c. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients who present immediately after traumatic episodes. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Medical histories and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.

- d. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of patients who are less than 18 years of age.
- e. Biomechanical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of locomotor disorders caused by congenital, neurological, and heritable factors. These experiences include, but are not limited to, performing comprehensive lower extremity biomechanical examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders..
- f. Comprehensive medical history and physical examinations: Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P. A focused history and physical examination does not fulfill this requirement.

The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

#### **4. Required Procedure Activities**

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable. For example, if a surgical procedure employed to correct a hammertoe includes a proximal interphalangeal joint component and a metatarsophalangeal joint component, these components cannot be counted as separate procedures.

Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies.

#### **C. Assuring Diversity of Surgical Experience**

The construct of the procedure categories assures some degree of diversity in the resident's surgical training experience. The two paragraphs below relate to first assistant procedures only.

To assure proper diversity within each procedure category and subcategory, at least 33 percent of the procedure codes within each category and subcategory must be represented with first assistant procedures. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedure codes must have at least one activity as first assistant.

To avoid overrepresentation of one procedure within a category and subcategory, one procedure code must not represent more than 33 percent of the total number of procedures logged in each procedure category and subcategory. This statement applies more to a resident just meeting the minimum procedure requirement in a procedure category than to a resident significantly exceeding the procedure requirement in a procedure category. For example, the number of partial osteotomies must not exceed 26 when the minimum of 80 required Digital procedures are logged.

#### **D. Programs with Multiple Residents or Fellows**

1. Only one resident may take credit for first assistant participation on any one procedure.
2. More than one resident may take credit for second assistant participation.

3. The activity of a fellow should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

4. When multiple procedures are performed on a single patient, more than one resident or fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

# **APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS**

The following categories, procedures, and codes must be used for logging surgical procedure activity:

## **1 Digital Surgery** (lesser toe or hallux)

- 1.1 partial ostectomy/exostectomy
- 1.2 phalangectomy
- 1.3 arthroplasty (interphalangeal joint [IPJ])
- 1.4 implant (IPJ)
- 1.5 diaphysectomy
- 1.6 phalangeal osteotomy
- 1.7 fusion (IPJ)
- 1.8 amputation
- 1.9 management of osseous tumor/neoplasm
- 1.10 management of bone/joint infection
- 1.11 open management of digital fracture/dislocation
- 1.12 revision/repair of surgical outcome
- 1.13 other osseous digital procedure not listed above

## **2 First Ray Surgery**

### Hallux Valgus Surgery

- 2.1.1 bunionectomy (partial ostectomy/Silver procedure)
- 2.1.2 bunionectomy with capsulotendon balancing procedure
- 2.1.3 bunionectomy with phalangeal osteotomy
- 2.1.4 bunionectomy with distal first metatarsal osteotomy
- 2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
- 2.1.6 bunionectomy with first metatarsocuneiform fusion
- 2.1.7 metatarsophalangeal joint (MPJ) fusion
- 2.1.8 MPJ implant
- 2.1.9 MPJ arthroplasty

### Hallux Limitus Surgery

- 2.2.1 cheilectomy
- 2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
- 2.2.3 joint salvage with distal metatarsal osteotomy
- 2.2.4 joint salvage with first metatarsal shaft or base osteotomy
- 2.2.5 joint salvage with first metatarsocuneiform fusion
- 2.2.6 MPJ fusion
- 2.2.7 MPJ implant
- 2.2.8 MPJ arthroplasty

### Other First Ray Surgery

- 2.3.1 tendon transfer/lengthening/capsulotendon balancing procedure
- 2.3.2 osteotomy (e.g., dorsiflexory)
- 2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
- 2.3.4 amputation
- 2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
- 2.3.6 management of bone/joint infection (with or without bone graft)
- 2.3.7 open management of fracture or MPJ dislocation
- 2.3.8 corticotomy/callus distraction
- 2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
- 2.3.10 other first ray procedure not listed above

### **3 Other Soft Tissue Foot Surgery**

- 3.1 excision of ossicle/sesamoid
- 3.2 excision of neuroma
- 3.3 removal of deep foreign body (excluding hardware removal)
- 3.4 plantar fasciotomy
- 3.5 lesser MPJ capsulotendon balancing
- 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
- 3.7 open management of dislocation (MPJ/tarsometatarsal)
- 3.8 incision and drainage/wide debridement of soft tissue infection (including plantar space)
  
- 3.9 plantar fasciectomy
- 3.10 excision of soft tissue tumor/mass of the foot or ankle (without reconstructive surgery)
- 3.11 external neurolysis/decompression (including tarsal tunnel)
- 3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
- 3.13 microscopic nerve/vascular repair (forefoot only)
- 3.14 other soft tissue procedures not listed above (limited to the foot)

### **4 Other Osseous Foot Surgery**

- 4.1 partial ostectomy (including the talus and calcaneus)
- 4.2 lesser MPJ arthroplasty
- 4.3 bunionectomy of the fifth metatarsal without osteotomy
- 4.4 metatarsal head resection (single or multiple)
- 4.5 lesser MPJ implant
- 4.6 central metatarsal osteotomy
- 4.7 bunionectomy of the fifth metatarsal with osteotomy
- 4.8 open management of lesser metatarsal fracture(s)
- 4.9 harvesting of bone graft distal to the ankle
- 4.10 amputation (lesser ray, transmetatarsal amputation)

- 4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
- 4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
- 4.13 open management of tarsometatarsal fracture/dislocation
- 4.14 multiple osteotomy management of metatarsus adductus
- 4.15 tarsometatarsal fusion
- 4.16 corticotomy/callus distraction of lesser metatarsal
- 4.17 revision/repair of surgical outcome in the forefoot
- 4.18 detachment/reattachment of Achilles tendon with partial osteotomy
- 4.19 other osseous procedures not listed above (distal to the tarsometatarsal joint)

## **5 Reconstructive Rearfoot/Ankle Surgery**

### Elective - Soft Tissue

- 5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
- 5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
- 5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
- 5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
- 5.1.5 delayed repair of ligamentous structures
- 5.1.6 ligament or tendon augmentation/supplementation/restoration
- 5.1.7 open synovectomy of the rearfoot/ankle
- 5.1.8 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

### Elective - Osseous

- 5.2.1 operative arthroscopy
- 5.2.2 subtalar arthroeresis
- 5.2.3 midfoot, rearfoot, or ankle fusion
- 5.2.4 midfoot, rearfoot, or tibial osteotomy
- 5.2.5 coalition resection
- 5.2.6 open management of talar dome lesion (with or without osteotomy)
- 5.2.7 ankle arthrotomy with removal of loose body or other osteochondral debridement
- 5.2.8 ankle implant
- 5.2.9 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
- 5.2.10 other elective rearfoot reconstructive/ankle osseous surgery not listed above

### Non-Elective - Soft Tissue

- 5.3.1 repair of acute tendon injury
- 5.3.2 repair of acute ligament injury
- 5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
- 5.3.4 excision of soft tissue tumor/mass of the foot (with reconstructive surgery)
- 5.3.5 excision of soft tissue tumor/mass of the ankle (with reconstructive surgery)
- 5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
- 5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above

## Non-Elective - Osseous

- 5.4.1 open repair of adult midfoot fracture
- 5.4.2 open repair of adult rearfoot fracture
- 5.4.3 open repair of adult ankle fracture
- 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
- 5.4.5 management of bone tumor/neoplasm (with or without bone graft)
- 5.4.6 management of bone/joint infection (with or without bone graft)
- 5.4.7 amputation proximal to the tarsometatarsal joints
- 5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above

## **6. Other Podiatric Procedures** (these procedures **cannot** be counted toward the minimum procedure requirements)

- 6.1 debridement of superficial ulcer or wound
- 6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
- 6.3 nail avulsion (partial or complete)
- 6.4 matrixectomy (partial or complete, by any means)
- 6.5 removal of hardware
- 6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)
- 6.7 biological dressings
- 6.8 extracorporeal shock wave therapy
- 6.9 taping/padding (limited to the foot, and ankle)
- 6.10 orthotics (limited to the foot, and ankle casting for foot orthosis and ankle orthosis)
- 6.11 prosthetics (including prescribing and/or dispensing toe filler and prosthetic feet)
- 6.12 other biomechanical experiences not listed above (may include, but is not limited to, physical therapy, shoe prescription shoe modification)
- 6.13 other clinical experiences
- 6.14 Percutaneous procedures, i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma.

## **7. Biomechanics**

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment.

## **8. History and Physical Examination**

- 8.1 complete history and physical examination

## **9. Surgery and surgical subspecialties**

- 9.1 general surgery
- 9.2 orthopedic surgery
- 9.3 plastic surgery
- 9.4 vascular surgery

## **10. Medicine and medical subspecialty experiences**

- 10.1 anesthesiology
- 10.2 cardiology
- 10.3 dermatology
- 10.4 emergency medicine
- 10.5 endocrinology
- 10.6 family practice
- 10.7 gastroenterology
- 10.8 hematology/oncology
- 10.9 imaging
- 10.10 infectious disease
- 10.11 internal medicine
- 10.12 neurology
- 10.13 pediatrics
- 10.14 physical medicine and rehabilitation
- 10.15 psychiatry/behavioral medicine
- 10.16 rheumatology
- 10.17 sports medicine
- 10.18 wound care

CPME 320 October 2010

# CPME 330

Council on Podiatric  
Medical Education  
2011

# PROCEDURES FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

## COUNCIL ON PODIATRIC MEDICAL EDUCATION

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## INTRODUCTION

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council's approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of doctoral education, postdoctoral education, certification, and continuing education. By confirming that these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council was established by the APMA House of Delegates in 1918 and charged with formulating educational standards. The Council began accrediting colleges of podiatric medicine in 1922. The Council conducted its first residency evaluation in 1964.

The Council has been authorized by the APMA to approve institutions that sponsor residency programs that demonstrate and maintain compliance with the standards and requirements published in CPME 320, *Standards and Requirements for Approval of Residencies in Podiatric Medicine and Surgery*. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council.

The American Board of Podiatric Surgery (ABPS) and the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) collaborate with the RRC and the Council in evaluating residencies.

“Approval” is the recognition accorded residencies that are determined to be in substantial compliance with established standards and requirements. The approval process related to a residency is essentially a six-step process, involving: (1) development of application and/or pre-evaluation materials documenting the ability of the program to comply with the Council's standards and requirements; (2) on-site evaluation conducted at the institution, at which time the application and/or pre-evaluation materials are validated by an evaluator or evaluation team appointed by the Council; (3) subsequent review by the RRC of findings identified in the report of the on-site evaluation and any information that the program provides following the visit; (4) an approval recommendation from the RRC to the Council; (5) determination of approval status by the Council; and (6) periodic follow-up of progress in improving the quality of the program. Procedural reconsideration, reconsideration, and appeal of a proposed adverse approval action are available as described in this document.

Recommendations and decisions relative to the approval process for residencies are the sole responsibilities of the RRC and/or the Council, as indicated in this publication. Neither Council staff, on-site evaluators, individual members of the RRC or Council, nor any other agent of the RRC or the Council is empowered to make or modify approval recommendations or decisions.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council's community of interest may be affected.

The following evaluation/approval procedures have been developed to assist residencies in preparing for initial or continuing approval and to guide the RRC and the Council in their deliberations concerning the approval of residencies.

Throughout this publication, the use of the terms "institution" and "program" is premised on the idea that the program exists within and is sponsored by an institution.

## **COMMUNICATION BETWEEN THE RRC/COUNCIL AND THE SPONSORING INSTITUTION**

The RRC and the Council have adopted the following general policies related to communication with an institution sponsoring a residency. Information related to specific correspondence (e.g., notification of approval actions) appears in the pertinent sections of this document.

**The RRC and the Council require that the program's director is the individual responsible for submitting all materials to Council staff related to all application, on-site evaluation, and approval processes.** All materials submitted by the sponsoring institution must be submitted on media as determined by the Council or its committees accompanied by a cover letter signed by the program director. The RRC, Council, and evaluators will not consider unsigned, unverified, or signature-stamped correspondence, resident logs, and/or resident evaluation forms. Such materials do not document review and validation by the director. Unsigned, unverified, or signature-stamped correspondence or residency materials will be returned to the program director; submission of such materials may adversely affect the approval status of the residency.

All correspondence and inquiries must be directed to the Council office. Utilization of other channels of communication may delay the processing of information submitted by the sponsoring institution and result in inconvenience to the institution.

The RRC and the Council mail correspondence to the program director at the director's office address indicated on the institution's application and/or most recent annual or pre-evaluation report. The institution's chief administrative officer is copied on all correspondence. In a co-sponsored program, the mailing address is that of the institution at which the program director is based (although administrators of all co-sponsoring institutions will receive copies of correspondence from the Council).

The sponsoring institution is responsible for informing the Council office in writing within 30 calendar days of substantive changes in the program. The institution must inform the Council of changes in areas including, but not limited to, sponsorship, appointment of a new program director, training sites, and curriculum. Notice of appointment of a new program director or new chief administrative officer must be submitted by an appropriate member of the institution's administrative staff rather than by a representative of the residency.

The Council's residency documents and forms are available on the Council's website ([www.cpme.org](http://www.cpme.org)). Additionally, copies of the Council's "Memo to Program Directors" are available on the website. These memos include all proposed changes to Council documents (standards, requirements, and procedures) with a request for comments by a specific deadline. The memo also is designed to inform directors and sponsoring institutions of document changes adopted by the Council, as well as any revisions that were tabled, modified, or deleted as a result of comments provided previously by the community of interest. When the RRC or the Council develops a policy (e.g., interpretation of a particular requirement in a Council or RRC document), the policy is included in the memo to program directors.

## **RESIDENCY REVIEW COMMITTEE**

The RRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in or reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

Composition of the RRC includes two representatives each from ABPOPPM and ABPS, one representative from the Council of Teaching Hospitals (COTH) of the American Association of Colleges of Podiatric Medicine, one representative from residency programs at large (selected by the Council), and at least two Council members.

Although the RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of the RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the RRC.

## **APPLICATION FOR PROVISIONAL APPROVAL OF A NEW RESIDENCY PROGRAM**

### **Submission of the Application**

A residency seeking initial approval or reclassification to a new residency category must follow the procedures stated for new residencies. The Council encourages the applicant institution to contact Council staff early in the developmental stages of the program should questions arise related to the Council's standards, requirements, and procedures.

The Council recognizes that programs seeking approval do so voluntarily. Therefore, the burden of proof regarding compliance with Council standards and requirements is the responsibility of the sponsor. Submission of a new application may be required when an approved sponsoring institution or residency has undergone a change so substantial that it is essentially a new institution or program.

The applicant institution must be in operation for at least 12 months before applying for approval to assure that sufficient resources are available for the program. The institution should have an active podiatric service for at least 12 months prior to applying for approval.

An institution seeking approval of a new podiatric residency is required to submit an application fee and the appropriate number of copies of RRC form 309, *Application for Provisional Approval*, and required supplementary documentation (the requested number of copies is indicated on the application) (see Fee Policies). **The application must be submitted prior to activation of the residency, at least 12-15 months before the anticipated starting date.** The entire review process for a residency requesting approval may require a period of 12-24 months from the time an application is received in the Council office until the Council takes an approval action.

Council staff reviews the application for completeness. If the application is considered to be incomplete, Council staff corresponds with the program director and specifies the information required to complete the application. If the application, supplementary documentation, and fee are in order, Council staff forwards the institution's application to the RRC for determination of eligibility for on-site evaluation.

If the sponsoring institution ascertains that it has the capability to train more residents than the number indicated on the application, the institution must amend its application. This amendment must occur **before** eligibility for on-site evaluation has been determined. The program director must inform the Council office of the institution's intention and provide appropriate documentation substantiating the ability of the program to increase its proposed number of positions. Council staff will include this information in the materials to be presented to the RRC once the application is complete. (Alternatively, the sponsoring institution may request an increase in or reclassification of positions following the granting of provisional approval; see Authorization of Increases in Residency Positions.)

### **Determination of Eligibility for On-site Evaluation**

The RRC considers the application for provisional approval by mail ballot, conference call, or at one of its semi-annual meetings. The RRC will consider a complete application within 60 calendar days of its receipt.

The RRC reviews the application to determine whether the new residency is eligible for on-site evaluation. In determining eligibility, the RRC will not consider a number of resident positions other than that for which the institution has applied. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent conference call or upcoming regularly-scheduled meeting.

When the Residency Review Committee determines that a new residency is eligible for on-site evaluation, this status indicates that the institution appears to be developing a residency that has the potential for meeting the Council's standards and requirements for approval. **Neither**

**eligibility for on-site evaluation nor the conduct of an initial on-site evaluation ensures eventual approval.**

Correspondence regarding the RRC action is addressed to the program director. A copy of the letter is forwarded to the chief administrative officer of the sponsoring institution. If eligibility for on-site evaluation is confirmed, the letter includes a copy of CPME 311, *Agenda Guide*, to assist the program director in planning for the initial on-site evaluation.

If the RRC proposes denial of eligibility for on-site evaluation, justification for the action is delineated in the letter and provisions for requesting procedural reconsideration, reconsideration, and appeal are identified (see Procedural Reconsideration, Reconsideration, and Appeal). If the RRC proposes denial of eligibility for on-site evaluation, the institution is required to verify to the Council, in writing, that all program applicants selected for interview and/or incoming residents have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

### **Withdrawal or Termination of the Application**

A sponsoring institution that has submitted an application for provisional approval or for which eligibility for on-site evaluation has been determined may withdraw its application at any time before the RRC takes an action on the approval status of the program.

If the sponsoring institution fails to respond in writing within six months to written requests from Council staff and/or the RRC for information to complete the application, the application will be terminated by staff. Council staff will correspond with the program director and the institution's chief administrative officer to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

### **RE-EVALUATION AND CONTINUING APPROVAL OF AN EXISTING RESIDENCY PROGRAM**

Council staff regularly reviews the list of approved programs and contacts the appropriate program directors when re-evaluation is due (see Categories of Approval and Approval Period). For reasons of economic feasibility, Council staff gives consideration to the geographic proximity of institutions when developing the list of institutions to be evaluated during each evaluation cycle.

The Council may elect to deviate from the established on-site evaluation cycle by conducting either a comprehensive or focused visit to follow up on identified concerns. Circumstances that may warrant scheduling a follow-up visit include: when a program has been transferred to another institution, when a residency has undergone a substantial change, when major deterioration in the residency has occurred, and when a formal complaint against an approved residency requires on-site evaluation of the issues related to the complaint. In any event, the Council reserves the right to conduct an evaluation of the residency whenever circumstances require such review. Continuation of approval by the Council is contingent upon the findings of

the on-site evaluation. Therefore, the re-evaluation may have an impact on the previously-granted approval status.

## **Pre-evaluation Materials**

Institutions seeking continuing approval of residencies must submit CPME form 310, *Pre-evaluation Report*, along with all required supplementary documentation. If the pre-evaluation report is considered to be incomplete, the program director will be notified and requested to submit the required information. An on-site evaluation will not be conducted if this requested material is not received, which may jeopardize the approval status of the program.

## **ON-SITE EVALUATION (NEW AND EXISTING RESIDENCY PROGRAMS)**

The on-site evaluation is conducted to assess the general quality of the residency, the institution's ability to establish a curriculum that assures that each resident achieves the competencies identified by the Council, and the institution's plans for continued improvement. The evaluation team appointed to conduct the visit gathers information related to validation of the institution's application for provisional approval or pre-evaluation report. The evaluation team develops a report of its findings that includes a narrative summary that identifies program strengths and weaknesses and areas of potential noncompliance.

Evaluation team members do not act as consultants to the residency or the sponsoring institution. The team members' primary roles as fact-finders and observers are to provide the RRC an assessment of the sponsor's potential compliance with the Council's standards and requirements. With a view toward assisting the institution to understand more completely its role as related to the residency, the evaluation team report may include non-binding recommendations for improvement of the program.

## **Evaluation Team**

The Council chair appoints the evaluation team based upon a recommendation from the RRC chair and Council staff. The initial on-site evaluation is conducted by at least two evaluators, one of whom must be a podiatric physician. On-site re-evaluation of an approved residency is conducted by a team comprised of at least three persons, two of whom must be podiatric physicians. Under certain circumstances, two podiatric physicians may evaluate an approved residency.

The institution has the prerogative of rejecting any member of the proposed evaluation team when an appropriate cause related to conflict of interest can be clearly identified. In such a case, a written statement from the sponsoring institution is to be submitted to the Council office no later than 30 calendar days before the date of the on-site evaluation, affording the Council sufficient opportunity to appoint a replacement evaluator. The Council does not appoint members to the evaluation team who have any known conflict of interest in the evaluation of the

institution, including graduates and current and former faculty members or administrators of the institution.

The evaluation team represents the Council and the RRC. At least one of the members of the evaluation team is an ABPOPPM diplomate, and at least one of the members of the evaluation team is an ABPS diplomate. Potential evaluators representing the RRC are identified as a collaborative effort of the Council, RRC, ABPOPPM, and ABPS.

Evaluation team members also may include, but not be limited to, current and former members of the Council and the Council's committees and members of the Council's professional staff. Another individual (e.g., a representative of the state board for examination and licensure) may accompany an evaluation team to observe the on-site evaluation.

If the Council and/or the RRC elect to conduct a focused visit, the individual(s) appointed to conduct the visit may represent either the Council or the RRC, depending upon the reason(s) for which the visit is scheduled.

Individuals who are selected to serve on Council evaluation teams will have participated in a training session for residency evaluators. Individuals who are selected to serve as team chairs will have participated previously in on-site evaluations of residencies.

## **Preparation for On-site Evaluation**

The chair of the evaluation team determines the date of the on-site evaluation in conjunction with the program director and the other member(s) of the evaluation team. Once eligibility for on-site evaluation is determined for a new program, the evaluation is conducted in sufficient time to allow for consideration of the report of the on-site evaluation at regularly-scheduled meetings of the RRC and the Council. Ordinarily, an institution sponsoring an existing program is given approximately 45 calendar days notice prior to the on-site evaluation. The timeline for evaluating an existing program may be abbreviated when the on-site evaluation is conducted in response to RRC and/or Council concerns about major deterioration or change in the residency or when a formal complaint against an approved residency requires on-site evaluation of the issues related to the complaint.

Once the evaluation team and the sponsoring institution have agreed on the date and time of the evaluation, Council staff corresponds with the program director to confirm the names of the members of the evaluation team and the time and date of the evaluation. A copy of CPME 311, *Agenda Guide* is forwarded to the program director. Using the agenda guide, the director is required to prepare a schedule identifying personnel to be interviewed by the evaluation team. The agenda must be forwarded to the Council office at least four weeks prior to the on-site visit.

The program director of a provisionally-approved or an existing residency also must make available appropriate resident log forms to the evaluation team at least four weeks prior to the date of the evaluation. The team members review the logs to establish a list of charts that they wish to review during the on-site evaluation. The team provides this list to the director in

advance of the on-site evaluation. The evaluation team retains the prerogative of requesting additional charts on the day of the visit if warranted.

When a focused visit is scheduled, the letter informing the program director of the date of the evaluation includes specific information related to interviews to be conducted and information to be available for review by the evaluator.

## **Conduct of the On-site Evaluation**

Depending on the number of individuals and facilities involved, a minimum of one day (8 hours) is required to evaluate a podiatric residency. In order that the evaluation team may assess the curriculum content and the extent of resident supervision, the agenda for the on-site evaluation requires that key participants in the program be interviewed, as indicated in CPME 311.

As part of the on-site evaluation, the team conducts interviews with the program director, chief administrative officer, director of medical education, members of the podiatric and non-podiatric faculty, and, for provisionally-approved and existing programs only, the podiatric resident(s). The evaluation includes a tour of the physical facilities, executive sessions of the evaluation team to discuss findings and recommendations, and a concluding session with the program director and the chief administrative officer to discuss the findings. During the exit interview with institutional representatives, the evaluation team chair explains the Council's procedures for initial and/or continuing approval of residencies (specifically, the sequence of events that will follow the visit).

Failure of key participants in the residency to be available will be cause for cancellation of the on-site visit, which may jeopardize the approval status of the program.

## **Preparation of the Report**

The evaluation team prepares a draft report based on observations and impressions from the on-site evaluation. The team forwards this draft report to the Council office for editing. The edited draft of the report is then returned to each member of the team for review and comments.

A draft copy of the report, consisting of a summary of findings, a list of interviewees, areas of potential noncompliance, and recommendations, is forwarded to the program director and the chief administrative officer of the sponsoring institution.

The sponsoring institution is encouraged to provide a substantive response to areas of potential noncompliance and recommendations identified by the evaluation team, as well as any supporting documentation, prior to consideration of the report by the RRC. The cover letter to the institution specifies the deadline for their receipt. Factual information included in the report may be corrected by the institution; however, impressions and observations based on the on-site visit will not be modified.

The following steps are included in the approval process:

## **CONSIDERATION BY THE RRC AND THE COUNCIL**

### **RRC Review**

The RRC meets prior to each of the semiannual meetings of the Council. The Committee reviews evaluation team reports, institutional responses to evaluation team reports, interim progress reports from provisionally-approved programs, progress reports from provisionally-approved and approved programs, and requests for reconsideration.

During discussions about the approval status of individual residencies, any member of the RRC who is affiliated with the institution under consideration in a governance, administrative, staff, or faculty capacity must recuse himself or herself from the deliberations. Members of the RRC who served on the most recent residency evaluation team are required to recuse themselves from voting until the Council has determined a final approval action.

#### **Review of Evaluation Team Reports**

For each residency visit where a member of the RRC is a member of the evaluation team, the RRC member provides a verbal summary of team findings and answers any questions of the Committee. For each visit where a member of the RRC is not on the team, a member of the Committee is designated by Council staff as a “liaison” to the team. The liaison Committee member communicates the team's findings and presents the team's evaluation report to the Committee. The liaison is expected to be fully prepared for the presentation of the team report to the RRC. This includes detailed review of pre-evaluation materials, the team report, and all pertinent correspondence, such as the response(s) to the report, and consultation with the team chair after the visit. Council staff forwards the materials to the liaison Committee member.

The liaison Committee member is expected to have open communication with the team chair in order to facilitate discussion of the report. If the liaison has any questions regarding the report these should be discussed with the team chair and clarified prior to the RRC meeting at which the report is presented. In addition, the liaison should inform the team chair of the dates of the RRC meeting at which the report will be considered and obtain a telephone number where the team chair can be reached during the time frame of the meeting. Telephone contact during the meeting may be needed to clarify ambiguities or to answer questions that arise during Committee's discussion of the report.

Based upon discussion with the RRC member on the team or the RRC liaison to the team, review of the draft of the evaluation team report and any response submitted by the sponsoring institution, the RRC makes a confidential recommendation to the Council regarding the approval status of the program (see Categories of Approval and Approval Period). The confidential recommendation includes the approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas that are in noncompliance with Council standards and requirements, identification of areas of noncompliance that have been addressed in the institution's response to the evaluation team report, identification of areas that merit commendation, and a schedule for requesting progress reports, including the interim progress report required of a provisionally-approved program.

In reviewing an on-site evaluation report, the RRC has the prerogative of recommending that the Council revise the report, which may include adding, modifying, or deleting areas of potential noncompliance.

#### Review of Interim Progress Reports and Progress Reports

The RRC considers interim progress reports submitted by provisionally-approved programs related to development of the proposed clinical and didactic curriculum once the resident is active in the program (see Categories of Approval and Approval Period).

The RRC also considers progress reports submitted by existing provisionally-approved and approved programs related to correction of specific areas of noncompliance and/or concerns identified by the RRC and/or the Council.

Based upon review of the progress report and/or the interim progress report, the RRC determines the extent to which the submitted information addresses previously-identified concerns and/or makes a confidential recommendation to the Council regarding the approval status of the program (see Categories of Approval and Approval Period).

The confidential recommendation includes the approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas that are in noncompliance with Council standards and requirements, identification of areas of noncompliance that have been addressed in the progress report, identification of areas that merit commendation, and a schedule for requesting progress reports. The institution may be requested to submit further documentation of progress made in addressing areas of noncompliance and/or concerns expressed by the RRC.

In reviewing an interim progress report and/or a progress report, the RRC has the prerogative to add, modify, or delete areas of noncompliance or to recommend that the Council add, modify, or delete areas of noncompliance.

### **Council Action**

At a meeting of the Council, the chair of the RRC presents for each residency program the confidential recommendation of the RRC regarding approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas that are in noncompliance with Council standards and requirements, identification of areas of noncompliance that have been addressed in the institution's response to the evaluation team report or in the institution's progress report, identification of areas that merit commendation, and a schedule for requesting progress reports. Areas of noncompliance determined by the Council may include, but are not limited to, those indicated by the evaluation team and the RRC. The institution may be requested to submit documentation of progress made in addressing areas of noncompliance and/or concerns expressed by the RRC or the Council.

Approval actions are taken by the Council at official meetings of the Council. Under special circumstances, mail ballots or conference calls may be used for residency approval decisions.

During discussions about the approval status of individual residencies, any member of the Council who is affiliated with the institution under consideration in a governance, administrative, staff, or faculty capacity must recuse himself or herself from the deliberations. Members of the Council who served on the most recent residency evaluation team are required to recuse themselves from discussion and voting until the final approval action has been determined.

## CATEGORIES OF APPROVAL AND APPROVAL PERIOD

The following approval actions are available to the Council:

- For a **new residency that has completed an initial on-site evaluation**, the Council grants provisional approval or withholds provisional approval.
- For a **provisionally-approved residency that has submitted an interim progress report and/or a progress report**, the Council extends provisional approval (with or without further progress reports) or probation with an immediate on-site evaluation.
- For a **provisionally-approved residency that has completed an on-site re-evaluation**, the Council extends approval (with or without further progress reports) or extends probation.
- For an **existing approved residency that has completed an on-site re-evaluation or that has submitted a progress report**, the Council extends approval (with or without further progress reports), extends probation, or withdraws approval (the option of withdrawal of

The Council bases the approval action on the category and number of resident positions that each institution has requested. The Council has established the following categories of approval:

### Provisional Approval

Provisional approval indicates recognition of a new residency that, in general, is expected to be in substantial compliance with the Council's standards and requirements for approval upon activation of the program. Provisional approval is determined on the basis of on-site evaluation prior to activation of the residency. When the Council grants provisional approval, this status is effective on the date the action is taken by the Council (see Activation of a Provisionally-approved Residency). Provisional approval will not be considered for any training year or portion of a training year prior to the effective date of granting of provisional approval.

As a condition of continued provisional approval, the institution must provide an **interim progress report** by a date identified in the approval letter. The interim progress report allows the RRC to monitor the continued development of the program in accordance with the program's proposed clinical and didactic curriculum once the resident is active in the program. The interim progress report includes, but is not limited to, resident logs documenting participation in all relevant podiatric activities, documentation of the program's assessment of the resident's

progress in achieving the competencies identified by the Council, the formal schedule for clinical training, and the signed resident contract or letter of appointment.

As a further condition of continued provisional approval, the institution also may be requested to provide one or more **progress reports** at specified intervals, as indicated in the approval letter. The progress report(s) is to demonstrate correction of specific areas of noncompliance in meeting one or more requirements and/or to address concerns identified by the RRC and/or the Council. Customarily, the institution is provided at least six months from the time of the on-site evaluation or submission of the most recent progress report to correct areas of noncompliance.

Provisional approval extends no longer than 24 months beyond the designated length of the program.

The approval letter includes the date by which the next scheduled on-site evaluation will occur. Ordinarily, on-site re-evaluation of a **new** provisionally-approved podiatric residency is conducted during the program's fourth year of operation. The RRC and/or the Council may schedule an earlier on-site re-evaluation should significant concerns become evident from review of the program's progress report(s).

## **Approval**

Approval indicates recognition of an existing residency that, in general, is in substantial compliance with the Council's standards and requirements for approval. In granting an extended period of approval, the Council expresses its confidence in the abilities of the institution to continue providing adequate support and implementing ongoing improvements in the residency.

As a condition of continued approval, the institution may be requested to provide one or more progress reports at specified intervals, as indicated in the approval letter. The progress report(s) is to demonstrate correction of specific areas of noncompliance in meeting one or more requirements or to address concerns identified by the RRC and/or the Council. Customarily, the institution is provided at least six months from the time of the on-site evaluation or submission of the most recent progress report to correct areas of noncompliance.

The approval letter includes the date by which the next scheduled on-site evaluation will occur. Re-evaluation of an existing program is scheduled no later than six years from the date of its previous evaluation. The RRC and/or the Council may schedule an earlier on-site re-evaluation should significant concerns become evident from review of the program's progress report(s).

## **Probation**

Probation indicates that a residency is in noncompliance with the Council's standards and requirements for approval to the extent that the quality and effectiveness of the residency are in jeopardy. This category serves as a strong warning to the institution that serious problems exist that could cause the residency to fail. When probation is extended, the residency is considered to be a candidate for withdrawal of approval. The RRC and/or the Council have the prerogative of adding to the probationary action the requirement that no new residents or transfers enter the

residency until areas of noncompliance have been addressed to the satisfaction of the RRC and the Council.

The program must provide evidence of significant progress in correction of areas of noncompliance within a specified period. Customarily, the institution is provided at least six months from the time of the on-site evaluation or submission of the most recent progress report to correct areas of noncompliance. Probation may not extend for more than two years. This category applies only to previously-approved programs (including provisionally-approved programs) and is a published approval status. A decision to extend probation is not subject to the Council's procedures for procedural reconsideration, reconsideration, or appeal.

The institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

## **Administrative Probation**

Administrative probation indicates that a residency has failed to submit information or fees following two separate requests. The category of administrative probation may be activated automatically without vote by the Council based upon a lack of response by the institution to requests related to progress reports, annual or pre-evaluation reports, payment of annual assessment or on-site evaluation fees, resident transfers (releasing and accepting institutions) or other information about the program. The following procedures apply to administrative probation:

- The institution will be notified in writing that materials and/or fees are past due and that the Council will consider placing the residency on administrative probation if no response is received within 30 calendar days.
- If no response is received within 30 calendar days, the institution will be notified in writing that materials and/or fees remain past due and that the Council will place the residency on administrative probation if no response is received within 15 calendar days.
- The program will be placed on administrative probation if materials and/or fees are not received within 15 calendar days.
- Administrative probation is removed when all requested materials and/or fees are received.

- If no response is received from the institution, the Council will withdraw approval of the program at its next scheduled meeting. Withdrawal of approval is based upon the perception that the institution no longer desires to be recognized by the Council and voluntarily withdraws from approved status. The action is viewed as a voluntary decision of the institution; it is not subject to the Council's procedures for procedural reconsideration, reconsideration, or appeal.

This category applies only to previously-approved programs (including provisionally-approved programs and programs approved on a probationary basis) and is a published approval status. A decision to grant administrative probation is not subject to the Council's procedures for procedural reconsideration, reconsideration, or appeal.

The institution is required to verify to the Council, in writing, that all current and incoming residents and program applicants selected for interview have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

## **Withholding of Provisional Approval**

Withholding of provisional approval is determined in the event that a new program seeking provisional approval evidences substantial noncompliance with the Council's standards and requirements for approval. When the Council proposes withholding provisional approval of a residency, factors that have a significant impact on the effectiveness of the program are identified as the basis for the action. A decision to withhold provisional approval will not become final or be published until the processes of procedural reconsideration, reconsideration, and appeal are exhausted (see Procedural Reconsideration, Reconsideration, and Appeal).

When the Council proposes to withhold provisional approval of a program, the institution is required to verify to the Council, in writing, that all program applicants selected for interview and/or prospective incoming residents have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

## **Withdrawal of Approval**

Withdrawal of approval is determined under any one of the following conditions:

- A program on probation has failed to correct one or more areas of noncompliance, or a new area(s) of noncompliance has emerged, and therefore the program evidences substantial noncompliance with the Council's standards/resident requirements. Action to withdraw approval voluntarily are not subject to the Council's procedures for procedural reconsideration, reconsideration, and appeal.
- Two or more programs merge into a single new program, resulting in the loss of identity of a previously approved program.  
An institution that has been replaced on administrative probation does not provide requested materials and/or fees.

- A program has remained inactive for a period of more than two consecutive training years (see Inactive Status).

When the Council considers an action to withdraw approval, factors that have a significant impact on the effectiveness of the residency are identified as the basis for the action. The RRC and/or the Council have the prerogative of adding to the action to withdraw approval the requirement that no new residents/transfers enter the residency until areas of noncompliance have been addressed to the satisfaction of the RRC and the Council. A decision to withdraw approval will not become final or be published until the processes of procedural reconsideration, reconsideration, and appeal are exhausted. Reconsideration and appeal are available only to sponsors on probation that have failed to correct areas of noncompliance (see Procedural Reconsideration, Reconsideration, and Appeal).

When the Council proposes to withdraw approval of a program, the institution is required to verify to the Council, in writing, that all current and incoming residents, and program applicants selected for interview have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

## **NOTIFICATION OF ACTION**

Within a reasonable period following each of the Council's two meetings, an approval letter indicating the Council action is forwarded to each institution currently under consideration. Confidential correspondence regarding Council actions is addressed to the program director. A copy of the letter is forwarded to the chief administrative officer of the sponsoring institution.

When the Council action is to place the program on probation, to continue probation, to place the program on administrative probation, to withhold provisional approval, or to withdraw approval, the letter to the director is sent by certified mail, with a return receipt requested. Letters to withhold provisional approval or to withdraw approval are forwarded to the director within 30 calendar days of the Council action.

Each letter indicates the approval status of the program and the number of authorized positions, including identification of the number of added credential positions. When the Council takes an action that requests submission of an interim progress report and/or a progress report, the letter identifies the reason(s) for taking the action. The letter outlines the necessary information that must be submitted for the RRC and Council to review the approval status of the program at future scheduled meetings, as well as the date on which this information is due in the Council office.

When the Council considers withholding provisional approval or withdrawing approval, the letter advising the institution of the proposed action contains: (a) the specific reason(s) for taking the proposed action, (b) the date the action becomes effective unless a request for procedural reconsideration or reconsideration is received from the institution, (c) the right of the institution to request procedural reconsideration, reconsideration, and appeal and the date by which such a request must be received by the Council, and (d) the institution's obligation to inform current residents, incoming residents, and program applicants selected for interview regarding the approval status of the program.

When a residency is placed on administrative probation, the program director and the chief administrative officer of the institution receive notification from Council staff that the institution has failed to respond to at least two requests for information or payment of fees. The institution is informed of its responsibility to notify current residents, incoming residents, and program applicants selected for interview of the approval status of the program. The letter to the institution also describes the consequence of withdrawal of approval if immediate attention is not directed to responding to the Council's previous requests.

When the approval action is based on the report of an on-site evaluation, a final copy of the report is enclosed with the approval letter. The report reflects the residency program as it existed at the time of the on-site evaluation. The final report does not, therefore, reflect program modifications made subsequent to the on-site evaluation that may have been described in the institution's response to the draft report. The institution may distribute the final report as it wishes and is encouraged to provide as wide a distribution as possible to the faculty members who participate in the program.

The Council awards a certificate to institutions sponsoring programs recognized in the categories of provisional approval and approval.

## **RESIDENT NOTIFICATION OF ACTION**

When the Council or the RRC takes or proposes certain actions, the sponsoring institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been notified (applicants must be notified in writing prior to the interview). Current residents, incoming residents, and program applicants must be notified of denial of eligibility for initial on-site evaluation, probation, administrative probation, withholding of provisional approval, withdrawal of approval, denial of an increase in positions, and voluntary termination of the program.

The institution must submit a copy of the letter sent to the applicant/incoming resident/current resident. The institution also must submit either the applicant's/incoming resident's/current resident's written acknowledgment of the status of the program or verifiable documentation of this individual's receipt of the institution's letter (i.e., signed copies of return receipts for certified mail). These materials must be received in the Council office within 50 calendar days of the director's receipt of the letter informing the institution of the action taken by the RRC or the Council.

## **ACTIVATION OF A PROVISIONALLY-APPROVED RESIDENCY**

As stated previously, when the Council grants provisional approval, this status is effective on the date the action is taken by the Council. Provisional approval will not be considered for any training year or portion of a training year prior to the effective date of granting of provisional approval.

The Council recognizes that a residency may have an effective date of provisional approval that is later than the customary starting date of July 1. The Council permits the sponsoring institution

to begin its second complement of residents on its preferred starting date (e.g., July 1) during the program's second year of operation.

The Council will withdraw provisional approval if the residency is not activated within two calendar years of the effective date of provisional approval. This action is not subject to the Council's procedures for reconsideration, reconsideration, or appeal.

## **PROCEDURAL RECONSIDERATION, RECONSIDERATION, AND APPEAL**

The following reconsideration and appeal procedures are available for each of the following proposed adverse actions.

If the RRC proposes **denial of eligibility for on-site evaluation**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, followed by appeal, **or**
- Reconsideration, followed by appeal.

If the RRC proposes **denial of either an increase in positions or reclassification of positions**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, **or**
- Reconsideration.

If the Council proposes **withholding provisional approval or withdrawing approval**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, followed by appeal, **or**
- Reconsideration, followed by appeal.

**A request to initiate the processes of procedural reconsideration, reconsideration, or appeal will be accepted for cause and will not be accepted solely on the basis of dissatisfaction with the proposed adverse action, nor will it be accepted on the basis of modifications made subsequent to the determination of the adverse action.** A residency that conforms to Council standards, requirements, and/or procedures following determination of an adverse action (resulting in withholding of provisional approval or withdrawal of approval) will be viewed as a new residency and will be required to follow the application procedures described earlier in this publication.

The institution receives formal written notification of the adverse action following the action of the RRC or the Council. The basis for the adverse action and the institution's right to request

procedural reconsideration, reconsideration, and appeal are stated clearly in the notification letter.

When the RRC or the Council considers an adverse action, the action does not become final, nor is it published, until the institution has been afforded opportunity to complete the processes related to procedural reconsideration, reconsideration, and/or appeal. If the institution does not initiate the procedural reconsideration, reconsideration, or appeal processes, the institution's rights to due process through the Council are viewed to be exhausted.

During this due process period, the approval status of the residency reverts to the status prior to the adverse action. If the Council sustains an action to withdraw approval, the final action becomes effective at the conclusion of the academic year in which the action is sustained.

## **Procedural Reconsideration**

Procedural reconsideration is the process that allows the institution the opportunity to request that the Council review the proposed adverse action for the purpose of determining whether the Council, the RRC, or the evaluation team failed to follow Council procedures described in this publication. Because procedural reconsideration is designed for the review of errors in the application of Council procedures, matters of disagreement related to issues of substance will not be reviewed within the procedural reconsideration process. Such matters, however, may be identified as the basis for a request for reconsideration and/or appeal.

A request for procedural reconsideration must be submitted within 15 calendar days following receipt of the notification letter. If such a request is not submitted and postmarked within this 15-day period, the Council considers the institution to have waived all rights to procedural reconsideration. The sponsoring institution is encouraged to submit its written request to the Council office by certified mail, with a return receipt requested.

The request for procedural reconsideration must identify the procedure(s) in question and describe in detail the institution's claim that the procedure(s) was not followed, including any documentary evidence to support the claim. Following receipt by Council staff, the request for procedural reconsideration is considered by the Council's Executive Committee by conference call or actual meeting. The Council acknowledges in writing the receipt of all procedural reconsideration materials.

Based on a recommendation of the Executive Committee, a decision may be made by the Council, either by conference call or meeting to: (1) sustain the previous action, (2) rescind the previous action and refer the matter for additional review by the RRC, or (3) defer action and conduct a new on-site evaluation. If a new evaluation is conducted, the cost of the evaluation is shared equally by the institution and the Council. The program director and the institution's chief administrative officer are notified of the action taken with respect to the procedural reconsideration no later than 30 calendar days following the next scheduled meeting of the Council following the original determination of the action that led to the request for procedural reconsideration.

## **Reconsideration**

Reconsideration is the process that allows the institution the opportunity to request that the RRC and/or the Council review the proposed adverse action for the purpose of determining whether any error or omission occurred in making the decision.

A written request for reconsideration must be received in the Council office within 30 calendar days following receipt of the notification letter. If a request for reconsideration is not received within this 30-day period, the Council considers the institution to have waived all rights to reconsideration and subsequent appeal. The sponsoring institution is encouraged to submit its written request to the Council office by certified mail, with a return receipt requested.

The request must include specific facts and reasons for which the institution contends the adverse action should not be taken, as well as an appropriate number of copies of substantiating materials. Council staff acknowledges in writing the receipt of all reconsideration materials. Following receipt by Council staff, the materials are considered by the RRC by conference call or at its next scheduled meeting. Reconsideration related to denial of eligibility for on-site evaluation or an increase in positions may be considered by the RRC by conference call or at its next scheduled meeting. Reconsideration related to withholding of provisional approval or withdrawal of approval must be considered by the RRC at its next meeting.

Related to proposed actions to deny eligibility for on-site evaluation or to deny an increase in positions, the RRC has the options of rescinding or sustaining the proposed action.

Reconsideration of the adverse action is completed no later than the next scheduled meeting of the RRC following the original determination. The program director and the institution's chief administrative officer are notified of the RRC action.

Based on a recommendation of the RRC, a decision to sustain or rescind a proposed action to withhold provisional approval or withdraw approval is considered by the Council at its next scheduled meeting. A recommendation may be made by the RRC and/or the Council to assess the request for reconsideration by conducting an on-site evaluation of the residency. The on-site evaluation is designed to evaluate the particular issues or concerns related to the adverse action. When an on-site evaluation is conducted, action is deferred to the second scheduled meeting following the original determination of the adverse action. The program director and the institution's chief administrative officer are notified of the Council's action.

During the reconsideration process, a representative(s) of the institution under reconsideration may request in writing the opportunity to provide a statement to the RRC regarding the proposed adverse action. Any additional information that is to be brought to the attention of the RRC must be submitted to the Council office prior to the meeting. The institution must provide an appropriate number of copies of all written materials.

## **Appeal**

Following completion of the procedural reconsideration and/or reconsideration processes, the institution may appeal the decision to a hearing committee. The appeal process followed by the

Council is articulated in CPME 935, *Guidelines for the Conduct of Appeal Hearings*. The institution is free to pursue a substantive and/or procedural claim.

## **REAPPLICATION FOLLOWING WITHHOLDING OR WITHDRAWAL OF APPROVAL**

An institution seeking approval of a residency program that has had provisional approval withheld or approval withdrawn is expected to follow the procedures outlined for new residencies (see Application for Provisional Approval of a New Residency Program and Fees). With respect to re-evaluation of a program that has had provisional approval withheld or approval withdrawn, the RRC will focus principal attention on those areas that were of greatest concern in the original decision to withhold provisional approval or withdraw approval.

## **AUTHORIZATION OF INCREASES IN RESIDENCY POSITIONS**

Increases in residency positions are considered and authorized by the RRC. Applications for increases are considered by mail ballot, conference call, or at a regularly-scheduled meeting of the RRC. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent mail ballot, conference call, or upcoming regularly-scheduled meeting.

Institutions seeking authorization of increases in positions in provisionally-approved and/or approved residencies are required to submit RRC form 345, *Application for Increase in Positions*, required supplemental materials, and an application fee (see Fee Policies). The application must be submitted prior to activation of the residency position(s), preferably at least six months before the anticipated starting date. A six-month lead time is necessary should additional information be required. The RRC will consider the request for an increase within 60 calendar days of receipt of a complete application.

**The effective date of granting an authorization of increased residency positions by the RRC will be no earlier than the date on which the program has both authorization of the increase and the additional resident(s) in place.**

In order to determine whether the institution has the appropriate resources for an increase in residency positions, the RRC will review the following information:

- The last on-site evaluation report, pertinent progress report materials, and most recent approval letter.
- Pertinent section(s) of annual report(s) submitted since the most recent on-site evaluation.

- A completed *Application for Increase in Positions*, RRC form 345. The application provides information regarding the rationale for the proposed increase with supporting documentation to justify the increased number of positions.

**The RRC will not consider an application for an increase submitted by a program on probation.** If a program on probation increases positions without authorization, the Council will withdraw approval of the program at its next scheduled meeting.

If the new positions have already been activated in an approved program and authorization is denied, the RRC will mandate, by placing the program on probation, a reinstatement of the number of positions existing prior to the increase, effective at the beginning of the next residency year.

If the RRC proposes denial of the increase in positions, the institution is required to verify to the Council, in writing, that all current and incoming residents and program applicants selected for interview have been notified of the proposed denial (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

If the sponsoring institution fails to respond in writing within six months to written requests from Council staff and/or the RRC for information to complete the application, the application will be terminated by staff. Council staff will correspond with the program director and the institution's chief administrative officer to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

## **RECLASSIFICATION OF APPROVED POSITIONS**

Applications for reclassifying approved positions are considered by mail ballot, conference call, or at a regularly-scheduled meeting of the RRC. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent mail ballot, conference call, or upcoming regularly-scheduled meeting.

A program may request reclassification of one or more non-added credential positions to added credential positions in provisionally-approved and/or approved residencies by submitting RRC form 346, *Application for Reclassifying Positions*, required supplemental materials, and an application fee (see Fee Policies). The application must be submitted prior to reclassification of the residency position(s), preferably at least six months before the anticipated change. A six-month lead time is necessary should additional information be required. The RRC will consider the request for an increase within 60 calendar days of receipt of a complete application.

In order to determine whether the institution has the appropriate resources for the reclassification of residency positions, the RRC will review the following information:

- The last on-site evaluation report, pertinent progress report materials, and most recent approval letter.
- Pertinent section(s) of annual report(s) submitted since the most recent on-site evaluation.

- A completed *Application for Reclassifying Positions*, RRC form 346. The application provides information regarding the rationale for the proposed increase with supporting

**The RRC will not consider the application for reclassification submitted by a program on probation.** If a program on probation reclassifies positions without authorization, the Council will withdraw approval of the program at its next scheduled meeting.

If the RRC proposes denial of the reclassification in positions, the institution is required to verify to the Council, in writing, that all current and incoming residents and program applicants selected for interview have been notified of the proposed denial (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

If the sponsoring institution fails to respond in writing within six months to written requests from Council staff and/or the RRC for information to complete the application, the application will be terminated by staff. Council staff will correspond with the program director and the institution's chief administrative officer to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

## **INACTIVE STATUS**

A residency or position(s) in an approved residency that are temporarily inactive will be considered eligible for continued approval for a period not to exceed two years immediately following completion of the last full year of training. A residency that is not reactivated within two years must follow the application procedures for new programs if and when training is reinitiated. If a residency position(s) is not reactivated within two years, the sponsoring institution must submit RRC form 345, *Application for Increase in Positions*, and the application fee if and when the position(s) are to be reactivated. (An inactive program or position is one in which funding, staffing, or available training resources have been interrupted or in which a suitable or interested candidate for the residency has been unavailable.)

Institutions with inactive, approved programs are required to submit annual report forms and annual assessment fees throughout the recognized period of inactivation.

## **RESIGNATION, TERMINATION, OR SUSPENSION OF THE RESIDENT**

If a resident resigns from or is terminated or suspended from a residency for any reason, written notice must be sent to the Council office within 30 calendar days of the termination date. It is the responsibility of the program director to notify the Council of any resignation, suspension, or termination of a resident, regardless of the approval status of the program.

If the resident's appointment is suspended or terminated, the notice must indicate the general cause for the termination but need not contain a statement of specific facts. The notice also must contain a description of the process by which the suspension or termination decision was reached to assure that institutional due process procedures were followed.

## **TERMINATION OF THE PROGRAM**

If an institution with an approved residency closes or if for any other reason the program is discontinued, the Council will withdraw approval of the program based on voluntary termination by the sponsoring institution, effective on the date of closure or termination of the residency.

It is the responsibility of the program director and the chief administrative officer to notify the Council in writing of termination of the residency. Additionally, the institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been informed of the voluntary termination of the program (when possible, applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

When an institution voluntarily discontinues a residency prior to completion of the training cycle, arrangements may be made to transfer the resident(s) to another approved residency (see Resident Transfer).

## **RESIDENT TRANSFER**

Situations such as the following may arise and require completion of a resident transfer: (1) a resident cannot complete a provisionally-approved or an approved residency because the sponsoring institution has ceased operations or discontinued the program; (2) a resident is released from a provisionally-approved or an approved residency; (3) a resident who has successfully completed an approved residency may wish to transfer into another approved residency to obtain additional training.

The charts below indicate acceptable resident transfers across residency categories. The following abbreviations for previous and new residency categories are utilized:

Previous categories

RPR (Rotating Podiatric Residency)

PPMR (Primary Podiatric Medical Residency)

POR (Podiatric Orthopedic Residency)

PSR-12 (12-month Podiatric Surgical Residency)

PSR-24 (24-month Podiatric Surgical Residency)

PM&S-24 (Podiatric Medicine and Surgery-24)

PM&S-36 (Podiatric Medicine and Surgery-36)

The Podiatric Medicine and Surgery Residency is a program into which a resident would not ordinarily transfer. However, positions in PMSR programs may be vacant and graduates of residencies approved under the previous categories may seek additional training. In such instances, the following resident transfers are permitted:

- **For RPR, PPMR, POR, and PSR-12 programs:** The resident may receive up to one year of training credit (with program director discretion.) A resident who completed one or more programs approved under former residency categories (CPME 320, dated April

2000) may receive a maximum of one year of credit from an approved non-surgical residency program, and a maximum of one year of credit from an approved PSR-12 program towards the podiatric residency.

- **For PSR-24 programs:** The resident may receive up to two years of training credit (with program director discretion.)

- **For PM&S-24 programs:** The resident may receive up to two years of training credit (with program director discretion.) If the resident is active in but has **not yet completed a PM&S-24**, he or she may transfer into a PM&S-36 or Podiatric Residency and receive credit for all training received to date, pending review by the program director at the institution accepting the resident of the competencies attained by the resident (see below).

- If the resident has been active in but has **not yet completed either a PM&S-36 or a Podiatric Medicine and Surgery Residency**, he or she may transfer into a PM&S-36 or Podiatric Medicine and Surgery Residency and receive credit for all training received to date, pending review by the program director at the institution accepting the resident of the competencies attained by the resident (see below). If acceptance of the resident transfer constitutes an increase in residency positions, the sponsoring institution must apply for authorization of the increase (see Authorization of Increases in Residency Positions).

The RRC and the Council expect that the resident will be appointed to another provisionally-approved or approved residency within a reasonable time period. The director of the program releasing the resident must submit written notification to the Council office within two weeks of the resident's departure. The director of the program releasing the resident must submit the following information in a timely manner to the director of the provisionally-approved or approved program accepting the resident:

- Training schedule.
- Signed assessments validating the resident's progress in achieving prescribed performance indicators and competencies.
- Signed resident logs from the resident's starting date in the program to the date on which the resident was released from the program.

The director of the program accepting the resident must submit the application fee (see Fee Policies) and the following information to the Council office within 30 days of the resident's official acceptance:

- Confirmation that all required materials have been submitted by the institution releasing the resident and have been reviewed. The review by the director of the program

accepting the resident must ascertain the acceptability of all previous educational experiences as based upon the resident's progress toward and successful achievement of competencies and assigned activities that have been validated formally by written assessment.

- Comprehensive training schedule that allows for achievement of all prescribed competencies specific to the residency category. (If the resident has not successfully completed a previous program, the director must confirm that the length of the resident's time in the new program will be extended to provide training for the appropriate completion of the training period.)

Once Council staff has determined that the transfer request is complete, it is forwarded to the RRC chair for consideration. If, in consultation with Council staff, the RRC chair approves the transfer, the institution to which the resident has transferred may grant a certificate indicating successful completion of a residency. The institution is authorized to grant only a certificate of completion for the residency category in which it is approved by the Council. A resident may retain a certificate issued for training completed (e.g., RPR, POR, PPMR, PSR-12, PSR-24, and/or PM&S-24) when this training is counted towards the requirements of a new program into which the resident has transferred.

If the Council's procedures for resident transfers are not followed, the resident involved may not be granted a certificate of completion by any residency.

## **PROGRAM TRANSFER**

Institutional sponsorship of a training program may be transferred from one institution to another under certain circumstances. The program director should contact the Council office to determine whether transfer of the program is appropriate or whether reapplication as a new program is necessary. A request for transfer of institutional sponsorship should be submitted as early in the training year as possible should reapplication and on-site evaluation be necessary.

The following documentation is required in all cases (i.e, the program transfer involves institutions owned by the same corporate entity and retaining the same administrative staff and podiatric and non-podiatric medical faculty, or the former sponsoring institution has closed or has changed to such an extent as to preclude providing the necessary resources for residency training):

- Letter of intent from the chief administrative officer of the new sponsoring institution.
- Letter from the chief administrative officer of the original sponsoring institution acknowledging the transfer.

- For institutions owned by the same corporate entity: written acknowledgement that all administrative staff and podiatric and non-podiatric medical faculty are retained from the original sponsor. If there are any changes, listings are required of the names of the administrative staff and podiatric and non-podiatric medical faculty retained from the original sponsor as well as any new administrative staff and podiatric and non-podiatric medical faculty (with educational and professional qualifications).

- For new institutions: listing of any new administrative staff and podiatric and non-podiatric medical faculty (with educational and professional qualifications).
- Copy of the signed contract with each resident and each resident's schedule for the entire training time.
- Curriculum vitae of the program director (if new).
- Copies of affiliation agreements (if applicable).
- Curriculum.

A full or focused on-site evaluation may be required. The institution to which the program is transferred must grant a certificate to each resident who successfully completes the program. The certificate must be appropriate for the resident's entire training sequence and the type of program that is approved by the Council.

## **ANNUAL REPORT**

Completion of an annual report form, CPME 340, is required of each institution sponsoring an approved residency beginning with the program's first year of provisional approval. The annual report provides the Council current information for CPME publication 300, *Approved Podiatric Medicine and Surgery Residencies*. As part of the annual report, the Council requests the names of residents completing the program and the residents selected for the next training year.

Co-sponsoring institutions must submit a single copy of CPME 340 that provides information about the program as a whole, rather than each individual co-sponsor submitting its own annual report. The annual report for the co-sponsored program is to include the signatures of the program director and of the chief executive officers, or their designees, of each co-sponsoring institution. (If an institution is involved in a co-sponsorship and also sponsors a separate residency program, the institution is required to participate in preparation of the annual report for the co-sponsored program and to submit a separate annual report for the residency for which it is the sole sponsor.)

If extenuating circumstances exist relative to resident completion of a training year, the program director must provide this information in the annual report. Examples of extenuating circumstances include, but are not limited to, an extension of a resident's training period to address instances of unsatisfactory performance and or to complete a portion of the training year that the resident was unable to fulfill due to illness and/or disability.

The Council requests specific quantitative information related to clinical experiences. This information is reviewed by the RRC and may be consulted in determining increases in authorized residency positions and/or approval status, as well as in preparation for on-site evaluation.

Council staff reviews annual reports and brings concerns to the attention of the RRC at its next scheduled meeting. Council staff may correspond with the program director to request that the sponsoring institution provide specific information for consideration at the RRC meeting.

Failure to submit the annual report and/or annual fee is cause for the Council to place the sponsor on administrative probation and subsequently to consider withdrawal of approval. The RRC

and/or Council reserve the right to request additional materials to clarify information in the annual report.

## **CONFIDENTIALITY AND DISCLOSURE POLICIES**

All reports and communications regarding residencies are confidential within the Council, RRC, appeal committees, evaluation teams, and Council staff. On-site evaluators, RRC members, and Council members sign a confidentiality statement on a periodic basis, confirming that privileged information will not be disclosed in any manner.

Because of the tripartite relationship of accreditation, certification, and licensure, the Council has the prerogative of providing confidential information regarding the approval status of residencies to the appropriate Council-recognized specialty boards and to state boards for examination and licensure, upon the specific written requests of these organizations.

All proceedings of the RRC and the Council with respect to determining residency recommendations and actions are held in executive session.

The Council office, the RRC, and the Council will not release or confirm the following information in any form:

- The name or status of a sponsoring institution that has initiated contact with the Council office concerning an application for provisional approval, increase in positions, or reclassification of approved positions.
  - The name or status of a sponsoring institution that has applied for provisional approval or an increase in positions but has not yet been apprised of a decision; or
  - The name or status of a sponsoring institution that has applied for and been denied eligibility for on-site evaluation or authorization of an increase in or reclassification of approved positions (prior to exhaustion of the procedural reconsideration, reconsideration, and appeal processes, as applicable).
  - The name or status of a sponsoring institution that has had provisional approval withheld or approval withdrawn (prior to exhaustion of the procedural reconsideration, reconsideration, and appeal processes).
- All inquiries regarding the approval status of a specific sponsoring institution will be answered by referral to the published directory of podiatric residencies or to the institution in question.

The Council publishes a directory of residencies on an annual basis and makes a frequently-updated version of the directory available on its website. The directory identifies residencies that are eligible for on-site evaluation, residencies holding provisional approval, residencies that are approved, and residencies approved on a probationary basis (including administrative probation). Areas of noncompliance, as reflected by standard and requirement numbers, will be included in the probationary information.

Denial of eligibility for on-site evaluation, withholding of provisional approval, and withdrawal of approval are published following exhaustion of the entire process of procedural reconsideration, reconsideration, and appeal or following the institution's indication that it does not wish to pursue these processes. Denials of increases in or reclassification of residency positions are published following exhaustion of the entire process of procedural reconsideration and reconsideration or following the institution's indication that it does not wish to pursue these processes.

### **THIRD-PARTY COMMENT**

The Council provides opportunity for individuals or organizations to submit written comments concerning an institution's qualifications for provisional or continued approval. The Council will publish notices in the *APMA News* and on its website regarding its plans to conduct either a focused evaluation or a comprehensive evaluation of an institution that seeks provisional approval or continuation of approval. The notice will indicate the deadline for receipt of third-party comments.

Third-party comments must be signed, address substantive matters relating to the quality of the program and the CPME standards and requirements, and be received 30 days prior to the program's scheduled visit date. Comments will be forwarded to the evaluation team, and to the program director for response if appropriate, during the evaluation visit process. An updated list that includes the date of each visit will be maintained on the Council's website.

### **REVIEW OF FORMAL COMPLAINTS**

A mechanism exists for reviewing formal complaints against approved residencies. The Council reviews only those complaints related to the alleged noncompliance of a program with the Council's standards and requirements. The mechanism for reviewing formal complaints is specified in CPME publication 925, *Complaint Procedures*.

### **STATEMENTS OF APPROVAL STATUS**

An institution sponsoring a provisionally-approved residency must use the following statement in reference to its approval status:

The (category of program) sponsored by (name of institution) has been granted provisional approval by the Council on Podiatric Medical Education. Provisional approval is the recognition accorded a new residency that is determined to be in substantial compliance with established standards and requirements. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

An institution sponsoring an approved residency must use the following statement in reference to its approval status:

The (category of program) sponsored by (name of institution) is approved by the Council on Podiatric Medical Education. Approval is the recognition accorded a residency that is determined to be in substantial compliance with established standards and requirements. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

An institution sponsoring a residency that is approved on a probationary basis must use the following statement in reference to its approval status:

The (category of program) sponsored by (name of institution) is approved on a probationary basis by the Council on Podiatric Medical Education. Probation indicates that a residency is in noncompliance with the Council's standards and requirements for approval to the extent that the quality and effectiveness of the residency are in jeopardy. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

No other statements regarding approval by the Council may be used without the permission of the Council.

## **ASSESSMENT OF EVALUATOR EFFECTIVENESS**

The effectiveness of the on-site evaluation process is assessed formally by the institution and the evaluation team. The Collaborative Residency Evaluator Committee (CREC) monitors the effectiveness of on-site evaluators by reviewing evaluation questionnaires completed by institutions regarding the performance of on-site evaluators, as well as those completed by the team leaders and other team members. CREC forwards a report of its review, identifying areas requiring follow-up and evaluators who might require remediation or dismissal to the Executive Committee of the Council for its review. CREC is the collaborative effort of ABPOPPM, ABPS, and the Council to develop, implement, and review procedures to select, train, and assess podiatric residency evaluators and team chairs.

In reviewing evaluation team reports, the RRC may forward comments about individual evaluators to the Council's Executive Committee. To assure objectivity in its approval recommendations, the RRC is never provided the post-evaluation questionnaires completed by the sponsoring institution and evaluation team members.

The Council commends effective evaluators and provides remediation for ineffective evaluators. The RRC, CREC, and/or the Executive Committee may suggest to the Council that evaluators who demonstrate repeated ineffectiveness be removed from the list of residency evaluators.

## **NONDISCRIMINATION POLICY**

The Council prohibits discrimination in accord with federal, state, and local regulatory guidelines and policies in the election and appointment of members, students, and public representatives to the Council and its committees and in the selection of evaluation team members, consultants, employees, and others involved in its activities.

## **FEE POLICIES**

Application fees have been established for institutions seeking provisional approval of a new program, reclassification of the approval category, and for institutions requesting authorization of increased residency positions, resident transfers, and one-time residency certificate authorizations.

All costs related to on-site evaluations of new and approved programs are borne by the sponsoring institution. The Council requires pre-payment of a specified on-site evaluation fee. Following the on-site evaluation, the Council office bills the sponsoring institution for the remainder of the full cost of the visit.

Institutions that have had provisional approval withheld or approval withdrawn and subsequently reapply must submit a reapplication fee.

The Council has established an annual fee assessed each institution sponsoring an approved residency or residencies. The Council assesses a per-program fee and a per-resident fee. A late fee is assessed related to submission of the annual assessment fee.

Institutions requesting appeals of adverse actions are assessed a portion of the anticipated actual costs prior to the appeal. Institutions are billed the remainder of any additional actual costs after the appeal.

The fees are nonrefundable. The Council reserves the right to revise established fees.

CPME 330  
October 2010

**Council on Podiatric Medical Education**  
9312 Old Georgetown Road  
Bethesda, Maryland 20814-1621  
(301) 581-9200FAX  
(301) 571-4903

[www.APMA.ORG/CPME](http://www.APMA.ORG/CPME)