

Residency Documents Adopted

November 4, 2010

OFFICIAL NOTICE

CPME Documents 320 and 330 Adopted by the Council on Podiatric Medical Education, effective July 1, 2011

At its October 2010 meeting, the Council on Podiatric Medical Education adopted revision of the standards and procedures for podiatric residency programs. The new documents - CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies*, and 330, *Procedures for Approval of Podiatric Medicine and Surgery Residencies* – will become effective on July 1, 2011.

The adoption of the documents marked the end of a two-year revision process that solicited and responded to ongoing feedback from many in the CPME community of interest (residency programs, student and young member organizations, professional organizations, and podiatric physicians). The process was highlighted by six open forums, which were attended by more than 300 program directors, residency faculty, and other interested parties. The Council also received more than 150 written comments about the proposed document changes.

The following is a summary of the most significant changes in each document; however, the Council strongly encourages members of the residency community of interest to read and review each document in its entirety.

CPME 320

- Creation of a single three-year category: the Podiatric Medicine and Surgery Residency (PMSR). Completion of the 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).
- Residencies that can provide a sufficient volume and diversity in reconstructive rearfoot and ankle (RRA) procedures may grant an added RRA credential. Completion of a Podiatric Medicine and Surgery Residency with the added credential leads to the RRA certification pathway of ABPS.
- The PMSR may now be conducted primarily in a healthcare institution approved by the Centers for Medicare and Medicaid Services (CMS) rather than limited to institutions accredited by the Joint Commission or the American Osteopathic Association.

- The amount of time that the resident may spend at sites located beyond daily commuting distance from the sponsoring institution and/or co-sponsor has been raised from no more than one-twelfth to no more than one-sixth of the residency.
- The Council confirmed its previous policy that training provided abroad may not be counted toward rotation requirements.
- Resident interviews may 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.
- Applicants must pass both Part I and Part II examinations of the National Board of Podiatric Medical Examiners prior to beginning the Residency.
- The sponsoring institution must develop a residency manual that includes all policies and mechanisms affecting the resident.
- The sponsoring institution must provide compensation to the program director that is 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 individual rotation requirements have been incorporated into the competencies for the Podiatric Medicine and Surgery Residency.
- Sponsoring institutions are encouraged to afford the resident training above the minimum expectations identified in CPME 320 and to ensure that the competencies reflect the additional training.
- The infectious disease and internal medicine and/or family practice and medical subspecialties rotations must be scheduled for the equivalent of at least three full-time months of training.
- Patient care activity requirements have been adjusted to either reflect those volumes as required for certifying board qualification or reflect to the extent possible the expectations expressed by the community of interest.

CPME 330

- On-site evaluations no longer include observation of resident participation in podiatric patient treatment related to the specialty areas.
- During discussions about the approval status of individual residencies, members of the Residency Review Committee (RRC) who served on the most recent residency evaluation team were required previously to recuse themselves from discussion and voting until the Council had determined a final approval action. For each residency visit where a member of

the RRC is a member of the evaluation team, the RRC member may now provide a verbal summary of team findings and answer any questions of the Committee. For each visit where a member of the RRC is not on the team, a Committee member will be 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.

- Procedures are established to enable reclassification of one or more non-added credential positions to added credential positions in provisionally-approved and/or approved residencies.
- Program transfer procedures have been clarified and identify specific documentation to be submitted by the institutions for consideration by the RRC.

**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 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 (COH). 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 program) and externally (by outside organizations).

Residency Review Committee (RRC)

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 medical and surgical 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 medical and surgical 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:

a. resident duties and hours 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 medical and surgical 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 by medical, biomechanical, and surgical means.
- Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident’s competencies in the perioperative 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 medical and surgical evaluation and management.
- Didactic experience, providing an opportunity to expand the resident’s knowledge in the breadth of podiatric and non-podiatric medical and surgical 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, vascular imaging.
 - Laboratory tests in hematology, serology/immunology, toxicology, and microbiology, to 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.
 - Surgical management when indicated, including
 - evaluating, diagnosing, selecting appropriate treatment and avoiding complications.
 - 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 medical and surgical 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 experiences:
 - Recognizing and diagnosing common infective organisms.
 - Using appropriate antimicrobial therapy.
 - 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. 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 with appreciation of healthcare costs.

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 Workers' Compensation.
4. Understand medical-legal 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.
4. 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 majority of didactic activities must include participation by faculty.

The residency curriculum must include instruction in research methodology. The resident should participate in research activities to broaden the scope of training. 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.

The program should require that the resident take in-training examinations 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 examinations. Examination results are used as a guide for resident remediation and as part of the annual self-assessment of the program.

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

<u>A. Patient Care Activity Requirements</u>	<u>MAV</u>
(Abbreviations are defined in section B.)	
<u>Case Activities</u>	
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
<u>Procedure Activities</u>	
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

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