Cambridge Health Alliance Podiatric Medicine and Surgery with Reconstructive Rearfoot/Ankle Residency Program

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1. **CAMBRIDGE HEALTH ALLIANCE MISSION STATEMENT AND VALUES**

Mission: To improve the health of our communities.
Vision: To be the premier academic public health care system in the nation.
Values: Community, Integrity, Respect, Compassion, Learning, Excellence (CIRCLE).

2. RECRUITMENT AND APPOINTMENT OF RESIDENTS

Eligibility - Residents will be eligible for appointment to The Council on Podiatric Medical Education (CPME) accredited Cambridge Health Alliance Podiatric Medicine and Surgery Residency if they have graduated from an accredited United States Podiatric Medical School.
An application fee of $40 shall be paid to the Cambridge Health Alliance Podiatric Medicine and Surgery Residency Program by each interested Podiatric Medical Student applicant. This fee is only used to recover costs associated with conducting the interview process (transportation, hotel, food) at CRIP. The application fee amount and due date will be listed in the CASPR Directory of Participating Programs. This fee is non-refundable.
Selection Process

i. The Cambridge Health Alliance Podiatric Medicine and Surgery Residency Program selects residents from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. The program does not discriminate with regard to sex, race, age, religion, color, sexual orientation, national origin, disability or veteran status. This CPME accredited residency program participates in the national

podiatric resident match process (CASPR / CRIP). The residency program is a member of the American Association of Colleges of Podiatric Medicine (AACPM) and the Council of Teaching Hospitals (COTH).

Match Selection Criteria

ii. **Step 1:** All applicants must have completed or anticipate satisfactory completion of podiatric medical school by June of the year starting residency. The candidates complete a uniform application provided by CASPR that is forwarded to the hospital. A non-refundable fee of forty dollars is required of the applicant to recover the costs associated with processing the application and conducting the interview process. The applications are screened by the residency selection committee and rated by reviewing academic credentials, clinical rotation evaluations, letters of recommendation, personal applicant statement, board scores and research activities. The program informs all applicants as to the completeness of their application and as to whether or not a formal interview is granted by utilizing the notification postcards supplied by CASPR.

Those that pass the initial screening are invited to interview with the program at the CRIP.

ii. **Step 2:** All candidate interviews are performed during the CRIP. The interview team consists of the program director or assistant program director, division chief and one other designee, which is usually a current resident. The interview is composed of social and academic aspects.

During the CRIP weekend, the program sponsors a call back only reception for all potential residency candidates. A presentation highlighting the Cambridge Health Alliance Podiatric Medicine and Surgery Residency program is oftentimes given. The social also provides the opportunity for the candidates to interact with the residency selection committee in a more informal arena.

iii. **Step 3:** The applicant folders are then reviewed independently by the residency selection committee. Applicants are ranked based upon their application and personal interview. The program director, assistant program director and division chief review the files and an overall rank is applied to each candidate. The final rankings are submitted to CASPR and the program is notified on the specified match date. Binding commitment from the prospective resident is not obtained until after CASPR notifies the resident and institution.

3. RESIDENT'S INDIVIDUAL RECORD AND FILE:

An individual file will be kept for each resident. This file will contain the resident's application, licensure documents, rotation evaluations, semi-annual progress reports, and other records which document the resident's progress both academically and professionally.

The resident will have the opportunity to review and discuss the information in his/her file by making an appointment to do so with the program director.

4. RESIDENT EVALUATIONS:

Resident evaluations are conducted and documented at the end of each course, rotation or segment of training by the faculty member who most closely observed the resident's performance. The documentation, usually an evaluation form, must be signed by the faculty member and by the resident.

In addition to course evaluations, each resident's performance is evaluated on at least a semi-annual basis by the podiatric residency teaching committee. A copy of the semi-annual progress report must be given to the resident and a copy added to the resident's file.

5. SEXUAL HARASSMENT POLICY

It is the goal of Cambridge Health Alliance (CHA) to promote a workplace that is free of sexual harassment, as that term is defined below. Sexual harassment of employees which occurs in the workplace or in other settings in which employees may find themselves in connection with their employment is unlawful and will not be tolerated by CHA. Furthermore, any retaliation against an individual who has complained about sexual harassment, or retaliation against individuals for cooperating with an investigation of a sexual harassment complaint is similarly unlawful and will not be tolerated. CHA has established a procedure by which inappropriate conduct will be dealt with, if encountered by employees. CHA will respond promptly to complaints of sexual harassment, and, where it is determined that inappropriate conduct has occurred, CHA will act promptly to eliminate the conduct and to impose such corrective action as is necessary, including disciplinary action where appropriate.

b. This policy applies to all employees of Cambridge Health Alliance. If any portion of this policy is inconsistent with either an applicable collective bargaining agreement or civil service statute, the applicable collective bargaining agreement or civil service statute shall take precedence in defining CHA's rights and obligations with regards to that portion. However, the invalidity or modification of a portion of the policy shall not affect the applicability of the policy as whole.

c. **Complaint of Sexual Harassment**

If any CHA employee believes that he or she has been subjected to sexual harassment, the employee has the right to file a complaint. This may be done in writing or orally. If an employee wishes to file a complaint, he or she may do so by contacting any of the following individuals:

1) the employee's immediate supervisor, service line leader(s), area's Senior Vice President or senior administrator, or:

2) The Senior Director of Human Resources or, in the case of physicians, The Director of Human Resources, CHAPO. These persons are also available to discuss any concerns that employees may have and to provide information to employees about CHA's policy on sexual harassment and our complaint process.

d**. Sexual Harassment Investigation**

When CHA receives the complaint, it will promptly investigate the allegation in a fair and expeditious manner. The investigation will be conducted in such a way as to maintain confidentiality to the extent practicable under the

circumstances. The investigation will generally include a private interview with the person alleged to have committed sexual harassment. When we have completed our investigation, we will, to the extent appropriate, inform the person filing the complaint and the person alleged to have committed the conduct of the results of that investigation. If it is determined that inappropriate conduct has occurred, we will act promptly to eliminate the offending conduct, and where it is appropriate we will also impose disciplinary action.

e**. Retaliation Against Complainants**

No employee shall be subject to reprisals or retaliatory acts for reporting a situation of perceived sexual harassment. Individuals who engage in acts of reprisals or retaliation in these matters will be subject to disciplinary action up to and including termination.

f**. State and Federal Remedies**

In addition to the above, if you believe you have been subjected to sexual harassment, you may file a formal complaint with either or both of the following

government agencies:

1. The United States Equal Employment Opportunity Commission
1 Congress Street, 10th Floor
Boston, MA
(617) 565-3200

g**.** The Massachusetts Commission Against Discrimination
Boston Office:
One Ashburton Place - Room 601
Boston, MA 02108

h.. **Disciplinary Action**

If it is determined that inappropriate conduct has been committed by one of our employees, we will take such action as is appropriate under the circumstances.

Such action may range from counseling to termination from employment, and may include such other forms of disciplinary action as we deem appropriate under the circumstances.

In accordance with Massachusetts law, this policy will be distributed to all CHA employees on an annual basis. In addition, while not mandated by statute, CHA will provide sexual harassment avoidance training to its supervisory and managerial employees.

H. False Accusations

CHA also recognizes that the question of whether a particular course of conduct constitutes discrimination or harassment often requires a factual determination, and that false accusations can have a serious detrimental effect on innocent persons. Therefore, if an investigation results in a finding that a person accused another of discrimination or harassment maliciously or recklessly, or the complaining employee made false accusations, that employee may be subject to appropriate corrective action up to and including termination of employment.

I. Definitions

A. In Massachusetts, the legal definition for sexual harassment is the following:

"Sexual Harassment" means sexual advances, requests for sexual favors, and verbal or physical conduct of a sexual nature when:

1. Submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of employment or as a basis for employment decisions; or,
2. Such advances, requests or conduct have the purpose or effect of unreasonably interfering with an individual's work performance by creating an intimidating, hostile, humiliating or sexual offensive work environment. Sexual harassment may occur regardless of the intention of the person engaging in the conduct. While it is not possible to list all those circumstances that constitute sexual harassment, the following are some examples of conduct, which, if unwelcome, may constitute sexual harassment, depending upon the totality of the circumstances, including the severity of the conduct and its pervasiveness:

- Sexual advances - whether they involve physical touching or not;
- Requests for sexual favors in exchange for actual or promised job benefits such as favorable reviews, salary increases, promotions, increased benefits;
- Sexual jokes;
- Use of sexual epithets, written or oral references to sexual conduct, gossip regarding one's sexual life; comment on an individual's body, comment about an individual's sexual activity, deficiencies, or prowess;

• Displaying sexually suggestive objects, pictures, cartoons;
• Leering, whistling, brushing against the body, sexual gestures, suggestive or insulting comments;
• Inquiries into one's sexual experiences;
• Discussion of one's sexual activities.

6. DISCIPLINARY AND GRIEVANCE DUE PROCESS POLICY

PURPOSE: The residency maintains a program of progressive constructive discipline to inform residents who are not meeting the program's expectations. The resident is informed of how and why their performance / conduct are not acceptable and how the resident must improve to meet the program's standards.

POLICY:

iii. **SCOPE:** This policy applies to all residents who are enrolled in the podiatric medicine and surgery residency program (PMSR/RRA) at the Cambridge Health Alliance. When the resident signs his/her training and employment agreement, he/she accepts that he/she has read, understands and accepts the provisions of this policy as a condition of his/her employment.

iv. **PERFORMANCE STANDARDS:** The standards for academic advancement, clinical performance and professional growth are set forth in the residency manual. These standards are documented in writing, distributed and explained to new and advancing residents. Residents are expected to observe the rules of employment.

v. **PERFORMANCE MANAGEMENT:** It is the responsibility of the program director to take any corrective disciplinary action, which may include any or all of the following: verbal warning, written warning, incident notice, probation, suspension and/or termination. If the resident has demonstrated unsatisfactory performance, conduct or attendance, the incident or behavior should be addressed immediately by the program director. The program director must use the specific guidelines for the management of resident performance. An important part of each step of the corrective discipline process is the corrective action plan. This is agreed upon by the resident and the program director and is designed to outline the conditions for improving the resident's performance. The modes of intervention available to the program director include:
    1. Active mediation between resident, faculty member, rotation or service, or with supervisor.
    2. Reassignment of the resident to another rotation site or supervisor should the problem be seen as existing substantially within the service or faculty member.

vi. If the resident does receive a marginal or unsatisfactory evaluation, a plan for ending the behavior and / or remediating the behavior is

established between the program director and resident. Methods may include:

1. Increased supervisory contact with the program director or other faculty member(s).
2. Appointment of a faculty member as advocate.
3. Remediation plan with faculty, with development of a timetable for completion of tasks which may include:
    a. Increased supervisory contact
    b. Increased didactic work, self-study, or tutorial
    c. Repetition of a particular rotation or didactic experience
4. In the event of a troubling developmental conflict, psychiatric difficulties, or if the impairment involves alcohol or substance abuse. A referral for private, confidential psychiatric care with assistance in financing, covered time away and leave of absence will be provided.

7. DISCIPLINE PROCESS / GRIEVANCE AND APPEAL PROCESS:

In the event that an academic / professional or administrative behavior problem documented by the program director has not been corrected with remediation. The program director will provide a written notification to the resident of probation (including length or time and reasoning), proposed disciplinary action, or a contemplated delay in progression decision or expulsion.

The purpose of the grievance process is to assure that a formal "due process" method is available for the resident to voice questions or concerns about an evaluation, a disciplinary action or other program related issue. It is the responsibility of the program director to make every effort to investigate and resolve the concerns and grievances of the residents. It is the prerogative of the program director to consult with the residency teaching committee as part of the resolution process.

In the event of an alleged administrative misconduct, should the resident disagree with the assessment or the suggested remedy, the resident has access to the already agreed upon grievance procedure (Article III) and arbitration (Article IV) outlined in the CHHOA contract. The resident may have the situation reviewed sequentially by the Chief or Service, Chief Medical Officer, and Chief Executive Officer of the Alliance; culminating in the use of an outside arbitrator should all other reviews fail to resolve the situation.

In the event of alleged professional misconduct (including allegations of poor medical care, lapses in professional / ethical conduct, inadequate academic performance, etc.) should the resident disagree with the assessment or the suggested disciplinary recommendations, the

resident has access to the Disciplinary Procedures (Article XVII) in the agreement between the CHA and the CHHOA. These procedures provide for a sequential review including: a full hearing by the Chief of Service; the right to a review board of 3 attendings and 3 fellow house officers; culminating in a review by an outside group of 3 physicians, including the opportunity to present evidence, witnesses, and to cross-examine witnesses.

8. RESIDENT TRANSFER, FAILURE TO PROGRESS / GRADUATE OR EXPULSION:

The training program will assist a resident transferring to another program by completing reference letters, career counseling and discussing the situation with other program directors at the request of the resident. The program will provide secretarial assistance and protected time for interviewing by the resident.

The program director will aspire to be an advocate of the resident even in cases of probation, discipline or expulsion. However, as a physician he may also be ethically and legally obligated to report incidences of dangerous medical care, physician impairment or ethical lapses to other training programs or governmental agencies overseeing the licensure of physicians. Such notification will only occur following completion of all of the above steps of due process after much consultation with the program faculty and hospital administration.

9. PROCESS OF ERRORS OF EVALUATION

At any point in the process, should a negative evaluation of a residents' functioning be unsubstantiated or considered incorrect, all material associated with the incorrect assessment will be removed from the residents training record.

10. POLICY ON DUTY HOURS

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences, workshops and journal club. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.

One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period, and must consist of an 8 hour time period provided between all daily duty periods and after in-house call.

Any recent changes in ACGME/GMEC rules supersede this document

Residents are not currently required to take in-house call but must be available to the emergency department or wards within 20 minutes.

Call must occur no more frequently than every third night.

If the resident is called in and must remain in-house, patient care must not exceed 24 consecutive hours (or 16 hours for PGY1 as of July 2011). Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical care.

No new patients may be accepted after 24 hours of continuous duty.

As of July 1, 2011, according to new ACGME guidelines, a PGY1 is limited to 16 working hours per 24 hours with at least 8 hours between shifts.

Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service. Residents will report on duty hours when they evaluate rotations at the end of each block and at the end of the year if they feel they have been excessive or inappropriate.

Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. Residents so affected will page the chief podiatry resident, program director or division chief.

11. LEAVE OF ABSENCE POLICY

Residents will be provided the opportunity to take leave of absence for up to 12 months with the approval of the Program Director. Residents who take an approved leave of absence must still satisfy all criteria for completion of the residency program unless specifically exempted by the Program Director.

MEDICAL LEAVE: Consistent with the Family and Medical Leave Act of 1993 (summarized in Appendix A), House Officers covered by this agreement are entitled to up to twelve (12) weeks of unpaid medical leave for serious illness or serious illness of said person's spouse, parent or child, and up to twelve (12) weeks of unpaid family leave for the birth or care of a child, for adoption of a child under age eighteen or foster care placement of a child under age eighteen.

vii. During a medical leave of absence the Cambridge Public Health Commission will continue to pay for the cost of the disabled House Officer's insurance in accordance with contribution rates defined in this Agreement, dental and visual and disability insurance.

viii. In cases where a House Officer has advance knowledge of a temporary and partial disability, said House Officer is encouraged to notify his/her department at the earliest possible date. Where a House Officer so requests, the Chief of Service and the affected House Officer shall work out an arrangement that will protect the House Officer's health while taking into account the House Officer's accreditation requirements. These arrangements will be made in accordance with departmental policy jointly developed in negotiations with the union. Such a plan requires an explicit written statement to include: the length of time allowed, the House Officer's right to return, credit for time completed, projected minimum/maximum requirements for board eligibility, and whether there will be any required make up time, including number of nights on call. Such a plan must be agreed to at least 2 months in advance of the expected date on which maternity leave is to begin.

MATERNITY LEAVE:

ix. A leave of absence without pay will be granted for a period of up to six (6) months on or about the date of delivery or adoption. Upon the expiration of said leave, the employee shall be reinstated to her former position and department. Failure to return to work upon expiration of said leave will result in termination unless the employee had received a written extension thereto prior to the expiration date.

x. The leave policy described above shall also be extended to a House Officer who assumes primary care of a newborn or adopted child in his or her immediate household.

xi. Disabilities connected with childbirth and pregnancy must receive treatment at least as favorable as that accorded to other disabilities.

xii. While each particular department and each House Officer is different and therefore specific rules for every situation cannot be developed the following options must be considered in developing a mutually acceptable program for an individual House Officer who is temporarily and partially disabled.

1. Rescheduling of less taxing rotations or electives
2. Relief from some night call by example, hiring moonlighters using the sick call pay pool
3. Use of paid sick leave
4. Relief from exposures to and guidance concerning certain radiation, chemicals, diseases and hazards
5. Flexible rescheduling of vacation time
6. Part-time residencies and extended leaves of absence, at the request of the affected House Officer
7. Time must be allowed for medically indicated doctor's visits

RETURN TO WORK NOTIFICATION: Employees returning from any of the leave times specified above shall notify their Department when they intend to return to work at least two (2) weeks prior thereto.

PARENTAL LEAVE: House Officers are entitled up to fourteen (14) days parental leave in order to attend the birth, adoption, or care of a child in the employee's immediate household. These days shall be deducted from the employee's unused sick leave.

CHILD CARE RESOURCE: The Cambridge Public Health Commission shall provide a child care resource and referral program through the Child Care Resource Center or any other appropriate Child Care Agency for employees.

ACCREDITATION REQUIREMENTS: House Officers returning from family or maternity leave may be required to complete missed rotations in order to become board eligible. Should a department require a House Officer to complete missed rotations, the Commission shall compensate the House Officer at his/her current PGY level and provide malpractice coverage and all other applicable benefits. Said House Officer's schedule will be arranged to complete accreditation requirements as quickly as possible.

Bereavement Leave:

xiii. Day Allowances: Employees will be granted leave of absence with pay for not more than three (3) days on account of the death of a father, mother, brother, sister, husband, wife, child, son-in-law, daughter-in-law, or parent-in-law, whether such relative was a member of the employee's household or not. Pay for absence not to exceed three (3) calendar days will be also allowed on account of the death of any other relative who was a permanent member of

the employee's household or of any other person with whom said employee made his/her home.

xiv. 1 Day Allowances: Employees as defined in Section 1, also will be paid full salary for absence not to exceed one (1) day to attend the funeral of a first cousin, grandparent, grandchild, brother-in-law, sister-in-law, aunt, uncle, nephew or niece, and spouse's grandparent, brother-in-law or sister-in-law.

xv. If additional time off is needed for either section a) or b) of this article, the House Officer may make use of his/her accrued sick leave, subject to the approval of the program director.

EMERGENCY STAFFING SITUATIONS:

xvi. A serious staffing situation is defined to include, but not limited to, absence due to prolonged illness, disability, pregnancy, approved leaves of absence, emergency absence, removal from payroll, and/or resignation. In the event of a serious under staffing situation, the Chief of Service and Program Director will meet with representatives of the CHHOA and representatives of the CHA administration to devise contingency plans to deal with the situation. In no event shall a resident be required to work more than 25 nights in a quarter. If the resident agrees to be on call in excess of 25 nights in a quarter and such extra nights results in a net excess of the yearly maximum cap for that individual, then the individual resident shall be compensated.

xvii. Residents who are ill are encouraged to seek appropriate medical attention. The sick resident will notify the Program Director or his/her designee as soon as it is evident that s/he will not be able to report to work. The Chief resident and Program Director will determine which rotation services will be covered and will recruit the designated on-call intern to work. The sick resident will not be penalized for reporting sick but may have to compensate the covering resident for a call night if applicable.

CRITERIA FOR PROGRAM COMPLETION:

xviii. Upon returning to the residency program, the resident must satisfy the requirements for program completion as set forth by the Council on Podiatric Medical Education. Core rotations that must be satisfactorily completed prior to program completion include: Podiatric Surgery, Podiatric Clinic, Medical Imaging, Medicine, Emergency Medicine, Pathology, General / Vascular Surgery, Plastic Surgery, Orthopedic Surgery, Behavioral Medicine, Infectious Disease, Rheumatology, Endocrinology and Anesthesiology.

Case Activities

Podiatric Surgical cases	300
Trauma cases	50
Podopediatrics cases	25
Other podiatric procedures	100
Lower extremity wound care	50
Biomechanical cases	50
Comprehensive medical H&P's	50

Procedure Activities

First and second assistant procedures (total)	400
First assistant procedures, including:	
Digital procedures	80
First Ray procedures	60
Other soft tissue procedures	45
Other osseous procedures	40
Reconstructive Rearfoot / ankle	50

The resident must be able to document in his/her surgical logs that the minimum podiatric surgical criteria have been accomplished. The Cambridge Podiatric Residency Review Committee will review all evaluations and surgical logs to insure that all completion criteria have been achieved and that there are no reservations as to the skills and competence of the resident.

12. GENERAL RULES AND REGULATIONS

The residents shall observe those proprieties of conduct and courtesies that are consistent with the profession and in accordance with the rules and regulations governing the physician staff of The Cambridge Health Alliance and the Division of Podiatric Surgery. Breach of rules shall be brought to the attention of the Director of Podiatric Residency Training and appropriate corrective disciplinary action instated. (see Disciplinary Process section of manual)

Questions or criticisms related to general hospital operations or personnel may be brought to the attention of the Residency Director. The Residency Director will discuss concerns with the proper hospital administrator.

Questions relating to the podiatric resident's training will be discussed with the Residency Director.
Questions and criticisms of Podiatric Staff members will be discussed at designated resident meetings. If necessary, concerns will be directed to the Chief of the Division of Podiatric Surgery.
The residents shall follow the prescribed resident program schedule. The resident will report to his designated assignment at the prescribed hour. Tardiness will not be tolerated. The assigned resident should try to attend all scheduled conferences. All residents will function under the auspices of the Director of the Podiatric Residency Program.
Daily rounds shall be performed by the residents involved in the surgical cases and on all active podiatric patients in the hospital. All available residents should be in attendance with the chief resident or first assistant acting as lead resident. Weekend rounds should begin no later than 7:00AM unless otherwise discussed with the attending physician on call.
No surgical case should be scheduled in the operating room without the knowledge of the attending podiatric surgeon.
Residents shall perform Podiatric History and Physicals as well as preoperative notes on all podiatric surgical patients. The H&P shall be reviewed and signed by the attending surgeon prior to any procedure.
The residents shall make preoperative evaluations and review the next day's surgical charts. The resident is responsible for reviewing the preoperative lab results, radiographs and should be able to discuss the proposed surgical procedure with the attending.
No visitors are permitted in the operating room without proper approval and signed consent of the patient.
The first assistant is responsible for obtaining the necessary surgical instruments and supplies for the procedure.
The first assistant is responsible (unless otherwise stated by the attending) for dictating the operative report and/or discharge summary within 24 hours of the procedure or under the established guidelines of the hospital / surgical center.
The resident shall keep accurate, legible and complete patient documentation for each patient encounter.
The assigned podiatric medicine & surgery resident must keep the attending physician updated on his patient(s) on a daily basis. Any call from a patient during the initial postoperative period should be discussed with the surgeon of record (or on-call attending if the surgeon is not available).
The assigned podiatric medicine & surgery resident must have each patient's room stocked with the necessary dressing supplies for daily rounds.
Transition of care - The assigned podiatric medicine and surgery resident must submit an appropriate written or electronic sign out with all pertinent medical information on each hospitalized patient to the "on call" resident.

The residents shall be attired in the appropriate professional manner.
Every resident is responsible for maintaining a current residency log in Podiatric Residency Resource. These records will be reviewed regularly with the Director of the Program. Logs should be updated at least weekly.
Residents are to give no patient information to news reporters, lawyers, insurance companies etc.
The resident is responsible for keeping the chief resident informed of his whereabouts at all times.
Residents are responsible to submit a written request for personal and vacation days desired to assure there is minimal conflict within the structure of the program. All time off must be approved by the Residency Director.
Residents must make documentation available (doctors notes, police reports, etc) for all unexcused absences or tardiness. If no documentation is available, the time will be deducted from vacation / personal time.
Residents that anticipate a leave of absence for 2 weeks or more must notify the Residency Director & CHHOA of the leave. (see complete policy)
Smoking will not be tolerated within the hospital or on hospital property.

13. UNSUPERVISED PROCEDURES

A Podiatry Resident of the designated year may perform the following procedures on the Medical/Surgical floor on in Emergency Department unsupervised:

Nail Avulsions and Matrixectomy	PGY1, PGY2, PGY3
Ulcer Debridement	PGY1, PGY2, PGY3
Incision and Drainage of abscess	PGY1, PGY2, PGY3
Removal of Foreign bodies	PGY1, PGY2, PGY3

14. CRITERIA FOR ADVANCEMENT

Advancement from PGY-1 to PGY-2:

xix. Successful completion of all PGY-1 rotations.
xx. Competent to supervise PGY-1 residents and podiatric medical students.
xxi. Successfully performed all entry level procedures as outlined on rotation competencies and documented on operative / clinical logs.
xxii. Able to perform resident duties with limited independence.
xxiii. Acceptable performance on the in-training examination.

Advancement from PGY-2 to PGY-3:

xxiv. Successful completion of all PGY-2 rotations.
xxv. Competent to supervise PGY- 2 residents.
xxvi. Successfully performed all basic procedures as outlined on rotation competencies and documented on operative / clinical logs.
xxvii. Able to perform PGY-2 resident duties with limited independence.

Completion of Program:

xxviii. Successful completion of all PGY-3 rotations.
xxix. Successful completion of all required medical and surgical competencies.
xxx. Able to perform the practice of podiatric medicine and surgery independently.

At every level of advancement and at the time of completion of training, the resident must demonstrate the following:

xxxi. Works well with patients, fellow residents, faculty, consultants, ancillary staff and other members of the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues as demonstrated by satisfactory staff and faculty professional behavior evaluations. Any disciplinary action plans as a result of unprofessional behavior must have been successfully completed.
xxxii. Policy regarding absence or impaired function due to mental or emotional illness, personality disorder or substance abuse: Any disciplinary actions or treatment programs implemented per the CHA – GMEC policies on impaired function must have been successfully completed and reinstatement approved by the Podiatric Surgical Residency Program Director.

15. POLICY ON MOONLIGHTING

Residency is a full-time responsibility. Activities outside the educational program must not interfere with the resident's performance in the educational process. Accordingly, Department of Surgery-sponsored training programs adhere to Cambridge Health Alliance policies on moonlighting (Sect. 2.14, Professional Activities outside the Educational Program, Graduate Medical Education Committee):

Residents are strongly discouraged from moonlighting during the PGY1 year.

Recognizing the financial constraints on some of our residents, moonlighting is permitted during the PGY2 and PGY3 years.

Moonlighting that occurs within the residency program and/or CHA must be counted toward the 80-hour weekly limit on duty hours. The program director must document in writing prospectively that s/he has granted permission for the resident to moonlight, and must include this information as part of the resident's folder.

Moonlighting must not interfere with the resident's ability to provide patient care and should not interfere with the resident's ability to participate in the educational opportunities of the training program.
If a resident experiences educational difficulty necessitating additional support or remediation, the program director may strongly discourage the resident from moonlighting. **The resident's performance will be monitored for the effect of moonlighting activities. Moonlighting may be disallowed if adverse effects are documented.**
Residents must never be required to engage in moonlighting.
All residents engaged in moonlighting outside the Cambridge Health Alliance (or within the Cambridge Health Alliance, but not subject to the usual supervision provided to residents) must be licensed for unsupervised medical practice in the state where the moonlighting occurs.
It is the responsibility of the institution hiring the resident to moonlight to determine whether such licensure is in place, adequate liability coverage is provided, and whether the resident has the appropriate training and skills to carry out assigned duties.

16. Policy Regarding Pharmaceutical/Medical Device Industry Relations

Guidelines Regarding Interactions with Pharmaceutical and Medical Device Companies - The Division of Podiatry follows the Cambridge Health Alliance Pharmaceutical / Medical Device Industry Relations Policy which is also located in this manual.

xxxiii. **Purpose:** To establish ethical principles of conduct for interactions between the attending staff / residents of the CHA division of podiatric surgery and pharmaceutical / medical device companies (P/D Companies) and their representatives.

xxxiv. **Principles:** Inappropriate promotional activities by P/D companies compromise the professional relationships maintained by physicians and patients and should not be contaminated by profit driven interests of these entities. Attendings and residents should obtain information and form clinical decision making around evidence-based practice priniciples, critical appraisals of scholarly literature and should be subject to rigorous dialogue and review in order to continually improve the practice of medicine and surgery.

xxxv. **Guidelines:**

1. The training program shall educate trainees on the influence of P/D companies .
2. P/D representatives will not be provided direct access to trainees without the presence of attending staff. Nor will they be given permission to distribute promotional materials through CHA e-mail, mailboxes, conference rooms or the resident office. Additionally, trainees' contact

information will not be made available to P/D representatives.

3. Trainees may not sign for sample medications. At sites where medication samples may be dispensed, trainees shall not distribute medication samples without discussing the advantages and disadvantages with the clinic attending. Furthermore, samples should be managed at the clinical site in accordance with JCAHO guidelines and any relevant CHA policies.
4. Medical device representatives are not permitted to be present during patient treatment except as approved by the appropriate CHA entity (e.g., a policy on medical device representatives' presence in the operating room). In addition, prior to permitting a representative to be present for a patient's treatment, the patient's consent must be obtained and documented in accordance with HIPPA requirements.
5. Speakers at all educational conferences, including trainees, will fully disclose any P/D support and relationships, financial and otherwise, that may pose a real, or perceived, conflict of interest with respect to the content of their presentation.
6. Subsidies to underwrite the costs of medical education conferences or lectures that may contribute to patient care will be permissible if approved by the training director and/or division chief. Funds should be in the form of an unrestricted educational grant.
7. Personal gifts to health providers by P/D companies should be avoided. Any gifts to be accepted by a trainee / program should entail a benefit to patients, be related to work and education, and should be of insignificant value. Gifts must be disclosed to the training director and / or division chief, preferably in advance. Cash gifts should not be accepted under any circumstances.
8. Educational activities on CHA premises including surgical workshops / skills laboratories etc. sponsored by P/D companies should have direct participation of trainees and attendings. The content and format should be reviewed by the training director in advance of the proposed activity.

17. SUMMER VACATION POLICY: August tends to be a slow month due to attending vacations. Overall, the surgical schedule seems to be quite slow during August. The revised policy dictates that there will be no scheduled vacation time from mid-June until July 31. During the month of August, the 3rd year residents may take up to 1 week (5 working days) of vacation, but they may not overlap. If the 3rd year residents opt out of taking August vacation time, then the 2nd year

residents may take up to 1 week. No 2 residents may be on vacation at the same time (which includes weekends).

18. ANTICIPATED ROTATION SCHEDULE FOR 2024-25:

		July	August	September	October	Novemb er	December	January	February	March	April	May	June
PGY 1	A	Surg/ vasc	PodSu	PodSu	EM	ID	PodSu	PodS u/End o	BM/Pod	Med	PodSu/ Anes	PodS u	MedIM/Endo
PGY 1	B	PodS u	Surg/va sc	EM	PodSu	PodS u/Me dIM	BM/PodSu	PodS u	PodSu	Anes/PodSu	ID	Med	PodSu/E ndo
PGY 2	A	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu	PodS u	Ortho	PodSu	Rheum /PodSu	PodS u	PodSu
PGY 2	B	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu	Ortho	PodSu	PodSu/ Rheum	PodSu	PodS U	Podsu
PGY 3	A	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu
PGY 3	B	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu	PodS u	PodSu	PodSu	PodSu	PodS u	PodSu

2024-25

PGY1A - Sharon Dei-Tumi

PGY1B - Claudia Barajas

PGY2A - Anna Guo

PGY2B - Shuran Zhang

PGY3A - Dylan Hemsted

PGY3B - None

19. ROTATION COMPETENCIES:

The Cambridge Health Alliance PMSR/RRA Residency has written goals constituting a realistic overall mission for the residency program as well as specific objectives for each experience which are appropriate for each core

and clinical rotation. Copies of these goals and competencies are contained within this manual. These goals and competencies focus on the educational development of the resident and do not place emphasis on service responsibility to individual faculty members.

At the completion of each block experience, the resident shall be evaluated by the rotation director. Each rotation director will require members of that rotation's teaching faculty to submit evaluations for residents he or she has worked with during that time. The rotation director will review these prior to completing the evaluation if applicable. It shall be the responsibility of the resident to present to the director of podiatric medical education, the completed and signed evaluation forms for each rotation within two weeks of completion of the rotation unless extenuating circumstances exist.

For ongoing rotations, the resident shall be evaluated quarterly. The rotation director will communicate with members of the rotation teaching faculty for residents he or she has worked with during that month. The rotation director will complete these evaluations.

All of the evaluation forms, including those from members of each rotation's teaching faculty, will be submitted to the residency director within two weeks of completion of the rotation. Each evaluation performed shall be signed by the rotation director, the resident, and the director of podiatric medical education. All evaluation forms indicate the dates of the rotation.

If any competency is not met, the director of podiatric medical education will arrange for additional time to be spent in that rotation. The resident will be given additional teaching in the forms of lectures, assigned self-study, or clinical experiences as determined appropriate and necessary by the rotation director. The resident will then be reevaluated. Failure to pass a core experience after two consecutive attempts will result in dismissal.

Each rotation director will also report any attendance, disciplinary, or behavioral difficulties to the director of podiatric medical education.

Comprehensive Goals of the PMSR/RRA Program

To graduate fully, a competent podiatric physician who will:
1. Demonstrate proficiency in the evaluation and surgical treatment of commonly and uncommonly encountered foot and ankle disorders;

2. Demonstrate proficiency in the palliative and biomechanical management of foot and ankle disorders;
3. Demonstrate technical operative proficiency in the performance of office based and hospital based podiatric surgery;
4. Demonstrate proficiency in the evaluation and treatment of
    a. traumatic disorders of the foot and ankle;
    b. infectious disorders of the foot and ankle;
    c. congenital/pediatric disorders of the foot/ankle;
    d. adult/geriatric disorders of the foot/ankle;
    e. dermatologic disorders / wound management of the foot/ankle;
    f. vascular/diabetic disorders of the foot/ankle;
    g. neurologic disorders of the foot/ankle;
    h. rheumatic disorders of the foot and ankle;
5. Demonstrate proficiency in the interpretation of medical/bone and joint imaging techniques relevant to the management of the patient with a foot or ankle disorder,
6. Demonstrate an understanding of the ethical practice of podiatry;
7. Demonstrate proficiency in the performance of a complete medical history and physical examination;
8. Demonstrate the ability to evaluate, manage, or appropriately refer for treatment problems or concerns which occur in the perioperative patient;
9. Demonstrate an understanding of the "business" of podiatry, including practice management;
10. Demonstrate proficiency in the utilization of special techniques, including but not limited to laser surgery, application of external fixation, arthroscopic surgery, internal fixation techniques, implant and biomaterial utilization.

Specialty Rotation Competencies

Anesthesia Rotation Competencies – PGY1

1. The resident will be able to perform and interpret the findings of a pre-anesthetic evaluation.
    A. Demonstrate knowledge of anesthetic risk factors and ASA rating
    B. Demonstrate knowledge of fluid and electrolyte concerns in the perioperative period
2. Demonstrate knowledge of appropriate intra-operative monitoring of patients including, but not limited to: Patient positioning, establishing and assessing patient monitors
3. Demonstrate knowledge and ability to establish and maintain an airway
4. Demonstrate knowledge and indications for different anesthetic techniques:
    A. General, sedation, spinal, epidural, regional block
5. Demonstrate awareness of the pharmacologic agents used in general, spinal, local, and conscious sedation techniques.
6. Perform and interpret the findings of a post-anesthetic evaluation and recognizes appropriate care measures including:
    A. Monitoring vital signs, recovery techniques, airway maintenance, drug reversal, management of nausea and pain, resuscitation techniques

Behavioral Science Competencies - PGY1

1. Manage individuals and populations in a variety of socioeconomic and health care settings.
2. Demonstrate an awareness of how to manage a patient who refuses a recommended intervention or requests ineffective or harmful treatment.
3. Recognize interview techniques to identify patient behavior. Able to perform a mental status exam.
4. Utilize effective methods to modify behavior and enhance compliance.
5. Demonstrate an awareness of the signs and symptoms of common psychological/psychiatric conditions and accepted treatment options
6. Demonstrate an awareness of the various medications employed in the treatment of mental illness and their common side effects.

Emergency Department Competencies – PGY-1

1. Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination. HEENT, vital signs, chest, heart, lungs, abdomen, neurologic and extremities
2. Diagnose and manage diseases, disorders, and injuries by non-surgical and/or surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam:
    A. Problem-focused neurologic examination.
    B. Problem-focused vascular examination.
    C. Problem-focused dermatologic examination.

D. Problem-focused musculoskeletal examination.

3. Perform (and/or order) and interpret appropriate diagnostic studies, including medical imaging
   A. Radiographic contrast studies
   B. Stress radiography
   C. Fluoroscopy
   D. Bone scans, CT, MRI
   E. Plain radiographs – including Chest, KUB, Skeletal imaging
4. Interpret appropriate diagnostic laboratory tests including: hematology, serology, toxicology, and microbiology
5. Formulate an appropriate diagnosis and/or differential diagnosis
6. Appropriate management when indicated of closed fractures and dislocations of pedal/ankle fractures and dislocations and cast/brace management
7. Appropriate indications and use of injection or aspiration techniques.
8. Formulate and implement appropriate plan of management including: consultation and/or referrals.
9. Recognize the need for (and/or orders) additional diagnostic studies when indicated including: EKG, chest x-ray, nuclear medicine, blood work, etc
10. Appropriate pharmacologic management [IV , PO, or topical] including the use of : NSAID, narcotics, muscle relaxants, antibiotics, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents tetanus toxoid/immune globulin
11. Appropriate management of fluid and electrolyte agents when required
12. Maintain appropriate medical records
13. Partner with health care managers and health care providers to assess, coordinate and improve health care.

Orthopedics Competencies - PGY2

1. Perform and interpret the findings of a comprehensive medical history and physical examination including preoperative history and physical examination
2. Diagnose and manage diseases, disorders, and injuries of the body by nonsurgical and surgical means.
3. Perform and interpret the findings of a thorough problem-focused history and physical exam.
4. Perform and interpret the findings of a thorough problem-focused history and physical exam, including:
   A. Neurologic examination
   B. Vascular examination
   C. Musculoskeletal examination
5. Perform (and/or order) and interpret appropriate diagnostic studies including:
   A. Plain radiography
   B. Radiographic contrast studies
   C. Fluoroscopy
   D. Nuclear medicine imaging

E. MRI
F. CT

6. Formulate an appropriate diagnosis and/or differential diagnosis in non-surgical and surgical orthopedic patient.
7. Interpret appropriate diagnostic studies including hematology, pathology, serology, microbiology, and synovial analysis as it pertains to the orthopedic patient.
8. Understand and recognize management of trauma via immobilization techniques including splinting, casting and bracing.
9. Recognize knowledge of anatomy and physiology of various structures.
10. Appropriate pharmacologic management of the orthopedic patient including: NSAIDs, narcotics, sedatives/hypnotics, anticoagulants.
11. Appropriate assessment and management of orthopedics including:
A. Closed management of fractures/dislocations of the lower extremity
B. Closed management of fractures/dislocations of the upper extremity
C. Open management of fractures/dislocations of the lower extremity
D. Open management of fractures/dislocations of the upper extremity
12. Demonstrate knowledge and techniques in internal and external fixation especially as it applies to osseous structures.
13. Demonstrate knowledge of soft tissue trauma and pathology (i.e. meniscus, ACL, rotator cuff, other disorders of cartilage, ligament and tendon) as well as treatment options and techniques.
14. Demonstrate knowledge and the treatment of infections in orthopedics including soft tissue, osseous, bacterial and fungal.
15. Formulate and implement appropriate surgical management when indicated

General Surgery Competencies - PGY1

1. Perform and interpret the findings of a comprehensive history and physical examination (including preoperative history and physical examinations). Including:
A. vital signs
B. Head, eyes, ears, nose, and throat (HEENT)
C. Chest
D. Heart/lungs
E. Abdomen
F. Genitourinary
G. Rectal
H. Musculoskeletal
I. Neurologic examination
2. Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).
3. Recognize the need for and the appropriate timing of additional diagnostic studies when needed, including:
A. EKG
B. Medical imaging studies including plain radiography, nuclear medicine, CT, MRI, diagnostic ultrasound

C. Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, urinalysis

4. Understand principles of perioperative management including fluid and electrolyte balance, pain management and blood and/or component therapy
5. Recognize and demonstrates= knowledge of conditions and problems that may be encountered in the management of the patient postoperatively including assessment of fever, postoperative infection, pulmonary function, fluid management, and gastrointestinal function
6. Understand management of the preoperative and postoperative surgical patient with an emphasis on complications.
7. Able to recognize intra-operative and/or postoperative complications and treatments available.
8. Understand surgical principles and procedures applicable to common pathologies of the human body.
9. Demonstrate proficient sterile technique within the operating room.
10. Recognize at-risk surgical patients and be knowledgeable of necessary precautions.
11. Perform (and/or order) and interpret appropriate diagnostic laboratory tests, including: hematology, blood chemistries, coagulation studies

Vascular Surgery Competencies (Added 7/1/23) - PGY1

1. Demonstrate the ability to evaluate a patient for comorbidities and risk factors that may contribute to vascular disease processes, including those related to arterial, venous and lymphatic disease.
2. Demonstrate the ability to help educate patients and caregivers regarding the implications of PAD and its potential morbidity, management and risk to life and limb.
3. Upon identification of relevant disease processes to make the appropriate medical and/or surgical referrals.
4. Demonstrate the ability to perform and interpret a comprehensive vascular physical Examination.
5. Understand tissue handling techniques including tissue handling, instrumentation and hand ties.
6. Understand and interpret noninvasive vascular studies.
7. Understand and interpret angiography as it pertains to the lower extremity.
8. Understand and formulate revascularization plans based on noninvasive and invasive arterial testing.
9. Recognize and manage superficial and deep vein thrombosis and its sequela.
10. Understand indications and functional differences of various amputation levels.
11. Understand management of dialysis access grafts.

Infectious Disease Competencies - PGY1

1. Perform and interpret the findings of a problem focused medical examination

2. Understand the indications and interpretation of common laboratory tests used to assess and manage patients with infectious diseases.
3. Demonstrate knowledge of the clinical signs and symptoms of infections in different parts of the body
4. Recognize and understand the diagnosis and management of osteomyelitis.
5. Recognize and understand the diagnosis and management of chronic infectious diseases
6. Understand evaluation of a patient with hepatitis through clinical and laboratory methods.
7. Understand thorough evaluation of patients with other infectious illnesses.
8. Demonstrate knowledge of the use, selection, indications, and adverse reactions of antibiotics
9. Appropriately interpret bacterial cultures and sensitivities.
10. Recognize and understand the diagnosis and management of cellulitis and complicated skin / skin structure infections, including diabetic foot infections.

Internal Medicine Competencies - PGY1

1. Perform and interpret the findings of a comprehensive medical history and physical examination:
    A. Vital signs
    B. HEENT
    C. Chest
    D. Heart / Lungs
    E. Abdomen
    F. Genitourinary
    G. Gastrointestinal
    H. Endocrine
    I. Neurologic
2. Formulate an appropriate differential diagnosis of the patient's general medical problem.
3. Recognize the need for and knowledge of the appropriate timing of additional diagnostic studies when needed such as EKG, chest x-ray, nuclear medicine, standard radiographs
4. Recognize the need for and the appropriate timing of additional laboratory studies when indicated
    A. EKG
    B. Medical imaging studies including plain radiography, nuclear medicine imaging, CT, MRI, diagnostic ultrasound
    C. Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, urinalysis, synovial fluid analysis
5. Recognize the appropriate pharmacologic management of patients, including the use of:
    A. Antibiotics / Antifungals
    B. Narcotic analgesics / NSAIDs
    C. Sedative/hypnotics
    D. Anticoagulants and other vascular medicaitons
    E. Medications for hyperuricemia
    F. Laxatives/cathartics
    G. Fluid and electrolyte agents
    H. Corticosterioids
    I. Management of hyper/hypoglycemia
6. Assess and manage the patient's general medical status.
7. Formulate and implement an appropriate plan of management, when indicated, including appropriate:
    A. Therapeutic intervention,
    B. Consultations and/or referrals, and
    C. General medical health promotion and education.

Pathology Competencies - (As of 7/1/23 - Quarterly Pathology Rounds only).

1. Understand indications and interpretations of results from the clinical laboratory.
2. Understand collection methods for specific tests in pathology.
3. Understand general principles in the evaluation of gross pathology.
4. Recognize the need for(and/or orders) additional diagnostic studies when indicated.
5. Demonstrates knowledge and understanding of basic histopathology including:
    A. Review and recognition of lower extremity surgical specimens
    B. Review and identification of common benign lesions
    C. Differentiation of benign and malignant neoplasia

Medical Imaging/Radiology Competencies - PGY1

1. Recognize basic chest film pathology including: pulmonary edema, cardiomegaly, pneumonia, atelectasis, neoplasia
2. Recognize basic components of skeletal radiology via different imaging techniques including: Neoplasms, fractures, anatomic variants
3. Recognize the indications for additional imaging studies when indicated.
4. Understand the indications and advantages of different imaging modalities (i.e. MRI vs. CT).
5. Recognize the indications for CT and MRI imaging with and without contrast.
6. Recognize the principles and basics of interpreting MRI and CT images.
7. Recognize the indications for nuclear medicine studies.
8. Recognize the indications for diagnostic ultrasound studies.

Podiatric Medicine and Surgery Competencies

1. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means.
2. Perform and interpret the findings of a thorough problem-focused history and physical exam including:
    A. Vascular evaluation,
    B. Neurologic evaluation,
    C. Dermatologic evaluation,
    D. Biomechanical/musculoskeletal evaluation
3. Perform and interpret the findings of a comprehensive medical examination (including preoperative H&P) that includes: vital signs, HEENT, chest, heart, lungs, abdomen, genitourinary, neurologic, and musculoskeletal.
4. Perform (and/or order) and interpret appropriate diagnostic medical imaging studies including: plain radiography, nuclear medicine, CT/MRI.
5. Perform (and/or order) and interpret appropriate diagnostic laboratory tests including: hematology, pathology/microbiology [anatomic and cellular], serology, synovial analysis
6. Perform (and/or order) and interpret appropriate diagnostic studies including: electrodiagnostic and vascular studies.

7. Perform (and/or order) and interpret appropriate examinations including: biomechanical examination of the podiatric patient.
8. Formulate an appropriate diagnosis and/or differential diagnosis
9. .Formulate and implement and appropriate plan of management with regards to anesthesia: Local, MAC, Regional or General for the podiatric surgical patient.
10. Appropriate closed management of pedal fractures and dislocations.
11. Appropriate closed management of ankle fracture/dislocation.
12. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
13. Appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals, sedatives,/hypnotics, muscle relaxants, laxatives, corticosteroids
14. Formulate and implement appropriate medical/surgical management when indicated of an ulcer or wound
15. Formulate and implement appropriate medical/surgical management for skin lesions, including: Excision or destruction of skin lesion (including skin biopsy and laser procedures).
16. Formulate and implement appropriate medical/surgical management for nail disorders including: nail avulsion or matrixectomy (partial or complete, by any means).
17. Formulate and implement appropriate medical/surgical management including repair for: simple laceration (no neurovascular, tendon, or bone/joint involvement) or complex (neurovascular, tendon, or bone/joint involvement).
18. Formulate and implement an appropriate plan of management in digital surgery including appropriate surgical management when indicated.
19. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: first ray surgery
20. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: soft tissue foot surgery
21. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: osseous foot surgery (distal to the tarsometatarsal joints.
22. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: osseous foot surgery of the midfoot.
23. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: reconstructive rearfoot and ankle surgery.
24. Demonstrates knowledge and techniques in internal and external fixation especially as it applies to the foot and ankle
25. Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals.
26. Able to assess the treatment plan and revise it as necessary including appropriate lower extremity health promotion and education.

Podiatric Clinic Rotation Competencies

1. Perform appropriate palliative management when indicated for: keratotic lesions and nail disorders.

2. Formulate and implement an appropriate plan of management including: footwear and padding when indicated for the podiatric patient
3. Formulate and implement an appropriate plan of management when indicated, including: orthotic, brace, prosthetic and custom shoe management.
4. Formulate and implement an appropriate plan of management in the care of foot/ankle fractures/dislocations and sprains including: immobilization techniques of casting, splinting, and taping
5. Formulate and implement appropriate medical/surgical management when indicated including: debridement of ulcer or wound
6. Formulate and implement appropriate medical/surgical management when indicated, including: excision or destruction of skin lesion (including skin biopsy and laser procedures).
7. Formulate and implement appropriate medical/surgical management when indicated, including: nail avulsion or matrixectomy (partial or complete, by any means), laser, debridement.
8. Appropriate management when indicated for manipulation/mobilization of the foot/ankle joint to increase range of motion/reduce associated pain.
9. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
10. Recommend appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals
11. Formulate and implement an appropriate plan of management in digital surgery including appropriate surgical management when indicated.
12. Formulate and implement an appropriate plan of management in first ray surgery, including appropriate surgical management when indicated.
13. Formulate and implement an appropriate plan of management for osseous surgery of the midfoot, including appropriate surgical management when indicated.
14. Formulate and implement an appropriate plan of management for reconstructive rearfoot and ankle surgery, including appropriate surgical management when indicated.
15. Formulate and implement an appropriate plan of management, including appropriate: consultation and/or referrals.
16. Demonstrate understanding of common business and management practices as they relate to the podiatry office, including: understands health care reimbursement.

Attitudinal and Other Non Cognitive Competencies

There are several competencies that by their very nature fit into the overall practice of medicine and do not reside in any one rotation. The content of this material is delivered and will be evaluated in the following areas. These competencies apply to ALL rotations.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

Rheumatology Competencies - PGY2

1. Perform and interpret the findings of a comprehensive medical history
2. Perform and interpret the findings of a comprehensive physical examination
3. Recognize the need for additional diagnostic studies, such as:
    a. Plain radiography
    b. MRI
    c. CT
4. Recognize the need for laboratory testing:
    a. Serology/immunology
    b. Blood chemistry
    c. Synovial fluid analysis
5. Formulate and implement appropriate plan of management
6. Understand methodology for diagnosing and treating rheumatologic disorders

Plastic Surgery Competencies - (As of 7/1/23 - Case by case only).

1. Perform and interpret the findings of a comprehensive medical history and physical examination:
    A. Vital signs
    B. HEENT
    C. Chest
    D. Heart / Lungs
    E. Abdomen
    F. Genitourinary
    G. Gastrointestinal
    H. Endocrine
    I. Neurologic
2. Understand basic plastic surgery principles including:

A. Local anatomy
B. Appropriate tissue handling
C. Layered wound closure

3. Understand basic principles of rotational muscle and skin flaps
4. Understand basic wound healing tenants

Endocrinology Competencies - PGY1

1. Formulate an appropriate endocrine differential diagnosis of the patient's presenting complaint.
2. Recognize the need for further imaging modalities as needed.
3. Understand and be able to interpret related laboratory data.
4. Understand basic medical management of patients with endocrine disorders.
5. Understand appropriate insulin therapy and management of blood glucose
6. Understand normal glucose ranges, as well as appropriate hemoglobin A1C levels
7. Understand the importance of managing chronic endocrine disorders to prevent complications.
8. Demonstrate ability to research and concisely present a topic related to diabetes and the end of the rotation.
    a. The resident will be assigned a topic to research at the start of the 2 week rotation: for example, what are the general guidelines for management of insulin and other DM meds pre- and post-op; OR what is the data on risk of amputation from SGLT2 inhibitors, OR what are the data on whether a high A1C at the time of surgery increases surgical risk/post-op infection risk or other post-op complications- any topic directly related to managing podiatry patients with diabetes (per communication with Dr. Brunt 5/21/24).

2. **PLANNED CURRICULUM:**

A. Clinic Duties –
    1. Patients are seen at any of the 3 Hospital Campuses, but mainly Cambridge and Somerville.
    2. Patients are seen by the resident, who then presents the case to the attending to discuss the diagnosis and treatment options. The attending sees every patient.

3. Clinic hours are from 8:30am-4:30pm. “Resident clinics” are Monday, Wed PM and Thursday. However, Residents are encouraged to attend any clinical session if it does not interfere with surgical caseload. On average, residents spend 1.5 days in clinic per week while on service. The clinical volume in all 3 clinics for FY18 was over 14000 patient visits.

B. Surgical Cases –
    1. Residents act as surgical assistants to the attending physician. The amount of surgery performed by the resident during the case will be dependent upon the attending and the level of resident expertise. Residents cover surgical cases at the 3 Cambridge Health Alliance Hospitals, as well as any of the other 7+ affiliated institutions. The on call resident must be available to cover add on cases at any of the institutions on an as needed basis.
    2. The required minimal patient care activities will be determined by the CPME 320.

C. Didactic Education –
    1. Residents are required to attend the Cambridge Health Alliance Department of Podiatry Monthly Lecture Series which runs October through May. It is highly recommended that the residents attend Lecture Series at Mt. Auburn and Beth Israel Deaconess Medical Center on a monthly basis.
    2. Rounds/Case presentations – every Thursday from 7-9am.
    3. Monday and/or Tuesday afternoons are dedicated teaching time for the Residency Teaching Committee. That time can be used for workshops, lectures, Journal Clubs, or dissection labs.
    4. Workshops include, but are not limited to: Suturing, tendon repair, plastic surgery techniques, sawbones for evaluation of fixation options, dressing and bandaging, casting, screw sets, cadaver dissection and vascular hand ties.
    5. **Research methodology** – lectures and assistance in research proposals and journal article submission. Every 3rd Tuesday, as needed.
    6. **Journal club** – Will be held on the 4th Monday of the month, after clinic.
    7. Surgical pearl review. These will be done monthly after clinic on Monday. Topics to be discussed:
        i. Lapidus
        ii. 2nd MTPJ pathology and 1st MTPJ fusion
        iii. Midfoot procedures - fusion/osteotomy
            1. Lisfranc injury
            2. Charcot correction - beaming, ex fix, locking plates
            3. Other midfoot fusons – NC
        iv. Flat foot repair
            1. Adult - corrective osteotomies, tendon transfer, arthroereisis

2. Pediatric - as above and to discuss presence of tarsal coalition

v. Major Hind Foot Fusions
   1. Isolated
   2. Triple
   3. Distraction arthrodesis

vi. Cavus Repair
   1. Flexible
   2. Rigid
   3. Neuromuscular presence

vii. Tendon Repair
   1. Suture techniques
   2. Anchoring
   3. Specific management - PT, achilles, FHL, peroneal
   4. Tendon transfers, FDL, FHL, PT (dropfoot), Peroneal (status forefoot amp, supple cavus, peroneal spasticity)

viii. Fracture Management
   1. Open - how long for abx, discuss inside/out vs outside/in injuries
   2. Closed - when is ORIF needed
   3. What is considered an emergency for immediate OR

ix. Sports Medicine
   1. Turf toe
   2. Lisfranc
   3. Ankle instability

x. Arthroscopy

xi. Complication management of foot surgery

xii. Diabetic Foot
   1. Wounds - neuropathic, ischemic
   2. Acute and chronic osteomyelitis

8. See spreadsheet below for planned didactic activities:

	20. Planned Didactic Activities:	
1	Sawbone workshop (hammertoes), Journal Club, Research - hammertoe study	Thursday AM Rounds - pre and post-op cases
2	Lecture Series - ID.	Thursday AM Rounds - pre and post-op cases
3	Practice Presentations for ACFAS Complications Conference in RI	Thursday AM Rounds - pre and post-op cases
4	Sawbone workshop, Wright medical products. Journal Club. Comp Conf. RI	Thursday AM Rounds - pre and post-op cases
5	Discuss student ranking for CRIP	Thursday AM Rounds - pre and post-op cases

6	Journal Club, Resident Reviews	Thursday AM Rounds - pre and post-op cases
7	Finish Resident Reviews, AO Mini frag set, Lecture Series	Thursday AM Rounds - pre and post-op cases
8	Journal Club, Wound care basics	Thursday AM Rounds - pre and post-op cases
9	DVT Prophylaxis and treatment	Thursday AM Rounds - pre and post-op cases
10	Journal Club, Gait analysis, Cadaver workshop	Thursday AM Rounds - pre and post-op cases
11	Athletic Shoe recommendations - Heffernan	Thursday AM Rounds - pre and post-op cases
12	Journal Club, Evidence Based Medicine, Lecture Series	Thursday AM Rounds - pre and post-op cases
13	Plantar fasciitis diagnosis, treatment options	Thursday AM Rounds - pre and post-op cases
14	Journal Club, Introduction to Research Methodology	Thursday AM Rounds - pre and post-op cases
15	Talipes Equino Varus Board Review, Lecture Series	Thursday AM Rounds - pre and post-op cases
16	Journal Club, Metatarsus Adductus Board Review	Thursday AM Rounds - pre and post-op cases
17	Cavus foot Board Review	Thursday AM Rounds - pre and post-op cases
18	Journal Club, Pes plano valgus Board Review	Thursday AM Rounds - pre and post-op cases
19	Tumors Board Review, Lecture Series	Thursday AM Rounds - pre and post-op cases
20	Journal Club, Ankle - fractures, Pilon, fusion, replacement Board Review	Thursday AM Rounds - pre and post-op cases
21	BOARDS	Thursday AM Rounds - pre and post-op cases
22	Journal Club, Triple arthrodesis video	Thursday AM Rounds - pre and post-op cases
23	Mortgage basics, Ultrasound workshop	Thursday AM Rounds - pre and post-op cases
24	Journal Club, Introduction to Coding	Thursday AM Rounds - pre and post-op cases
25	ACLS, Car care introduction	Thursday AM Rounds - pre and post-op cases
26	Journal Club, student presentations	Thursday AM Rounds - pre and post-op cases
27	Dressing workshop	Thursday AM Rounds - pre and post-op cases
28	Journal Club, Injection workshop	Thursday AM Rounds - pre and post-op cases
29	Casting workshop	Thursday AM Rounds - pre and post-op cases
30	Journal Club, Hand tie workshop, student presentations	Thursday AM Rounds - pre and post-op cases
31	Antiobiotic review	Thursday AM Rounds - pre and post-op cases
32	Journal Club, Review Mini frag sets	Thursday AM Rounds - pre and post-op cases

33	Bunion basics - techniques, tips, procedures - with saw bones	Thursday AM Rounds - pre and post-op cases
34	Journal Club	Thursday AM Rounds - pre and post-op cases
35	Cadaver workshop, student presentations	Thursday AM Rounds - pre and post-op cases
36	Journal Club, Sawbone workshop	Thursday AM Rounds - pre and post-op cases
37	Biomechanical exam	Thursday AM Rounds - pre and post-op cases
38	Journal Club	Thursday AM Rounds - pre and post-op cases
39	Student presentations	Thursday AM Rounds - pre and post-op cases
40	Journal Club, Fundamentals of External Fixation	Thursday AM Rounds - pre and post-op cases
41	Gait analysis, Lecture Series	Thursday AM Rounds - pre and post-op cases
42	Journal Club	Thursday AM Rounds - pre and post-op cases
43	Student presentations	Thursday AM Rounds - pre and post-op cases
44	Journal Club	Thursday AM Rounds - pre and post-op cases
45	Tendon suturing workshop	Thursday AM Rounds - pre and post-op cases
46	Journal Club, Lecture Series	Thursday AM Rounds - pre and post-op cases
47	Lisfranc Fracture/Dislocations	Thursday AM Rounds - pre and post-op cases
48	Journal Club	Thursday AM Rounds - pre and post-op cases
49	Chapter Review from Chang or McGlamry	Thursday AM Rounds - pre and post-op cases
50	Journal Club, Lecture Series	Thursday AM Rounds - pre and post-op cases
51	2nd MTPJ Pathology	Thursday AM Rounds - pre and post-op cases
52	Journal Club	Thursday AM Rounds - pre and post-op cases

3. This residency program abides by all rules and regulations as set forth by the Council on Podiatric Medicine in the CPME 320 document. This document can be accessed at:

   www.cpme.org/cpme320

4. CPME 330 Document, which delineates procedures for approval of Podiatric Medicine and Surgery, can be assessed at:

   www.cpme.org/cpme330

5. **HOUSE OFFICERS CONTRACT follows the end of the document -**

24. Logging and Evaluation process - (Specific language added 5/5/21)

Patient/Activity Logs

Patient / Activity Logs must be signed by the residency program director on a monthly basis following the guidelines of the Council on Podiatric Medical Education (CPME). Clinical and surgical logs should be entered into Podiatry Residency Resource on an ongoing basis, but no later than 1 week after the activity to prevent errors and missed submissions.

The following logs are to be submitted:

1. Surgical Logs
2. Clinic Logs
3. H&P Logs
4. Biomechanics Logs

Logs are to be submitted utilizing Podiatry Residency Resource (www.podiatryrr.com) when appropriate. Instruction and assistance with logs will be provided by the chief resident and residency director.

The timely submission of comprehensive logs is required by CPME and the Centers for Medicare and Medicaid. Logs serve as verification of a resident's involvement with patient care and they reassure that each resident is receiving a well rounded education. Resident logs are utilized by CPME for reaccreditation of the residency program. Surgical and Clinic Logs are also required for submission to the respective podiatric boards to sit for the podiatric surgical and medical board qualifying examinations.

Performance improvement –

1. For the first 3 missed submission deadlines, reminder emails will be sent.

2. After the first 3 failures to submit weekly, the program director will meet with the resident to determine how to best improve logging.
3. After 3 more failures to submit timely logs, a formal note will be placed in the resident's record and the resident will not be able to scrub any surgical cases until the logs are updated.
4. If the resident fails to log after performance improvement 3, will be reported to human resources for failure to comply with mandated policies.

25. **RESIDENT WELL-BEING -**

1. Cambridge Health Alliance provides residents the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during working hours.
    a. Tend Health is utilized to provide services for CHA residents as needed.
2. Cambridge Health Alliance provides education and resources that support sponsoring institution-employed faculty members and residents in identifying in themselves or others the risk factors of developing or demonstrating symptoms of fatigue, burnout, depression, and substance abuse, or displaying signs of self-harm, suicidal ideation, or potential for violence.
3. Cambridge Health Alliance provides access to confidential and affordable mental healthcare, necessary for either acute or ongoing mental health issues.
4. Cambridge Health Alliance provides an environment in which the physical and mental well-being of the resident is supported, without the resident fearing retaliation of any kind.
5. Resources are available through Occupational Health, Tend Health and the Department of Professional and Academic Development.
6. Residents will take annual modules in HealthStream regarding Well-Being, burnout, self care and other modules are required by the institution.

Completed Evaluation Forms

All completed evaluation forms must be delivered to the Program Director within 7 days for signature. To comply with CPME guidelines, all forms must be signed and dated by the evaluator, resident and program director.

The residents must submit an end of rotation evaluation form within 30 days of a rotation and an end of year evaluation form within 30 days of the end of the academic year.

26. Rotation Assessment Documents -