MERCY HEALTH - ST. RITA'S MEDICAL CENTER

PODIATRIC MEDICINE AND SURGERY RESIDENCY TRAINING MANUAL PMSR/RRA

Approval by:
Council on Podiatric Medical Education

Program Director: Shawn C. Ward, DPM, FACFAS
Associate Program Director: Heather M. Gray, DPM
Designated Institutional Official: Stacy L. Schulte, MHA
Chief Administrator: Matthew T. Owens, MD
Program Manager: Christina E. Landin, MBA

Mercy Health - St. Rita's Medical Center
730 West Market Street
Lima, OH 45801
800-232-7762 x5559

First edition 4/1/2007; revised PMS-36 7/15/2008; 7/1/2010; revised PMSR 7/1/2011; revised PMSR RRA 4/30/2013; revised 11/11/2013; revised 5/18/2016; revised 5/15/2018; revised 7/01/2020;revised 7/01/2021; revised 7/1/2022; revised 7/1/2023; revised 7/1/2024; revised 7/1/2025

TRAINING MANUAL

I. PREAMBLE

The Residency Training Program at Mercy Health - St. Rita's Medical Center provides the recent graduate with the opportunity to gather experience in the problems of a general podiatric practice and to study advanced and related sciences essential for the practice of podiatric medicine.

The teaching program will attempt to demonstrate to the Resident a more effective method for improving community foot health and to better prepare the resident for his/her position in the total community health structure.

Since podiatric medicine may be defined as *"That specialty of medicine and surgery which is concerned with the prevention, diagnosis and treatment of disease and disorders which affect the human foot and its contiguous lower extremity structures"*, it is recognized that the podiatric resident will be one who specializes in the lower extremity. However, it is the goal of the podiatric residency training program at Mercy Health - St. Rita's Medical Center to strive to produce a well-rounded podiatric physician and surgeon who is well appreciative of the total patient's medical well-being, since certainly the total patient cannot be divorced from the foot or lower extremity.

This manual describes the Residency Program at Mercy Health - St. Rita's Medical Center. In its design both the program and the manual fulfill the criteria and guidelines for Evaluating Podiatric Residency Programs Council on Podiatric Education through current CPME 320 and 330 documents and assessments
https://www.cpme.org/residencies/residency-documents-and-forms/

II. PURPOSE

The Podiatric Residency Training Program in the hospital is designed to:

A. Provide an opportunity for supervised advanced clinical experience in the recognition and management of foot and ankle pathology. The resident will learn to recognize pedal manifestations of the various systemic, cutaneous and functional diseases together with the concept of secondary prevention of chronic diseases as they relate to the foot and ankle.

B. Emphasize the relationship of the basic sciences to clinical practice by affording the opportunities to study and utilize the complete physical record of the patient before, during and after podiatric treatment.

C. Familiarize the podiatric resident with hospital procedure, scope and functions of other divisions of health services.

D. Familiarize the podiatric residents with the institutional requirement and accreditation standards of the Joint Commission and other health care accreditation bodies. Qualified health care professionals with appropriate credential and privileges provide patient care and provide supervision of residents.

To achieve these purposes, experience, and training in all of the major areas for the treatment of podiatric conditions have been approved through educational, clinical, research and public health programs. Education will be provided through scheduled lectures, seminars and conferences devoted to the integration of the basic sciences with the clinical treatment of patients.

The value and importance of a close liaison between osteopathic, allopathic, and podiatric professions will be stressed to the resident. To help further his/her relationship and broaden the podiatric resident's knowledge of medical sciences as applies to podiatric medicine, lectures, and demonstrations by personnel of the various departments of the hospital and affiliate institutions are given to the podiatric resident.

To still further enhance this interprofessional relationship, consultations between the professions is always encouraged and is available. The resident is assigned a prescribed tour of duty in each of the major departments of the hospital or affiliate institutions for further observation and training in the branch of medicine and surgery.

The Podiatric residency program is based on the resource-based, competency-driven, assessment-validated model of training. This provides the resources available to assure the residents opportunities for achievement of the competencies to successfully complete the residency program with effective validation by the institution and program.

The Residency Training Program will be guided by recommendation of the Council on Podiatric Medical Education (CPME) and its associated Councils and Committees.

III. DIRECTORS, COMMITTEES, & CHAIRPERSONS

PROGRAM DIRECTOR: (Dr. Ward)

The Program Director is to set the goals, milestones/competencies/objectives of the Residency Training Committee and give overall guidance to the functioning of the Residency Program.

It is the Program Director's responsibility to ensure that the first, second-, and third-year residents abide by and live up to the terms of their agreement as delineated in this manual and contract.

It is the responsibility of the Program Director to initiate those disciplinary steps as outlined in policy, when necessary to ensure the proper functioning of the residents during both in-house and outside rotations as assigned to them by the Program Director.

The Program Director is to serve as a liaison, when necessary, between the residents and Directors of other hospital departments in conjunction with the Associate Program Director.

It is the responsibility of the Program Director to appoint other Committee members to the Clinical Competency Committee, (i.e., Assistant Director, etc.).

The Program Director must be a member of the Graduate Medical Education Committee (GMEC).

It is the Program Director's responsibility to initiate steps leading to the dismissal of any appointed Director should such action be necessary. Dismissal of an appointed Director shall require a majority vote of the Residency Training Committee, (not to include the stated individual's vote).

The Program Director is responsible to the Podiatric Staff of Mercy Health - St. Rita’s Medical Center, the Board of Trustees, and the Hospital Administrator. The Program Director is to serve as the Director of Podiatric Medical Education.

The Program Director oversees the residency maintenance of records related to the educational program, scheduling of rotations, instruction, supervision, verification of logs, evaluation of the resident, periodic review and revision of curriculum content, or program self-assessment. Any difficulties or conflicts which develop during a rotation

are handled by the Program Director.

The program director must review, evaluate, and verify resident logs on a monthly basis.

The director must ensure resident participation in training resources and didactic experiences.

Program Director Semi-annual Assessment of the Resident.

Program Director Final Assessment of the Resident.

The Program Director serves as the liaison with the Council on Podiatric Education. The choice of appointee should be based heavily on the individual's ability to do the job and the availability of the 15 plus hours per week it requires.

The Program Director must participate at least annually in faculty development activities. The faculty development activities and programs should be delivered by continuing education providers approved by the Council or another appropriate agency.

The Program Director must maintain certification as outlined by the American Board of Podiatric Surgery. In addition, meet all relevant CPME requirements for Directors. When conflicts arise between an attending podiatric physician, or other hospital personnel and the resident, the resident is to contact the Program Director. In the event the Program Director is temporally unable to perform those duties or if the Program Director leaves the program on an interim basis until a new Program Director can be recruited; the Assistant Program Director will assume the duties, or an interim Program Director will be appointed. CPME must be notified within 30 calendar days in writing of the substantive change.

ASSOCIATE PROGRAM DIRECTOR: (Dr. Gray)

The Associate Program Director is responsible for assisting the Program Director with maintaining the educational mission; scholarly and clinical activities, and administrative requirements as outlined by the Council on Podiatric Medical Education (CPME) Standards and Requirements for Podiatric Medicine and Surgery Residencies for Graduate Medical Education of CPME-accredited GME programs. The sponsoring institution provides the associate program director with protected time and financial support for educational and administrative responsibilities to the program.

PROGRAM CORDINATOR

Mercy Health – St. Rita's Medical Center and the program jointly ensure the availability of all necessary administrative, educational, financial, human, and clinical resources for the effective administration of the program. The designated Program Coordinator who, in conjunction with the Program Director is held accountable to the GME Office for all sponsoring institution and program accreditation requirements. *See policy II B 3 Program Coordinator*

ACADEMIC RESEARCH COORDINATOR

The Academic Research Coordinator in conjunction with the Program Director is responsible for the residents performing their assigned research project. The Academic Research Coordinator will meet with the residents over the course of the research project to ensure that the residents are completing their assigned project. Academic Research Coordinator will coordinate research projects which may require resident participation.

FACULTY:

(Drs Gray, Haycock, Hensley, Miller, Rauh, Stucke, Ward)

The Podiatry Faculty consists of those podiatric physicians privileged to work in the hospital, as defined by the Bylaws and in accordance with the Joint Commission of Accredited Hospitals, office of Hospital Affairs, and the Council on Podiatric Medical Education. The program for Podiatric Residents is supervised by the Director of Podiatric Medical Education, in conjunction with the department of Surgery/Podiatric Section. Faculty is appointed by the Program Director and responsibilities are as follows:

1. Oversee medical and surgical rotations for residents.
2. Create new rotations; phase out non-productive rotations, as needed.
3. Yearly and monthly reminder letters to all participating physicians.
4. 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.
5. Receive direct feedback from Residents about rotations.
6. Active role in didactic activities.
7. Should participate in faculty development activities.
8. Annual self-assessment of the program's resources and curriculum.

ATTENDING PHYSICIAN

Attending physician refers to licensed, independent physicians, who have been formally credentialed and privileged at the training site, in accordance with applicable requirements. The Attending physician may provide care and supervision only for those clinical activities, podiatric or non-podiatric, for which they are privileged.

The attending physician will assist in the enhancement of resident knowledge of the resident and ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation, and direction. It includes the imparting of the practitioner's knowledge, skills, and attitudes by the practitioner to the resident and assuring that the care delivered in an appropriate, timely, and effective manner.

Within the scope of the training program, all residents, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed.

The attending physician will supervise written or electronic generate medical record evidence a patient encounter, following all hospital medical record policies as set forth.

ACADEMIC CHAIRMAN:

The Academic Chairman and Chief Resident responsibilities are as follows:

1. Coordination of monthly Journal Club. Review of pertinent articles and assignment of articles to members of Journal Club. Journals include: "Journal of Bone & Joint Surgery", "Journal of Foot Surgery", "Foot & Ankle", "Journal of American Podiatric Medical Association", and several other pertinent

journals.

2. Coordination of Book/Topic Review Club. Responsible for choosing the books or topics of interest then coordinating the copying of needed articles and distribution to the Book Club members. The Residents will be involved in the clerical aspects of the Book/Topic Review Club and will also be expected to have read all the materials so that they may participate fully in all the discussions.
3. Responsible for assigning monthly physician lectures to the residents and assigning Resident Lectures for the year.

RESIDENCY SELECTION COMMITTEE

A. The Program Director, Associate Program Director, Program Coordinator, and the Resident(s) and if necessary, members of the podiatric faculty as determined by the Program Director, are to make up the Residency Selection Committee for determination of new residents. A first-year resident and the two second-year residents are allowed to participate as non-voting members of this committee.

B. The Program Director may also appoint other members to this committee as needed. The residency candidates must complete the oral and social interview during the annual CASPR/CRIP Interview. The committee members must be in attendance to vote, voting by proxy or absentee ballot will not be allowed. It will be the responsibility of all committee members to review each application prior to attending the CASPR/CRIP Interview weekend. During the final meeting, the applications under consideration will be evaluated and discussed in detail. The results are tallied and form the basis on preliminary ranking order. The Residency Selection Committee bases final match order on preliminary ranking and review. A match list is developed and submitted to CASPR/National Resident Application Matching Service. Strict conformance with the rules of the match is maintained throughout the selection process. In the event that we fail to match PGY-1 position in a given year, the program will open up recruitment to all remaining applicants in the CASPR system in the scramble system they have developed. Those applicants will be required to forward a copy of their CASPR application to the Residency Program Coordinator. Interviewing protocols and timing will be determined at the time in this event.

C. The selection protocol for the interview weekend will be agreed upon by the Committee prior to the interview date. If no questions or changes are recommended, then the protocol used the previous year will be in force. Once in place it will not be changed until the following year. The sponsoring institution will participate in the national resident application matching service by abiding to the rules and regulations setup forth by the matching service.

D. The current Residents may be asked to comment and/or vote on the applicants.

E. All PGY-1 applicants must be graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education, pass all components of Parts I and II of the National Board of Podiatric Medical Examiners prior to the time they begin training as per CPME 320 3.5

F. The sponsoring institution will have the residency curriculum available for the prospective resident.

See policy IV A Resident Intern Recruitment and Selection

Clinical Competency Committee

This committee will meet twice a year to review the evaluations of each resident and will determine promotion of residents to higher degrees of autonomy. They continually assess how each resident is meeting the milestones and procedures.

This committee reviews all resident evaluations twice a year; prepares and assures the reporting of Milestones/Core Competency evaluations of each resident semiannually. This will advise the program director regarding resident progress, including promotion, remediation, and dismissal; prepares a report summarizing the Committee's recommendations and rationale for any adverse action recommendations from each meeting and submit report to the GMEC; and advises the Program Evaluation Committee about any program evaluation issues identified during Clinical Competence Committee meetings.

Program Evaluation Committee (PEC)

The PEC committee meets twice a year and participates actively in: Planning, developing, implementing and evaluation educational activities of the Program. The committee reviews and makes recommendations for revision of competency-based curriculum goals and objectives. The committee addresses areas of non-compliance with CPME standards and reviews the program annually using evaluations of faculty, residents, and other items. The committee actively ensures a continual quality improvement process regarding program outcomes.

The Program, through the PEC, documents formal, systematic evaluation of the curriculum and renders a written Annual Program Evaluation (APE).

The Program monitors and tracks each of the following areas:

a. Resident Performance
b. Faculty Development
c. Graduate Performance
d. Program Quality
e. Includes resident and faculty annual written confidential evaluations of program
f. Demonstrates how Program uses results of above with other program evaluation results to improve the program
g. Progress on the previous year's action plan(s)
h. CPME accreditation standards and communications.

The PEC prepares a written plan of action based on in-depth review of the APE components to formulate and document initiatives to improve performance in one or more of the areas listed above, including delineation of parameters to be measured and monitored. This is reviewed by the teaching faculty, documented in meeting minutes, and approved by the Graduate Medical Education Committee (GMEC). *See policy IX C PEC-Program Evaluation Committee*

IV. REQUIREMENT FOR RESIDENCY

A. Residents are required to maintain a satisfactory level of scholarship, performance, and competency. Residents are required to be graduates of a Podiatric Medical College, approved by the Council on Podiatric Medical Education. Residents are expected to be worthy in character, manners, and ethical conduct.

B. Appointees to the Residency must obtain a training license to practice podiatric medicine in the state of Ohio.

C. Appointees to the Residency must make application to the American Podiatric Medical Association, Ohio Podiatric Medical Association, and local chapter of this Society, if applicable.

D. While the program provides ample opportunity for training it is the responsibility of the resident to fulfill the training requirements including but not limited to the number and diversity requirements in the CPME 320. If a resident believes they are having issues meeting the requirements, they need to bring this to the attention of the Program Director.

E. All residents must take in-training examinations during each academic year, as offered by SBRC-0recognized specialty boards.

F. Residents who voluntarily separate from the residency program are considered to have resigned. A resident must give written notice to the Program Director at least 30 calendar days prior to resignation. Notice to the Program Director is also required at least three months before the end of the training year if the resident has been offered contract renewal as per terms of written employment agreement.

V. PHYSICAL FACILITIES

The sponsoring institution provides appropriate facilities and resources for the residency training to ensure an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, dedicated office space, training resources, and a health information management system are available for resident training. Educational resources including electronic retrieval of information are provided to the residents that include a diverse collection of current podiatric and non-podiatric medical databases.

VI. PROGRAM

A. Education

Since this is the primary purpose of the Residency Program, residents are encouraged to attend all scientific and professional meetings sponsored by the various departments and committees of the hospital whenever it is possible. Those required professional educational programs shall be posted and the residents shall attend when so notified. Attendance is required at all teaching conferences, all morning resident lectures, clinical pathological conferences, radiology conferences, and grand rounds.

GME Center

Cadaver limbs for medical education use will remain refrigerated in the Wet Lab refrigerator until they are utilized for study. It is the responsibility of the Podiatry Residents using the cadaver limbs and Simulation Center Labs for medical study to maintain the cleanliness of the lab during its use for education. The Chief Resident or Physician Educator will ensure all podiatry and medical residents and students comply with standard precautions, patient confidentiality, and other applicable regulations. Following completion of the medical studies, the cadaver limbs will be brought to the hospital loading dock biohazard storage room for disposal. Red biohazard bags and biohazard cardboard boxes are located outside of the biohazard storage room. Cadaver limbs need to be double bagged in red biohazard bags and then placed in a biohazard cardboard box. The box needs to be taped closed and labeled. Tape and labels are located inside the biohazard storage room in the top

drawer of the cabinet. Badge access is required for entry to the biohazard storage room. Write the date on the label affixed to the box and place in the biohazard storage room for disposal.

B. Orientation

At the beginning of the residency year, a period of orientation and instruction in duties, responsibilities and privileges of the podiatric resident is provided, so that each resident may attain a working knowledge of the functions and administration of the hospital's Podiatric department section.

The following subjects are included in this period of instruction:

1. Tour of the hospital to meet the medical staff and other department heads, and orientation as to departments.
2. General policies of the hospital related to the podiatric resident's responsibilities.
3. Standard procedures in the hospital related to patient care.
4. General policies and procedures of the Podiatric Medicine and Surgery section.
5. Explanation of the training program and CPME 320 requirements.
6. Explanation of the proper use of podiatric medical records for recording all clinical and laboratory findings, as well as the therapy employed.
7. Demonstrations and lectures covering the various phases of clinical podiatry are given to the newly appointed podiatric resident. These lectures and demonstrations are so presented that the new podiatric resident will adapt to the hospital atmosphere.
8. There will be a separate orientation with the Program Director, Chief Resident, Program Coordinator for the residents each July to review specifics of the training program, responsibilities, and introduction of committee members.

C. Duties

1. While your obligation to yourself, your profession, your hospital, and patients will be expressed by implication throughout this manual, the following reminders are added as a guide and checklist and are intended to summarize many of the details not specifically mentioned.
2. The resident must be familiar with and abide by the Rules and Regulations and Medical Staff Bylaws of the Professional Staff, departments, and committees.
3. Residents shall report as resident member of the medical staff on July 1 to the Program Director and begin duties as outline in employment contract.
4. Cooperate in the conservation of supplies.
5. Members of the resident medical staff are expected to abide by the policies of the hospital and to be cooperative and well-groomed/well-dressed *See policy: III K Dress Code Policy*
6. Be alert to the paging system during duty hours. Each resident will receive an annual cell phone stipend to reimburse on-call time. Residents will be "on-call" and required to notify the on call attending podiatrist should a schedule need to change for in-house coverage. In addition, update PerfectServe with annual schedule, and if any changes occur following approval from the Program Director and inform the Residency Program Coordinator.

7. Residents are not to accept fees or gratuities from patients, their relatives, or friends. You will not, of course, practice your profession or assist any physician outside the hospital; except by special assignment or permission for educational purposes only, which may be granted through the Program Director.
8. Professional and patient care activities that are external to the educational program are called "moonlighting." The Podiatry Program does not permit residents to moonlight. *See policy XG 4 Policy Moonlighting Policy and Procedure SRMC Podiatry Medicine & Surgery*
9. No alcoholic beverages are permitted in the hospital. No person who has been drinking may attend to a patient.
10. Smoking within the hospital which includes the hospital campus is prohibited for everyone.
11. AT ALL TIMES, YOUR PATIENTS ARE TO BE YOUR FIRST CONSIDERATION.
12. Give your patient conscientious professional care as the attending physician directs and make progress notes of all significant events in the development of the case. Residents should try to arrange to conduct rounds each day with the attending physician so that they may be cognizant of the conditions of the patient and have a better understanding of the form and mode of treatment which is being employed.
13. Provide complete privacy for each patient during dressings and examinations in which he or she might be exposed. Curtains are furnished in the multiple bedrooms.
14. Do not sit on the patient's bed unless it is necessary for examination.
15. Do not prop feet on beds, desks, or chairs. Make sure all hallways are cleared of equipment and furniture which includes pushing chairs under tables/counters, so they too are not left in the hallways.
16. Protect your patients by refusing information about him/her to lawyers, insurance personnel, and the news media, unless he/she specifies that he/she wishes to see them. Refer such inquiries to the Director of Nursing and/or House Supervisor.
17. Refer any questions about your patient's financial arrangements to the Business Office and/or Patient Accounts.
18. Refer any requests for extra visiting privileges to the Director of Nursing and/or House Supervisor, requests for transfer to other accommodations to the Admitting Office, and inquiry about discharge from the hospital, etc. to the patient's attending physician.
19. Report promptly through SafeCare, the incident reporting system, any unusual occurrences in the hospital such as falls, accidents, near-misses, patient care issues, or professional conduct/disruptive behaviors.
20. Guard against unnecessary or unwise talking in the hearing of a patient coming out from under anesthesia or from alcoholic or other stupor. Patients sometimes hear, and remember, surprisingly well.
21. Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he/she has been the victim of malpractice.
22. Residents will not order materials, supplies, or surgical equipment directly from

outside vendors. If the resident desires to order materials and supplies, approval will be obtained from the Program Director prior to submitting to the administrator for approval.

23. Residents may use the hospital duplicating equipment to copy articles and periodicals, lectures for staff, or as it pertains to the residency program.
24. The first- and second-year residents are under the direction of the third-year resident and the Program Director.
25. While the program provides ample opportunity for training, it is the responsibility of the resident to fulfill the training requirements including but not limited to the number and diversity requirements in CPME 320. If a resident believes they are having trouble meeting the requirements, they need to bring this issue to the attention of the Program Director as soon as possible.

D. Responsibilities

The residency training program is structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. *See policy II B 2 Professionalism Faculty and Resident*

Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, the residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and pre-certify certain treatment plans (e.g. Physical Therapy, Speech Therapy, etc.) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting, specific documentation. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.

During the performance of such procedures, an attending physician will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending physician within the context of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and of the complexity of the specific case. *See policy IV I Resident Supervision and IV I 1 POD Resident Supervision*

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient's record.

<u>PGY-1</u>

1. Responsible to round all post-operative patients
2. Wound Care Clinic
3. Responsible to attending with respect to infection management
4. Weekly/Monthly lectures and scholarly activities and research

5. Assist in monthly skills lab
6. Emergency Department Call

PGY-2

1. All complex rearfoot and ankle procedures
2. Assist the PGY-1 resident and externship students
3. Weekly lectures to podiatric residents
4. Monthly lectures to various hospital professionals
5. Completion of an advanced research project
6. Plan and assist monthly skills lab

PGY-3

1. All complex rearfoot and ankle procedures
2. Chief Resident, if assigned title
3. Assist PGY-1 and PGY-2 resident(s) and externship students
4. Weekly lectures to podiatric residents
5. Monthly lectures to various hospital professionals
6. Oversee PGY-2 planning and assist in monthly skills lab
7. Completion of an advanced research project

The first- and second-year residents are responsible directly to the third year (Chief Resident) and Program Director. The third year (Chief Resident) is responsible directly to the Program Director. The residents' actions are governed by the rules and regulations stated in this manual. Any questions or problems concerning a resident, whether they are from podiatric, medical, administrative, or nursing staff, should be brought to the attention of the Program Director.

E. Evaluations

1. The program expects a progression of knowledge in the specialty area from the beginning to the end of training, and such progress shall be monitored. It is further expected that residents will be eligible for the specialty board examination upon completion of the training program, with an overall goal that all residents will pass the examination and become board certified.
2. Evaluations must be completed for all rotations identified in the curriculum. The evaluation must assess competencies specific to the rotation including communication skills, professional behavior, attitudes, and initiative.
3. The residents are individually evaluated semi-annually, as in accordance with the CPME 320, by the Program Director and/or Clinical Competency Committee on their performance on outside as well as in house rotations. Evaluations are based on the fulfillment of the goals and objectives for the individual rotations and on evaluations submitted by members participating in the resident's education. Review of in-training examinations and projected attainment of Minimum Activity Volume (MAV's).
4. If a resident's performance or conduct is judged to be detrimental to the care of a patient(s) at any time, action will be taken immediately to ensure the safety of the patient(s).
5. Incident reports filed by hospital personal are considered as well.
6. Recommendations for improvement are made by the Residents, Faculty, and Clinical Competency Committee and reassessed at the next evaluation.

7. Residency logs are reviewed and signed on a monthly basis by the Program Director. In addition, annual reports are provided to the Clinical Competency Committee.
8. The Program Director must conduct a final meeting with each resident upon completion of the program. This final assessment will become part of the resident's permanent record that will contain verification of competency achievements and ensure attainment of MAVs in all categories. *See policy V A 1 Resident Final Evaluation*
9. The Program Director, faculty, and resident(s) will conduct an annual self-assessment of the program's resources and curriculum.

F. Promotion | Graduation

The resident is eligible for promotion and graduation upon the satisfactory completion of the training program. During their residency program the resident shall maintain satisfactory academic performance, demonstrate clinical competence, complete responsibilities as outlined by the Residency Training Manual, fulfill all the requirements set forth in the CPME 320 for the appropriate category of residency training program.

Certification of completion of the resident will be made by the Clinical Competency Committee. Following approval, the Program Director will issue a certification or diploma evidencing the successful completion of their residency.

With an unsatisfactory recommendation by the Residency Education Committee, the Resident will meet with the Clinical Competency Committee to determine what must be done to complete the Resident's requirements to advance to the second year. Appropriate appeal procedures will be made available as stated in the Resident's Contract, should the need arise. *See policy IV C Resident Promotion*

G. Dress Code

White jacket and name badge are provided before reporting for duty and must be worn above the waist on duty at all times. The white jacket should be kept as clean as possible. If uniform is unduly soiled through the normal routine of work, residents are required to change linen often enough to present a clean, well-groomed appearance at all times. Surgical scrubs, that is pants and shirts, shall not be worn by residents off the hospital area, but may be worn on the floor or making rounds. Residents shall assure that the podiatric externs refrain from wearing surgical scrubs off the hospital area, and that they wear a white jacket when attending to patients. Only those residents assigned to surgical service are permitted to wear surgical scrubs while performing their duties. A white jacket must also be worn over scrubs. *See policy III K Dress Code*

H. Scheduling and Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent from the work site. Resident duty schedules are organized so as to promote an educational environment and facilitate safe patient care while supporting the physical and emotional well-being of the resident. Residents must complete their full assigned shift and may not leave early, unless it is excused by the Program Director and/or Administrator to abide by the CPME duty

hour requirements. *See policy X F Policy and Procedure Clinical and Education Work Hours for Residents*

To ensure compliance with the Duty Hours policies, the following guidelines will be followed:

1. Duty hours will be recorded by resident into residency management software on a weekly basis, by end of day Friday of the week or Monday morning if you worked the weekend.
2. Duty hours will be identified by "Activity Types" within the rotation, these are identified, but not limited to below
    a. House Officer (HO)
    b. Educational
    c. Meeting
    d. On Call (Inhouse)
    e. POD Medical
    f. POD Out Rotation Hospital
    g. POD Surgery
    h. POD Wound Care
    i. PTO (Paid Time Off)
    j. Leave of Absence
    k. Pt. Care Inpatient (Non-POD Services)
    l. Pt. Care Outpatient (Non-POD Services)

The resident is required to notify the program director or program coordinator and terminate all clinical duties if the resident is excessively fatigued and believes that fatigue will compromise clinical performance.

We will ensure that the resident performance is not impaired by excessive fatigue caused by program duties or other activities. The ratio of hours worked to on-call time will vary. In all cases the CPME Duty Hours policies will be upheld.

I. Relationship of Resident to Hospital, Staff, Physicians and Hospital Personnel

The residents will accompany members of the staff when possible while they are making rounds.

The first-year resident will make careful notes of orders given by the staff. In no case will the resident change the treatment without the permission of the staff members.

Supervision, control, and discipline of the first, second-, and third-year resident(s) are vested in the Program Director. Disagreement or criticism of any member of the nursing staff must be discussed with the Program Director who will take any necessary action. Questions or criticisms relating to the general hospital operation or personnel may be brought to the Program Director, who may discuss them with the hospital administrator.

Those questions relating to the podiatric residency training program will be discussed with the Program Director and the third-year resident.

Residents are expected, to conduct themselves with professional dignity in the relationship not only with patients, but also with nurses and other hospital employees. Both on and off duty, be true to your reputation as a gentleman/lady and

a doctor.

Cooperate in every way possible, and maintain friendly relations with all professional services, administrative departments, and other hospital personnel. You have no disciplinary jurisdiction over nurses or other hospital employees. If any personnel difficulties arise, discuss them with the Program Director. All formal complaints are to be in writing via SafeCare, incident reporting system. Always remember the attending physician is in full charge of his/her patient.

Inform him/her promptly of any major change in the patient's condition. Work closely and conscientiously under their direction and let them know that you want to learn from them.

Any problems or questions concerning patient care should be directed to the appropriate department head or the Program Director.

1. An attending physician must be identified for each case of patient care involving a resident.
2. The attending physician is responsible for the care provided to these assigned patients.
3. The attending physician is responsible for determining the level of supervision required to provide appropriate training and to assure quality of patient care.
4. Attending physician shall be identified in the chart and must meet with the patient within 24 hours of admission.

J. QUALITY IMPROVEMENT

The residents should demonstrate familiarity with utilization management and quality improvement. This will emphasize the practical importance of patient safety to demonstrate practices for teamwork, open communication, and patient centered focus.

K. TRAINING COMPETENCIES/OBJECTIVES

The objective of Mercy Health - St. Rita's Medical Center (Podiatry Medicine and Surgery Residency Training Program) is to enhance the resident's level of competence and training necessary to acquire experience and develop skills and attitudes to assure the special competence and judgment expected of today's podiatric specialist. The podiatric medicine and surgery residency is a resource-based, competency-driven, and assessment-validated program that conducts self-assessment and assessment of the resident based upon competencies.

The overall goal of the residency program is to create a graduate that is competent to practice podiatric medicine and surgery. The resident should acquire skills and knowledge to be competent to diagnosis and manage diseases, disorders, and injuries through the achievement of the competencies. affecting the foot and ankle. The resident should have appropriate skills to treat patients conservatively and surgically when surgery is indicated.

A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the lower extremity.
   1. Acquire experience with a thorough history and physical exam, including neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis as indicated.

2. Increase ability in examination to formulate an appropriate diagnosis and/or differential diagnosis and recognition of abnormalities, disease and conditions of the foot, ankle, and related structures and of pedal manifestations of systemic disease.

3. Understand the indication(s) for and interpret appropriate diagnostic studies, including:

    - Medical imaging (e.g., plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging)
    - Laboratory tests (e.g., hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis)
    - Pathology (e.g., anatomic and cellular pathology)
    - Other diagnostic studies (e.g., electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies).

4. Management of patients in inpatient and outpatient settings for management and evaluations, including the following:
    - Perform biomechanical examination and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
    - Dermatologic conditions.
    - Neurological conditions.
    - Orthopedic conditions.
    - Arterial and venous conditions.
    - Wound care.
    - Congenital deformities (e.g., manipulation, casting, bracing of foot/ankle).
    - Trauma.
    - Office-based procedures (e.g., injections and aspirations, nail avulsion, biopsies).
    - Pharmacologic management.
    - Lower extremity health promotion and education.

5. Evaluation and management of surgical patients by participating directly, including the following.

    - Evaluating, diagnosing, selecting appropriate treatment, and recognizing and managing complications.
    - Progressive development of knowledge, attitudes, and skills in perioperative assessment and management in foot and ankle surgery
    - Review the treatment plan to determine if revision is necessary.

B. Assess and manage the patient's general, medical and surgical status.
    1. Comprehensive medical history and physical exams performed and interpreted through experiences with podiatric and non-podiatric.
        - Comprehensive medical history
        - Comprehensive physical exam
            - Vital signs

- Physical exam (e.g., head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic exam).

2. Formulate an appropriate differential diagnosis of the patient's general medical problems.
3. Understand the indications(s) for and interpret the results of diagnostic studies including:
    - EKG.
    - Medical imaging (e.g., plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound)
    - Laboratory studies (e.g., hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, and 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, gender, psychosocial status, and socioeconomic status.
6. Participate actively in non-podiatric surgical rotations that include surgical evaluation and management of patients including, but limited to:
    - Understanding management of preoperative and postoperative surgical patients.
    - Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
    - Understanding surgical procedures and principles applicable to non-podiatric surgical patients.
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 antibiosis monitoring.
    - Managing patients with local and systemic infections.
10. Participate actively in a medical imaging rotation that should include musculoskeletal and non-musculoskeletal pathology and incorporates evaluating and interpreting various medical imaging modalities (e.g., plain radiography, nuclear medicine imaging, MRI, CT, and diagnostic ultrasound).
11. Participate actively in a behavioral medicine rotation that incorporates

evaluation and management of patients with behavioral, mental, and/or psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).

12. Participate actively in a vascular/endovascular surgery rotation that incorporates the evaluation and management of patients with peripheral arterial disease including, but not limited to, the following training experiences:
    - Evaluating and interpreting various vascular studies.
    - Understanding the indications for various vascular/endovascular revascularization procedures.

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 podiatry medicine and surgery.
2. Practice and abide by principles of informed consent.
3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.
4. Demonstrate professional humanistic qualities.
5. Develop proper charting methodology appropriate for medico-legal review. Gain insight into the medico-legal aspects of practice.

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

1. Demonstrate effective physician-patient communication skills.
2. Demonstrate effective physician-provider communication skills.
3. Demonstrate appropriate medical record documentation.
4. Demonstrate appropriate consultation and/or referrals.

E. Increase capacity to manage individuals and populations in a variety of socioeconomic and health care settings.

1. Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate cultural humility and responsiveness to values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender identity, 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 health-care delivery settings.

1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand health-care coding and reimbursement.
3. Explain contemporary health-care delivery systems.
4. Understand insurance issues including professional and general liability,

disability, and Workers' Compensation.

5. Understand medical-legal considerations involving health-care delivery.
6. Demonstrate understanding of common business practices.

G. Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and evidence-based practice.

1. Develop and practice skills of public speaking.
2. Increase writing abilities by authorizing a two-year research project.
3. Develop the appropriate skills for completing a research project.
4. Read, interpret, and critically analyze and present medical and scientific literature.
5. Demonstrate information technology skills in learning, teaching, and clinical practice.
6. Participate in education activities.

L. Resident Schedule

1. All Residents will follow the established Residency Program schedule *see Exhibit A*.
2. All Residents will report to their designated assignments at the designated time.
3. All unexcused absences may be made up during or at the end of the program before certification of completion of the prescribed program can be made.
4. Rotations will be divided into mandatory and elective rotation types:
    a. Mandatory - As the name implies, these rotations are required. They have been selected for their essential value to the education of the Resident.
    b. Elective - Third Year Resident may choose from a list of available elective rotations. Selection of elective rotations should be submitted to the Director of Residency Training six months prior to the beginning of rotation.
5. Arrangements for any departure from the schedule with the person to whom you report and from whom you take your assignments must be made. You will have a designated primary service schedule assignment and secondary one will be appointed to report to if the primary service activity is completed or inactive. There will be some natural normal combination of services.
6. A schedule will be established in the Resident Management Software. It is the responsibility of the in-house residents to update this schedule as changes occur in coverage.
    a. When the resident is serving on rotation, they will remain on the rotation unless such notified by the Program Director and/or Residency Program Coordinator.
    b. The first-year resident will be excused from their official duties only:
        i. While attending an approved meeting, conference, seminar, etc.
        ii. While absent due to illness (should be under the care of a

physician should the illness be greater than one day duration or occur in a continued episodic fashion).

7. While observing or participating in a special orthopedic or podiatric surgery. The Program Director and the attending at the specific rotation should be notified prior to missing the rotation. The resident should attempt to make up any missed rotations or duties upon his return to the hospital.

    a. The on-call resident will be notified and report for all Emergency Room calls cases involving the lower extremity if contacted by the ER Physician attending. Hours of duty shall include those listed on the podiatric call schedule. Leave at times other than specified above may be granted under reasonable circumstances by the Program Director, Associate Program Director, or the Administrator.

8. Residents must be granted protected/dedicated time for weekly educational activities. These educational sessions should be offered in diverse formats, such as lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

9. 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 with these rotations and competencies.

M. Resident Daily Log

The residents will:

1. Keep surgical logs via Podiatry Residency Resource containing patient name, hospital number, procedures performed or assisted, and date of operation **for both podiatric and non-podiatric cases.** Include in log notation if inpatient or outpatient surgery. (This should be typed). Non-podiatric cases should be coded with an x and not counted in surgical case numbers.
2. **Keep a <u>log of daily activities</u> for in house and outside rotations within residency resource software.**
3. Program Directors must review and verify logs <u>monthly</u> therefore residents MUST log experiences each week.
4. The format must categorize and summarize medical/surgical diversity and experiences (refer to Appendices A and B).
5. When logs are delinquent, not completed each week, discipline action will be reviewed by the Program Director.

N. Well-Being

Mercy Health - St. Rita's Medical Center is committed to providing residents with a high quality academic and clinical education, which must be carefully planned and balanced with concerns for patient safety and resident well-being. Podiatric Medicine & Surgery Residency Program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service

obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. Programs should be structured to achieve the best balance possible for patient safety, resident education and resident personal and professional development and fulfillment. *See policy IV H 1 Resident Well-Being*

VII. Time Off Leave of Absences

Work-Life Balance and a commitment to lifelong learning are important skills for residents to master. One of the many ways these can be addressed is through taking time away from work, both for leisure and for time spent in dedicated learning. Below are the general guidelines on time away from residency. Other guidelines regarding time off during residency can be found in the Graduate Medical Education Handbook. Please be aware that when you are away from work, others must deliver care in your absence. So, advance notice given to plan for these events allows the program and services to function better.

Time Off

Scheduled requests are important for wellness and planning personal activities. Residents make schedule request that are coordinated appropriately depending on rotation schedules because of service commitments on several rotations, we may be unable to grant time off leave during outside rotations or if no other resident(s) are available to cover call.

The first-year resident shall not request time off time during the first month of training. The second-year resident is encouraged to remain on service the first week of July. The third-year resident will remain on service to orientate and train the first-year resident during the month of July. The third-year resident is encouraged to remain on service the entire month of June prior to graduation.

1. Paid Time Off and conference time is assigned according to the guidelines in the Graduate Medical Education Handbook. It will vary according to the year of residency.
2. Paid Time Off/ conference time does not accumulate from year to year or get paid out.
3. Requesting paid time off/conference time is not the same as having the request approved. Residents are advised to not schedule trips or buy tickets until a request for time away is approved.
4. There are strict guidelines for time away from residency, and failure to follow these guidelines will result in the resident having to take extra months of residency.
5. The residents should plan their time off/conference time as far in advance as possible. All requests must be submitted a minimum of 4-6 months prior (barring extenuating circumstances that must be approved by the Program Director). When possible, half of the allowed time should be taken during the first six months of the academic year.
    a. A resident may lose time off due to rotation restrictions or other reasons.
    b. Time off may be assigned by the Program Director
6. In general, no more than 5 working days per one-month rotation will be permitted for time off /conferences.
    a. Paid time off request forms need to be completed with approval by the

chief resident for confirmation of schedule adjustments.

b. Completed request forms need to be turned in and signed by the Residency Program Coordinator a week prior to scheduled time off.

Occupational Injuries and Illness

A resident injury or illness while on duty should be reported promptly to the Program Director and/or Administrator. If medical treatment is indicated, refer to Employee Health, Occupational Health, family physician, or if acute to Emergency Express Care. An Employee Incident Report (SafeCare) should be initiated within 24 hours of the injury/illness by the resident for documentation purposes if the injury occurs at Mercy Health - St. Rita's Medical Center.

Needle stick or Bodily Fluid Exposure

The resident should seek medical care as soon as possible after the exposure. Monday through Friday (7:00 am – 3:30 pm) call Employee Health (419) 226-9385. Off shifts, holidays, and weekends call the House Supervisor at (419) 226-9711. This must be reported to the Program Director and Program Coordinator, in addition an online (SafeCare) Employee Incident Report should be completed within 24 hours of the incident.

Workers' Compensation

See policy V E Policy and Procedure Workers' Compensation

Family and Medical Leave Act (FMLA)

See policy V F Leave of Absence and SRMC GME Policies and Procedures Manual

Bereavement Leave

A resident may be eligible for bereavement leave as defined by Human Resources Policy and Procedure policy that is HRMH012 Bereavement Leave Policy and Procedure that can be found on "BSMH Central" under the Policies tab.

Seminars | Conferences

1. Must be approved by the Program Director and/or Administrator.
2. ACFAS Conference: first year resident will remain on service
3. CRIP Interview: third year residents will remain on service
4. Contractual allowances are determined each year with the new contracts from the hospital.
5. Must follow Mercy Health Travel and Business Expense Policy for all reimbursement of business expenses and business-related travel.

Sexual Harassment/Freedom of Harassment

Sexual Harassment will not be toleration by the residency program. Sexual Harassment will be dealt with by the method prescribed in the Sexual Harassment Policy (HRMH078), which is located on "The Hub". If the institution where the problem occurred is not Mercy Health - St. Rita's Medical Center, policies will be available on request. At any site where no such policy exists, policy will be followed.

Mercy Health - St. Rita's Medical Center is committed to maintaining a work environment free of discrimination and strongly disapproves and will not tolerate any kind of harassment of residents, employees, applicants, independent contractors, or medical staff by anyone, including any manager, supervisor, physician, co-worker,

or non-employee.

Equal Employment Opportunity (EEO)

Employment by Mercy Health St. Rita's is based on merit, qualifications, and competence. Residents and applicants will not be discriminated against on the basis of race, religion, color, national origin, ancestry, physical or mental disability, veteran status, medical condition, marital status, age, sex, sexual orientation, or gender identity.

Accommodation for Disabilities

Mercy Health - St. Rita's Medical Center provides job accommodations that are both reasonable and necessary to meet with known functional limitation of residents with disabilities. *See policy IV F Policy and Procedure Accommodating Residents with Disabilities*

Smoking Policy

Smoking is not permitted anywhere inside or outside buildings or on the Medical Center Campus.

VIII. POLICIES FOR PATIENT RELATIONS

A. **Admission procedure**

Patients are admitted to the hospital and are assigned beds through the Nursing Supervisor and the Admitting office. The attending physician calls these offices to make a reservation and to give the admitting diagnosis and other preliminary information. He/she may send written orders with the patient, leave them with the admitting clerk, or give them over the telephone to the resident (or the nurse). Verbal orders must be signed within 48 hours. After the patient arrives and the admitting data is completed, the patient is escorted to his/her room.

B. **In regard to transfer of patients**

After a patient has been admitted, transfer from one room to another is accomplished only through the Nursing Supervisor and Admitting office. Patients can be transferred from ward to semi-private or private rooms or vice versa by requesting the transfer through the floor nurse, who will make the necessary arrangements with the Nursing Supervisor. *See policy III J 3 Transitions of Care*

C. **First contact with patient**

Introduce yourself as a podiatric member of the house staff. Explain that the attending requested you to perform the H&P. As soon as the patient is in bed, the resident who is responsible for the case according to the schedule takes the history and makes the physical examination. He then calls the staff physician for orders if not already obtained. The history and physical examination must be signed, whether the report is handwritten or dictated and typed. Each new admission should be seen within a timely fashion, and preliminary procedures should be completed within 24 hours. In the absence of written or telephone orders from the attending physician, the resident writes the preliminary routine orders on the order sheet, with permission note on the chart, except for emergency cases.

D. **History and Physical Examination**

All podiatric patients admitted to the hospital will be given a complete history and physical examination. Complete diagnostic work-up is considered essential to a case. It is the responsibility of the podiatry resident to perform H&P's which must be completed within twenty-four (24) hours of admission and co-signed by the attending physician.

The history should be as complete as possible and should include:

1. Chief Complaint
2. Present Illness
3. Past Medical History
4. Family History
5. Review of Systems

The history should record clear, concise statements pertinent to the patient's story of his complaints and illnesses, including onset and duration of each. The report of the physical examination is the result of a thorough examination of the patient by the resident and is a detailed description of his observations and findings. The terms "negative" and "normal" are opinions and not facts and should not be used except when summing up the facts.

Genitourinary, rectal or breast examinations are not routinely done on podiatric surgical cases unless the particular case requires such an examination. In this event the resident should seek assistance from the physician responsible for the medical management of the patient or other responsible physician.

A complete physical examination does not include pelvic examinations unless otherwise specified by the attending physician's orders. It is performed only with the patient's permission and always in the presence of a nurse. No vaginal examination should be made of an unmarried female less than 21 years of age without the consent of her mother, guardian, or some other legally responsible member of the patient's family.

Please refer to "History and Physical Examination" format on the following pages.

HISTORY AND PHYSICAL EXAMINATION

(Note: Standard abbreviations may be used if written in longhand: i.e., C.C., P.I., etc.)

Date of Admission to the Hospital

C.C. or CHIEF COMPLAINT

The entrance complaint is generally a brief state-statement of the patient's subjective symptoms as some abnormality of sensation, pain or even some psychological reaction of which the patient, himself is aware.

A concise statement of complaints, preferable in the patient's own words, and should be an introduction to, and closely correlated with the present illness.

P.I. or PRESENT ILLNESS

An orderly story of the onset and course of the illness that gave rise to the chief complaint, with reasons, signs, severity, location and duration of each symptom. The date of onset should be given, or the number of days, as "two days ago."

The illness may be a brief episode, such as an accident which occurred just prior to

admission. Or, it may be an illness which began years ago and was marked by repeated attacks with periods between which, apparently, no subjective symptoms were noted.

In the case of chronic disease which may recur at intervals, details of the more recent events of the illness should be given. Interval treatment given in such cases may be described.

Since most symptoms, i.e., pain, nausea, vomiting, headache, dyspnea, etc., may be produced by widely divergent cause, the physician should learn as much about each symptom as possible; onset location, quality, intensity, possible radiation, distribution, persistency, or intermittency, duration and relationship to other complaints or certain body functions, such as eating, bowel movement, micturition, sleeping, working, menses, and also any measures which may grant relief.

P.H. or PAST HISTORY

A summary of the patient's past health status. This should include all operations with dates, injuries, complications, or experience which might have a bearing on the present illness. The patient should also be questioned for any problems with anesthesia in the past or in other family members.

Question the patient specifically on each of the following and record each condition he has had, P.H. or i.e., muscles, whooping cough, mumps, chicken pox, scarlet fever, diphtheria, rheumatic fever, typhoid fever, malaria, dysentery, arthritis, asthma, tonsillitis, influenza, pleurisy, pneumonia, tuberculosis, or tuberculosis contact, amebiasis, lues, gonorrhea, etc.

Include history of allergy of drug reaction and environmental allergies.

Other subdivisions of the past history may be contributory:

1. Birth and early development
2. Environmental history
3. Intellectual and social development
4. Occupation – Habit
5. Marital history

HISTORY

A record of familial tendencies, such as tuberculosis, lues, cancer, diabetes, arthritis, heart disease, kidney disease, allergy, high blood pressure, epilepsy, and any other which might have a bearing on the cause and development of the disease.

The health of immediate relatives (father, mother, siblings, children, ages at death, and causes of death should also be recorded.)

SYSTEMS REVIEW

The subdivision of the past medical history. The purpose of this is to reveal subjective symptoms which the patient forgot to describe, or may have considered unimportant. This should also give a clue to the diagnosis and indicate the nature and extent of the physical examination.

General Nutrition, fever, night sweats, falling hair, tremor, weight gain, weight loss, other. SKIN: A record of eruptions, cyanosis, jaundice or other skin conditions.

HEAD: Headache, history of trauma, syncope, or other affections.

EYES: Eye strain, diplopia, photophobic, lacrimation, glasses for correction of vision.

EARS: Deafness, discharge, tinnitus, dizziness, other.

NOSE: Colds, epistaxis, sinusitis, obstruction, postnasal drip, other.

THROAT: Soreness, redness, hoarseness, dysphagia, etc.

NECK: Disease of the neck are usually expressed by some disturbance in movement, pain and swelling. The causes may be classified into the etiologic factors of disease: congenital anomalies, trauma infections, tumors, degenerative and functional entities. A wide variety of systemic disturbances may be interrelated.

C.R. or CARDIORESPIRATORY:

Chest pain, hemoptysis, sputum, dyspnea and shortness of breath following ordinary exertion. If he coughs, determine the character of the cough, i.e., whether it is dry hacking, paroxysmal, explosive, persistent, and of equal importance, whether it is productive or nonproductive.

Insofar as the cardiac system is concerned, as Paul White has emphasized, "the first heart symptom is the keystone on which further examination of the cardiac patient depends." Inasmuch as the chief symptoms of heart disease - dyspnea, substernal or precordial pain, and palpitation -may not only be readily be confused with each other one cannot stress to greatly the development of the symptoms of the cardiac patient, with careful observation concerning time, character, intensity, variability, and relationship to extraneous or precipitation factors.

G.I. or GASTROINTESTINAL

Questions concerning the appetite, distress, pain, nausea, vomiting, belching, flatulence, constipation, diarrhea, stool, (shape, color, mucus, blood) Hemorrhoids, hernia, other.

G.U. or GENITOURINARY

Covers such items as frequency of urination, abnormal color of urine, pain or burning on urination, any passage of stones, or inability to pass urine.

OR

Discharge, sores, frequency, nocturia, incontinence, pyuria, hematuria, pain, other.

Female reproductive (Menarche or catamenia) Menstrual cycle, age at first appearance, date of last period, regularity, type, duration, and any sigh of abnormality in this respect.

Abortions, if any, pregnancies (type and complications), labor (type and complications).

N.M. or NEUROMUSCULAR

Emotional state, headaches, or convulsions. Includes question concerning loss of sensation in any part of the body, difficulty in walking and pain in muscles or joints.

P.E. or PHYSICAL EXAMINATION

(Age, T.P.R., B.P., Weight, Height)

This part of the report is based on the objective findings of the physician in his physical examination.

Opening statement concerning general condition of the patient. Example: "A well

developed, well-nourished white adult male lying in a right lateral recumbent position complaining of pain in the right, lower quadrant."

SKIN: The skin should be examined not only for the presence of an eruption, but also for changes which are indicative of symptomatic disease, such as pallor cyanosis, edema, jaundice, hemorrhage and changes of texture, elasticity, moisture and sensibility.

Also observe for scars, excoriation, ulcers, tumors and distribution of hair.

HEAD: Examination may include the symmetry or lack of symmetry of the skull, exostosis or bumps, as well as tenderness in certain areas, conditions of the scalp and hair. Special consideration for traumatic injuries.

EYES: Symptoms of common diseases can be detected through their examination. Examine pupils for regularity and reaction. Abbreviations may be used, as pupils are "round, regular and equal", (R.R.E.) and that react to light and accommodation", (R. to L. & A.) and the external ocular movements are normal (E.O.M.). Any exophthalmus or bulging of the eye is noted, so too, lacrimation or photophobia.

EARS: Should be examined by the otoscope if the present illness indicates a disease related to the ears. The degree of hearing is sometimes tested with a watch or tuning fork. Check drums, hearing, discharges, mastoid, etc.

Note airways, conditions of mucosa, discharge, deviation of perforation of nasal septum. Sinuses; not location of pain, tenderness upon pressure, related mucosal redness or swelling nasal discharges. May examine by **trans-illumination.**

THROAT: Signs of infection and presence or absence of tonsils and adenoids may be noted.

PHARYNX: Examinations may show a congested or inflamed pharynx or uvula.

MOUTH: Ulcerations, pigmentation and odor of breath are significant findings.

TEETH: If in poor condition, might be very significant as the foci of an infection.

GUMS: Bleeding or pale gums, pyorrhea, etc.

LARYNX: The character of the voice can be diagnostic. If the present illness indicates trouble in the larynx laryngoscopic examination may be indicated.

NECK: Note any disturbances of movement (stiffness and rigidity), pain and swelling. Palpitation of the cervical lymph glands, salivary glands and thyroid gland may show abnormality, and if so, the findings may be significant.

CHEST: Shape, symmetry, equality of expansion, respiratory rate, presence of rales, the character of the breathing, *as* deep or shallow, etc.

BREAST: Should be deferred to attending physician and not performed unless specifically requested by referring doctor

HEART: The apex beat of the heart, if felt at the left fifth intercostal space known as the point of maximum impulse - P.M.I., is considered normal. Any deviation may indicate an abnormal size of the heart.

Check P.M.I., pulsation, rate, rhythm, valve sounds - M-1, A-2, P-2 murmurs, fraction, thrill, etc. LUNGS: Usually examined by means of percussion and auscultation.

Check fremitus, percussion, breath sounds, adventitious sounds, spoken voice, whispered voice, etc.

ABDOMEN: If symptoms are related to the abdominal region, important findings are masses, tenderness, presence of hernia, incisional scars and other diagnostic signs.

Check contour, peristalsis, fluid, scars, tenderness, rigidity, hypertrophy of liver, gallbladder kidneys, spleen.

GENITALIA (female): Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

GENITALIA (male): Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

RECTAL: Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

BONE, JOINTS, MUSCLES: Deformities, swelling, redness, tenderness, limit of motion, etc. Includes testing for reflexes and range of motion of both upper and lower extremities. All podiatric findings. Check color, edema, tremor, clubbing, ulcers, varicosities, pulsations, etc.

NEUROLOGICAL: Cranial nerves, motor, sensory, coordination, gait, reflexes, Romber, etc.

BIOMECHANICAL EXAMINATION: Narration of positive findings should also include complete listing of all podiatric findings. Biomechanical findings will be discussed in detail with the second-year resident.

TENTATIVE DIAGNOSIS: Usually a statement of early diagnosis make before any tests have been completed or a final diagnosis has been reached. Diagnosis should include items described in attending admission diagnosis.

E. **Progress Notes**

Progress notes are specific statements by the physician relative to the course of the disease, special examinations made, response to treatment, new signs and symptoms, complications, and surgical cases, removal of drains, splints, and stitches, abnormal laboratory and x-ray findings, condition of surgical wound, development of infection and any other information pertinent to the course of the disease. The frequent use of general statements such as "condition fair", "general condition, good" and "no complaints", is unscientific and valueless. <u>All progress notes must be dated, timed, and signed.</u> Progress notes should be written daily. The admitting progress note is to be written by the attending physician. All patients are to be seen daily. If there is a change of resident services during the stay of the patient, the resident leaving the service should be sure that the progress notes are up-to-date and should summarize the condition of the patient on the day the resident leaves the case. The resident coming on the service should carry on the progress notes from that time. Remember this is not only a medical notation, but also a legal notation.

F. **Operation Report**

An operation report must be dictated immediately after surgery. Resident dictations must be co-signed by the attending staff physician. The operation report should include:

1. Preoperative diagnosis
2. Postoperative diagnosis
3. Operation performed
4. Surgeons, Assistants
5. Findings
6. Procedure in detail

G. **Clinical Summary**

A clinical summary should be dictated before the patient leaves the hospital. The discharge summary must be reviewed and signed by the dictating resident.

1. Reason for hospitalization
2. Procedures performed
3. Care treatments and services provided
4. Patient's condition and disposition at discharge
5. Information that was provided to the patient and family

H. **Orders – Resident Guidelines**

The resident may write orders for the patient on behalf of the admitting podiatrist. These orders may include necessary tests, therapy, etc. All orders written by residents are subject to the approval of the admitting podiatrist. Prior to writing orders, the resident should make an effort to contact the podiatrist by telephone or have written permission in the orders.

I. **Consultations**

Any podiatric consultation requested by the medical staff is to be handles on a rotational basis by the members of the active podiatry staff, unless a specific podiatrist is requested. Residents will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders. In accordance with the resident's contract, the resident shall not be permitted to participate in professional or clinical work outside of the hospital wherein others collect compensation.

J. **Completeness and Accuracy**

The value of the medical record is in direct proportion to the thoroughness and accuracy with which it is written. It should be remembered that any record may be summoned for legal use, such as in compensation, accident, alcoholic and criminal cases. Prompt and accurate recording of the facts is particularly beneficial in such instances. All entries in the medical record must be complete and accurate. Both the success of handling a patient efficiently and the basis for good teaching and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than none.

K. **Corrections**

Erasures and blanked-out alterations on records are illegal and make the record valueless to the patient or the hospital in case of litigation. If corrections are necessary, a single line should be drawn through the words to be deleted, and the

new entry should be made. Chart entries are permanent and must be in black or blue ink. It is the policy of the hospital to use ink and write the records in longhand. Pencils and carbon copies are prohibited. The original reports, not the carbon copies, of special examinations, such as x-ray and pathological examinations, are incorporated into the medical record. Neat, well kept, complete records may help to advance medical knowledge, and the condition of our records is one of the factors determining our approval by the Joint Commission of Accredited Hospitals. Not only is the patient's record a permanent reference file for subsequent admissions and for medical research, it is also a legal document and should be regarded as such. Notations tinged with frivolity, inappropriate remarks, or implied criticisms have no place in these documents. Notes or messages for attending physicians or other members of the house staff should not be written on the permanent records; these may be written and attached to the outside of the chart, if desired.

L. **Legibility**

All entries must be readable, and they must be dated, timed, and signed, not initialed. Treatments and medications should be carefully recorded as ordered, including dosage. Dates and hours should be carefully specified. Entries should be made consecutively, with a minimum amount of space between them. Abbreviations should be avoided except for a few recognized to be in common usage.

M. **Care of Records**

Records are privileged and confidential documents and must be safeguarded as such. Care must be taken that records do not fall into the hands of persons not authorized to review them. Therefore, insurance representatives, attorneys, etc., are required to present written permission of the patient and of the attending physician before reviewing a medical record. Information regarding the medical records is given to the patient only by his physician. Records should be handled with care and treated with respect, particularly if they are bulky or show signs of wear.

N. **Rules for Patient's Records**

Complete all information on each sheet of the chart and sign, date, and time it, whether typed or handwritten, before chart goes to the Medical Record Room. Record all information about your patients fully, including progress noted. Avoid the addition of extraneous material to the charts, and never use humor or flippancy.

Records are not to be removed from Medical Records in the following instances:

1. Must not be removed from the hospital.
2. Must not be taken to the Resident's quarters.
3. Must not be kept in desks or file drawers outside of the Medical Records Department.
4. Must not be kept in locked offices.

Records are to be removed from the Medical Records Department for the following purposes only:

1. For use by the physicians upon re-admission to the hospital or return to the hospital for out-patient care.
2. For use by the Resident or attending staff for reference or study with the Medical Records Librarian's knowledge and permission.
3. For use by other authorized hospital personnel upon request.

4. For use in court upon subpoena.

Any record may be requisitioned by members of the Intern and Resident Group or attending staff for use within the hospital building for teaching purposed only. No record should be taken from the Medical Records Department without the knowledge of some member of the personnel in this Department. If a record is required during hours when this department is closed, a request form should be competed and left in the record with the medical records office.

In case of emergency, the Director of Nurses or the Administrator of the hospital may obtain the record on request. Occasional special permission maybe granted by the medical records department for use of a record at a scientific meeting outside the hospital, but these records must be properly charged out to specific individuals or divisions and must not be moved from one place to another without notifying the Medical Records Department. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

O. **Requirement for Completing Records**

Residents, like attending physicians, are required to complete their records within 24 hours after the patient's dismissal. Those records which are over twenty-four hours old, subject the attending physician to the loss of their staff privileges.

P. **Discharges**

When a patient is discharged at the attending physician's discretion, the resident is responsible for discharging patients (on the authority of the attending podiatrist). It is the resident's responsibility to discharge the patient with the following:

1. Post-operative instructions.
2. Post-operative shoes, walker, or crutches.
3. Instruction to call the doctor's office for an appointment for observation and redressing.
4. Prescriptions for necessary medications. The resident should check with the attending podiatrist for types of medications preferred and/or special instructions.

Q. **Discharge Medications**

The resident is to write for medications to last only until the patient returns to the attending doctor's office for the post-operative visit.

Any questions or problems concerning types or quantity of medication should be brought to the immediate attention of the Director of Residency Training or his Assistant for discussion and action (if necessary).

R. **Unauthorized Discharges**

The resident is responsible in every case for the following, which should be noted on the discharge summary.

Occasionally, a patient may become dissatisfied and wish to leave the hospital without his doctor's permission. The Resident should explain the seriousness of such a step to the patient and try to dissuade him. If the patient insists, he must be requested to sign the form on the back of the admitting document, "Release from Responsibility for Discharge", stating the fact that he is leaving without his doctor's

permission, and releasing the hospital and his doctor from all responsibility for any complications which might arise because of his unauthorized departure. The form must be signed in the presence of the resident or nurse and witnessed. The resident is to dictate a discharge summary following the discharge, when requested by the attending physician.

S. **Deaths**

The resident shall not pronounce patients dead and is not allowed to sign death certificate.

T. **Witnessing Legal Documents**

Residents should not sign wills, power of attorney forms, or other legal documents as witnesses. Frequently, a proceeding to establish the validity of a will involves witnesses in lengthy court proceedings. A requires to act as witness to a document should be courteously, but firmly, refused.

U. **Responding to Legal Documents**

Receipt of a subpoena, summons to a court, request to examine a patient's medical record or otherwise obtain information from it, or a letter from a lawyer concerning patient or hospital matters should be reported immediately to the Program Director, Administrator, and Hospital General Council.

Patient information is confidential and protected by law. Patient or chart information cannot be released to anyone without the consent of the patient or as authorized by law. The Health Information Management Department (Medical Records) handles release of medical records.

IX. TEACHING CONFERENCES, REPORTS, AND MEETINGS

A. The podiatric resident is required to attend all conferences conducted by the various hospital departments and to participate whenever a podiatric case is presented.

B. The podiatric resident is encouraged to attend all Podiatry Staff and general meetings.

C. The podiatric resident is encouraged to attend all conferences conducted under the medical educational programs. The resident will attend all in-hospital training lectures, allopathic, osteopathic and podiatry. Notification will be provided prior to the program(s).

D. The residents should attempt to attend the Ohio and regional official podiatric seminars and meetings.

E. Each resident may be required to give a scientific report at staff meetings. A schedule of assignments will be provided. Copies of all reports will be placed in the resident's hospital permanent record.

X. SCHOLARY ACTIVITY REQUIREMENTS

Scholarly Activity Requirements

The Podiatric Medicine and Surgery Residency Program has set forth clear expectations for scholarly activity requirements, as outlined below, which not only meet the minimum requirement provided by the CPME but will set graduates up for success in future practice. Residents will be offered ample opportunities to participate in scholarly

activities and will be provided with access to resources and personnel to assist in the processes.

Residents Must:

- Complete one research project or quality improvement project within their three years of residency. All projects should have at least one faculty mentor as a co-investigator.
    - This project should be completed no later than November 1st of PGY-3.
- Present aa CPC/M&M Conferences in PGY-1 and PGY-2.
- Submit a poster abstract to the Ohio Foot and Ankle Medical Association (OHFAMA) Meeting as a PGY-1, PGY-2, and PGY-3.
- Submit at least one abstract for the annual Scholarly Activity Symposium as a PGY-1, PGY-2, and PGY-3.
- Submit a poster abstract to the American College of Foot and Ankle Surgeons (ACFAS) Meeting as a PGY-2 and PGY-3.
- Present at the Quickie Seminar in the fall of PGY-3 in Dayton, OH.
- Meet with the Academic Research Coordinator at least quarterly per academic year to review any updates with ongoing scholarly activities.
- Provide the Academic Research Coordinator with a brief final write-up summarizing the project, resident role, key takeaways, and possible future directions. Residents are required to share any additional documents pertaining to the project with the Academic Research Coordinator.

Residents have access to the Academic Research Coordinator, a biostatistician, a librarian, and an abundance of resources located on the Microsoft Teams GME Scholarly Activity Channel. While these are the minimum requirements set forth by the Podiatric Medicine and Surgery Residency Program, residents are encouraged to pursue additional scholarly activities. Additional guidance on scholarly activities can be located in the Scholarly Activity Guide found on Microsoft Teams.

XI. Due Process

The purpose of the due process policy is to outline the corrective and disciplinary actions that may be taken and the subsequent right of a resident/fellow to initiate the appeal procedures described in the policy. This policy and the procedures outlined herein serve as the exclusive remedies available to residents/fellows who wish to appeal Corrective Actions Eligible for Appeal, as defined within the policy. These procedures are specifically designed to ensure the fair and equitable resolution of disputes related to a resident's or fellow's performance and conduct, providing a structured process for addressing concerns and ensuring transparency in addressing any disciplinary actions. For further details, refer to the full Due Process Policy *IV G 1 Due Process* for details on the process and requirements.

XII. Grievance Procedure

Residents have the right to formally address disputes related to their training, including academic or non-academic concerns. The grievance process provides a structured way to escalate concerns that cannot be resolved at the program level.

The process includes multiple levels of review, beginning with the **Program Director** and escalating to the **Designated Institutional Official (DIO), Chief Clinical Officer (CCO), and beyond if necessary**. Specific timelines and procedures apply at each stage.

Residents who wish to file a grievance should refer to the full **Grievance Policy on BSMH Central** *See policy IV G Grievance*

XIII. ROTATIONS

For rotation goals and objectives, and evaluation forms, please see the Resident Management Software.

The following rotations are designed to give the resident graded experiences and responsibility in the management of patients and recognition and understanding of clinical entities (this will have reference particularly to the field of foot surgery but will also refer to all related medical and surgical areas). The residents will be given an educational program on the post graduate level which will emphasize the basic and clinical sciences. Instruction will be provided primarily by the medical, surgical, and podiatric staff members of Mercy Health - St. Rita's Medical Center Medical Staff. The Podiatric Resident will practice with professionalism, compassion, concern, in a legal, ethical, and moral fashion.

The Podiatric Resident will be evaluated by the assigned Rotational Faculty per department rotation for their individual performance in regard to the educational objectives listed for each rotation. In addition, each faculty will also rate the Podiatric Resident in the regards of their individual professional behavior and overall ratings of performance. Rotational Evaluations will be made available to faculty members to complete on each resident at the conclusion of each rotation.

The rotation curriculum is designed to 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:

Medical Knowledge

Goal: Demonstrate Knowledge of established and evolving sciences, demonstrate and apply knowledge of acceptable standards of clinical medicine to their practice, and remain current with new developments in medicine. Demonstrate Knowledge of established and evolving sciences, demonstrate and apply knowledge of acceptable standards of clinical medicine to their practice, and remain current with new developments in medicine.

Systems Based Practice

Goal: Residents should exhibit awareness and responsiveness to the broader healthcare context and system, including recognizing structural and social factors influencing health outcomes. They should effectively leverage additional resources to deliver optimal healthcare. Understanding healthcare delivery systems and utilizing available resources efficiently to provide cost-effective care is essential. Additionally, residents should demonstrate awareness of patient safety and engage in quality improvement initiatives to contribute effectively to the team and ensure safe patient care.

Practice – Based Learning Improvement

Goal: Demonstrate ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and lifelong learning.

Interpersonal and Communication Skills

Goal: Demonstrate interpersonal and communication skills that results in effective exchange of information and teaming with patients, their families, and professional associates.

Showcase strong interpersonal and communication abilities that facilitate productive information sharing and collaboration with patients and their families. Effectively communicate within interprofessional teams and diverse settings, including peers, consultants, nursing staff, ancillary professionals, and support personnel. Demonstrate proficient utilization and accurate completion of health records.

Professionalism

Goal: Demonstrate a commitment to caring out professional responsibilities and an adherence to ethical principles

Refer to Exhibit A Resident Rotation Schedule.

The Podiatric Resident will rotate through the following Departments:

a. Anesthesiology
b. Behavioral Science
c. Endovascular / Vascular Surgery
d. Emergency Medicine
e. Family Practice
f. General Surgery
g. Infectious Disease
h. Internal Medicine/Hospitalist
i. Pathology
j. Physical Medicine and Rehabilitation
k. Plastic Surgery
l. Podiatry – Foot and Ankle Medicine
m. Podiatry – Foot and Ankle Surgery
n. Sports Medicine – Family Medicine
o. Radiology
p. Vascular/Endovascular Surgery
q. Wound Care

XIV. INFORMATION

Locations and Passcodes:

- Resident office – 3, 4
  - 3F
- Women's Main OR Locker Room – 1, 5
  - 2F
- Men's Main OR Locker Room – 2, 3
  - 2F
- Sleep Room – 3, 4
  - 6B
- Surgery Center – 1, 2, 3
  - 770 West High Street, Suite 100
- Wound Care Center – 1, 5, 4
  - 830 West High Street, Suite 250
- Kindred Supply Room – 2/4, 3

Didactic Activities

The didactic program incorporates practical training and academic exercises to prepare residents for professional careers. Residents must be afforded protected time for weekly didactic activities. The format of didactics should consist of lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continued education.

Subject to change based on needs of residents and guest lecturer availability.

Month	Wk of the Month	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
July	1st		McGlamry - Rearfoot & Ankle	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th	McGlamry - Rearfoot & Ankle		Cadaver Labs			
August	1st		McGlamry - Medicine	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)	AAFAO (PGY1)	AAFAO (PGY1)	
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			Academic Day Peripheral Nerve
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Medicine		Cadaver Labs			
September	1st		McGlamry - Forefoot	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			OHFAMA (PGY1, PGY2, PGY3)
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Forefoot		Cadaver Labs			
October	1st		McGlamry - Trauma	GME Grand Rounds (12pm)			Academic Day Heel Pathology
	1st			Journal Club			
	1st		Student Skills Lab				
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)	CLESS	CLESS	
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Trauma		Cadaver Labs			
November	1st		McGlamry - Misc. Tumor of Soft Tissue	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			Academic Day Digital deformities
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Misc. Tumor of Soft Tissue		Cadaver Labs			
December	1st		McGlamry - Misc. Intra-Articular Osteochondroma of the Ankle Joint	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Misc. Intra-Articular Osteochondroma of the Ankle Joint		Cadaver Labs			
January	1st		McGlamry - Misc. Malignant Melanoma Masquerading as Ganglion Cyst	GME Grand Rounds (12pm)			
	1st			Journal Club	CRIP	CRIP	
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			Academic Day MT osteotomis
	4th	McGlamry - Misc. Malignant Melanoma Masquerading as Ganglion Cyst		Cadaver Labs			
February	1st		McGlamry - Misc. Inroductin the Enahnaced Recovery After Surgery Approach	GME Grand Rounds (12pm)			
	1st			Journal Club			
	1st		Student Skills Lab				
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)	ACFAS (PGY2 & PGY3 (Optional)	ACFAS (PGY2 & PGY3 (Optional)	
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Misc. Inroductin the Enahnaced Recovery After Surgery Approach		Cadaver Labs			
March	1st		McGlamry - Misc. Foot Dominance and Function	GME Grand Rounds (12pm)			
	1st			Journal Club			Academic Day Lapidus
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Misc. Foot Dominance and Function		Cadaver Labs			
April	1st		McGlamry - Formation of Heterotopic Ossification with Use of Standard Saw Versus Ultrasonic Saw following Tansmetatarsal Amutation	GME Grand Rounds (12pm)	AAFAO (PGY2)	AAFAO (PGY2)	
	1st			Journal Club			
	2nd			CPC Conference (12pm)			Academic Day Tendon Pathology/Balancing
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Formation of Heterotopic Ossification with Use of Standard Saw Versus Ultrasonic Saw following Tansmetatarsal Amutation		Cadaver Labs			
May	1st		McGlamry - Current Guidelines for Narcotic Prescribing DPMs	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Current Guidelines for Narcotic Prescribing DPMs		Cadaver Labs			Academic Day Orthoplastics:Soft tissue repair/flaps Frames
June	1st		McGlamry - Staple Fixation for First Metatarsal Transverse Closing Base Wedge Osteotomy	GME Grand Rounds (12pm)			
	1st			Journal Club			
	2nd			CPC Conference (12pm)			
	3rd		Grand Rounds (6 am)	M&M Conference (12pm)			
	4th			GME Leadership in Residency (12pm)			
	4th	McGlamry - Staple Fixation for First Metatarsal Transverse Closing Base Wedge Osteotomy		Cadaver Labs			

POD Presenting for GME
GME Required

Committees

IPCE Committee	Wednesday's – quarterly 3:00 – 4:00 pm
Graduate Medical Education Committee (GMEC)	2nd Tuesday – monthly 7:00 – 8:00 am
Infection Control/Prevention	Tuesday – quarterly 7:00 -8:00 am
Medical Student Workshop	1st Tuesday 5:30 – 7:00 pm
Wellness Activity Group	Monday's – quarterly 5:30 – 7:00 pm
Residency Council	Monday's – quarterly 5:30 – 7:00 pm

EXIHIBIT A | Resident Rotation Block Diagram PMSR

Block Schedule
Mercy Health- St. Rita's Podiatric Medicine and Surgery

PGY 1

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	All	1	1	1	1	1	1	1	1	1	All	All
Rotation name	POD	PM | PLASTIC	SPORTMED | PATH	RAD | PMR	POD | WC	EM	ANES | IM	ID | FM	POD | BHS	GS	POD | WC	POD | WC
% Outpatient	100	90 | 50	100 | 100	100 | 100	50 | 25	100	0 | 0	25 | 100	50 | 100	50	50 | 25	50 |25
% Research	0	0	0	0	0	0	0	0	0	0	0	0

PGY2

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	All	1 & 2	1 & 3	1 & 4	5	All	1 & 2	1 & 3	1 & 4	5	1	All
Rotation name	POD | WC	POD	POD	POD	POD	POD | WC	POD	POD	POD	POD	VASC | PLASTIC	POD | WC
% Outpatient	50 | 25	50	50	50	50	50 | 25	50	50	50	50	50 | 50	50 | 25
% Research	0	0	0	0	0	0	0	0	0	0	0	0

PGY3

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	All	1 & 4	5	1 & 2	1 & 3	All	1 & 4	5	1 & 2	1 & 3	All	All
Rotation name	POD | WC	POD | WC	POD	POD	POD	POD | WC	POD	POD	POD	POD	POD	POD | WC
% Outpatient	50 | 25	50 | 25	50	50	50	50 | 25	50	50	50	50	50	50 | 25
% Research	0	0	0	0	0	0	0	0	0	0	0	0

Elective Options Dermatology, Endocrinology, Intensive/Critical Care Unit, Pediatrics, Geriatrics

Rotation Key	ANES	Anesthesia	GS	General Surgery	PM	Pain Management	RAD	Radiology	
	BHS	Behavioral Health	ID	Infectious Disease	PLASTICS	Plastics	SPORTSMED	Sports Medicine	
	EM	Emergency Medicine	IM INPT	Internal Medicine	PMR	Physician Medicine & Rehab	VASC	Vascular surgery	
	FM	Family Medicine	PATH	Pathology	POD	Podiatry	WC	Wound Care	

Sites	1	Mercy Health - St Rita's	5	Orthopedica Institute of Ohio / Institute of Orthopedic Surgery
	2	Lima Memorial		
	3	Joint Township District Memorial		
	4	Van Wert County Hospital		

MERCY HEALTH - ST. RITA'S MEDICAL CENTER

PODIATRIC MEDICINE AND SURGERY RESIDENCY
PMSR/RRA

at

Mercy Health - St. Rita's Medical Center
730 West Market Street
Lima, OH 45801

I have thoroughly reviewed the Residency Training Manual of the Mercy Health - St. Rita's Medical Center Foot and Ankle Surgical Residency Program including Exhibits; the CPME 320; and the CPME 330 and agree to abide by the rules and regulations stated within. I fully understand the current disciplinary and remediation policies in place. I accept the position as Podiatric Resident for the three-year term as defined in the contract provided by the Hospital.

_____ _____

Physician Resident Signature Date

_____ _____

Program Director Signature Date