Ascension St. Vincent Hospital
Podiatry Residency Manual

Indianapolis, IN

PMSR/RRA

2024-2025

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Verification Form for Receipt and Review of Handbook

I. Introduction to St. Vincent Hospital and Health Services

Overview
St.Vincent Health is a non-profit healthcare system consisting of 18 locally-sponsored ministries serving 45 counties throughout central Indiana. Sponsored by Ascension Health, the nation's largest Catholic health care system, St. Vincent Health (including its sponsored ministries) employs more than 11,600 associates and has more than 2,500 physicians on medical staff, making St. Vincent Health one of the largest healthcare employers in Indiana. From its inception, the vision of St.Vincent Health has been to be the leading, values-driven health care system in Indiana, delivering a continuum of holistic, high-quality health services through its sponsored health care ministries and improving the lives and health of Indiana individuals and communities, with special attention to the poor and vulnerable. This is accomplished through strong partnerships with businesses, community organizations, local, state and federal government, physicians, St.Vincent associates and others.

Mission Statement and Core Values
The mission and values of St.Vincent Health provide a strong foundation for the work of the organization. This framework expresses priorities in what St.Vincent will achieve and how it will be achieved.

St.Vincent Health Mission Statement
"Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and words."

St. Vincent Core Values

Service of the Poor
Generosity of spirit for persons most in need

Reverence
Respect and compassion for the dignity and diversity of life

Integrity
Inspiring trust through personal leadership

Wisdom
Integrating excellence and stewardship

Creativity
Courageous innovation

Dedication

Affirming the hope and joy of our ministry

St.Vincent Indianapolis Hospital is a 550-bed, quaternary level, full-service, level one trauma hospital that serves the Indianapolis metropolitan area and surrounding counties.
St.Vincent Indianapolis provides core inpatient and outpatient services through eight Centers of Excellence:

- St.Vincent Oncology Center
- Indiana Neuroscience Institute at St.Vincent
- St.Vincent Heart Center of Indiana (see separate report)
- St.Vincent Orthopedic Center
- Peyton Manning Children's Hospital at St.Vincent (see separate report)
- St.Vincent Women's Hospital (see separate report)
- St.Vincent Spine Center
- St.Vincent Bariatric Center of Excellence

Purpose
The podiatric residency training program at St. Vincent offers a 36 month training program that, upon successful completion, leads to the foot surgery certification and reconstructive rearfoot and ankle surgery certification pathways of the American Board of Foot and Ankle Surgery (ABFAS) and the certification pathway of the American Board of Podiatric Medicine (ABPM), American Board of Wound Management (ABWM), and the American Board of Multiple Specialties in Podiatry (ABMSP).

The podiatric residency training program is designed to include the following essential training experiences:

- Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot and ankle by medical, biomechanical, and surgical means

- Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident's competencies in the perioperative care of diseases, disorders, and injuries of the foot and ankle

- Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management

- Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management

A. Competencies: The program will strive to enhance the resident's level of competence in the following:

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

- Assess the patient's general medical status.

- Practice with professionalism, compassion, and concern, in a legal, ethical, and moral fashion

- The ability to communicate effectively and function in a multidisciplinary setting

- Has the capacity to manage individuals and populations in a variety of socioeconomic and health care settings

- Has the capacity to manage a podiatric practice in a multitude of health care delivery settings

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

II. Director and Committees

The hospital shall designate a podiatric residency program director to serve as administrator of the program. He/she shall be provided proper authority by St. Vincent Hospital to fulfill the responsibilities required of the position, including the authority to appoint an Assistant Director to assist in the administration of the program.

The director should be able to devote sufficient time to fulfill the responsibilities required of the position and ensure that each resident receives equitable training experiences. The director is responsible for maintenance of records related to the educational program, communication with the Joint Residency Review Committee and the Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. He/she must ensure resident participation in training resources and didactic experiences.

The responsibility of the director is to oversee the general administration of the residency. It is the director's responsibility to insure that the residents follow the guidelines established for them within their contracts and within this manual. If the need arises the director appoints individuals or committees to assist him/her in his/her responsibilities as director. The director or his designee will coordinate with attending podiatrists at the various outside rotations. If a conflict should arise in respect to the curriculum and/or management of an outside rotation, the residency committee in consultation with the staff at the affected affiliated institution(s) will make the final decision regarding the rotational structure. The program director shall participate in faculty development activities as least once annually.

The assistant program director will be responsible for performing the duties of the program director in the program director is out of town or unable for any reason to perform their duties. Specifically the assistant program director is responsible for overseeing the student clerkship selection and rotation, assisting in residency selection during CRIP and serves as a member of the residency selection committee, maintaining attendance records (along with the program coordinator) or resident activities, organizing graduation events, and assisting the program director and program coordinator and students and residents in any way that is needed.

The program coordinator is responsible for maintaining resident rotation, compliance with CPME and hospital policies, maintaining PTO records of residents, organizing student rotations and orientation (along with the assistant PD and student coordinator). The program coordinator

reports to the manager of the medical education department, and is responsible for all resident related activities including, but not limited to, rotation schedules, call schedules, maintaining affiliation agreements, assisting the chief resident with weekly surgical schedules, maintaining the budget and tracking of expenses.

Residency Selection Committee and resident selection
The Residency Selection Committee will be made up of members appointed by the program director. The director shall chair the committee unless the director has appointed another committee member to assume chairmanship. It will be the responsibility of all committee members to screen each application prior to attending the final selection meeting. During the final meeting the applicants under consideration will be discussed in detail. The current residents will be asked to comment on the applicants.

The Committee is authorized to appoint and facilitate the residency selection committee to interview and select prospective residents in an equitable and ethical manner. Only graduates of colleges or schools of podiatric medicine accredited by the CPME are eligible for consideration. Appointees to this committee shall be chosen based on their activity in the podiatric residency program.

Candidates for this program are selected based on their preparedness, ability, academic credentials, communication skills, and personal qualities such as motivation and integrity.

In the event that we fail to match all PGY 1 positions in a given year, the program will open up recruitment to all remaining applicants in the CASPR system under the “scramble” system they have developed. All that will be required of the applicant is a copy of their CASPR applications package. Interviewing protocols and timing will be determined at the time in this event.

St. Vincent Hospital participates in the Central Application Service for Podiatric Residencies (CASPR) and shall inform all applicants as to the completeness of their application as well as the final acceptance or denial of the application via CASPR. This program attends the annual Centralized Residency Interview Program (CRIP). Two to three residents from any year will be selected by the program director and assistant program director to attend CRIP. All related expenses will be covered by the residency program. All students will be interviewed during the designated time periods as instructed by CASPR. Prospective residents shall then be interviewed during which time they shall be provided with a copy of the curriculum upon request.

Once the resident selection has been determined and both the resident and St. Vincent are in receipt of a signed contract, the resident shall be informed of the orientation process (typically 1-2 weeks) which shall be conducted prior to the start of the residency (July 1 each year). This shall include BLS and ACLS Certification, instruction in hospital protocol and medical record keeping, and other areas necessary to familiarize the resident with hospital procedures and policies

Residency Selection Committee:
Patrick DeHeer, DPM
Chase Stuart, DPM
4 residents (rotating yearly and typically PGY-2 residents) to be determined by the director and assistant director prior to CRIP

III. Podiatric Residents

PGY-1
Tierra Binder, DPM
Damien Correa, DPM
Savannah Santiago, DPM
Peter Sorensen, DPM

PGY-2
Amanda Hasty, DPM
Elyse Hoy, DPM
Zachary Hulst, DPM
Ashlee Starr, DPM

PGY-3
Eric Deig, DPM
Preeti Kumrah, DPM
Niral Patel, DPM
Andrew Syndergaard, DPM

Program Director: Patrick DeHeer, DPM
Director of Medical Education (DIO): Grace Greist, MD FACP
Program Coordinator: Kerri Brinson-Morris
Clinic Director: Chase Stuart, DPM
Student Coordinator: Zak Hulst, DPM and Amanda Hasty, DPM
Chief Resident: Eric Deig DPM and Niral Patel, DPM
Section Chief: Chase Stuart, DPM

All PGY 1 applicants must have passed the American Podiatric Medical Licensing Examination (APMLE) Parts I, II

All PGY 2 and above applicants must pass Parts I, II and III of the national boards prior to the time they begin training.
All PGY 1 must apply through CASPR. The program requires applicants who are in podiatry colleges to rotate through a month clerkship at the hospital. The program at its discretion may waive this requirement for students who participated in a clerkship program at the hospital.

All PGY 2 and above applicants must have the following:

- CV and personal statement
- National Board part I, II and III scores
- Podiatry college transcripts
- Three letters of recommendation
- Letter from current/former program director
- Notarized proof of graduation from podiatry school with date of graduation

The program will provide applicants the following information on request:

Instructions for submitting the application and required documentation (PGY 2 and above)
Program training and policy manuals

Graduate Medical Education brochure
In the event that we fail to match all PGY 1 positions in a given year, the program will open up recruitment to all remaining applicants in the CASPR system under the “scramble” system. All that will be required of the applicants is a copy of their CASPR application package. Interviewing protocols and timing will be determined at the time in this event.

Appointees to the residency must fulfill the current licensing requirements for podiatric residents in the State of Indiana and must obtain a license as soon as possible during their PGY 2 year. Part III of the boards must be taken in December of PGY 1 year and resident must have passed the exam to have renewal of the contract. If the resident fails in December the exam may be taken in June with special authorization from the director to continue until results are available and if a failing score, the resident will not be able to continue pending review by the director and the hospital.

IV. Faculty
The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident. Faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible. The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.

V. Physical Facilities
The physical plant will be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources and a health information management system will be available for resident training. These facilities will have sufficient library resources including electronic retrieval capabilities, and personnel. A residency office if afforded at the hospital for use by the residents. A small, separate library of books and journals will also be maintained separate from the hospital library in the residency office.

VI. Conduct of the Resident

A. Orientation
Prior to the beginning of residency, typically two weeks prior to July 1, a period of orientation and instruction in duties and responsibilities and privileges of the podiatric resident is provided so that each resident may attain a working knowledge of the function and administration of the hospital podiatry department and its affiliated institutions. This will include:

- St. Vincent new hire orientation
- Salary and benefits
- BCLS/ACLS training
- Podiatry Residency Resource proper logging techniques
- Residency schedule
- Policies manual
- Orientation to various affiliated institutions

B. Dress Code
The resident is expected to present a professional appearance to patients, staff, and the public at all training sites, and to comply with The Joint Commission (TJC) standards where applicable.

Resident appearance and conduct should at all times reflect the dignity and standards of the medical profession. Dress guidelines for residents assist in achieving this goal while also acknowledging individual desires for diversity and self-expression. Following are guidelines for professional attire. These guidelines apply to each work day, including days with no patient care responsibilities. Maternity clothes are not exempt from these guidelines.

Specific Standards

ID/Name Tags: Proper identification as required by each training site must be worn and clearly displayed at all times while on duty

White coats: White coats are recommended, and must be clean and neat. If wearing scrubs outside the operating area, it is recommended that a clean white coat be worn over the scrubs

Scrubs: Scrubs should not be worn outside of the hospital premises. Scrubs may be worn in the operating room, emergency room, ICU and wound care center. In patient care areas, it is recommended that a coat with name tag be worn over the scrubs.
Scrubs may not be worn in/to affiliated hospitals and surgery centers. Clinic attire must be worn from institution to institution. This includes all rotations
Each rotational director has the authority for specific attire guidelines related to their rotation. Check with each individual rotation director for guidance in this area.

Shoes: Footwear must be clean, in good condition, and appropriate. Open-toed shoes and sandals are not recommended in patient care areas for safety reasons.

Style: No tank or halter tops, midriffs or tube tops. No sweatshirts or shirts with messages, lettering or logos. No shorts. Jeans are not allowed. A tie is recommended for men on weekdays. Scrubs or business casual is acceptable on weekends.
Fragrance: No strong colognes or perfumes as patients may be sensitive to strong fragrances.

Hands: Fingernails must be clean and short to allow for proper hand hygiene, use of instruments, prevent glove puncture and injury to the patient. Artificial nails do not allow for proper hand hygiene.

Hair: Mustaches, hair longer than chin length, and beards must be clean and well trimmed. Residents with long hair who render patient care should wear hair tied back to avoid interfering with performance of procedures or coming into contact with the patient.

Jewelry: Should not be functionally restrictive or excessive.

Piercings: There should be no visible body piercings, except of ears. There should be no visible tattoos. Tattoos/piercings which have religious significance are acceptable.

Violation: If a resident is in violation of his/her department's guidelines, he/she may be asked to return home to change into more appropriate attire. Repeat violations will result in a letter being placed in the resident's permanent file, addressing deficiencies in the professionalism competency portion of training.

C. Relation to Staff and Personnel

The resident will make careful notes of orders given by the staff. In no case will the resident change the treatment plan without the knowledge of the staff members. Disagreement with or criticism of any member of the nursing staff must be discussed with the appropriate rotation director who will take any necessary action. Questions or criticisms relating to general hospital operation or personnel may be brought to the appropriate rotation director who may discuss them with the hospital administrator. Those questions relating to podiatric residency training program will be discussed with the appropriate rotation director or director of podiatric medical education.

Residents are expected, while in the hospital, 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. 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, talk them over with the appropriate rotation director.

Remember, always, that the attending physician is in full charge of the patient. Inform them 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.

Leave policy

Refer to the House Staff Handbook for complete descriptions of the hospital policy.

Disability and Funeral leave policies as stated in the House Staff Handbook.

Regarding maternity leave, our program will require the resident to make up all the days that are missed, beyond the normal PTO, during the maternity leave. For example if the resident takes 8 weeks for maternity leave, and has 2 weeks of PTO accumulated, then the resident must extend their residency training by 6 weeks. Please see specific guidelines in the house staff handbook.

Short term disability will also be dealt with in a similar manner to maternity leave. Therefore, if a resident misses an extended period of time beyond their PTO, they will be required to extend their residency training for the exact amount of time beyond their PTO in order to complete their 36 months of training.

The resident is allowed 15 days of paid time off (PTO). Included in addition to these 15 days are 8 holidays (New Year's, Martin Luther King, Good Friday, Memorial, Independence, Labor and Thanksgiving Day, Christmas) and 1 personal day. If a resident is on call and works during one of these days they will be granted one day of vacation.

Up to 5 days (including travel) per academic year will be allowed for attendance at a medical conference. This will not be counted against the PTO. Additional time may be granted if a resident is presenting at a local or national meeting.

Up to 2 days (including travel) per academic year will be allowed for attendance at a podiatric college residency fair.

Up to 2 days (including travel) per academic year will be allowed for attendance at CRIP.

Up to 4 days (including travel) per academic year will be allowed for employment interviews during PGY-3 year.

Vacation may not be taken during rotations of Adult Inpatient Medicine (AIMS), Infectious Disease, ER, Radiology, Pathology, Behavioral Sciences, General Surgery, Anesthesiology, or any of the medical or surgical subspecialties.

All vacations requests should be turned in 6 weeks prior to the planned absence. The residency director has the right to refuse the leave if the director deems that there is not sufficient coverage on the podiatry service to all multiple residents off at the same time.

Vacation must be taken while on podiatric medicine or podiatric surgery rotations.

Leave taken for medical reasons falls under The Family Medical Leave Act of 1993.

E. Resident duties

- **On Call Activities**
    - The on call resident for podiatric surgery is expected to see Emergency Room patients within 60 minutes (or within reason depending on the requesting ED physician) and inpatient consults within 4 hours (within reason and depending on the severity of the consult). An attending must be notified after the resident has seen the patient and the care of the patient must be discussed with the attending.
    - The on call resident for podiatric surgery should round at least once daily on all in house patients. An attempt at a regular structure should be arranged with the students and/or attendings. This includes weekends when the resident is on call. In the event that the on call resident is unable to see an ER or in house consult in the required time frame, then the on call resident is required to find another resident to take that call.
    - Each resident will be responsible for coverage of the resident clinic, as scheduled by the chief resident. The hospital will assure that there is always attending coverage in the clinic, physically or available for consultation. An attending will be present at some point during the clinic hours and will countersign the notes.
    - Residents must not take call for podiatric surgery while on any outside rotation. Call must only be taken when the resident is scheduled to be on podiatric surgery.

- **Moonlighting**
  The podiatry program does not allow residents to moonlight. This is defined as professional and patient care activities that are external to the educational program.

F. Other Rules and Responsibilities

- The resident must be familiar with and abide by the rules and regulations of the hospital staff, departments, and committees of all affiliated institutions.

- Resident shall not be late to clinic or surgery. Every attempt should be made to arrive early for clinic and surgery. Excessive tardiness will be subject to disciplinary measures including, but not limited to, extra call days (including PGY-3), extra clinic days in the PCC resident clinic, and/or any other measures as determined by the director and/or assistant director
- Residents are not to accept fees or gratuities from patients, their relatives or friends. You will not practice your or assist any physician outside the affiliated institutions.
- At all times, your patients are to be your first consideration.
- Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he has been the victim of malpractice.
- Fraternization with patients is prohibited.
- 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 the resident believes they are having trouble meeting the requirements, they need to bring the problem to the attention of the residency director.

G. Academic/Discipline/Grievance Policies and Procedures

PURPOSE: To ensure that residents are aware of their right to file a complaint or grievance. To ensure that concerns are addressed and responded to in an appropriate and timely manner.
POLICY
Academic and Behavioral Due Process

Educational and behavioral standards have been established by the hospital and by each residency program. Any member of the house staff not meeting the program's educational requirements is considered to have academic deficiencies; a resident not meeting a professional or behavioral expectation is considered to have a behavioral deficiency. The program director and the resident should attempt to resolve problems with a resident's performance and/or behavior using appropriate means of feedback, simulation, remediation and coaching. Should the issue not be resolved, or the issue is of an egregious nature, the program director may escalate the intervention, including but not limited to more extensive remediation, probation and termination. The due process policy creates a means for the resident to challenge these actions.

PROCESS
Grievance Process

1. The first step is to discuss concerns with the program director. If the issue is not resolved following this meeting, either party may request a hearing before the program's Education Committee (or program committee that has oversight for education e.g. Evaluation Committee, Clinical Education Committee, etc.). The Education Committee will hear testimony from the resident and program director, review other relevant information, and vote without the resident and program director in attendance. The outcome of the vote will be conveyed to both parties. If the grievance is between the resident and the program director, the resident has the option of bringing the problem to the attention of the Manager of Medical Education, the DIO or the ombudsman. If the problem is not resolved the issue may be delegated to the program's Education Committee.
2. Within 10 working days of an attempt to resolve the conflict at the Education Committee level, either the resident or the Program Director may petition the Chairman of the

Graduate Medical Education Committee to schedule a special meeting of the GME committee to resolve the matter. The special meeting of the GMEC must include a resident (either GMEC member or nonmember if a member is unavailable) from each residency program and a majority of the non-resident (faculty) members of the GMEC. The resolution to the conflict will be decided by a majority vote. In case of a tie, the Chair of the GME will cast the deciding vote. Within 10 working days after the request for a hearing, the committee will investigate the complaint, bringing the involved parties together and provide a written decision after a hearing on the dispute. The decision of the special meeting of the GMEC is final and there is no further appeal for the resident.

Definitions

"Resident" means intern, resident or clinical fellow.

"Remediation" means the academic tools used to strengthen the resident's performance deficiencies and/or behaviors that may cause disruption to a resident's progression or continuation within the program. Examples of remediation include but are not limited to repeating a rotation, attending a required program or participating in some other learning activity. Remediation for behavioral issues may also include loss of certain program privileges, including but not limited to loss of:

- Ability to moonlight
- Local meeting travel
- Continuing Medical Education and Conference Travel
- Choice Spending Account

"Probation" is a period of remediation and critical evaluation designated by the program director and faculty. During probation, a resident may repeat rotations, do additional learning activities, have more frequent meetings with program faculty and advisors, and other such activities to achieve a desired outcome. The terms of probation and the expected outcomes are provided to the resident in writing by the program director. Substandard performance during probation may be cause for immediate dismissal from the program. The period of probation shall be specified and normally should not exceed six months; however, there may be instances where it is appropriate for the period to be as long as 12 months. There are limited circumstances where the period of probation may be indefinite and could be imposed for the remainder of the program. These circumstances include, but are not limited to, substance abuse and ethical misconduct. Instances of probation become part of the resident file (permanent record) and are reflected in all letters of recommendation/reference from the program to future training institutions and employers.

"Immediate Suspension from Clinical Responsibilities" means removal from clinical responsibilities for an indefinite period of time, usually not to exceed 30 days, without prior notice or the probationary/remedial period described herein, due to significant performance deficiencies related to quality care and/or patient safety. Immediate Suspension from Clinical Responsibilities may be imposed at the discretion of the program director. During the period of immediate suspension, the program director, education committee, Manager of Medical Education and the hospital's ACGME Designated Institutional Official (DIO) must determine whether the resident should be reinstated to clinical service. Immediate Suspension from Clinical Responsibilities is not grievable.

“Immediate Suspension from the Program” means removal from the program for an indefinite period of time without prior notice or the probationary/remedial period described herein due to significant violations of program policy, hospital or human resources policy, or performance deficiencies related to patient care and/or professionalism, including but not limited to behavior that is potentially dangerous to patients, himself/herself, or others. The decision to immediately suspend a resident from the Program may be made at the discretion of the program director with the prior approval of the DIO. During the period of immediate suspension, usually not to exceed 30 days, the program director, education committee, Manager of Medical Education and the DIO must determine whether the resident should be reinstated to the Program or dismissed. An Immediate Suspension from the Program is grievable under the process set herein.

“Dismissal” means the permanent termination by the program director of the resident from the educational program for failing to maintain academic and/or other standards (including but not limited to moral, ethical, employment and professional standards) required to progress in or to complete the program. This can occur at any point other than the end of the academic year or end of stated contract period. In most cases, dismissal occurs after a formal period of probation, but this is not required. A dismissal is grievable under the process set herein.

“Nonrenewal” means the decision of the program to not offer a contract to the resident for the next academic year or training period. Nonrenewal of contract is grievable.

“Renewal without Promotion” means the decision of the training program to not advance the resident to the next PGY level of training. Renewal without Promotion from the Program is grievable under the process set herein.

Information on Period of Probation and Remediation
If the performance of a resident is found to be unsatisfactory for, but not limited to, any of the CPME or ACGME general competencies, program policy, hospital or Human Resources policy, or expectations of the program’s specialty board, the program director must notify the resident of the specific deficiencies in a writing. The resident may be placed into a remediation status, or placed on a formal probation (which includes remediation). The resident will be placed on probation for a specified period of time spelled out in the Letter of Probation. The program director may assign a mentor for the resident and will designate a period of remediation during which the resident must either correct the deficiencies or be dismissed. The probationary and remedial period together should not be less than 30 days in length and should not normally exceed six months, but may last as long as 12 months if appropriate (such as in the case of academic probation for yearly board exams, etc.). For ethical misconduct or substance abuse, a resident may be placed on probation indefinitely, through the remainder of the training program. The mentor and program director shall meet with the resident regularly during the probationary period to formally review the resident’s progress. (Meetings may be held more frequently if deemed necessary.) At the program director’s discretion certain privileges, including but not limited to moonlighting, meeting travel, Choice Spending Account monies, etc. may be suspended.

During and at the end of the probationary period, the program director will review the resident’s progress and determine whether satisfactory improvement has been made based on information obtained from various sources and results relating to terms of remediation outlined in the Letter of Probation. Information may be solicited from faculty, staff, patients and peers of the resident. If improvement has been unsatisfactory during the probation period, the resident may be (1) continued on probation for a specific period of time not to exceed an additional six months or (2) dismissed. Any resident who is placed on probation for a third time for any reason

may be continued on probation indefinitely, through the remainder of the training program, or dismissed without further notice (either immediately or through contract non-renewal). In the case of a resident who has been placed on probation for substance abuse or ethical misconduct, if that resident's performance again becomes unsatisfactory for either of the above reasons during the length of the residency/fellowship period, the resident can be dismissed without an additional probationary/remedial period. Examples of ethical misconduct include, but are not limited to, sexual harassment, patient abandonment, abuse of prescribing privileges and unlawful discrimination. Certain programs may have stricter standards regarding substance abuse which supersede this policy.

Information on Dismissal

If the resident's deficiencies are not satisfactorily corrected or if other deficiencies arise during the remedial/probationary period, the program director will notify the Manager of Medical Education and the DIO of the intent to dismiss the resident from the residency training program. The DIO will review the department's intended action prior to any notification being sent to the resident. After such a review, the program director must notify the resident in writing of the decision to dismiss the resident. (If mailed, certified mail is required.) The letter must identify the deficiencies that have not been adequately corrected. In cases of suspension from the program, dismissal, nonrenewal or renewal without promotion of a contract, it is expected that the appropriate probationary and remedial periods will have occurred as described in this policy. However, there may be instances where immediate suspension or dismissal from the program without probation or remediation will occur. In all instances where a program is considering immediate dismissal, without providing appropriate probationary and remedial periods, the Program Director must first obtain the approval of the Manager of Medical Education and the DIO. If the resident believes the action of suspension from the program, dismissal, nonrenewal or renewal without promotion is unwarranted, the process of grieving this action is described above.

H. Chief Resident Selection

The following protocol will be updated annually and is to serve as a guideline to avoid professional conflict in the selection of chief.

1. The role of chief is a full year role extending from May to May, with corresponding transition time
2. There will be no more than 2 chief residents per year. If more than one person takes on the chief role:
    a. They may choose to rotate tasks but must be actively involved the full term
        i. AKA you are all chiefs the whole year
    b. They are expected to put forth equal amounts of effort
    c. They are responsible for handling any program issues promptly at all times in coordination with the program director
3. Co-Chiefing is an option every year IF:
    a. All parties interested in being chief are agreeable and approved by program director and assistant director
    b. Understand that they will have chief responsibilities the full year
4. How Chief will be Elected
    a. February/March prior to the election all 2nd year residents will be asked if they are interested in the chief position
    i. If only 1: No election as long as the prospective chief is approved by the director and assistant director

ii. If 2 residents express interest: Full Election in March/April unless residents present interest in being co-chiefs and approved by the program director and assistant director

iii. If 3: Election of 1 or 2 chiefs, anonymous vote among first and second year residents and attendings with majority win. Based on first and second place votes, those two residents will then decide amongst themselves if they wish to be co-chiefs. If yes then voting is complete and see above. If the first and second place residents do not wish to be co-chiefs, then a runoff election will be held

I. Duties of chief resident

Adjunct managing schedule with Lisa

i. Call facilities for updates on schedule throughout the week

ii. Contact attendings if their cases will be missed as professional courtesy

1. ALL residents are to notify the chief if they will miss a case
2. Chief should not allow a case to knowingly go uncovered without attempting to notify the attending physician in order to maintain good relationships

iii. Establish a system to manage add-ons. Work with office managers to improve system

iv. Call schedule management

v. Attend meetings and relay information to co-residents & work with director to implement appropriate changes with changes in policy. This includes mandatory monthly GME meetings on the first Friday of each month at 700am in the PCC.

vi. Development of weekly surgical and didactic schedule. This will be emailed weekly (preferably on Sunday) to all residents and the director and assistant director and any rotating students. If any attending wishes to have the schedule they are welcome to have it.

vii. Every effort will be made by the chief to equally distribute cases amongst all nine residents to allow a wide breadth of experience with as many different attendings as possible.

J. Resident Attendance Policy

Resident is expected to attend all assigned surgical procedures and clinical activities. If the resident is unable to attend for any reason you must contact the chief resident. All schedule changes must be agreed upon by the chief and residents who are altering the schedule. Excused absences include sickness of the resident or immediate family or other emergencies. Unexcused absences will be dealt with through disciplinary measures as decided by the program director and/or assistant director. Disciplinary measures include, but are not limited to, extra call days, including PGY-3 residents, extra time in the PCC resident clinic, or any other measures deemed necessary by the program director and/or assistant director.

If it is discovered that a resident is altering the assigned surgical schedule to avoid working with certain attendings the director and assistant director will be notified. This will not be tolerated. This is in the best interest of all residents to allow them a wide variety of experiences and education.

No resident should ever be forced off an assigned surgical case without their consent. If it is discovered that a resident is doing this it will result in disciplinary action.

VII. Supervision/Evaluation

It is expected of the residents to observe such rules of decorum and order in the hospitals, clinics, and private podiatric offices as are becoming to professional men and women. In the

event that the resident fails to fully and faithfully perform each and all of his obligations as stated in his contract and as contained in this manual or conducts himself in a manner objectionable to the hospital, the attending staff or the administration of the hospital, it is understood and agreed that the hospital may suspend the resident's contract immediately and without prior notification to the resident subject to appeal. In the event that the resident's contract is terminated, the same shall be of no further force or effect and each of the parties hereto shall be relieved and discharged of any and all further obligations pertaining to the residency program. It is clearly understood that any contract between a resident and the program may be terminated at any time by mutual consent.

A. Resident Evaluation

The program expects a progression of knowledge in the specialty area from beginning to end of training, and such progress needs to be monitored. It is further expected that residents will be eligible for the specialty board examination upon completion of the training program.

Monthly electronic evaluations will be sent to the rotation directors to review the progress of the resident. These will be reviewed by the program director. The resident is eligible for promotion/graduation upon the satisfactory completion of the training program. During residency the resident shall maintain satisfactory academic performance, demonstrate clinical competence, complete responsibilities as outlined by the residency rotation/training manual, fulfill all the requirements set forth in the CPME 320 for the appropriate category of residency training and fulfilled all financial obligations to all institutions with the program.

Any resident who fails to perform satisfactorily in a rotation will be given the opportunity to remediate the deficiencies identified in the evaluation of any rotation where the overall assessment in minimally acceptable or deficient.

If the resident was graded as deficient in the rotation, the resident will be assigned to repeat the rotation or an equivalent rotation(as defined by the director). The rotation time will be added to the end of the training program and will be the same length as the original rotation.

Remediation will not extend beyond 3 months. Any resident still failing after that period will be dismissed without a certificate. A resident's contract will not be renewed if failed/incomplete rotations constitute 25% or more of the year's training, except where this percentage is exceeded because of leave under the Family Medical Leave Act, or if the committee deems that remediation attempts have failed (in any case a second failure of any rotation will constitute failure of remediation).

B. Resident Supervision

- An attending physician must be identified for each episode of patient care involving a resident
- The attending physician is responsible for the care provided to these assigned patients.

- The attending physician is responsible for determining the level of supervision required to provide appropriate training and to assure quality of patient care.
- Resident supervision must be documented.
- The program director directs and supervises the program.
- An attending physician is identified in the inpatient chart.
- The attending will meet with the patient within 24 hours of admission and/or consultation and write a note and sign the chart
- Document supervision with progress note by the end of the day following admission/consult.
- An attending is identified in the outpatient clinic chart.
- The attending will discuss the patient with the resident during the initial visit and document attending involvement by either an attending note or documentation of attending supervision in the resident progress note.
- The attending will countersign the outpatient note
- In the Emergency Room, an attending must always be made aware of a resident seeing a patient. It is the attending's decision whether or not the attending must see the patient.
- For consultations inhouse, there must be a discussion with the resident doing the consultation within 24 hours
- There must be documentation of supervision of consultation by the end of the next working day.
- An attending must be identified in all surgical procedures
- An attending documents agreement with the planned surgical procedure
- The attending countersigns the note
- An attending call schedule will be available online and in print for the Emergency Department and for inpatient consults. Attendings are to be notified of all consults that a resident sees.
- An attending will be present during the resident clinic at the hospital. During an extreme or emergent situation, an attending may be late or absent. In that case, the attending will contact the clinic and the resident responsible for clinic that day and should make themselves available for telephone consultation if they are unable to be present in the clinic.

C. Expectations

The following applies to all residents:

- Call will be shared required of all the first and second year residents. PGY-1 residents will have a greater number of call days than PGY-2 residents. PGY-3 residents are not required to take call for podiatric surgery but are free to do so if they wish.
- Residents will not take call when on outside, non podiatric medicine or podiatric surgery, rotations. Call will only be taken by those residents when on podiatric medicine or podiatric surgery rotations.
- All residents are expected to maintain a working knowledge of the current inhouse patients as updated daily by the resident on call for podiatric surgery. All residents on podiatric surgery are expected to be updated through the internal St. Vincent website that allows tracking of patients.
- If the resident on call for podiatric surgery is unable to see a patient in the ER, OR, or on the floor then another resident is expected and required to assist the on call resident with the care of that patient until the on call resident becomes available. A first call and second call system will be used so that at no time there is a lack of coverage for the hospital.

- Inhouse rounds will be done at least daily. Students should be actively involved in the inhouse rounds and should be made aware of any changes or updates to the care of the patients.
- The resident is expected and required to write a note daily on all inhouse patients. The student may write the note but the resident is expected to countersign the note. The attending responsible for that particular patient should be made aware daily of any updates or changes in the plan of care. The attending will also see the patient and review the plan of care and countersign the student and/or resident's note.
- It is always the responsibility of the attending to make the final decision on the care of the patient, but it is the responsibility of the resident to follow the patient daily and be up to date on all of the patients in the hospital.
- An attempt should be made to maintain coverage at all times in the hospital based Monday and Tuesday podiatry clinic sessions. There will always be an attending available on site or available for consultation should they not be available on site for consultation. Coverage in the clinic will be shared equally among all the residents throughout the training. Only residents on podiatry will be required to cover the podiatry clinic. It is expected that the other residents, if available, will assist in coverage of the clinic should a need arise.
- There shall always be at least 2 residents (typically there are 4-7) on podiatry at all times. The Chief Resident will be given the task of making sure this standard is met throughout the year when making the schedule at the beginning of the year and distributed to all residents.
- Residents are expected to first cover the surgical cases at the hospital and cover the podiatry clinic at the hospital.

The PGY-1 resident is expected to:

- Demonstrate ability in the basic principles of podiatric surgery including suturing, sterile technique, fixation technique, instrumentation, proper tissue handling, hemostasis, and operating room protocol.
- Know hospital protocol including appropriate admission, discharge procedures and maintaining appropriate medical records.
- Be able to properly evaluate a patient as to the appropriateness of a surgical procedure including the taking of the podiatric history and physical, the ordering of appropriate laboratory and/or radiologic tests and the interpretation of lab and x-ray results.
- Be able to recognize and treat postoperative complications including the handling of postoperative infections.
- Demonstrate by the end of the first year, proficiency in the performance of basic podiatric surgery.
    - Soft tissue and nail procedures including excision of soft tissue tumors, neuroma excision, incision and drainage, excision of foreign bodies.
    - Toe surgery including arthroplasties, arthrodesis, sesamoidectomies, osteotomies, exostectomies.
    - First ray procedures-bunionectomies with or without osteotomies, and with total or hemi implants
    - Metatarsal procedures including osteotomies, lesser metatarsal osteotomies with or without implants, exostectomies.
    - Midfoot-rearfoot procedures including heel spur excision, exostectomies, fasciotomies, tarsal tunnel decompressions, and debridement for osteomyelitis
    - Proficiency in performing a podiatric biomechanical examination

- Responsible for keeping a record of all meetings, grand rounds and journal clubs and logging those and keeping that information current with the residency coordinator.

The PGY-2 resident is expected to:

- Thoroughly understand the anatomy and biomechanics of the rearfoot and ankle, and their bearing on function, choice of surgical procedure and outcome.
- Demonstrate knowledge of congenital, degenerative and traumatic pathology of the rearfoot and ankle, and current and historical surgical procedures for each class of pathology.
- Be able to select and apply appropriate rigid internal and external bone fixation, including screws, plates, pins, staples, anchors, and various external fixators.
- Understand the principles and techniques of bone grafting
- Demonstrate proficiency in the performance of midfoot, rearfoot, and ankle surgery
    - Soft tissue procedures including wide excision and biopsy, tumor excisions, nerve decompression, and excision of foreign bodies
    - Lengthening, transfer and repair of the tendons
    - Lateral and medial ankle ligaments repairs and stabilizations
    - Calcaneal osteotomies, their indications and techniques
    - Midtarsal, subtalar, and ankle fusions, with special attention to surgical approaches and fixation
    - Repair of congenital deformity of the midfoot and rearfoot, including clubfoot reductions, vertical talus and metatarsus adductus
    - Correction of flat foot and pes cavus conditions
    - Subtalar arthroeresis, emphasizing indications, biomechanics, implant design, and techniques
    - Classification and repair of ankle fractures
    - Arthroscopic diagnostic and operative techniques, including a thorough understanding of instrumentation, surgical approaches, and arthroscopic anatomy
- Assist in training and supervising the first year resident, fostering a sense of commitment to postgraduate education.
- Be responsible for the organization and introduction of the 4th year podiatric students into the hospital and ensuring them a good educational experience during their clerkship.

The PGY-3 resident is expected to:

- Develop growth and maturation in surgical skills acquired in years one and two
- Assist in training and supervising the first and second year resident, fostering a sense of commitment to postgraduate education.
- Create and maintain a call schedule for the residents when serving as chief resident. The PGY-3 is not expected to take call unless they so desire.
- Work with the attending on call to coordinate a call schedule for the emergency room and for in-house consults.
- Attend the monthly Graduate Medical Education Conference if chief resident.
- Encouraged to serve on hospital committees or to designate other residents to do so in order to better understand the workings of a teaching hospital.

VIII. Resident Logs

The resident is required to maintain logs documenting all relevant podiatric medical and surgical, biomechanical activities and all other medical and surgical subspecialty rotations. Logs shall be maintained by utilizing Podiatry Residency Resource (PRR), which has been approved by the JRRC. Logs shall be kept current and must be up to date monthly for review by the residency director. Once a month, the residency director will ask for copies of the operative notes, biomechanicals, H&Ps or any other form of pertinent documentation substantiating the resident involvement in the activity that has been logged.

The resident shall have at least one activity (didactic, surgery, medical and/or surgical subspecialty, biomechanical, clinic, rounds, research, case presentation) logged each day Monday through Friday. Failure to comply with this rule will result in disciplinary measures including, but not limited to, extra call (including PGY-3), a meeting with the director and assistant director, and any other measures that the director and assistant director deem necessary

Surgery and Activity Didactic logs must be kept on the PRR. It is highly recommended that at least one-third of the required biomechanical examinations be completed per year.
Once you have reached your minimum activity volume (MAV) you should continue logging every encounter on every rotation. This includes didactics, H&Ps, clinic patients, hospital rounding, medical and surgical subspecialty rotations and surgical procedures.

IX. Teaching Conferences/Seminars
Attendance is mandatory by all residents and students. Exceptions will occur when the resident is needed to cover an operation either in the hospital or at a surgery center. Attendance will be taken and submitted to the program coordinator who will keep these records. Excessive absences will result in disciplinary action to be determined by the program director and assistant director.

Morbidity & Mortality / Radiology Rounds
1st Tuesday of the month 7:00am, Shaefer Conference Rooms A & B

Podiatry Debate
2nd Tuesday of the month 7:00am, Shaefer Conference Rooms A & B

Journal Article Reviews
3rd Tuesday of the month 7:00am, Shaefer Conference Rooms A & B

Board Review
2nd Saturday of the month 8:00am, Shaefer Conference Rooms A & B

Student presentations
4th Tuesday of the month 7:00am, Shaefer Conference Rooms A & B
Cadaver Lab
3rd Monday of the month 5:30pm, St. Vincent Simulation Center

Quarterly Grand Rounds
St. Vincent Simulation Center

American Health Network
Time: 6:30pm-8:30pm 2nd Wednesday every month
Location: 10689 N. Pennsylvania St, Suite 200, Indianapolis, IN 46280

Other meetings such as additional cadaver labs and lectures will be arranged and organized throughout the year with other local podiatrists or other surgeons. The resident is encouraged to attend as many lectures locally throughout the year.

The residents shall also participate in the teaching conferences and rounds provided by the non-podiatry services on which they rotate.

Seminars

- Residents are required to attend the annual Indiana Podiatric Medical Association meeting in Indianapolis.

- Residents will be excused from surgical and clinical obligations for the full length of the IPMA. If a resident is off service they are expected to attend the IPMA on Saturday and Sunday. The On-Call resident should attend the IPMA after rounding and may leave for consults or other issues at the hospital.

- Residents are required to present a lecture at the resident section of the IPMA annual meeting.

- Other approved seminars are: APMA national meeting, ACFAS, Midwest Podiatry Conference among others.

- Additional programs are also options but must be approved by the residency director.

X. Academic requirements for residents

The following will be required of all residents in order to complete this residency:

- Produce one paper on a podiatry related subject of a quality consistent for publication. Outline with bibliography due by January 1 of their PGY-2 year; rough draft completed by February 1 of their PGY-3 year; Nearly completed article ready for submission due by June 1 of their PGY-3 year.

- Curriculum will be established and reviewed between the director and resident and will be approved by the director. The schedule will be determined at the beginning of training year.

A suggested schedule of curriculum is as follows:

PGY-1
Internal Medicine or Family Medicine – 1 month
Anesthesiology – 2 weeks
Radiology – 2 weeks
Pathology – 2 weeks
Wound Care – 2 weeks

Infectious Disease – 1 month
Podiatric Surgery – 7 ½ months
Emergency Medicine – 4 weeks

PGY-2
General Surgery – 2 weeks
Vascular Surgery – 2 weeks
Required Research – 2 weeks
Orthopedic Surgery – 4 weeks
Podiatric Medicine – 1 month
Podiatric Surgery – 8 1/2 months
Electives – 1 month (to include dermatology, neurology, infectious disease, pediatric orthopedics, rheumatology, pain management, endocrinology, physical medicine and rehabilitation, wound care)

PGY-3
Behavioral Science – 2 weeks
Podiatric Office – 1 month
Electives – 1 -2 months (to include dermatology, neurology, rheumatology, pain management, physical medicine and rehabilitation, infectious disease, wound care, and pediatric orthopedics). A resident may add another 2-4 week rotation if they feel they need further training in a specific area.
Research – 2 weeks
Podiatric Surgery – 8-9 months

ANESTHESIOLOGY CURRICULUM

INTRODUCTION

The Anesthesiology Curriculum is designed to help teach the Podiatry Resident fundamental clinical skills and the basics of anesthesiology and pain management. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Directors: Mark Fletcher, MD
MVFletch@stvincent.org
Rotation Sites: All St. Vincent Hospital sites
Rotation Duration: 4 weeks
Evaluation: New Innovations electronic evaluation specific to Podiatry/Anesthesiology Rotation

ROTATION GOALS / OBJECTIVES

During Anesthesiology rotations, the Podiatry resident will:

- Serve as a consultant under the supervision of a board certified anesthesiologist and will care for patients with:
    - a diverse range of medical and surgical conditions
    - a wide range of ages from adolescents to the elderly
    - a diverse socioeconomic and cultural population
- Learn the fundamental clinical skills required for effective and efficient patient evaluation and management

- Develop a basic working knowledge of common anesthetic and pain management techniques and practices
- Better understand how to deliver cost-effective, evidence-based, quality care
- Be effective communicators to colleagues, patients and their families and other members of the health care system.
- Maintain a professional demeanor and be role models for others.
- Learn to identify deficiencies in knowledge and patient care skills and access the literature and other resources to improve these deficiencies
- Work to help patients and families navigate the healthcare system and seek to improve the system when possible and feasible.

SPECIALTY SPECIFIC COMPETENCY BASED OBJECTIVES
The following are competency based objectives in relation to the Anesthesiology Curriculum. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the corresponding residency curriculum sections.

PATIENT CARE: Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems in patients requiring anesthesia and/or pain management.

Anesthesiology Patient Care Objectives
In a patient requiring anesthesia and/or pain management:
- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating an assessment and plan of care
- Perform follow-up as needed to address old and any new problems
- Understand indications/interpretations of testing related to this care
- Perform/interpret basic procedures/tests pertinent to this care
- Understand the indications for consulting on these patients
- Plan appropriate disposition and follow-up for these patients
- Document adequately and appropriately the above in the medical record

Assessment Methods
- Direct observation of history and/or physical exam
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE:
Residents are expected to demonstrate basic knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to the care of patients requiring anesthesia and/or pain management.

Anesthesiology Knowledge Objectives
Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following anesthesiology and pain management topics:
- The scope of anesthesia and pain management practices
- Basic anesthetic and pain medication pharmacologic principles

    - Inhaled anesthetics
    - Intravenous anesthetics
    - Neuromuscular blocking drugs
    - Opioid and non-opioid pain meds
- Basics of anesthetic and pain medication delivery systems
- Basic cardiac, pulmonary and autonomic physiology
- The phases of anesthesia care: preop, intraop, postop
- The pre-operative evaluation and risk stratification
- The formulation of an anesthesia plan
- The benefits/risks of different anesthesia modalities eg regional, general
- Airway management principles
- The basics of anesthetic and pain control monitoring and follow-up
- The basics of intra-operative monitoring and management
- Positioning considerations and risks
- Care of the immediate post-op patient
- The basics of spinal and epidural anesthesia
- The basics of peripheral nerve blocks
- Basic fluid and blood product therapy
- Special considerations for pediatric, elderly and obstetric patients
- Basic electrocardiogram and chest X-ray interpretation

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion

PRACTICE BASE LEARNING AND IMPROVEMENT:
Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients requiring anesthesia and/or pain management.

Anesthesiology PBLI Objectives
Identify/improve deficits in medical knowledge and patient care skills
Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion
- Self directed learning logs

I**NTERPERSONAL AND COMMUNICATION SKILLS**: Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients requiring anesthesia and/or pain management.

Anesthesiology ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a healthcare team
- Communicate effectively with patients and their families/guardians

- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assessment Methods
- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

PROFESSIONALISM:
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients requiring anesthesia and/or pain management.

Anesthesiology Professionalism Objectives
- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods
- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

SYSTEMS-BASED PRACTICE: Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients requiring anesthesia and/or pain management.

Anesthesiology Systems-Based Practice Objectives
- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care

Assessment Methods
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

LEARNING METHODS / VENUES / RESOURCES

Learning Methods

- Direct patient care in inpatient critical care setting
    - Case presentation and discussion
    - Topic review and discussion

- Review of assigned reading materials
    - Teaching rounds
    - Conference attendance
- Learning Venues
    - Anesthesiology rotation (see below)
    - Pain Management rotation (see below)
    - IM Noon Conference
    - Other rotation specific conferences
- Learning Resources
    - SVH Library
    - Up to Date
    - Assigned Reading materials

CURRICULUM GOALS

A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
1. Perform and interpret the findings of a thorough problem-focused history and physical exam, including problem-focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis.
2. Formulate an appropriate diagnosis and/or differential diagnosis.
3. Perform (and/or order) and interpret appropriate diagnostic studies, including:
Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, vascular imaging.

Laboratory tests in hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis.
Pathology, including anatomic and cellular pathology.
Other diagnostic studies, including electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies.
4. Formulate and implement an appropriate plan of management, including:
Direct participation of the resident in the evaluation and management of patients in a clinic/office setting.
- perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
Management when indicated, including
- dermatologic conditions.
- manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
- closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation.
- cast management.
- tape immobilization.
- orthotic, brace, prosthetic, and custom shoe management.
- footwear and padding.
- injections and aspirations.
- physical therapy.
- pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral

vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications.
Surgical management when indicated, including
- evaluating, diagnosing, selecting appropriate treatment and avoiding complications.
- progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, the following: Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, Reconstructive Rearfoot/Ankle Surgery (added credential only), Other Procedures (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia.
Consultation and/or referrals.

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

Understanding management of preoperative and postoperative surgical patients with emphasis on complications.
Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.

Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.
7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:
Local anesthesia.
General, spinal, epidural, regional, and conscious sedation anesthesia.
8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.
9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:
Recognizing and diagnosing common infective organisms.
Using appropriate antimicrobial therapy.
Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
Exposure to local and systemic infected wound care.
10. Participate actively in a behavioral science rotation that includes, but is not limited to:
Understanding of psychosocial aspects of health care delivery.
Knowledge of and experience in effective patient-physician communication skills.
Understanding cultural, ethnic and socioeconomic diversity of patients.
Knowledge of the implications of prevention and wellness.
C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.
2. Practice and abide by the principles of informed consent.
3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

4. Demonstrate professional humanistic qualities.
5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of health-care costs.
D. Communicate effectively and function in a multi-disciplinary setting.
1. Communicate in oral and written form with patients, colleagues, payers, and the public.
2. Maintain appropriate medical records.
E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
1. Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.
F. Understand podiatric practice management in a multitude of health-care delivery settings.
1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand health-care reimbursement.
3. Understand insurance issues including professional and general liability, disability, and Workers' Compensation.
4. Understand medical-legal considerations involving health-care delivery.
5. Demonstrate understanding of common business practices.

G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
1. Read, interpret, and critically examine and present medical and scientific literature.
2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.
3. Demonstrate information technology skills in learning, teaching, and clinical practice.
4. Participate in continuing education activities.

BEHAVIORAL SCIENCE CURRICULUM

INTRODUCTION

Behavioral science and to some extent general psychiatry encompasses a knowledge base of human behavior related to both our patients and ourselves. This evolving knowledge is gained somewhat didactically, but just as often experientially throughout the residency with patient exposure and personal reflection. To that end our purpose of this 2-week experience is to prepare the podiatry resident with a working knowledge of human behavior, mental health, and psychiatric disorders appropriately. Encompassed within this is an objective understanding of the dynamics of the doctor-patient relationship, the ethical and emotional aspect of organic illness and the effect illness has on family and environment. Therefore knowledge of transference and counter-transference, child/adult/family development and the adaptations of our patients and ourselves become our venue.

ROTATION SUMMARY

Rotatation Director: Dr. Thomas Barbera – tjbarber@stvincent.org and Dr. Jerry Fletcher –jhfletch@stvincent.org
Rotation Site: St. Vincent Hospital and Primary Care Center
Rotation Duration: two weeks
Required Conference: Program conference and as noted above
Readings: Rotation-specific readings are found on the St. Vincent Sharepoint Site; supplemental readings will be provided by the rotation preceptor
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Behavoiral Health/Science Rotation

ROTATION GOALS / OBJECTIVES

Upon completion of this experience, the resident will:

- Describe the doctor-patient relationship and how each contributes to its success.
- Demonstrate working knowledge of human behavior and developmental stages across the life span.
- Describe major psychiatric disorders and there impact on effective podiatric care.
- Demonstrate an understanding of the emotional and psychosocial aspects of physical illness.
- Describe the following disorders and their potential impact on podiatric care:
    - Mental conditions diagnosed in Infancy, Childhood and Adolescence such as mental retardation, Learning Disorders, ADHD, Autism, Behavior Disorders, Tic Disorders and Elimination Disorders
    - Substance use and abuse disorders
    - Psychotic Disorders including Schizophrenia
    - Mood Disorders including major Depression and Bipolar Disorders
    - Anxiety Disorders including OCD, Panic Disorders, PTSD and GAD
    - Somatoform and Factitious Disorders
    - Eating Disorders including Obesity

    - Sleep Disorders and Impulse Control Problems
    - Adjustment Disorders and Psychological Factors Affecting Physical Illness
    - Personality Disorders
    - Abuse/Neglect and other Phase of Life Problems
- Describe setting ethical limits on care, the task of being a Podiatrist, personal sacrifices of our profession, and protecting practitioner emotional well-being.

DERMATOLOGY ELECTIVE CURRICULUM

INTRODUCTION

The Dermatology curriculum is designed to teach the resident the appropriate evaluation and management of dermatologic diseases as outlined in the goals below. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: Peter Winters, MD poredoc@sbcglobal.net
Rotation site(s): 9002 N Meridian St #214, Indianapolis, IN 46260
Rotation duration: 2 weeks
Rotation status: Elective
Residents: 1 resident per month, any training level
Required Conferences: Program conferences only
Evaluation: New Innovations electronic evaluation specific to Podiatry/Dermatology Rotation

Purpose: The Dermatology rotation is a supplemental component of the larger residency dermatology experience. The purpose of the Dermatology rotation is to help meet and evaluate the competencies in the care of patients with dermatologic diseases outlined below.

Activities: The resident on the Dermatology rotation will be under the direct supervision of a board certified Dermatologist and they will adhere to the residency program supervision and work hours rules. Residents will function as a primary physician and/or consultant in the outpatient settings and rarely in the inpatient setting. They will see a diverse population of adult patients ranging in age from adolescents to geriatric patients with a variety of acute and chronic dermatologic diseases. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with dermatologic diseases. Outpatient precepting will occur at least 30 minutes per half day clinic session.

GOALS (from FCIM2)

Dermatology is the management of disorders of the skin, mucous membranes, and adnexal structures, including inflammatory, infectious, neoplastic, metabolic, congenital, and structural disorders. Competence in medical and surgical interventions and dermatopathology are important facets.

The podiatrist should have a general knowledge of the major diseases and tumors of the skin. He or she should be proficient at examining the skin; describing findings; and recognizing skin signs of systemic diseases, normal findings (including benign growths of the skin), and common skin malignancies. The general internist should be able to diagnose and manage a variety of common skin conditions and make referrals where appropriate.

DERMATOLOGY COMPETENCIES

The following are competencies in relation to the dermatology curriculum with assessment methods and evaluation tools. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the Competencies core curriculum.

PATIENT CARE: Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with dermatologic diseases.

General Dermatology Patient Care Objectives

In a patient with dermatologic disease:

- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating and assessment and plan of care
- Understand indications/interpretations of testing related to skin diseases
- Perform and/or interpret procedures/tests pertinent to care of patient
- Understand the indications for referral of patients with skin diseases
- Plan appropriate disposition and follow-up for patients with skin diseases
- Document adequately and appropriately above in the medical record

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE:

Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to care of patients with dermatologic diseases.

General Dermatology Medical Knowledge Objectives (from FCIM2)

Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following dermatology topics:

Abscess
Cellulitis
Condyloma
Cyst
Eczematous reaction pattern
  Acute contact dermatitis
  Atopic dermatitis
  Dyshidrotic eczema
  Nummular eczema
  Stasis dermatitis
Erythema nodosum
Follicular disease
  Acne
  Rosacea

Malignancy and premalignancy
  Actinic keratosis
  Basal cell carcinoma (see also Oncology)
  Melanoma (see also Oncology)
  Squamous cell carcinoma (see also Oncology)
Molluscum contagiosum
Papulosquamous reaction pattern
  Fungal, yeast infections
  Lichen planus
  Psoriasis
  Seborrheic dermatitis
  Syphilis (see also Infectious Disease)
Paronychia
Pityriasis rosea
Scabies
Skin Ulcers
Skin signs of systemic disease
  Dermatomyositis
  Diabetes mellitus
  Gastrointestinal polyposis
  Inflammatory bowel disease
  Internal malignancy
  Kaposi's sarcoma
  Liver disease
  Lupus erythematosus
  Rheumatoid arthritis
  Scleroderma
  Sepsis
  Thrombocytopenia
  Thyroid disease
Vascular reaction pattern
  Drug hypersensitivity
  Erythema multiforme
  Toxic epidermal necrolysis
  Urticaria
  Vasculitis
  Viral exanthems
Vesiculobullous reaction pattern
  Bullous pemphigoid
  Herpes simplex infection
  Herpes zoster infection
  Pemphigus vulgaris
  Varicella
Warts

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam

PRACTICE BASE LEARNING AND IMPROVEMENT: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with dermatologic diseases.

General Dermatology PBLI Objectives

- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion
    - Optional PEBLE

INTERPERSONAL AND COMMUNICATION SKILLS: Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with dermatologic diseases.

General Dermatology ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a healthcare team
- Communicate effectively with patients and their families
- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Direct observation of interactions with patients, nurses and/or peers
    - Case presentation and discussion
    - Review of written note(s) and/or consult(s)
    - Feedback from nursing/support staff and/or patient/family member

PROFESSIONALISM:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients with dermatologic diseases.

General Dermatology Professionalism Objectives

- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

SYSTEMS-BASED PRACTICE:

Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with dermatologic diseases.

General Dermatology Systems-Based Practice Objectives

- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care
- Understand the insurance provider coverage and payment systems for elective / non-elective dermatologic visits.

Assessment Methods

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

EARNING METHODS/VENUES/RESOURCES

Learning Methods

- Direct patient care in outpatient/inpatient setting
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds
- Conference attendance
- Self-directed learning

Learning Venues

- Dermatology rotation
- 'Derm Day'
- Primary Care Center Longitudinal Ambulatory Clinic
- Adult Inpatient Medicine Service Rotation

Learning Resources

- St Vincent Medical Library
- Up to Date
- VisualDx
- www.mededmentor.com
- Assigned Reading materials

EMERGENCY MEDICINE CURRICULUM

INTRODUCTION

The Emergency Medicine curriculum is designed to teach the resident the appropriate evaluation and management of acute medical diseases as outlined in the goals below. The resident will develop skills necessary to diagnose and manage common presentations of medical problems seen in an emergency room setting, including resuscitation of patients with cardiopulmonary arrest. The resident will gain experience in distinguishing true medical emergencies and in determining the need for acute hospitalization. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

EMERGENCY MEDICINE ROTATION SUMMARY

Rotation Directors: Louis Profeta, MD and Tonya Hole, MD
louermd@att.net
Rotation site(s): St Vincent Indianapolis Emergency Room
Rotation duration: 2 weeks

Rotation status: Required
Residents: 1 PGY-1 residents per month
Vacation is not permitted on this rotation. A minimum of 2 weeks assignment are needed for rotation credit.
Required Conferences: Noon Conference, Grand Rounds, Ambulatory Case Conference, Study Club
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Emergency Medicine Rotation

Purpose: The emergency medicine rotation is a key component of the larger residency emergency medicine curriculum. The purpose of the emergency medicine rotation is to help meet and evaluate the competencies in the care of patients with acute medical diseases outlined above.

Activities: The resident on the emergency medicine rotation will be under the direct supervision of a board certified emergency medicine physician and they will adhere to the residency program supervision rules. Residents will function as a primary physician for patients seen in the emergency room. The resident will have responsibility for the initial evaluation of un-triaged patients presenting to a busy emergency room, with presentation to and supervision by teaching Emergency Medicine specialists. They will see a diverse population of adult patients ranging in age from adolescents to geriatric patients with a variety of acute medical diseases. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with acute medical diseases. Interaction with supervising attending physicians will occur with every patient and will amount to greater than 30 minutes total per ER shift. The resident will also read and formally discuss with an attending physician a series of core curriculum articles prepared by the course directors. The residents will participate in the Noon Conference and Grand Rounds lecture curriculum, during the rotation.

PATIENT CHARACTERISTICS:
The resident will see an un-triaged mix of self-referred and physician-referred patients with perceived urgent medical conditions. They will represent a broad spectrum of ethnic and socioeconomic backgrounds, as represented by the general population of central Indiana. The department is a level three trauma unit.

TYPES OF CLINICAL ENCOUNTERS:
Residents will see patients in general emergency room with pediatric, orthopedic, ENT/Ophth, Ob/Gyn, surgical, and general medical problems.

PROCEDURES:
The resident will gain experience in blood gas interpretation, ACLS protocol, EKG interpretation, endotracheal intubation, abdominal paracentesis, thoracentesis, lumbar puncture, suturing technique, and central line placement, as the clinical material requires.

GOALS (from FCIM2)
Emergency medicine involves the evaluation and care of acute illness and injuries that require intervention within a limited time span. It is defined by a time interval rather than by a particular organ. Some conditions may be encountered in office practice, others in acute care settings.

Regardless of the setting, the general internist should be able to manage common emergency conditions and provide consultation and management for a variety of acute serious illnesses. The range of competencies expected of a general internist will depend on the availability of emergency physicians and other specialists in the community.

EMERGENCY MEDICINE COMPETENCIES

The following are competencies in relation to the emergency medicine curriculum with assessment methods and evaluation tools. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

PATIENT CARE:

Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with acute medical diseases.

General Emergency Medicine Patient Care Objectives

In a patient with an acute/emergent medical illness:

- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating and assessment and plan of care
- Understand indications/interpretations of testing related to acute medical illness
- Perform and/or interpret procedures/tests pertinent to care of patient
- Understand the indications for referral of patients with acute medical illness
- Plan appropriate disposition and follow-up for patients with acute medical illness
- Document adequately and appropriately above in the medical record

- **Assessment Methods**
- Direct observation of history, physical exam, or patient education / counseling
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to the care of patients with acute medical diseases.

General Emergency Medicine Medical Knowledge Objectives (from FCIM2)

Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following emergency medicine topics:

Cardiovascular

- Acute or chronic congestive heart failure
- Arrhythmias
- Cardiopulmonary arrest
- Chest pain, stable and unstable angina, myocardial infarction
- Hypertension, hypertensive emergencies
- Shock

Syncope
Unstable thoracic or abdominal aortic aneurysms
Dermatology
Cutaneous ulcers
Rash
Domestic Violence
Endocrine
Acute complications of hyperthyroidism, hypothyroidism
Addisonian crisis
Diabetes mellitus, hypoglycemia, hyperglycemia, diabetic ketoacidosis
Gastroenterologic
Acute abdomen
Acute diarrhea
Acute liver failure
Acute pancreatitis
Ascites
Bleeding
Bowel obstruction
Gallstones, cholecystitis
Nausea and vomiting
Hematologic
Acute complications of sickle cell disease
Anemia, leukopenia, thrombocytopenia
Easy bruising, purpura, ecchymosis
Polycythemia, leukocytosis, thrombocytosis
Hyperthermia, hypothermia
Infectious
Active tuberculosis
Encephalitis
Herpes simplex infection
Herpes zoster infection
HIV infection (including infectious complications)
Meningitis
Otitis externa media
Pharyngitis
Pneumonia, bronchitis
Prostatitis, urethritis, epididymitis
Sepsis
Sexually transmitted diseases
Sinusitis
Upper respiratory infection
Urinary tract infection, pyelonephritis
Viral hepatitis
Neurologic
Coma
Head trauma
Headache
Seizure
Transient ischemic attack, stroke, subarachnoid hemorrhage
Ophthalmologic
Acute loss of vision
Red eye
Otolaryngologic
Epistaxis
Vertigo
Overdose, poisoning
Pulmonary
Acute respiratory failure
Asthma
Chronic obstructive pulmonary disease
Pneumothorax
Pulmonary embolism, deep venous thrombosis, phlebitis
Severe airway obstruction
Renal
Acute renal failure, chronic renal insufficiency
Electrolyte, acid-base disorders
Renal colic, kidney stones
Rheumatologic
Acute arthritis (including gout)
Back pain
Sexual abuse

Assessment Methods

- Case presentation and discussion

- Review of written note(s) or consult(s)
- Discussion of assigned reading materials
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam

PRACTICE BASE LEARNING AND IMPROVEMENT: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with acute medical diseases.

General Emergency Medicine PBLI Objectives

- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

INTERPERSONAL AND COMMUNICATION SKILLS: Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with acute medical diseases.

General Emergency Medicine ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a healthcare team
- Communicate effectively with patients and their families
- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)

PROFESSIONALISM:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients with acute medical diseases.

General Emergency Medicine Professionalism Objectives

- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling

- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Evaluation Tools

- End of Rotation Competency Evaluation of Resident by Faculty
- Mini-CEX Form
- Praise/Concern Card
- Professionalism Matrix (optional)

SYSTEMS-BASED PRACTICE:

Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with acute medical diseases.

General Emergency Medicine Systems-Based Practice Objectives

- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care
- Develop rapid patient triage skills to determine appropriate patient disposition.

Assessment Methods

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

LEARNING METHODS / VENUES / RESOURCES

Learning Methods

- Direct patient care in outpatient/inpatient setting
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds
- Conference attendance
- Self-directed learning

Learning Venues

- Emergency Medicine rotation (see below)
- Acute Care Clinic rotation (see below)
- Primary Care Center Longitudinal Ambulatory Clinic
- Adult Inpatient Medicine Service Rotation
- St Vincent ICU Rotation
- Other internal medicine residency rotations
- Morning Report, Ambulatory Case Conference
- Noon Conference

- Grand Rounds

Learning Resources

- St Vincent Medical Library
- Up to Date
- Hopkins Modules
- MKSAP 12 Ambulatory Medicine Section
- Assigned Reading materials

Assigned Readings

Emergency Medicine, A Complete Study Guide, by Tintinalli, Krone and Ruiz, available in the medical library;
Assigned articles, available at Sharepoint http://svaa.collaboratenow.com
ACLS manual.

FAMILY MEDICINE AMBULATORY ROTATION CURRICULUM

Introduction:

Ambulatory medicine requires an understanding of a broad range of disease states in the adult and pediatric population. Beyond comprehension of pathology, ambulatory medicine involves coordination of care with other providers and effective communication skills in dealing with patients, their families, and other members of the healthcare system. Important elements of ambulatory medicine include the development of continuity of care, interaction with other healthcare providers, coding/billing/practice management, and acquiring and maintaining the knowledge and skills to manage a wide spectrum of diseases.
This curriculum is designed to introduce the resident to the appropriate evaluation and management of a broad range of disease states commonly seen in the outpatient setting as outlined in the goals below. Housestaff assigned to this rotation are expected to read this curriculum and discuss the key goals/objectives and rotation structure with the faculty preceptor at the beginning of the rotation. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.
NOTE: while the primary goal of podiatric residency training is to achieve a highly level of competency in the practice of podiatric medicine and surgery, there is significant value to learning and integrating principles and practice of general medicine. As such, podiatric trainees will be expected to see patients presenting with problems entirely unrelated to podiatry; the preceptor will assist the resident with clinical issues beyond their knowledge and scope, and help the resident to integrate this learning into the broader practice of podiatry.

ROTATION SUMMARY

Rotation Director: Elizabeth Roth, MD – elroth@stvincent.org
Rotation duration: 4 weeks
Rotation status: Required (option to AIMS)
Residents: 1-2 residents per month
Learning Venues: St. Vincent Primary Care Center Family Medicine Clinic

Learning Methods: Direct patient care in outpatient setting, Case presentation and discussion, Topic review and discussion, Review of assigned reading materials, Conference attendance, Self-directed learning.
Resources: Assigned reading materials and web-links, Clinical Pharmacists, Primary Care Center Library, Hospital Library
Conferences: Noon Conference, Ambulatory Case Conference, and Grand Rounds required during rotation; Program conferences
Evaluation: New Innovations eletronic evaluation specific to Podiatry/Family Medicine Rotation

Educational Objectives
Be able to analyze recommendations for preventive care from multiple organizations and formulate a strategy for evidence-based preventive care as it relates to the practice of podiatry.

- Be able to competently evaluate and manage common problems seen in general outpatient settings. See specific learning objectives in Appendix A.
- Be able to apply clinical skills and analyze laboratory findings to obtain an appropriate differential diagnosis for the above problems.
- Recognize the role of poverty, limited access, cultural bias, language barriers, and educational barriers in delivering health care.
- Develop counseling and patient education skills pertinent to general medicine.
- Participate in quality improvement by auditing one's own charts

Principal Teaching Methods

Supervised Patient Care - Residents evaluate patients in outpatient clinics, supervised by Board Certified specialists in (but not limited to) Family Medicine, Internal Medicine, and Pediatrics. All faculty are expected to uphold this competency-based curriculum. The resident on this rotation will adhere to the residency program supervision and duty hours rules. Residents will function as a primary physician and/or consultant in the outpatient setting. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with a wide range of conditions commonly seen in the outpatient setting. Patients are seen and examined by the resident, who formulates an assessment, differential diagnosis, and treatment plan and presents it to the attending faculty. Both the resident and the attending then examine the patient and discuss the care. Teaching focuses on evaluation and management of the specific case as well as its relationship to the core Family Medicine medical knowledge topics. Outpatient precepting will occur at least 30 minutes per half-day clinic session

- ***Didactic Teaching Sessions*** –
    - o One-on-one discussions of patient care during that patient's appointment in the ambulatory setting
    - o Small group discussions with faculty, based on rotation objectives
- ***Self-directed learning***-

- Residents should independently read recommended Family Medicine texts.
- Residents should read articles from the Study Module Readings (see Appendix C) and as directed by their attending preceptor, pertinent to cases seen during the rotation.
- Residents should independently research topics related to patients they encounter during th rotation. For subspecialty experiences it is encouraged that the resident's preceptor provide the resident with as much relevant literature as possible.

- ***Procedures*** - Residents will participate with the attending physician in various procedures performed on their assigned patients. These may include (but are not limited to) joint/bursal injections, arthrocentesis, skin biopsies, cyst/toenail removals, skin lesion removals, suturing of lacerations, and cryotherapy. Exposure to procedures will vary depending on a given resident's patient mix and their disease states.

Educational Content / Rotation Structure

- **Mix of diseases**
  The disease mix is broad, due to the multiple referral sources to St Vincent and the diverse population of Indianapolis and surrounding areas.
- **Patient characteristics**
  The resident will see a diverse population of adult patients ranging in age from infant to geriatric patients, of diverse socioeconomic backgrounds.
- **Learning venues**
  - Outpatient experiences will be through the Family Medicine Center in the Joshua Max Simon Primary Care Center.
  - Residents continue to attend their continuity clinic and required didactics.

Ancillary Teaching Materials

- At the beginning of the rotation this curriculum is provided to each resident as a guide to the rotation. Appendix B contains an additional list of recommended readings for the month.
- All residents can access Up-to-Date (expert opinion), Access Medicine/Stat!Ref on-line textbooks, and Ovid (peer reviewed literature search) from the intranet.
- The St. Vincent medical library and the Primary Care Center Library contain additional Family Medicine texts and a comprehensive collection of medicine and surgery subspecialty texts.

Institutional Resources (Strengths and Limitations)

- Faculty- teaching is provided by board certified family medicine faculty. Strong clinical pharmacist support is present in the Family Medicine Primary Care Clinic, and they are actively involved in teaching residents.
- Research – St Vincent has a complete range of research support (including funding) available to residents.

- Facilities and Technology: The St. Vincent Primary Care Center is both located within one block of St. Vincent Hospital. The clinic uses a comprehensive electronic health record, and all residents are expected to show competence in use of an EHR for the benefit of comprehensive documentation, as well as tracking of quality measures and clinical/demographic research. St. Vincent Primary Care Center has a well-structured charity care program that operates on a sliding scale system with federal poverty guidelines as the reference point. This allows even the poorest of patients without medical coverage to receive basic primary care.
- St. Vincent serves a patient population with a diverse range of ages, races, ethnicities, socioeconomic levels, religious beliefs, and languages. This allows residents to experience a wide spectrum of patient demographics and further encourages cultural sensitivity and competency.
- St. Vincent employs a number of ancillary staff to serve the diverse needs of our population, including clinical pharmacists, social workers, and certified Spanish medical interpreters. This allows residents to further meet the needs of their patients on educational and social levels.

Rotation-Specific Competency-Based Objectives and Assessment

The following competency-based objectives are presented as they apply to the field of Ambulatory Medicine..

- **Patient Care**
  Objectives

Residents are expected to:

- Complete a comprehensive or focused history appropriate for the patients' particular complaints, with special attention to conditions listed in Appendix A
- Perform an appropriate and accurate physical exam directed to the patient's particular complaints
- Provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in the outpatient setting
- Perform or order and accurately interpret procedures and tests as appropriate for a patient with conditions listed in Appendix A
- Perform and/or interpret procedures/tests pertinent to care of patients, including (but not limited to) KOH prep/wet mounts, dipstick urinalysis, basic spirometry, ECG tracings, in-office HbA1C
- Understand the indications for referral of patients with renal and orthopedic complaints
- Develop an evidence-based approach to preventive health and to counsel patients effectively on preventive health based on this approach
- Use sound clinical judgment in formulating an assessment, differential diagnosis, and plan of care.
- Demonstrate clinical documentation skills.
- ***Plan appropriate disposition and follow-up for patients with conditions listed in Appendix A.***

Assessment

- Direct observation of history and/or physical exam
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

- **Medical Knowledge**
  Objectives

  Residents are expected to demonstrate:
  - Knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences as they pertain to the care of patients with a broad spectrum of diseases seen in the ambulatory setting.
  - Understanding of the standard evaluation and management of adult and pediatric patients with illnesses commonly seen in the outpatient setting with special focus on preventive health and patients with musculoskeletal complaints.
  - Understanding of the proper use of laboratory testing and imaging in patients with the conditions mentioned above and in Appendix A.
  - Understanding of environmental issues that influence personal health, such as secondhand smoke, sanitation, exposure to lead or other toxic substances, housing safety, and occupational exposures.
  - Ability to identify local, regional and national resources to assist patients and their families in the development and maintenance of healthy lifestyles and disease prevention
  - Knowledge of mandated reporting requirements for communicable diseases.
  - Knowledge of medical treatment of patients who are refugee status.
  - Understanding of the importance of the evaluation and treatment of TB.
  - Understanding of vaccination programs in U.S.

    A comprehensive listing of specific medical knowledge goals for the rotation, expected to serve as a guide for reading, is listed in Appendix B and Appendix C.

  Assessment
  - Case presentation and discussion
  - Review of written note(s) or consult(s)
  - Observed performance/ordering/interpretation of clinical test or procedure
  - Topic review and discussion
  - In-Training Evaluation (annually)

- **Communication**
  Objectives

Residents are expected to demonstrate interpersonal and communication skills that

- Result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of their patients
- Create and sustain a therapeutic and ethically sound relationship with patients
- Allow residents to work effectively with others as a member of a health care team
- Result in comprehensive, accurate and legible records

Assessment

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

- **Professionalism**

Objectives

Residents must demonstrate a commitment to

- Excellence in carrying out professional responsibilities and respecting patient confidentiality.
- Demonstrating respect, compassion, altruism, integrity, and accountability
- Demonstrating sensitivity and responsiveness to patient's culture, age, gender, and needs
- Creating and sustaining a therapeutic and ethically sound relationship with patients and their families.
- Self awareness, self-improvement, and continuous professional development.

Assessment / Evaluation of Professionalism

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Practice-based Learning and Improvement

Objectives

Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with illnesses and diseases encountered in the ambulatory setting. By the end of the rotations, each resident will be able to:

- identify/improve deficits in his/ her own medical knowledge and patient care skills
- locate, critically appraise, and assimilate evidence from scientific studies and apply this to his/her own patients' health problems.
- use information technology to manage information, access on-line medical resources, and support self-education, patient care decisions and patient education.
- apply to their clinical practice the principles of appropriate subspecialty referral
- prepare for Team Huddle prior to each clinic session using the "pre-visit review" sheet (attached to this curriculum)
- participate in Team Huddle before the start of each clinic session

Assessment
- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

- **Systems-based Practice**

  Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with illnesses and diseases encountered in the ambulatory setting. As such, residents will

  - practice cost effective health care and resource allocation
  - advocate for quality patient care and assist patients in dealing with the immediate health care system
  - productively and cooperatively participate in Multidisciplinary Treatment Planning.
  - actively work with ambulatory support staff (eg nursing, pharmacy, interpreters, social workers) and demonstrate the ability to work well in a team setting.
  - understand and demonstrate the accurate coding of Evaluation and Management Office Visits.
  - understand the roles of the health care team and when to involve them in the patient care plan.

Assessment
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Appendix A.

Specific Medical Knowledge Objectives (from FCIM2 and MKSAP14)Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should become familiar with the following ambulatory topics:

Diabetes (Type 1 and Type2)

Osteoarthritis

Hypertension

Hyperlipidemia

Chronic obstructive pulmonary disease

Asthma

Thyroid disease

Dementia

Skin lesions (many forms)

Gastritis/acid reflux

Chronic kidney disease

Coronary artery disease
Depression/anxiety
Fibromyalgia
Musculoskeletal and orthopedic complaints (various)

Urinary incontinence

Irritable bowel syndrome

Vaginitis

Anemia

Arrhythmia

Upper respiratory infections

Allergies

Urinary tract infection

Hypercoagulability/Anticoagulation

Chronic pain syndromes

Chronic hepatitis B and C

Congestive heart failure
Morbid obesity
Low back pain

Appendix B: Reading List

Texts:

Harrison's Internal Medicine. 16th edition. McGraw Hill.
Principles of Ambulatory Medicine. 6th edition. Lippincott Williams & Wilkins.
Griffith's 5-Minute Clinical Consult. 10th edition. Lippincott Williams & Wilkins.
Multiple subspecialty texts are available in Primary Care Library and St. Vincent Hospital Library

Websites:

Up to Date
StatRef
MedConsult
Procedure Consult

Articles (to be supplemented by faculty and attendings):

Articles found in Appendix C are to be read by the resident before the end of the rotation. P

Appendix C: Study Module Readings

Chobian AV et al. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure—the JNC 7 Report. *JAMA* 2003;289:2560-2572.
Standards of Medical Care in Diabetes—2008. *Diabetes Care* 2008;31:S12-S44.
Grundy SM et al. Implication of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines. *Circulation* 2004;110:227-239.
U.S. Preventive Services Task Force Recommendations on Screening and Preventive Health

Acknowledgments: University of Illinois, Peoria; Michigan State University; St. Vincent Family Medicine Residency; St. Vincent Internal Medicine Residency

INFECTIOUS DISEASE CURRICULUM

INTRODUCTION

Infectious disease medicine requires an understanding of the microbiology, prevention, and management of disorders caused by viral, bacterial, fungal, and parasitic infections, including the appropriate use of antimicrobial agents, vaccines, and other immunobiologic agents. Important elements include the environmental, occupational, and host factors that predispose to infection, as well as basic principles of the epidemiology and transmission of infection.
The infectious diseases curriculum is designed to teach the resident the appropriate evaluation and management of infectious diseases as outlined in the goals below. Housestaff assigned to the Infectious Disease Rotation are expected to read this curriculum and discuss the key goals / objectives and rotation structure with the Infectious Disease faculty preceptor at the beginning of the rotation. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: Hassan Elmalik, MD, helmalik@idipsc.com (Carla Henderson, Director of Operations; CHenderson@idipsc.com always copy her on any rotation email)
Rotation Sites: St. Vincent 86th St.
Rotation duration: 4 weeks,Rotation status: Required
Residents: 1 resident per month, any training level (typically PGY-1)
Duty Hours: Monday – Friday
Learning Methods: Direct patient care in outpatient/inpatient setting, Case presentation and discussion, Topic review and discussion, Review of assigned reading materials, Teaching rounds, Conference attendance, Self-directed learning , Post testing. Residents will also be exposed to Infectious Disease core topics during AIMS, ICU, Primary Care Clinic, and other Internal medicine rotations. The curriculum will serve as a useful foundation for knowledge acquisition during the rotation.
Resources: MKSAP, Assigned reading materials and web-links, Hopkins Modules, Infection Control Dept, Laboratory Services, Clinical Pharmacists.

Conferences: Program Conferences, ID Noon Conference and Grand Rounds required, Morning Report optional but encouraged
Evaluation: New Innovations electronic evaluation specific to Podiatry/Infectious Disease Rotation

ROTATION GOALS/OBJECTIVES

- To evaluate symptoms that may be caused by a wide range of infectious disorders and to expand the differential diagnosis to include infectious and noninfectious causes.
- To become competent in the appropriate evaluation and treatment of patients with commonly encountered infectious diseases.
- To gain a practical understanding of the epidemiologic, microbiologic, and pathologic features of commonly encountered pathogens.
- To refine the use and interpretation of microbiologic and serologic diagnostic testing including gram stains of sputum.
- To gain proficiency in safe, rational antibiotic prescribing through knowledge of local susceptibility antibiograms, minimum inhibitory concentrations, pharmacokinetic and pharmacodynamic properties of commonly used agents.
- To learn appropriate treatment plans for situations requiring empiric therapy versus organ / pathogen specific therapy.
- To become familiar with public health aspects of Infectious Disease Medicine (ID), including hospital infection control, primary prevention strategies (vaccination).
- To develop counseling and patient education skills pertinent to Infectious Disease Medicine.
- To develop an appreciation of the multidisciplinary support network utilized by the Infectious Disease specialist, (including but not limited to microbiology, pathology, and infection control nurses).
- To gain an appreciation of the effects of regional trends and globalization on disease presentation.
- To learn about diagnostic and management approaches to patients with HIV infection.

Principal Teaching Methods

- *Supervised Patient Care* - Residents evaluate patients in the hospital and (ideally) in the outpatient Infectious Diseases clinic, supervised by Board Certified and/or Board Eligible Infectious Disease specialists. The resident on the infectious diseases rotation will adhere to the residency program supervision and duty hours rules. Residents will function as a primary physician and/or consultant in the inpatient and outpatient settings. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with infectious diseases. Patients are seen and examined by the resident, who formulates an assessment, differential diagnosis, and treatment plan and presents it to the attending faculty. Both the resident and the attending then examine the patient and discuss the care. Teaching focuses on evaluation and management of the specific case as well as its relationship to the core Infectious Disease medical knowledge topics. Inpatient teaching rounds will occur at least 4.5 hours per week and outpatient precepting will occur at least 30 minutes per half-day clinic session

- *Didactic Teaching Sessions* –
    - i core lecture series to include a combination of
      - Small group discussions and article presentations with faculty, based on rotation objectives;
      - Noon conference core lecture series;
      - Medicine Grand Rounds presentations.
    - ii microbiology laboratory tour
    - iii meet with HIV Program Coordinator Teri Cardwell.

- *Self-directed learning*
    - The ID resident will be expected to utilize the Infectious Disease MKSAP content as a reading resource, and will be expected to complete the questions.
    - The resident will review the Hopkins Modules and complete at least two ID-related modules toward the 20 module annual expectation.
    - The resident will read articles from the ID reading list (see Section 9, Reading list / References) pertinent to cases seen during the rotation, or as directed by the ID attending. Residents are expected to independently research topics related to patients they encounter during the rotation.
    - The resident will complete and submit to the Program Coordinator a Self-Directed Learning Log summarizing a typical week's self-directed learning activities during the rotation.
    - The resident will complete an Evidence-Based Learning Exercise. This involves the formulation of a specific clinical question, completion of an Ovid search, and a critique / summary of the clinical literature to determine the appropriate answer to the question.
- Procedures - The resident is introduced to techniques used in clinical microbiology, including: proper handling, staining and interpretation of specimens including gram stains; bacterial, viral and fungal culture techniques; performance and interpretation of serologic tests. Additional potential diagnostic and therapeutic procedures available on a case-dependent basis include (but are not limited to) lumbar puncture, arthrocentesis, incision and drainage of abscesses, fungal skin scrapings, and punch biopsy of the skin.

Educational Content / Rotation Structure

- **Mix of diseases**
- The disease mix is broad, due to the multiple referral sources to St Vincent and the diverse population of Indianapolis and surrounding areas. Appendix A highlights the scope of diseases applicable to this rotation.
- **Patient characteristics**
- The ID resident will see a diverse population of adult patients ranging in age from adolescents to geriatric patients, of diverse socioeconomic backgrounds.
- **Learning venues**
    - Most encounters are hospital consultations, ranging from 3-4 per resident per day.

- Residents may also see patients in the ID Clinic, on average one half day per week. Each ID resident will see an average of 3 – 4 Clinic patients per half day of assigned clinic.
- The resident will attend the Infection Control Committee meetings during the course of the rotation, in order to gain an understanding of population level infectious disease management.
- The resident will attend a didactic session in the Laboratory Services Department to learn basic principles of microbiologic specimen preparation.
- The resident will attend an educational session on HIV Care Coordination with Teri Nelson Cardwell, medical Social Services / Community Outreach (338-6714).
- Residents continue to attend their continuity clinic and mandatory didactics.
- Rotation-specific didactic lectures, Noon Conferences and Medicine Grand Rounds.

Ancillary Teaching Materials

- At the beginning of each rotation this curriculum is provided to each resident as a guide to the rotation. This is to be reviewed with the attending physician.
- All residents can access Clin-eguide, Access Medicine / Stat!Ref on-line textbooks, and Ovid from the intranet.
- Tobramycin and Vancomycin dosing nomograms as well as best practice guidelines for cellulitis, complicated UTI, and a growing number of other infectious diseases are available via Sharepoint.

Assessment and Evaluation Tools

Global:

- **Resident evaluation by faculty**
  - Verbal feedback between faculty and resident must occur at mid-month and at the end-of-rotation. Faculty complete a web based resident evaluation form using *New Innovations* At the end of each rotation. The evaluation is sent to the Residency Office where it is placed in the resident's evaluation file. The evaluation assesses core competency performance. It is shared with the resident and may be reviewed by the resident via *New Innovations*. The evaluation is incorporated as part of the semi-annual review for directed resident feedback.
- **Faculty and rotation evaluation by residents**
  - Upon completion of the rotation, residents complete an evaluation form commenting on the faculty, facilities, and educational experience. A member of the administrative faculty will review the written evaluation and add it to a collated report of anonymous evaluations from other residents having taken the rotation and will provide it to the attending physician, every 6-12 months. Constructive criticism will be utilized to improve each

rotation as warranted. The Evaluations Committee reviews results semiannually.

- **Competency Based:** see ID Rotation-Specific Competency-Based Objectives and Assessment

Institutional Resources (Strengths and Limitations)

- Faculty- teaching is provided by 6 full-time board certified ID faculty. Pharmacists with specialization in antibiotic pharmacologic principles participate in teaching residents. Infection control nurses are engaged in hospital quality improvement
- Research – both groups are actively engaged in clinical research and supportive of resident involvement in research activity. St Vincent has a complete range of research support (including funding) available to residents.
- Patients – should an additional HIV learning experience be desired, this can be facilitated.
- Facilities and Technology: A comprehensive range of Radiology, Nuclear Medicine, Microbiology and Pathology services are available to support ID testing.
- The hospital transplant program is restricted to cardiac transplants, and does not have a transplant unit, thus limiting exposure to infectious complications of organ transplant. Residents are encouraged to attend Transplant Committee meetings as allowable within the rotation schedule.

ID Rotation-Specific Competency-Based Objectives and Assessment

The following competency-based objectives are presented as they apply to the field of Infectious Disease Medicine. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

Patient Care Objectives

Residents are expected to:

- complete a comprehensive history and record review with particular focus paid to prior antibiotic use within the past 12 months, history of immunizations, previous infections, travel/sexual history and history of pet/animal exposure.
- perform an appropriate and accurate physical exam and recognize / interpret physical findings seen in infectious diseases including
- Skin rashes, cellulitis, lymphangitis, wound infections
- Animal and insect bites
- Retinal/ocular abnormalities
- Pharyngitis
- Neck stiffness and neurologic abnormalities
- New or changing heart murmurs or rub
- Adventitious pulmonary sounds

- Abdominal or flank tenderness, organomegaly
- Lymphadenopathy
- Joint or limb swelling, tenderness
- Urethral or vaginal/cervical discharge as appropriate
- provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with infectious diseases.
- understand indications/interpretations of testing related to infectious diseases
- perform and/or interpret procedures/tests pertinent to care of patient, including Gram stains, fungal stains, acid-fast stains, KOH preps, serologic antigen and antibody testing for viral, bacterial and fungal diseases, antibiotic sensitivity testing, anaerobic and aerobic culture results and their relevance in the appropriate clinical setting.
- understand the indications for referral of patients with infectious diseases
- use sound clinical judgment in formulating an assessment, differential diagnosis, and plan of care.
- demonstrate clinical documentation skills.
- *plan appropriate disposition and follow-up for patients with infectious diseases*

Assessment

- o Direct observation of history and/or physical exam
- o Case presentation and discussion
- o Review of written note(s) and/or consult(s)
- o Observed performance/ordering/interpretation of a clinical test and/or procedure
- o Feedback from nursing/support staff and/or patient/family member

Medical Knowledge

Objectives

Residents are expected to demonstrate

- knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences as they pertain to the care of patients with infectious diseases.
- understanding of the standard evaluation and management of common infections
- understanding of the use of antimicrobial agents including commonly used antibiotics and antifungal medications. Residents will reflect understanding of the spectrum of antimicrobial drugs, their clinical indications, and their side effects.
- A comprehensive listing of specific medical knowledge goals for the Infectious disease rotation, expanding on i-iii, and expected to serve as a guide for reading, is listed as '**Appendix A**'.

Assessment

- Case presentation and discussion
- Review of written note(s) or consult(s)

- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam – post-test questions.
- In-Training Evaluation (annually)

Communication

Objectives

- Residents are expected to demonstrate interpersonal and communication skills that
- result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with infectious diseases.
- create and sustain a therapeutic and ethically sound relationship with patients
- allow housestaff to work effectively with others as a member of a health care team
- result in comprehensive, accurate and legible records
- allow for educated counseling regarding HIV testing and disclosure and regarding community resources available to those whose lives are affected by HIV / AIDS.

Assessment

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

Professionalism Objectives

Residents must demonstrate a commitment to:

- excellence in carrying out professional responsibilities and respecting patient confidentiality.
- demonstrating respect, compassion, altruism, integrity, and accountability
- demonstrating sensitivity and responsiveness to patient's culture, age, gender, and needs
- creating and sustaining a therapeutic and ethically sound relationship with patients and their families.
- self awareness, self-improvement, and continuous professional development.

Assessment

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
    a. Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Practice-based Learning and Improvement
Objectives

- Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with infectious diseases. By the end of the rotations, each ID resident will be able to:
  - identify/improve deficits in his/ her own medical knowledge and patient care skills
  - locate, critically appraise, and assimilate evidence from scientific studies and apply this to his/her own patients' health problems.
  - use information technology to manage information, access on-line medical resources, and support self-education, patient care decisions and patient education.
  - apply to their clinical practice the principles of antimicrobial chemotherapy.
  - recognize costs of nosocomial infections in terms of mortality and morbidity and will take steps to improve patient safety by better infection control to minimize hospital acquired infections.

Assessment / Evaluation of Practice-based Learning and Improvement

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

Evaluation of PBLI

- ABIM Competency Evaluation Form
- Praise/Concern Card
- Self Directed Learning Logs
- Review of completed Evidence-Based Medicine Exercise.

Systems-based Practice

Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with infectious diseases. As such, residents will

- practice cost effective health care and resource allocation
- advocate for quality patient care and assist patients in dealing with the immediate health care system
- productively and cooperatively participate in Multidisciplinary Treatment Planning.
- actively work with the ID support staff (e.g. infection control nurses, HIV case managers) and demonstrate the ability to work well in a team setting.
- attend an Infection Control Committee meeting - checklist
- attend a didactic session in the Microbiology Laboratory - checklist
- attend a didactic session with the HIV Care Management Coordinator - checklist

Assessment

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure

- Feedback from nursing/support staff and/or patient/family member

Appendix A. General Infectious Diseases Specific Medical Knowledge Objectives
(from FCIM2 and MKSAP14)
Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents at St Vincent Hospital should be able to demonstrate knowledge of the following Infectious Disease topics. The level of knowledge will vary according to the PGY training level ranging from "beginning" knowledge of the topic to an "advanced" knowledge of the topic. Beginning knowledge objectives are identified in **regular print** below whereas advanced knowledge objectives are identified in **italics print**.

Microbiology
- Understand the concept of Minimal Inhibitory Concentration (MIC) and how this relates to the determination of antibiotic sensitivity.
- Understand the concepts of "concentration-dependent" and "time-dependent" bactericidal activity and identify which characteristic applies to the main classes of antibiotics.
- Understand the concept of antibiotic resistance and the factors believed to influence resistance*. Be specifically familiar with the prevalence and clinical significance of: Penicillin-resistant S. pneumoniae, Beta lactamase-resistance, Methicillin-resistant Staphylococci, and Vancomycin-resistant Staphylococci and Enterococci.*

Antibiotic Agents
- Describe the mechanism of action, pharmacodynamics, pharmacokinetics and the commonest sensitivity patterns for agents in each antibiotic class.

Adult immunizations / Immune Disorders
- Outline the routine immunizations recommended for healthy adults who have already received the recommended childhood immunizations.
  - *Recognize that live vaccines (OPV, BCG, Vaccinia, Typhoid, Yellow Fever) are contraindicated in patients with severe immunodeficiency.*
  - *Discuss the clinical presentation and differential diagnosis of the primary immunodeficiencies.*

Fever of unknown origin
- Demonstrate a working knowledge of the definition, infectious / noninfectious differential diagnosis, and evaluation of Fevers of Unknown Origin.

Viral Infections
- Understand Influenza in terms of virology / antigenic shift, chemoprophylaxis, antiviral therapies and drug resistance.
- *Discuss the treatment of Varicella Zoster infections (chickenpox, shingles)*
- *Discuss the presentation, evaluation, and Management of CMV infections.*
- Discuss the presentation, evaluation and differential diagnosis of Epstein-Barr Virus mononucleosis.
- Discuss the presentation, evaluation and treatment of oral, genital, CNS, and ophthalmic complications Herpes Simplex Virus.

- Discuss the presentation, evaluation and clinical implications of parvovirus B19 infection.
- Recognize the associations between: human papilloma virus and cervical cancer; *Kaposi's sarcoma and human herpesvirus 8.*

Fungal Infections

- Recognize that Candida sp. can cause mucocutaneous infections, deep focal infections, and candidemia.
    - List the common risk factors for mucocutaneous Candida infection.
    - List the common risk factors for candidemia.
    - Discuss appropriate treatments for the following candidal infection*s:*
        Oropharyngeal (Thrush)
        Esophagitis
        Vaginitis
        Asymptomatic candiduria
        Candidemia
    - Recognize that frequent drug resistance of C. glabrata and C, krusei affects antifungal selection
- Describe the clinical presentation and appropriate treatment of acute pulmonary and Disseminated Histoplasmosis.
- Describe the pathological and clinical differentiation between Allergic Bronchopulmonary Aspergillosis, Aspergilloma (fungus ball), and Invasive Aspergillosis. Outline the appropriate treatment for each type of Aspergillus infection
- Contrast the epidemiologic and clinical characteristics of Blastomycosis, Coccidiomycosis and Sporotrichosis*.*

Sepsis, septic shock syndrome

- Describe the clinical differentiation of systemic inflammatory response syndrome (SIRS), sepsis, severe sepsis, and septic shock.
- Discuss the clinical markers that are useful in the emergency room to identify patients at high risk for death from severe sepsis and the hemodynamic interventions that are shown to improve survival.
- Define the APACHE II system for categorizing the severity of severe sepsis and describe the statistical correlation of APACHE II scores with mortality.
- Understand the theory of hypercoagulability in the pathogenesis of severe sepsis and describe the indications, contraindications and statistical benefit of Activated Protein C in its treatment.
- Discuss the significance of asplenia in the evaluation of patients with sepsis.
- Describe the clinical presentation and typical skin lesion of N. meningitidis bacteremia.
- Demonstrate familiarity with the St Vincent 'Sepsis Bundle'

Skin Infections

- Define cellulitis, erysipelas and impetigo and list the commonest bacterial causes.
- Describe the clinical features that differentiate bacterial cellulitis from Toxic Shock Syndrome, Necrotizing Fasciitis, and Stevens-Johnson syndrome.
- Discuss the role of IV Immunoglobulin in the management of Toxic Shock Syndrome.
- Describe the physical exam, radiographic and MRI findings in Necrotizing Fasciitis caused by gas forming bacteria, and identify the most likely pathogens.
- Understand the primary role of surgical debridement in the management of Necrotizing Fasciitis.
- Diagnose Viral exanthems

Infections of the CNS

- Bacterial / viral meningitis
    - In patients with suspected acute meningitis, describe the CSF findings that help differentiate between bacterial, viral, cryptococcal and tuberculous causes.
    - List the common bacterial causes of acute meningitis based on risk factors of: age, basilar skull fracture, recent neurosurgery, chronic CSF shunt, immunodeficiency.
    - Taking into consideration CNS permeability and developing antibiotic-resistance patterns, list appropriate empiric antibiotic regimens for patients in each of the above risk groups.
    - Discuss the recommended use of corticosteroids in the treatment of bacterial meningitis.
- Brain abscess.
- Epidural abscess/ subdural empyema.
- Cellulitis, necrotizing fasciitis, toxic, shock syndrome.
- Encephalitis and prion diseases

Respiratory

- Acute epiglottitis, pharyngitis
- Bronchitis, Upper respiratory infection
- Sinusitis
- Community-acquired pneumonia
    - Identify the co morbidities, vital sign parameters and basic laboratory data (Pneumonia Severity Index) that suggest a higher risk of complications in patients with community-acquired pneumonia and require consideration of inpatient management.
    - Identify the organisms most commonly causing pneumonia in non-hospitalized patients and suggest appropriate, empiric antibiotic treatment regimens.
    - Identify the organisms more commonly causing pneumonia in hospitalized patients (nosocomial pneumonia) and suggest appropriate, empiric antibiotic treatment regimens.
    - Identify the vital sign parameters that suggest consideration for hospital discharge of patients being treated for pneumonia.
- Nosocomial pneumonia, atypical pneumonias
- Empyema

Cardiac

- Pericarditis
- Endocarditis
    - List the common (“typical”) bacteria causing infective endocarditis and further differentiate which of the common bacteria are more likely to be seen in infections of native or chronic prosthetic left sided valves, prosthetic valves within 2 months of implantation, and right sided valves.
    - Define the “Modified Duke Criteria” for the diagnosis of infective endocarditis.
    - Recognize that the prevalence of transesophageal echocardiographic evidence of infective endocarditis in patients with S. aureus bacteremia is about 25% and has led to the recommendation by many experts that TEE be routinely performed in these patients, to help guide the duration of antibiotic therapy.
    - Define the recommended medical therapy of infective endocarditis based on infecting organism.
    - *Define the indications for valve replacement in infective endocarditis.*

- Recognizing that antibiotic prophylaxis for infective endocarditis is unproven and controversial, list the cardiac lesions and invasive procedures for which the American Heart Association recommends antibiotic prophylaxis, and the recommended antibiotic regimens.

Gastrointestinal

- Biliary tract infection
- Gastroenteritis
- List the risk factors and recommended diagnostic testing for the commonest causes of infectious diarrhea, classified by: i) acute (<7d) community acquired; ii) persistent (>7d) community acquired; iii) nosocomial.
- *Discuss the role of empiric antibiotic treatment of infectious diarrhea, recognizing that antibiotic treatment of Shiga toxin-producing E.coli may be associated with an increased risk of Hemolytic Uremic Syndrome.*
- Recognize the association between *C. jejuni* enterocolitis and Guillain-Barre Syndrome.
- Liver abscess
- Peritonitis / Intra-abdominal infections
  - Recognize the biphasic characteristic of intra-abdominal and pelvic infections (initial acute contamination and subsequent abscess formation) and the frequency of polymicrobial involvement.
  - List the underlying or associated diseases that predispose to intra-abdominal and pelvic infections and the commonest pathogens for each.
  - While recognizing that drainage of infected material and treatment of the underlying diseases are central to the management of intra-abdominal infections, discuss appropriate antimicrobial regimens based on the suspected underlying source.
- Viral hepatitis

Genitourinary

- Cervical cancer (HPV)
- Cervicitis, vaginitis
- Prostatitis, epididymitis
- Urethritis
- Urinary tract infection – acute and recurrent infections
  - Differentiate between the following clinical entities and discuss the management considerations including diagnostic criteria (such as urinalysis interpretation), common organisms, antibiotic choice and duration, and evaluation for secondary causes.
    - Asymptomatic bacteriuria
    - Uncomplicated urinary tract infection
    - Complicated urinary tract infection
    - Acute pyelonephritis, with and without complications
  - *Demonstrate an understanding of the pros and cons of chronic suppressive antibiotic therapy for recurrent UTIs.*

Rheumatologic/musculoskeletal

- Osteomyelitis
  - Identify the commonest bacteria causing osteomyelitis that secondary to: i.) contiguous spread [post-operative, traumatic, dental, post-XRT, etc.]; ii.) complication of vascular insufficiency; iii.) hematogenous spread.

- Discuss the advantages and disadvantages of X-ray, bone scan and MRI in the diagnosis of osteomyelitis.
- *Recognize that blood cultures are specific but insensitive and superficial or sinus tract cultures are unreliable in the bacteriologic diagnosis of osteomyelitis. Deep aspiration or bone biopsy are best.*
- Discuss the treatment considerations (duration of antibiotics, role of surgical debridement) in acute and chronic osteomyelitis.

- Septic arthritis
- Diabetic Foot Infections
  - Identify the complications of diabetes that predispose to foot ulceration and the physical findings of the feet that suggest increased risk for ulceration and infection.
  - Describe the physical findings that help differentiate between infected and non-infected foot ulcers.
  - Identify the bacterial pathogens commonly associated with acute, superficial foot infections and those associated with chronic, deep foot infections.
  - Recognize the inherent difficulty in obtaining useful culture data in diabetic foot infections, and identify the types of specimens that are most reliable.
  - Identify appropriate, empiric antibiotic regimens for diabetic foot infections based on duration of ulceration and clinical assessment of depth of infection.
  - Recognize the importance of assessing arterial supply and role of surgical debridement of infected bone and devitalized tissues in the management of diabetic foot infections.

Mycobacterial infections.

- Tuberculosis –
  - Discuss the natural history of M. tuberculosis infection, understanding the differences between active and latent infection.
  - List the risk groups for whom tuberculin skin testing is recommended, the thresholds of induration considered a positive response, and the appropriate treatment regimens of responders.
  - Describe the diagnostic criteria for active Tuberculosis and appropriate empiric treatment of patients in whom multi-drug resistance is not suspected.
  - Discuss the clinical presentations of Non-tuberculous mycobacterial infections (avium, kansasii, marinum etc)

Fungal infections (histoplasmosis, coccidioidomycosis, cryptococcosis)

Sexually Transmitted Diseases (e.g. gonorrhea, chlamydia, trichomonas, herpes simplex, syphilis)

- Discuss the clinical presentation, diagnostic methods and appropriate treatment regimens for the following infections:

  Syphilis, primary, latent and tertiary (*T. pallidum*)
  Gonorrhea (*N. gonorrhoeae*)
  Chlamydia (*C. trachomatis*)
  Chancroid (*H. ducreyi*)
  Herpes genitalis (*HSV*)
  Trichomonas (*T. vaginalis*)

Vector-borne diseases.

West Nile Encephalitis
Lyme disease
Rocky Mountain Spotted Fever, Babesiosis, Ehrlichiosis
Malaria

Infectious Agents of Bioterrorism
- Anthrax
- Smallpox

Travel Medicine
Infections in Transplant Recipients / Immunosuppressed patients

Healthcare-associated infections

HIV and AIDS

- Describe the natural history of acute HIV infection, including clinical symptoms (acute retroviral syndrome) and laboratory findings (viral load, CD_4 count, antibody formation).
- Discuss the sensitivity and specificity of antibody testing by enzyme linked immunoassay, and the role of confirmation by Western blot testing.
- List the appropriate laboratory evaluations for patients newly diagnosed with HIV infection.
- *List the recommended immunizations for patients with HIV infection.*
- Identify the criteria for initiating and discontinuing chemoprophylaxis for *Pneumocystis carinii, Mycobacterium avium,* Cryptococcosis, and Cytomegalovirus.
- Outline the indications for initiating antiretroviral therapy in patients with HIV infection.
- *Recognize the rare but serious risk of severe hepatic steatosis and metabolic acidosis with nucleoside reverse transcriptase inhibitors, the risk of nephrolithiasis with indinavir, and the general risk for GI intolerance and hepatotoxicity with most antiretroviral agents*
- Discuss the prophylactic treatment of individuals with occupational exposure to HIV.
- Understand the clinical features of HIV as listed:

AIDS-defining malignancies
- Kaposi's sarcoma
- Non-Hodgkin's lymphoma
- Squamous cell carcinoma (cervix or anus)

Cardiovascular Complications
- *Cardiomyopathy*
- *Myocarditis*
- *Pericarditis*

Dermatologic complications
- *Bacillary angiomatosis*
- *H. zoster*
- *Kaposi's sarcoma*
- *Molluscum contagiosum*
- *Scabies*
- *Seborrheic dermatitis*

Endocrine Complications
- *Hypoadrenalism*
- *Hypogonadism*
- *Hypothyroidism*
- *Lipodystrophy*

Gastrointestinal complications
- *Diarrhea*
- *Esophageal candidiasis*
- *Esophageal ulcer disease*
- *Hepatomegaly, hepatitis, jaundice*
- *Wasting syndrome*

General management
- *Evaluation and management of early disease*
- *Advance directives evaluation*
- *Assessment of alternative health practices*
- *Assessment of social support systems*
- *Monitoring progression to AIDS*
- *Ongoing staging*
  - *Diagnosing AIDS-defining opportunistic infections*
  - *Functional assessment*
  - *Mental status evaluation*

        - *Nutritional assessment*
        - *Referral to case-management agencies*
    - *Palliative and terminal care*
    - *Pregnancy counseling (pretest, post-test, risk factors)*

Gynecologic complications

- *Cervical dysplasia/neoplasia*
- *Pelvic inflammatory disease*
- *Vaginal candidiasis*

Hematologic Complications

- *Anemia*
- *Antiphospholipid antibody*
- *Immune thrombocytopenic purpura*
- *Thrombotic thrombocytopenia purpura*

Infectious diseases (see also Preventive measures and specific organ-based complications)

- Cytomegalovirus disease
- Mycobacterial disease
- Pneumocystis carinii pneumonia
- Syphilis (diagnosis, treatment)

Neurologic complications

- Central nervous system mass lesions
- Cryptococcal meningitis
- Dementia
- *Myelopathy*
- *Myopathy*
- Neurosyphilis
- *Peripheral neuropathy*
- *Polyneuropathy*

Wasting syndrome

Occular Complications

- *Conjunctivitis*
- *Iritis*
- *Keratitis*
- *Retinitis*

Oral complications

Preventive measures

- Antibiotic prophylaxis
    - Pneumocystis carinii pneumonia
    - Tuberculosis
- Antiretroviral drug therapy
- Immunizations
- *Mycobacterium avium complex*
- *Protease inhibitor therapy*
- Toxoplasmosis
- Transmission of HIV

Psychiatric Complications

- *Anxiety-panic disorders*
- *Pain management*
- *Depression*

Renal

- *Lactic acidosis*
- *Renal tubular acidosis*

INPATIENT MEDICINE CURRICULUM

INTRODUCTION

Inpatient General Internal Medicine (GIM) requires a broad understanding of pathologies in multiple organ systems and the potential interactions between systems. The curriculum for the Adult Inpatient Medicine Service (AIMS) rotation is not meant to reproduce the depth of understanding of the subspecialty services but is designed to teach the resident the appropriate evaluation and management of the common conditions encountered in the inpatient portion of a GIM practice, as outlined in the goals below. Residents assigned to the AIMS Rotation are expected to discuss the key goals, objectives and rotation structure with the faculty preceptor at the beginning of the rotation. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: Lorrie Miller-Rice, MD – lxmiller@stvincent.org
Rotation Site: St Vincent Indianapolis Hospital
Rotation duration: 1 month
Rotation status: Required

Duty Hours:
PGY-1: 65-67 hrs per wk; 4-5 days off per month

5-6 shifts	7a-9p
4-5 shifts	7a-6p
9-10 shifts	7a-3p
6-7 shifts	5:45p-7:15a

Please also refer to the AIMS Monthly Reference Book for further details about duty hours, clinical responsibilities and practice protocols.
Learning Methods: Supervised primary care responsibility for the management of inpatients admitted to a GIM service, including: Daily supervision of patient management decisions, Small group bedside teaching rounds for case presentation and discussion, Classroom topic review and discussion (see section 9 b), Conference attendance, Self-directed & Faculty-directed independent study.
Resources: Assigned reading materials and web-links (see Appendix A), MKSAP
Continuity Clinic: Yes, Primary Care Center
Conferences: Daily bedside teaching rounds required; Daily Noon Conference required, Weekly Grand Rounds required; Morning Report (M, Th, F) required, Tumor Board optional but encouraged.
Evaluations: New Innovations electronic evaluation form specific to Podiatry/Internal Medicine Rotation

ROTATION OBJECTIVES

At the end of a month experience, the resident will achieve at a minimum novice competency in the following areas:

- Be able to competently evaluate and manage common and unusual inpatient GIM problems involving all organ systems.
- Be able to apply clinical skills and analyze laboratory findings to synthesize a prioritized differential diagnosis and a cost-efficient management plan for the encountered problems.
- Understand the pharmacology, indications and side effects of commonly used medications in the management of inpatient medical illnesses.
- Recognize the importance of an interdisciplinary team (physicians, nurses, pharmacists, dietitians, social workers, discharge planners) in the competent management of medical inpatients.
- Develop counseling and patient education skills pertinent to the management of medical inpatients including the coordination of appropriate outpatient follow up and the compassionate delivery of bad news.
- Understand the role of the General Internist in requesting and providing inpatient consultative services.
- Understand the systems of inpatient care that promote cost-effective, evidence-based management with a focus on patient safety.

PRINCIPAL TEACHING METHODS

- *Supervised Patient Care* – PGY-1 residents evaluate and manage assigned inpatients under the direct supervision of their senior IM residents and their Board Certified Internal Medicine

faculty, assuming primary care responsibility for all aspects of care. For each assigned patient, the PGY-1 resident will perform an appropriate history and physical examination, formulate a problem list, differential diagnosis, and treatment plan, and present it to the supervising resident and attending faculty. Both the supervising resident and the attending faculty will examine the patient and discuss the care. The residents will observe/perform and interpret the various special tests and procedures used in the evaluation and management of their assigned patients and will adhere to the residency program supervision and duty-hours rules. Teaching focuses on evaluation and management of the specific cases as well as their relationship to the core GIM medical knowledge topics. Inpatient teaching rounds will occur at least 4.5 hours per week and will include direct bedside interactions.

- *Didactic Teaching Sessions* -
    - o Small group discussions with faculty, based on Rotation Objectives
    - o Noon Conference core lecture series
    - o Medicine Grand Rounds
    - o Scheduled ancillary services didactics (Rehab {PT, OT, ST}, Respiratory Therapy, Pharmacy)
- *Self-directed learning* –
    - o Residents should read the articles in the attached reading list (see Appendix A).
    - o Residents should independently research topics related to patients they encounter during the rotation.
    - o Residents should personally review the radiologic images on their assigned patients.
- Procedures – Residents will participate in all bedside procedures performed on their assigned patients. Senior residents may supervise interns in procedures for which the senior resident has demonstrated competency. Residents should observe any subspecialty procedures performed on their patients by consultants.

EDUCATIONAL CONTENT / ROTATION STRUCTURE

Mix of diseases

- Residents will see patients admitted to the GIM service at St. Vincent Hospital from the IM and FM Residency Continuity Clinics, from the private offices of designated referring Primary Care Physicians (PCP's) and from the ED when patients do not have a recognized PCP. Residents will also provide GIM consultation when requested by non-GIM inpatient attendings. The core diseases will include:

- Acute coronary syndromes; Acute & chronic CHF; Acid-base disorders; Pulmonary, urinary, soft tissue and CNS infections; Inflammatory & Peptic GI diseases; Stroke/TIA; Complications of Diabetes Mellitus; Venous thromboembolic disease; Acute & chronic renal failure; Acute & chronic hepatic failure; Alcohol withdrawal syndrome; Perioperative hemodynamic & metabolilc complications.

Patient characteristics

- The resident will see a diverse population of adult patients ranging in age from adolescence to geriatrics, and from the full range of racial and socioeconomic backgrounds.

Learning venues

- All encounters are hospital admissions or consultations, ranging from 1-5 new patients per intern (2-10 per senior resident) per day.
- The resident will attend all scheduled Small Group rounding sessions, Morning Report conferences, Noon Conferences, Medicine Grand Rounds, and Ancillary Services didactics (PT, OT, ST, RT, Pharm).
- Residents will be excused from inpatient rounding to attend their weekly IM continuity clinics and will cross cover for each other during those sessions.

ANCILLARY TEACHING MATERIALS

- At the beginning of the rotation, this curriculum is provided to the AIMS resident as a guide to the rotation. Appendix A contains a list of recommended readings for the month. Additional reading materials may be provided by the faculty preceptor.

- All residents can access E-Medicine (expert opinion), Clin-eguide (Medical database search engine), Ovid (peer reviewed literature search), Access Medicine and Stat!Ref (on-line textbooks) from every hospital computer.

- The St. Vincent medical library contains additional GIM Texts and print journals, including interlibrary loan and fax services.

INSTITUTIONAL RESOURCES

- Faculty - Teaching is provided by board certified GIM faculty who are full-time employees of the Medical Education Department.
- Patients – The inpatient census for each resident is large but controlled and provides the opportunity to care for patients with a wide variety of pathological conditions and from a wide range of ethnic and socioeconomic backgrounds.
- Research – The GIM faculty are actively engaged in clinical research and supportive of resident involvement in research activity. St Vincent has a complete range of research support (including funding) available to residents.
- Facilities and Technology – St. Vincent Hospital supports a full array of Laboratory, Imaging and Procedural facilities in every medical specialty.

COMPETENCY-BASED OBJECTIVES AND ASSESSMENT

The following competency-based objectives are presented as they apply to the AIMS rotation. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

Patient Care
Objectives
Residents are expected to:

- Collect a comprehensive history and record review appropriate for a patient admitted to a GIM inpatient service.
- Perform a complete and accurate physical examination.
- Perform or order and accurately interpret procedures and tests appropriate for patients with a wide array of presenting complaints.
- Demonstrate sound clinical judgment in formulating an assessment, differential diagnosis, and plan of care for assigned patients.
- Plan and coordinate appropriate disposition and follow-up for patients released from the inpatient setting**.**
- Demonstrate compassion and empathy in interactions with patients.

Methods of Assessment of Patient care
- Direct observation of history and or physical exam
- Case presentation and discussion between resident and faculty
- Review of written notes
- Observed performance of ordering and interpretation of tests and procedures
- Feedback from nursing, support staff, patients and family members

Medical Knowledge
Objectives
- Clinical experience on the AIMS rotation includes patients with diseases of every organ system. Therefore, medical knowledge objectives listed in each of the individual subspecialty rotations are also relevant for the AIMS rotation. The following is a limited list of objectives to guide the resident in their study.

DVT and PE
- List the important risk factors for developing venous thromboembolism. Outline the difference in risk between general surgical, orthopedic, and general medicine inpatients. What are the three most common groups (diagnoses) of non-surgical patients developing DVT? Describe the efficacy of various preventive measures for venous thromboembolism in these groups.
- Review the common presenting symptoms, signs and tests for pulmonary embolus. Include: CXR appearance, EKG findings, oxygen saturation, respiratory rate, Q-dimer, and CT angiography.
- Discuss the relative frequency of hypercoagulable states (for which we can test) in patients presenting with venous thromboembolism. Note the effect of race, ethnicity, and family history on the pretest probability of the tests. Propose what you think would be the most reasonable, cost-effective hypercoagulable workup.
- Outline an appropriate treatment of uncomplicated DVT and PE? How long is it required? When is coumadin initiated? How long should coumadin be continued? Describe a testing strategy for following the level of anticoagulation during and immediately post-hospitalization.

Peri-operative Consultation

- Describe the important characteristics for being an effective clinical consultant.
- Outline the ACC recommendations for preoperative evaluation of patients undergoing noncardiac surgery, focusing on clinical risk factors and type of surgery being planned.
- Discuss risks and benefits of using a beta-blockers perioperatively. What about in chronic renal failure?
- What is the calculated post-op FEV-1 suggested as a threshhold for precluding pneumonectomy in COPD patients?
- What body systems deserve special attention in the pre-op evaluation of the diabetic patient?
- Discuss the peri-operative recommendations for oral hypoglycemic agents, insulin and blood sugar management. When should IV dextrose be used?
- Outline appropriate perioperative DVT prevention techniques.
- Describe strategies to prevent the following conditions:
  - atelectasis
  - catheter-associated urinary tract infections
  - intravascular device-related infections
  - nosocomial pneumonia
- Outline the indications and appropriate strategies for prophylaxis of gastrointestinal ulceration.
- Describe the importance of nutrition in the peri-operative patient, and methods by which to monitor and achieve nutritional goals.

Pneumonia

- Understand and apply the Pneumonia Severity Index to each of your patients suspected of having pneumonia.
- How do you determine when a pneumonia patient has reached clinical stability and can be released from the hospital?
- Discuss the mechanism of *S. pneumo* resistance to penicillin and macrolides. Discuss the clinical importance of this in meningitis vs. pneumonia and how that affects antibiotic choices.
- Describe the initial evaluation and management of a patient with nosocomial pneumonia – specific tests and appropriate therapies.
- What are the current recommendations for antibiotic therapy, how long should they be used, when should a transition from IV to oral therapy occur, and at what point is a patient considered a treatment failure?

Acute Renal Failure

- Define oliguria and acute renal failure and outline an initial approach to the evaluation and treatment of both. What will the test results show for each type of acute renal failure?
- What common medications, procedures, and interventions commonly contribute to acute renal failure in hospitalized patients?
- Calculate a patient's estimated creatinine clearance based on age, body weight, gender and serum creatinine.

Acute Coronary Syndrome and CHF

- Define “acute coronary syndrome” and outline an appropriate initial evaluation and management.
- Discuss the difference between systolic and diastolic ventricular dysfunction.
- Outline the appropriate pharmacologic management of chronic Congestive Heart Failure, recognizing those measures shown to improve survival.
- What preventative care is applicable to CHF patients? What is their most common cause of death?

Asthma and COPD

- Discuss the effects of quitting smoking on pulmonary function and risk of cancer and non-cancer death.
- Outline an appropriate therapeutic approach to a patient desiring to quit smoking.
- Outline the acute and chronic side effects of systemic corticosteroids.
- Outline an appropriate decision model for whether to hospitalize a patient with an acute exacerbation of asthma or COPD.
- Outline an appropriate management approach to a patient with an acute exacerbation of Asthma or COPD.
    - Describe discharge considerations after treatment for exacerbation of COPD. When should oxygen be used and how is it prescribed? When is pulmonary rehabilitation indicated?

Stroke and TIA

- Outline an appropriate initial evaluation of a patient with stroke or TIA.
- Discuss the indications, contraindications, benefits and risks of thrombolytic therapy in acute ischemic stroke.
- Outline the goals of blood pressure treatment in acute ischemic stroke. Discuss the risks, side effects and pharmacology of intravenous, oral and transdermal therapies.
- Discuss the most important neurologic complications of CVA and how are they managed?
- Discuss the data related to primary and secondary prevention of stroke in patients with carotid artery disease or atrial fibrillation.

Electrolyte Abnormalities

- Outline an approach for determining the etiology of hyponatremia based on serum and urine osmolalities and on the patient’s overall volume status.
- List the criteria for a diagnosis of Syndrome of Inappropriate Antidiuresis?
- Outline a differential diagnosis and management approach for a patient with hypernatremia.
- Discuss the risks of rapid fluctuation in serum osmolality. What is the recommended rate of increase or decrease in patients with abnormal sodium levels?
- Outline a differential diagnosis and appropriate management approach for patients with hypo or hyperkalemia and hypo or hypercalcemia.

DKA and Hyperosmolar Hyperglycemic States

- Compare and contrast the diagnosis and treatment of diabetic ketoacidosis with hyperosmolar nonketotic hyperglycemic state? What percentage of patients with type II diabetes out of control leading to hospital admission have a weakly positive serum acetone due to starvation or relative insulin deficiency?
- Understand the pharmacokinetics (onset, peak, duration) of the various insulins and use that to describe appropriate management changes in patients with fasting and postprandial hypo and hyperglycemia.
- Understand the mechanisms of action, side effects and toxicities of the classes of oral hypoglycemic agents.
- Ask the AIMS Advanced Practice Nurse about the blood sugar monitor that is most comfortable for patients to use. Call a retail pharmacy and find out how much 50 test strips cost.
- Define “Somogyi Effect” and its relevance in managing Diabetes Mellitus?
- Outline the signs and symptoms of hypoglycemia.

Osteomyelitis and Cellulitis
- Outline an appropriate approach to the diagnosis and management of patients with a neuropathic foot ulcer, including assessment for osteomyelitis.
- Compare and contrast the appearance, evaluation, and management of erysipelas, cellulitis, and necrotizing fasciitis.
- Outline the clinical characteristics and appropriate management with Streptococcal or Staphylococcal Toxic Shock Syndrome?

Anemia and Gastrointestinal Bleeding
- Outline the causes of microcytic and macrocytic anemia.
- Discuss the clinical features helpful in assessing the severity of acute GI bleeding and their contribution to the decision of whether to transfuse.
- Outline the types of transfusion reactions and an appropriate management approach when a transfusion reaction is suspected.
- With current screening protocols, outline the infectious risks of blood transfusion.

Thyroid Abnormalities
- What are the effects of acute illness and hospitalization on TSH, T4 and T3?
- Outline an appropriate evaluation and management plan for a patient with hyperthyroidism / thyroid storm.
- Understand the potential complications of rapid thyroxine replacement in a patient with hypothyroidism and coronary artery disease.

Pancreatitis
- Outline the causes of acute pancreatitis, there relative frequency, and an appropriate diagnostic evaluation.
- Outline the clinical and laboratory features indicative of more severe acute pancreatitis?
- Outline the local and systemic complications of acute pancreatitis?
- Outline the appropriate management of acute pancreatitis and chronic pancreatitis.
- Outline the appropriate management of necrotizing pancreatitis and pseudocyst.

Miscellaneous

- Identify the presenting characteristics patients intoxicated with or withdrawing from the following substances:
  - Alcohol
  - Cocaine
  - Amphetamines
  - Opiates
  - Gamma-hydroxybutyrate
- Discuss an appropriate approach to management of insomnia in the hospitalized patient.
- Define the appropriate use of restraints. Describe various ways to prevent falls and injuries in the hospitalized patient.
- Define the difference between competency and decisional capacity. Describe useful components of a family meeting and the steps needed to communicate goals, plans and prognosis.
- Define delirium and list 10 common reasons why patients develop it while hospitalized. What initial tests should you check? List 5 non-pharmacologic measures you can order to manage delirium.
- Describe an appropriate initial evaluation and management of a patient with syncope.
- Work with the AIMS pharmacist to understand the categories of drug categories used to control nausea. How do you limit the use of high-dose anti-emetics (and thus, the side effects)?
- Review with the AIMS pharmacist the acute and chronic pain management protocols. Understand the side effects, routes of administration and bio-equivalence of each medication. Describe the appropriate use of a PCA pump and how to transition someone from PCA or IV to other medication delivery systems

Methods of Assessment of medical knowledge

- Case presentations and discussion with faculty
- Review of the assessment portion of written notes
- Multiple Choice Question Exam (post-test questions)
- Performance on …. portion of annual In-Training Examination

Communication

Objectives

- Residents are expected to demonstrate interpersonal and communication skills that
  - o Result in effective information exchange and dialogue with patients, patient's families, and professional associates.
  - o Create and sustain a therapeutic and ethically sound relationship with patients and families, including in the discussion of end-of-life issues.
  - o Allow residents to work effectively with others as a member of a health care team
  - o Result in comprehensive, accurate and legible records
- Ask at least 2 nurses and 1 pharmacist for their honest opinions about how legible your notes and orders are.

Methods of Assessment of Communication Skills

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion with attending faculty
- Review of written notes and consults
- Feedback from nursing, support staff, patients and family members

Documentation of Evaluation

- New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
- Mini-CEX Form
- Written evaluations of H&P's, Progress Notets, D/C Summaries
- Praise/Concern Card (available but not required)

Professionalism

Objectives

- Residents must demonstrate a commitment to
  - Excellence in carrying out professional responsibilities and respecting patient confidentiality.
  - Demonstrating respect, compassion, altruism, integrity, and accountability
  - Demonstrating sensitivity and responsiveness to patient's culture, age, gender, social situations and unique needs
  - Creating and sustaining a therapeutic and ethically sound relationship with patients and their families.
  - Self awareness, self-improvement, and continuous professional development.

Methods of Assessment of Professionalism

- Direct observation of interactions with patients, nurses and peers
- Case presentations and discussion
- Review of written notes and/or consults
- Feedback from nursing, support staff, patients and family members

Practice-based Learning and Improvement

Objectives

- Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of GIM inpatients. Each resident will be able to:
  - Identify deficits in his/her own medical knowledge and patient care skills
  - Locate, critically appraise, and assimilate evidence from scientific studies and apply this to his/her own patients' health problems, with evidence of appropriate changes in practice patterns. The resident will complete at least one Practice / Evidence-Based Learning Exercise for presentation to the team.
  - Use information technology to manage information, access on-line medical resources, and support self-education, patient care decisions and patient education.
  - Present the results of independent literature reviews at small group teaching rounds.

Methods of Assessment of Practice-based Learning and Improvement

- Serial discussions with the attending faculty regarding management plans
- Presentations to attending faculty & team of the results of personal literature searches with discussion of implications for management plans
- Review of written notes and consults on assigned patients

Systems-based Practice

Objectives

- Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of GIM inpatients. Residents will:
- Practice cost effective health care and resource allocation.
- Advocate for quality patient care and assist patients in dealing with the health care system.
- Productively and cooperatively participate in a multidisciplinary approach to patient management.
- Work cooperatively as a team member with support staff in the hospital.
- Understand the role of the P&T Committee in managing medication use.
- Meet with a Discharge Planner to understand the services they offer.
- Attend scheduled didactic sessions with RT, PT, OT, ST, Pharmacist.

Methods of Assessment of Systems-Based Practice

- Observed performance in resource utilization in the hospital and outpatient office.
- Observed relationships in small group sessions and on the nursing units.
- Case presentations that include a focus on the implications of multidisciplinary resources and health care systems.
- Feedback from nursing, support staff, patients and family members

Appendix A: Reading List

Texts:

Cecil, Russel L (ed). **Cecil Textbook of Medicine**. 2004. Saunders, Phila

Websites:

Harrison's Online: *Harrison's Principles of Internal Medicine, 17th Edition*
http://www.accessmedicine.com/resourceTOC.aspx?resourceID=4

Articles (to be supplemented by AIMS attendings):

ACC/AHA 2005 Guideline Update for the Diagnosis and Management of **Chronic Heart Failure** in the Adult. *Circulation* 2005;112: e154-e235.
http://circ.ahajournals.org/cgi/reprint/112/12/e154?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=112&firstpage=e154&resourcetype=HWCIT

ACC/AHA 2007 Guidelines on **Perioperative Cardiovascular Evaluation** and Care for Noncardiac Surgery. *Circulation* 2007;116: 1971-1996.

http://circ.ahajournals.org/cgi/reprint/116/17/1971?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=116&firstpage=1971&resourcetype=HWCIT

Risk Assessment for and Strategies To Reduce **Perioperative Pulmonary Complications** for Patients Undergoing Noncardiothoracic Surgery: A Guideline from the ACP. *Ann Intern Med.* 2006;144: 575-580.
http://www.annals.org/cgi/search?sendit=Search&pubdate_year=2006&volume=144&firstpage=575&author1=&author2=&title=&andorexacttitle=and&titleabstract=&andorexacttitleabs=and&fulltext=&andorexactfulltext=and&resourcetype=1%2C10&fmonth=Jan&fyear=1993&tmonth=Mar&tyear=2008&fdatedef=1+January+1993&tdatedef=18+March+2008&RESULTFORMAT=1&hits=10&hitsbrief=25&sortspec=relevance&sortspecbrief=relevance&bcsi_scan_24E4C0F8750746C8=08GrkeoN7kFncMu6Mpo+qgEAAABnZP4A

ACC/AHA 2007 Guidelines for the Management of Patients With **Unstable Angina/Non–ST-Elevation Myocardial Infarction**. *Circulation.* 2007;116:e148-e304.
http://circ.ahajournals.org/cgi/reprint/116/7/e148.pdf?bcsi_scan_24E4C0F8750746C8=XARDyqiaVp5D/YheMrP1BQEAAACm3usA&bcsi_scan_filename=e148.pdf

Acute **Pulmonary Embolism**. *N Engl J Med.* 2008;358:1037-52.
http://content.nejm.org/cgi/reprint/358/10/1037.pdf

Testing for **Thrombophilia**: an evidence-based approach. *Postgrad. Med. J.* 2006;82: 699-704.
http://pmj.bmj.com/cgi/reprint/82/973/699?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=82&firstpage=699&resourcetype=HWCIT

Guidelines for the Early Management of Adults With **Ischemic Stroke**. *Stroke.* 2007;38:1655-1711.
http://stroke.ahajournals.org/cgi/reprint/38/5/1655?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=38&firstpage=1655&resourcetype=HWCIT

IDSA / ATS Consensus Guidelines on the Management of **Community-Acquired Pneumonia** in Adults. *Clinical Infectious Diseases.* 2007; 44: S27–72.
http://www.journals.uchicago.edu/doi/pdf/10.1086/511159

Global strategy for the diagnosis, management, and prevention of **COPD**: GOLD executive summary. Am J Respir Crit Care Med. 2007; 176(6): 532-55.
http://ajrccm.atsjournals.org/cgi/reprint/176/6/532?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=1&FIRSTINDEX=0&volume=176&firstpage=532&resourcetype=HWCIT

Normotensive Ischemic **Acute Renal Failure**. *N Engl J Med.* 2007; 357: 797-805.
http://content.nejm.org/cgi/reprint/357/8/797.pdf

In addition to your own literature searches, please refer to the bibliography at the end of each section in MKSAP 14 (available in the Internal Medicine Med Ed Office) for relevant articles related to your patients' problems.

Appendix B: Reading List

Texts:
Mandell, Douglas, and Bennett's Principles & Practice of Infectious Diseases. 6th edition. Churchill Livingstone.
Manson's Tropical Diseases, Cook et al (eds). 21st edition. Saunders.
Websites:
National Center for Infectious Diseases http://www.cdc.gov/ncidod/
Infectious Disease Society of America http://www.idsociety.org
Morbidity and Mortality Weekly Report http://www.cdc.gov/mmwr
Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm.
DHHS panel on antiretroviral guidelines for adults and adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
Specific recommendations for vaccinations and disease prevention. http://www2.ncid.cdc.gov/.

Articles (to be supplemented by ID attendings and housestaff):
Please see the bibliography at the end of each section in MKSAP 14 – Infectious Diseases (available in Internal Medicine Med Ed Office) for a current summary of relevant articles for each topic in Infectious Diseases.
It is your responsibility as the Infectious Disease Resident to recommend additions or subtractions from this reading list. An acknowledgement of this process is included in the Checklist of Requirements for this rotation.
American College of Physicians/Society of Critical Care Medicine Consensus Conference: definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. Crit Care Med. 1992; 20:864-74.
American Thoracic Society; CDC; Infectious Diseases Society of America. Treatment of tuberculosis. MMWR Recomm Rep. 2003;52(RR-11):1-77.
Bartlett JG Update in Infectious Diseases. Annals of Internal Medicine. 2006;144:49-56.
Crowder CD, Gyure KA, Drachenberg CB, Werner J, Morales RE, Hirsch HH, et al. Successful outcome of progressive multifocal leukoencephalopathy in a renal transplant patient. Am J Transplant. 2005;5:1151-8.
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Acknowledgments: University of Illinois, Peoria; Michigan State University.
Put ID rotation Checklist here:

Recommended additional activities for enhanced competency:

- Schedule a meeting with the HIV Care Coordination office (Teri Nelson Caldwell 338-6714) to discuss the resources available to patients with HIV infection.
- Schedule a tour of the Microbiology Lab to better understand the process of culture and sensitivity testing.
- Attend a meeting of the Infection Control Committee
- Attend a meeting of the Pharmacy & Therapeutics Committee

NEUROLOGY ELECTIVE CURRICULUM

INTRODUCTION

The neurology curriculum is designed to teach the resident the appropriate evaluation and management of neurologic diseases as outlined in the goals below. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: Mark Janicki, MD[1]; David Josephson MD[2]
Rotation site(s): Indiana Neuroscience Associates,
8333 Naab Road, Suite 260, Indianapolis, IN 46260
Tel: 317.570.7900
JWM Neurology
8402 Harcourt Road, Suite 615,Indianapolis, IN 46260
Tel: 317.806.6991
Rotation duration: up to 4 weeks
Rotation status: Elective
Residents: 1 resident per month, any training level
Duty Hours: Monday-Friday daytime office hours,
Required conferences: Program conferences only
Evaluation: New Innovations electronic evaluation specific to Podiatry/Neurology Rotation

Purpose:

The Neurology rotation is a key component of the larger residency Neurology experience. The purpose of the neurology rotation is to help meet and evaluate the competencies in the care of patients with neurologic diseases outlined below.

Activities:

The resident on the neurology rotation will be under the direct supervision of a board certified neurologist and they will adhere to the residency program supervision rules. Residents will function as a primary physician and/or consultant in the inpatient and outpatient settings. They

will see a diverse population of adult patients ranging in age from adolescents to geriatric patients with a variety of acute and chronic neurologic diseases. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with neurologic diseases. Inpatient teaching rounds will occur whenever the resident is assigned to inpatient neurology and outpatient precepting will occur at least 30 minutes per half day clinic session.

GOALS (from FCIM2)

Neurology encompasses the prevention and management of disorders of the central and peripheral nervous systems. Other conditions, such as headache, may be caused by non-neural dysfunction but are often considered under the category of neurology.

The general internist should possess a broad range of competency in neurology. He or she should be able to perform and interpret a detailed neurologic examination; should be competent in the primary and secondary prevention of neurologic diseases; and should be familiar with the presenting features, diagnosis, and treatment of common neurologic disorders.

The podiatrist may encounter neurologic disorders in various settings, including ambulatory care, hospital, long-term care, and home care. In communities where a neurologist is not available, the general internist may be a consultant for some complex neurologic disorders (for example, control of status epilepticus).

NEUROLOGY COMPETENCIES – see competencies curriculum for detailed description

The following are competencies in relation to the neurology curriculum with assessment methods and evaluation tools. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the Competencies core curriculum.

PATIENT CARE:

Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with neurologic diseases.

General Neurologic Patient Care Objectives

In a patient with neurologic disease:

- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating and assessment and plan of care
- Understand indications/interpretations of testing related to neurologic diseases
- Perform and/or interpret procedures/tests pertinent to care of patient
- Understand the indications for referral of patients with neurologic diseases
- Plan appropriate disposition and follow-up for patients with neurologic diseases
- Document adequately and appropriately above in the medical record

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Case presentation and discussion
- Review of written note(s) and/or consult(s)

- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE:
Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to care of patients with neurologic diseases.

General Neurology Medical Knowledge Objectives (from FCIM2)
Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following neurology topics:

- **Benign positional vertigo**
- **Central nervous system infection**
    - Brain abscess
    - Encephalitis
    - Meningitis
- Labyrynthitis
- Lumbar disk syndromes
- Multiple sclerosis
- **Neuromuscular disease**
    - Amyotrophy
    - Guillain-Barré syndrome
    - Multiple sclerosis
    - Muscular dystrophy
    - Myasthenia gravis
    - Myopathy
- Parkinson's disease
- Peripheral neuropathy
- Spinal stenosis
- Toxic encephalopathies, e.g. alcohol withdrawal (see also substance abuse)

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam

PRACTICE BASE LEARNING AND INPROVEMENT:
Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with neurologic diseases.

General Neurology PBLI Objectives

- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

INTERPERSONAL AND COMMUNICATION SKILLS:

Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with neurologic diseases.

General Neurology ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a health care team
- Communicate effectively with patients and their families
- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assesment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

PROFESSIONALISM:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients with neurologic diseases.

General Neurology Professionalism Objectives

- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods

- Direct observation of history, physical exam, or patient education / counseling
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

SYSTEMS-BASED PRACTICE:

Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with neurologic diseases.

General Neurology Systems-Based Practice Objectives

- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care
- Develop an understanding of the importance of physiatry, palliative care, and occupational / physical / speech therapies in neurologic disorders.
- Gain an appreciation of the role of patient support groups, web forums, and dedicated caregiver support in neurologic illness.

Assessment Methods

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

LEARNING METHODS/VENUES/RESOURCES

Learning Methods

- Direct patient care in outpatient/inpatient setting
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds
- Conference attendance
- Self-directed learning

Learning Venues

- Neurology rotation
- Primary Care Center Longitudinal Ambulatory Clinic
- Adult Inpatient Medicine Service Rotation

Learning Resources

- St Vincent Medical Library
- Up to Date
- MKSAP 12 / Medstudy Neurology Section
- Hopkins Modules
- Assigned Reading materials

ORTHOPEDICS CURRICULUM

INTRODUCTION

The field of Orthopedic Surgery is very similar to the principles and techniques commonly used in Podiatric Surgery and thus experience in this field can serve a vital purpose in the training of a Podiatric Surgical Resident. This experience will be one month in duration and will occur in the second and third years of training. The purpose of this experience is to expose the resident to the work-up, management and long term care of the orthopedic patient. The resident will be exposed to the pre and post management of the orthopedic patient with a heavy emphasis on surgical principles and potential complications. The principles of casting, traction and immobilization will also be addressed. The Podiatric resident will make daily rounds with the Orthopedic Attendings. The resident will also be involved with Emergency room coverage of orthopedic patients under the supervision of the Orthopedic surgeon on call. The resident will also be exposed to office based work up and treatment of the orthopedic patient.

ROTATION SUMMARY

Rotation Directors: currently being discussed
Rotation Site: St. Vincent Hospital (Surgical Pavillion) or outside locations to be determined
Rotation Duration:2- 4 weeks
Rotation Status: Required
Duty Hours: Day shifts
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Orthopedic Rotation

ROTATION GOALS

- Understand normal anatomy and physiology of musculoskeletal system
- Be familiar with normal growth and development
- Become proficient in musculoskeletal history taking and physical examination
- Learn appropriate use of laboratory testing as pertains to bone, joint and muscle disorders.
- Understand the use of radiologic procedures in the care of patients with orthopedic problems
- Understand the pathogenesis/pathophysiology/recognition of common musculoskeletal conditions, both congenital and acquired
- Understand the diagnosis, therapy (surgical and nonsurgical), and rehabilitation of common acute and chronic musculoskeletal injuries
- Be able to discuss the prevention of injuries and medical conditions of the musculoskeletal system.
- The residents will learn procedures necessary to care for fractures, sprains and strains, joint effusions, bursitis and tendinitis, and arthritis

ROTATION OBJECTIVES

- The residents will have knowledge of normal anatomy, physiology, growth, and development.

- The residents will demonstrate ability to perform an appropriate history and physical examination of the cervical, thoracic, and lumbar spine, the shoulder, elbow, wrist, fingers, hips, knee, ankle, and foot.
- Residents will demonstrate knowledge of the appropriate use of plain films, MRI, CT scan, and bone scan for evaluation of musculoskeletal problems.
- Residents will demonstrate understanding of the pathogenesis/pathophysiology/recognition of the following:
    - joint pain, swelling and erythema
    - muscular pain, swelling and injury
    - musculoskeletal trauma including fractures, dislocations, tendon and nerve injuries, bone and joint deformities
    - bone and joint infections
    - metabolic bone diseases
    - musculoskeletal congenital anomalies
    - musculoskeletal birth injuries
    - child battering
    - compartment syndrome
    - avascular and necrosis

- Residents will be exposed to and demonstrate an understanding of the management of common pediatric problems including the following:
    - hip dislocation/DDH
    - Legg Calve-Perthes disease (LCP)
    - slipped capitofemoral epiphysis (SCFE)
    - club foot
    - in toeing, bow legs, knock knees
    - epiphyseal injuries in children

- Residents will understand the use of therapy and rehabilitation in the treatment of orthopedic problems
    - use of patient education for home exercise programs
    - pharmacologic treatment using NSAIDs, steroids, muscle relaxants, antibiotics
    - appropriate use of supportive and corrective devices including braces and corrective shoes
    - rehabilitation principles including use of modalities, occupational therapy, were gardening and disability
- Residents will be familiar with common orthopedic surgical procedures including operative placement of wires, pins and plates as well as artificial joint replacement
- Residents will demonstrate understanding in care of simple, stable, closed and non -displaced fractures.
    - metacarpal, metatarsal, phalangeal fractures
    - forearm, single bone midshaft
    - humerus
    - clavicle

    - ribs
    - vertebrae, lumbar or thoracic compression type
    - pelvis, excluding interruption of the pelvic ring
    - patella
    - lower leg, single bone mid shaft
    - unimalleolar ankle
    - calcaneus
- Residents will understand appropriate care of Sprains and strains
    - finger
    - toe
    - ankle
    - knee
    - vertebral column
    - wrist
    - elbow
    - shoulder
    - neck
- Residential will understand the management of the following:
    - costochondritis
    - bursitis/tendinitis/tenosynovitis
    - nursemaid and Little League elbow
    - osteochondromatoses
    - osteoarthritis
    - metabolic bone disease including osteoporosis and Paget's disease
    - acute and chronic low back pain
- Residents will know the indications, contraindications, and be able to perform the following procedures:
    - joint aspiration and injection
    - splinting of upper and lower extremities using plaster and/or fiberglass
    - fiberglass casts including short leg, short and long arm
    - dislocation reduction of simple anterior shoulder, radial head, simple posterior elbow, phalanges, patella
    - traction application
- Residents will understand advanced care features for specific problems:
    - closed tarsal and carpal fractures particularly navicular
    - Colles
    - meniscal tears
    - recurrent shoulder dislocation

CURRICULUM DESIGN

Residents will rotate on a one month block rotation with one or more orthopedic groups that admit their patients to St. Vincent hospital. Residents will divide their time between the ambulatory clinic setting with their orthopedic preceptor and the operating room in order to

become familiar with common orthopedic surgical procedures. The daily clinical assignments will be made by the rotation director.

RECOMMENDED READINGS

Snyder, Robert K., Essentials of Musculoskeletal Care. American Academy of Orthopedic Surgeons, 1997

Reider, Bruce. The Orthopedic Physical Examination. Philadelphia PA, W. B Saunders, 1999

PAIN MANAGEMENT ELECTIVE CURRICULUM

INTRODUCTION

The Pain Management curriculum is designed to teach the resident the appropriate evaluation and management of pain syndromes as outlined in the goals below. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues. Realization that a cure for most pain syndromes is not possible changes the focus of the doctor-patient relationship from one of cure to one of comfort and palliation. Being knowledgeable about technologic advancements and their appropriate use in the care of acute and chronic pain is increasingly important. Using a holistic approach to encompass the patient's psychosocial wellbeing, physical wellbeing, family dynamic, and quality of life makes the podiatrist well suited to this care.

ROTATION SUMMARY

Rotation Director: David Ratzman, MD
Rotation site(s): private office, varies
Rotation duration: 2 weeks
Rotation status: Elective
Residents: 1 resident per month, any training level
Duty Hours: Monday-Friday daytime office hours
Required conferences: Program conferences only
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Pain Management Rotation

ROTATION GOALS / OBJECTIVES

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

Competencies

- Be able to negotiate a treatment plan for ill patients based on the patient and family's expressed values, goals and needs.

- Be able to communicate how the plan will be implemented with the patient and family.
- Maintain flexibility in implementing the plan when conditions change.
- Integrate knowledge of local palliative and hospice resources for terminally ill pts

Objectives

- Demonstrate effective and appropriate communication skills when interacting with patients and their families.
- Identify, appreciate, and incorporate spiritual, religious, and cultural beliefs and customs in negotiating a treatment plan.
- Gather essential and accurate information from the history and physical assessment.
- Demonstrate recognition, assessment, and management of pain syndromes.
- Demonstrate knowledge about benefits and drawbacks of different care locations.
- Demonstrate effective and appropriate use of technology, that is understanding when useful (palliative) and when futile

Medical Knowledge

Goal

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents are expected to:

Competencies

- Demonstrate a solid foundation of core knowledge of common conditions and complications specific to acute and chronic pain management.

Objectives

- Be able to estimate prognosis of terminal illness
- Knowledge about the philosophy of palliative care
- Management of major pain syndromes, including initial and ongoing assessment
    - Neuropathic pain
    - Bone pain
    - Visceral pain
    - Non-physiologic pain
- Effective use of alternative routes of analgesia
- Treatment of non-pain syndromes
    - Nausea
    - Dyspnea
    - Anorexia
    - Vomiting
    - Sleeplessness
    - Depression
    - Anxiety
    - Cough
    - Constipation
    - Diarrhea
    - Dry mouth

Practice-Based Learning and Improvement

Goal

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life long learning. Residents are expected to develop skills and habits to be able to :

Competencies

- Identify strengths, deficiencies and limits in one's knowledge and expertise;
- Understand the impact of personal experience (negative or positive) on the delivery of pain management.
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
- Use information technology to optimize learning

Objectives

- Demonstrate improvement of in-service exam scores.
- Effect holistic and humane patient care

Systems Based Practice

Goal

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

Competencies

- Coordinate patient care within the health care system relevant to their clinical specialty
- Advocate for quality patient care and optimal patient care systems
- Work in multidiscipliary teams to enhance patient safety and improve patient care quality

Objectives

- Integrate knowledge of local pain management resources
- Identify and understand roles and abilities of local and state resources
    - City/community
        - Public and private organizations
    - County
    - State

Professionalism

Goal

- Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

Competencies

- Compassion, integrity, and respect for others
- Respect for patient privacy and autonomy
- Understand the impact of personal experience (negative or positive) on the delivery of pain management and palliative care

    - Striving to balance and potentially mitigate personal feelings/convictions in identifying patient preferences and negotiating treatment plans.

Objectives

- Demonstrate respectful behavior towards patients and families, as well as colleagues and others on the healthcare team.
- Assess patient needs via, and maintain communication, with patient and caregivers.
- Maintain appropriate medical record keeping commensurate with the regulations of the place of service.
- Demonstration (when appropriate) of self-care and seeking support when patients die.

Interpersonal and Communication Skills

Goal

- Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Competencies

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies
- Work effectively as a member of a health care team or other professional group

Objectives

- Assess patient care preferences through effective communication with patient and his/her caregiver(s).
- Demonstrate effective counseling of patient and others
    - Grief reaction
    - Continuing relationships
- Demonstrate knowledge of the ethical and legal issues that may affect carrying out the persons preferences.
- Skillfully negotiate treatment decisions with the terminally ill patient and his/her family, including concepts of medical futility.

ASSESSMENT METHODS

- Preceptor evaluations and in-service exam scores.
- 360 evaluations

PATHOLOGY CURRICULUM

INTRODUCTION

The resident will obtain a general knowledge of assessment of pathologic specimens beginning with the obtaining of a gross specimen, preparing of the specimen for evaluation, the technical

aspects of microscopic and macroscopic evaluation, and then interpreting of the specimen. The podiatric surgical resident will be under the discretion and direction of the pathology director.

ROTATION SUMMARY

Rotation Director: Daniel Klink, MD dklink@ameripath.com
Rotation Site: St. Vincent Hospital
Rotation Duration: 2 weeks
Rotation Status: Required
Duty Hours: Day shifts
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: New Innovations electronic evaluation specific to Podiatry/Pathology Rotation

ROTATION GOALS

- Resident will show knowledge of use of light microscopy, electron microscopy, and
- macroscopy.
- Resident will demonstrate knowledge of laboratory assessment of pathology specimens.
- Resident will show ability to prepare and fix specimens
- Resident will demonstrate knowledge of microscopic specimens and how they relate to a possible disease.

ROTATION OBJECTIVES

During the Pathology rotation, the podiatry resident will achieve the following:

- The pathology experience will be 2 weeks total, obtaining at a minimum 10 half day sessions before the end of the month.
- The resident will be involved with obtaining pathology specimens.
  The resident will be involved with analysis of microscopic specimens.
- The resident may participate in the preparing of specimens for evaluation.
- The resident may participate in the technical aspects of the equipment and operation.
- The resident will prepare and present to the pathology director a concise overview with a literature search and article presentation once per week on a topic selected by the pathology director.

PEDIATRIC ORTHOPEDICS CURRICULUM

Contact Person: TBD

Goals & Objectives

GOAL 1. Normal vs. Abnormal. Understand how to differentiate between normal and pathological states related to orthopedics.

PRIMARY COMPETENCIES:

- Knowledge
- Patient Care

OBJECTIVES:

1. Identify normal growth and development from birth to adolescence relative to the musculoskeletal system.

2. Demonstrate a complete orthopedic history and physical exam which can distinguish normal variants from true pathology.

GOAL 2. Common Conditions Not Referred. Understand how to diagnose and manage orthopedic conditions generally *not requiring* a referral.

PRIMARY COMPETENCIES:
Knowledge
Patient Care

OBJECTIVES:

- Recognize, describe the pathophysiology of, and manage these conditions:
    - Minor trauma
    - Simple stable fractures
    - Overuse syndromes
    - Nursemaid's elbow
    - Benign lower extremity alignment/ rotation deformities
    - Patellofemoral pain
    - Ganglions
- Toxic synovitis
- Scoliosis <20 degrees

GOAL 3. Conditions Generally Referred. Understand how to recognize and initiate management of orthopedic conditions which generally *require* referral.

PRIMARY COMPETENCIES:
Knowledge
Patient Care

OBJECTIVES:

- Identify and provide initial management of and know how to refer appropriately these conditions:
    - Legg-Calve-Perthes disease
    - Back and neck conditions
    - Talipes Equinovarus (Clubfoot)

    - Dislocations of joints
    - Unstable fractures
    - Major ligament injuries
    - Osteochondritis dissecans
    - Scoliosis >20 degrees
    - Bone and joint infections
    - Slipped capital femoral epiphysis
    - Spondylolysis/ Spondylolisthesis
    - Tarsal coalition
    - Leg length discrepancy
    - Child abuse
    - Bone and soft tissue tumors
    - Neuromuscular disorders
    - Pathologic angular / rotation deformities
    - Developmental dysplasia of the hip

GOAL 4. Orthopedic Complications. Understand the orthopedic complications of chronic pediatric illnesses.

PRIMARY COMPETENCIES:
Knowledge

OBJECTIVES:
- Describe orthopedic complications of the following chronic illnesses:
    - Cerebral palsy
    - Neuromuscular disease
    - Myelomeningocele
    - Renal failure
- Osteogenesis imperfecta

GOAL 5. Prevention. Understand the importance of screening for orthopedic problems and prevention of orthopedic injuries in the pediatric population.

PRIMARY COMPETENCIES:
Knowledge
Systems-based practice

OBJECTIVES:
- Understand the purpose and methods of screening for the following
- conditions:
    - Developmental dysplasia of the hip
    - Scoliosis
- Learn how to promote safe play and sports

PLASTIC SURGERY

INTRODUCTION

This training experience will include direct participation of the resident in surgical evaluation and management of non-podiatric patients. The podiatric surgical resident will be exposed to the fine and intricate methods of proper tissue handling. The resident will also be exposed to a variety of wound closure techniques.

ROTATION SUMMARY

Rotation Director: Jason Blocksom, MD
Rotation Site: St. Vincent Hospital (Surgical Pavilion)
Rotation Duration: 2 weeks
Rotation Status: Elective

Duty Hours: Day shifts

Required Conferences: Program conferences and rotation-specific conferences
Evaluation: New Innovations electronic evaluation specific to Podiatry/Plastic Surgery Rotation

GOALS

The resident will develop competencies and experiences in:

- Physiology of wound healing
- Skin grafting principles and techniques
- Tendon repair
- Nerve repair
- Repair and reconstruction of skin wounds
- Competence in utilizing various suture techniques
- Skin flap and tension reduction surgical technique
- Management of keloids and hypertrophic scars
- Management of plastic surgical aspects of acute
- Various incisional techniques
- Tissue dissection techniques
- Frequently used plastic surgery instrumentation
- Advanced suture techniques
- Flaps and grafts as they pertain to the foot and ankle

OBJECTIVES

- The resident should be exposed to various techniques
- The resident should become proficient in tissue dissection techniques
- The resident should gain exposure to commonly used instrumentation
- The resident should gain exposure to and become proficient in suturing techniques
- The resident should develop an understanding of flaps and grafts as they pertain to the foot

PM & R ELECTIVE CURRICULUM

INTRODUCTION

Podiatrists frequently interface with the field of Physical Medicine and Rehabilitation for acute, chronic and developmental problems related to the lower extremity. The purpose of this experience is to expose the resident to principles and practice of PM&R, including the work-up, management and long term care of patients needing these health care services. The Podiatric resident will make daily hospital rounds with the attending. The resident will also be exposed to office based work up and treatment of PM&R patient.

ROTATION SUMMARY

Rotation Site: St. Vincent Hospital
Rotation Duration: up to 4 weeks
Rotation Status: Elective
Duty Hours: Day shifts plus podiatry call
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: End of month rotation evaluation, praise and concern cards

ROTATION GOALS / OBJECTIVES

GOAL 1. Normal vs. Abnormal. Understand how to differentiate between normal and pathological states related to physical medicine and rehabilitation.

PRIMARY COMPETENCIES:
Knowledge
Patient Care

OBJECTIVES:

- Identify normal growth and development for age, including motor, cognitive, language, social development, and physical growth.

- Understand the role of assessment tools in general management of adult and pediatric rehabilitation, including general health measures, developmental attainment measures, functional measures, and specific outcome measures.

GOAL 2. Common Conditions. Understand how to assess and manage common physical medicine and rehabilitation problems in children and adults as related to podiatric medicine.

PRIMARY COMPETENCIES:
Knowledge
Patient Care

OBJECTIVES:

- Recognize, describe the pathophysiology of, and manage these *inpatient* conditions:
  - Traumatic brain injury
  - Spinal cord injury
  - Skin management
  - DVT prophylaxis
  - Feeding disorders/ Nutrition
  - Infectious diseases
  - Psychosocial/ behavioral complications
  - Hypertonia management
  - Contracture management and prevention
  - Community and School reintegration

- Recognize, describe the pathophysiology of, and manage these *outpatient* conditions:
  - Spinal defects (spinal dysraphism/ spina bifida, spinal cord injury)
  - Neuromuscular disorders (muscular dystrophy, neuropathy, myopathy, neuromuscular junction disorders, peripheral nerve injury)
  - Pediatric amputee/ limb deficiency management (prosthetics)
  - Tone management (general spasticity, baclofen pump, intramuscular botulinum toxin injections, phenol injections)
  - Musculoskeletal disorders (brachial plexus palsy, scoliosis management, growth associated changes, gait abnormalities)
  - Prescription of specialized equipment for children and adults with disabilities (seating/ wheelchairs and positioning, orthotics, prosthetics- upper/lower extremity, activity of daily living aids, interfaces/ environmental control technology, augmentative communication technology)

GOAL 3. Comprehensive Treatment. Understand the multidisciplinary approach to treatment and major diagnostic and treatment modalities of the pediatric rehabilitation patient.

PRIMARY COMPETENCIES:
Knowledge
Patient Care
Systems-Based Practice

OBJECTIVES:

- Be actively involved in the multidisciplinary evaluation and treatment team.
- Describe electrodiagnostic tests, including EMG/ nerve conduction studies, intraoperative monitoring/ SSEP, NMEP, and ERG/VEP.

- Describe appropriate therapies for the pediatric rehabilitation patient including the following:
  - Early intervention
  - Therapeutic programming (OT, PT, Speech/ language therapy)
  - Discharge planning
  - Educational planning
  - Transitional planning
  - Wellness and health promotion
  - Prevention strategies
  - Therapy modalities (serial casting, ultrasound, therapeutic electrical stimulation)
  - Medications

CURRICULUM DESIGN

Residents will rotate on a block rotation with one or more PM&R physicians that admit their patients to St. Vincent Hospital. Residents will divide their time between the ambulatory clinic setting and the hospital setting with their preceptor. The daily clinical assignments will be made by the rotation director.

PODIATRIC MEDICINE CURRICULUM

INTRODUCTION

The rotation in podiatric medicine will allow the resident to prevent, diagnose, and medically manage diseases, disorders, and injuries of the pediatric and adult lower extremity. Learners will gain the confidence in distinguishing conditions that can be managed in the outpatient setting and those that require more acute surgical intervention and/or hospitalization. The resident will gain broad knowledge and skills that build sequentially over the course of the experience, allowing the resident to transition for a novice learner to a competent practitioner. This curriculum is accompolished utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: Shelly Bowers, DPM
Rotation Sites: Podiatry offices (AHN, Podiatry Clinic, etc.)
Rotation duration: 4 weeks
Rotation Status: Required
Duty Hours: Day shifts plus call
Required Conferences: All
Evaluation: New Innovations electronic evaluation specific to Podiatry/Podiatric Medicine Rotation

ROTATION GOALS/OBJECTIVES

During the course of study, they will be expected to achieve the following goals/objectives:

- Perform and interpret the findings of a thorough problem-focused history and physical exam, including problem-focused history, neurologic examination, vascular examination,

dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis.

- Formulate an appropriate diagnosis and/or differential diagnosis.
- Perform (and/or demonstrate the proposer ordering of) and interpret appropriate diagnostic studies, including:
    - Medical imaging, including plain radiography, stress radiography, fluroscopy, nuclear medicine imagine, MRI, CT, diagnostic ultrasound, vascular imaging.
    - Laboratory tests in hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screen, coagulation studies, blood gases, synovial fluid analysis, urinalysis.
    - Pathology, including anatomic and cellular pathology.
    - Other diagnostic studies, including electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressures.
- Formulate and implement an appropriate plan of management, including:
    - Direct participation of the resident in the evaluation and management of patients in a clinic/office setting.
    - Perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
    - Management when indicated, including:
        - dermatologic conditions
        - manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
        - closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation.
        - cast management
        - tape immobilization
        - orthotic, brace, prosthetic, and custom shoe management
        - footwear and padding
        - injections and aspirations
        - physical therapy
        - pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications
    - Surgical Management, when indicated including:
        - evaluating, diagnosing, selecting appropriate treatment and avoiding complications
        - progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas
    - Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedations anesthesia

- Consultation and/or referrals
- Lower extremity health promotion and educations

PODIATRIC SURGERY CURRICULUM

INTRODUCTION

The podiatric surgery curriculum is designed to teach residents the appropriate evaluation and surgical management of conditions commonly encountered in the practice of podiatry. This curriculum is designed to be an ongoing broad-based developmental experience throughout the 36 month training cycle, not a single month experience that will allow the resident to achieve competency and surpass the minimum surgical case volumes expected by the CPME. The resident will have exposure to a wide variety of techniques and surgical procedures by many different podiatric surgeons. It is expected that, through this curriculum, the resident will grow in their capabilities, transitioning from a novice surgery to a competent surgeon (and achieve mastery in some surgical techniques).

ROTATION SUMMARY

Rotation Director: Scott Hoffman, DPM
Rotation Sites: All St. Vincent Hospital Sites, various Surgery Centers that have been approved by the Rotation Director and GME leadership for training
Rotation Duration: 36 months (ongoing)
Rotation Status: Required
Duty Hours: Day shifts plus call
Required Conferences: All program conferences
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Podiatric Surgery Rotation

Darlenia F. Thomas
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Podiatric surgery staff physicians (on and off site)
Higgins, Blacklidge, Blackburn, DeHeer, Graves, Vogel, Kilberg, Gohil, Gumbiner, Elliott, Hoffman, Keyes, Isaacson, Malament, Mandresh, Helms, Chae, Perry, Schweikher, Bean, Vestile, Spaulding, Stuart, Kreuger
(There are others that the residents will work with throughout their training)

Off -Site Coordinators

Sycamore Springs Surgery Center– Shelly Bowers, DPM
Naab Road – Kellie Higgins, DPM
IU Arnett – Douglas Blacklidge, DPM
IU North – Douglas Blacklidge, DPM
STV Carmel – Christopher Winters, DPM
St. Francis (Indy & Mooresville) – Scott Neville, DPM
IPG – Noblesville – Scott Schulman, DPM
IPG – Columbus – Brandon Gumbiner, DPM
Major Hospital – Brian Elliott, DPM
Eagle Highlands SC – Scott Hoffman, DPM
STV Kokomo – Pratap Gohil, DPM
IU Tipton – Nathan Graves, DPM

ROTATION GOALS / OBJECTIVES

While the resident is on podiatric surgery, he/she will be expected to learn and become proficient in the following areas: PGY-1 expectations:

- Soft tissue and nail procedures including excision of soft tissue tumors, neuroma excision, incision and drainage, excision of foreign bodies.
- Toe surgery including arthroplasties, arthrodesis, sesamoidectomies, osteotomies, exostectomies.
- First ray procedures-bunionectomies with or without osteotomies, and with total or hemi implants
- Metatarsal procedures including osteotomies, lesser metatarsal osteotomies with or without implants, exostectomies.
- Midfoot-rearfoot procedures including heel spur excision, exostectomies, fasciotomies, tarsal tunnel decompressions, and debridement for osteomyelitis
- Proficiency in performing a podiatric biomechanical examination

The PGY-2 resident will be exposed to and understand as well as perform the following procedures:

- Thoroughly understand the anatomy and biomechanics of the rearfoot and ankle, and their bearing on function, choice of surgical procedure and outcome.
- Demonstrate knowledge of congenital, degenerative and traumatic pathology of the rearfoot and ankle, and current and historical surgical procedures for each class of pathology.

- Be able to select and apply appropriate rigid internal and external bone fixation, including screws, plates, pins, staples, anchors, and various external fixators.
- Understand the principles and technique of bone grafting
- Demonstrate proficiency in the performance of midfoot, rearfoot, and ankle surgery
    - Soft tissue procedures including wide excision and biopsy, tumor excisions, nerve decompression, and excision of foreign bodies.
    - Lengthening, transfer and repair of the tendons
    - Lateral and medial ankle ligaments repairs and stabilizations
    - Calcaneal osteotomies, their indications and techniques
    - Midtarsal, subtalar, and ankle fusions, with special attention to surgical approaches and fixation
    - Repair of congenital deformity of the midfoot and rearfoot, including clubfoot reductions, vertical talus and metatarsus adductus
    - Correction of flat foot and pes cavus conditions
    - Subtalar arthroeresis, emphasizing indications, biomechanics, implant design, and techniques
    - Classification and repair of ankle fractures
    - Arthroscopic diagnostic and operative techniques, including a thorough undertstanding of instrumentation, surgical approaches, and arthroscopic anatomy

The PGY-3 resident will build upon their knowledge gained in the podiatric surgery rotations over the past 2 years and refine that knowledge and skill base and will focus on the advanced procedures as well as fine tuning their skills with the procedures learned earlier in their training.

RADIOLOGY CURRICULUM

INTRODUCTION

The Radiology Curriculum is designed to help teach the Podiatry Resident fundamental clinical skills and the basics of diagnostic and/or interventional radiology including radiation therapy. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues. Radiology rotations are required as part of the Residency Curriculum and therefore all residents will meet all of these goals and objectives.

ROTATION SUMMARY

Rotation Director: Eric Elliott, MD eric.elliott@stvincent.org
Rotation site(s): St Vincent Hospital
Rotation duration 2 weeks
Residents: 1 resident per month
Duty Hours: Weekdays, 7 am – 5 pm
Conferences: Program conferences
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Radiology Rotation

ROTATION GOALS / OBJECTIVES

During Radiology rotations, the Podiatry resident will:

- Serve as a consultant under the supervision of a board certified radiologist or radiation oncologist and will care for patients with:
- a diverse range of medical and surgical conditions
- a wide range of ages from adolescents to the elderly
- a diverse socioeconomic and cultural population
- Practice the fundamental clinical skills required for effective and efficient patient evaluation and management
- Develop a basic working knowledge of common diagnostic and/or interventional radiology practices including radiation therapy
- Better understand how to deliver cost-effective, evidence-based, quality care
- Be effective communicators to colleagues, patients and their families (when appropriate) and other members of the health care system.
- Maintain a professional demeanor and be role models for others.
- Learn to identify deficiencies in knowledge and patient care skills and access the literature and other resources to improve these deficiencies
- Work to help patients and families navigate the healthcare system and seek to improve the system when possible and feasible.

SPECIALTY SPECIFIC COMPETENCY BASED OBJECTIVES

The following are competency based objectives in relation to the Radiology Curriculum. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the corresponding residency curriculum sections.

PATIENT CARE:

Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems in patients requiring radiology imaging and/or intervention including radiation therapy.

Radiology Patient Care Objectives

In a patient requiring radiology imaging and/or intervention including radiation therapy:

- Collect an adequate history and record review including prior imaging results
- Perform an appropriate and accurate physical exam when needed
- Use sound clinical judgment in formulating an assessment and plan
- Recommend follow-up as needed to address old and any new problems
- Understand indications/interpretations of radiology testing and treatment
- Perform/interpret basic radiology procedures/tests
- Understand the indications for consulting on these patients

Plan appropriate disposition / follow-up for these patients

Document adequately and appropriately the above in the medical record

Assessment Methods

- Direct observation of history and/or physical exam
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a radiologic test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE:

Residents are expected to demonstrate basic knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to the care of patients requiring radiology imaging and/or intervention including radiation therapy.

Radiology Knowledge Objectives

Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following radiology topics:

- The scope and function of radiology and radiation oncology practices
- The principles of radiology including physics and different imaging modalities
- Basic human anatomy including common normal variants
- The strengths/weakness of different imaging modalities for specific organs
- The concept of radiographic tumor staging for various solid tumors
- The acute and chronic complications of radiologic imaging and therapy
- The evolving role and scope of interventional radiology procedures
- The principles of and the indications for radiation therapy for cancer
- Basic plain film (chest, abdomen, bone) and non-contrast head CT interpretation

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of radiologic test or procedure
- Topic review and discussion

PRACTICE BASE LEARNING AND INPROVEMENT:

Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients requiring radiology imaging and/or therapy.

Radiology PBLI Objectives

- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion

- Review of written notes and/or consults
- Image review and discussion

Topic review and discussion

- Self directed learning logs

INTERPERSONAL AND COMMUNICATION SKILLS:

Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients requiring radiology imaging and/or therapy.

Radiology ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a health care team
- Communicate effectively with patients and their families (when appropriate)
- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assessment Methods

- Direct observation of history and/or physical exam
  Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)

PROFESSIONALISM:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients requiring radiology imaging and/or therapy.

Radiology Professionalism Objectives

- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

SYSTEMS-BASED PRACTICE:

Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients requiring radiology imaging and/or therapy.

Radiology Systems-Based Practice Objectives

- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care

Assessment Methods

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

LEARNING METHODS / VENUES / RESOURCES

Learning Methods

- Direct patient care and/or imaging review
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds and/or image discussion
- Conference attendance
- Self-directed learning

Learning Venues

- Radiology rotation (see below)
- Interventional radiology rotations
- Program Conferences
- Other rotation specific conferences

Learning Resources

- SVH Library
- Up to Date
- Assigned Reading materials

RHEUMATOLOGY ELECTIVE CURRICULUM

INTRODUCTION

The rheumatology curriculum is designed to teach the resident the appropriate evaluation and management of rheumatic diseases as outlined in the goals below. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY
Rotation Director: Stephen Neucks, MD
Rotation Site: St. Vincent Hospital
Rotation Duration: 2 weeks
Rotation Status: Elective
Duty Hours: Day shifts
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: New Innovations electronic evaluation form specific to Podiatry/Rheumatology Rotation

GOALS (from FCIM2)
Rheumatology and nonoperative (office) orthopedics deal with the prevention, diagnosis, and management of crystalline diseases, systemic rheumatic diseases, spondyloarthropathies, vasculitis, inflammatory muscle disease, osteoporosis, osteoarthritis, recreational and sports injury, and soft-tissue diseases and trauma. The goal of rheumatology is early diagnosis and treatment of these conditions to prevent disability and death.

The podiatrist needs to have competency in the initial diagnosis and management of acute arthritis and musculoskeletal disorders and in the long-term care of systemic disorders. He or she must also be aware of the effects of anti-inflammatory, immunosuppressive, and cytotoxic drugs.

RHEUMATOLOGY COMPETENCIES
The following are competencies in relation to the rheumatology curriculum with assessment methods and evaluation tools. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

PATIENT CARE:
Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with rheumatic diseases.

General Rheumatology Patient Care Objectives
In a patient with rheumatologic disease:

- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating and assessment and plan of care

- Understand indications/interpretations of testing related to rheumatic diseases
- Perform and/or interpret procedures/tests pertinent to care of patient
- Understand the indications for referral of patients with rheumatic diseases

Plan appropriate disposition and follow-up for patients with rheumatic diseases

- Document adequately and appropriately above in the medical record

Assessment Methods

- Direct observation of history and/or physical exam
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

MEDICAL KNOWLEDGE: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to care of patients with rheumatic diseases.

General Rheumatology Medical Knowledge Objectives (from FCIM2)

- Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following rheumatology topics:
  - Crystal-induced synovitis
  - Degenerative joint disease
  - Fibromyalgia
  - Inflammatory myopathy
  - Mixed Connective Tissue Disease
  - Occupational/sports-related overuse syndromes
    - Achillis tendonitis
    - Iliotibial band
    - Plantar fasciitis
    - Trochanteric bursitis
  - Osteomyelitis
  - Osteoporosis and complications
  - Other Systemic Autoinflammatory Diseases
    - Bechet's Disease
    - Relapsing Polychondritis
    - Retroperitoneal Fibrosis
    - Adult Still's Disease
    - Sjogrens Syndrome
  - Regional pain syndromes
    - Acute or chronic bursitis (hip, knee)
    - Acute or chronic tendinitis
    - Back, neck pain
    - Foot pain
  - Rheumatoid arthritis
  - Scleroderma
  - Septic arthritis
    - Gonococcal
    - Nongonococcal
  - Seronegative spondyloarthritis
  - Systemic lupus erythematosus
  - Systemic Vasculitis
  - Large Vessel Vasculitides
    - Giant Cell arteritis and Polymyalgia Rhematica
    - Takasyasu's Arteritis
  - Medium-Sized Vessel Vasculitis
    - Polyarteritis Nodosa

- o Small-Vessel Vasculitides
  - Wegener's Granulomatosis
  - Microscopic Polyangiitis
  - Churg-Strauss Syndrome
  - Henoch-Schonlein Purpura
  - Cryoglobulinemic Vasculitis
  - Cutaneous Leukocytoclastic Vasculitis

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam

PRACTICE BASE LEARNING AND INPROVEMENT:

Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with rheumatic diseases.

General Rheumatology PBLI Objectives

- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods

- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

INTERPERSONAL AND COMMUNICATION SKILLS:

Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with rheumatic diseases.

General Rheumatology ICS Objectives

- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a health care team
- Communicate effectively with patients and their families
- Communicate effectively with other members of the health care team
- Maintain comprehensive, accurate and legible records

Assessment Methods

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

PROFESSIONALISM:
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients with rheumatic diseases.

General Rheumatology Professionalism Objectives
- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods
- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

SYSTEMS-BASED PRACTICE:
Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with rheumatic diseases.

General Rheumatolgy Systems-Based Practice Objectives
- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care

Assessment Methods
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

LEARNING METHODS / VENUES / RESOURCES
Learning Methods
- Direct patient care in outpatient/inpatient setting
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds
- Conference attendance
- Self-directed learning

Learning Venues

- Rheumatology rotation (see below)
- Noon Conference

Learning Resources

- ST. Vincent Library and Reading Room
- Up to Date
- MKSAP 15 Rheumatology Section
- Assigned Reading materials

RHEUMATOLOGY ELECTIVE CURRICULUM

INTRODUCTION

The rheumatology curriculum is designed to teach the resident the appropriate evaluation and management of rheumatic diseases as outlined in the goals below. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY

Rotation Director: John Hague, MD and Stephen Neucks, MD
Rotation Site: St. Vincent Hospital
Rotation Duration: up to 4 weeks
Rotation Status: Elective
Duty Hours: Day shifts plus podiatry call
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: End of month rotation evaluation, praise and concern cards

GOALS (from FCIM2)

Rheumatology and nonoperative (office) orthopedics deal with the prevention, diagnosis, and management of crystalline diseases, systemic rheumatic diseases, spondyloarthropathies, vasculitis, inflammatory muscle disease, osteoporosis, osteoarthritis, recreational and sports injury, and soft-tissue diseases and trauma. The goal of rheumatology is early diagnosis and treatment of these conditions to prevent disability and death.
The podiatrist needs to have competency in the initial diagnosis and management of acute arthritis and musculoskeletal disorders and in the long-term care of systemic disorders. He or she must also be aware of the effects of anti-inflammatory, immunosuppressive, and cytotoxic drugs.

RHEUMATOLOGY COMPETENCIES – see core curriculum for detailed description

The following are competencies in relation to the rheumatology curriculum with assessment methods and evaluation tools. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

PATIENT CARE: Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with rheumatic diseases.

General Rheumatology Patient Care Objectives

In a patient with rheumatologic disease:

- Collect an adequate history and record review
- Perform an appropriate and accurate physical exam
- Use sound clinical judgment in formulating and assessment and plan of care
- Understand indications/interpretations of testing related to rheumatic diseases
- Perform and/or interpret procedures/tests pertinent to care of patient
- Understand the indications for referral of patients with rheumatic diseases
- Plan appropriate disposition and follow-up for patients with rheumatic diseases
- Document adequately and appropriately above in the medical record

Assessment Methods

- Direct observation of history and/or physical exam
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of a clinical test and/or procedure
- Feedback from nursing/support staff and/or patient/family member

Evaluation Tools

- Mini-CEX Form
- Praise/Concern Card

MEDICAL KNOWLEDGE: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to care of patients with rheumatic diseases.

General Rheumatology Medical Knowledge Objectives (from FCIM2)
Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should be familiar with the following rheumatology topics:

Crystal-induced synovitis
Degenerative joint disease
Fibromyalgia
Inflammatory myopathy
Mixed Connective Tissue Disease
Occupational/sports-related overuse syndromes
    Achillis tendonitis
    Iliotibial band

Plantar fasciitis
Trochanteric bursitis
Osteomyelitis
Osteoporosis and complications
Other Systemic Autoinflammatory Diseases
Bechet's Disease
Relapsing Polychondritis
Retroperitoneal Fibrosis
Adult Still's Disease
Sjogrens Syndrome
Regional pain syndromes
Acute or chronic bursitis (hip, knee)
Acute or chronic tendinitis
Back, neck pain
Foot pain
Rheumatoid arthritis
Scleroderma
Septic arthritis
Gonococcal
Nongonococcal
Seronegative spondyloarthritis
Systemic lupus erythematosus
Systemic Vasculitis
Large Vessel Vasculitides
Giant Cell arteritis and Polymyalgia Rhematica
Takasyasu's Arteritis
Medium-Sized Vessel Vasculitis
Polyarteritis Nodosa
Small-Vessel Vasculitides
Wegener's Granulomatosis
Microscopic Polyangiitis
Churg-Strauss Syndrome
Henoch-Schonlein Purpura
Cryoglobulinemic Vasculitis
Cutaneous Leukocytoclastic Vasculitis

Assessment Methods

- Case presentation and discussion
- Review of written note(s) or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Topic review and discussion
- Multiple Choice Question Exam

Evaluation Tools

- ABIM Competency Evaluation Form
- Praise/Concern Card
- In-Training Evaluation (annually)

PRACTICE BASE LEARNING AND INPROVEMENT: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with rheumatic diseases.

General Rheumatology PBLI Objectives
- Identify/improve deficits in medical knowledge and patient care skills
- Use an evidence based approach to the evaluation and management of patients

Assessment Methods
- Case presentation and discussion
- Review of written notes and/or consults
- Topic review and discussion

Evaluation Tools
- ABIM Competency Evaluation Form
- Praise/Concern Card

INTERPERSONAL AND COMMUNICATION SKILLS: Residents are expected to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with rheumatic diseases.

General Rheumatology ICS Objectives
- Create and sustain a therapeutic and ethically sound relationship with patients
- Work effectively with others as a member of a health care team
- Communicate effectively with patients and their families
- Communicate effectively with other members of the health care team

Assessment Methods
- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Feedback from nursing/support staff and/or patient/family member

Evaluation Tools
- ABIM Competency Evaluation Form
- Mini-CEX Form
- Praise/Concern Card

PROFESSIONALISM: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population in the care of patients with rheumatic diseases.

General Rheumatology Professionalism Objectives

- Demonstrate respect, compassion, altruism, integrity, and accountability
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and needs
- Demonstrate a commitment to ethical principles and patient confidentiality

Assessment Methods

- Direct observation of history and/or physical exam
- Direct observation of interactions with patients, nurses and/or peers
- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Evaluation Tools

- ABIM Competency Evaluation Form
- Mini-CEX Form
- Praise/Concern Card

SYSTEMS-BASED PRACTICE: Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with rheumatic diseases.

General Rheumatolgy Systems-Based Practice Objectives

- Practice cost effective health care and resource allocation
- Advocate for quality patient care and assist patients in dealing with the system
- Collaborate with other members of the health care team to improve patient care

Assessment Methods

- Case presentation and discussion
- Review of written note(s) and/or consult(s)
- Observed performance/ordering/interpretation of clinical test or procedure
- Feedback from nursing/support staff and/or patient/family member

Evaluation Tools

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- Praise/Concern Card

LEARNING METHODS / VENUES / RESOURCES

Learning Methods

- Direct patient care in outpatient/inpatient setting
- Case presentation and discussion
- Topic review and discussion
- Review of assigned reading materials
- Teaching rounds
- Conference attendance
- Self-directed learning

Learning Venues

- Rheumatology rotation (see below)
- Noon Conference

Learning Resources

- ST. Vincent Library and Reading Room
- Up to Date
- MKSAP 15 Rheumatology Section
- Assigned Reading materials

Apendix Learning References

Texts:

Current rheumatology diagnosis and treatment / Imboden, John B. [ed.] -- New York: Lange Medical Books/McGraw-Hill, Medical Pub. Division, 2007.

Kelley's Textbook of Rheumatology 6th Edition Volumes 1&2

By Shaun Ruddy, Edward D. Harris, Clement Sledge John S. Sergent and William N Kelley

Websites

American College of Rheumatology

http://www.rheumatology.org/

Online Journals

APLAR Journal of Rheumatology

Acad

ISSN:
0219-0
494

Current Medical Literature. Rheumatology

Acad

ISSN:
0261-3
360
Current opinion in rheumatology

LWW

ISSN:
1040-8
711
Online
ISSN:
1531-6
963
The Internet journal of rheumatology

Acad

ISSN:
1528-8
412
JCR: Journal of Clinical Rheumatology

LWW

ISSN:
1076-1
608
Online
ISSN:
1536-7
355
Rheumatology

Free

Free

ISSN:
1462-0
324
Online
ISSN:
1462-0
332
Scandinavian Journal of Rheumatology

Acad
ISSN:
0300-9
742
Online
ISSN:
1502-7
732

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Bardin T. Gonococcal arthritis. Best Pract Res Clin Rheumatol. 2003;17:201-8. [PMID: 12787521]

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Scandinavian Journal of Rheumatology

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SPORTS MEDICINE ELECTIVE CURRICULUM

INTRODUCTION

Sports Medicine requires an understanding of common musculoskeletal conditions and also medical conditions that arise among active individuals. Important elements include the diagnosis and management of a variety of orthopedic injuries and conditions in addition to understanding medical problems that occur with physical activity, including asthma, chest pain, concussions, infections, and psychosocial issues.
The sports medicine curriculum is designed to teach the resident the appropriate evaluation and management of acute and chronic musculoskeletal and medical conditions as outlined in the goals below. Housestaff assigned to the Sports Medicine Rotation are expected to read this curriculum and discuss the key goals / objectives and rotation structure with the Sports Medicine faculty preceptor at the beginning of the rotation. Curricular objectives will be accomplished by utilizing a variety of educational methods in a variety of venues.

ROTATION SUMMARY
Rotation Director: Timothy VonFange, MD

Rotation duration: 2 weeks

Rotation status: Elective

Residents: 1 resident per team per month, any training level

Duty Hours: Monday – Friday

Learning Venues: St Vincent Indianapolis Hospital, St. Vincent Sports Performance

Learning Methods: Direct patient care in outpatient/surgical/training room/sideline settings, Case presentation and discussion, Topic review and discussion, Review of assigned reading materials, Teaching rounds, Conference attendance, Self-directed learning , Pre/post testing . Residents will also be exposed to Sports Medicine core topics during AIMS, Primary Care Clinic, and other rotations.

Resources: MKSAP, Assigned reading materials and web-links, Clinical Pharmacists, Orthopedic Casting Technician, Physical and Occupational Therapists

Conferences: Program Conferences only

Evaluation: Resident Evaluation by Faculty

EDUCATIONAL OBJECTIVES

- To understand the concepts and skills necessary to perform a comprehensive preparticipation sports physical examination.
- To understand the role of exercise in health promotion and disease prevention, including the ability to identify risk factors for chronic disease that are suitable for prevention.
- To understand the guidelines and methods to provide patients with an aerobic and strength training exercise prescription depending health status.

- To understand the history, physical examination and diagnostic criteria, treatment, and appropriate referral of joint injuries, spinal disorders and injuries, soft tissue injuries, neurovascular injuries and fractures.
- To gain an appreciation of specific injuries associated with running, football, basketball, baseball, tennis and soccer.
- To understand the diagnosis of overuse syndromes, including the general classification of these injuries.
- To recognize common injuries in the elderly and will be able to recommend measures to prevent injuries during exercise or sport for individuals of 65 years old.
- To understand the appropriate use of rehabilitation services, including physical therapy and common modalities used in treatment.
- To understand common surgical procedures used to treat surgical sports injuries.
- To understand the role of taping, splinting and casting and will gain expertise in the application and use of common splints and casts used for ankle, knee, wrist, finger and elbow injuries.
- To explore the role of the team physician in providing onsite care and supervision of athletes.

PRINCIPAL TEACHING METHODS

- Supervised Patient Care - Residents evaluate patients in the outpatient Sports Medicine and Orthopedic Surgery clinic, training rooms, sidelines, and operating rooms, supervised by Board Certified Sports Medicine and Orthopedic specialists. The resident on the Sports Medicine rotation will adhere to the residency program supervision and duty hours rules. Residents will function as a primary physician and/or consultant in the inpatient and outpatient settings. They will observe/perform and interpret the various special tests/procedures used in the evaluation and management of patients with musculoskeletal disease. Patients are seen and examined by the resident, who formulates an assessment, differential diagnosis, and treatment plan and presents it to the attending faculty. Both the resident and the attending then examine the patient and discuss the care. Teaching focuses on evaluation and management of the specific case as well as its relationship to the core Sports Medicine topics. Outpatient precepting will occur at least 30 minutes per half-day clinic session

DIDACTIC TEACHING SESSIONS

- core lecture series to include a combination of small group discussions with faculty, based on rotation objectives;quarterly noon conference sports medicine lecture series; biannual workshops on joint injection, casting and splinting, physical diagnosis, treadmill exercise testing, and emergency care of the injured athlete.
- Self-directed learning- by the end of the first week of the rotation, the resident will be expected to have read articles from the Sports Medicine reading list (see Section 9, Reading list / References) pertinent to cases seen during the rotation, or as directed by the Sports Medicine attending. Independently research topics related to patients they

encounter during the rotation. Research and write the monthly "Sports Medicine Minute" which is a brief review of a selected Sports Medicine topic.

- Procedures - Additional diagnostic and therapeutic procedures available on a case-dependent basis include (but are not limited to) casting and splinting, joint injection and aspiration, interpretation of radiographs.

EDUCATIONAL CONTENT / ROTATION STRUCTURE

- **Mix of diseases**
  - The disease mix is broad, due to the multiple referral sources to St Vincent and the diverse population of Indianapolis and surrounding areas.
- **Patient characteristics**
  - The Sports Medicine resident will see a diverse population of adult patients ranging in age from adolescents to geriatric patients, of diverse socioeconomic backgrounds.
- **Learning venues**
  - **Required**
    - Most encounters are in the Sports Medicine Clinic, on average two half days per week. Each Sports Medicine resident will see 4 - 6 Clinic patients per clinic.
    - Residents also see patients with an Orthopedic Surgeon 4-6 half days per week, mainly in the office, but also with a minimum of one half day per week in the operating room.
    - Residents also see patients Residents also participate in casting and splinting one half day per week with an Orthopedic Casting technician.
    - The resident will participate one half day per week in Rehabilitation Clinic with Physical and Occupational Therapies.
    - Residents continue to attend their continuity clinic and required didactics.
  - **Recommended**
    - The resident may attend preparticipation sports physicals at local high schools and colleges in partnership with St. Vincent Sports Medicine.
    - The Sports Medicine resident may attend team sporting events at schools/organizations associated with St. Vincent Sports Medicine as sideline team physicians.
    - Residents may participate in training room coverage at local schools in partnership with St. Vincent Sports Medicine.
    - Residents may attend the monthly Sports Medicine journal club.

ANCILLARY TEACHING MATERIALS

- At the beginning of each rotation this curriculum is provided to each resident as a guide to the rotation. Additional reading materials will be provided by the Sports Medicine faculty preceptor.
- All residents can access Up-to-Date (expert opinion), Access Medicine / Stat!Ref on-line textbooks, and Ovid (peer reviewed literature search) from the intranet.

ASSESSMENT AND EVALUATION TOOLS

- **Global:**

- **Resident evaluation by faculty**
  - Verbal feedback between faculty and resident occurs at mid-month and at the end of the rotation. In addition, at the end of each rotation faculty complete a web based resident evaluation form using *New Innovations*. The evaluation is sent to the Residency Office where it is placed in the resident's evaluation file. The evaluation assesses core competency performance. It is shared with the resident and may be reviewed by the resident via *New Innovations*. The evaluation is incorporated as part of the semi-annual review for directed resident feedback.
- **Faculty and rotation evaluation by residents**
  - Upon completion of the rotation, residents complete a rotation evaluation form commenting on the faculty, facilities, and service experience. A member of the administrative faculty will review the written evaluation and add it to a collated report of anonymous evaluations from other residents having taken the rotation and will provide it to the attending physician, every 6-12 months. Constructive criticism will be utilized to improve each rotation as warranted. The Evaluations Committee reviews results semiannually.
- **Competency Based Evaluation:** see Sports Medicine Rotation-Specific Competency-Based Objectives and Assessment

INSTITUTIONAL RESOURCES (STRENGTHS AND LIMITATIONS)

- Faculty- teaching is provided by 3 full-time board certified Sports Medicine faculty. Other teaching is provided by Orthopedic Surgeons, physical and occupational therapists, and casting technicians.
- Research –St Vincent has a complete range of research support (including funding) available to residents.
- Patients – should an additional team physician learning experience be desired, this can be facilitated.
- Facilities and Technology: A comprehensive range of Radiology, Nuclear Medicine, Microbiology and Pathology services are available to support Sports Medicine

SPORTS MEDICINE ROTATION-SPECIFIC COMPETENCY-BASED OBJECTIVES AND ASSESSMENT

The following competency-based objectives are presented as they apply to the field of Sports Medicine. Detailed descriptions of the competencies, assessment methods, and evaluation tools can be found in the residency core curriculum.

- **Patient Care**
  - **Objectives**
    - Residents are expected to

- complete a comprehensive history and record review with particular focus paid to sport and physical activity, injury and surgical history.
- perform an appropriate and accurate physical exam and recognize / interpret physical findings seen in sports medicine including
  - Overuse injuries
  - Low back pain in athletic and non-athletic populations, including LS spine strain/sprain, DJD, DDD, and spinal stenosis
  - Joint sprains, including ankle sprains and knee ligament injuries
  - Fractures that are simple, stable, non- or minimally displaced and require closed treatment. Examples include metacarpal, unimalleolar ankle, wrist and clavicle, stress fractures
  - Neck injuries, including sprain/strain, myofascial pain
  - Osteoarthritis of multiple sites, especially hip, knee and foot
  - Neurovascular injuries such as cervical, and lumbar radiculopathy

▪ provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health in patients with musculoskeletal illness.
▪ understand indications/interpretations of testing related to sports medicine.
▪ perform and/or interpret procedures/tests pertinent to care of patients, including casting and splinting, joint injection and aspiration, interpretation of radiographs, treadmill exercise testing.
▪ understand the indications for referral of patients with musculoskeletal and sports-related medical conditions.
▪ use sound clinical judgment in formulating an assessment, differential diagnosis, and plan of care.
▪ demonstrate clinical documentation skills.
▪ ***plan appropriate disposition and follow-up for patients with sports medicine-related illness.***

- **Assessment and Evaluation of Patient Care**
  - Direct observation of history and/or physical exam
  - Case presentation and discussion
  - Review of written note(s) and/or consult(s)
  - Observed performance/ordering/interpretation of a clinical test and/or procedure
  - Feedback from nursing/support staff and/or patient/family member
- **Evaluation**
  - New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
  - Mini-CEX Form (available but not required)
  - Praise/Concern Card (available but not required)

● **Medical Knowledge**

- **Objectives**
  - Residents are expected to demonstrate
    - knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences as they pertain to the care of patients with musculoskeletal and sports-related medical conditions.
    - understanding of the standard evaluation and management of common sports medicine conditions
    - understanding of the therapy, casting and splinting and need for surgery for injuries and chronic musculoskeletal conditions.

  A comprehensive listing of specific medical knowledge goals for the Sports Medicine rotation, expanding on i-iii, and expected to serve as a guide for reading, is listed as 'Appendix A'.

- **Assessment / Evaluation of Medical Knowledge**
  - Case presentation and discussion
  - Review of written note(s) or consult(s)
  - Observed performance/ordering/interpretation of clinical test or procedure
  - Topic review and discussion
  - Multiple Choice Question Exam
  - In-Training Evaluation (annually)
- **Evaluation**
  - New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
  - Praise/Concern Card

- **Communication**
  - **Objectives**
    - Residents are expected to demonstrate interpersonal and communication skills that
      - result in effective information exchange and teaming with patients, their patient's families, and professional associates in the care of patients with sports-related illness
      - create and sustain a therapeutic and ethically sound relationship with patients
      - allow housestaff to work effectively with others as a member of a health care team
      - result in comprehensive, accurate and legible records
      - allow for educated counseling regarding sport medicine injury and illness.
  - **Assessment / Evaluation of Communication Skills**
    - Direct observation of history and/or physical exam
    - Direct observation of interactions with patients, nurses and/or peers
    - Case presentation and discussion
    - Review of written note(s) and/or consult(s)
    - Feedback from nursing/support staff and/or patient/family member
  - **Evaluation**

- New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
- Mini-CEX Form
- Praise/Concern Card

- **Professionalism**
  - **Objectives**
    - Residents must demonstrate a commitment to
      - excellence in carrying out professional responsibilities and respecting patient confidentiality.
      - demonstrating respect, compassion, altruism, integrity, and accountability
      - demonstrating sensitivity and responsiveness to patient's culture, age, gender, and needs
      - creating and sustaining a therapeutic and ethically sound relationship with patients and their families.
      - self awareness, self-improvement, and continuous professional development.
  - **Assessment / Evaluation of Professionalism**
    - Direct observation of history and/or physical exam
    - Direct observation of interactions with patients, nurses and/or peers
    - Case presentation and discussion
    - Review of written note(s) and/or consult(s)
    - Observed performance/ordering/interpretation of clinical test or procedure
    - Feedback from nursing/support staff and/or patient/family member
  - **Evaluation**
    - New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
    - Mini-CEX Form
    - Praise/Concern Card
- **Practice-based Learning and Improvement**
  - **Objectives**
    - Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices in the care of patients with musculoskeletal and sports-related illness. By the end of the rotations, each resident will be able to:
      - identify/improve deficits in his/ her own medical knowledge and patient care skills
      - locate, critically appraise, and assimilate evidence from scientific studies and apply this to his/her own patients' health problems.
      - use information technology to manage information, access on-line medical resources, and support self-education, patient care decisions and patient education.

- apply to their clinical practice the principles of sports medicine
- recognize costs of sports related injury in terms of mortality and morbidity and will take steps to improve patient safety by improving patient education.

  - **Assessment / Evaluation of Practice-based Learning and Improvement**
    - Case presentation and discussion
    - Review of written notes and/or consults
    - Topic review and discussion

  - **Evaluation**
    - New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
    - Praise/Concern Card

- **Systems-based Practice**
  - Residents are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value in the care of patients with sports-related illness. As such, residents will
    - practice cost effective health care and resource allocation
    - advocate for quality patient care and assist patients in dealing with the immediate health care system
    - productively and cooperatively participate in Multidisciplinary Treatment Planning.
    - actively work with the Sports Medicine support staff (eg athletic trainers, physical therapists) and demonstrate the ability to work well in a team setting.
- **Assessment / Evaluation of Systems-Based Practice Competency**
  - Case presentation and discussion
  - Review of written note(s) and/or consult(s)
  - Observed performance/ordering/interpretation of clinical test or procedure
  - Feedback from nursing/support staff and/or patient/family member Evaluation
  - New Innovations Competency Evaluation Form: Resident Evaluation by Faculty
  - Mini-CEX Form
  - Praise/Concern Care

Appendix A. Sports Medicine Specific Medical Knowledge Objectives (from FCIM2 and MKSAP14)

Through direct patient care, case presentation and discussion, topic review and discussion, assigned readings, self-directed learning, and conference attendance, residents should become familiar with the following Sports Medicine topics:

- Anatomy, physiology, and biomechanics of exercise
- Basic nutritional principles and their application to exercise
- Psychological aspects of exercise, performance, and competition
- Guidelines for evaluation prior to participation in exercise and sport

- Physical conditioning requirements for various activities
- Special considerations related to age, gender, and disability
- Pathology and pathophysiology of illness and injury as they relate to exercise
- Effects of disease, eg, diabetes, cardiac conditions, arthritis, on exercise and the use of exercise in the care of medical problems
- Prevention, evaluation, management, and rehabilitation of injuries
- Understanding pharmacology and effects of therapeutic, performance-enhancing, and mood-altering drugs
- Promotion of physical fitness and healthy lifestyles
- Functioning as a team physician
- Ethical principles as applied to exercise and sports
- Medical-legal aspects of exercise and sports
- Environmental effects on exercise

Appendix B: Reading List
Texts:

Essentials of Musculoskeletal Care. Greene, WB, editor. American Academy of Orthopedic Surgeons, 3rd Edition, 2005.

The Team Physician's Handbook. Mellion MB, Walsh WM, Madden C, and Putukian M. 3rd Edition, 2001.

The Orthopedic Physical Examination. Reider B, Christopher D. 2nd Edition, 1999.

ACSM's Primary Care Sports Medicine. McKeag DB, Moeller JL. 2007.

Fracture Management for Primary Care. Eiff MP, Hatch RL, Calmbach WL. 2nd Edition, 2003.

Websites:
Instructional Videos:
"Physical Examination of the Musculoskeletal System", American Academy of Orthopedic Surgery

Articles (to be supplemented by Sports Medicine attendings):

1. **The Clinical Management of Sports Concussion**
   Collins MW, Hawn KL. Current Sports Medicine Reports 2002;1:12-22.

2. **Summary and Agreement Statement of the 2nd International Conference on Concussion in Sport, Prague 2004**
   McCrory P, Johnston K, Meeuwisse W, et al. Clin J Sport Med 2005;15

3. **Unilateral Cervical Nerve Injuries: Brachial Plexopathies**
   Olson DE, McBroom SA, Nelson BD, et al. Current Sports Medicine Reports

2007;6:43-49.

4. **The Painful Shoulder: Part I. Clinical Evaluation**
   Woodward TW, Best TM. AFP 2000;61:3079-3088.

5. **The Painful Shoulder: Part II. Acute and Chronic Disorders**
   Woodward TW, Best TM. AFP 2000;61:3291-3300.

6. **Evaluation of Overuse Elbow Injuries**
   Chumbley EM, O'Connor FG, Nirschl RP. AFP 2000;61:691-700.

7. **A Clinical Approach to Diagnosing Wrist Pain**
   Forman TA, Forman SK, Rose NE. AFP 2005;72:1753-1758.

8. **Acute Finger Injuries: Part I. Tendons and Ligaments**
   Leggit JC, Meko CJ. AFP 2006;73:810-816.

9. **Acute Finger Injuries: Part II. Fractures, Dislocations, and Thumb Injuries**
   Leggit JC, Meko CJ. AFP 2006;73:827-834.

10. **Back Injuries in the Pediatric Athlete**
    Waicus KM, Smith BW. Current Sports Medicine Reports 2002;1:52-58.

11. **Hip Pain in Athletes**
    Adkins SB, Figler RA. AFP 2000;61:2109-2118.

12. **Acute Knee Effusions: A Systematic Approach to Diagnosis**
    Johnson MW. AFP 2000;61:2391-2400.
13. **Management of Patellofemoral Pain Syndrome**
    Dixit S, DiFiori J, Burton M, et al. AFP 2007;75:194-202.

14. **Evaluation of Patients Presenting with Knee Pain: Part I. History, Physical Examination, Radiographs, and Laboratory Tests**
    Calmbach WL, Hutchens M. AFP 2003;68:907-912.
15. **Evaluation of Patients Presenting with Knee Pain: Part II. Differential Diagnosis**
    Calmbach WL, Hutchens M. AFP 2003;68:917-922.

16. **A Practical Approach for the Differential Diagnosis of Chronic Leg Pain in the Athlete**
    Edwards PH, Wright ML, Hartman JF. AJSM 2005;33:1241-1249.

17. **Management of Ankle Sprains**

Wolfe MW, Uhl TL, Mattacola CG, et al. AFP 2001;63:93-104.

18. **Foot Fractures Frequently Misdiagnosed as Ankle Sprains**
Judd DB, Kim DH. AFP 2002;66:785-794.

19. **Current Treatment of Plantar Fasciitis**
May TJ, Judy TA, Conti M, et al. Current Sports Medicine Reports 2002;1:278-284.

20. **Basics of Joint Injection: General Techniques and Tips for Safe, Effective Use**
Rifat SF, Moeller JL. Postgraduate Medicine 2001;109:157-166.

21. **Overuse Tendinosis, Not Tendinitis. Part 1: A New Paradigm for a Difficult Clinical Problem**
Khan KM, Cook JL, Taunton JE, et al. Physician and Sportsmedicine 2000;28:38-47.

22. **Overuse Tendinosis, Not Tendinitis. Part 2: Applying the New Approach to Patellar Tendinopathy**
Cook JL, Khan KM, Maffulli N, et al. Physician and Sportsmedicine 2000;28

23. **Sideline Management of Common Dislocations**
Hodge DK, Safran MR. Current Sports Medicine Reports 2002;1:149-155.

24. **Marfan Syndrome: Screening for Sudden Death in Athletes**
Glorioso J, Reeves M. Current Sports Medicine Reports 2002;1:67-74.

25. **Hypertrophic Cardiomyopathy: Who Plays and Who Sits**
Rizvi AA, Thompson PD. Current Sports Medicine Reports 2002;1:93-99.

26. **Evidence-based Management of Exercise-induced Asthma**
Holzer K, Brukner P, Douglass J. Current Sports Medicine Reports 2002;1:86-92.

27. **Cardiac Arrhythmias in the Athlete: The Evolving Role of Electrophysiology**
Link MS, Homoud MK, Wang PJ, et al. Current Sports Medicine Reports 2002;1:75-85.

28. **Electrocardiographic Findings in Sports Medicine: Normal Variants and the Ones That Should Not Be Missed**
Kane SF, Oriscello RG, Wenzel RB. Current Sports Medicine Reports 2005;4:68-75.

29. **Infectious Mononucleosis and the Spleen**
    Kinderknecht JJ. Current Sports Medicine Reports 2002;1:116-120.

30. **Vocal Cord Dysfunction: A Practical Approach to Diagnosis**
    Bacharier LB, Strunk RC. Journal of Respiratory Diseases 2001;22:93-100.

31. **Community-Acquired Methicillin-Resistant Staphylococcus aureus**
    Rihn JA, Michaels MG, Harner CD. AJSM 2005;33:1924-1929.

32. **Prescribing Exercise for Health Promotion and Disease Management**
    Harsha DM, Mikesky AE, et al. JCOM 1997;4:48-63.

33. **Exercise During Pregnancy: A Practical Approach**
    Paisley TS, Joy EA, Price RJ. Current Sports Medicine Reports 2003;2:325-330.

34. **Training Principles for Elite Senior Athletes**
    Franklin BA, Fern A, Voytas J. Current Sports Medicine Reports 2004;3:173-179.

35. **Training Issues in Elite Young Athletes**
    Demorest RA, Landry GL. Current Sports Medicine Reports 2004;3:167-172.

36. **Core Stability: The Centerpiece of Any Training Program**
    Bliss LS, Teeple P. Current Sports Medicine Reports 2005;4:179-183.

37. **Nutrition and Athletic Performance: ACSM Position Statement**
    Med Sci Sports Exerc 2000;32:2130-2145.

VASCULAR SURGERY CURRICULUM

INTRODUCTION

This training experience will include direct participation of the resident in surgical evaluation and management of non-podiatric patients.This experience will be one month in duration and will occur in the second or third years of training. The podiatric surgical resident is directly responsible to the chief of surgery, his resident or designee. The resident shall receive didactic and clinical training in the evaluation of patients with both general disease, peripheral vascular disease, skin defects, cosmesis and various wound closure techniques. Rationale and interpretation of various diagnostic modalities such as arteriography, noninvasive vascular studies and their clinical application will also be stressed. The podiatric surgical resident will receive didactic instruction in vascular surgical techniques and procedures, as well as general

and plastic surgical techniques, at the discretion of the surgeon. The resident will assist in patient care responsibility and may serve as an assistant during surgery.

ROTATION SUMMARY

Rotation Director: George Sheng, MD
Rotation Site: St. Vincent Hospital 86th St. and CorVasc office Harcourt Rd
Rotation Duration: 2 weeks
Rotation Status: Required
Duty Hours: Day shifts

Required Conferences: Program conferences and rotation-specific conferences
Evaluation: End of month rotation evaluation

ROTATION GOALS

- The resident will have clinical experiences and gain competency in:
- Comprehensive clinical peripheral vascular examinations
- Knowledge of general and vascular disease
- Knowledge of vascular surgery procedures
- Knowledge of general surgical techniques
- Invasive and noninvasive diagnostic tests to determine patency of arterial system
- Ability to interpret arteriograms and venograms
- Ability to perform and interpret diagnostic procedures
- Understanding management of preoperative and postoperative surgical patients with
- emphasis on complications
- Prophylaxis and treatment of stasis disorders, phlebitis and peripheral edema
- Techniques and indications for support stockings
- Noninvasive and invasive diagnostic techniques and their clinical applications
- Recognition and treatment of both deep and superficial thrombophlebitis
- Invasive and noninvasive diagnostic tests to determine patency of arterial system
- Understanding arterial disease and it's implication on wound healing and the
- indications for lower extremity bypass
- Physiology of wound healing
- Skin grafting principles and techniques
- Competence in utilizing various suture techniques

ROTATION OBJECTIVES

- The resident should be exposed to various techniques
- The resident should become proficient in tissue dissection techniques
- The resident should gain exposure to commonly used instrumentation
- The resident should gain exposure to and become proficient in suturing techniques
- The resident should develop an understanding of flaps and grafts as they pertain to the foot

WOUND CARE CURRICULUM

INTRODUCTION
This experience allows the podiatric surgical resident to gain competencies in advance wound care at St. Vincent's Wound Care and Diabetic Foot Center. In addition to the 2 WEEK dedicated rotation, this will be an ongoing experience throughout the tenure of the residency with the residents rotating with Drs. Stuart and Winters. The resident will be exposed to a multidisciplinary approach toward wound care.

ROTATION SUMMARY
Rotation Director: Christine Davis, MD
Rotation Site: St. Vincent Hospital Wound Care Center
Rotation Duration: 2 weeks
Rotation Status: Required
Duty Hours: Day shift
Required Conferences: Program conferences and rotation-specific conferences
Evaluation: End of month rotation evaluation, praise and concern cards

ROTATION GOALS / OBJECTIVES
During the Wound Care rotation, the podiatry resident will achieve the following:

- Understand the principles of wound healing
- Understand the different pathogeneses of wounds
- Become proficient with the variety of wound care products
- Understand indications of total contact casting
- Understand indications for skin grafts
- Understand the team approach for limb salvage
- Become proficient with surgical and nonsurgical approaches for wound care

General Surgery

ROTATION GOALS

Develop basic surgical skills including exposure, suturing, tying, flap elevation wound closure and vascular access.

Gain skills in the perioperative management of the surgical patient including management of common postoperative problems such as fever, wound infection, hypoxia, hypotension, low urine output, mental status changes, nausea, vomiting and inadequate pain control.

Gain skills in the interpretation of imaging studies including CXR, abdominal films, MRI and CT scans.

Assist in the operating room: be able to provide exposure, suture, tie, use electrocautery properly, dissect tissue appropriately and close wounds effectively using interrupted and/or subcuticular sutures

CPME 320 COMPETENCIES FOR THIS ROTATION
Section 6.1
B. Assess and manage the patient's general medical and surgical status.
1,2,3,5
C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
1,2,3,4,5
D. Communicate effectively and function in a multi-disciplinary setting.
1,2
E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
1,2,3,4,5
G. Be professionally inquisitive, life-long learners and teachers utilizing research,scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
1,2,3,4,5

ATTENDING PHYSICIAN(S) / CHIEF RESIDENT(S)
Douglas Kaderabeck, MD dkaderabek@aol.com
Jonathan Saxe, MD program director
General surgery chief resident

CHECK-IN / POINT OF CONTACT
Before/at the beginning of the rotation, resident should contact Dr. Kaderabeck to determine initial meeting location and time on the first day of the rotation
WEEKLY SCHEDULE varies by the day. check with attending or chief resident

RESIDENT RESPONSIBILITIES
The residents are to assume responsibility and perform technical procedures commensurate with their experience, competence, respect and mutual trust. In general, this increases yearly with added experience, judgment and ability. Residents will follow the attending and/or chief resident

DRESS CODE
Scrubs

ROTATION SPECIFIC ASSESSMENT QUESTIONS:
All questions are answered by "Excellent, Above Average, Average, Below Average, or Not Assessed"

Resident is able to adequately assist in formulating working diagnoses/plan with general surgical concerns in the outpatient clinical setting.
Resident is able to assist in and take an active role in general surgical cases.
Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
Resident is able to function with professionalism in general surgical settings.

XI. Hospital Charting

All podiatric patients admitted to the hospital must be done through an M.D. This is usually arranged through the AIMS service. The M.D. will perform the admission history and physical as well as dictating the discharge summary. The podiatry service may write any orders and medications that are deemed appropriate and necessary for the care of the podiatric patient.

The podiatric medical student should also perform a podiatric H&P which is to be reviewed and discussed with the resident on call as well as being reviewed by the attending podiatrist.

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 data pertinent to the course of the disease. Progress notes should be written by the resident or if by a student reviewed by the resident. A note should be written at least once a day on all patients. An admitting progress note is to be written by the attending physician. A 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 he leaves the case. The person coming on the service should carry on the progress notes from that time. All notes should be signed by the person writing the note and cosigned as necessary.

Orders: The resident can write orders for the patient. These orders may include necessary tests, therapy, etc. All orders written by residents are subject to approval of the attending podiatrist. Prior to writing orders, the resident should contact the podiatrist or podiatrist on call if the resident is unsure or has any questions about an order.

Consultations: Any podiatric consultation requested by the medical staff is to be handled directly by the resident in consultation with an attending podiatrist. An on call schedule will be maintained for the attending podiatrists for inhouse and emergency room consultations. Residents will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders.

Operative Notes: The resident should always first check with the attending podiatric surgeon before or after the case to find out their wishes. The resident may dictate the case if it has been discussed with the surgeon. Some surgeons prefer to dictate their own cases. This will be surgeon dependent so it is imperative to communicate that with the surgeon.

XII. Additional Materials

Any other information not contained in this manual can be found and referenced in the St. Vincent Hospitals and Health Services House Staff Handbook (revised March 2015) and is available in the Department of Medical Education (317-338-2281)

The residents are also expected to abide by the rules set forth in the CPME 320 document (revised edition effective July 1, 2015). All specific requirements for the program can be found in that document.

All house staff are required to have a podiatric medical license. Residents must apply for a NPI number and provide this information to Medical Education before the first day of residency. The Medical Education Department will assign the hospital DEA number to each resident who requests to use it for prescriptions at or for St. Vincent. As soon as the resident obtains a permanent license, he/she should request his/her own DEA number. This can be done by requesting a CSR from the Indiana Board of Pharmacy and a Federal DEA from the Federal Drug Enforcement Agency. The Medical Education Department should be advised when the resident no longer needs to use the hospital DEA number.

NPI and DEA Numbers

You obtain your NPI number and DEA number only after you receive your state licenses. Again, you must pass boards Part III of the American Podiatric Medical Licensing Examination prior to beginning PGY-2. Typically this examination is given in December and June of each year.

- Indiana Podiatric Medicine License application can be found here: http://www.in.gov/pla/files/DPM_LImited_License_Appliction.pdf

- Indiana Controlled Substance Application can be found here: http://www.in.gov/pla/3026.htm

- NPI info: https://nppes.cms.hhs.gov/NPPES/Welcome.do

- DEA info: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/onlineforms_new.htm
- The hospital will provide you with their DEA for the time you are a resident

Any other information that is not contained in this document can be found in the St. Vincent Hospital Department of Medical Education House Staff Handbook 2014-15.

CPME 320 and 330

To review the CPME 320, Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies (July 2015), access this link: http://www.cpme.org/files/FileDownloads/CPME%20320%20July%202011%20with%20December%202012%20updates.pdf

To review the CPME 330, Procedures for Approval of Podiatric Medicine and Surgery Residencies (October 2012), access this link:

http://www.cpme.org/files/FileDownloads/CPME%20330%20October%202010%20updated%202012%20for%20web.pdf

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I have received and have electronic access to the St. Vincent Podiatric residency manual. I understand that the manual is subject to change given reasonable notice and I agree to abide by the policies and procedures outlined in the manual. A copy of this document will be kept in the resident training file.

_____

Podiatric Resident Signature

_____

Podiatric Resident Printed Name

_____

Date