Intermountain Medical Center (IMC) Podiatric Medicine & Surgery Residency
With the Added Credential in Reconstructive Rearfoot/Ankle Surgery
Training Program Manual
TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

I. PURPOSE

The Podiatric Medicine and Surgery Residency Training Program is designed as a 36-month training experience including the following essential training experiences:

1) 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.

2) Clinical experience, providing participation in complete pre-operative and post-operative patient care in order to enhance the resident's competencies in the perioperative care of diseases, disorders, and injuries of the foot and ankle.

3) 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.

4) 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.

5) The required training to obtain an added credential in reconstructive rearfoot/ankle surgery.

Competencies

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

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

2) Assess and manage the patient's general medical status.

3) Practice with professionalism, compassion, and concern, in a legal, ethical, and moral fashion.

4) The ability to communicate effectively and function in a multi-disciplinary setting.

5) The capacity to manage individuals and populations in a variety of socioeconomic and health care settings.

6) The capacity to manage a podiatric practice in a multitude of health care delivery settings.

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

II. COMMITTEES

A. Residency Training Committee

This committee is responsible for the overall direction, regulation, and functioning of the residency training program. It is composed of the Director of Podiatric Medical Education, the Assistant Director, and the Rotation Directors for IHC, St. Mark's Hospital, and the VAMC, as well as appropriate representatives of the Medical Teaching Staff, a representative of the administration of IMC, and other members as deemed appropriate by the Committee and/or the affiliated institutions. The committee should not exceed 15 members. Appointments to this committee are made by the director and include the rotational directors following their appointment by their respective centers.

The function of this committee is to set policies for the program, develop the curriculum of the training program, and review overall resident and program performance. In addition, this committee will mediate conflicts arising within the teaching program, whether they are generated by the residents, podiatry staff,

medical staff, nursing staff, or administration. This committee will have the power to recommend the dismissal of the resident should the situation arise. Each member of the committee will have 1 vote unless otherwise stated below. The Director of Podiatric Medical Education will be the chairman of this committee and will be responsible to schedule the meeting dates of the committee at least semi-annually. The committee may also serve as the Evaluation/Grievance Committee (see below).

The responsibility of the Director of Podiatric Medical Education is to oversee the general administration of the residency. It is the director's responsibility to ensure that the residents follow the guidelines established for them within their contracts and within this manual. If the need arises, the Director of Podiatric Medical Education may appoint individuals or committees to assist him/her in his/her responsibilities as director. The Director or Rotation Director 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 Director of Podiatric Medical Education is directly responsible to the Residency Committee. The director serves as the liaison with the Council on Podiatric Medical Education. The director may only vote to break a tie. The director may hold additional positions on the committee that include voting rights. The Intermountain Medical Center GME Committee employs the director, who will be selected by the GME Department.

The Director of Podiatric Medical Education must meet all CPME requirements for directors. The Assistant Director will assume any or all of the director's responsibilities in the event the director is temporarily unable to perform those duties or, if the director leaves the program, may assume those duties on an interim basis until a new director can be recruited.

The position of Rotation Director at each major affiliate will be held by a member of the podiatric staff from that institution as long as the affiliation agreement between the residency and the institution is in force. The affiliated institution may choose the individual by any method they wish, as long as the term of office is for at least 1 year. The Rotation Directors are responsible for the day to day functioning of each resident at their respective institutions. The Rotation Director will serve as an advisor to the resident and a liaison between the residency and the heads of the various affiliated rotations and departments at their institution.

B. Residency Selection Committee

The Residency Selection Committee will be made up of a sub-committee of members of the residency training committee as chosen by the director. The director shall chair the committee unless he/she 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. Current residents may be asked to comment on applicants. If the committee cannot reach a consensus, a final vote by the committee members will be held by closed ballot.

C. The Residency Evaluation/Grievance Committee

The Residency Evaluation Committee will be made up of the director, the chief resident(s), and at least 1 other member of the Residency Training Committee as appointed by the director. The director shall chair the committee unless he/she appoints another committee member to assume chairmanship. The committee will review the progress of the residents at least annually to determine the promotion status of each resident. The committee will also review/self-assess the program on an annual basis and make

recommendations to the Residency Training Committee regarding any needed changes or program enhancements. The committee will meet more frequently in cases where a resident is having academic problems and at least monthly when a resident is on academic probation. The committee will serve as the initial hearing body for any appeal of a resident evaluation.

III. Podiatric Resident Selection Policy/Process

To be eligible for appointment to the podiatric housestaff at IMC, an applicant must:

1) Be a graduate of a college of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME).

2) Be a US citizen and, if applicable, registered with Selective Service (as required by the VA).

3) All PGY-1 positions will be offered through the Centralized Application Service for Podiatric Residencies (CASPR), following their established guidelines and policies. All interviewing will be done through the Centralized Residency Interview Process (CRIP).

4) In accordance with the above, all PGY-1 applicants must apply through CASPR. Applicants who are currently enrolled in a podiatry college should be in the upper 50% of their class. The program may, at its discretion, waive this requirement for students who have participated in a clerkship at the institution.

5) All PGY-1 applicants must pass parts I and II of the national boards prior to the time they begin training.

6) All PGY-2 and above (as well as Fellowship) applicants must provide a curriculum vitae and personal statement. They must have passed parts I, II, and III of the national boards prior to beginning their PGY-2 year and must be able to supply their test scores. They should also include their podiatry college transcripts, 3 letters of recommendation, a letter from their current/former program director, and notarized proof of graduation from podiatry school with the date of graduation.

7) DPMs or applicants who have already graduated from podiatry school must provide the following in addition to their CASPR application: a letter from their current program director or a similar letter detailing their activity after graduation; notarized proof of graduation from podiatry school with the date of graduation; national board parts I, II & III scores; podiatry college transcripts; and 3 letters of recommendation.

The program will provide applicants with the following information upon request:

1) Instructions for submitting the application and required documentation (PGY-2 and above)

2) Program training and policy manuals

3) Graduate Medical Education brochure

4) A written statement verifying that “IMC does not discriminate based on sex, race, age, religion, color, national origin, disability, or veteran’s status.”

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

Application packets are reviewed via criteria set forth by the CPME program requirements, COTH (CASPR), and this institution. A designated committee member will review applicants who meet the criteria. Based on the quality of the application packet and academic credentials, the applicant is

subsequently invited (if appropriate) for an interview. At the CRIP, applicants may receive an informational packet and interview with members of the Resident Selection Committee, including the program director whenever possible. At the conclusion of the interview, the interviewers complete a standard evaluation form for each applicant. The results are tallied and form the basis of the preliminary rank order. The Resident Selection Committee bases the final match rank order on preliminary ranking and review.

A match list is developed and submitted to CASPR. Strict conformance with the rules of the match is maintained throughout the selection process. In the event that the program fails to match all PGY-1 positions in a given year, recruitment will be opened up to all remaining applicants in the CASPR system under the MPII system they have developed. All that will be required of applicants is a copy of their CASPR application package. Interviewing protocols and timing will be determined when/if this situation arises.

Appointees to the residency must fulfill the current licensing requirements for podiatric residents in the state of Utah 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 the PGY-1 year and the resident must pass the exam in order to have their contract renewed. If a resident fails the boards in December, the exam may be re-taken in June with special authorization from the director to continue until results are available. If a failing score is received in June, the resident will not be able to continue, pending review by the Residency Training Committee.

IV. 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.

V. Conduct of the Resident

A. Orientation

At the beginning of the residency year, a period of orientation and instruction in the duties, responsibilities, and privileges of a 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.

The following subjects are included in this period of instruction:

1) IMC new hire orientation (PGY-1)

2) VAMC new hire orientation and training (PGY-1)

3) EMR training

4) Salary and benefits

5) BCLS/ACLS

6) Podiatry Residency Resource proper logging techniques

7) New Innovations procedures for rotation and faculty evaluations

8) Residency policies and schedule

9) Research methodology

10) Program competencies

11) Orientation to various affiliated institutions

12) Demonstrations and lectures covering the various phases of clinical podiatry are given to the newly appointed podiatric resident throughout the year. These lectures and demonstrations are so presented that the new podiatry resident will adapt to the hospital atmosphere.

B. Dress Code

These are podiatry department guidelines, in addition to all IMC guidelines.

Purpose: to present a professional appearance to patients, staff, and the public at all training sites, and to comply with Joint Commission standards where applicable.

Policy

Resident appearance and conduct should always 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. The following are guidelines for professional attire. Different departments or specialties may have requirements that are either more specific or less rigorous than these. The purpose of this policy is to provide general guidelines that will assist each department or specialty in establishing its own dress code to meet individual needs. These guidelines apply to each workday, including days with no patient care responsibilities. Maternity clothes are not exempt from these guidelines.

Specific Standards:

Name Tags: Proper identification as required by each training site must be worn and clearly displayed while on duty.

White Coats: White coats are considered professional attire and should be worn in all patient-facing areas. They 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 the hospital premises. Scrubs are expected to be clean and pressed. Scrubs may be worn in the operating room, delivery areas, or on the following rotations (unless otherwise delineated by department policy): emergency room, AO, and all ICUs. In patient care areas, it is recommended that a coat with a name tag be worn over scrubs.

Scrubs may not be worn in a hospital to which they don't belong. Clinic attire must be worn from institution to institution. This includes all rotations.

Scrubs may be worn at the VA for ulcers, casting, and procedure/post-op clinics.

Each rotation director has the authority for specific attire guidelines for their rotation.

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 clothing with messages, lettering or logos except UUMC, IMC, or VAMC. Athletic wear, including yoga pants, is not appropriate. Shorts are not allowed

and jeans are discouraged. A tie is recommended for men on weekdays and is also recommended on weekends unless described as optional in the individual department policy.

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, and to prevent glove puncture and injury to the patient. Artificial nails do not allow for proper hand hygiene.

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

Jewelry: Should not be functionally restrictive or excessive.

Piercings: There should be no visible body piercings, with the exception of the ears. There should be no visible tattoos. Nose piercings or tattoos which have religious significance are acceptable.

Violations: If a resident is in violation of his/her department guidelines, they 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 professional competency portion of their training.

C. Relation to Staff & Personnel

Supervision, control, and discipline of the resident are vested in the Residency Committee. 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 related to general hospital operations or personnel should be brought to the appropriate rotation director who may, at his/her discretion, discuss them with the hospital administrator. Questions relating to the Podiatric Medicine and Surgery Residency training program will be discussed with the appropriate rotation director or the Director of Podiatric Medical Education.

While in the hospital, residents are expected to conduct themselves with professional dignity, not only in their relationship with the patients, but also with nurses and other hospital employees, both on and off duty. Residents are expected to cooperate in every way possible and maintain friendly relations with all professional services, administrative departments, and other personnel. A resident has no disciplinary jurisdiction over nurses or other hospital employees. If personnel difficulties arise, they should be discussed with the appropriate rotation director.

Always remember 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.

All complaints must be in writing and will be considered by the rotation director, director, or training committee as appropriate.

D. Leave Policy

For each rotation, residents are expected to be in clinic or surgery when scheduled, which may include weekends. Whenever a resident is out of the area or reports as sick to their attending, PTO (personal time off) must be used.

Time spent studying or conducting research away from the resident's scheduled clinic or surgery must be approved in advance by the program director. Study or research days lacking prior approval will be counted as unexcused absences.

Vacation: Each resident directly employed by IMC is allotted 21 days of personal time (for both vacation and sick purposes) per year. Vacation requests must be made at least **45** days in advance and should include weekends if the resident will be unavailable on those days. The request must also include the rotation the resident will be on and the name of the attending that approved the vacation. After the chief of the rotation involved has approved the leave, the request must be made in writing to the program director (clint.larsen@imail.org) with a copy to the program coordinator (shirley.hamblin@imail.org).

Vacation may not be taken on the dates of required seminars or during specific rotations such as St. Marks Family Medicine, Vascular Surgery, and IMC Trauma.

Vacation time is limited to no more than 10% of any assigned rotation unless arrangements to make up the time are approved in advance. No more than 1 week may be taken at any single time. If the rotation is not in session due to a clinic closure or because the primary faculty is on vacation, the resident must request and take leave for that period or arrange to be at an alternate rotation site. Unused vacation is lost at the end of each year.

PGY-3 residents: Leave is not allowed between June 1st and the 4th Friday in June or is discouraged during the first 2 weeks of any rotation. PGY-3 residents are typically released on the Friday falling between June 19th and June 25th, if they have enough available PTO to cover the remainder of the month.

PGY-2 residents: Taking leave between June 15th and June 30th is strongly discouraged. PGY-2 start their year on July 1 and end on the third Friday in June when they advance to PGY-3. This may not apply to PGY-2 residents on non-podiatric rotations.

PGY-1 residents: Leave should not be taken in June or July; however, the program will consider granting single Fridays or Mondays in June.

**Special requests will be considered by the program director. However, consideration is not a guarantee of approval. At all times, the requirements of the residency program will take top priority.

*PGY-2 and PGY-3 residents will also be allowed 10 days of leave for employment interviews. This is a total of 10 days combined over the 2 years, not 10 per year. If more than 10 days are needed, the extra days must be charged to PTO or approved by the program director.

Sick Leave: Each resident must report sick days taken to their rotation director/attending at the beginning of the day on which the absence occurs (no later than 8:00 am) and, at the same time, should also send an email to shirley.hamblin@imail.org with a copy to the program director. *If a resident leaves clinic/surgery early due to illness, this must be reported and the program director will determine if the day should be charged as a sick day.

Any resident failing to abide by these policies will be placed on corrective action which may include loss of all leave privileges (first offense), suspended for 30 days without pay with time to be made up at the end of the program (second offense), or terminated (third offense).

Unused PTO is lost annually and will not be paid out at the end of the training. Leave taken for any reason that exceeds 30 days in any year must be made up without compensation (unless prior arrangements have been made) in order to complete the program. The program may limit the number of

residents who take PTO at the same time. Only 1 resident from each of the trauma on-call teams may be gone at the same time. Preference goes to authorized leave requests and the order of request submissions.

Authorized CME Leave: Each resident will be eligible for 5 days of leave each year to attend seminars. Leave must be approved **45** days in advance (see above). A maximum of 1 travel day per seminar will be allowed and must be included with the leave request.

Medical Leave: The program follows the ACGME policy for resident medical, parental and caregiver leave (https://www.acgme.org/newsroom/blog/2022/acgme-answers-resident-leave-policies/) Intermountain Health also adheres to The Family & Medical Leave Act of 1993. To be eligible for FMLA leave, a house officer must have been employed for at least 12 months and must be requesting leave for a serious medical condition of the employee, serious medical condition of a spouse, parent, or child, or birth or adoption of a child.

Illness which results in periods of absence longer than a week will be handled under the Family & Medical Leave Act.

Housestaff must inform the program director and the GME office immediately about any needed medical leave to allow time to arrange clinical coverage. Upon learning that a house officer is requesting FMLA leave, the program director or program coordinator will require that the house officer contact a Benefits Office representative to apply for FMLA. Employees are required to provide the Benefits Office with at least 30 days' notice before FMLA leave is to begin, or within 2 business days in the case of an unforeseen emergency. The Benefits Office will approve or disapprove all FMLA leave requests. Extended leave may result in the necessity of time being made up at the end of the year.

Other questions about requesting leave, leave policies, or other forms of leave available should be directed to the HR Benefits Office.

Emergency Leave: On a case by case basis, emergency leave may be granted (with or without the necessity of time being made up) at the discretion of the director, assistant director, and rotation director at the institution where the resident is rotating, or (if they are unavailable) by a member of the Residency Committee. The definition of emergency will be at the discretion of the program and the resident agrees to abide by the decision of the committee, whose available members will be polled in the case of a disagreement. Failure to abide by the decision will result in the termination of the resident.

Unexcused Absences: Any unexcused absence will be treated as a violation of the sick leave policy above with the same penalties applying. An unexcused absence is defined as any time a resident is not in attendance at a scheduled rotation, conference, or other residency function, and has not notified the program director and coordinator prior to the absence, or is unavailable when on call, unless prior arrangements have been made and approved. This can include leaving early or coming in late. If a resident is not at a rotation site during normal hours, they are expected to be at a different rotation site or working on didactic requirements for the program (with prior approval from the director). The resident must leave word with the rotation staff regarding how they can be reached and must be ready and available to return within a reasonable amount of time (usually no more than 30 minutes) if they are needed.

E. Podiatric Resident Work Hours

Work Hours

1) Work hours are defined as all clinical and academic activities related to the residency or fellowship program. This includes patient care, administrative duties related to patient care, provision for transfer of

patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Work hours do not include reading and preparation time spent away from the work site.

2) Work hours will be limited to 80 hours (68 for PGY-1s) per week, averaged over a 4-week period and inclusive of all in-house call activities. The 4-week period will be averaged during a single rotation. For example, we will not average two 2 weeks of a clinical rotation with 2 weeks of research.

3) In-house call will not be scheduled more frequently than every 3rd night, unless an exception has been approved by the GMEC.

4) Residents and fellows will be provided with 1 day in 7 free from all educational, administrative, and clinical responsibilities. This will be averaged over a 4-week period and inclusive of call. One day is defined as 1 continuous 24-hour period.

5) A reasonable time period for rest and personal activities will be provided between all daily work periods.

6) The resident may be required to periodically track their work hours using Podiatry Residency Resource to provide documentation that the number of hours worked on various rotations does not violate these rules.

On-Call Activities:
1) In-house call is defined as work hours, beyond the normal workday, when residents are required to be immediately available within the assigned institution.

2) In-house call will occur no more frequently than every 3rd night, averaged over a 4-week period.

3) Continuous on-site work hours, including in-house call, will not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.

4) No new patients may be accepted after 24 hours of continuous duty except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.

5) At-home or pager call is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the "every 3rd night" limitation. However, at-home call shall not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call will be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

6) When residents are called into the hospital from home, the hours spent in-house will be counted toward the 80-hour limit.

7) The program may monitor the demands of at-home call by periodically reviewing resident work hours as recorded in Podiatry Residency Resource. A separate category of hours will be recorded as "called to hospital".

Moonlighting of Residents and Fellows in Podiatric Programs:
1) Professional and patient care activities that are external to the educational program are called "moonlighting". The podiatry programs do not permit students to moonlight.

2) Work hour exceptions may be granted for up to 10% (8 hours) of the 80-hour limit based on sound educational rationale. Prior approval, as required, would need to be obtained from the GMEC. The program has no plans to request an exception at this time. (See Work Hours Exception Policy)

Back-Up System:
The program's back-up system to cover patient care responsibilities, when those responsibilities are unusually difficult or prolonged or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care, will include coverage of those duties by attending physicians and/or the temporary reassignment of residents from less demanding rotations to assist in the patient care duties. Any negative impact on resident education will be considered and, to the greatest extent possible, avoided in making reassignments. As a last resort, patient care will be rescheduled.

F. Miscellaneous Responsibilities:
While your obligation to yourself, your profession, your hospital and patients will be expressed by implication throughout this manual, the following reminders are added as guidelines and are intended to summarize many details not specifically mentioned. Members of the resident staff are expected to abide by these guidelines at all times.

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

2) Resident shall report to the director as a member of the house staff on the third Monday in June or sooner if informed in writing by the program.

3) The resident must cooperate in the conservation of supplies.

4) Residents are not to accept fees or gratuities from patients, their relatives, or friends. You will not practice your profession or assist any physician outside the affiliated institutions.

5) No alcoholic beverages are permitted in the hospitals. No person who has been drinking may attend a patient.

6) Smoking in the hospitals is prohibited except in designated areas.

7) At all times, your patients are to be your first consideration.

8) Visit each of your inpatients at least once daily, giving them such conscientious professional care as the attending physician directs, and make progress notes of all significant events in the development of the case.

9) Provide complete privacy for each patient during any and all dressings and examinations in which he/she might be exposed. Curtains are furnished in multiple-bed rooms.

10) Do not sit on a patient's bed unless it is necessary for the examination.

11) Protect your patient's privacy. Refer any information release inquiries to the appropriate department at the institution.

12) Refer any questions about your patient's financial arrangements to the appropriate department or individual at the institution.

13) Refer any requests for extra visiting privileges to the Director of Nurses, requests for transfers to other accommodations to the Admitting Office, and inquiries about discharge from the hospital, etc. to the patient's attending physician or chief resident.

14) Using an Incident Report Form, promptly report any unusual occurrences in the hospital, such as accidents, fire, or a disturbed patient.

15) Guard against unnecessary or unwise talking in the hearing of a patient, even one coming out of anesthesia or from alcoholic or other stupor. Patients sometimes hear and remember surprisingly well.

16) 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.

17) Residents will not order materials, supplies, or surgical equipment directly from outside vendors unless directed by an appropriate individual.

18) Fraternization with patients is prohibited.

19) While the program provides ample opportunity for training, it is the responsibility of the resident to fulfill the training requirements, including but not limited to the number and diversity requirements in CPME 320. If a resident believes they are having trouble meeting the requirements, he/she should bring the problem to the attention of the director.

VI. Supervision/Evaluation

The Residency Training Committee expects all 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 a resident fails to fully and faithfully perform each and all of his/her obligations as stated in the contract and in this manual, or conducts him/herself 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. The resident will maintain the right to appeal the decision (see below). If 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. Grievance Policy (Due Process Policy)

Purpose: To assure fairness in all evaluations, the Graduate Medical Education Committee has adopted standards of review for actions that may affect the status of the resident. Any resident being disciplined or placed on probation, or otherwise affected by the policy, will receive a second copy of this policy, along with the discipline and dismissal policy, by mail from the chairman of the Graduate Medical Education Committee. The policy will be sent with a cover letter as soon as the Graduate Medical Education Committee is notified of the problem by the program director.

1) Policy:

a) Standards not met will be considered to be academic problems. No resident will be dismissed for academic problems without a remediation period unless extraordinary circumstances exist (i.e. the resident is an immediate threat to patient safety). No resident will be dismissed without consultation with the chairman of the Graduate Medical Education Committee to ensure that appropriate evaluation, documentation, and probationary procedures have been followed.

b) A resident's pay will stop at the time of termination by the program. If the decision is later reversed by the appeals process, back pay must be awarded as part of the decision.

c) The Podiatric Training Committee will attempt to facilitate informal discussions to resolve differences.

d) Any resident dissatisfied by discipline imposed by the Podiatric Training Committee may appeal in writing to the Program Grievance Committee. The Program Grievance Committee will be comprised of an equal number of residents and faculty. Members of the committee should be broadly representative of the program faculty and the residents. Appeals may be for any action considered capricious, arbitrary, or not in keeping with the previously mentioned criteria. The resident may appear before the committee to testify on his/her own behalf with an advocate from the faculty or residency. This committee will take into consideration the resident's overall performance when arriving at a decision. The committee will reach a decision and give written notice no longer than 14 days after receiving an appeal. The committee will be called in by the Podiatric Training Committee when a need arises.

e) Any party dissatisfied with the decision of the Program Grievance Committee may appeal in writing to the chairman of the Graduate Medical Education Committee for further review by the GMEC. This appeal must be made within 1 week of receipt of the written decision of the Program Grievance Committee, unless other arrangements have been made. The Graduate Medical Education Committee will review the appeal and provide notice of their decision to the resident no longer than 14 days after receiving the appeal.

2) The Resident:

a) Will be notified in writing by the program director of any negative evaluations which may affect his/her standing or progress in the training program.

b) Has the right to provide additional or explanatory information. If the Program Grievance Committee or the Graduate Medical Education Committee has requested that the resident provide or expand upon the information in person, he/she will be excused from committee deliberations after presenting his/her information.

c) Has the right to be accompanied by a faculty member or another resident to act as an advocate during any personal appearance at an appeal procedure. A summary of the proceedings will be made available to the resident. The resident may take notes during the meeting.

B. Grievance Policy II (Discipline and Dismissal Policy)

1) Any resident who receives an unsatisfactory rating on any rotation or who is otherwise not performing in a satisfactory manner in the opinion of the program, or as defined by the program standards of performance, should be reviewed for corrective action. Such corrective actions may include repeating a rotation, repeating a year, placement in a special program which may include special supervision, or termination (if previous corrective action has been unsuccessful or if the resident was placed on academic probation earlier in the training year). Any corrective action will require an affirmative vote of the Podiatric Training Committee and will be reported to the GMEC.

2) The resident should have an opportunity to remediate unsatisfactory performance. The program will determine the length of the probationary period and what must be accomplished in order for the resident to be removed from probation. In general, the probationary period will not extend beyond the end of the

current contract year, unless the contract year ends within 3 months. In this case, the program has the option of extending the probationary period into the next year, but the extension shall not exceed 3 months. Any house officer contract that may have been issued by the program for the subsequent year will be considered invalid until the resident has fulfilled the probationary requirements and has been removed from probation.

3) If the resident and the program director cannot agree on the terms of remediation, the resident can request a review of his case by the GMEC as per the Grievance Policy.

4) Virtually all actions of a resident, in connection with the performance of duties, relate to the suitability of the resident as a medical practitioner. Therefore, issues of integrity, abusive behavior toward patients, the public, or other health professionals, tardiness or unexcused absences, theft or abuse of property, substance abuse, or insubordination will be considered as part of the comprehensive academic evaluation.

C. Resident Evaluation Policy

Purpose: The Graduate Medical Education Committee of IMC has the responsibility for the overall academic quality of each of the graduate medical training programs. A part of that quality can be measured by the performance of the residents (a term used to include interns, residents, and clinical fellows in CPME accredited training programs). The program expects a progression of knowledge in the specialty area from the beginning to the 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, with an overall goal that all residents will pass the examination and become board certified.

In addition to achieving board certification, the training of effective and competent physicians is the goal of each training program, and all evaluations will be directed toward that ultimate objective.

Standards of Performance:
The program will have a written set of standards of performance for residents. These standards include a definition of clinical competence including:

1) Appropriate Behavior of the Resident:

Appropriate behavior is expected towards patients, colleagues, and staff while attaining the following competencies (see rotation specific competencies and indicators later in this manual):

a) Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity.

b) Assess and manage the patient's general medical status.

c) Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.

d) Communicate effectively and be able to function in a multi-disciplinary setting.

e) Manage individuals and populations in a variety of socioeconomic and healthcare settings.

f) Understand podiatric practice management in a multitude of healthcare delivery settings.

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

2) Promotion/Graduation:
The resident is eligible for promotion/graduation upon the satisfactory completion of the training program. During his residency program, 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 CPME 320 for the appropriate category of residency training, and fulfill all financial obligations to all institutions affiliated with the program.

At least 3 months prior to the completion of the resident's training year, the Residency Training Committee will review the resident's performance and research proposals/paper(s). At this time, the Residency Training Committee will or will not recommend that the resident graduate or be promoted (have contract renewed). A negative recommendation may be accompanied by a proposed remediation plan including the type of remediation, the location, and the expected duration. If the plan extends beyond the end of the current training appointment, a statement regarding the employee's status in the position (i.e. with or without compensation) will be attached. However, in cases where corrective action/remediation has already been attempted, the decision will be final, subject to the institutional due process procedure.

Certification of completion of the residency will be made by an approval vote from the Residency Training Committee. Following approval, the Director of Residency Training will cause to be issued to the resident a certificate evidencing the successful completion of the residency.

3) Remediation:
Any resident who fails to perform satisfactorily in a rotation will be given the opportunity to remediate the areas identified in the evaluation as minimally acceptable or deficient.

If the grade of minimally acceptable is received, one of the following remediation methods will be used:

a) If the specific objectives which were graded as 3 or less are part of another rotation in which the resident will participate before the end of the program, the director of the future rotation will be asked to emphasize those areas. If the resident performs satisfactorily in those areas, the deficiency will be considered to have been satisfied.

b) Extra clinical and/or didactic work in the area will be assigned. If clinical work is needed, it will be worked into the resident's schedule. The resident must obtain a satisfactory rating on the work assigned.

c) The resident will be required to repeat the rotation or an equivalent as defined by the director. This rotation may be added to the end of the training program and may or may not be the same length as the original rotation, at the discretion of the Residency Training Committee. Training beyond the end of the standard 36-month training period will be without compensation.

d) If the grade of deficient is received, the following remediation method will be used:

i) The resident will be assigned to repeat the rotation or an equivalent as defined by the director. The rotation time will be added to the end of the training program and will be the same length of time as the original rotation.

ii) 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. Training beyond the end of the standard 36-month training period will be without compensation.

A written copy of these standards will be given to each resident on or before the first day of training in the program and a copy will also be filed with the Office of Graduate Medical Education. The policy shall spell out the method and frequency of evaluation for residents in the training program. If an in-service examination is given, the purpose will be spelled out. If it is used as a performance measure, that information will be clearly communicated to the resident.

4) Renewal of House Officer Agreements:
Residents performing satisfactorily may have the resident agreement renewed for the subsequent year. The resident agreement is renewable annually as agreed upon by the resident, the program director, and IMC. Issuance of an agreement for 1 year does not imply the resident will complete the training program. Agreements for succeeding years of training will be issued only after specific conditions have been met.

a) Residents will have regular academic evaluation

1) In addition to regular contact with supervisors, each resident will be evaluated in writing at the end of each rotation or at least quarterly. Rotations should have an interim evaluation if the resident's progress is unsatisfactory.

2) Written evaluations will be placed in the resident's file and will be available for review by the resident upon request.

3) Residents new to a training program require a higher level of supervision during the first 6 months. Supervisors are responsible for early detection of problems and remedial programs must be established.

b) For any evaluation of less than satisfactory performance for any reason, the program director will:

1) Discuss the evaluation with the resident.

2) Outline in written form and in discussion any corrective action to be taken to remedy the deficiency, as well as how the resident will be evaluated to determine if the problem has been corrected.

3) Notify the program evaluation committee of the unsatisfactory evaluation.

c) The resident will be allowed to refute in writing any evaluation, and the written rebuttal will be placed in the resident's file along with the evaluation.

d) The residency program will designate an evaluation committee, with resident representation, to be responsible for resident evaluation. That committee will meet at least quarterly to review the performance of all residents who are not progressing satisfactorily. Residents having performance difficulty may need to be placed on a special program immediately, in order to resolve the problem before it is time to renew the agreement for the coming year. The evaluation committee may make recommendations on corrective action as described below:

1) The Residency Evaluation Committee will be made up of the director, the chief resident(s), and at least one other member of the residency training committee to be appointed by the director. The committee shall be chaired by the director unless (s)he has appointed another committee member to assume chairmanship. The committee will review the progress of the residents at least annually to determine the promotion status of each resident. The committee will also review (self-assess) the program on an annual basis and make recommendations to the Residency Training Committee regarding

any needed changes or program enhancements. The committee will meet more frequently in cases where residents are having academic problems and will meet at least monthly if a resident is on academic probation. The committee will serve as the initial hearing body for any appeal of a resident evaluation.

e) The resident will meet with the program director quarterly to review the accumulated written evaluations of the year's performance.

f) A final written evaluation will be done for each resident who completes a program or changes to another program. That evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final written evaluation will state whether a resident has successfully completed requirements for board eligibility or list areas of deficiency. This final evaluation should be part of a resident's permanent record maintained by the Office of Graduate Medical Education.

D. Academic Probation

Any resident who receives an unsatisfactory rating on any rotation, or who is otherwise not performing in a satisfactory fashion as defined by the program standards of performance, should be reviewed for corrective action. Such corrective actions can include repeating a rotation(s), repeating a year, a special program which may include special supervision, termination if previous corrective action has been unsuccessful, or academic probation in addition to any of the above. Each program will designate who has the authority to instigate corrective action, i.e. the evaluation committee or the program director. The Director of Graduate Medical Education should be notified at this time.

The resident will have an opportunity to remediate unsatisfactory performance. The program will determine the length of the probationary period and what must be accomplished for the resident to be removed from probation. In general, the probationary period will not extend past the end of the current agreement year, unless the agreement year ends within 3 months, in which case the program has the option of extending the probationary period into the next agreement year as long as the extension does not exceed 3 months. Any house officer agreement which may have been issued by the program for the subsequent year will be considered invalid until the resident has fulfilled the probationary requirements and been removed from probation. At the time the house officer is removed from probation, the program has the option to:

1) Allow the resident to complete the remainder of the training year

2) Offer a house officer agreement for the next agreement year

3) Not offer an agreement for the next agreement year

House officer agreements offered for a subsequent year may contain a written clause stating conditions under which the agreement may be terminated immediately. Usually that clause will refer to continuing problems of the kind that resulted in the first probationary period.

If the resident and the program director cannot agree on the terms of remediation, the resident can request a review of his case by the program evaluation committee.

The decision of a program not to renew an agreement shall be made by the chair of the GME committee after consultation with the program director. Any decision not to renew shall be made and communicated in writing to the house officer no later than four months prior to the end of the agreement year when possible.

Virtually all actions of a house officer in connection with the performance of duties relate to the suitability of the house officer as a medical practitioner. Therefore, issues of integrity, abusive behavior toward patients, the public or other health professionals, tardiness or unexcused absences, theft or abuse of property, substance abuse or insubordination will be considered as part of the comprehensive academic evaluation.

E. Resident Supervision Policy

Intermountain-wide policies may be found online in the Policy Library:
https://intermountainhealth.sharepoint.com/sites/IHPolicy

Summary of Main Points:
Key Principles

1) An attending physician must be identified for each episode of patient care involving a resident.

2) The attending physician is responsible for the care provided to these patients.

3) The attending physician is responsible for determining the level of supervision required to provide appropriate training and to assure quality of patient care.

4) Resident supervision must be documented.

5) Program directors direct and supervise the program.

Key Supervision Issues

1) Attending physician/staff practitioner responsibilities:

a) Inpatient:
Attending physician is identified on the patient chart
Meet with the patient within 24 hours of admission
Document supervision with progress note by the end of the day following admission
Follow local admission guidelines for attending notification
Ensure discharge is appropriate
Ensure transfer from one inpatient service to another is appropriate

b) Outpatient:
Attending physician is identified on the patient chart
Discuss patient with resident during initial visit and document attending involvement with either an attending note or documentation of attending supervision in the resident progress note
Countersign note

c) Emergency Room
An attending physician must always be available

d) Consultation
Discuss with the resident doing the consultation within 24 hours
Document supervision of consultation by the end of the next working day

e) Surgery/Procedures
Attending physician is identified
Attending meets with the patient before surgery/procedure

Document agreement with surgery/procedure(s)
Countersign procedure note
Sign initial DNR orders and document compliance with local DNR policies.

f) Program Director/Program Coordinator
Establish and write program-specific supervision policy
Provide orientation for residents
Conduct or oversee education of attending physicians
Implement and follow up on policy

Policy for Supervision of Podiatric Postgraduate Trainees at IMC Affiliated Hospitals in Salt Lake City, UT

1) Definitions

a) Graduate Medical Education: post-graduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire those skills, knowledge, and attitudes which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitate the resident's professional and personal development, and ensure safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty.

b) Program Director: the program director is responsible for the quality of the overall affiliated education and training program in podiatric medicine & surgery and for ensuring that the program is in compliance with the policies of the Council on Podiatric Medical Education.

c) Residents: the term "residents" refers to individuals who are engaged in a postgraduate training program in podiatry. The term "resident" for the purposes of this policy includes individuals in their first year of training (typically referred to as interns) and individuals in advanced postgraduate education programs who are typically referred to as fellows.

d) Attending Physician: attending physician refers to licensed, independent physicians who have been formally credentialed and privileged at a training site in accordance with applicable requirements. The attending physician may provide care and supervision only for those clinical activities for which they are privileged.

e) Supervision: supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation, and direction. It includes the imparting of the practitioner's knowledge, skills, and attitudes from the practitioner to the resident and assuring that care is delivered in an appropriate, timely, and effective manner.

f) Documentation: documentation is the written or computer-generated medical record evidence of a patient encounter. In terms of resident supervision, documentation is the written or computer-generated medical record evidence of interaction between a supervising practitioner and a resident concerning a patient encounter.

g) Supervising Practitioner: a supervising practitioner must provide an appropriate level of supervision. Determination of the level of supervision required is a result of the experience and demonstrated competence of the resident and of the complexity of the patient's health care needs.

2) Policy

In a health care system where patient care and the training of health care professionals occur together, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether the practitioner is a trainee or staff. It is recognized that as resident trainees acquire the knowledge and judgment that accrue with experience, they will be allowed the privilege of increased authority for patient care.

a) The hospital must comply with the institutional requirements and accreditation standards of the Joint Commission and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide patient care and supervision of residents.

b) The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and the provision of excellent education and training for future health care professionals.

c) The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent upon the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently.

d) The principles of good training and educational supervision are not likely to change radically over time. Rules governing billing and documentation, however, will inevitably evolve. This policy focuses on resident supervision from the educational perspective.

e) CPME requires that the residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences. This process is the underlying educational principle for all podiatry residents. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and resident.

f) The podiatry program(s) which includes residents within the IMC Affiliated Hospital System must be approved by CPME (Council for Podiatric Medical Education) or have special approval by the GMEC (Graduate Medical Education Committee).

3) Responsibilities

The Residency Program Director is responsible for the overall quality of the education and training program in podiatry and for ensuring that the program is in compliance with the policies of CPME. The Residency Program Director defines the levels of responsibility for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity.

a) Assess the attending physician's discharge of supervisory responsibilities. At a minimum, this includes written evaluations by the residents and interviews with the residents, other practitioners, and other members of the health care team.

b) Structure training programs consistent with the requirements of CPME and the affiliated sponsoring entity.

c) Arrange for all residents entering their first rotation to participate in an orientation on policies, procedures, and the role of residents within the affiliated training program.

d) Ensure that residents are provided the opportunity to contribute to discussions in committees where decisions being made may affect their activities.

The attending physician is responsible for and must be personally involved in the care provided to individual patients in both inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible attending physician must continue to maintain a personal involvement in that care. The attending must provide an appropriate level of supervision. The level of supervision required is determined by considering the experience and demonstrated competence of the resident and the complexity of the patient's health care needs. The procedures by which the attending physician provides and documents appropriate supervision are outlined in section 5 below.

The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside that scope of service. Each resident is responsible for communicating significant patient care issues to the attending physician and for documenting such communication in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities.

Procedures

a) Resident Supervision by the Attending Physician:

Attending physicians are responsible for the care provided to each patient and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with each patient and with each resident who is providing care as part of the training experience. Each patient will be assigned an attending physician whose name will be clearly identified in the patient's record. It is recognized that other attending physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to, the assigned practitioner. It is the responsibility of the attending physician to be sure the resident(s) involved in the patient's care is informed of such delegation and can readily access an attending physician at all times. Such a delegation will be documented in the patient's record. At a minimum, the attending physician is expected to fulfill this responsibility in the following manner:

1) The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Medical, surgical, or mental health services must be personally furnished or rendered under the supervision of the attending physician. Documentation of this supervision will be made by progress notes entered into the record by the attending physician or reflected within the resident's progress note at a frequency appropriate to the patient's condition. The medical record must reflect the degree of the attending physician's involvement, either by staff physician progress note or the resident's description of the attending's involvement. The resident's note shall include the name of the attending physician with whom the case was discussed, as well as a summary of that discussion. The attending may choose to countersign and add an addendum to the resident's note detailing his/her involvement and supervision. Pathology and radiology reports must be verified by an attending physician. Attending physicians will be responsible for following the admitting procedures required by the institution to which they are admitting patients in association with resident physicians.

2) For patients admitted to an inpatient team, the attending physician must meet the patient early in the course of care (within 24 hours of admission, including weekends and holidays). This supervision must be personally documented in a progress note no later than the day after admission. The attending physician's progress note will include any findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed, dated, and timed. Attending physicians are expected to be personally involved in the ongoing care of the patients assigned to them, in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the trainee.

3) The attending physician, in consultation with the resident, ensures that the discharge of the patient from an inpatient service is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen. This may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the attending physician's countersignature on the discharge summary.

4) The attending physician, in consultation with the resident, ensures that the transfer of any patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The attending physician from the transferring service must be involved in the decision to transfer the patient. The attending physician from the receiving service must treat the patient as a new admission and write an independent note or an addendum to the resident's transfer acceptance note.

5) For patients admitted to or transferred into an Intensive Care Unit (ICU), including medical, cardiac, and surgical ICUs, the attending physician must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays.

6) For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for the night float must be clearly designated by local policy.

7) An attending physician must be physically present in the outpatient clinic area during clinic hours. All patients to the clinic for which the attending physician is responsible should be supervised by the same attending physician. This supervision must be documented in the chart via a progress note by the attending physician or the resident's note. The documentation must include the name of the attending physician or be co-signed by the attending. New patients should be supervised as dictated by the graduated level of responsibility outlined for each discipline. The supervision for new patients should be documented by either an independent note from the attending physician, an addendum to the resident note, or the attending's co-signature. Unless otherwise specified by the graduated levels of responsibility, new patients should be seen and evaluated by the attending physician at the time of the patient visit. Returning patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective and appropriate. This supervision must be documented in the record by a note from the attending physician or a resident's note that indicates the nature of the discussion with the attending physician. The medical record reflects the degree of involvement of the attending physician, either by staff physician progress note or the resident's description of the attending's

involvement. All notes must be signed, dated, and timed by the resident. The attending's co-signature of the resident's note is an acceptable method for the attending physician to document resident supervision.

8) The attending physician is responsible for official consultations on each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for the supervision of these residents. The supervision of residents performing consultations will be determined by the graduated levels of responsibility for the resident. The attending physician must document this official consultation supervision by writing a personal progress note, by writing his/her concurrence with the resident consultation note, or by co-signature no later than the close of the next working day. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement.

9) An emergency department attending physician must be physically present in the emergency department. Each new patient to the emergency department must be seen by or discussed with an attending physician. The attending physician, in consultation with the resident, ensures that the discharge of the patient from the emergency department is appropriate.

10) Emergency room consultations by residents may be supervised by a specialty attending physician or the emergency room attending physician. All emergency room consultations by residents should involve the attending physician supervising the resident's discipline-specific specialty consultation activities for which the consultation was requested. After discussion of the case with the discipline-specific attending physician, the resident may receive direct supervision in the emergency room from the emergency room attending physician. In cases where the emergency room attending physician is the principal provider of care for the patient's emergency room visit, the specialty-specific attending physician does not need to meet directly with the patient. However, the specialty-specific attending physician's supervision of the consultation should be documented in the medical record by co-signature of the consultation note or reflected in the resident's physician consultation note.

11) Ensure all Do Not Resuscitate (DNR) orders are appropriate and be certain the supportive documentation for DNR orders is in the patient's medical record. All DNR orders must be signed or counter-signed by the attending physician.

b) Assignment and Availability of Attending Physicians

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

2) To ensure patient safety and quality patient care while providing opportunities to maximize the educational experience of the resident in an ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than 1 clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

3) Facilities must ensure that their training programs provide appropriate supervision for all residents as well as a duty hour schedule and a work environment that are consistent with proper patient care, the educational needs of residents, and all applicable program requirements.

c) Graduated Levels of Responsibility

1) Each training program will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment.

2) As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, however, residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify some treatment plans (i.e. physical therapy or speech therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above the standard setting-specific documentation requirements. Since the patient is the personal responsibility of the attending physician, the overriding consideration must be the safe and effective care of that patient.

3) The Residency Program Director will define the levels of responsibility for each year of training by preparing a description of the types of clinical activities residents may perform and those for which a resident may act in a teaching capacity. The documentation of the assignment of graduated levels of responsibility will be made available to other staff members as appropriate. These guidelines will include the knowledge, attitudes, and skills which will be evaluated and must be present for a resident to advance in the training program, assume increased responsible (such as the supervision of lower-level trainees), and be promoted at the time of the annual review.

d) Supervision of Procedures

1) Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part in the education of the resident, such procedures may be performed only by residents with the required knowledge, skill, and judgment, and under an appropriate level of supervision by attending physicians. Examples include operative procedures performed in the operating suite, angiograms, endoscopy, bronchoscopy, and any other procedures where there is a need for informed consent. Attending physicians will be responsible for authorizing the performance of such procedures and such procedures should only be performed with the explicit approval of the attending physician. NOTE: Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Examples are the placing of intravenous and arterial lines, nail procedures, simple skin biopsies, injections, aspirations, wound debridement, and drainage of superficial abscesses.

2) Attending physicians will provide appropriate supervision for the patient's evaluation, management decisions, and procedures. For elective or scheduled procedures, the attending physician must evaluate the patient and write a pre-procedural note (or addendum to the resident's pre-procedural note) describing the findings, diagnosis, treatment plan, and/or the choice of specific procedure to be performed. This pre-procedural evaluation or note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be followed. A pre-procedure note may also serve as the admission note if it is a) written within 1 calendar day of admission by the attending physician who has responsibility for continuing care of the inpatient and b) meets criteria for both admission and pre-operative notes. Other services involved in the patient's operative care (i.e.

anesthesiology) must write their own pre-procedure notes, such as for the administration of anesthesia, as required by JCAHO. However, such documentation does not replace the pre-operative documentation required by the surgery attending physician.

3) During the performance of such procedures, an attending physician will provide an appropriate level of supervision. Determination of what constitutes an appropriate level of supervision is generally left to the discretion of the attending physician within the context of the previously described levels of responsibility already assigned to the individual resident involved. This determination is based on the experience and competence of the resident and the complexity of the specific case.

e) Emergency Situations

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

f) Evaluation of Residents and Supervisors

1) Each resident will be evaluated according to CPME requirements based on clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of a patient. Evaluations will occur as indicated by the CPME at the end of the resident's rotation or every six months, whichever is more frequent. Written evaluations will be discussed with the resident.

a) If a resident's performance or conduct is judged to be detrimental to the care of a patient(s) at any time, action will immediately be taken to ensure the safety of the patient(s).

b) At least annually, each resident rotating through the program will be given the opportunity to complete a confidential written evaluation of attending physicians and of the quality of the resident's training. Such evaluations will include the adequacy of clinical supervision by the attending physician. The evaluations will be reviewed by the program director.

c) All written evaluations of residents and attending physicians will be kept on file by the Residency Program Director in an appropriate location and for the required time frame set forth by the guidelines of the CPME.

g) Monitoring Procedures

1) The goal of monitoring resident supervision is to foster a system-wide environment of peer learning and collaboration among managers, attending physicians, and residents. The monitoring process involves the use of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications. Monitoring of compliance with these procedures will be performed by the program director and as part of the scheduled internal program reviews.

2) The basic foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (attending physicians and residents) working collaboratively in well-designed health care delivery systems.

VII. Sexual Harassment

Sexual harassment will not be tolerated by the residency program. Any sexual harassment will be dealt with by the method prescribed in the individual sexual harassment policy at the institution where the problem occurred (policies available upon request). If no such policy exists, the Intermountain Health Care policy will be followed. In this case, any complaints must be filed through a member of the Residency Training Committee.

VIII. Resident Logs

Clinical logs must be kept on Podiatry Residency Resource and, each Monday, must be current through the previous Friday. The program requires that at least 2 cases be logged each day, including all surgeries and at least 1 case from each ½ day clinic session (all specialties). The resident is required to log all cases which would count toward a MAV requirement. The director at his/her sole discretion will determine the adequacy and completeness of each log. Repeated or chronic logging delinquency is grounds for dismissal without appeal. Activity logs (didactics only) must be kept on Podiatry Residency Resource and each Monday, must be current through the previous Friday.

IX. Teaching Conferences/Seminars

All dates and times are subject to change at the discretion of the program director.

Pre-Op Conference is held between 6:30 am and 8:00 am on Mondays at the VAMC. Topics include pre-op, m&m, and case discussions.

Podiatry Grand Rounds are held from 6:30 am to 8:30 am on the first Tuesday of each month. The day of the week may be changed for the convenience of the attending.

Podiatry Conference is held from 6:30 am to 8:30 am on Tuesday of each week in which Grand Rounds are not held. These are normally held at Intermountain Medical Center.

McGlamry Review: current schedule is the second Tuesday of each month. *(This is subject to change and updated schedules may be placed in this manual.)*

Journal Club: is currently held on the third Tuesday of each month *(subject to change)*.

The residents shall also participate in all the teaching conferences and rounds provided by the services they rotate on (see schedule). Residents will be required to write a case report including a literature review to make up for any unexcused absences. Absences must be approved in advance to be considered excused.

Residents will be required to complete 2 online lectures, assigned by the director, to make up approved absences from the weekly didactic conferences. This does not apply to individuals on St. Mark's Medicine, IMC Trauma or VA Emergency Medicine rotations. However, this does apply to all other approved absences including vacations.

Seminars: The residents are required to attend the annual Utah Podiatry Association Seminar in Park City. Residents are encouraged to attend an additional seminar from an approved list available from the program director.

Additional programs or conferences must be approved by the Training Committee.

X. Academic Requirements Including Research

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

1) One paper on a podiatry-related subject of a quality consistent for publication. Outline with bibliography due April 1st of the 1st year, rough draft complete by April 1st of the 2nd year, and completed article due by April 1st of the 3rd year.

2) Two formal presentations (including audiovisuals and all relevant data) of cases seen in the clinics, suitable for inclusion in a teaching file.

3) Two lectures per year on topics in podiatry suitable for presentation at a didactic conference (including audiovisual aids, etc.).

4) A minimum of 12 case presentations for podiatry conferences (short audiovisuals optional).

5) One research project to be approved by the residency director. Outline with bibliography to be submitted by October 1st of the 1st year, the section of the project for which the resident is responsible to be completed by Jan 1st of the final year of training with a formal write-up complete by April 1st. The program will assign a mentor. The purpose of this exercise is to teach research methodology to the resident. The following areas will be evaluated (see evaluation form):

Background (Review of literature)			
Primary Question and Response Variables			
Secondary Question and Response Variables			
Subgroup Hypotheses			
Study Population (inclusion/exclusion criteria)			
Sample Size Assumptions and Estimate			
Informed Consent			
Assessment of Eligibility/Baseline Exam			
Randomization method/plan			
Description and Schedule			
Measures of Compliance			
Data Collection			
Quality Control			
Data Analysis			
Termination Policy			

Interim reviews may only address a limited subset of these items. Some elements will not be relevant for all proposals. Relevance will be determined by your mentor, who will evaluate your proposal. Fundamentals of Clinical Trials by Lawrence Friedman is a required reference.

6) Satisfactory completion of all sections of the Surgical Review Course.

XI. Policies for Patient Relations

A. Admission Procedures

Patients are admitted to the hospital and assigned beds by the Admitting Office. The attending physician or chief resident calls these offices to make a reservation and to give the admitting diagnosis and other preliminary information. An H&P and admitting orders must be completed at the time of admission.

B. Transfer of Patients
After a patient has been admitted, transfer from one room to another is accomplished only through the Nursing Supervisor and/or Admitting Office. Transfers to other services require completion of formal transfer orders and a transfer summary.

C. History and Physical Examination
All podiatric patients admitted to the hospital will be given a complete diagnostic workup which is considered essential to the case. The history should be as complete as possible and should include:

1) Chief complaint

2) History of present illness

3) Past medical history

4) Social history

5) Review of systems

The history should record clear, concise statements pertinent to the patient's story of his complaints and illnesses, including onset and duration of each. The report of the physical examination is the result of a thorough examination of the patient by the resident and is a detailed description of the resident's observations and findings. The terms "negative" and "normal" indicate opinion, not fact, and should not be used except when summing up stated facts. Pelvic examinations are not routinely done. If the particular case requires such an examination, the resident should seek assistance from the attending physician responsible for this aspect of care.

D. Progress Notes
Progress notes are specific statements by the physician relative to the course of the disease, as well as special examinations made, response to treatment, new signs and symptoms, complications, and in surgical cases, removal of drains, splints and stitches, abnormal laboratory and X-ray findings, condition of the surgical wound, development of infection, and any other pertinent data. The frequent use of general statements such as "condition fair", "general condition good" or "no complaints" lacks value. Progress notes should be written by the resident or, if written 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 certain that the progress notes are up to date and should summarize the condition of the patient on the day the resident leaves the case. The person coming on the service should carry on the progress notes from that time forward. All notes should be signed by the same person who wrote the note and co-signed as necessary.

E. Orders
The resident can write orders for the patient. These orders may include necessary tests, therapy, etc. Order changes by the resident should be discussed with the attending in a timely fashion.

F. Consultations
Any podiatric consultation requested by the medical staff is to be handled directly by the resident in consultation with an attending (IMC & VA) or by members of the active podiatric staff at other affiliated institutions. Residents will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders. In accordance with the resident's contract, the resident shall not be permitted to participate in professional or clinical work wherein others collect compensation for the resident's services.

G. Discharges
When a patient is discharged, the attending physician writes the discharge except when the resident has been given the responsibility of discharging podiatric patients on the attending podiatrist's authority. It is the resident's responsibility to ensure that the patient being discharged has the following:

1) Post-operative instructions

2) Post-operative shoes, walker, or crutches

3) Instructions to call the doctor's office for a follow-up appointment

4) Prescriptions for necessary medications. The resident should check with the attending podiatrist for types of medications preferred and/or special instructions. The resident is to dictate or record a discharge summary following the discharge.

Discharge Medications:
The resident may be asked to write prescriptions for discharge medications for the patient. The resident is to prescribe only enough medication to last until the patient returns for the first post-operative visit.

Any questions or problems concerning types or quantities of medication should be brought to the immediate attention of the appropriate rotation director, the Director of Residency Training, or a member of the Residency Committee for discussion and action (if necessary).

Occasionally, a patient may become dissatisfied and wish to leave the hospital without his doctor's permission. The resident should explain the seriousness of such a decision to the patient and try to dissuade him. If the patient insists, he must be requested to sign a form or note indicating that he left against medical advice and releasing the hospital and his doctor from all responsibility for any complications which might arise because of his unauthorized departure. The form must be signed in the presence of the resident or nurse and must be witnessed. The attending physician must be notified immediately if possible. If the patient refused to sign, that fact must be documented by both the resident and the nursing staff.

H. Completeness and Accuracy
The value of the medical record is directly proportional to the thoroughness and accuracy with which it is written. It should be remembered that any record may be summoned for legal use. All entries in the medical record must be complete and accurate. The efficiency of handling patients, good teaching, and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than no information.

I. Corrections
Erasures and blacked-out alterations on records are illegal and make the record valueless to the patient and to the hospital in case of litigation. If corrections are necessary, a single line should be drawn through the words to be deleted and a new entry should be made. Corrections to electronic medical records shall be made as an addendum to the note being corrected. Chart entries are permanent and must be made in permanent ink. The original reports, not copies, of special examinations such as X-ray and pathological examinations are incorporated into the medical record. Neat, well-kept, complete records may help to advance medical knowledge and the condition of our records is one of the factors determining our approval by certifying committees. Not only is the patient's record a permanent reference file for subsequent admissions and for medical research, it is also a legal document and should be regarded as such. Notations tinged with frivolity, inappropriate remarks, or implied criticisms have no

place in these documents. Notes or messages for attending physicians or other members of the house staff should not be written on the permanent records; these may be written and attached to the outside of the chart if desired.

J. Legibility

All entries must be readable and must be signed, not initialed. Treatments and medications should be carefully recorded as ordered, including dosage. Dates and hours should be carefully specified. Entries should be made consecutively, with a minimum amount of space between them. Abbreviations should be avoided except for a few recognized abbreviations which are in common usage in the medical profession in general.

K. Rules for Patient's Records

Complete all information on each sheet of the chart and sign it, whether typed or handwritten, before the chart goes to the Medical Records Room. Sign all electronic notes in a timely fashion. Fully record all information about your patients, including progress noted. Avoid the addition of extraneous materials to the charts and never use humor or flippancy. Records are not to be removed from Medical Records except for brief periods to complete documentation. The following rules must be followed:

1) Must not be removed from the hospital

2) Must not be taken to the resident's quarters

3) Must not be kept in desks or file drawers outside of the Medical Records Department

4) Must not be kept in locked offices

5) Electronic charts must be closed if you walk away from them

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

1) For use by the physicians upon re-admission to the hospital or return to the hospital for out-patient care

2) For use by the resident or attending staff for reference or study with the Medical Records Librarian's knowledge and permission and, in the case of research, an IRB approval or waiver

3) For use by other authorized hospital personnel upon request

4) For use in court upon subpoena (copies only)

5) Never give a patient or anyone else a copy of any part of a medical record. The patient should be sent to Medical Records to sign an appropriate release form.

Any record may be requisitioned by a resident or attending staff for use within the hospital building for teaching purposes only. No record should be removed from Medical Records without the knowledge of that department. If a record is required during hours when this department is closed, a request form should be in the Record Librarian's office. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

XII. Basic Hospital Charting

A. Admitting Orders

1) Admit Mrs. H.A. Valgus to Hospital

2) List diagnosis including medical diagnosis when appropriate

3) Labs: SMA12, CBC with differential, PT, UA, others as appropriate

4) Chest X-rays, PA and lateral (as necessary)

5) Foot X-rays (as desired)

6) EKG (as necessary)

7) H&P and medical consult by Dr. Co Admit

8) Diet

a) Regular diet

b) Special instructions to dietician (i.e. 1800 calorie ADA diet for diabetics)

9) Dalmane 30 my po hs sleep (or sleep medication of choice)

10) NPO after midnight

11) Sterile below the knee bone prep

12) Doctor (list names of resident and assistant surgeon) may write orders and assist in management

13) Signature and degree

You may desire to include other orders for completion pre-operatively such as incentive spirometry or crutch training. It should be remembered, however, that all pre-operative orders become completely and immediately invalidated the moment the patient enters surgery.

B. Admitting Notes

The chart of every patient admitted to the hospital should have an admitting note included in the chart.

1) Date and time of admission

2) Mrs. I.P. Hallux, age 54, is admitted to (name of hospital) for surgical/medical treatment of (list admitting diagnosis)

3) History of present illness/chief complaint (HPI of C/C)

a) Chief complaint

b) Location and duration

c) Previous therapy with effect

d) Type of conservative treatment and proposed surgery

4) Previous medical history (PMH)

a) Include serious illnesses/injuries

b) Current medications

c) Allergies

d) Past surgical history

e) Review of systems

5) Full body examination including vital signs and biomechanical exam

6) Assessment and plan for all current medical and podiatric problems

7) Note any contraindications or state that no contraindications to surgery are evident

8) Signature and degree

C. Post-operative Notes

Every hospitalized patient should have a post-op note recorded in the progress notes. This may be delegated to the resident. As always, notations should be dated and timed.

1) Surgeon, 1st assistant, 2nd assistant

2) Pre-operative diagnosis

3) Post-operative diagnosis

4) Procedures performed

5) Primary anesthetic: agents, route of administration, amount

6) Injectable: (steroid, type of local at close of case)

7) Hemostasis: type (thigh cuff), pressure (250 mm Hg), time

8) Materials: type of sutures, pins or wire, implants, drains

9) EBL (estimated blood loss)

10) Pathology (i.e.: soft tissue sent for gross and micro)

11) Dressing, splint, or cast

12) Complications

13) The patient tolerated the procedure well and left the OR for the RR in apparent satisfactory condition (this summary statement should be altered if the procedure was NOT well tolerated or if the patient was not in satisfactory condition). Add a note on new vascular status.

14) Signature and degree

D. Post-Operative Orders

The following list is only an outline and should be modified to meet the specific needs of the patient or the preferences of the surgeon. Order writing may be delegated to the resident but must be counter-signed. In general, experts agree that surgeons tend to under-medicate post-surgical patients with insufficient analgesics. It is preferable to give a little more medication a little more often during the first day or two to abolish pain. Remember all pre-op orders have been discontinued and must be re-written.

1) Monitor vital signs q 15 min until stable, then q shift

2) Activity level (CBR – complete bed rest, BRP – bathroom privileges)

3) Diet (liquid to regular diet as tolerated)

4) Elevate FOB, dispense foot cradle

5) IM analgesic (Demerol 50mg/Vistaril 50mg IM q 3-4 hrs prn severe pain)

6) Oral analgesic (Tylox caps, po q 3-4 hrs prn moderate pain)

7) Antiemetic (Trilafon 5 mg IM TID prn N/V)

8) Sleep medication (Dalmane 30 mg po hs prn sleep)

9) PO X-rays

10) Orders for any IV antibiotics, anti-inflammatories, or other medications

11) Therapeutic adjuncts such as mini-heparinization, incentive spirometry, breathing exercises, physical therapy

12) Notify doctor of any unusual circumstances

13) Signature and degree

E. Operative Reports

This is a report of operative findings and of the procedures used by the attending doctor during surgery, and it should be dictated immediately after the operation. Details may be overlooked if there is a delay in completing the report. The resident may dictate the operative report if s/he participated and was scrubbed in for the case. The following is a detailed explanation of the contents of an operative report. It is important that all points are included to give an accurate report of the surgery.

1) Name – spell out completely for identification and clarification

2) Hospital number – this is also important for identification and clarification

3) Surgeon – the actual surgeon who performed the procedure

4) First assistant/other assistant – mention of these names will ensure that these individuals receive a copy of the report for their records.

5) Type of anesthesia – local or general

6) Date – actual date of surgery

7) Pre-operative diagnosis

8) Post-operative diagnosis

9) Procedure – the exact operative procedures used during surgery, designated by the site (for example: arthroplasty, left foot, 5^{th} digit). Include all procedures.

10) Operation and findings – This information comprises the main body of the report. It should be concise but must be completed to alleviate confusion and verbose reports. It describes the following:

a) The prepping and draping

b) Administration of local anesthesia, including type, amount, and manner, or administration of general anesthesia

c) Type of hemostasis (cuff, etc.)

d) Type and length of incision

e) The procedures used in relation to the disease entity, using correct medical terminology

f) Any pathology related to the disease entity, using correct medical terminology

g) All methods of closure, including type and suture material

h) Dressing

i) Condition of patient upon completion of surgery. The information on this report must be consistent, i.e. the post-operative original reports must be signed by the surgeon. To ensure that a report has been dictated accurately, listen to or reread the entire report before signing.

F. Progress Notes

The specific information that should be included in a proper progress note will be listed below. Many physicians prefer to use the SOAP method of recording progress notes. This technique aids the physician in organizing his thoughts and then expressing them in the chart. It also aids any other readers of the chart in following the findings and the intent of the attending physician. The SOAP method provides 4 sections in a progress note: S = subjective findings, O = objective findings, A = assessment, P = plan.

1) Date

2) Time

3) Patient's general condition or comments

4) Medications and allergies

5) Vital signs

6) Condition of bandages

7) LE exam

a) Neurovascular status of feet

b) Evaluation for DVT

c) Description of surgery site and/or wound (if applicable).

8) Condition of lungs

9) Assessment of patient's progress

10) List any proposed future plans or changes in treatment for the patient

11) Note anything you did or said, or anything the patient did or said, that may be important to the case.

12) Sign with name and degree

XIII. Medical License Information

1) Utah Podiatry License Application

2) Utah Controlled Substance Application

Both applications require a "take-home test" which is included with the applications. View the documents to help answer the questions. These are from the DOPL website: www.dopl.utah.gov

The application for licensure needs to be completed and awaiting the director's signature by mid-June, prior to beginning your PGY2 year.

You are also required to have an NPI and DEA number. You are required to have your state licenses in order to obtain a DEA license. You must apply for your NPI number at the beginning of your 1st year. Put "Resident" and/or "Pending" for your license number.

NPI information: https://nppes.cms.hhs.gov/#/

DEA information: https://www.deadiversion.usdoj.gov/online_forms_apps.html

XIV. CPME Approval Requirements

CPME 320: https://www.cpme.org/wp-content/uploads/2025/05/CPME-320-Standards-and-Requirements-for-Approval-of-Podiatric-Medicine-and-Surgery-Residencies-effective-July-2023.pdf

CPME 330: https://www.cpme.org/wp-content/uploads/2023/12/CPME_330_Procedures_for_Approval_of_Podiatric_Medicine_and_Surgery_Residencies_7_2023_2023-2a_.pdf

XV. Rotation Information and Competencies

The following rotations are designed to give the resident graded experiences and responsibility in the management of patients, and recognition and understanding of clinical entities (this will have reference particularly to the field of foot surgery but will also refer to all related medical and surgical areas). The residents will be given an educational program on the post-graduate level which will emphasize both basic and clinical sciences. Included are the competencies to be achieved in each training experience. The resident will be responsible to the attending physician(s) and the chief resident (where applicable).

PGY1 Rotations

Anesthesiology – Anesthesia Service, VA Medical Center
During this rotation, you are directly under the supervision of the Chief of Anesthesia Service, who will be responsible for your written evaluation at the end of your rotation. The purpose of this rotation is to provide the podiatric resident with clinical training in all aspects of the administration of anesthesia.

Competencies
Formulate and implement an appropriate plan of management, including appropriate anesthesia management when indicated:

Local anesthesia
General anesthesia
Spinal anesthesia
Epidural anesthesia
Regional anesthesia
Conscious sedation

Perform and interpret the findings of an appropriate medical history and physical examination

Recognize the need for additional laboratory and diagnostic studies when indicated

Demonstrate the ability to perform intravenous placement

Demonstrate the ability to manage an airway including intubation

Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature

1) OR Structure & Rules

a) Operating rooms: the VA OR has 6 operating rooms, numbered circularly 1-6

b) Telephones: Anesthesia direct line (801) 584-2512

c) Communication in the OR: regular phone intercom (2 digit), OR intercom system (2 or 3 digit) -To make an "all over" announcement on the OR intercom, hit 81, give your message and hit C to finish.

d) Hospital beeper system: dial 7, wait for the tone, and then dial the 3-digit number. Wait for the beeping to stop, then give your message twice. If you are outside the hospital, call the hospital operator at 582-1565 and ask for paging or leave a message.

e) Some routines: all the patients are brought into the room from the outside hallway surrounding the clean central core area. The patient going to room 1 is transferred directly from the holding area.

2) Scheduling

a) Requests for surgery are made using the CDCP computer system and are ready for anesthesia assignment around 11:00 am the day before the surgery.

b) For cases starting at 8:00 am, you are expected to take the patient(s) into the room by 7:40 am and proceed with anesthesia.

3) Pre-Operative

Assigned residents are responsible for their own pre-operative evaluation and for writing pre-op orders. During the pre-op visit, an anesthesia evaluation form is filled out. Discuss difficult or complicated cases with a staff anesthesiologist.

4) Documentation

a) Residents are responsible for completing a minimum of 4 documents:

1) Pre-op evaluation

2) Anesthesia records

3) Post-anesthetic note (recovery room discharge note) – write any problems or complications in the progress note and make a discharge order in the order sheet for cases in which you expect an uneventful recovery

4) Computer Data Input: all anesthesia information must be entered in the computer. Details of the procedure will be explained at the beginning of your rotation.

5) Post-Anesthetic Follow-Up Note: all anesthetized patients must be followed up within 72 hours by residents who gave anesthetics. The follow-up note is written on the patient's progress note with the caption of "Post Anesthesia Follow-Up" and must include date and time.

If one resident took over the case during the procedure, the resident who finished the case must take ultimate responsibility for the post-op follow up. Local and local stand-by cases do not require follow-up by the anesthesiology resident, unless patients received heavy sedation during the procedure. If patients have been discharged before you make rounds, state so on the sheet. Delinquency of the post-op follow up will result in serious credential problems in your residency.

Beyond this routine paperwork, you must complete a complication report whenever deviation from routine procedures is seen. You must also report any activities performed outside the OR such as emergency intubations, cardioversions, etc. by filling out a sheet located on a clipboard in the Anesthesia Workroom.

5) On-Call

a) Podiatry residents are typically not expected to take on-call duty. However, interesting cases are frequently seen during the off time. Notify the on-call anesthesia residents or staff if you wish to be called in for emergency cases.

6) Controlled Substances

Narcotics and other controlled substances (Valium, Versed, barbiturates, etc.) are dispensed from a computer operated dispensing machine (Pyxis). You will be given a temporary password to access the instrument during your rotation. BUT – you must check back unused controlled substances at the end of the day. Controlled substances loaded in syringes should be disposed of in front of a witness.
No drugs are to be left unattended at the end of the day in your cart or locker. All drugs in syringes or ampules must be disposed of daily.

Once any violation of the handling of controlled substances is spotted, no excuse will be accepted. The FBI will be involved as a federal offense and criminal charges are inevitable.

7) General

Podiatry residents report to the OR every morning regardless of their case assignments. When leaving the OR suite, always inform someone, preferably either a staff anesthesiologist or the OR secretary, of where you are going and when you plan to return.
Refrain from wearing scrubs outside the hospital. Scrubs worn outside the OR, such as in the hallways, ICU, etc., should be changed prior to returning to sterile areas.

Dermatology

During this rotation, the podiatric resident is directly responsible to dermatology attendings at the University of Utah. The dermatology attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of skin diseases.

Competencies

Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by surgical and non-surgical means.

Perform and interpret the findings of a thorough problem-focused history and physical exam including dermatologic examinations.

Be able to order and interpret appropriate diagnostic studies including anatomic and cellular pathology.

Formulate an appropriate diagnosis and/or differential diagnosis.

Formulate and implement an appropriate plan of pharmacologic management including the use of antibiotics, antifungals, corticosteroids, and topical preparations.

Formulate and implement an appropriate plan of management including excision or destruction of skin lesions (including skin biopsy and laser procedures).

Formulate and implement a plan for appropriate anesthesia management when indicated, including local anesthesia.

Assess the treatment plan and revise it as necessary.

Recognize the need for and/or order additional diagnostic studies, when indicated.

Demonstrate ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

Emergency Medicine
During this rotation, the podiatric resident is directly responsible to the emergency department attending. The emergency department attending will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of this rotation is to train the podiatric resident in all aspects of emergency medicine.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam. Perform and interpret the findings of a comprehensive medical history and physical exam, including pre-operative history and physical examination. These exams should include:

Head, eyes, ears, nose & throat
Neck & chest/breast
Heart & lungs
Abdomen
Genitourinary & rectal
Upper extremities
Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Order and interpret appropriate diagnostic studies and medical imaging, including:

Plain radiography
Stress radiography
MRI
CT

Order and interpret appropriate diagnostic laboratory blood tests, including non-invasive vascular studies and compartment pressure studies.

Formulate an appropriate diagnosis and/or differential diagnosis.

Formulate and implement an appropriate plan of management for non-surgical procedures when indicated, including:

Closed management of fractures and dislocations
Closed management of pedal fractures and dislocations
Closed management of ankle fracture and dislocation
Cast management
Injections and aspirations
Pharmacologic management

Formulate and implement an appropriate plan of management for medical/surgical procedures when indicated, including:

Repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)
Appropriate anesthesia management when indicated including local anesthesia

Assess and manage the patient's general medical status.

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

Recognize the need for and/or order additional diagnostic studies when indicated, including:

EKG
Nuclear medicine imaging
MRI
CT
Diagnostic ultrasound
Other diagnostic studies

Demonstrate the ability to communicate effectively and function in a multi-disciplinary setting and be able to maintain appropriate medical records.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

St Mark's Podiatry
During this rotation, the resident is directly responsible to the podiatry attendings. The podiatry attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of podiatry. The resident will actively participate in surgical cases from initial evaluation through to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care when applicable. They will participate in surgical cases and will scrub in at the discretion of the podiatry attending.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies such as:

Electrodiagnostic studies
Non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis

Perform appropriate non-surgical management when indicated:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures/dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management:

Cast management
Tape immobilization
Orthotic, brace, or prosthetic management
Custom shoe management
Footwear selection and/or modification
Padding
Injections
Aspirations
Physical therapy

Perform appropriate pharmacologic management when indicated including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Anti-hyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids
Anti-rheumatic medicines
Topicals

Formulate and implement an appropriate plan of management, when indicated, including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rear foot and ankle surgery

Formulate and implement an appropriate plan of management including:

Appropriate consultation and/or referrals
Appropriate lower extremity health promotion and education
Reassessment of the treatment plan with revision as necessary

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

Infectious Diseases

The infectious disease attendings shall be responsible for a written evaluation of the resident at the end of this rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of infectious disease. This rotation shall include the direct participation of the resident. Training should include exposure to a variety of pathology.

IMC Infectious Diseases Orientation & Curriculum

Orientation

This is an inpatient infectious diseases consultation service.

Contact: The Infectious Diseases Office is in the Women's Center, LL2, next to the Human Resources office. This is at the east end of the hall, immediately north of the IMC Hospital Administration main office. The administrative assistant, Armeny Gutierrez, can help you with questions. Call (801) 507-7781. Contact numbers for the current consulting attending are posted in the ID office.

Schedule: The ID administrative assistant will email you your schedule, including your start date. The resident is assigned to work with the assigned ID attending from 8:00 am to 5:00 pm, Monday-Friday. The resident will not work on weekends or holidays. On your first day, please arrive at 8:45 am and go to the Infectious Disease office for a general orientation. Computers are available for your use. You should then contact the ID consult attending for new consults. All resident notes must be countersigned by the attending physician. In general, mornings will be spent seeing new consultations and established patients, self-study, and visiting the microbiology lab. Afternoons are reserved for teaching rounds with a priority placed on new consults and established patients that are followed by house staff. The daily schedule will vary depending on the consult attending. Residents are limited to 2 new consults per day and care for a maximum of 8 patients.

Continuity Clinic: Residents are expected to attend their regularly assigned half-day continuity clinic weekly throughout the duration of the rotation. Please alert the attending on service of your clinic day.

Conferences: You are expected to attend IMC morning report, noon conference, and Grand Rounds. Additionally, you are required to attend ID-specific conferences as dictated by the attending on service.

Self-Study: The resident is expected to read all of the MKSAP 15 Infectious Disease section during this rotation. A 50-question online examination will be assigned on the last Thursday of the rotation at 4:00 pm in the HSEB Computer Lab. You are expected to score a minimum performance of 80%. If you do not achieve at least 80%, you will be required to repeat the exam until you reach the minimum score. The U of U IM Housestaff office will notify you via email regarding this examination.

Microbiology Lab: The IMC Clinical Microbiology Laboratory is located on the second floor of the southernmost building on the IMC campus. The resident will look at gram stains, bacterial cultures, etc., as determined by the ID attending. Lab technicians are available to review the above every morning.

Evaluation: At the conclusion of the rotation, you are expected to evaluate the faculty's teaching performance. The ID faculty you worked with will also evaluate your performance. Attainment of learning objectives will be documented by your attending in a written evaluation at this time. The attending will base his or her evaluation on the quality of your performance on daily rounds, the quality of your written clinical notes, and the effort you made to improve and/or refine your infectious disease knowledge base.

Curriculum

A one-month rotation on the Infectious Diseases Services will introduce you to an ever-growing information base and will provide you with an experience that teaches principles to be applied in many difficult situations where infection may be involved in the clinical problems you deal with. It is hoped that you will develop a genuine interest in infectious diseases and will continue to refine your infectious diseases knowledge and skills throughout your career as a physician.

To that end, we provide a list of minimal infectious diseases learning objectives that you should attain. You are responsible to search for information that applies to your patients in guidelines published by the Infectious Diseases Society of America (IDSA) and the American College of Physicians (MKSAP). These provide you with an up-to-date and authoritative source for an annotated infectious diseases

bibliography as well as a self-assessment test based on short case histories. In book I, you will find the syllabus and self-assessment test. In book II, you will find answers, critiques, and bibliographies to the test. A copy of MKSAP is available in the IMC Housestaff office. We encourage you to discuss selected case histories in the MKSAP self-assessment test with your attendings. The following are topics that you should read about and discuss with your attending during this rotation:

CNS infections
Endocarditis
Pneumonia
Septic Shock/Toxic Shock Syndrome
Antibiotics
Infectious diarrhea
Urinary tract infections
Sexually transmitted diseases
Infections of immunocompromised patients
Nosocomial infections
Skin and soft tissue infections
Bone & joint infections
Fever of unknown origin
HIV disease
Unusual infections
Zoonosis
Immunizations

Responsibilities of the Resident on the Infectious Diseases Subspecialty Service: Medical residents have daily contact with a faculty member during their inpatient infectious diseases rotation. All infectious diseases consultations are discussed with and examined by the faculty attending within 24 hours of being seen. Subsequent decisions are discussed daily.

Consults are seen on the day of the request and in order of patient need. For non-emergent consults late in the day, at least a preliminary note should be left in the chart indicating that the patient has been seen and the case discussed with the attending. After the patient has been evaluated by the attending, the consult note must be annotated and signed by the attending. Recommendations should be explicit and should include pertinent references with your consultation note. Every effort should be made to contact and personally discuss the case with the individual who requested the consult. In some cases, this can be done on a medical resident level. In others, it may be necessary for the attending to discuss the case. Direct communication is very important in order to avoid unnecessary confusion or a delay in implementing recommendations.

Follow-up visits should document the level of involvement in patient care, i.e. if the patient was examined and laboratory results or x-rays were reviewed, this should be stated in the note. The level of involvement must be documented by the attending for billing purposes.

Most patients will initially require daily notes until their problem has stabilized. After that, less frequent notes to monitor antibiotic therapy, adverse effects, laboratory data, etc. may be appropriate. A patient should be followed until discharge or until the ID problem on which you were initially consulted has completely resolved.

Some patients will require one or more outpatient visits to assure resolution of their ID problem. You, the attending and the referring physician will determine the appropriate follow-up plan.

Informal consultations in the absence of evaluation of the patient should be discouraged, as inadequate information can result in errors by the consultant.

Guidelines for Effective Consultation

1) You should put a note on the chart on the day of the consultation to acknowledge that the patient has been seen and to provide your initial recommendations.

2) The referring physician should be noted.

3) The reason for the contact should also be noted. Eliciting the precise reason for the request will make for a specific and relevant consultation.

4) You and your attending will determine whether or not to discuss findings and recommendations directly with the patient or their family. Defer to the primary physician and discuss findings with that physician to maintain non-conflicting communication with the family. The primary physician may ask the consultant to discuss the situation directly with the family.

5) Do not use the chart as a forum for debate or argument. Discuss recommendations with the primary physician before writing a note, as they may have good reasons for disagreeing with your recommendations.

6) If an error in patient care is detected, use diplomacy in correcting it.

7) Whenever possible, verbally discuss recommendations with the primary physician. This is a courtesy, which demonstrates interest, allows for amplification of the consult note, and reinforces recommendations.

8) Direct the consultation note toward the infectious disease issues. The note should provide a concise summary of data pertinent to the consultation, including relevant points from the history, physical examination, and diagnostic tests. You should title sections of the note so that areas of interest will be readily identifiable.

9) Recommendations should be labeled as such and clearly stated in an organized format at the end of the note. Therapeutic measures should be spelled out with respect to drug, dose, route of administration, and monitoring of the desired effect and potential toxicity.

10) Impressions and recommendations should be supported with data. The consultant should review the patient's chart, take his or her own history as it relates to the consultation, perform a relevant physical exam, and personally review relevant gram stains, cultures, and x-rays. Reliance solely on the chart or primary physician for information and data may lead to faulty recommendations and adds little to what the primary physician already knows.

11) Pertinent points from the literature should be cited and an attempt made to teach the reader.

12) Do not make diagnoses that are not supported by the data. Recommend a consultation by others who can deal with non-ID conditions, as needed.

13) The consult should include what progress is expected and should provide the opportunity to elaborate on impressions as the database expands. The ID team should follow patients until discharge or until

resolution of the infectious problem since details such as drug dosage and the frequency with which the patient is being monitored for drug toxicity may be overlooked. You and your ID attending will determine which patients you will follow.

14) At the end of the rotation, or for weekend coverage, arrange to meet with those who will be following the patients to review in detail the active cases to ensure accurate follow-up.

A. Educational Purpose:

1) Provide experience and instruction in the care of patients with illnesses and complaints related to infectious disease, in both an inpatient and outpatient setting. You will serve as a consultant to both internal medicine and non-internal medicine specialties.

2) Patient Care

a) Understand and demonstrate basic physical exam and history taking skills needed to evaluate the infected patient using their history and physical examination, appropriate microbiological and serological tests, and imaging studies, as well as other laboratory studies.

b) Maintain focus and timeliness in the evaluation and management of consults and ambulatory patients.

c) Recognize and be able to respond skillfully to the signs/symptoms of acute, life-threatening infectious diseases such as sepsis, septic shock, acute meningitis, and pneumonia.

d) Understand modes of transmission of communicable disease and modes of blocking that transmission.

3) Medical Knowledge

a) Expand a clinically applicable physiology knowledge base to the underlying care of the infected patient.

b) Access and critically evaluate current medical information relevant to the infected patient.

c) Understand the diagnostic approach and management of patients with HIV infection including the use of antiretroviral therapy and in the management of opportunistic infections in patients with AIDS.

d) Understand the diagnostic approach and management of patients with TB, community acquired pneumonia, endocarditis, central nervous system infections, urinary tract infections, nosocomial infections, soft tissue and bone infections, fever of unknown origin, and medical device associated infections.

e) Understand the sensitivity, specificity, and clinical application of laboratory and microbial tests in infectious disease.

f) Understand the mechanism of action, utility, and adverse effects of medications commonly used to treat infectious disorders. Understand the importance of antibiotic resistance.

g) To be familiar with the diagnosis and management of infections occurring in different types of compromised hosts: diabetes mellitus, chronic renal and liver disease, neutropenia, cell-mediated immuno-deficiencies, and immunoglobulin disorders.

4) Practice-based Learning & Improvement

a) Identify and acknowledge gaps in personal knowledge and skills in the care of the patient with infectious disease.

b) Develop real-time strategies for filling care gaps that will benefit patients in a busy practice setting.

c) Become familiar with Infectious Disease literature through text, current guidelines, and online resources.

5) Interpersonal Skills & Communication

a) Communicate effectively with patients and families across a broad range of socioeconomic and ethnic backgrounds.

b) Communicate effectively with physician colleagues and members of the health care professions to assure comprehensive patient care, both verbally and in the written record.

6) Professionalism

a) Behave professionally toward patients, families, colleagues, and all members of the health care team.

7) Systems-based Practice

a) Understand and utilize the multi-disciplinary resources necessary to optimally care for patients with infectious disease.

b) Collaborate with other members of the health care team to assure comprehensive medical care.

c) Use evidence-based, cost-conscious strategies in the care of patients with infectious disease in both the inpatient and outpatient settings.

B. Teaching Methods:

1) Educational Encounters

Each typical educational encounter consists of:

a) The resident seeing the patient independently, followed by

b) The resident presenting the findings to the attending who will ask questions, followed by

c) Brief teaching points and/or discussion, followed by

d) The resident and attending conducting a focused exam/history together at the patient's bedside, followed by

e) Brief teaching points or discussion, followed by

f) The resident, attending, referring physician, and patient making decisions regarding the medical plan and follow-up

2) Teaching Rounds 5 Days per Week

3) Individual Attending/Resident Teaching

The attendings spend a considerable amount of time teaching residents on an individual basis.

4) Self-Directed Study

All residents are expected to complete required reading on patients they have seen.

5) Reading List

The Infectious Diseases reading list includes important topics with learning objectives and suggested readings (see above).

6) Radiologic Studies

CT, MRI, CXR, and other radiologic studies along with echocardiograms and nuclear medicine studies are reviewed daily by the team when relevant to patient care.

7) Autopsies

Autopsies are reviewed by the medical team with the pathology team when indicated.

C. Mix of Diseases, Patient Characteristics, and Types of Clinical Encounters:
1) Mix of Diseases
The rotation provides exposure to patients with a broad range of medical problems, such as evaluation and management of patients with TB, HIV, CAP, UTI, and CNS infections, STDs, nosocomial infections, bone and soft tissue infections, and fever of unknown origin.

2) Patient Characteristics
The patients include an even mix of men & women. Socioeconomic classes vary considerably. We care for privately insured, self-pay, Medicare, Medicaid, and uninsured patient populations.

3) Clinical Encounter
The type of clinical encounter is a consultation to the inpatient wards or ICU (medicine, surgical, or other subspecialty).

4) Procedures
Procedures that may be performed vary according to patient needs.

5) Services
The ID team does not directly admit patients. They serve as consultants to other teams, services, and the ICU.

D. Pathological Material:
1) Surgical and nonsurgical pathology cases should be reviewed when indicated.

2) Radiologic studies are reviewed daily.

E. Other Educational Resources:
1) All charting areas are equipped with computers and internet access to medical literature and major online ID texts as well as others. Our residents and preceptors routinely consult many internet sites and resources to help with clinical decision making.

F. Method of Evaluation of Resident Performance:
1) The residents and attendings evaluate each other's performance using the ABIM standard evaluation form based on the six ACGME competencies. Attendings reach their evaluation conclusion via direct contact with each resident while reviewing the patient and the medical record. Each resident evaluation should be discussed in detail with the resident by a faculty member. All procedures are evaluated by the attending using the standardized ABIM form.

G. Method of Evaluation of the Program Performance:
1) The ID rotation will be reviewed annually by the Housestaff – Faculty Committee. In addition, the attendings and rotations are evaluated by the resident at the end of each rotation using the standard ABIM form and at the end of the academic year. Additional methods of evaluation include the resident's performance on the ITE, the ABIM certifying exam, and feedback from graduating residents.

H. Definition of Resident's Supervision by Faculty:
The attending of record must be familiar with and is responsible for the care provided to each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with each patient and with the resident who is providing care as part of the training experience. At a minimum, the attending of record is expected to fulfill this responsibility in the following manner:

a) The attending will direct the care of the patient and provide the appropriate level of supervision, based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being

supervised. Medical services must be rendered under the supervision of or be personally furnished by the attending. Documentation of the supervision will be entered by progress note in the medical record.

b) The attending and the resident will ensure that follow-up is appropriate, based on the specific circumstances of the patient's diagnosis and therapeutic regimen.

c) Within the scope of the training program, all residents, without exception, will function under the supervision of attending physicians. A responsible attending must be immediately available, in person, to the resident during the rotation.

Competencies
Evaluation and management of patients with the following disorders:

Skin and soft tissue infection
Bone and joint infections
Infections of prosthetic devices
Infections related to trauma
Sepsis syndrome
Nosocomial infection

Basic knowledge of hospital epidemiology and infection control

Basic knowledge of clinical microbiology

Knowledge of dosing and monitoring of antibiotics

Exposure to the techniques in the evaluation and management of the following disorders:

Infections of reproductive organs
Infections in solid organ transplant patients
Infections in bone marrow transplant recipients
Sexually transmitted diseases
Viral hepatitis, including hepatitis B and C
Infections in travelers
Pleuropulmonary infections
Cardiovascular infections
Central nervous system infections
Gastrointestinal and intra-abdominal infections
Urinary tract infection
HIV infected patients with major impairment of host defenses

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

Psychology

The resident will report to the attending at the assigned site.

Competencies
Demonstrate an understanding of the psychosocial and health care needs for patients in all stages of life.

The podiatric resident will be able to discuss and describe the psychological issues related to the management of:

Obesity

Smoking cessation
Behavior modification
Dependency / Addiction

The resident should also be able to describe treatment strategies for the above conditions.

Be able to identify patients who require referral to mental health practitioners.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

Radiology
This rotation shall include the opportunity for review and identification of pathology in imaging studies under the direction of the radiology attendings.

Competencies
Perform and/or interpret appropriate diagnostic studies including:

Medical imaging
Radiographic contrast studies
Stress radiography

Interpret appropriate diagnostic studies including:

Plain Radiography
Medical imaging
Bone mineral densitometry
Nuclear medicine imaging
MRI
CT
Diagnostic ultrasound

Recognize the need for additional diagnostic studies when indicated including:

Medical imaging
Plain radiography
Nuclear medicine imaging
MRI
CT
Diagnostic ultrasound
Other diagnostic studies

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

St Mark's Family Medicine
During this rotation, the podiatric resident will be assigned to both inpatient and outpatient care. The resident will report to the chief primary resident and the primary care attendings. The primary care attendings shall be responsible for a written evaluation of the resident at the end of the rotation. The purpose of this rotation is to provide the podiatric resident with clinical training in aspects of primary

care. This rotation shall include direct participation of the resident. Training should include exposure to a wide variety of general medical pathology with an emphasis on pediatrics and women.

Competencies
Assess and manage the patient's general medical status both as an inpatient and an outpatient.

Perform and interpret the findings of a comprehensive medical history and physical examination (including pre-operative history and physical examination) including:

Comprehensive history
Vital signs
Head, eyes, ears, nose and throat exam
Neck exam
Chest/breast exam
Heart exam
Lung exam
Abdomen exam
GU/rectal exam
Upper extremity exam
Neurologic exam

Assess and manage the patient's general medical status.

Formulate an appropriate differential diagnosis of the patient's general medical problem(s) with particular emphasis on the following:

Diabetes Mellitus
Hypertension
Coronary artery disease
Kidney disease
Liver disease
Common gastrointestinal disorders
Common genitourinary disorders
Infectious disease processes
Common oncology disorders

Recognize the need for (and/or order) additional diagnostic studies when indicated such as:

EKG
Medical imaging

Order and interpret appropriate laboratory tests including:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

When indicated, formulate and implement an appropriate plan of management including:

Appropriate therapeutic intervention
Appropriate consultations and/or referrals

Appropriate general health promotion and education

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

VAMC Podiatry Clinics
During this rotation, the podiatric resident will be assigned to one of the podiatry clinics at the VA and will be directly responsible to that clinic's attending. The podiatry attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotations is to provide the resident with clinical training in all aspects of podiatry. The resident will actively participate in surgery cases from initial evaluation through to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care when applicable. They will participate in surgical cases and scrub in at the discretion of the podiatry attending.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies:

Electrodiagnostic studies
Non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis

Perform appropriate non-surgical management when indicated such as:

Palliation of keratotic lesions
Palliation of toenails

Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures/dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management:

Cast management
Tape immobilization
Orthotic, brace, or prosthetic management
Custom shoe management
Footwear selection and/or modification
Padding
Injections
Aspirations
Physical therapy

Perform appropriate pharmacologic management when indicated including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Anti-hyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids
Anti-rheumatic medications
Topicals

Formulate and implement an appropriate plan of management when indicated including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rearfoot and ankle surgery

Formulate and implement an appropriate plan of management including:

Appropriate consultation and/or referrals
Appropriate lower extremity health promotion and education
Reassessment of the treatment plan with revision as necessary

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

Podiatry Clinic Scheduling Information:

Days	Time	Type of Patient Scheduled
Monday	7:30 am – 4:30 pm	Surgery (except 3rd) General Podiatry (All)
Tuesday	8:20 am – 4:30 pm	General Podiatry
Wednesday	8:00 am – 4:30 pm	Foot & Leg Ulcers
Thursday	8:00 am – 11:00 am	Post-Op & Pre-Op Clinic
Thursday	1:00 pm – 4:30 pm	Pre-Op Conference
Friday		Special Procedures (1,3) Surgery (2,4) General Podiatry (All)

General Information:

a) Every resident needs computer access codes. Contact Surgical Services for assistance.

b) Patients should be scheduled for the appropriate clinic, based on their specific problem.

c) Outpatient care is a team effort. It is expected that professionals will treat other team members with courtesy and respect.

d) Patient education pamphlets are available on foot care, cast care, unna boot, and post-op care. Please check with the clinic nurse to obtain educational materials.

e) Surgical consent (Imed) needs to be obtained for all surgical procedures. If in doubt, obtain consent.

Supplies:

Note: Cost containment is a reality in modern medicine. Use only those supplies that are necessary. Please keep supplies neat and orderly. You are expected to clean up after yourself.

a) Supply, Processing, and Distribution (SPD) is our Central Supply and can be reached by contacting extension 1605.

b) Refills for the supply carts are completed on a routine basis. The small supply carts in each room should contain medications, dressings, and instruments. Pharmacy supplies can be found in room 1A16DA. For supplies not found or otherwise needed, check with your clinic nurse.

c) Keep clean and dirty instruments separated.

d) Instruments are sterilized in SPD daily. An adequate supply of sterile instruments is available. To prevent cross contamination, please do not use one set of instruments on more than one patient.

e) Use only VA supplied instruments. No personal instruments should be used. If personal instruments are used, there is danger of cross contamination and violation of quality control. These instruments may also become mixed up with hospital supplies.

f) Place all disposable sharps in the special sharps containers (red plastic puncture-proof jars) provided, not in the dirty instrument tray.

g) Special Podiatry Supplies

1) Extra supplies are stored in room 1A16D.

2) Special podiatry supplies are ordered through SPD (nurse manager).

3) Check with the attending podiatrist regarding the need for special supplies.

Pharmacy

a) Stock supplies:

1) Clinic nurse will order when needed.

2) Do not contaminate large jars of ointment. Use sterile applicators to dispense contents from these containers. Do not dip a sterile applicator into a jar of ointment more than once.

3) Clinic supplies are for clinic use only. Do not dispense supplies to patients from stock.

4) All medications, dressing supplies, and ointments for patient use at home must be ordered on a prescription and dispensed by the pharmacy.

5) Please fill out the appropriate prescription forms to include all required refills.

6) For non-formulary items use a reasonable substitute or discuss the need with the staff podiatrist.

Prosthetics

Note: Prosthetic items include such things as crutches, orthotics, shoes, canes, walkers, wheelchairs, and compression stockings.

a) Eligibility is required for some items coming from this department. Check with the clinic nurse for patient eligibility. If you are still not sure whether or not a patient is eligible for equipment, contact the Prosthetics Service at extension 1220.

b) Fill out a Prosthetics/PT Consult for prosthetic items.

Consults

a) Consult forms to be filled out in CPRS.

b) Specialty clinics – patients may not be eligible for follow-up. Check with the clinic clerk for regulations in specific clinics.

c) Diabetes Education: consults can be directed to the library with follow up to the Diabetes Clinic Specialist Nurse if the patient requires ongoing diabetic medications from a VA physician.

d) Diet instruction can be obtained by consulting the Nutrition Clinic.

Lab/X-Ray

a) Labs are drawn in the blood drawing room Mon-Fri 8:00 am to 4:30 pm. There are a few exceptions to the above so please check with the clinic nurse.

1) Results from labs are available on the computer.

2) Stat labs are to be ordered only when absolutely necessary (life or death).

3) There is a minimum 1-hour period before lab results are available.

4) Chart checks may be ordered for lab results on uncommon labs not done daily (e.g. HgA1C, ANA, etc.).

5) Document the results of chart checks on the progress note.

b) X-ray is located in Building One on the first floor.

1) Requests are to be filled out by the podiatrist.

2) To obtain old films, please ask the clinic clerk to obtain them from the X-ray file room. Most old imaging studies are now online. Use the viewing station in room 1A16D.

c) Vascular Lab

1) Location: Building 1, 1st floor

2) Hours: A technician is available Monday-Friday 8:00 am to 4:00 pm. For after hours and when a tech is on annual leave, patients go to HCH-Emergency only.

3) Requests: An X-ray request needs to be filled out in CPRS.

4) Scheduling: Call extension 1544 to schedule an appointment

5) Dopplers are available for use in the clinic.

ED

a) The ED is primarily an emergency/screening area for acute problems. Call the ED physician to inform him/her regarding the patient referral and intended arrival.

b) PEU (Psychiatric Evaluation Unit) is located in the ED. Patients can be sent to this unit for evaluation Monday-Friday 8:00 am to 5:00 pm.

c) Security (Hospital Police) is located in the ED. Contact extension 4444 for patient problems, locked doors, etc.

Social Work

a) A social worker is available. Ask the clinic clerk or clinic nurse who to contact.

Cultures

a) Form: Fill out the yellow microbiology form.

b) Specimen label: Be sure specimen is labeled with both the patient's name and their Social Security number. Make sure specimens are labeled correctly.

c) Specimen transport: Specimens need to be transported to the lab quickly. Please give specimens to the clinic clerk or clinic nurse.

d) Special sampling technique information can be obtained by calling the microbiology lab at extension 1474.

Biopsy (see Cultures above)

a) Be sure to have patients sign a surgical consent form before taking a biopsy.

b) Fill out the tissue exam form and give the form to the clinic nurse.

Vascular Surgery

During this rotation, the podiatric resident is directly responsible to the surgery attendings. The surgery attendings will be responsible for a written evaluation of the resident at the end of this rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of vascular surgery. The resident will actively participate in surgery cases from initial evaluation through to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care. They will participate in surgical cases and scrub in at the discretion of the surgery attending.

Competencies
Assess and manage the patient's general medical status.

Perform and interpret the findings of a comprehensive medical history and physical examination (including pre-operative history and physical examination) including:

Perform and interpret the findings of a thorough problem focused history and physical exam including:

- Vital signs
- Head, eyes, ears, nose, & throat exam
- Neck, chest/breast exam
- Heart & lung exam
- Abdomen exam
- Genitourinary/rectal exam
- Upper extremities
- Neurologic examination
- Vascular Examination

Formulate an appropriate differential diagnosis of the patient's general medical problem(s).

Recognize the need for (and/or order) additional diagnostic studies, when indicated, including:

- EKG
- Plain radiography
- Nuclear medicine imaging
- MRI
- CT
- Diagnostic ultrasound

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

- Laboratory tests
- Non-invasive vascular studies
- Medical Imaging
- Vascular Imaging

Formulate and implement an appropriate plan of management when indicated, to include appropriate therapeutic interventions.

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

Perform appropriate non-surgical management when indicated, including pharmacologic management.

Participate in surgical cases as appropriate.

Formulate and implement an appropriate plan of management including medical/surgical management when indicated.

PGY2 Rotations

IMC Podiatry Biomechanics
During this rotation, the podiatric resident is directly responsible to the podiatry attendings. The podiatry attendings shall be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of lower

extremity biomechanics. The resident will actively participate in surgery cases and will scrub in at the discretion of the podiatry attending.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Interpret appropriate medical imaging including:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Interpret appropriate laboratory tests such as:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic & cellular pathology

Interpret other appropriate diagnostic studies such as electro-diagnostic and non-invasive vascular studies.

Formulate an appropriate diagnosis and/or differential diagnosis.

Formulate and implement an appropriate plan of management including cast management and physical therapy.

Perform appropriate pharmacologic management when indicated, including:

NSAIDs
Antibiotics
Narcotic analgesics
Corticosteroids

Formulate and implement and appropriate plan of management, when indicated, to include:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)

Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rear foot and ankle surgery
Tape immobilization
Footwear modification and padding, including custom shoes
Orthotic, brace, and prosthetic management

Formulate and implement an appropriate plan of management including appropriate consultation and/or referrals and appropriate lower extremity health promotion and education

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

IMC Limb Salvage
During this rotation, the podiatric resident is directly responsible to the podiatry attendings. The podiatry attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of this rotation is to provide the podiatric resident with clinical training in all aspects of podiatry. The resident will actively participate in surgery cases from initial evaluation to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care when applicable. They will participate in surgical cases and scrub in at the discretion of the podiatry attending.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging including:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests including:

Hematology
Serology/immunology
Blood chemistries

Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies:

Electrodiagnostic studies
Non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis

Perform appropriate non-surgical management when indicated such as:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures/dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management:

Cast management
Tape immobilization
Orthotic, brace, or prosthetic management
Custom shoe management
Footwear selection and/or modification
Padding
Injections
Aspirations
Physical therapy

Perform appropriate pharmacologic management when indicated including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Anti-hyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids
Anti-rheumatic medications
Topicals

Formulate and implement an appropriate plan of management when indicated including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)

Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rear foot and ankle surgery

Formulate and implement an appropriate plan of management including:

Appropriate consultation and/or referrals
Appropriate lower extremity health promotion and education
Reassessment of the treatment plan with revision as necessary

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

IMC Trauma

The resident will function as part of the IMC Trauma team and will be directly responsible to the attending trauma surgeon or lead APP. The surgery attendings will be responsible for a written evaluation of the resident at the end of the rotation. Residents will be evaluated on their professional demeanor. This will include demonstration of a readiness and commitment to fulfilling patient care needs; professional and ethical conduct with patients and their families, as well as with other health care staff; and a sensitivity to special concerns of their patients as relates to their economic or social concerns.

- Able to complete orders/admitting note in a timely and complete fashion
- Assist colleagues with management and disposition issues
- Dresses appropriately at all times
- Presents case studies at trauma conferences
- Demonstrate professionalism, integrity, compassion with one's own peers, faculty, and patients
- Perform with accountability to patients and one's own profession with a commitment and performance dedicated to excellence.
- Maintain patient's rights responsibilities to include privacy, informed consent, and confidentiality
- Demonstrate sensitivity and responsiveness to culture, gender, age, and disabilities
- Attend and fully participate in all conferences on time except when post call
- Attend and fully participate in all clinics on time except when post call
- Maintains integrity on trauma service

Residents will be encouraged to work with patients and their families to master communication skills which allow for effective explanation of the patient's current condition, plan of care and questions regarding such matters from the patient and family. Residents will be encouraged to identify themselves with the patient and family as one of the responsible care providers on the team, and to interact accordingly. They will be expected to work and communicate effectively with nursing and respiratory staff to facilitate achievement of the goals set daily for the patients. Residents will also be expected to communicate daily with the patient's primary surgical team, as well as in the situation of a change in plan of care or condition of the patient.

Competencies
The resident will demonstrate a cognitive understanding of the following topics and an ability to translate the issues into clinical practice:

- Identify the Blunt Trauma Patient
- Identify the Penetrating Injury Trauma Patient
- Perform primary exam for resuscitation
    - Identify problematic airway
    - Identify pulmonary contusion
    - Identify hemothorax/pneumothorax
    - Identify ongoing hemorrhage
    - Identify hypotension
    - Identify Shock
        - Identify Hemorrhagic shock
        - Identify Neurogenic shock
        - Identify Spinal shock
    - Identify asymmetric exam results
- Perform secondary exam for resuscitation
    - Includes complete physical exam with special attention to the following
        - Identify neurologic deficits
        - Identify gross abnormalities of the extremity
        - Perform spine examination
    - Facilitate patient transfers
    - Perform beside procedures
        - Able to maintain STERILE technique
        - Able to perform simple closures of soft tissues injuries
        - Able to irrigate and debride simple superficial wounds
        - Able to reduce simple fracture/dislocations
- Identify laboratory abnormalities
    - Correct lab abnormalities
    - Identify necessary and unnecessary labs
- Working knowledge of patient's injuries and co-morbidities
- Know and apply the basic and clinical sciences applicable to the patient's disease chiefly pertaining to their surgical disease and management
- The resident will demonstrate compassionate and effective care in dealing with all patients, especially those with end-of-life situations and those with special needs (e.g., due to drug/alcohol withdrawal or overdose).
- The resident will demonstrate appropriate courtesy and respect for all patients during examination, procedures and rounds regardless of whether the patient is awake, or intubated and sedated.
- Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

Plastic Surgery
During the rotation, the resident will be responsible to the attending plastic surgeons at various affiliated institutions.

Competencies
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by surgical means.

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

Interpret appropriate medical imaging
Interpret appropriate laboratory tests
Interpret appropriate non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis.

Perform appropriate pharmacologic management when indicated, including:

NSAIDs
Antibiotics
Narcotic analgesics
Corticosteroids

Formulate and interpret an appropriate plan of management when indicated, including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Repair of simple laceration
Other soft tissue surgery of the foot
Flaps and grafts
Other plastic surgery

Demonstrate ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

St Mark's Family Medicine
See PGY1 rotations (page 51)

IMC Surgery
During this rotation, the resident is directly responsible to the podiatry attendings. The podiatry attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of podiatric surgery. The resident will actively participate in surgical cases from initial evaluation through to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care when applicable. They will participate in surgical cases and will scrub in at the discretion of the podiatry attending.

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

Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination

Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies such as:

Electrodiagnostic studies
Non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis

Perform appropriate non-surgical management when indicated:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures/dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management:

Cast management
Tape immobilization
Orthotic, brace, or prosthetic management
Custom shoe management
Footwear selection and/or modification
Padding
Injections
Aspirations
Physical therapy

Perform appropriate pharmacologic management when indicated including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy

Sedatives/hypnotics
Peripheral vascular agents
Anti-hyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids
Anti-rheumatic medicines
Topicals

Formulate and implement an appropriate plan of management, when indicated, including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rear foot and ankle surgery

Formulate and implement an appropriate plan of management including:

Appropriate consultation and/or referrals
Appropriate lower extremity health promotion and education
Reassessment of the treatment plan with revision as necessary

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

VAMC Podiatry Clinics
See PGY1 rotations (page 53)

PGY3 Rotations

IHC Cottonwood Podiatry
During this rotation, the podiatric resident is directly responsible to the podiatry attending. The podiatry attending shall be responsible for a written evaluation of the resident at the end of the rotation. The purpose of this rotation is to provide the podiatric resident with clinical training in all aspects of podiatry. The resident will actively participate in surgery cases from initial evaluation through discharge. The resident is expected to involve her/himself in admitting patients, history and physical examination, and on-going hospital care when applicable. They will participate in surgical cases and scrub in at the discretion of the podiatry attending.

Competencies
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by surgical and non-surgical (educational, medical, physical, biomechanical) means.
Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging including:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests such as:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies such as electro-diagnostic and non-invasive vascular studies.

Formulate an appropriate diagnosis and/or differential diagnosis.

Perform appropriate non-surgical management when indicated, including:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures and dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management for cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, and physical therapy.

Perform appropriate pharmacologic management when indicated, including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Antihyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin

Laxatives/cathartics
Corticosteroids
Anti-rheumatic medications
Topicals

Formulate and implement an appropriate plan of management when indicated, including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rearfoot & ankle surgery

Formulate and implement an appropriate plan of management including appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, and reassessment of the treatment plan with revisions as necessary.

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

Layton IHC and Riverton IHC Podiatry
During these rotations, the podiatric resident is directly responsible to the podiatry attendings. The podiatry attendings will be responsible for a written evaluation of the resident at the end of the rotation. The purpose of the rotation is to provide the podiatric resident with clinical training in all aspects of podiatry. The resident will actively participate in surgery cases from initial evaluation through to discharge. The resident is expected to involve him/herself in admitting patients, history and physical examinations, and ongoing hospital care when applicable. The resident will participate in surgical cases and scrub in at the discretion of the podiatry attending.

Competencies
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging:

Plain radiography
Radiographic contrast studies
Stress radiography

Nuclear medicine imaging
MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies:

Electrodiagnostic studies
Non-invasive vascular studies

Formulate an appropriate diagnosis and/or differential diagnosis

Perform appropriate non-surgical management when indicated such as:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures/dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management:

Cast management
Tape immobilization
Orthotic, brace, or prosthetic management
Custom shoe management
Footwear selection and/or modification
Padding
Injections
Aspirations
Physical therapy

Perform appropriate pharmacologic management when indicated including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Anti-hyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids

Anti-rheumatic medications
Topicals

Formulate and implement an appropriate plan of management when indicated including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion, including skin biopsy
Nail avulsion (partial or complete)
Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rearfoot and ankle surgery

Formulate and implement an appropriate plan of management including:

Appropriate consultation and/or referrals
Appropriate lower extremity health promotion and education
Reassessment of the treatment plan with revision as necessary

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

McKay-Dee IHC Podiatry
During this rotation, the podiatric resident is directly responsible to the podiatry attending. The podiatry attending shall be responsible for a written evaluation of the resident at the end of the rotation. The purpose of this rotation is to provide the podiatric resident with clinical training in all aspects of podiatry. The resident will actively participate in surgery cases from initial evaluation through discharge. The resident is expected to involve her/himself in admitting patients, history and physical examination, and on-going hospital care when applicable. They will participate in surgical cases and scrub in at the discretion of the podiatry attending.

Competencies
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by surgical and non-surgical (educational, medical, physical, biomechanical) means.
Perform and interpret the findings of a thorough problem-focused history and physical exam including:

Neurologic examination
Vascular examination
Dermatologic examination
Musculoskeletal examination

Perform (and/or order) and interpret appropriate medical imaging including:

Plain radiography
Radiographic contrast studies
Stress radiography
Nuclear medicine imaging

MRI
CT

Perform (and/or order) and interpret appropriate laboratory tests such as:

Hematology
Serology/immunology
Blood chemistries
Microbiology
Synovial fluid analysis
Urinalysis
Anatomic and cellular pathology

Perform (and/or order) and interpret other appropriate diagnostic studies such as electro-diagnostic and non-invasive vascular studies.

Formulate an appropriate diagnosis and/or differential diagnosis.

Perform appropriate non-surgical management when indicated, including:

Palliation of keratotic lesions
Palliation of toenails
Manipulation/mobilization of foot/ankle joint(s)
Closed management of pedal fractures and dislocations
Closed management of ankle fracture/dislocation

Formulate and implement an appropriate plan of management for cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, and physical therapy.

Perform appropriate pharmacologic management when indicated, including:

NSAIDs
Antibiotics
Antifungals
Narcotic analgesics
Muscle relaxants
Medications for neuropathy
Sedatives/hypnotics
Peripheral vascular agents
Antihyperuricemic/uricosuric agents
Tetanus toxoid/immune globulin
Laxatives/cathartics
Corticosteroids
Anti-rheumatic medications
Topicals

Formulate and implement an appropriate plan of management when indicated, including:

Debridement of superficial ulcer or wound
Excision or destruction of skin lesion including skin biopsy
Nail avulsion (partial or complete)

Matrixectomy (partial or complete)
Repair of simple laceration
Digital surgery
First ray surgery
Other soft tissue foot surgery
Other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rearfoot & ankle surgery

Formulate and implement an appropriate plan of management including appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, and reassessment of the treatment plan with revisions as necessary.

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine and present medical and scientific literature.

Orthopedic Surgery (IMC Ortho)
During the rotation, the resident will be responsible to the attending orthopedic surgeon.

Competencies
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by surgical means.

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

Interpret appropriate medical imaging (such as plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, and CT)
Interpret appropriate laboratory tests
Interpret other appropriate diagnostic studies like electrodiagnostic studies or non-invasive vascular studies
Formulate an appropriate diagnosis and/or differential diagnosis
Formulate and implement an appropriate plan of management, which may include cast management or physical therapy
Perform appropriate pharmacologic management when indicated, including NSAIDs, antibiotics, narcotic analgesics, or corticosteroids
Formulate and implement an appropriate plan of management when indicated, including digital surgery, first ray surgery, other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies)
Reconstructive rearfoot and ankle surgery
Hand surgery
Other orthopedic surgery

Demonstrate the ability to formulate a methodical and comprehensive treatment plan with an appreciation of health care costs.

Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. Read, interpret, critically examine, and present medical and scientific literature.

VAMC Podiatry Clinics
See PGY1 rotations (page 53)

XVI. ROTATION SCHEDULE

The following are the rotation schedules for 2025-2026.

PGY-1 Schedule

	PGY-1 Resident #1	**PGY-1 Resident #2**	**PGY-1 Resident #3**
July	Emergency Medicine	St Mark's Podiatry	VA Podiatry Clinic
Aug	Infectious Diseases	St Mark's Podiatry	VA Podiatry Clinic
Sept	VA Podiatry Clinic	VA Podiatry Clinic	Radiology / Anesthesiology
Oct	VA Podiatry Clinic	VA Podiatry Clinic	Emergency Medicine
Nov	Radiology / Anesthesiology	Emergency Medicine	St Mark's Podiatry
Dec	Dermatology	Anesthesiology / Radiology	St Mark's Podiatry
Jan	VA Podiatry Clinic	St Mark's Medicine	Dermatology
Feb	VA Podiatry Clinic	Psych / Vascular	Infectious Diseases
March	St Mark's Podiatry	VA Podiatry	Vascular / Psych
April	St Mark's Podiatry	VA Podiatry	St Mark's Medicine
May	Vascular / Psych	Dermatology	VA Podiatry
June	St Mark's Medicine	Infectious Diseases	VA Podiatry
	PGY-1 Resident #4	**PGY-1 Resident #5**	**PGY-1 Resident #6**
July	VA Podiatry Clinic	Radiology / Anesthesiology	Dermatology
Aug	VA Podiatry Clinic	Emergency Medicine	Radiology / Anesthesiology
Sept	Emergency Medicine	Dermatology	St Mark's Podiatry
Oct	Anesthesiology / Radiology	Infectious Diseases	St Mark's Podiatry
Nov	VA Podiatry Clinic	VA Podiatry Clinic	Infectious Diseases
Dec	VA Podiatry Clinic	VA Podiatry Clinic	Emergency Medicine
Jan	St Mark's Podiatry	Vascular / Psych	VA Podiatry Clinic
Feb	St Mark's Podiatry	St Mark's Medicine	VA Podiatry Clinic
March	Dermatology	VA Podiatry Clinic	St Mark's Medicine
April	Infectious Diseases	VA Podiatry Clinic	Psych / Vascular
May	St Mark's Medicine	St Mark's Podiatry	VA Podiatry Clinic
June	Psych / Vascular	St Mark's Podiatry	VA Podiatry Clinic

PGY-2 Schedule

	PGY-2 Resident #1	PGY-2 Resident #2	PGY-2 Resident #3
July	IMC Podiatry Biomechanics	VA Podiatry Clinic	IMC Trauma
Aug	IMC Podiatry Biomechanics	VA Podiatry Clinic	St Mark's Family Medicine
Sept	IMC Surgery	IMC Podiatry Biomechanics	VA Podiatry Clinic
Oct	IMC Surgery	IMC Podiatry Biomechanics	VA Podiatry Clinic
Nov	IMC Trauma	St Mark's Family Medicine	IMC Surgery
Dec	St Mark's Family Medicine	IMC Trauma	IMC Surgery
Jan	VA Podiatry Clinic	IMC Limb Salvage	IMC Trauma
Feb	VA Podiatry Clinic	IMC Limb Salvage	Plastic Surgery
March	IMC Limb Salvage	IMC Surgery	IMC Podiatry Biomechanics
April	IMC Limb Salvage	IMC Surgery	IMC Podiatry Biomechanics
May	IMC Trauma	Plastic Surgery	IMC Limb Salvage
June	Plastic Surgery	IMC Trauma	IMC Limb Salvage
	CC Wed PM	**CC Thurs PM**	**CC Wed PM**
	PGY-2 Resident #4	**PGY-2 Resident #5**	**PGY-2 Resident #6**
July	IMC Limb Salvage	IMC Surgery	St Mark's Family Medicine
Aug	IMC Limb Salvage	IMC Surgery	IMC Trauma
Sept	IMC Trauma	St Mark's Family Medicine	IMC Limb Salvage
Oct	St Mark's Family Medicine	IMC Trauma	IMC Limb Salvage
Nov	VA Podiatry Clinic	IMC Limb Salvage	IMC Podiatry Biomechanics
Dec	VA Podiatry Clinic	IMC Limb Salvage	IMC Podiatry Biomechanics
Jan	IMC Surgery	IMC Podiatry Biomechanics	Plastic Surgery
Feb	IMC Surgery	IMC Podiatry Biomechanics	IMC Trauma
March	IMC Trauma	Plastic Surgery	VA Podiatry Clinic
April	Plastic Surgery	IMC Trauma	VA Podiatry Clinic
May	IMC Podiatry Biomechanics	VA Podiatry Clinic	IMC Surgery
June	IMC Podiatry Biomechanics	VA Podiatry Clinic	IMC Surgery
	CC Tues PM	**CC Thurs PM**	**CC Tues PM**

PGY-3 Schedule

	PGY-3 Resident #1*	PGY-3 Resident #2	PGY-3 Resident #3
July	IMC Ortho	VA Chief Podiatry Clinic	Layton IHC Podiatry
Aug	IMC Ortho	VA Chief Podiatry Clinic	Layton IHC Podiatry
Sept	VA Chief Podiatry Clinic	IMC Ortho	Layton IHC Podiatry
Oct	VA Chief Podiatry Clinic	IMC Ortho	Layton IHC Podiatry
Nov	IHC/Cottonwood Podiatry	Layton IHC Podiatry	McKay-Dee IHC Podiatry
Dec	IHC/Cottonwood Podiatry	Layton IHC Podiatry	McKay-Dee IHC Podiatry
Jan	IHC/Cottonwood Podiatry	Layton IHC Podiatry	McKay-Dee IHC Podiatry
Feb	IHC/Cottonwood Podiatry	Layton IHC Podiatry	McKay-Dee IHC Podiatry
March	Riverton IHC Podiatry	McKay-Dee IHC Podiatry	IMC Ortho
April	Riverton IHC Podiatry	McKay-Dee IHC Podiatry	IMC Ortho
May	Riverton IHC Podiatry	McKay-Dee IHC Podiatry	VA Chief Podiatry Clinic
June	Riverton IHC Podiatry	McKay-Dee IHC Podiatry	VA Chief Podiatry Clinic
	PGY-3 Resident #4*	**PGY-3 Resident #5**	**PGY-3 Resident #6**
July	Riverton IHC Podiatry	IHC/Cottonwood Podiatry	McKay-Dee IHC Podiatry
Aug	Riverton IHC Podiatry	IHC/Cottonwood Podiatry	McKay-Dee IHC Podiatry
Sept	Riverton IHC Podiatry	IHC/Cottonwood Podiatry	McKay-Dee IHC Podiatry
Oct	Riverton IHC Podiatry	IHC/Cottonwood Podiatry	McKay-Dee IHC Podiatry
Nov	IMC Ortho	Riverton IHC Podiatry	VA Chief Podiatry Clinic
Dec	IMC Ortho	Riverton IHC Podiatry	VA Chief Podiatry Clinic
Jan	VA Chief Podiatry Clinic	Riverton IHC Podiatry	IMC Ortho
Feb	VA Chief Podiatry Clinic	Riverton IHC Podiatry	IMC Ortho
March	IHC/Cottonwood Podiatry	VA Chief Podiatry Clinic	Layton IHC Podiatry
April	IHC/Cottonwood Podiatry	VA Chief Podiatry Clinic	Layton IHC Podiatry
May	IHC/Cottonwood Podiatry	IMC Ortho	Layton IHC Podiatry
June	IHC/Cottonwood Podiatry	IMC Ortho	Layton IHC Podiatry

*Chief Resident(s)

XVII. Evaluations

Evaluations need to be obtained at the end of every rotation. Residents should ensure that the correct individual has received an email notification from New Innovations, our online evaluation site. Information on how to log into New Innovations can be obtained by calling the GME Housestaff Office at (801) 507-3747 or by emailing Shirley.Hamblin@imail.org

The PGY-3 rotation IMC Ortho should have at least 1 evaluation from an orthopedic surgeon.

Faculty and Rotation Evaluations

Separate forms are available on New Innovations for these evaluations. You must fill out at least one for each rotation. Additional evaluations should be filled out when you work extensively with more than one faculty member. These forms are due no later than 2 weeks after the end of a rotation. Evaluations of faculty are anonymous and more detailed comments can be emailed to the program director as part of the evaluation process.

Examples of evaluation forms are given below. In addition, hard-copy forms are available from the program coordinator. Once a faculty member has completed an evaluation, the resident is given the opportunity to review the form and add comments prior to signing.

Anesthesiology

Subject Name: (Person being evaluated)
Status:
Employer:
Program:
Rotation:
Evaluation Dates:

Evaluated by: (Evaluator Name)
Status:
Employer:
Program:

Legend:
1 Demonstrates inadequate knowledge of the task 2 Demonstrates knowledge but is unable to perform

3 Performs only with constant direction 4 Performs with minimal direction

5 Performs the entire task independently n/a Did Not Observe

COMPETENCY	1	2	3	4	5	n/a
Formulate & implement appropriate plan of management including: local anesthesia						
General anesthesia						
Spinal anesthesia						
Epidural anesthesia						
Regional anesthesia						
Conscious sedation						
Perform & interpret findings of appropriate medical H&P exam						
Recognize need for additional lab & diagnostic studies when indicated						
Demonstrate ability to perform intravenous placement						
Demonstrate ability to manage airway including intubation						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines & presents medical & scientific literature						

Legend for Attitudinal Assessment:
1 Never 2 Some of the time 3 Most of the time 4 Always N/A Not applicable

Attitudinal Assessment	1	2	3	4	N/A
Accepts criticism constructively					
Acts as a patient advocate, involving the patient/family in decision making process					
Communicates effectively with colleagues & staff					
Communicates effectively with the patient/family, recognizing concerns for safety, comfort, and medical necessity.					
Provides high quality, comprehensive care in an ethical manner					
Demonstrates moral & ethical conduct					
Respects & adapts to cultural differences					
Establishes trust & rapport with patients & peers					
Demonstrates primary concern for patient's welfare & well-being					

Please rate this resident's overall competence.
Deficient – should repeat rotation Minimally Acceptable-some remediation needed
Acceptable for Level of Training Outstanding for Level of Training

Faculty Comments: What do you find striking (positive or negative) about this resident?
_____
_____

Signature: _____ Date: _____

Resident Response (circle one): Accept Accept with Comment* Protest without Action* Appeal
Resident Signature: _____ Date: _____

- Resident must include comments at time of review

Reviewed with Director on: Date: _____
Director Signature: _____ Date: _____

Evaluation of Faculty/Rotation by Trainee

Subject Name: (Person being evaluated)
Status:
Employer:
Program:
Rotation:
Evaluation Dates:

Evaluated by: (Evaluator Name)
Status:
Employer:
Program:

Evaluation – Faculty

1 Knowledge of Medicine – General Medicine

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

2 Knowledge of Medicine – Sub-specialty

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

3 Involvement in Patient Care (interaction, judgment, follow up)

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

4 Interest in Teaching

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

5 Punctuality and Availability

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

6 Personal Qualities as relates to Medical Care & Teaching

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

7 Overall Rating

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

8 Would you recommend this person for a similar assignment in the future?
Yes No* Maybe*

**Please include comments. Please comment on how well the program competencies were met.*
9 Comments (Use other side if necessary):

Please include the type of trainee and year in the program (i.e. PGY-2 Podiatry, etc.) Please complete the faculty portion for every faculty member you worked with.

Evaluation – Rotation

10 Teaching

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

11 Patient Load – Clinic

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

12 Patient Load – Inpatient

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

13 Interest of Faculty

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

14 Service to Education Ratio

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

15 Overall Rating

Poor	Satisfactory	Very Good	Outstanding
1	2	3	4

16 Would you recommend this rotation be continued in its present format in the future?
Yes No* Maybe*

**Please include comments. Please comment on how well the program competencies were met.*
17 Comments (Use other side if necessary):

Intermountain Medical Center Podiatric Medicine and Surgery Residency

Research Proposal
Resident:
Mentor:

	Satisfactory	Unsatisfactory	N/A
Background (Review of Literature)			
Primary Question and Response Variables			
Secondary Question and Response Variables			
Subgroup Hypotheses			
Study Population (inclusion/exclusion criteria)			
Sample Size Assumptions and Estimate			
Informed Consent			
Assessment of Eligibility/Baseline Exam			
Randomization Method/Plan			
Description and Schedule			
Measures of Compliance			
Data Collection			
Quality Control			
Data Analysis			
Termination Policy			

**Interim reviews may only address a limited subset of these items. Some elements will not be relevant for all proposals.*
Please rate this resident's overall competence.

Deficient: should repeat rotation	
Minimally Acceptable: some remediation needed	
Acceptable for Level of Training	
Outstanding for Level of Training	

Mentor Comments: What do you find striking (negative or positive) about this proposal?
_____
_____
Signature: _____
Date: _____
Resident Response (circle one)
Accept Accept with comment* Protest without action Appeal

_____
Signature: _____
Date: _____

- Resident must include comments at time of review.

Reviewed with Director on _____ Signature: _____

(Residency Director)

Resident Acknowledgement

I have received and read the IMC Podiatric Medicine and Surgery Residency Manual. I understand that the manual is subject to change annually and at other times, given reasonable notice, and I agree to abide by the policies and procedures delineated in the manual and any subsequent changes.

Podiatric Resident Signature: _____

Date: _____

Print Name:

Appendix A: Evaluation Forms

If you would like copies of all forms, please contact the program coordinator to have the appendix sent to you.