BETH ISRAEL DEACONESS MEDICAL CENTER

PODIATRIC MEDICINE AND SURGICAL RESIDENCY (PMSR / RRA)

PROGRAM MANUAL

REVISED JUNE 2025

Beth Israel Deaconess Medical Center
Podiatric Residency Program Curriculum

The PMSR with RRA residency is designed with a rotational structure with an emphasis on resource based, competency driven, assessment validated training. The resident is provided with a greater responsibility in patient care and decision making as they progress through their training. These experiences coincide with a complementary curriculum of advancing didactic study. The residents and attending faculty have teaching responsibilities to students, medical staff / house officers and the surrounding community.

The rotations of the residency include: podiatric surgery, clinical podiatric medicine, internal medicine, vascular surgery, emergency medicine, medical imaging, anesthesiology, rheumatology, endocrinology, behavioral medicine, infectious disease, orthopedic surgery, plastic surgery.

Complete standards and requirements of Podiatric Medicine and Surgery Residencies can be found in CPME Documents 320 and 330. These documents can be obtained through the residency director / coordinator, within the electronic residency manual or on the internet at http://www.cpme.org/cpme320 http://www.cpme.org/cpme330

1st Year:

Podiatric Med / Surg	26 weeks
Emergency Medicine	4 weeks
Vascular Surgery	4 weeks
Anesthesia	2 weeks
Medical Imaging	2 week
Internal Medicine	4 weeks
Rheumatology	2 weeks
Endocrinology	2 weeks
Orthopedics	3 weeks

2nd Year

Podiatric Med / Surg	40 weeks
Infectious Disease	4 weeks
Plastic Surgery	3 weeks
Behavioral Medicine	2 weeks

3rd Year

Podiatric Med / Surg	47 weeks
Behavioral Medicine	2 weeks (for 2025-26 academic year only)

In addition, the residents may rotate through several other regional healthcare facilities including: VA Medical Center of Boston, BI Needham, New England Baptist / Surgicare, Signature Brockton Hospital, Boston Children's Hospital, Norwood Surgical Center on a case by case basis.

SITE	SUPERVISOR
VA Medical Center	James Sang, DPM
BI Needham	JT Marcoux or Dan Rutowicz, DPM
New England Baptist / Surgicare	JT Marcoux, DPM
Signature Brockton Hospital	Barry Rosenblum, DPM
Boston Children's Hospital	Thanh Dinh, DPM
Norwood Surgical Center	Emily Pugh, DPM

Core Faculty at BIDMC:

John T. Marcoux DPM, FACFAS	Program Director
Thanh Dinh, DPM, FACFAS	Division Chief
Barry Rosenblum DPM, FACFAS	Assistant Chief
Kevin Reimer DPM, FACFAS	Externship Director
Elena Manning DPM, FACFAS	Faculty

Residents are required to undergo periodic evaluation, as per the Council on Podiatric Medical Education Guidelines. These evaluations are used not only to evaluate the residents, but also to evaluate and assess the capabilities of meeting goals established for these rotations by the instructors / supervisors. The Director of the specific rotation and/or their designee provides the evaluation through observation of the resident. Observation forms are open to inspection by the individual resident, the director and the Council on Podiatric Medical Education. Residents and the program director review their evaluations to ensure that competencies related to the rotation are met. Upon satisfactory completion of all mandatory rotations and demonstrated competence during the residency training, the resident is awarded a PMSR with Reconstructive Rearfoot / Ankle completion certificate from the sponsoring institution.

PMSR with RRA Activity Requirements:

Foot and ankle surgical cases	300
Foot and ankle surgical procedures	400
Trauma cases	50
Podopediatric cases	25
Other podiatric procedures	100
Lower extremity wound care	50
Biomechanical examinations	50
Comprehensive history and physical examinations	50

Procedure Activities: (First assist)

Digital	80
1st Ray	60
Other soft tissue	45
Other osseous	40
Reconstructive Rearfoot/Ankle	50

EDUCATIONAL METHODS AND INSTRUMENTS

A. Didactic Lectures

The Beth Israel Deaconess Podiatric Residents will attend formal lectures both internally and at nearby institutions either in person or virtually throughout the academic year. Guest lecturers will consist of podiatric and allopathic physicians. Topics vary from year to year but encompass podiatric medicine and surgery as well as medical imaging, infectious disease and other medical and surgical topics.

B. Research Paper

The resident shall prepare a topic for study which will include a pertinent literature review, development of research questions, generation of a hypothesis, selection of an appropriate research methodology and development of a proposal for data analysis. For the subsequent years after the first year, the resident will prepare one publishable research project or a new proposal.

Topic selection is expected by October 1. Generation of a hypothesis, research questions and appropriate research is expected by January 1. A completed paper, acceptable for publication is expected by May 1 of the second year.

As a supplementary activity, the residents are encouraged to prepare posters and submit for publication case studies on unusual or interesting podiatric pathologies.

C. Clinical Pathological Conferences

Each resident shall present at the Clinical Pathological Conference (CPC) throughout the year. The conference will be attended by all residents and moderated by the senior surgical resident and attending staff. Affiliated faculty members are welcome and encouraged to participate. During each session, one of the residents shall present a case report or a complete topic review. Included in the case report shall be the following:

1. Subjective findings:

    a. patient profile
    b. patients chief complaint
    c. history of present illness

d. current general medical health
e. social history
f. past medical history
g. family history

2. Physical findings:

a. description of observations
b. related system examination
c. adjunctive systems examination
d. review of pertinent radiographic and laboratory studies
e. provisional diagnosis
f. treatment plan (surgical or medical)
g. prognosis and follow-up care

Active discussion will follow each case. Pertinent literature shall be included.

D. Journal Club

The Journal Club is intended to provide the resident with a current knowledge of important developmental articles written in recognized journals. The Journal Club will be held at least twice a month. All residents should read the provided articles prior to the meeting and are expected to participate and contribute to the session. Members of the attending faculty staff moderate each session. Each article should be critically reviewed for soundness and significance of the research.

E. Workshops

Workshops shall consist of laboratory instruction in psychomotor skills and practical application of operative and clinical techniques. The workshops may include:

1. Suturing techniques
2. Internal fixation
3. Bandaging
4. Casting
5. Plastic skin maneuvers
6. Arthroscopy
7. External fixation
8. Osteotomies
9. Endoscopic procedures
10. New technologies

F. Grand Rounds

The division provides monthly educational conferences with lecturers who are authoritative on specific topics. Residents are required to attend these didactic activities.

G. **Seminars**

Residents are encouraged to attend accredited postgraduate education seminars and symposiums.

H. **Virtual Lectures:**

Virtual lectures on several procedures are provided to supplement the didactic and surgical instruction. Residents are encouraged to view these instructional courses / procedures prior to surgical cases.

I. **Residency Teaching**

It is well-recognized that teaching itself is a learning experience. Residents are encouraged to teach to the level of their development in knowledge and skill. Residents should instruct each other and externs who are visiting the hospital.

J. **Rotations**

Clinical rotations have been developed to provide the resident a solid foundation in podiatric medicine and surgery as well as the opportunity to gain a similar grasp in the fundamentals of medicine. The rotations allow the resident to interact and understand the multidisciplinary approach to patient care within the mainstream medical health care delivery system.

K. **In-training examination**

The program mandates that all residents complete an in-training examination developed by ABFAS and ABPM to assess the resident's post-graduate development and in preparation for sitting for board certification examinations.

L. **Mortality and Morbidity (M&M) Conferences**

Residents and faculty are required to attend all monthly divisional M&M conferences at the sponsoring institution. The division is mandated to present cases that meet the requirements for M&M review as stipulated by the surgery department.

BETH ISRAEL DEACONESS MEDICAL CENTER
PODIATRIC RESIDENCY PROGRAM
CRITERIA FOR ADVANCEMENT

Advancement from PGY-1 to PGY-2:

1. Successful completion of all PGY-1 rotations.
2. Competent to supervise PGY-1 residents and podiatric medical students.
3. Successfully performed all entry-level procedures as outlined on rotation competencies and documented on operative / clinical logs.
4. Able to perform resident duties with limited independence.
5. Acceptable performance on the in-training examination(s).

Advancement from PGY-2 to PGY-3:

1. Successful completion of all PGY-2 rotations.
2. Competent to supervise PGY- 2 residents.
3. Successfully performed all basic procedures as outlined on rotation competencies and documented on operative / clinical logs.
4. Able to perform PGY-2 resident duties with limited independence.
5. Acceptable performance on the in-training examination(s).

Completion of Program:

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

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

Works well with patients, fellow residents, faculty, consultants, ancillary staff and other members of the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues as demonstrated by satisfactory staff and faculty professional behavior evaluations. Any disciplinary action plans that

result from unprofessional behavior must be resolved to allow for successful program completion.

Absence of impaired function due to mental or emotional illness, personality disorder or substance abuse. Any disciplinary actions or treatment programs implemented per the Beth Israel Deaconess Medical Center GMEC policies on impaired function must have been successfully completed and reinstatement approved by the Podiatric Residency Program Director.

BETH ISRAEL DEACONESS MEDICAL CENTER
PODIATRIC RESIDENCY
GENERAL RULES AND REGULATIONS

The residents shall observe those proprieties of conduct and courtesies that are consistent with the profession and in accordance with the rules and regulations governing the physician staff of Beth Israel Deaconess Medical Center.
Breach of rules shall be brought to the attention of the Program Director and appropriate corrective disciplinary action instated. (see Disciplinary Process)

Questions or criticisms related to general hospital operations or personnel may be brought to the attention of the Program Director. The Program Director will discuss concerns with the Division Chief and proper hospital administrator. Questions relating to the podiatric residents training will be discussed with the Program Director.

Questions and criticisms of Podiatric faculty members will be discussed at designated resident meetings. If necessary, concerns will be directed to the Program Director and if necessary the Division Chief.

The residents shall follow the prescribed resident program schedule. The resident will report to his designated assignment at the prescribed hour. For most standard rotations, including podiatry, it is expected that you be in the hospital no later than 7:00AM unless otherwise stated by the rotation director. Tardiness will not be tolerated. The assigned resident should try to attend all scheduled educational conferences.

Daily rounds begin at 7:00AM by resident's on-service to assess all active podiatric patients in the hospital. All available residents should unless covering cases at an outside facility. Weekend rounds should be performed no later than 8:00AM or at the discretion of the attending on-call.

The attending surgeon must be notified prior to scheduling add on cases in the operating room.

Residents shall perform History and Physicals as well as preoperative notes on all podiatric surgical patients. The attending must review and sign these documents prior to any procedure.

The residents shall make preoperative evaluations and review the next days surgical charts. The resident is responsible for reviewing the preoperative lab results, radiographs and should be able to discuss the proposed surgical procedure with the attending.

Visitors are not permitted in the operating room without proper hospital approval and signed consent of the patient.

The first assistant is responsible for obtaining the necessary surgical instruments and supplies for the procedure.

The first assistant is responsible (unless otherwise stated by the attending) for dictating the operative report and/or discharge summary within 24 hours of the procedure or under the established guidelines of the hospital / surgical center.

The first assist is responsible for contacting surgical day care patients on the first postop day for follow up assessment.

The resident shall keep accurate and complete patient documentation for each patient encounter whether the patient was evaluated in person or had an indirect interaction.

The assigned podiatric surgery resident must keep the attending physician updated on their patient(s) on a daily basis.

The assigned podiatric surgery resident must have available with them or have each patient's room stocked with the necessary dressing supplies for daily rounds.

The assigned podiatric surgery resident must submit a verbal and electronic signout with all pertinent medical information on each hospitalized patient to the "on call" resident for continuity of care.

Residents shall wear clean, hospital provided scrubs or appropriate professional clothing while at the hospital.

Every resident is responsible for maintaining a current residency log. Residents are required to keep their surgical and activity logs up to date as they are reviewed at least monthly by the Program Director.

Residents are to give no patient information to news reporters, lawyers, insurance companies etc.

The resident is responsible for keeping the chief resident informed of their whereabouts at all times.

Residents are responsible to submit a written request for personal and vacation days desired to assure there is minimal conflict within the structure of the program. All time off must be approved by the Program Director and forwarded to the coordinator.

Residents must make documentation available (doctors notes, police reports, etc) for all unexcused absences or tardiness. If no documentation is available, the time will be deducted from vacation / personal time.

Residents are responsible to contact the chief resident and program coordinator if sick. If off-service, they should also notify the contact person for that rotation.

Residents that anticipate a leave of absence for 2 weeks or more must notify the Program Director of the leave. (see complete policy)

Smoking will not be tolerated within the hospital.

Beth Israel Deaconess Medical Center
Graduate Medical Education (GME) Manual

Title: Vacation and Leave of Absence Policy

Policy: GME-06

I. PURPOSE

To provide guidance on vacation and leaves of absence for all residents/fellows who are enrolled in graduate medical education ("GME") programs sponsored by Beth Israel Deaconess Medical Center ("BIDMC").

II. REFERENCE

ACGME Institutional Requirements require Sponsoring Institutions to have a policy for vacation and leaves of absence, consistent with applicable laws, which provides residents with a minimum of six (6) weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during a program, starting the day the resident is required to report. This policy must also provide residents with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations by the relevant certifying board(s).

III. POLICY

A. General

This Policy applies to residents enrolled in both accredited and non-accredited GME programs sponsored by BIDMC.

There may be circumstances when a resident is unable to attend work, including but not limited to, due to fatigue, illness, family emergencies, and medical, parental or caregiver leave. Each program shall have policies, consistent with this Policy, which allow a resident unable to perform patient care and/or training responsibilities to take an appropriate leave of absence. These policies and procedures must be implemented without fear of negative consequences to the resident who is unable to provide the clinical work.

Program policies must set forth the program's procedures for submitting requests for vacations and leaves of absence, including appropriate timing for such requests (generally at least 30 days' advance notice, absent illness or extenuating circumstances) and to whom the resident must submit his/her written request for leave, typically the Program Director and Program Coordinator. Written requests

for a leave of absence should include the reason for leave, dates requested for the leave and any additional information required by the program. Program Directors should timely approve or reject resident requests. Each program's policy/procedures on requesting planned leaves should be communicated and made available to residents.

To the extent possible, residents should work with their Program Directors and other clinical supervisors to minimize disruption to clinical care for any vacation or non-urgent paid time off. When advance notice is not possible (due to illness or other reasons), the resident must provide notice as soon as practicable and in accordance with any additional program procedures or policies. Any resident absences from a program must be recorded appropriately in MedHub.

Program policies should also specify the program's policy for resident attendance at outside professional conferences (funding and amount of time allowed), and time away for job or fellowship interviews.

B. Paid Time Off

Each resident, per academic year, will be provided with a minimum of [21] paid vacation days (15 weekdays plus six (6) weekend days). In general, vacation should be scheduled as a week with the weekend prior to or after included. Programs may provide additional vacation days or paid time off to residents at their discretion.

Each resident, per academic year, is also provided with seven (7) additional days of paid time off for unexpected absences (bereavement; an acute illness of the resident or family member; personal or childcare emergencies; elective healthcare appointments; or other reasons). [Except for absences taken under the Family and Medical Leave Act ("FMLA"), Massachusetts Paid Family and Medical Leave Law ("PFMLL"), and/or Massachusetts Parental Leave Act ("MPLA"), addressed below, these additional days of paid time off are to be used in lieu of the benefits provided in BIDMC policy 11, Employee Leaves of Absence Policy and/or in other BIDMC policies.]

Unused paid time off cannot be carried over into subsequent academic years.

C. Medical, Parental, Caregiver Leaves of Absence

BIDMC provides residents with medical, parental, caregiver leaves of absence as set forth below. Eligibility for the following medical, parental, caregiver leaves of absence will be determined consistent with this Policy, other BIDMC policies/procedures, ACGME Requirements, and applicable state or federal law.

1. Paid Medical, Parental and Caregiver Leave for Residents in ACGME-accredited Programs

Each resident in an ACGME-accredited and approved program shall be provided, **up to 12 weeks** (and a minimum of six (6) weeks) **paid medical, parental, and caregiver leave of absence per academic year** for qualifying reasons that are consistent with applicable ACGME Requirements and law, including FMLA, PFMLL and MPLA, starting on the day the resident is required to report.

Paid medical, parental, or caregiver leave shall be provided at an equivalent of 100 percent of the resident's salary. One (1) week of paid time off shall also be reserved for use outside of paid leave during the academic/appointment year that a resident takes a paid medical, parental or caregiver leave. Health and disability insurance benefits for residents and their eligible dependents during any approved, qualifying medical, parental, or caregiver leave(s) of absence shall continue on the same terms and conditions as if the resident was not on leave. BIDMC will continue to deduct the employee portion of benefit premiums from the resident's salary continuation.

With the exception of unforeseen circumstances, approval of paid medical, parental and caregiver leave shall be requested in writing, in advance, and in accordance with program policies/procedures on requesting leave, with sufficient time to allow programs to coordinate patient care and rotation schedules. Additional information on the process for requesting approval for paid medical, parental, and caregiver leaves of absence is provided to residents with their benefit information at the time of onboarding and detailed in program and BIDMC policies.

Residents in programs which are not BIDMC-sponsored ACGME accredited programs are *not* eligible to receive paid medical, parental, and caregiver leave in accordance with this section.

This policy constitutes a paid family and medical policy within the meaning of 458 CMR 2.12(6)(d)(2). Paid leave under this section of the Policy will run concurrently with – not in addition to – any other family or medical leave available under state or federal law or other BIDMC policy.

2. *Family Medical Leave Act, Massachusetts Paid Family and Medical Leave Law, and Massachusetts Parental Leave Act*

Residents may be eligible for leave or additional leave for their own serious health condition, to care for a family member with a serious health condition, or for family bonding/parental leave under BIDMC policies relating to the FMLA, PFMLL, and MPLA. Any period of family or medical leave under state or federal law or BIDMC policy that does not qualify for salary continuation under section C.1 of this Policy will be subject to BIDMC's PM-11, Employee Leaves of Absence and/or PM-40, Massachusetts Paid Family and Medical Leave Law Policy, as applicable. This includes with respect to residents' ability to elect to use vacation time concurrent with any such leave and the maintenance of benefits during such leave.

During any leave of absence that is unpaid by BIDMC, health insurance coverage and other benefits will continue as if the resident worked continuously during the leave period, provided that residents continue to pay their share of the premiums, as applicable. Residents should contact the BIDMC Benefits Department for more information about maintenance of benefits during an unpaid leave of absence.

Residents seeking to take leave under BIDMC's PM-11, Employee Leaves of Absence and/or PM-40, Massachusetts Paid Family and Medical Leave Law Policy should contact Human Resources for more details regarding eligibility for and initiating leaves under these policies.

D. Effect on Training

Leaves of absence may impact a resident's training. This Policy does not consider minimum training or competency requirements of programs, departments, the ACGME, ACGME Review Committees, state licensing boards, or any other authority as to the adequacy of medical training and should not be construed as altering minimum attendance or any of these other requirements.

Residents should be aware that any leave, including any medical, caregiver, family leave, may require extension of his/her training in a program or making up certain aspects of the program as required by ACGME accreditation, specialty board certification requirements, or other applicable requirements. The Program Director, based on program requirements, board requirements and state licensing policies for the specialty, shall provide the resident with a timely, accurate written notice regarding the effect of a proposed extended leave of absence, both for completing the program and with respect to the resident's eligibility to participate in specialty board examinations. As necessary, this notification should detail the required length of additional training and the time period over which it should occur. Residents should review and discuss this written notification prior to starting any leave of absence and finalize it in writing, within thirty (30) days of returning to work.

Additional information on resident extensions of training may be found in GME-04, Policy for Extension of Training.

E. Institutional Oversight

In fulfilling institutional oversight responsibilities, the GMEC will monitor program compliance with this Policy and with program policies and procedures regarding vacations and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually.

Resident questions about this policy may be directed to BIDMC Human Resources, the resident's Program Director, or the Administrative Director of Graduate Medical Education. This policy does not constitute a contract between BIDMC and its residents.

Adopted and approved by:

Graduate Medical Education Committee:

Original Date: 10/28/2024

Next Review Date: October, 2025

Medical Executive Committee on behalf of BIDMC: 11/20/2024

Previously

Institutional Vacation Policy, Original Date: 12/18/2023; and

Paid Family and Medical Leave Policy for Graduate Trainees in ACGME Programs: Original Date: 1/26/2004

Revised: 05/17/2004, 03/09/2006, 05/24/2006, 03/16/2009, 05/19/2014, 01/04/2017, 04/24/2021

Title: Policy and Procedure for Trainee Supervision for Interns, Residents and Fellows

Policy: GME-15

Purpose: To establish guidelines for individual departmental supervision policies

Policy Statement:

This Policy establishes hospital-wide supervision guidelines for all interns, residents and fellows (Trainees) appointed to graduate medical Education (GME) programs sponsored by the Beth Israel Deaconess Medical Center (BIDMC). It also establishes institutional supervision guidelines for medical students enrolled in courses sponsored by BIDMC.

This Policy is intended to comply with applicable standards set by the Massachusetts Board of Registration in Medicine (BoRM), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), requirements of the Accreditation Council of Graduate Medical Education (ACGME), and provisions of the BIDMC Medical Staff Bylaws.

General Principles:

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

The below is the section from the ACGME Common Program Requirements:

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically

present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision by Members of the Medical Staff:

All Trainees must be supervised by a member of the medical and/or teaching staff taking care of patients at all training sites, including both inpatient and outpatient experiences and daytime routine and on-call activities. The medical staff member must have a current Full License issued by the Massachusetts BoRM, and be properly credentialed, with appropriate clinical privileges at the institution or facility where the supervision is occurring. This information should be available to residents, faculty members, and patients. Residents and faculty members should inform patients of their respective roles in each patient's care.

The supervision of Trainees must allow for 'graduated responsibility'. Trainees should be allowed the opportunity to assume increasing patient care responsibilities according to their level of education, ability, and experience. The level of responsibilities assumed by each Trainee must be determined by the teaching medical staff, and should be based on written descriptions of the roles and responsibilities of trainees. Trainees should receive regular evaluations that include an assessment of their ability to assume increasing levels of clinical responsibilities. The program director must evaluate each trainee's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Faculty and Trainees must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects

Program Responsibilities:

1. Each GME program is required to supplement this Policy with written, program specific policies regarding supervision of Trainees. The program policy should describe the supervisory responsibilities of the faculty and the Trainee. In any situation in which a program-specific policy conflicts with the GME Policy, the terms of the GME Policy # 15 shall prevail.

2. Each program must define the general responsibilities for each PGY level, including supervisory responsibilities, medical/surgical procedures or orders that require direct supervision or countersignature, in emergency and non-emergency situations.

3. Each program director must define the levels of responsibility for each Trainee by preparing a description of the types of clinical activities each Trainee may perform with and without direct supervision and those for which the Trainee may act in a teaching/supervisory capacity. The program will communicate the defined levels of responsibility to each Trainee.

4. Trainees should receive regular evaluations that assess their competency. The assessment of a Trainee's competence shall serve as the basis for determining the minimum level of supervision required for different activities.

5. On-call schedules for attending physicians shall provide for supervision that is readily available to a Trainee on duty 24 hours per day, 7 days per week. The program director must ensure and document adequate supervision of Trainees at all times. Trainees must be provided with rapid, reliable systems for communicating with supervising faculty.

6. Programs should define standard indications and principles to guide Trainees in determining the need for communication with the attending physician in all circumstances.

7. Under certain circumstances determined by the program, urgent judgments by highly experienced physicians are required, and for these specialties attending physicians must be immediately available on site at all times. Under other circumstances, attending physicians can provide adequate supervision off site as long as their physical presence within a reasonable time can be assured in case of need.

8. The Program Director must assure that a schedule with the name and contact number of the responsible attending physician is available at all times to program Trainees. Faculty schedules must be structured to provide Trainees with continuous supervision and consultation.

9. All patients seen by Trainees on an outpatient basis must be seen by, discussed with, or reviewed by the responsible attending physician.

10. Each program will determine how to monitor and improve compliance with its supervision policies and competency assessments, using such methods as chart audits, quality audits, procedure logs, Trainee feedback, attending physician feedback, risk management reports and quality improvement reports.

Attending Physician Responsibilities:

1. An attending physician is responsible for and actively involved in the care provided to each patient, both inpatient and outpatient.

2. Faculty members functioning as supervising physicians should delegate portions of care to residents based on the needs of the patient and the skills of the residents.

3. An attending physician directs the care of each patient and provides the appropriate level of supervision for a Trainee, based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and level of education, ability, experience, and judgment of the resident being supervised.

4. The attending physician, in consultation with the program director, accords a Trainee progressive responsibility for the care of the patient based on the Trainee's clinical

experience, judgment, knowledge, technical skill, and capacity to function.

5. The attending physician advises the program director if he/she believes a change in the level of the Trainee's responsibility and supervision should be considered. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.

6. The attending physician fosters an environment that encourages questions and requests for support or supervision from the Trainee, and encourages the House officer to call or inform the attending physician of significant or serious patient conditions or significant changes in patient condition.

Trainee Responsibilities:

1. A Trainee's responsibilities shall include patient care activities within the scope of his/her clinical privileges, attendance at clinical rounds and seminars, timely completion of medical records, and other responsibilities as assigned or are required of all members of the Medical Staff.

2. Each Trainee will take action as necessary to remain knowledgeable of the clinical status of all patients assigned to him/her, and discuss any significant changes in clinical status with the attending as soon as possible.

3. In life-threatening emergencies (e.g., code situations), Trainee's may initiate or modify major diagnostic and therapeutic actions consistent with their level of ability and training.

4. In case of an emergency, the Trainee may ask another health care provider to immediately contact the attending physician while the Trainee initiates emergency interventions but must inform the attending as soon as possible and receive additional instruction as indicated.

5. Prior to performing an invasive procedure on a patient, Trainees must have approval of the attending physician, and follow the attending physician's directions regarding supervision, consistent with residency policy.

Supervision of Medical Students:

1. Trainee's Responsibilities in Medical Student Instruction:

   a) All Trainees in BIDMC Sponsored Residency Programs are expected to provide guidance, instruction and evaluation for medical students and any other medical personnel or its students who may be in training on the service.
   b) Trainees may be delegated responsibility for medical student supervision by an attending physician.
   c) Trainees may be delegated the responsibility by an attending to review, correct and

countersign the medical records presented to them by medical students.

2. Faculty Responsibilities in Medical Student Instruction

   a) Harvard Medical School, through its faculty governance process, will outline responsibilities for teaching and supervision of medical students.
   b) The attending physician is ultimately responsible for the supervision of a medical student, however, a Trainee may be delegated such responsibility by a faculty member.
   c) Attending physicians should endeavor to remain aware of the activities and performance of any medical student(s) assigned to them for supervision.

3. Medical student responsibilities

   a) To participate in clinical learning experiences, medical students must be enrolled in the specific course related to the clinical activity.
   b) Medical students are expected to be appropriately dressed, and have an appropriate name identification card.
   c) Medical students are expected to properly identify themselves to patients, by name and level of training
   d) Medical students must communicate with the attending physician, or supervising Trainee, prior to initiating any procedure or implementing any changes in the treatment plans.
   e) Medical students may enter information into the medical record, i.e., history and physical, discharge summary, and progress notes. *However, any such entries must be countersigned by a physician.* Each participating hospital sets its own policies about what a student may enter into the medical record.

Monitoring and Reporting on Trainee Supervision

Any alleged infractions of the supervision policy should be reported to the Trainee's Program Director or his/her designee.

The Program Director or his/her designee is responsible to investigate and if possible resolve the issue.

If not resolved, the problem should be brought to the attention of the Chair of the department and other relevant house staff committees.

Each program will determine how to monitor and improve compliance with its supervision policies and competency assessments, using such methods as chart audits, quality audits, procedure logs, Trainee feedback, attending physician feedback, risk management reports and quality improvement reports.

Supervision policies and the adequacy of supervision will be addressed during each Internal Review conducted by the GME office in compliance with ACGME regulations as well as though regular ACGME surveys.

Vice President Sponsor: Richard M. Schwartzstein, MD Vice President for Education

Approved By:

☒ Graduate Medical Education Committee **7/1/2022**
Carrie Tibbles, MD, DIO/Director, GME

☒ Medical Executive Committee **7/20/2022**
Daniel Talmor, MD, Chair, MEC

Original Date Approved: 1/8/2004
Revisions: 3/9/06, 11/24/2008, 9/2/2014, 1/4/2017
Next Review Date: 7/25

Eliminated:

Beth Israel Deaconess Medical Center
Lines of Responsibility for the Care of Patients

Division of Podiatric Surgery and Medicine

The Division of Podiatric Surgery and Medicine maintains the principle that all physicians on the patient care team share a heartfelt sense of responsibility for all aspects of their patients' medical care. We strive for this ideal within the context of a well-supervised and individualized educational experience for our residents and students.

Beth Israel Deaconess Medical Center Inpatient Services and Operating Room

Residents are encouraged to take a great deal of independent responsibility for formulating diagnostic, surgical and management decisions, The degree of attending input will vary on a case by case basis, depending upon the complexity of the case, the level of resident skill, and the prior attending-patient and attending-resident relationship. The attending-of-record holds ultimate responsibility for patient care.

The Lines of Responsibility:

1. Student → supervising resident/covering resident→ chief resident → attending-of-record
2. If the attending is unavailable, consult
   - the covering attending or if unavailable,
   - the program director or chief of the division

If the attending on-call does not respond to pages / cell phone, call the answering service and ask that they call the attending at home.

Ambulatory Clinics

In the ambulatory setting, residents assume graduated responsibility for the care of patients. All patient visits are staffed by a member of the Beth Israel Deaconess Medical Center Podiatry Division, who provides the supervision required by each resident.

Emergency Department

Every patient seen in the Emergency Department (ED) must be discussed with, and evaluated by, the ED attending physician. In addition, there is 24/7 podiatric attending staff coverage by telephone based upon the on-call schedule.

Beth Israel Deaconess Medical Center

Podiatric Residency Program: Work Hours Policy

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

a. Clinical and education work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home.
b. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
c. Adequate time for rest and personal activities must be provided.

Residents are not currently required to take in-house call but must be available to the emergency department or inpatient floor within 20 minutes. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

a. Call must occur no more frequently than every third night when averaged over a 4-week period.
b. If the resident is called in, and must remain in-house, patient care must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical care. After such a period, residents must have at least eight hours free of clinic work and education between scheduled work periods.
c. No new patients may be accepted after 24 hours of continuous duty.

Residents are required to log work hours. Adequate rest must be sufficient to ensure an appropriate balance between education and service. The resident should discuss and review these hours with the program director if they feel the work hours have been excessive or inappropriate.

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

Outside Activities / Moonlighting: The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the residents' ability to function in the training program. For this reason, moonlighting is not allowed for trainees of the program.

Title: Policy and Procedure for Trainee Grievances

Policy: GME-05

Purpose: To provide a mechanism for resolving 'grievances' or disputes and complaints from trainees

Policy Statement:

To provide a mechanism for resolving 'grievances' or disputes and complaints that may arise between a trainee and his/her program director or other faculty member. The procedures described below are applicable to all trainees, including interns, residents and fellows. To appeal a formal disciplinary action the trainee is referred to policy GME-10 "*Remediation and Disciplinary Actions*."

A grievance is any unresolved dispute or complaint a trainee has with the policies or procedures of the residency training program or any unresolved dispute or complaint with his/her program director or other faculty member.

A trainee may appeal disagreements, disputes, or conflicts with his/her program using the procedure outlined below.

Grievances:

The following grievances shall be subject to this procedure:

a. Disputes or complaints related to perceived unfair or improper application of a policy, procedure, rule, or regulation;
b. Unresolved disputes or complaints with the program director or other faculty member not related to performance or disciplinary actions;
c. Complaints of retaliatory action associated with use of this procedure or other appeal procedures.

Complaints based solely on the following actions are not subject to this procedure. In some instances these examples constitute disciplinary actions that may be subject to appeal through GME-10 policy.

a. Establishment and revision of salaries, position classifications, or general benefits
b. Work activity accepted by a trainee as a condition of employment or work activity which may reasonably be expected to be part of the job
c. The contents of policies, procedures, rules, and regulations applicable to

trainees

d. Means, methods, and personnel by which work activities are to be conducted;
e. Layoff or suspension because of lack of work, reduction in the work force, or job abolition (GME-11 *Residency Closure/Reduction Policy)*
f. Relief of trainees from duties in emergencies
g. Formal disciplinary actions resulting in suspension or dismissal of a trainee (GME-10 Policy).

1. Informal Resolution of a Grievance

a. Step 1

A good faith effort will be made by an aggrieved trainee and the program director to resolve a grievance at an informal level. This will begin with the aggrieved trainee notifying the program director, in writing, of the grievance within thirty (30) calendar days of the event or action giving rise to the grievance. This notification should state the nature of the complaint, all pertinent information and evidence in support of the claim, and the relief requested.

The program director shall inform the Department Chair and the Director of GME that notice of a grievance has been received. Within seven (7) calendar days after notice of the grievance is given to the program director, the trainee and the program director will set a mutually convenient time to discuss the complaint and attempt to reach a resolution.

Step 1 of the informal resolution process will be deemed complete when the program director informs the aggrieved trainee, in writing, of the final decision following such discussion. This written response should address the issues and the relief requested. A copy of the program director's final decision will be sent to the appropriate department chair and to the Director of GME.

In instances where the event or action giving rise to the grievance directly involves the program director, the trainee may choose to initiate informal resolution of the grievance with the department chair. The department chair will be responsible to provide the written notification to the trainee as outlined above.

b. Step 2

If the program director's final written decision is not acceptable to the aggrieved trainee, the trainee may choose to proceed to a second informal resolution step which will begin with the aggrieved trainee notifying the department chair, in writing, of the grievance. Such notification must occur within ten (10) calendar days of receipt of the program director's final decision. This notification should

include all pertinent information, including a copy of the program director's final written decision, evidence that supports the grievance, and the relief requested. Within seven (7) calendar days of receipt of the grievance, the trainee and the department chair will set a mutually convenient time to discuss the complaint and attempt to reach a resolution. The trainee and the department chair may each be accompanied at such meeting by one person, other than legal counsel. Step 2 of the informal process of this grievance procedure will be deemed complete when the department chair provides the aggrieved trainee with a written response to the issues and relief requested. Copies of this decision will be kept on file in the offices of the department chair and the Director of GME.

2. Formal Resolution

   a. Request for Formal Resolution

      If the trainee disagrees with the final decision of the department chair, he or she may pursue formal resolution of the grievance. The aggrieved trainee must initiate the formal resolution process by presenting a written statement to the Director of GME within fifteen (15) calendar days of receipt of the department chair's final written decision. The statement should describe the nature of and basis for the grievance and include copies of the final written decisions from the program director and the department chair and any other pertinent information. Failure to submit the grievance in the fifteen-day period will result in the trainee waiving his or her right to proceed further with this procedure. In this situation, the decision of the department chair will be final.

   b. Confirmation

      Upon timely receipt of the written grievance, the Director of GME will notify the trainee and department chair in writing confirming that the complaint has been received.

      If the Director of GME should determine that the complaint is not subject to the procedure under this policy, a written explanation of this finding will be provided to the trainee and department chair. To the extent possible, the Director of GME will suggest available alternative steps.

      For complaints that fall under the Grievance policy appropriately, the Director of GME will initiate the steps for a formal resolution of the grievance, and appoint a Grievance Committee. The Grievance Committee will review and carefully consider all material presented by the trainee, his/her program director and party complained of, at a scheduled meeting, following the protocol outlined below.

The Grievance Committee:

1. Composition of the Grievance Committee

   Upon request for a formal resolution and following confirmation that the complaint is subject to the procedure under this policy, the Director of GME will select a Grievance Committee composed of two (2) trainee members, two (2) program directors and an Associate Director of GME. No members of this Grievance Committee will be members of the aggrieved trainee's department. The Director of GME will choose a member to be the chair of the Grievance Committee. Both parties involved in the dispute will be notified in writing of the Grievance Committee composition and may object in writing within five (5) calendar days. The Director of GME will consider any objection and within five (5) calendar days of receipt of an objection, may, at his/her discretion, substitute one or more members of the Grievance committee. Either party will have only one opportunity to object to the selected Grievance Committee members. Once the selection of the Grievance Committee is complete, the Director of GME will send a copy of the trainee's written grievance to each member of the Grievance Committee.

2. Grievance Committee Procedures

   a. Hearing Date

      The Chair of the Grievance Committee will set the date, time, and place for a hearing which is mutually convenient to the Grievance Committee members, the trainee, and the department chair.

   b. Attendance

      All Grievance Committee members shall be present throughout the hearing except for brief periods due to emergencies. The trainee must appear personally at the Grievance Committee hearing. The trainee, the department chair, and a representative of each one's choice is entitled to be present during the entire hearing, excluding deliberations. The Grievance Committee will determine the propriety of attendance at the hearing of any other persons. Witnesses other than the trainee, the department chair, and their representatives may remain in the hearing room only while giving their testimony unless the Grievance Committee, the trainee, and the department chair agree otherwise.

   c. Conduct of Hearing

      The Chair of the Grievance Committee will preside over the hearing, determine procedure, assure there is reasonable opportunity to present relevant oral or written information, and maintain decorum. Both the trainee and the department chair, or their representatives, will have the right to present evidence, call and question witnesses, and make statements in defense of his or her position.

Before testifying, each witness shall affirm that his or her testimony shall be the truth, the whole truth, and nothing but the truth. The Grievance Committee Chair will determine if information is relevant to the hearing and should be presented or excluded. The Grievance Committee Chair is authorized to exclude or remove any person who is disruptive.

d. Legal Representation

The Grievance Committee shall be entitled to have an attorney present to advise the Grievance Committee on procedural and evidentiary issues.

e. Recesses and Adjournment

The Grievance Committee Chair may recess and reconvene the hearing, continuing for such additional sessions, as the Grievance Committee deems necessary. Upon conclusion of the presentation of oral and written information, the hearing record is closed. Once the hearing is completed, it may be reopened, for good cause, by the Grievance Committee at any time prior to the rendering of its written decision. The Grievance Committee will deliberate outside the presence of the involved parties.

f. Decision

Decisions are determined by a majority vote of members of the Grievance Committee and are final. After deliberation, the written decision will be reviewed and signed by the Grievance Committee members.

g. Meeting Record

Arrangements will be made for the hearing to be accurately recorded and for any transcription of the recording it determines to be appropriate. Such recording and transcription may be made by such Medical Center employee or employees as the Grievance Committee may designate. The final written decision of the Grievance Committee and the transcript, if one is prepared, will be placed on file in the GME Office.

3. Final Decision of the Grievance Committee

The Grievance Committee will provide the aggrieved trainee, the department chair, and the Director of GME with a written decision within ten (10) calendar days of the meeting. The decision shall consist of two sections, one containing findings of fact, and the other containing recommendations to the Director of GME. The recommendations may include affirmation, reversal or modification of action taken with respect to the trainee, and also may include suggested changes in Medical Center policies and procedures that the Grievance Committee feels would be appropriate in light of the grievance. The recommendations also may include any

suggested action that should be taken with respect to persons other than the trainee and any other suggestions that the Grievance Committee feels appropriate. The decision of the Grievance Committee will be final.

Confidentiality:

All participants in the grievance process are expected to maintain confidentiality by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedure.

Vice President Sponsor: Richard M. Schwartzstein, MD Vice President for Education

Approved By:

☒ **Graduate Medical Education Committee** **7/1/22**
Carrie Tibbles, MD, DIO/Director, GME
☒ **Medical Executive Committee** **7/20/22**
Daniel Talmor, MD, Chair, MEC

Requested By: Graduate Medical Education Committee

Original Date Approved: 5/17/2004
Revised: 5/21/2007, 4/26/2010, 5/19/2014, 1/4/2017, 6/19/2019
Next Review Date: 7/25

References: www.acgme.org

Beth Israel Deaconess Medical Center
Performance Improvement Plan

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

It is the responsibility of the program director to take corrective action, which may include any or all of the following: verbal warning, written warning, incident notice, probation, suspension and/ or termination. If the resident has demonstrated unsatisfactory performance, conduct or attendance, the incident or behavior will be addressed immediately by the program director. The director must use specific guidelines for the management of resident performance. An important part of each step of the corrective discipline process is the corrective action plan. This is agreed upon by the resident and the program director and is designed to outline the conditions for improving the resident's performance. The modes of intervention available to the program director include:

- Active mediation between resident, faculty member, rotation or service or with supervisor.
- Reassignment of the resident to another rotation site or supervisor should the problem be seen as existing substantially within the service or faculty member.

If the resident does receive a marginal or unsatisfactory evaluation, a plan for ending the behavior and / remediating the behavior is established. Methods may include:

- Increased supervisory contact with the program director or other faculty member.
- Appointment of a faculty member as advocate.
- Performance improvement plan with faculty, with development of a timetable for completion of tasks which may include:
    - Increased supervisory contact
    - Increased didactic work, self-study or tutorial
    - Repetition of a particular rotation or didactic experience.
- In the event of a troubling developmental conflict, psychiatric difficulties or impairment with alcohol or substance abuse, referral to a private confidential psychiatric care will be provided. (see substance abuse policy)

Title: Participation in Institutional Quality Improvement

Policy: GME-08

Purpose: To delineate expectations for participation in quality improvement programs

Policy Statement:

1. Departments participating in GME programs sponsored by BIDMC must conduct formal quality improvement programs in accordance with BIDMC Staff By-Laws. This process may take place through the Participating Institutions. The quality improvement education program is developed collaboratively by quality officers, residents/fellows, faculty members, nurses, and other staff members to reflect the clinical site's quality programs' experience and goals.

2. All departments sponsoring GME programs must meet the requirements for Quality Assessment and Improvement as defined in the Medical Staff By-Laws and the BIDMC Performance Improvement Plan.

3. Residents/fellows shall receive progressive education and training on quality improvement that involves experiential learning. Residents/fellows and faculty members shall engage in quality improvement educational activities where the clinical site's systems-based challenges are presented, and techniques for designing and implementing systems changes are discussed.

4. The Institution must provide specialty-specific data on quality metrics and benchmarks related to resident/fellows' patient populations and their direct patient care.

5. Residents/fellows should have the opportunity to participate in departmental and clinical site-wide QI committees.

6. Departments sponsoring programs with off-site rotations must ensure that Quality Assessment and Improvement programs exist at those sites, and that residents have opportunities to participate.

7. Residency Program Directors will provide opportunities for residents to participate in clinical quality improvement activities.

8. Departments and/or Participating Institutions for GME programs sponsored by BIDMC must have a medical records system that is available at all times and documents the course of each patient's illness and care.

9. The medical records system must be adequate to support the education of residents and provide data for residents integral to the support of transitions of care.

10. Whenever possible and appropriate, residents will be provided with opportunities to participate in autopsies.

11. Residency Program Directors will instruct all residents to complete medical records in a timely manner, and will develop strategies to enforce this policy.

Vice President Sponsor: Richard M. Schwartzstein, MD Vice President for Education

Approved By:

☒ **Graduate Medical Education Executive Council** **7/20/2022**
Carrie Tibbles, MD, DIO/Director, GME
☒ **Medical Executive Committee** **7/1/2022**
Daniel Talmor, MD, Chair, MEC

Requested By: Graduate Medical Education Committee

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Next Review Date: 7/25

Eliminated:

Title: Policy for Extension of Training

Policy : GME-04

Purpose: To describe the policy for trainees who may need to extend training due to a leave of absence

Policy Statement:

This Policy establishes hospital-wide guidelines for extending training as might be applicable for Trainees appointed to ACGME programs sponsored by Beth Israel Deaconess Medical Center. The extension of training guidelines described in this Policy relate to those Trainees who might need to compensate for excused days (vacation, sick, or personal) or leaves of absence (medical, family, parental, general or bereavement), or in the event of insufficient experience during the training period.

1. Extension of Training Requirements
   A program director may require a trainee to compensate for excused days, or a leave of absence. The extension of training period may be accomplished by either extending the Trainee's appointment year, or by reappointing the Trainee for the time period sufficient to make up the lost days.

   Alternatively a program director may require a trainee to extend his or her training in order to complete all RRC-required clinical experiences, or otherwise to meet specialty board examination eligibility requirements. In this instance, additional training shall be determined by the program director, the pertinent RRC and/or the certifying board.

2. Stipend for Extension of Training
   The trainee may receive a stipend during any extension of training, subject to the availability of funding. The decision to provide a stipend is dependent upon available budget, and whether the trainee's excused days or leave was paid or unpaid. In the event a stipend is paid, it will be at the pay rate the trainee received during the last regular appointment year.

3. Notification
   Prior to the extension of the program, the trainee will receive written notification from the program director indicating the required length of additional training and the time period over which it will occur. It is the responsibility of the program to notify the ACGME and /or specialty certifying board accordingly.

Vice President Sponsor: Richard M. Schwartzstein, MD, Vice President of Education

Approved By:

☒ Graduate Medical Education Committee **7/1/22**
Carrie Tibbles, MD, DIO/Director, GME
☒ Medical Executive Committee **7/20/22**
Daniel Talmor, MD, Chair, MEC

Requestor Name: Graduate Medical Education Committee

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Next Review Date: 7/25

Eliminated:

References: www.acgme.org

Title: Policy and Procedure for Restrictive Covenants

Policy: GME-13

Purpose: To delineate policy on restrictive covenants

Policy Statement:

The Beth Israel Deaconess Medical Center strongly supports the policy of the Accreditation Committee on Graduate Medical Education which prohibits the inclusion of any restrictive covenants or non-compete clauses for residents.

It is the policy of the Beth Israel Deaconess Medical Center, in accordance with the laws of the Commonwealth of Massachusetts {MGL Ch. 112, Sec. 12X], that no residency program will ask for a signature by a resident on a non-compete or restrictive covenant clause as a contingency of Graduate Medical Education training.

Residents are advised to note that it is also improper to sign a non-compete/restrictive covenant clause in conjunction with any Beth Israel Deaconess Medical Center documents.

Procedure(s) for Implementation:

1. Procedure and Responsibilities

Responsible Party - Program Directors

Action
Ensures that program documentation required for signature by residents does not contain a non-compete or restrictive covenant clause. Trainees advise the Office of GME of any documents that contain language which could be construed as non-compete or restrictive covenant language.

Vice President Sponsor: Richard M. Schwartzstein, MD, Vice President of Education

Approved By:

☒ Graduate Medical Education Committee **7/1/2022**
Carrie Tibbles, MD, DIO/Director, GME
☒ Medical Executive Committee **7/20/2022**
Daniel Talmor, MD, Chair, MEC

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Eliminated

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Competencies Required for all Rotations

Required Competencies:

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 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, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

Attitudinal & patient management competencies required for all rotations:

Accepts criticism constructively

Continued self-study & literature review

Punctuality, attendance & appearance

Charting & dictation / record keeping

Interpersonal relations with peers & other health providers

Communicate in oral and written form with patients, colleagues, payers, and the public

Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

Practice and abide by the principles of informed consent

Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

Demonstrate professional humanistic qualities

Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of healthcare costs

Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric

Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own

Demonstrate an understanding of public health concepts, health promotion, and disease prevention

Demonstrate familiarity with utilization management and quality improvement

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Podiatric Surgery

Locations: Beth Israel Deaconess Medical Center, Boston VA Hospitals, New England Baptist Hospital / Surgicenter, Brockton Hospital, Norwood Surgical Center, BI -Needham

Competencies Specific for Rotation:

Comprehensive knowledge in the basic principles of podiatric surgery, including suturing techniques, sterile techniques, fixation techniques, instrumentation, proper tissue handling, hemostasis, and operating room protocol

Understands and utilizes appropriate hospital protocol including appropriate admission and discharge procedures, maintains appropriate medical records, and adheres to hospital safety measures

Perform and interpret the findings of a thorough problem-focused history and physical exam on podiatric patients, including problem-focused history, and where appropriate vascular, dermatologic, neurologic and musculoskeletal examination

Evaluates a patient as to the appropriateness of a surgical procedure, including the problem-focused history and physical, along with review of laboratory and radiologic studies, and performs a biomechanical examination where indicated

Assessment of appropriateness of a surgical procedure, includes assessment of efficacy and potential complications relating to procedure

Demonstrates progressive competency in preoperative, intraoperative, and postoperative assessment and management of podiatric surgical cases

Demonstrates progressive development of knowledge, attitude and skills in performance of podiatric procedures by performing as per CPME 320 requirements an appropriate volume and diversity of cases and procedures in the categories of digital surgery, first ray surgery, other soft tissue foot surgery, other osseous foot surgery, and reconstructive rearfoot/ ankle surgery:

A. By end of first year, the resident is expected to demonstrate basic proficiency in the performance of forefoot surgery and minor procedures of the rearfoot, i.e.:

- Soft tissue and nail procedures
- Toe surgery
- First Ray procedures
- Metatarsal procedures

Basic non-reconstructive midfoot-rearfoot procedures
A.O. fixation of the forefoot
Laser surgery
Debridement – wounds & soft-tissue

B. By the end of the second year, the resident is are expected to demonstrate increased proficiency in the first year procedures and demonstrate basic proficiency in the performance of more advanced procedures of the rearfoot and ankle including but limited to:

Arthrodesis
Nerve decompressions
Tendon transfer and repair procedures
Osteotomies
Debridement – bone & soft- tissue
Flat foot surgery
Pes cavus surgery
Fracture repair - forefoot
A-0 fixation - rearfoot

C. By the end of the third year, the resident is expected to demonstrate increased proficiency in the performance of first and second year procedures and demonstrate proficiency in the performance of more advanced procedures of the rearfoot and ankle including but not limited to:

Arthrodesis – ankle
Midfoot and rearfoot fracture repair
Ankle fracture repair
Ankle arthroscopy
Diabetic foot reconstruction
Flat foot and cavus foot reconstruction
External fixation

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Podiatric Office
Location: BIDMC affiliated clinical sites

Competencies Specific for Rotation:

Perform and interpret the findings of a thorough problem-focused history and physical exam on podiatric patients, including problem focused history, and where appropriate vascular, dermatologic, neurologic and musculoskeletal examination

Pharmacological management utilizing medications commonly prescribed in podiatric medicine, including proper ordering of, being fully cognitive of indications, dosages, interactions, side effects and anticipated results.

(These medications include NSAIDS, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic, uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, and anti-rheumatic agents)

Recognize the need for, and the appropriate ordering and interpretation of additional diagnostic studies, including, but not limited to, electrodiagnostic studies, noninvasive vascular studies, bone densitometry studies, compartment pressure studies

Order and interpret appropriate laboratory studies, including but not limited to:
ie hematology, blood chemistries, drug screens, bacteriologic and fungal cultures, urinalysis, serology/immunology, toxicology, coagulation studies, blood gases, synovial fluid analysis

Utilize information obtained from the history and physical examination and ancillary studies, after appropriate investigation, observation, and judgment, to arrive at an appropriate differential diagnosis and treatment plan utilizing appropriate consultations and/or referral; and assess treatment plan and revise as necessary

Provide appropriate lower extremity health promotion and education

Able to perform manipulation/mobilization of the foot/ankle joint to increase/reduce associated pain and/or deformity

Performing biomechanical evaluations and managing patients with lower extremity disorders utilizing appropriate prosthetics, orthotic devises and footwear

Knowledge of the indications and contraindications of the use of orthotic devises, bracing, prosthetics, and custom shoe management; and able to fabricate appropriate casts for these devises, or write appropriate referrals to the prosthetist/orthotist

Appropriate podiatric surgical management when indicated
Office Rotation
(See appendix in CPME 320 for list of procedures)

Recognition and management of post-operative complications i.e. infections, DVT's, hematomas, cellulitis, etc.

Appropriate use of local anesthetic agents, with knowledge of pharmacology, indications, dosages, potential interactions, & side effects

Appropriate ordering and interpretation of medical imaging, including plain radiography, radiographic contrast studies, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging

Performance, where indicated, of palliation of keratotic lesions and toenails

Management of closed fractures and dislocations including pedal fractures/dislocations, and ankle fracture/dislocation including the use of cast management and tape immobilization as indicated

Performance of appropriate injections and, or aspirations, with knowledge of pharmacology, indications, dosages, potential interactions, & side effects

Able to write appropriate referral for physical therapy for patients, and able to monitor and modify the treatment plan as needed

Performing biomechanical evaluations and managing patients with lower extremity disorders utilizing appropriate prosthetics, orthotic devises and footwear

Understand the complexity of modern healthcare reimbursement, with an understanding of common business practices

Understand insurance issues including professional and general liability, disability, Workers' Compensation, and the medical-legal considerations involving healthcare delivery

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Internal Medicine – 4 weeks
Location: BIDMC

Competencies Specific for Rotation:

A. Perform and interpret the findings of a comprehensive medical history and physical examination, including:

a. Comprehensive medical history. Including chief complaint, review of systems history of present illness, social and family history
b .Comprehensive physical examination, including vital signs and physical examination including: HEENT, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, extremities, neurologic examination

B. Order and interpret appropriate laboratory tests as appropriate, based on presenting medical history and clinical findings

C. Pharmacologic management of patients including the proper ordering of medications, being fully cognitive of indications, dosages, interactions, side effects and anticipated results

D. Recognize the need for, and the appropriate ordering and interpretation of additional diagnostic studies, including EKGs, medical imaging, vascular studies and laboratory studies

E. Interpret and evaluate EKGs

F. Utilize information obtained from the history and physical examination and ancillary studies, after appropriate investigation, observation, and judgment, to arrive at an appropriate differential diagnosis and treatment plan

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Infectious Disease – 4 weeks
Location: BIDMC

Competencies Specific for Rotation:

Perform and interpret the findings of a history and physical exam on the infectious disease consultation service

Order and interpret appropriate laboratory studies, ie hematology, blood chemistries, cultures, urinalysis, serology/immunology

Order and interpret appropriate diagnostic modalities, ie. nuclear medicine imaging, MRT, CT, vascular imaging.

Can interpret culture and sensitivity results, as well as properly collect culture specimens

Knowledgeable in the performance and procedures of bacteriological testing, (i.e. gram stains, cultures), in the bacteriology laboratory

Understands antibiotic therapy, both oral and parental, in both the normal and compromised patient, including drug pharmacology, potential interactions with other medications, side effects, and cost factors

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Emergency Medicine – 4 weeks
Location: BIDMC

Competencies Specific for Rotation:

Understands and appreciates the principles of general emergency medicine and emergency room protocol

Recognize and be able to assist in the care of acute systemic emergencies (ie cardiac arrest, diabetic coma, insulin reactions, etc.)

Handling of common emergencies with emphasis on the lower extremity,(ie dirty and infected wounds, burns, lacerations, fractures, etc.)

Handling of orthopedic emergencies with emphasis on the lower extremity

Perform and interpret the findings of a comprehensive medical history and physical examination of the emergency room patient, including:

a. Comprehensive medical history. Including chief complaint, review of systems history of present illness, social and family history

b .Comprehensive physical examination, including vital signs and physical examination including: HEENT, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, extremities, neurologic examination

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Anesthesiology -2 weeks
Location: BIDMC

Competencies Specific for Rotation:

Knowledge of the pharmacology of common anesthetic agents, both regional & local, including indications, dosages, potential interactions, & side effects

Assess the patient's pre-anesthesia physical status

Demonstrate, via hands-on direct participation, knowledge of intubation techniques and maintenance of airway

Demonstrate knowledge of the basic management of patients during the perioperative period

Demonstrate knowledge of the techniques and appropriate management of general, spinal, epidural, regional and conscious sedation anesthesia

Demonstrate proficiency in the performance of local anesthetic blocks of the lower extremity

Participate in pre-operative anesthetic evaluation and learn to assess the Physical Status Classification of the American Society of Anesthesiologists

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Behavioral Medicine -2 weeks
Location: BIDMC

Description of Rotation:
The primary emphasis of this rotation will be on behavioral science, especially as it relates to patient/physician communications. Working in conjunction with members of the Psychiatry Department, the podiatric residents will obtain exposure to the management of inpatients in need of psychiatric care. They will obtain exposure to the differential diagnosis and treatment of mental illness in the in-patient setting. They will obtain exposure to the use of medication, psychotherapy, and psychosocial interventions.

Competencies:

Demonstrate an understanding of the psychiatric approach to the management of in-patients with mental illness

Demonstrate professional humanistic qualities

Demonstrate an understanding of the psychosocial and healthcare needs for inpatients with mental illness

Demonstrate familiarity with the psychiatric approach in establishing a differential diagnosis in the treatment of patients with mental illness

Demonstrate familiarity with the various medications used in the treatment of mental illness including potential interactions and side-effects

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Medical Imaging 2 weeks
Location: BIDMC

Competencies Specific for Rotation:

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

a. plain radiographs
b. contrast studies
c. stress radiographs
d. magnetic resonance imaging (MRI)
e. Computed tomography (CT)
f. Ultrasound (US)
g. Nuclear medicine
h. Interventional radiology

Recognize the need for additional diagnostic studies when necessary

Recognize basic chest radiograph pathology such as pulmonary edema, cardiomegaly, pneumothorax and infiltrates

Recognize and become familiar with various bone and soft tissue neoplasms

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Vascular Surgery – 4 weeks
Location: BIDMC

Competencies Specific for Rotation:

Knowledgeable in the appropriate evaluation of patients with peripheral vascular disorders, including the ordering of noninvasive and invasive vascular tests

Knowledgeable in the performance and interpretation of noninvasive vascular testing techniques, i.e. doppler, duplex doppler, ABI's, toe pressures, etc.

Understands and appreciates the performance and interpretation of invasive vascular testing, i.e. angiography

Understands and appreciates the various types of interventional revascularization procedures, i.e. lower extremity bypass, angioplasty/ stenting, thrombolysis, DVA, etc.

Proficiency in principles of surgery, including suturing techniques, atraumatic tissue handling, and instrumentation, especially as it pertains to vascular procedures

Understands and appreciates the protocol of managing patients pre and post - interventional revascularization

Knowledgeable in the comprehensive team approach to patient management for patients with lower extremity vascular conditions

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Endocrinology- 2 weeks
Location: BIDMC

Competencies Specific for Rotation:

Understand the epidemiology, pathophysiology, and treatment of common endocrine disease, including but not limited to thyroid disorders, diabetes, disorders of calcium metabolism, metabolic bone disease, adrenal disease, pituitary disease and hypoglycemia.

Develop experience in the management of diabetes in surgical patients.

Interpret blood glucose readings and titrate insulin accordingly.

Demonstrate proper monitoring, management and/or referral to specialists for diabetic complications.

Demonstrate knowledge of various endocrine disorders and the importance of a comprehensive team approach to patient management.

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Orthopedic Surgery - 3 weeks
Location: VA Medical Center / BIDMC

Competencies Specific for Rotation:

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

Pharmacologic management of orthopedic patients, including the proper ordering of medications, being cognitive of indications, dosages, interactions, side effects and anticipated results

Recognize the need for, and the appropriate ordering and interpretation of additional diagnostic studies, including EKGs, medical imaging, and laboratory studies

Proficiency in principles of surgery, including suturing techniques, atraumatic tissue handling, and instrumentation, especially as it pertains to orthopedic surgery

Knowledgeable in orthopedic techniques and instrumentation, i.e. AO/ASIF technique, fixation techniques, external fixation, total joint implant arthroplasty, arthroscopy, bone grafting

Understands the principles of pre, peri and post-operative care of trauma patients.

Able to apply the principles and techniques required in the management of fractures including fracture / dislocation reduction and splinting.

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Rheumatology – 2 weeks
Location: BIDMC

Competencies Specific for Rotation:

Demonstrates the ability to perform H&P focused on the rheumatologic condition.

Recognizes the need for and ability to order and interpret appropriate diagnostic imaging studies.

Recognizes the need for and ability to order and interpret appropriate laboratory studies

Demonstrates the ability to obtain and interpret synovial fluid analyses.

Demonstrate familiarity with the various medications used in the treatment of rheumatologic conditions

Knowledgeable in the comprehensive team approach to patient management of patients with foot and ankle rheumatologic conditions

Beth Israel Deaconess Medical Center
Podiatric Residency Program

Rotation: Plastic Surgery – 3 weeks
Location: BIDMC

Demonstrates proficiency in the principles of surgery, including suturing techniques, atraumatic tissue handling, and instrumentation, especially as it pertains to plastic surgery procedures

Demonstrates the indications for and understanding of when various types of skin flaps would be appropriate

Demonstrates the ability to obtain and apply skin grafts

Understands and appreciates the pre and post-operative protocols of managing patients undergoing plastic surgery procedures

Knowledgeable in the comprehensive team approach to patient management with complex wounds in the lower extremities

2025-26 BIDMC Podiatric Residency Rotation Schedule

DATES	Miko Fogarty	Mei Reina	Stacy Peralta	John Speight	Michelle Kung	Drishti Dhawan
	PGY-1	PGY-1	PGY-2	PGY-2	PGY-3	PGY-3
7/1/2025	Emergency Medicine	Emergency Medicine	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
7/7/2025	Emergency Medicine	Emergency Medicine	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
7/14/2025	Emergency Medicine	Emergency Medicine	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
7/21/2025	Emergency Medicine	Emergency Medicine	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
7/28/2025	Internal Medicine ©	Internal Medicine ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
8/4/2025	Internal Medicine ©	Internal Medicine ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
8/11/2025	Internal Medicine ©	Internal Medicine ©	Podiatric Surgery	Podiatric Surgery	Vacation	Podiatric Surgery
8/18/2025	Internal Medicine ©	Internal Medicine ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
8/25/2025	Podiatric Surgery	Anesthesia	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Vacation
9/1/2025	Podiatric Surgery	Anesthesia	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
9/8/2025	Podiatric Surgery	Vacation	Infectious Disease	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
9/15/2025	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Vacation	Podiatric Surgery	Podiatric Surgery
9/22/2025	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
9/29/2025	Vacation	Podiatric Surgery	Infectious Disease	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
10/6/2025	[redacted]	Podiatric Surgery	Vacation	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
10/13/2025	[redacted]	Vascular Surgery ©	Podiatric Surgery	Podiatric Surgery	Vacation	Podiatric Surgery
10/20/2025	Radiology	Vascular Surgery ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
10/27/2025	Radiology	Vascular Surgery ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
11/3/2025	Podiatric Surgery	Vascular Surgery ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
11/10/2025	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Plastic Surgery	Podiatric Surgery	Podiatric Surgery
11/17/2025	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Plastic Surgery	Podiatric Surgery	Vacation
11/24/2025	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Plastic Surgery	Podiatric Surgery	Podiatric Surgery
12/1/2025	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
12/8/2025	Vascular Surgery ©	Podiatric Surgery	Vacation	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
12/15/2025	Vascular Surgery ©	Radiology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
12/22/2025	Vascular Surgery ©	Radiology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
12/29/2025	Vascular Surgery ©	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
1/5/2026	[redacted]	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
1/12/2026	[redacted]	Podiatric Surgery	Podiatric Surgery	Vacation	Podiatric Surgery	Podiatric Surgery
1/19/2026	Podiatric Surgery	Podiatric Surgery	Plastic Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
1/26/2026	Podiatric Surgery	Vacation	Plastic Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
2/2/2026	Podiatric Surgery	Podiatric Surgery	Plastic Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
2/9/2026	Podiatric Surgery	Endocrinology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Vacation
2/16/2026	Vacation	Endocrinology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
2/23/2026	Podiatric Surgery	Podiatric Surgery	ACFAS	ACFAS	ACFAS	ACFAS
3/2/2026	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Vacation	Podiatric Surgery
3/9/2026	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Podiatric Surgery	Podiatric Surgery
3/16/2026	Orthopedics	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Podiatric Surgery	Podiatric Surgery
3/23/2026	Orthopedics	Podiatric Surgery	Podiatric Surgery	Infectious Disease	Podiatric Surgery	Podiatric Surgery
3/30/2026	Orthopedics	Podiatric Surgery	Vacation	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
4/6/2026	Podiatric Surgery	Rheumatology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
4/13/2026	Podiatric Surgery	Rheumatology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Behavioral Med
4/20/2026	Podiatric Surgery	Orthopedics	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Behavioral Med
4/27/2026	Podiatric Surgery	Orthopedics	Podiatric Surgery	Behavioral Med	Podiatric Surgery	Podiatric Surgery
5/4/2026	Podiatric Surgery	Orthopedics	Podiatric Surgery	Behavioral Med	Podiatric Surgery	Podiatric Surgery
5/11/2026	Podiatric Surgery	Podiatric Surgery	Behavioral Med	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
5/18/2026	Podiatric Surgery	Vacation	Behavioral Med	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
5/25/2026	Rheumatology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Behavioral Med	Podiatric Surgery
6/1/2026	Rheumatology	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Behavioral Med	Podiatric Surgery
6/8/2026	Vacation	Podiatric Surgery	Podiatric Surgery	Vacation	Podiatric Surgery	Podiatric Surgery
6/15/2026	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
6/22/2026	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery
6/29/2026	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery	Podiatric Surgery

All rotations take place at BIDMC unless otherwise noted. Refer to the legend below to determine other locations.

Legend:

General Orthopedics — Boston VA Healthsystem

Boston VA Healthsystem: Cases covered on Tuesdays

NE Surgicare: Cases covered on case by case basis

ABFAS ITE for 1st and 2nd years 9/15-9/20/2025

ABFAS ITE for 3rd years 9/25 and 9/26/2025

Research: Residents work with Dr. Veves throughout the academic year.

ACFAS meeting: 2nd/3rd year residents excused ONLY for the conference days.

ABPM ITE date to be determined - presumed to be February 2026

Council on Podiatric Medical Education

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July 2023

TO: Program Directors and Residents
FROM: Council on Podiatric Medical Education
SUBJECT: Proper Logging Guide

- The new guidelines are effective July 1, 2023, to allow for updates to the CLAD report in Podiatry Residency Resource.
- New sections added include the following:
  - Category 6 – Other Podiatric Procedures
  - Category 11 – Lower Extremity Wound Care
  - Category 13 – Other Clinical Experiences

All logged procedures, biomechanical examinations, and comprehensive history and physical exams must comply with these guidelines beginning July 1, 2023.

Proper Logging Guide
(Effective July 1,2023)

GENERAL GUIDELINES:

1) For the procedure codes listed below, the program director must review each entry to determine proper usage. The following surgical codes may only be used if a more appropriate procedure does not exist. A full documentation in the "Procedure Note" is required to justify use.

    1.13 other osseous digital procedure not listed above
    2.3.10 other first ray procedure not listed above
    3.14 other soft tissue procedures not listed above (limited to the foot)
    4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)
    5.1.9 other elective reconstructive rearfoot/ankle soft-tissue surgery not listed above
    5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above
    5.3.7 other non-elective reconstructive rearfoot/ankle soft tissue surgery not listed above
    5.4.8 other non-elective reconstructive rearfoot/ankle osseous surgery not listed above

2) In cases where a subchondroplasty procedure is performed as part of another procedure, only the index procedure must be logged. For example, a talar dome or distal tibial subchondroplasty may only be logged as:

    5.2.1 Operative arthroscopy without removal of loose body or other osteochondral debridement

    5.2.7 open management of talar dome lesion (with or without osteotomy) or

    5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement.

    If subchondroplasty is performed in isolation, the appropriate logging mandates use of the following subcategories: 5.2.7, 5.2.8

    1.13 other osseous digital procedure not listed above
    2.3.10 other first ray procedure not listed above
    4.18 other osseous procedures not list (distal to the tarsometatarsal joint)
    5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above

3) Laterality (left or right) must be selected for all surgical procedures in categories 1 through 5.

4) The "Procedure Notes" must always reflect additional procedures that were performed but not logged individually.

5) Procedures may not be fragmented or unbundled into individual component parts to allow more than one resident to claim first assist.

6) Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to but not including the tarsometatarsal/Lisfranc joint.

Category 1: Digital Surgery (lesser toe or hallux)

A procedure performed at the PIPJ and DIPJ can only be logged once. Include both procedures in the procedure notes.

- A resident may only log one category 1 procedure per toe (the Procedure Note may reflect additional procedures performed) and no more than one resident may claim a first assistant on a single toe.
- The digit (toe) number must be documented for all digital surgical procedures.

1.6 Phalangeal Osteotomy

- **May not** be used in conjunction with:
  - 2.1.1 bunionectomy (partial ostectomy/Silver procedure) – (use 2.1.3 bunionectomy with hallux osteotomy)
  - 2.1.3 bunionectomy with phalangeal osteotomy
  - 2.1.7 metatarsophalangeal joint (MPJ) fusion
  - 2.1.8 MPJ implant (with phalangeal implantation)
  - 2.2.1 cheilectomy
  - 2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
  - 2.2.6 MPJ fusion
  - 2.2.7 MPJ implant (with phalangeal implantation)
  - 2.3.4 amputation

- **May** be used as an "add on" in conjunction with:
  - 2.1.4 bunionectomy with distal first metatarsal osteotomy
  - 2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
  - 2.1.6 bunionectomy with first metatarsocuneiform fusion
  - 2.1.8 MPJ implant (when used, a metatarsal component implantation only)
  - 2.1.9 MPJ arthroplasty
  - 2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis
  - 2.2.3 joint salvage with distal metatarsal osteotomy
  - 2.2.4 joint salvage with first metatarsal shaft or base osteotomy
  - 2.2.5 joint salvage with first metatarsocuneiform fusion
  - 2.2.7 MPJ implant (when used, a metatarsal component implantation only)
  - 2.2.8 MPJ arthroplasty
  - 2.3.1 tendon transfer/lengthening/procedure
  - 2.3.2 osteotomy (e.g., dorsiflexory)
  - 2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
  - 2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
  - 2.3.7 open management of fracture or MPJ dislocation
  - 2.3.8 corticotomy/callus distraction
  - 2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
  - 2.3.10 other first ray procedure not listed above (only as indicated)

1.8 Amputation

- **May not** be used in conjunction with the following procedures if in reference to the same numerical ray:
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.8 incision and drainage of soft tissue
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, transmetatarsal amputation)

1.10 Management of Bone/joint Infection

- **May not** be used in conjunction with:
  - 1.8 amputation (if done on the same digit)
  - 3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

Category 2: First Ray Surgery

In general:

- The soft tissue component **of *all* First Ray Surgery** repair is inclusive and is **not** separately claimed as an additional procedure for all subcategories. The use of 2.1.1 is limited to isolated soft tissue repair/partial ostectomy of the first MPJ when no other osteotomy or fusion procedure is completed on the first ray.

- A resident **may** only log one 2.2.1-2.3.10 procedure per foot and no more than one resident may claim a first assistant procedure per foot.

Hallux Valgus Surgery

- Osteotomy (Akin) of the proximal phalanx treatment, see above in Digital Surgery
- Use of suture and button construct as the primary method to repair a bunion deformity should be logged as 2.1.1
- 2.1.10 can only be used when two separate osteotomies and/or arthrodesis are performed on the same first ray to correct the bunion deformity. EXAMPLE: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Hallux Limitus Surgery

- All of these procedures **shall be inclusive** and count as **one First Ray Surgery** procedure

Other First Ray Surgery

2.3.1 Tendon Transfer/lengthening Procedure

- The soft tissue component of all first ray surgery repair is inclusive and is not separately claimed as an additional procedure.

2.3.4 Amputation

- **May not** be used in conjunction with:
  2.3.6 management of bone/joint infection (with or without bone graft)
  3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

2.3.5 Management of Osseous Tumor/neoplasm (with or without bone graft)

- **May not** be used for removal of simple bone cyst

2.3.6 Management of Bone/joint Infection (with or without bone graft)

- **May not** be used in conjunction with:
  1.8 amputation (if the amputation involves the great toe)
  2.3.4 amputation
  3.8 incision and drainage of soft tissue infection (includes foot, ankle, or leg)

2.3.10 Other First Ray Procedures Not Listed Above

- When two separate procedures are performed on the same first ray to correct the bunion deformity, please use 2.1.10.
- **EXAMPLE**: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Category 3: Other Soft Tissue Foot Surgery:

3.1 Excision of Ossicle/sesamoid

- Can only be used if it is performed as an isolated primary procedure
- **May not** be used in conjunction with First Ray Surgery or tendon transfer/augmentation
- **May not** be used in conjunction with Other Osseous Foot Surgery
- **EXAMPLES**: os peroneum, os tibiale externum, os vesalianum

3.4 Plantar Fasciotomy

- May include open, endoscopic, or minimal incision approach
- TOPAZ and PRP injection are logged as 6.14
- Includes localized lipectomy and associated soft tissue excision
- Includes plantar heel spur/exostosis resection
- Includes local nerve (i.e. Baxter's nerve) release or ablation
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- May not be used in conjunction with:
  - 3.9 plantar fasciectomy /plantar fibroma resection

3.5 Lesser MPJ Capsulotendon Balancing

- Excludes percutaneous tenotomy/capsulotomy
- **May not** be used in conjunction with:
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  - 3.7 open management of dislocation (MPJ/tarsometatarsal)
  - 4.2 lesser MPJ arthroplasty
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy
  - 4.5 lesser MPJ implant
  - 4.6 central metatarsal osteotomy
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy

3.6 Tendon Repair, Lengthening, or Transfer Involving the Forefoot (including digital flexor digitorum longus transfer)

- **May not** be used in conjunction with
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.7 open Management of dislocation (MPJ/tarsometatarsal)
  - 4.2 lesser MPJ arthroplasty
- **May not** be used if percutaneous

3.7 Open Management of Dislocation (MPJ/tarsometatarsal)

- **May** be claimed as an additional procedure in conjunction with Digital Surgery.
- Includes plantar plate repair and soft tissue repair of LisFranc injury
- **May not** be used if percutaneous
- **May not** be used in conjunction with
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  - 4.2 lesser MPJ arthroplasty
  - 4.13 open management of tarsometatarsal fracture/dislocation
  - 4.15 tarsometatarsal fusion
- Can be used with digital procedure and lesser metatarsal osteotomy

3.8 Incision and Drainage/wide debridement of Soft Tissue Infection (includes foot, ankle, or leg)

- Full documentation in the "Procedure Note" to justify use of procedure 3.8 with another procedure is required.
- If an I&D performed at a different site as an amputation, can be logged separately.

  EXAMPLE: an I&D of a first interspace with a 5th digit amputation

- If the I&D, amputation, and bone biopsy are all occurring at the same surgical site, only one of these procedures may be logged.

- **May not** be used in conjunction with:
  - 1.8 amputation
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.12 plastic surgery techniques
  - 3.17 decompression of compartment syndrome (includes foot or leg)
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, tarsometatarsal amputation)
  - 4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
  - 5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
  - 5.4.6 management of bone/joint infection (with or without bone graft)
  - 5.4.7 amputation proximal to the tarsometatarsal joints

- This is inclusive of distal plantar space infection and therefore **may not** be claimed as Reconstructive Rearfoot/Ankle Surgery

3.9 Plantar Fasciectomy

- Includes localized lipectomy or soft tissue excisions and includes the heel spur (exostectomy) resection
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- TOPAZ and PRP injection are logged as 6.14
- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy

3.10 Excision of Soft Tissue tumor/mass (without reconstructive surgery; includes foot, ankle, or leg)

- **EXAMPLES**: Excision of a ganglion cyst in the foot, sinus tarsi decompression
- Excision of verrucae or other skin lesion is excluded (use 6.2)

3.12 Plastic Surgery Techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)

- Excludes synthetic/Biologic grafts (use 6.7)
- Excludes elliptical or wedge excisions such as a derotational 5th toe arthroplasty
- Full documentation in the Procedure Note to justify the extent of 3.12 is required
- The harvesting and application of skin graft/flap count as one procedure
- **May be** used in conjunction with Digital Surgery and in conjunction with 3.5 (lesser MPJ capsulotendon balancing), when **extensive**, such as to correct severe digital deformities, i.e. Muir-Ruiz
- Wound bed preparation/debridement is included in this procedure

3.13 Microscopic Nerve/vascular Repair (forefoot only)

- Requires the use of microscopic equipment / loupes

3.14 Other Soft Tissue Procedures Not Listed Above (limited to the foot)

- Harvesting of split thickness skin grafts (STSG) from any source (i.e., foot, ankle, leg, or thigh) and application of the graft to the foot or ankle should be logged as 3.12, 5.1.1 or 5.3.4

3.16 External Neurolysis/decompression (including tarsal tunnel)

- Multiple nerve decompressions of the same extremity are logged as **one** procedure

Category 4: Other Osseous Foot Surgery:

- **One procedure per metatarsal. Exceptions are noted below.**

4.1 Partial Ostectomy (includes foot, ankle, or leg)

- **May** include calcaneal ostectomies, i.e. simple Haglund's excision, retrocalcaneal exostectomy and resection of os trigonum (see 4.19 below)

- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy if associated with plantar calcaneal exostosis (see 3.4 above)
  - 3.9 plantar fasciectomy if associated with plantar calcaneal exostosis (see 3.9 above)
  - 4.2 lesser MPJ arthroplasty, if associated with the same metatarsal
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy, if associated with the same metatarsal
  - 4.5 lesser MPJ implant, if associated with the same metatarsal
  - 4.6 central metatarsal osteotomy, if associated with the same metatarsal
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy, if associated with the same metatarsal

4.2 Lesser MPJ Arthroplasty

- **May not** be used in conjunction with:
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot
  - 3.7 open management of dislocation (MPJ/tasometatarsal
  - 4.1 partial ostectomy (includes foot, ankle or leg)
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy
  - 4.4 metatarsal head resection (single or multiple)
  - 4.5 lesser MPJ implant
  - 4.6 central metatarsal osteotomy
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy

4.4 Metatarsal Head Resection (single or multiple)

- single, multiple, or adjoining metatarsal head resections are considered as one procedure
- non-adjoining metatarsal head resections can be counted as two procedures with procedure note documentation.

EXAMPLE: 1st and 5th metatarsal head resection

- adjoining metatarsal head resections are considered as one procedure

4.6 Central Metatarsal Osteotomy

- May be used in conjunction with 3.7, plantar plate repair, if performed at the same location

4.8 Open Management of Lesser Metatarsal Fracture(s)

- Repair of multiple metatarsal fractures is logged as individual procedures

4.10 Amputation (lesser ray, transmetatarsal amputation)

- Transmetatarsal amputation is considered as one procedure
- Amputation of adjoining metatarsals or rays are considered one procedure
- Non-adjoining metatarsal ray amputations can be counted as two procedures

EXAMPLE, 1st and 5th ray amputations

- Lesser ray amputation **includes** the amputation of the toe(s) and metatarsal(s) segment(s)
- **Includes** the incision and drainage

4.11 Management of Bone/joint Infection Distal to the Tarsometatarsal Joints (with or without bone graft)

- Full documentation in the "Procedure Note" to justify use of procedure 4.11 with another procedure is required.

4.13 Open Management of Tarsometatarsal Fracture/dislocation

- Claimed as one procedure for repair of the metatarsal cuneiform and cuboid joints. Also inclusive of the first metatarsal cuneiform joint
- Cannot be logged with 3.7 open management of dislocation (MPJ/tarsometatarsal) or 4.15 tarsometatarsal fusion

4.14 Multiple Metatarsal Osteotomy Management of Metatarsus Adductus

- One procedure for the correction of metatarsus adductus (independent of the number of osteotomies performed)

4.15 Tarsometatarsal Fusion

- Fusion of the tarsometatarsal joints (complete or partial) is **one** procedure
- This code is to be used in cases of Lisfranc joint ORIF or osteoarthritis. **Cannot** be logged with 3.7 open management of dislocation (MPJ / tarsometatarsal) or 4.13 open management of tarsometatarsal fracture dislocation.
- This code is not to be used for bunion correction (use 2.1.6 or 2.2.6 or 2.3.3)

4.17 Revision/repair of Surgical Outcome in the Forefoot

- Full documentation in the "Procedure Note" to justify use of procedure 4.17 with another procedure is required.

4.19 Detachment/reattachment of Achilles Tendon with Partial Ostectomy

- **May not** be used in conjunction with:
  - 4.1 partial ostectomy (includes foot, ankle or leg)
  - 5.3.1 repair of acute tendon injury

Category 5: Reconstructive Rearfoot/Ankle Surgery:

- Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- The rule of thumb to follow when logging ankle procedures is, "an ankle is an ankle." This means that all procedures performed within a single case must be logged as a single procedure, even if one could log multiple procedures if they were performed at different times. Exceptions are noted below.

Elective – Soft tissue:

5.1.1 Plastic Surgery Techniques Involving the Midfoot, Rearfoot, or Ankle

- **May not** include skin plasty repair that utilizes just ellipses/wedges.
- Documentation of details in the procedure note is required.
- The harvesting and application of skin graft/flap count as **one** procedure.
- Wound bed preparation/debridement is included in this procedure

5.1.2 Tendon Transfer Involving the Midfoot, Rearfoot, Ankle, or Leg

- Any tendon transfer except plantaris with an Achilles tendon repair is acceptable (logged as two procedures)
- **May not** be used in conjunction with:
  5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)

See 5.1.5

- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.3 Tendon Lengthening Involving the Midfoot, Rearfoot, Ankle, or Leg

- **May** include percutaneous or "stab" type lengthening (e.g., percutaneous tendon Achilles lengthening)
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.5 Primary or Secondary Repair of Ligamentous Structures

- **Repair of multiple ligaments in the same ankle are logged as one procedure**
- **May** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
  5.1.6 ligament or tendon augmentation/supplementation/restoration

5.1.6 Tendon Augmentation/supplementation/restoration

- Includes excision of an ossicle or ostectomy

EXAMPLE: Os peroneum with a peroneal tendon repair and Os tibiale Externum with a kidner

- Repair of both peroneal tendons at the same time is counted as one procedure
- **May not** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc. (see 3.6 above)

5.1.7 Open Synovectomy of the Rearfoot/ankle

- **May not** be used in conjunction with:
  5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
  5.2.9 ankle implant

Elective – Osseous:

5.2.1 Operative Arthroscopy without removal of loose body or other osteochondral debridement

- Cannot be separately counted when converted into an open ankle procedure

- Can be logged with medial or lateral ankle stabilization as long as the ankle stabilization was not performed through the scope
- **May not** be claimed as a diagnostic arthroscopy or if the arthroscopy results in an "open" procedure.
- **May not** be claimed in conjunction with:
  5.1.7 open synovectomy of the rearfoot/ankle
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
  5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.4 Midfoot, Rearfoot, or Ankle Fusion

- multiple procedures count as one procedure
- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- **EXAMPLES**: double arthrodesis, triple arthrodesis, pan talar arthrodesis, talonavicular with a calcaneocuboid arthrodesis are all logged as one procedure
  NOTE: 5.2.4 can be claimed in conjunction with 5.2.5, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

5.2.5 Midfoot, Rearfoot or Tibial Osteotomy

- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.
- **May not** be claimed in conjunction with the following procedures if the osteotomy was performed to access pathology:
  - 5.2.4 midfoot, rearfoot or ankle fusion
  - 5.2.7 open management of talar dome lesion (with or without osteotomy)
  - 5.2.9 ankle implant

NOTE: 5.2.5 can be claimed in conjunction with 5.2.4, 5.2.6, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

May be logged more than once if separate osteotomies are performed to correct a deformity i.e. Evans and Cotton or Evans and medial sliding calcaneal osteotomy

5.2.6 Coalition Resection

- **Cannot be** used if it is done as part of an arthrodesis or arthroeresis procedure
- **May not** be claimed in conjunction with:
  - 5.2.3 subtalar arthroeresis
  - 5.2.4 midfoot, rearfoot, or ankle fusion

- **5.2.4, 5.2.5 may** be claimed when an arthrodesis or osteotomy was done to correct RRA deformity not at the coalition site

5.2.7 Open Management of Talar Dome Lesions (with or without osteotomy)

- **Includes associated:**
  - 5.2.1 operative arthroscopy (does not include STJ arthroscopy)

May not be used in conjunction with
- 5.2. 4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
- 5.2.5 malleolar osteotomy
- 5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
- 5.2.9 ankle implant
- 5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e. subchondroplasty)

5.2.8 Ankle Arthrotomy / Arthroscopy with Removal of Loose Body or Other Osteochondral Debridement

May not be used in conjunction with

- 5.2.4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
- 5.2.5 malleolar osteotomy
- 5.2.9 ankle implant
- 5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.9 Ankle Implant

May not be used in conjunction with

5.1.5 primary or secondary repair of ligamentous structures
5.1.7 open synovectomy of rearfoot / ankle
5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy
5.3.2 repair of acute ligament injury
5.4.3 open repair of acute ankle fracture

Non-Elective – Soft Tissue:

5.3.2 Repair of Acute Ligament Injury

- **May not** be used in conjunction with fracture repair or ankle implant

  5.2.9 ankle implant
  5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
  5.4.1 open repair of adult midfoot fracture
  5.4.2 open repair of adult rearfoot fracture
  5.4.3 open repair of adult ankle fracture
  5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **Claim** only **one** procedure per foot/ankle even if multiple ligaments are repaired

5.3.4 Excision of Soft Tissue Tumor/mass of the Foot, Ankle or Leg (with reconstructive surgery)

- The harvesting and application of related skin graft/flap count as **one** procedure

5.3.6 Open Repair of Dislocation (proximal to the tarsometatarsal joints)

- **May not** be used in conjunction with fracture repair
  - 5.4.1 open repair of adult midfoot fracture
  - 5.4.2 open repair of adult rearfoot fracture
  - 5.4.3 open repair of adult ankle fracture
  - 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **May not** be used in conjunction with
  - 5.3.2 repair of acute ligament injury

- **Claim** only **one** procedure per foot/ankle

Non-Elective – Osseous:

5.4.1 Open Repair of Adult Midfoot Fracture

- **Claim** only **one** procedure per foot

5.4.2 Open Repair of Adult Rearfoot Fracture

- **Claim** only **one** procedure per foot

5.4.3 Open Repair of adult Ankle Fracture

- Repair of ligaments is included in the repair
- Repair of syndesmosis is included in the repair
- Uni/Bi/Tri malleolar fracture repairs are considered one procedure
- **Claim** only **one** procedure per ankle

5.4.4 Open Repair of Pediatric Rearfoot/ankle Fracture or Dislocation

- **Claim** only **one** procedure per foot/ankle

Additional Guidelines

Category 6: Other Podiatric Procedures

6.2 Excision or destruction of skin lesion (i.e. verruca) by any means. Includes biopsy of skin lesion.

6.3 Nail avulsion (partial or complete)

6.4 Matrixectomy (partial or complete, by any means). Use this for procedures performed in the clinic or operating room.

6.5 Removal of hardware. Includes Internal and External Fixation removal.

6.6 Repair of simple laceration / delayed primary closure. Use this for procedures performed in clinic, emergency department or operating room.

6.8 Extracorporeal shock wave therapy

6.9 Taping/ padding/ splinting / casting (limited to the foot and ankle

6.10 Orthotics / prosthetics (limited to the foot and ankle -casting, scanning, impressions for foot and / or ankle orthoses

6.14 Percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma).

6.15 Foot care (nail debridement, callus paring)

6.16 Therapeutic / diagnostic injections (without sedation)

6.17 Incision and drainage (performed outside of the operating room)

6.18 Closed reduction of fracture or dislocation

6.19 Removal of foreign body (not performed in the operating room)

6.20 Acpplication of any type of external fixation device

Category 7: Biomechanical Examinations

A biomechanical case is identified as procedure code 7. 1

- Biomechanical case must include diagnosis, evaluation (biomechanical and gait examination), and treatment.
  - Demonstrates understanding of pathomechanics of biomechanical condition
  -
  - Biomechanical cases should be performed in a variety of settings (surgical and non-surgical) and should include diverse pathology and treatment methods. Biomechanical exams should be a representation of the learning experiences of the residents.

- A biomechanical exam includes static and dynamic exam of the area of chief complaint.

- The biomechanical exam and gait analysis must be comprehensive **relative to the diagnosis** and consistent with the clinical findings.

- Patient encounters such as taping and padding, orthotics, prosthetics, and other biomechanical experiences that do not include a biomechanical examination and gait analysis are not counted as biomechanical cases.

- Gait analysis may range from basic visual gait analysis to complex computerized gait analysis. An interpretation of the gait analysis must be documented.

- Treatment plans must be justified and supported by findings of the biomechanical exam.

Category 8: History and Physical Examinations

8.1 Comprehensive History and Physical Examination:

- Comprehensive medical history: Past medical history, past surgery history, family history, social history, medications, allergies, and review of systems
- Vital signs
- Physical exam: Head, Eyes, Ears, Nose, Throat, Neck, Chest/breast, Lungs, Abdomen, GU, rectal, upper extremity, and neurological
- At least 25 of the 50 required comprehensive H&P's must be performed during non-podiatric rotations under the direction of MD or DO faculty. Comprehensive H&P's must be performed in variety of settings including admission, preoperative, emergency department or during medicine / surgical consultation in the inpatient or outpatient setting. **A focused history and physical examination does not fulfill this requirement.**

8.2 Problem-Focused History and Physical Examination:

- Problem-focused history
- Problem focused exam: vascular, dermatological, neurological, and musculoskeletal exam
- Biomechanical examination
- Gait analysis

Category 11: Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal

11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based products, total contact casting, multi-layer compression therapy / Unna boot)

11.3 hyperbaric oxygen therapy

Category 13: Other Clinical Experience

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

The following categories, procedures, and codes must be used for logging surgical procedure activity:

1 Digital Surgery (lesser toe or hallux)

1.1 partial ostectomy/exostectomy
1.2 phalangectomy
1.3 arthroplasty (interphalangeal joint [IPJ])
1.4 implant (IPJ) (silastic implant or spacer)
1.5 diaphysectomy
1.6 phalangeal osteotomy
1.7 fusion (IPJ)
1.8 amputation
1.9 management of osseous tumor/neoplasm
1.10 management of bone/joint infection
1.11 open management of digital fracture/dislocation
1.12 revision/repair of surgical outcome
1.13 other osseous digital procedure not listed above

2 First Ray Surgery

Hallux Valgus Surgery

2.1.1 bunionectomy (partial ostectomy/Silver procedure), with or without capsulotendon balancing procedure
2.1.2 (procedure code number no longer used)
2.1.3 bunionectomy with phalangeal osteotomy
2.1.4 bunionectomy with distal first metatarsal osteotomy
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
2.1.6 bunionectomy with first metatarsocuneiform fusion
2.1.7 metatarsophalangeal joint (MPJ) fusion
2.1.8 MPJ implant
2.1.9 MPJ arthroplasty
2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis

Hallux Limitus Surgery

2.2.1 cheilectomy
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
2.2.3 joint salvage with distal metatarsal osteotomy
2.2.4 joint salvage with first metatarsal shaft or base osteotomy
2.2.5 joint salvage with first metatarsocuneiform fusion
2.2.6 MPJ fusion
2.2.7 MPJ implant
2.2.8 MPJ arthroplasty

Other First Ray Surgery

2.3.1 tendon transfer/lengthening/procedure
2.3.2 osteotomy (e.g., dorsiflexory)
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
2.3.4 amputation
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
2.3.6 management of bone/joint infection (with or without bone graft)
2.3.7 open management of fracture or MPJ dislocation
2.3.8 corticotomy/callus distraction
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
2.3.10 other first ray procedure not listed above

3 Other Soft Tissue Foot Surgery

3.1 excision of ossicle/sesamoid
3.2 excision of neuroma
3.3 removal of deep foreign body (excluding hardware removal)
3.4 plantar fasciotomy
3.5 lesser MPJ capsulotendon balancing
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
3.7 open management of dislocation (MPJ/tarsometatarsal)
3.8 incision and drainage/wide debridement of soft tissue infection (includes foot, ankle or leg)
3.9 plantar fasciectomy/ plantar fibroma resection
3.10 excision of soft tissue tumor/mass (without reconstructive surgery; includes foot, ankle or leg)
3.11 (procedure code number no longer used)
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
3.13 microscopic nerve/vascular repair (forefoot only)
3.14 other soft tissue procedures not listed above (limited to the foot)
3.15 (procedure code number no longer used)
3.16 external neurolysis/decompression (including tarsal tunnel)
3.17 decompression of compartment syndrome (includes foot or leg)

4 Other Osseous Foot Surgery

4.1 partial ostectomy (including the talus and calcaneus) (includes foot, ankle, or leg)
4.2 lesser MPJ arthroplasty
4.3 bunionectomy of the fifth metatarsal without osteotomy
4.4 metatarsal head resection (single or multiple)
4.5 lesser MPJ implant
4.6 central metatarsal osteotomy
4.7 bunionectomy of the fifth metatarsal with osteotomy
4.8 open management of lesser metatarsal fracture(s)
4.9 harvesting of bone graft (includes foot, ankle, or leg)
4.10 amputation (lesser ray, transmetatarsal amputation)
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
4.13 open management of tarsometatarsal fracture/dislocation
4.14 multiple osteotomy management of metatarsus adductus
4.15 tarsometatarsal fusion
4.16 corticotomy/callus distraction of lesser metatarsal
4.17 revision/repair of surgical outcome in the forefoot
4.18 other osseous procedures not listed above (distal to the tarsometatarsal joint)
4.19 detachment/reattachment of Achilles tendon with partial ostectomy

5 Reconstructive Rearfoot/Ankle Surgery

Elective - Soft Tissue

5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
5.1.5 delayed primary or secondary repair of ligamentous structures
5.1.6 tendon augmentation/supplementation/restoration
5.1.7 open synovectomy of the rearfoot/ankle
5.1.8 (procedure code number no longer used)
5.1.9 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

Elective - Osseous

5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.2 (procedure code number no longer used)
5.2.3 subtalar arthroeresis
5.2.4 midfoot, rearfoot, or ankle fusion
5.2.5 midfoot, rearfoot, or tibial osteotomy
5.2.6 coalition resection
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy/arthroscopy with removal of loose body or other osteochondral debridement
5.2.9 ankle implant
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
5.2.11 other elective rearfoot reconstructive/ankle osseous surgery not listed above

Non-Elective - Soft Tissue

5.3.1 repair of acute tendon injury
5.3.2 repair of acute ligament injury
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
5.3.4 excision of soft tissue tumor/mass of the foot, ankle, or leg (with reconstructive surgery)
5.3.5 (procedure code number no longer used)
5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above
5.3.8 (procedure code number no longer used)

Non-Elective - Osseous

5.4.1 open repair of adult midfoot fracture
5.4.2 open repair of adult rearfoot fracture
5.4.3 open repair of adult ankle fracture
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
5.4.5 management of bone tumor/neoplasm (with or without bone graft)
5.4.6 management of bone/joint infection (with or without bone graft)
5.4.7 amputation proximal to the tarsometatarsal joints
5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above
5.4.9 (procedure code number no longer used)

6 Other Podiatric Procedures

6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
6.3 nail avulsion (partial or complete)
6.4 matrixectomy (partial or complete, by any means)
6.5 removal of hardware (internal or external fixation)
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement); includes simple delayed wound closure
6.8 extracorporeal shock wave therapy
6.9 taping/padding/splinting/casting (limited to the foot and ankle)
6.10 orthotics/prosthetics (limited to the foot and ankle casting/scanning/impressions for foot and/or ankle orthosis)
6.14 percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma, digital tenotomy)
6.15 foot care (nail debridement, callus paring)
6.16 therapeutic/diagnostic injections (without sedation)
6.17 incision and drainage (performed outside of the operating room)
6.18 closed reduction of fracture or dislocation
6.19 removal of foreign body (not in the operating room)
6.20 application of external fixation

7 Biomechanics

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment

8 History and Physical Examination

8.1 comprehensive history and physical examination
8.2 problem-focused history and physical examination

9 Surgery Specialties

9.1 general surgery
9.2 orthopedic surgery
9.3 plastic surgery
9.4 vascular surgery
9.5 cardiothoracic surgery
9.6 hand surgery
9.7 neurosurgery
9.8 orthopedic/surgical oncology
9.9 pediatric orthopedic surgery
9.10 surgical intensive care unit (SICU)
9.11 trauma team/surgery
9.12 other

10 Medicine and Medical Subspecialty Experiences

10.1 anesthesiology
10.2 cardiology
10.3 dermatology
10.4 emergency medicine
10.5 endocrinology
10.6 family practice
10.7 gastroenterology
10.8 hematology/oncology
10.9 imaging
10.10 infectious disease
10.11 internal medicine
10.12 neurology
10.13 pain management
10.14 pathology
10.15 pediatrics
10.16 physical medicine and rehabilitation
10.17 psychiatry/behavioral medicine
10.18 rheumatology
10.19 sports medicine
10.20 wound care (non-podiatric)
10.21 burn unit
10.22 intensive/critical care (ICU/CCU)
10.23 geriatrics
10.24 vascular medicine
10.25 other

11 Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal)
11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot)
11.3 hyperbaric oxygen therapy

13 Other Clinical Experiences

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

Council on Podiatric Medical Education

CPME

Proper Logging of Wound Care Cases

One of the most common occurrences of logging errors is logging for wound care.

The following changes were made to logging categories effective July 2023:

- Category 6.1, debridement of superficial ulcer or wound was deleted
- Category 11, Lower Extremity Wound Care was added:

11.1	excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal)
11.2	advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot)
11.3	hyperbaric oxygen therapy

- Category 10.20, wound care, was modified to 10.20 wound care (non-podiatric)

Rules for application of these are found below:

- Category 11 should be used no matter where lower extremity wound care service is provided (e.g. OR, outpatient/clinic, ED, floors)
- ANY sharp debridement of an ulcer or wound of any type is category 11.1 and should not be miscategorized as category 3.8 I+D. Although traditionally referred to as "non excisional debridement", RRC includes hydrostatic debridement such as Versajet and Misonix type debridement in this category.
- If a procedure note states "debridement of ulcer" or "debridement of wound" then it is miscategorized if it is 3.8; it should be logged as 11.1.

Further:

- If a wound is debrided and a biologic dressing is placed, the debridement is inclusive with the biologic being placed and should only be categorized as 11.2 without a separate debridement code.
- If a wound is debrided and a split thickness skin graft is applied, it should only be categorized as 3.12 Plastic Surgery Techniques (Including Skin Graft, Skin Plasty, Flaps, Syndactylization, Desyndactylization, and Debulking Procedures Limited to The Forefoot); the debridement is inclusive.
- If a wound is debrided and a wound VAC is placed, the debridement is inclusive, and the procedure should only be categorized as 11.2 (without a separate debridement code).
- If a wound is debrided and then hyperbaric oxygen treatment is utilized, it should only be logged as an 11.3.

Council on Podiatric Medical Education

When is 3.8 properly used?

3.8 is incision and drainage/wide debridement of soft tissue infection (includes foot, ankle, or leg) and is intended for an incision and drainage (I+D) of an infection such as plantar space infection, necrotizing fasciitis, gas gangrene, etc. It is NOT used for excisional debridement of non-infected tissue.

In cases where a foot/ankle remains infected after an initial I+D and returns for another washout, then 3.8 is appropriate.

If an infected case is left open and returns to the OR for light debridement and delayed wound closure (because infection has resolved) then it is properly categorized as 6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement); includes simple delayed wound closure.

An Incision and drainage performed away from the OR, no matter how extensive, is properly logged as 6.17 incision and drainage (performed outside of the operating room) and not a 3.8.

Category 10.20 wound care (non-podiatric)

Category 10.20 is to be used for non-lower extremity wound care experiences.

Wound Care Medical Specialty Rotations

Many programs offer a rotation in wound care that they utilize as one of the two required rotations under "medical specialties." CPME is clarifying that in order for a wound care rotation to qualify as a medical specialty rotation, it must involve training and assessment by non-DPMs. Programs certainly may have wound care rotations that only involve training by DPMs, but a rotation like that would not qualify as one of the two required "medical specialty" rotations.

If you offer a wound care rotation that does not involve training and assessment by non-DPMs, please note that this rotation is not considered a medical specialty; the program must offer two other medical specialty rotations in order to fulfill requirement 6.4 in CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies.*

June 2024

Beth Israel Deaconess Medical Center Podiatric Residency Program
Semi-annual Resident Evaluation

Resident:_____ **Date:**_____

Ability:	(1- Poor, 5-Excellent)				
Knowledge	N/A 1	2	3	4	5
Clinical Skills_	N/A 1	2	3	4	5
Professional Judgement	N/A 1	2	3	4	5
Technical Skills	N/A 1	2	3	4	5
Interpersonal Skills					
With Staff	N/A 1	2	3	4	5
With Peers	N/A 1	2	3	4	5
With Patients / Families	N/A 1	2	3	4	5
Personal Traits					
Integrity	N/A 1	2	3	4	5
Dependability	N/A 1	2	3	4	5
Communication Skills					
Documentation	N/A 1	2	3	4	5
Case Presentations	N/A 1	2	3	4	5
Interest / Motivation					
Active Participation	N/A 1	2	3	4	5
Attendance / Tardiness	N/A 1	2	3	4	5
Leadership					
Teaching	N/A 1	2	3	4	5
Administrative tasks	N/A 1	2	3	4	5
Supervision	N/A 1	2	3	4	5

In-training examinations:

Rotations:

MAV attainment:

Comments:

Resident Signature: **Date:**

Program Director Signature: **Date:**

Beth Israel Deaconess Medical Center Podiatric Residency Program
Final resident assessment

Resident:_____Date:_____

Ability:	(1- Poor, 5-Excellent)					
Knowledge	N/A	1	2	3	4	5
Clinical Skills_	N/A	1	2	3	4	5
Professional Judgement	N/A	1	2	3	4	5
Technical Skills	N/A	1	2	3	4	5
Interpersonal Skills:						
With Staff	N/A	1	2	3	4	5
With Peers	N/A	1	2	3	4	5
With Patients / Families	N/A	1	2	3	4	5
Personal Traits:						
Integrity	N/A	1	2	3	4	5
Dependability	N/A	1	2	3	4	5
Communication Skills:						
Documentation	N/A	1	2	3	4	5
Case Presentations	N/A	1	2	3	4	5
Interest / Motivation:						
Active Participation	N/A	1	2	3	4	5
Attendance / Tardiness	N/A	1	2	3	4	5
Leadership:						
Teaching	N/A	1	2	3	4	5
Administrative tasks	N/A	1	2	3	4	5
Supervision	N/A	1	2	3	4	5

Completion of required ITE's	Yes	No
Completion of all required rotations	Yes	No
Completion of all required MAV's	Yes	No

Comments:

Resident Signature: Date:

Program Director Signature: Date:

Workshop/Inservice Scheduling Tasks

1. Check main calendar by chart racks to look for attending vacations.
2. Check the google gmail calendar for potential conflicts.
3. Schedule event with rep and place on the google calendar
4. Confirm with reps the week prior to and the week of scheduled date.
5. Once the didactic activity is completed, all residents must log the experience in the activity log in PRR.

Other tasks depending on the didactic activity:

1. Check with Pathology to make sure we can use the morgue for a cadaver lab.
2. Escort any medical device representatives into and out of the morgue. It is the resident's responsibility to make sure the morgue and instruments are clean following the completion of the lab.

Foot Trauma Triage Consults

Summary

Trauma to the foot consists of a constellation of pathologies including fractures, dislocations, ligamentous/tendon injuries as well as soft-tissue lacerations, contusions, degloving-type injuries as well as foreign body penetration. The foot is defined anatomically as the talus to the phalanges.

The following foot trauma protocol has been developed following discussion and with the collaboration of Dr. John Kwon, Chief, Orthopaedic Foot & Ankle Service, Dr. Edward Rodriguez, Chief, Orthopaedic Trauma Service and Dr. John Giurini, Chief, Division of Podiatry and with the approval of Dr. Mark Gebhardt, Chair, Department of Orthopaedic Surgery and Dr. Elliot Chaikof, Chair, Department of Surgery.

1. In general, foot trauma should be triaged based on the following:
    a. On odd number dates → **CONSULT ORTHOPAEDIC TRAUMA SERVICE → PAGE ORTHOPAEDIC RESIDENT ON-CALL**
    b. On even number dates → **CONSULT PODIATRY SERVICE → PAGE PODIATRY RESIDENT-ON CALL**
2. Any patient not requiring formal consultation in the emergency department but that requires follow-up care should be referred based on date:
    a. On odd number dates → **REFER TO ORTHOPAEDIC FOOT & ANKLE CLINIC at 617-667-7654**
    b. On even number dates → **REFER TO PODIATRY URGERNT CLINIC at 617-632-8428**

Exceptions and Clarifications

1. Any foot trauma associated with a multi-injured/poly-traumatized patient (whether associated injuries are orthopaedic or non-orthopaedic) → **CONSULT ORTHOPAEDIC TRAUMA SERVICE**.
2. A patient who is directly referred to a particular clinician/service is directed to that clinician/service regardless of odd/even date.
3. A patient who has established care for prior treatment of the foot for the same or different problem by a particular clinician/service is directed to that clinician/service regardless of odd/even date.