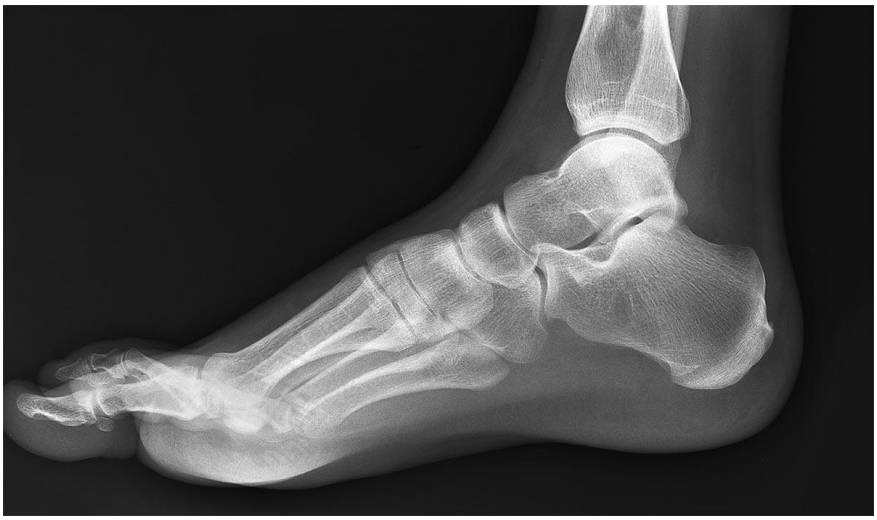


Henry Ford Providence Hospital

Podiatry Residents PMSR/RRA
Policy and Orientation Manual
2025-2026

In accordance with CPME 320/330 guidelines
(www.cpme.org/cpme320 and www.cpme.org/cpme330)

Anthony LaLama, DPM
Director of Podiatric Education

HENRY FORD HEALTH
Providence Hospital Southfield/Novi Michigan

Southeast Michigan Campus
College of Human Medicine
MICHIGAN STATE UNIVERSITY

Table of Contents

Podiatry Residency Program Goals and Objectives

Educational Objectives for Podiatric Surgery

The resident will participate in on-going podiatric surgery. During this period of time, the resident will be expected to:

1) Demonstrate ability in the basic principles of podiatric surgery including suturing, sterile technique, fixation technique, instrumentation, tissue handling and operating room protocol.
2) Demonstrate the ability to properly evaluate contemplated surgical procedures through the Experience of recording the complete podiatric history and physically the interpretation of appropriate laboratory testing and synthesizing the above information into an appropriate treatment plan.
3) Demonstrate competency in the management of common podiatric surgical procedures throughout the perioperative period.
4) Demonstrate proficiency in the administration of local various anesthetic techniques on the foot and ankle
5) Demonstrate an understanding and appreciation of the overall physical status of surgical patients in conjunction with other health care providers.
6) Demonstrate proficiency in the performance of common surgical procedures. Such procedures to include, at least: A) soft tissue and nail procedures, including excision of soft tissue tumors neuroma excision, incision and drainage procedures and excision of foreign bodies. B) Digital surgery, including various types of arthroplasties, arthrodesis, sesamoidectomy, and exostectomy. C) First ray procedures. D) Lesser metatarsal osteotomies. E) Internal and external fixation techniques. F) Forefoot and rearfoot osteotomy procedures. G) Procedures and techniques for the management of osteomyelitis and other infections of the foot. H) Procedures and techniques for the management of fractures of the foot and ankle, and I) Rearfoot, ankle and reconstructive surgical procedures.

Method of Monitoring and Assessment

1) Surgical evaluation forms completed following participation in surgical procedures
2) Biannual evaluation by podiatry staff members and the program director
3) Evaluations following monthly rotations
4) Residents participate, annually, in the in-training examinations offered by The American Board of Foot and Ankle Surgery and Primary Podiatric Medicine

Educational Objectives for Rotations on Anesthesia

1) Demonstrates understanding of the performance of general, spinal, epidural, regional and conscious anesthetic techniques
2) Demonstrates understanding in the physical evaluation of patients preoperative status as to the appropriateness of administering general or local anesthesia
3) Demonstrates understanding of the overall-management of patients who are about to undergo, or who are recovering from, anesthesia
4) Demonstrates familiarity and understanding of various pharmacologic products utilized in anesthesia
5) Demonstrates understanding of patients vital signs, and the appropriate management of anesthetic emergencies
6) Demonstrates understanding of various methods and techniques utilized in pain management

Educational Objectives for Rotations on Behavioral Medicine

1) Demonstrates understanding and appreciation of the psychosocial aspects of healthcare delivery
2) Demonstrates familiarity with the cultural, ethnic, and socioeconomic diversity among patients
3) Demonstrates understanding the use and prescription of pharmacologic products in the management of a broad range of behavioral conditions
4) Demonstrates an understanding of methods to deal with patients who refuse recommended intervention
5) Demonstrates an understanding of doctor/patient communication skills
6) Demonstrates knowledge and understanding of the implications of various prevention, wellness, and other social programs currently available
7) Demonstrates an ability to perform a focused history on patients exhibiting symptoms of behavioral disease

Educational Objectives for Rotations on Emergency Medicine

1) Demonstrates understanding and appreciation of the general principles of emergency care
2) Demonstrates ability to manage common medical emergencies such as infection, frostbite, burns, lacerations, sprains and fractures
3) Demonstrates an understanding of various emergency laboratory diagnostic procedures, including the interpretation of findings in hematology, urine analysis, serology, drug screens, toxicology and microbiology
4) Demonstrates an ability to utilize various pharmacologic products in a broad range of emergency situations
5) Demonstrates understanding of acute medical emergency situations, such as cardiac arrest, diabetic coma, insulin shock, and various examples of trauma
6) Demonstrates ability to perform a focused history and physical examination in an emergency situation, including neurological, vascular and muscular skeletal systems
7) Demonstrates an understanding of the interpretation of emergency radiographic techniques including MRI, radiographs and various scans

Educational Objectives for Rotations on Endocrinology

1) The resident is familiar with, and actively participated in the performance of focused history and physical examinations that would be required to gain information appropriate for a patient with endocrine disease
2) The resident is familiar with the evaluation, diagnosis, and development of treatment plans for patients suffering from various endocrine disease, particularly in the diabetic patient
3) The resident is familiar with the interpretation of common laboratory evaluations related to endocrine disease
4) The resident demonstrated knowledge in the use of pharmacologic products used the management of common endocrine disease and conditions

Educational Objectives for Rotations on Family Medicine

1) Demonstrates understanding of the performance complete medical history and physical examination in order to arrive at an appropriate diagnosis
2) Demonstrates knowledge in the use of pharmacologic products such as NSAIDS, antibiotics, anticoagulants, corticosteroids, muscle relaxants, antihypertensive and sedative medication and electrolyte balance for the management of common medical conditions
3) Demonstrates understanding in the interpretation of radiographic examinations including flat plates, contrast studies, MRI's and various scans
4) Demonstrates understanding of the interpretation of common laboratory findings including hematology, urine analysis, serology, drug screens, toxicology and microbiology, for example
5) Demonstrates knowledge of evaluation, diagnosis and development of various treatment plans in the management of various medical conditions
6) Demonstrates knowledge and understanding in the interpretation of normal and abnormal EKG finding

Educational Objectives for Rotations on Vascular Surgery

1. Demonstrates the ability to to perform appropriate physical and history examinations on patients with vascular disease
2. Demonstrates the ability to understand when a vascular surgery consultation or procedure is indicated for patients with lower extremity vascular pathologies
3. Demonstrates an understanding of the utilization and interpretations of various non-invasive and invasive vascular and arterial diagnostic techniques
4. Demonstrates an understanding of basic surgical principles, techniques and procedures in vascular surgery including proper tissue handling, suturing, angiography and stent placement
5. Demonstrates an understanding of diagnosis and management of patients exhibiting various forms of arterial and venous disorders such as venous stasis, deep and superficial venous disease, peripheral edema, etc
6. Demonstrates an understanding of common lower extremity vascular procedures
7. Demonstrates knowledge and understanding of the pre- and post-operative management of patients undergoing vascular intervention
8. Demonstrates understanding of pharmacological products commonly utilized in the management of vascular disease
9. Participates in and demonstrates an understanding of various approaches to both the mechanical and chemical debridement of wounds complicated by vascular disease
10. Participates in Vascular Surgery Grand Rounds

Educational Objectives for Rotations on General/Trauma Surgery

11. Demonstrates an understanding of basic surgical principles, techniques and procedures in general surgery including proper tissue handling, suturing, and instrumentation in a broad range of surgical procedures, as well as the appropriate use of monitoring devices used in the operating room.
12. Demonstrates knowledge and understanding of the management of uncomplicated surgical procedures, preoperatively and postoperatively
13. Demonstrates awareness of the prompt and/or emergency response to various surgical complications that may arise
14. Demonstrates knowledge and understanding regarding the effective management and importance of electrolyte balance and perioperative management
15. Demonstrates knowledge in prescribing pharmacologic products for the care and management of a broad range of common surgical situations
16. Demonstrates knowledge and understanding of ACS Trauma guidelines, including appropriate emergency response, complete medical history and physical examination, and appropriate imaging in order to arrive at an appropriate diagnosis
17. Demonstrate ability to admit, monitor and appropriately discharge patients under the primary care of a general surgery or trauma surgery team

Educational Objectives for Rotations on Infectious Disease

1) The resident is familiar with and actively participated in the performance of focused physical examinations to gain adequate information appropriate for a patient with infectious disease
2) The resident is familiar with evaluation, diagnosis and development of treatment plans for a broad range of infectious diseases, including local and systemic infected wound care, in a general cross section of patients
3) The resident is familiar with the interpretation of common laboratory evaluative methods including blood cultures, gram stains, microbiology studies and antibiosis monitoring, sensitivity examinations and other laboratory tests
4) The resident exhibited knowledge in the use of a wide array of pharmacologic products in the management of infectious disease conditions
5) The resident will demonstrate appropriate use of antimicrobial stewardship

Educational Objectives for Rotations on Interventional Cardiology

1) Demonstrates the ability to to perform appropriate physical and history examinations on patients with peripheral vascular disease
2) Demonstrates the ability to understand when a interventional cardiology consultation or endovascular procedure is indicated for patients with lower extremity vascular pathologies
3) Demonstrates an understanding of the utilization and interpretations of various non-invasive and invasive vascular and arterial diagnostic techniques
4) Demonstrates an understanding of basic surgical principles, techniques and procedures in endovascular surgery including angiography and stent placement
5) Demonstrates an understanding of diagnosis and management of patients exhibiting various forms of arterial and venous disorders such as venous stasis, deep and superficial venous disease, peripheral edema, etc
6) Demonstrates an understanding of common lower extremity endovascular procedures
7) Demonstrates knowledge and understanding of the pre- and post-operative management of patients undergoing endovascular intervention
8) Demonstrates understanding of pharmacological products commonly utilized in the management of vascular disease
9) Participates in Cardiology department Grand Rounds

Educational Objectives for Rotations on Plastic Surgery

1) The resident developed an understanding and demonstrated competence in the use of various suturing techniques
2) The resident demonstrated an understanding of various techniques and principles utilized for skin grafting
3) The resident demonstrated knowledge, ability and understanding in the performance of various skin flap and tension reduction surgical procedures
4) The resident demonstrated understanding of plastic surgical concerns in instances of trauma patients
5) The resident participated in performing plastic surgery procedures and in plastic surgery rounds
6) The resident demonstrated knowledge in prescribing pharmacologic products for the care and management of a broad range of plastic surgical situations

Educational Objectives for Rotations on Radiology

1) Demonstrates understanding in the performance of various techniques of radiographic examination on a wide variety of conditions
2) Demonstrates understanding with the interpretation of nuclear medical imaging, MRIs, various scans and diagnostic ultrasound
3) Demonstrates understanding with the interpretation of various plain radiographic examinations including flat plates, stress studies and contrast studies

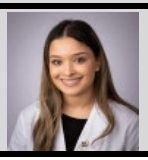
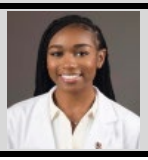
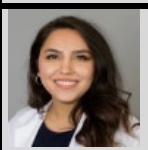
GENERAL PODIATRY ROTATION SCHEDULE

- Post Graduate Year 1
  - Radiology - 2 Weeks
  - Anesthesiology - 2 Weeks
  - General/Trauma Surgery - 4 Weeks
  - Behavioral Medicine - 2 Weeks
  - Emergency Medicine - 4 Weeks
  - Family Medicine - 4 Weeks

- Post Graduate Year 2
  - Endocrinology - 2 Weeks
  - Vascular Surgery - 2 Weeks
  - Interventional Cardiology - 2 Weeks
  - Wound Care - 2 Weeks

- Post Graduate Year 3
  - Infectious Disease - 4 Weeks
  - Plastic Surgery - 4 Weeks
  - Wound Care - 2 Weeks
  - Optional Elective - up to 2 Weeks

Podiatry Residency
2025-2026
Master Schedule

	Soha Ahmed	Emani Matthews	Maream Nori	Ereny Ayoub	Joseph Spampinato	Nathan Wilson	Marc DiGrande	Rosemary Joseph	Amin Niknam	
										
	(703) 987-5350 PGY 1	(248) 910-8613 PGY 1	(586) 744-8818 PGY1	(623) 277-6910 PGY 2	(517) 748-6270 PGY 2	(810) 841-8757 PGY 2	(248) 739-2600 PGY 3	(586) 553-7778 PGY 3	(763) 291-7964 PGY 3	
Jul	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry 06/30-07/13 WoundCare: 07/14 - 07/25	Podiatry	Jul
Aug	Anesth: 08/01-08/15	Podiatry Radio: 08/16-08/31	Podiatry	Podiatry	WoundCare: 08/01-08/15 Endo: 08/16-08/31	Podiatry	Podiatry 08/01-08/15 WoundCare: 08/15-08/31	Podiatry	Podiatry	Aug
Sep	Podiatry	Podiatry	Trauma	Podiatry	Podiatry	WoundCare: 09/01-09/14 Endo: 09/15-09/30	Podiatry	Podiatry	Plastics	Sep
Oct	Podiatry Radiio 10/6-10/17	Trauma	Podiatry	Endo: 10/21 - 11/1	Podiatry	Podiatry	Infectious Disease	Podiatry	Podiatry	Oct
Nov	Trauma	Anesth: 11/01-11/15	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Infectious Disease	Podiatry	Nov
Dec	Podiatry	Podiatry	Anesth: 12/1-12/14 Radio: 12/15-12/27	WC: 12/22-1/2	Podiatry	Podiatry	Podiatry	Podiatry	Infectious Disease	Dec
Jan	Podiatry	Emergency Medicine	Podiatry 1/1-1/26 Behavioral Med: 01/27-2/9	Podiatry	Podiatry: 01/01-01/15 Vascular: 01/16-01/31	Vascular: 01/01-01/15 Podiatry: 01/16-01/31	Podiatry	Podiatry	Podiatry	Jan
Feb	Emergency Medicine	Podiatry	Podiatry 2/10-2/28 Behavioral Med: 01/27-2/9	Vascular: 02/01-02/16 Inter. Cards: 02/17-02/28	Podiatry	Podiatry	Plastics	Podiatry	WC: 2/1-2/16 Podiatry	Feb
Mar	Podaitry	Podiatry 3/1-3/24 Behavioral Med: 03/23-4/5	Emergency Medicine	Podiatry	Podiatry: 03/01-03/16 Inter. Cards: 03/17-03/31	Int. Cards: 03/01-03/16 Podiatry: 03/17-03/31	Podiatry	Plastics	Podiatry	Mar
Apr	Family Medicine	Podiatry 4/7-4/30 Behavioral Med: 03/23-4/5	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Apr
May	Podiatry Behavioral Med: 5/4-5/17	Family Medicine	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	May
Jun	Podiatry	Podiatry	Family Medicine	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Podiatry	Jun

Podiatry Section Contact Information

Physician Name	E-mail Address	Practice Name	Practice Phone
Al-Sawah, Mohomad	mohomadalsawah@gmail.com	Associated Podiatrists	(248) 348-5300
Austin, Samuel	staustin89@gmail.com	Foot Docs	(248) 960-4444
Barnett, Sophie	cold982001@yahoo.com	Foot HealthCare Associates	(248) 258-0001
Belken, Thomas	tjbelken@gmail.com	Foot HealthCare Associates	(248) 258-0001
Berkowitz, Jeri	jeriberkowitz@gmail.com	Premier Foot & Ankle	(248) 847-3288
Bloch, Alan	abdpm@aol.com	Northville & South Lyon Podiatry	(248) 449-7156
Borovoy, Marc	maborovoy@gmail.com	Associated Podiatrists	(248) 348-5300
Elhouli, Ahmad	ahmadhaouli@hotmail.com	Reick Diegel DPM	(248) 738-5550
Foreman, Eric	dctrfoot@aol.com	Foot Docs	(248) 646-6882
Geller, Louis	lgeller123@gmail.com	Geller Foot Clinic	(248) 353-0096
German, Matt	mlgerman86@gmail.com	Foot HealthCare Associates	(248) 258-0001
Kallou, Bruce	brucekallou@gmail.com	Foot Health Care Associates	(248) 258-0001
Kaplan, Randy	rklions2@gmail.com	Family Footcare	(248) 851-4900
Kassab, Suha	suhakassab@yahoo.com	Bloomfield Family Foot Care	(248) 333-4900
Khalil, Mohammad	mkhalil39@yahoo.com	Family Foot & Ankle Specialists	(248) 423-4220
Klein, Jeffrey	jbkleindpm@yahoo.com	Dr. Klein Foot Care Center	(313) 864-7385
Lalama, Anthony	anthonyjlalama@gmail.com	Premier Foot & Ankle	(248) 847-3288
Leff, Randy	rmleffer@mac.com	Michfoot Surgeons PC	(248) 355-4000
Lefkowitz, Harvey	drl@michiganfootandankle.com	Michigan Foot and Ankle	(248) 548-7363
Mansour, Issam	issam_mansour@hotmail.com	Ankle & Foot Care Specialists	(734) 744-5661
Miller, John	jdmdpm@gmail.com	Associated Podiatrists	(248) 348-5300
Mozen, Neal	nmoz@aol.com	Foot HealthCare Associates	(248) 258-0001
Pavicic, Cindy	cindpm@gmail.com	Family Footcare	(248) 851-4900
Pupp, Guy	guypupp@comcast.net	Foot & Ankle Institute of Michigan	(248) 424-8637
Quereshi, Shahzad	qureshi2@msu.edu	Reconstructive Foot Clinic	(248) 444-7180
Salama, Daniel	dsdpm@aol.com	Salama Footcare	(313) 274-0990
Scott, Tara	drdst2@aol.com	Foot and Heal Pain Institute	(248) 557-6500
Sharpe, Kaitlyn	kaitlynrsharpe@gmail.com	Foot HealthCare Associates	(248) 258-0001
Sorenson, Kevin	kvnsorensen@gmail.com	Michfoot Surgeons PC	(248) 355-4000
Stefansky, Stacey	sastefansky@hotmail.com	Nationwide Foot & Ankle Care	(734) 261-3400
Stern, Milton	mstern@familyfootcare.org	Family Footcare	(248) 851-4900
Stock, Tara	tara697@hotmail.com	Michigan Foot and Ankle	(248) 548-7363
Stoinski, Meaghan	mhowe6@kent.edu	Feet First	(248) 624-8338
Taylor, Tameka	dr.tparham@gmail.com	Dr. T.P. Taylor Foot and Ankle Specialist	(586) 884-7087
Usen, Nsima	nusen@dmc.org	Family Foot & Ankle Specialists	(248) 423-4220
Ward, Alicia	drw@michiganfootandankle.com	Michigan Foot and Ankle	(248) 548-7363

Updated May 2023

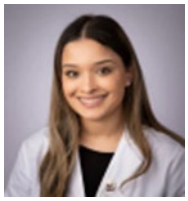
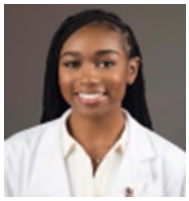
Providence Podiatry Resident Information 2025-2026

Podiatry on-call pager: 248-367-3651

Perfect Serve: Podiatry Resident HFPHS or Podiatry Resident

PGY-3		
Amin Niknam	**Marc DiGrande**	**Rosemary Joseph**
		
Cell: (763) 291-7964 **aniknamo@gmail.com**	**Chief Resident** **Cell: (248) 739-2600** **digrande2@gmail.com**	**Cell: (586) 553-7778** **rosemaryjoseph@gmail.com**

PGY-2		
Ereny Ayoub	**Joseph Spampinato**	**Nathan Wilson**
		
Student Coordinator **Cell: (623) 277-6910** **ereny.ayoub1@gmail.com**	**Lab Coordinator** **Cell: (517) 748-6270** **joeyspamp34@gmail.com**	**Journal Club Coordinator** **Cell: (810) 841-8757** **nwilso36@kent.edu**

PGY-1		
Soha Ahmed	**Emani Matthews**	**Maream Nori**
		
Cell: (703) 987-5350 **sarinasherry@gmail.com**	**Cell: (248) 910-8613** matthewsemani@gmail.com	**Cell: (586) 744-8818** mareamnori@gmail.com

Other Frequently Called Numbers		
Department	**Contact Person**	**Contact Information**
Program Director	Dr. Anthony J. LaLama	Cell: (586) 242-1604 AnthonyJLaLama@gmail.com
Program Coordinator	Saundia Cato (Dia)	Work: (248) 849-8441 Cell: (313) 802-1844 Scato1@hfhs.org

Providence Podiatry Resident Information 2024-2025

Journal Club

Fourth Tuesday of every month

- Three articles assigned per month – one PGY 1, one PGY-2 and one PGY-3
- One person per article will be picked at random to give a critique
- Every attending fills out evaluation of critique and presentations
- A PhD attends

Responsibilities

- Assign articles for whole year based on who is on service
- Each person should have four articles total per year
- Plan quarterly academic dinners
- Program Director picks dates for quarterly meetings
- One attending moderates all journal clubs – letter or e-mail
- Send e-mails three weeks in advance to remind of date and one week in advance to send out articles

***September quarterly – no articles presented – Stryker
December quarterly – no articles presented
March quarterly – no articles presented

Resident Log Completion

Henry Ford Providence Hospital & Medical Center
Resident Log and Record Requirements

1.) Clinical Logs and Activity Logs

All logs are to be entered daily, and in detail, on "PODIATRYRR"

2.) Biomechanical Forms

These are to be completed and turned in to the Program Director each week by Friday at 3:00 PM. Residents are required to complete two per week when on service, two per month when off service.

3.) Office rotation Hours

These are to be completed in PRR by the end of each week. One half day a week of clinic is required.

It is suggested that all residents maintain a notebook, or other record, to be kept on their person at all times. In this manner all services, patient experiences, lectures, rotations, and any instance of items to be logged or recorded, are done so as they occur, and subsequently transferred to the logging system, or other record, daily.

In this manner residents will receive credit for ALL educational experiences gained during the residency. This information is also required to be provided to The Council on Podiatric Medical Education, in order to maintain approval of the program.

Assessment of Residents' Competency/ Clinical Competency Committee

Henry Ford Providence Hospital and Medical Center Podiatric Education Policy

Assessment of Resident Competency

Through the use of various written qualitative and quantitative measurement devices, residents are evaluated to assure that the goals and objectives of the training program are being adequately met. In order to accomplish this goal, an ongoing evaluative procedure has been developed to assess the effectiveness of both the training program and the individual rate of progress of each resident.

1.) Residents will be evaluated for each monthly rotation.
2.) Surgical evaluations will be provided on the residents performance following each case in which the resident participates.
3.) A composite of evaluation results and milestones will be reviewed with the resident by the Clinical Competency Committee twice a year.
4.) Program evaluation, end of year/exit evaluations will be completed at the end of each year.
5.) Following completion of the Program, all evaluation forms are retained in the permanent resident files by the coordinator.

Core Competencies

PATIENT CARE

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

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- Develop and carry out patient management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education.
- Perform competently all medical and invasive procedures considered essential for the area of practice.
- Provide health care services aimed at preventing health problems or maintaining health.
- Work with health care professionals, including those from other disciplines, to provide patient-focused care.

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care. Residents are expected to:

- Demonstrate an investigative and analytic thinking approach to clinical situations.
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Use information technology to manage information, access online medical information and support their own education.
- Facilitate the learning of students and other health care professionals.

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and learning with patients, their patients' families, and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients.
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.

- Work effectively with others as a member or leader of a healthcare team or other professional group.

PROFESSIONALISM
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

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

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

PROVIDENCE HOSPITAL PODIATRIC
CLINICAL COMPETENCY COMMITTEE

POLICY PURPOSE: The goal of the Clinical Competency Committee (CCC) is to assess and evaluate the residents in the program in each of these six core competencies.

The committee's purpose is to serve as an advisory board to the Program Director with regards to all resident issues including, but not limited to: feedback, evaluation, curriculum organization, promotion, remediation, certification, disciplinary action, chief resident selection, special awards and commendations.

RESPONSIBLE PERSONS: The Residency Program Director and residents are responsible for appointing the Clinical Competency Committee.

PROCEDURE:
The Clinical Competency Committee (CCC) must:

1. Consist of at least 5 members of core faculty.
2. Meet and review all resident evaluations at least semi-annually
3. Consider all written and other evaluations and discuss any non-congruence between written evaluations and their experiences with each resident.
4. Provide Program Director with advice regarding each resident's progress, including but not limited to promotion, remediation and dismissal.

THE MEMBERS OF THE CCC WILL BE:
Harvey Levkowitz – Chairperson Stacey
Stefansky
Louis Geller
Anthony LaLama
Tara Stock
Matt German
Saundia Cato – Program Coordinator

Podiatry Resident Milestones

Resident Name: **Milestone Period:** July – December

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care For Diseases and Conditions (CDC)	PATIENT CARE (PC1)	This resident is not able to perform an efficient and accurate initial history and physical for patients admitted to the hospital.	This resident performs a focused, efficient, and accurate initial history and physical of a full spectrum of patients admitted to the hospital.	This resident accurately Diagnoses ***many*** surgical & non-surgical conditions of the foot & ankle. This resident can develop a diagnostic plan and implement initial care for patients seen in the Emergency Department (ED).	This resident accurately Diagnoses ***most*** surgical & Non-surgical conditions of the foot and ankle and initiates appropriate management for ***most*** surgical conditions independently.	This resident can lead a team that cares for patients with common and complex foot and ankle conditions and delegates appropriate clinical tasks to other health care team members. This resident recognizes atypical presentations of a large number of conditions.
		☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
		Comments:				
Care For Diseases and Conditions (CDC)	PATIENT CARE (PC2)	This resident is unable to recognize or manage common post- operative problems such as fever, blood sugar (BS) issues, hypotension, bleeding, abnormal lab values or cultureresults.	This resident recognizes and manages **common** post-op problems such as fever, BS issues, bleeding, hypotension,abnormal lab values orculture results with the assistance of senior residents or staff members who are physically present	This resident recognizes and manages **common** post-op problems such as fever, BS issues, hypotension, bleeding, abnormal lab or culture results with the assistance of senior residents or staff members who are available for consultation, but not physically present.	This resident recognizes and manages **complex** post- operative problems such as sepsis, fever, hypoxia, hypotension, bleeding,abnormal culture results or lab values **independently.** .	This resident can **lead** a team and provide supervision of junior residents in the evaluation and management of complex post-operative problems such as sepsis, fever, hypotension, , bleeding, abnormal lab valuesor culture results .
		☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Performance of Operations and Procedures (POP)	PATIENT CARE (PC3)	This resident lacks basic surgical skills such as knot tying, simple suturing, suture removal, use of doppler ultrasound, administration of local anesthetic, universal precautions and aseptic technique. Resident is unable to reliably perform simple bedside incision and drainage , repair of minor skin laceration, debridement of diabetic wounds and simple fracture reduction.	This resident has basic surgical skills such as knot tying, simple suturing, suture removal, use of doppler ultrasound, administration of local anesthetic, universal precautions, and aseptic technique. The resident is able to reliably perform a bedside incision and drainage, repair minor skin lacerations, debridement of diabetic wounds and can handle simple fracture reductions. .	This resident has developed respect for soft tissue planes, and is developing skill in instrument handling. This resident moves through portions of common lower level operations without coaching and makes straightforward intra-operative decisions.	This resident demonstrates proficiency in the handling of most instruments and exhibits efficiency of motion during procedures. This resident moves through the steps of *most mid level* operations without much coaching and is making intra-operative decisions.	This resident demonstrates proficiency in use of instruments and equipment required for "essential" operations, guides the conduct of most operations and makes independent intra-operative decisions. This resident can perform *all* of the "essential" operations and has significant experience in the "complex" operations. This resident can effectively guide other residents in "essential-common" operations.
		☐	☐	☐	☐	☐
		Comments:				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care For Diseases and Conditions (CDC)	MEDICAL KNOWLEDGE(MK1)	This resident does not have basic knowledge about common podiatric medical/surgical conditions to which a podiatric medical student would be exposed to in clerkship.	This resident has a basic understanding of the symptoms, signs, and treatments of the common podiatric disease processes and has basic knowledge about common surgical conditions to which a medical student would be exposed in clerkship.	This resident has basic knowledge about ***many*** of the common podiatric medical and surgical conditions and can make a diagnosis and recommend appropriate initial management. This resident can recognize variation in the presentation of common surgical conditions.	This resident has **significan**t knowledge about common and complex podiatric medical and surgical conditions, and can make adiagnosis and **initiate** appropriate initial management.	This resident has a **comprehensive** knowledge of the varying patterns of presentation and alternative and adjuvant treatments for common & complex podiatric medical and surgical conditions. The resident can make the diagnosis, initiate a treatment course, consult ancillary services, coordinate outpatient care & lead junior
		☐	☐	☐	☐	☐
		Comment :				
Performance of Operations and Procedures (POP)	MEDICAL KNOWLEDGE(MK2)	This resident does not have basic knowledge about the common operations to which a podiatric medical student would be exposed in clerkship.	This resident has a basic knowledge of podiatric surgical curriculum to which a medical student would be exposed in clerkship. (Ex: nail conditions, wounds, dermatologic conditions, diabetic foot wound and venous wounds)	This resident has a **basic** knowledge of the operative steps, peri-operative care, and post-operative complications for ***many*** of the category 1, 3 & 6 procedures. .	This resident has a **significant** knowledge of the operative steps, peri-operative care, and post-operative complications for ***most*** of the category1, 2, 3,4 & 6. A basic knowledge of **some** of the "complex" category 5 operations.	This resident has a **comprehensive** level of knowledge of the operative steps, peri-operative care, and post-operative complications for the category 1-6 operations. Resident has firm knowledge of **many** of the RRA complex procedures
		☐	☐	☐	☐	☐
		Comment :				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Coordination of Care (CC)	SYSTEMS-BASED PRACTICE (SBP1)	This resident does not have a basic understanding of the resources available for coordinating patient care, including social workers, visiting nurses, and physical and occupational therapists.	This resident has a basic understanding of the resources available for coordinating patient care, including social workers, visiting nurses, and physical and occupational therapists.	This resident knows the necessary resources to provide optimal coordination of care and how to access them. This resident is aware of specialized services like home nursing & home antibiotic infusion.	This resident is able to efficiently arrange disposition planning for his or her patients and takes responsibility for preparing all materials necessary for discharge or transfer of his or her patients.	This resident coordinates the activities of residents, nurses, social workers, and other health care professionals to provide optimal care to the patient at the time of discharge or transfer, and to provide post-discharge ambulatory care that is appropriate for the patient's particular needs.
		☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
		Comments:				
Improvementof Care (IC)	SYSTEMS-BASED PRACTICE (SBP2)	This resident does not demonstrate evidence that he or she considers how hospital and health care systems impact his or her practice. This resident does not demonstrate awareness of variation in practice within or across health care systems.	This resident has basic knowledge of how health systems operate. This resident knows system factors that contribute to medical errors and is aware that variations in care occur.	This resident understands how patient care is provided in his or her system and recognizes certain specific system failures that can affect patient care. This resident follows protocols and guidelines for patient care.	This resident makes suggestions for changes in the health care system that may improve patient care. This resident reports problems with technology (e.g., devices and automated systems) or processes that could produce medical errors.	This resident participates in work groups or performance improvement teams designed to reduce errors and improve health outcomes. This resident understands the appropriate use of standardized approaches to care and participates in creating such protocols of care.
		☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
		Comments:				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Teaching (TCH)	PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI1)	This resident does not communicate effectively as a teacher (e.g., is disorganized, is inattentive, uses language unsuitable for the level of the learner, discourages and disregards questions).	This resident willingly imparts educational information clearly and effectively to medical students and other health care team members. This resident uses media in presentations appropriately and effectively.	This resident communicates educational material accurately and effectively at the appropriate level for learner understanding. This resident accurately and succinctly presents patient cases in conferences.	This resident demonstrates an effective teaching style when asked to be responsible for a conference or formal presentation.	This resident recognizes teachable moments and readily and respectfully engages the learner. This resident is a highly effective teacher with an interactive educational style and engages in constructive educational dialogue. This resident facilitates conferences and case discussions based on assimilation of evidence from the literature.
		☐	☐	☐	☐	☐
		Comments:				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Self-directed Learning (SDL)	PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI2)	This resident does not engage in self-initiated, self-directed learning activities. This resident does not complete simulation assignments. This resident is frequently absent for scheduled simulation exercises without a valid excuse.	This resident completes learning assignments using multiple sources. This resident participates in assigned skills curriculum activities and simulation experiences to build surgical skills.	This resident independently reads the literature and uses sources publications, practice guidelines, textbooks, library databases, and online materials) to answer questions related to patients. This resident develops a learning plan based on feedback with some external assistance. This resident identifies gaps in personal technical skills and works with faculty members to develop a skills learning plan.	is resident looks for trends and patterns in the care of patients and reads and uses sources to understand such patterns. is resident can select an appropriate evidence-based information tool to answer specific questions while providing care. is resident independently practices surgical skills in a simulation environment to enhance technical ability.	is resident participates in local, regional, and national activities, optional conferences, and/or self- assessment programs. This resident demonstrates use of a system or process for keeping up with changes in the literature, and initiates assignments for other learners. This resident leads surgical skills experiences for students and residents and participates in skills curriculum development.
	Comments:					

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI3)	This resident does not demonstrate interest or ability in learning from the results of his or her practice. This resident fails to recognize the impact of errors and adverse events in practice.	This resident actively participates in Morbidity and Mortality (M&M) and/or other Quality Improvement (QI) conferences with comments, questions, and/or accurate presentation of cases. This resident changes patient care behaviors in response to feedback from his or her supervisors. This resident recognizes when and how errors or adverse events affect the care of patients.	This resident evaluates his or her own surgical results and the quality and efficacy of care of patients through appraisal and assimilation of scientific evidence. This resident uses relevant literature to support his or her discussions and conclusions at M&M and/or other QI conferences. This resident performs basic steps in a QI project (e.g., generates a hypothesis, conducts a cause-effect analysis, creates method for study). This resident understands how to modify his or her own practice to avoid errors.	This resident evaluates his or her own surgical results and medical care outcomes in a systematic way and identifies areas for improvement. This resident identifies probable causes for complications and deaths at M&M and/or other QI conferences with appropriate strategies for improving care. This resident begins to recognize patterns in the care of his or her patients and looks for opportunities to systematically reduce errors and adverse events.	This resident exhibits on-going self evaluation and improvement that includes reflection on practice, tracking and analyzing his or her patient outcomes, integrating evidence-based practice guidelines, and identifying opportunities to make practice improvements. This resident discusses or demonstrates application of M&M and/or other QI conference conclusions to his or her own patient care. This resident leads a QI activity relevant to patient care outcomes.
Improvementof Care (IC)						
		☐	☐	☐	☐	☐
		Comments:				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care for Diseases and Condition s (CDC)	PROFESSIONALISM (PROF1)	This resident displays undesirable behaviors, including not being polite or respectful, not respecting patient confidentiality and privacy, demonstrating lack of integrity, or failing to take responsibility for patient care activities. This resident consistently respects patient confidentiality and privacy	This resident is polite and respectful toward patients, their families, and other health care professionals. This resident demonstrates a commitment to continuity of care by taking personal responsibility for patient care outcomes. This resident responds to pages and consultation requests promptly. This resident is honest and trustworthy.	This resident maintains composure in accordance with ethical principles even in stressful situations. This resident exhibits compassion and empathy toward patients and their families. This resident recognizes the limits of his or her knowledge and asks for help when needed.	This resident ensures patient care responsibilities are performed and continuity of care is maintained. This resident accepts responsibility for errors in patient care and can initiate corrective action. This resident consistently demonstrates integrity in all aspects of care and professional relationships.	This resident serves as a role model for ethical behavior. This resident positively influences others by assertively modeling profession alism. The resident consistently places the interests of patients ahead of self interests when appropriate.
?			?	?	?	?	?	?	?	?

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Maintenance of Physical and Emotional Health (MPEH)	PROFESSIONALISM(PROF2)	This resident's behavior and/or physical condition concern me. This resident flagrantly and repeatedly violates duty hour requirements.	The resident understands the institutional resources available to manage personal, physical, and emotional health (e.g., acute and chronic disease, substance abuse, and mental health problems). The resident complies with duty hours standards. This resident understands the principles of physician wellness and fatigue mitigation.	This resident monitors his or her own personal health and wellness and appropriately mitigates fatigue and/or stress. This resident effectively and efficiently manages his or her own time and assures fitness for duty.	This resident sets an example by promoting healthy habits and creating an emotionally healthy environment for those working with him or her. The resident models appropriate management of personal health issues, fatigue and stress.	The resident promotes a healthy work environment. This resident recognizes and appropriately addresses personal health issues in other members of the health care team. This resident is proactive in modifying schedules or intervening in other ways to assure that those caregivers under his or her supervision maintain personal wellness and do not compromise patient safety (e.g., requires naps, counsels, refers to services, reports to program director).
		☐	☐	☐	☐	☐
		Comments:				

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL2	LEVEL 3	LEVEL 4
Performance of Assignments and Administrative Tasks (PAT)	PROFESSIONALISM (PROF3)	This resident consistently fails to meet requirements for timely performance of administrative tasks and/or requires excessive reminders, follow-up, etc.	This resident completes his or her operative case logs and duty hour logs, performs other assigned and required administrative tasks in a timely fashion, and does not require excessive reminders or follow-up (e.g., visa renewal, credentialing, obtaining a medical license).	This resident is prompt in attending conferences, meetings, operations, and other activities. This resident responds promptly to requests from faculty members and departmental staff members (e.g., pager responsiveness).	This resident assures that others under his or her supervision respond appropriately to responsibilities in a timely fashion.	This resident sets an example for conference attendance, promptness, and attention to assigned tasks.
		?	?	?	?	?	?	?

Comments:

Practice

Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care for Diseases and Conditions (CDC)	INTERPERSONAL AND COMMUNICATION SKILLS (ICS1)	This resident is not able to clearly, accurately, and respectfully communicate with patients and their families. This resident fails to effectively communicate basic health care information to patients and families.	This resident uses a variety of techniques to ensure that communication with patients and their families is understandable and respectful (e.g., non-technical language, teach back, appropriate pacing, and small pieces of information). This resident effectively communicates basic health care information to patients and their families.	This resident customizes communication, taking into account patient characteristics (e.g., age, literacy, cognitive disabilities, culture). This resident provides timely updates to patients and their families during hospitalizations and clinic visits.	This resident is capable of delivering bad news to patients and their families sensitively and effectively.	This resident can customize emotionally difficult information (e.g., when participating in end-of-life discussions). This resident is capable of negotiating and managing conflict among patients and their families.
?		?	?	?	?	?	?	?
	Comments:							

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Coordinati onof Care (CC)	INTERPERSON AL AND COMMUNICATIO N SKILLS (ICS2)	This resident displays disrespectful or resentful behaviors when asked to evaluate a patient or participate in a care conference with other members of the health care team.	This resident willingly exchanges patient information with team members. This resident responds politely and promptly to requests for consults and care coordination activities. This resident performs face-to-face hand-offs.	This resident exhibits behaviors that invite information sharing with health care team members (e.g., respect, approachability, active listening). This resident performs hand-off best practices (e.g., uses multiple forms of information transfer, confirms receipt of information, invites questions).	This resident discusses care plans with the members of the health care team and keeps them up to date on patient statuses and care plan changes. This resident delivers timely, complete, and well organized information to referring physicians and to providers of follow-up care at the time of patient care transitions.	This resident assumes overall leadership of a health care team responsible for his or her patients, while at the same time seeking and valuing input from the members of the team. This resident negotiates and manages conflict among care providers. This resident takes responsibilit y for ensuring that clear hand-offs are given at transitions of care.

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Performance of Operations and Procedures (POP)	INTERPERSONAL AND COMMUNICATION SKILLS (ICS3)	This resident does not communicate effectively with patients, hospital staff members, and/or the senior surgeon in the operating room.	This resident communicates basic facts effectively with patients, hospital staff members, and the senior surgeon in the operating room. This resident understands the necessary elements of informed consent for procedures.	This resident effectively describes various aspects of the procedure and peri-operative care to the patient and his or her family and other operating room team members. This resident leads a pre-operative "time out". This resident performs clear informed consent discussion for basic procedures.	This resident anticipates logistical issues regarding the procedure and engages members of the operating team to solve problems. This resident performs clear informed consent discussion for complex procedures.	This resident is capable of leadership when unexpected events occur in the operating room and is able to communicate effectively with the family when unexpected events occur in the operating room.
		☐	☐	☐	☐	☐
		Comments:				

Harvey Lefkowitz, DPM FACFAS		Anthony LaLama, DPM		Resident
Chair, CCC		Program Director		

Research Requirements

All Residents in the Providence Hospital Podiatry Program are required to perform a clinical or laboratory research project during their three training years. In addition, at least one manuscript must be submitted to a peer-reviewed journal no later than April of the PGY-3 year. Residents are encouraged to begin their research projects as early as possible. Each resident must provide a title and an abstract to the Research Director by September of the current year. Residents are encouraged to actively involve a research faculty member. The submission of abstracts, posters and manuscripts to state, regional and national meetings is highly encouraged.

Residents are required to meet at least quarterly with research faculty and the Research Director to ensure the quality of the project.

While research is mandatory, adequate clinical performance takes precedent. At no time can a resident allow his or her research requirements to interfere with the clinical responsibilities of the program.

Resident participation in research is a driving force behind the academic productivity of the Providence Podiatry Department and is supported to the full extent of the available resources. A number of resources devoted specifically to research are available to residents.

Guy R. Pupp, DPM, FACFAS

Interesting Case Policy

Each resident is required to prepare a complete report on an interesting case once a year

Interesting or unusual cases regularly appear in the Hospital, the Operating Room, in the Surgical Centers, in the individual offices of staff members, or during the various medical/surgical rotations in which each resident participates.

Such cases are to be made available for presentation. The case is to be researched, fully referenced and photographed and documented utilizing available x-ray MRI, scans, lab and pathology results, consultation reports, and any other related material that had been utilized in the particular case.

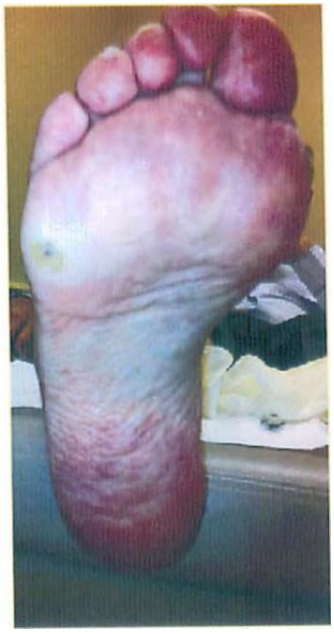
The material developed is to be submitted by email to the Director who may also request that the material be transferred to a Power Point presentation. Each case presentation will remain the property of the Hospital. They may be utilized at Hospital meetings to fulfill the educational requirements of the staff. Also, from time to time the material may be sent to our staff members in an effort to keep them up to date of your continuing educational efforts and responsibilities, or you may be requested to present the material at various local professional meetings.

Wagner Classification for Diabetic Wounds

Wagner Classification for Diabetic Wounds

Grade 0: Pre-ulcerative lesion or healed diabetic wound that is at risk for breakdown

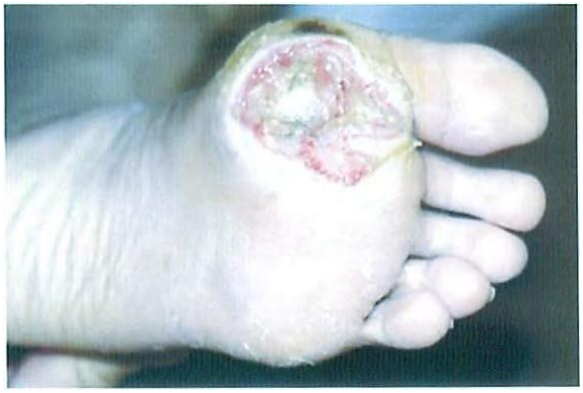
- *No skin breakdown is noted*



Grade 1: Superficial diabetic ulcer

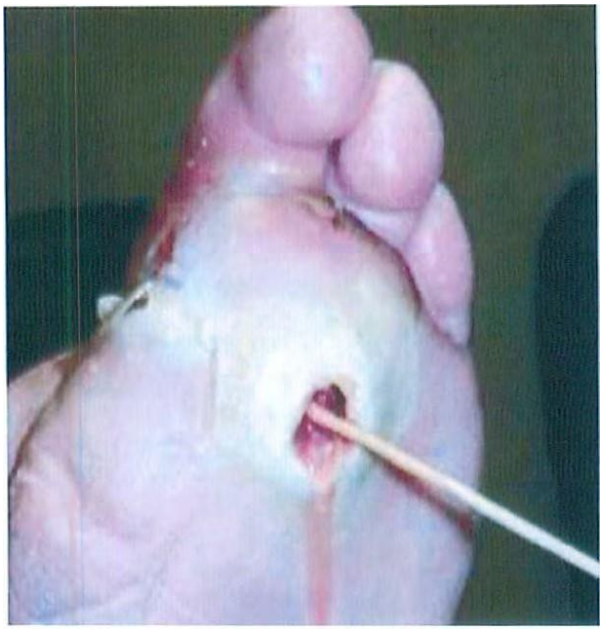
- *partial or full thickness*

Grade 2: Ulceration extending to a ligament, tendon, ajoint capsule or to the deep fascia

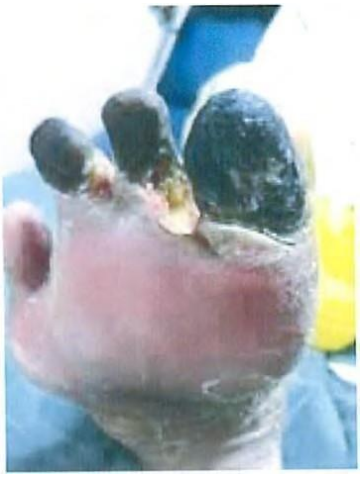


Grade 3: Deep ulcer with abscess, extending to bone

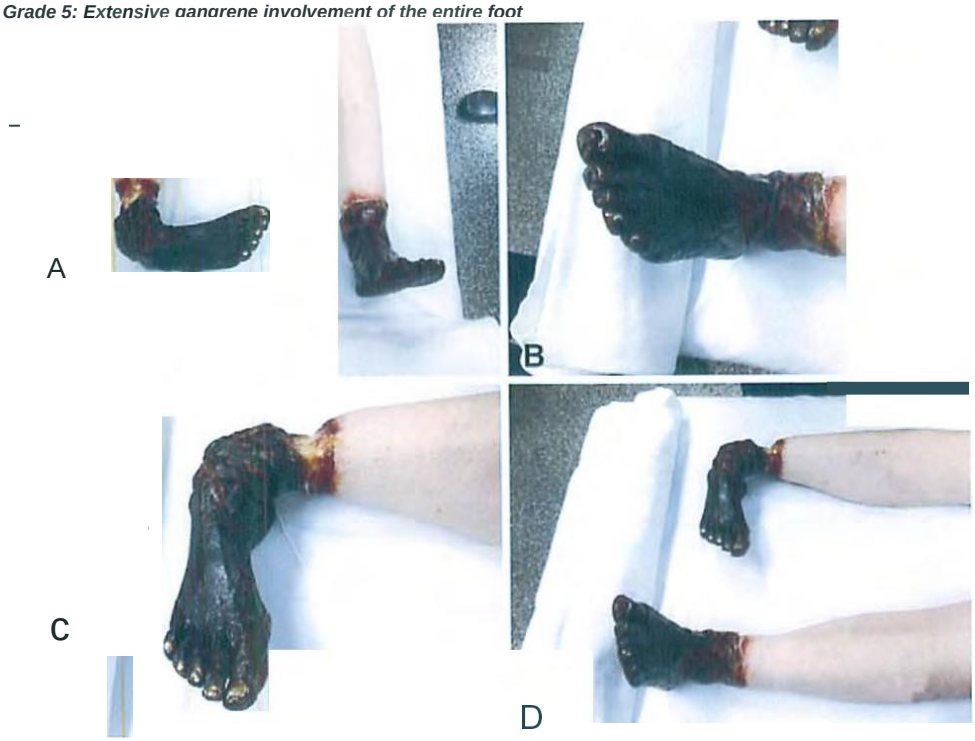
- *Clinical osteomyelitis or joint sepsis*



Grade 4: Gangrene to the toes/forefoot



Grade 5: Extensive gangrene involvement of the entire foot

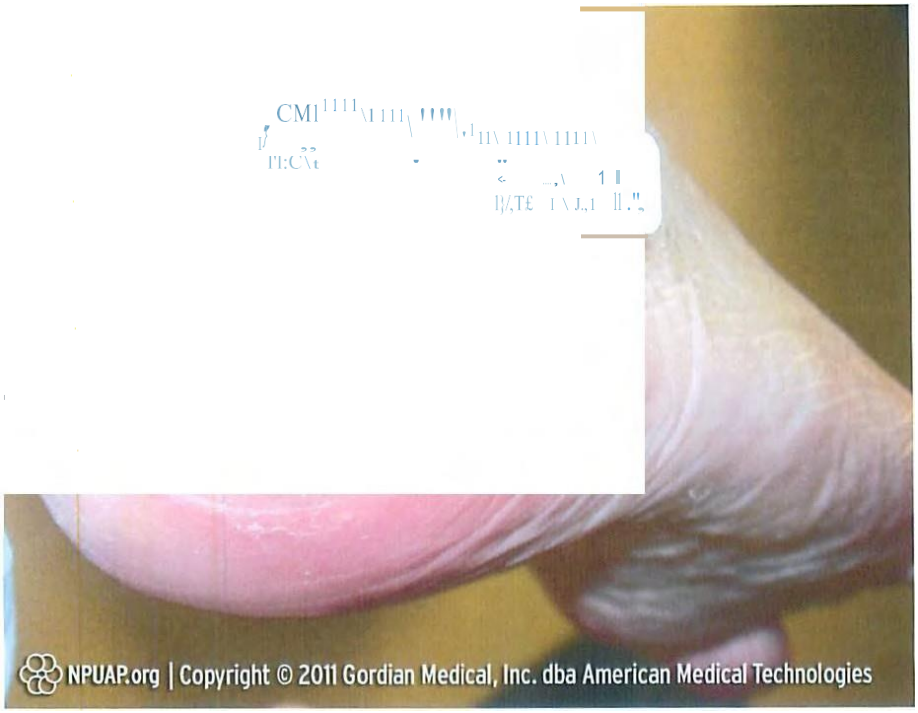


NPUAP- National Pressure Ulceration Advisory Panel

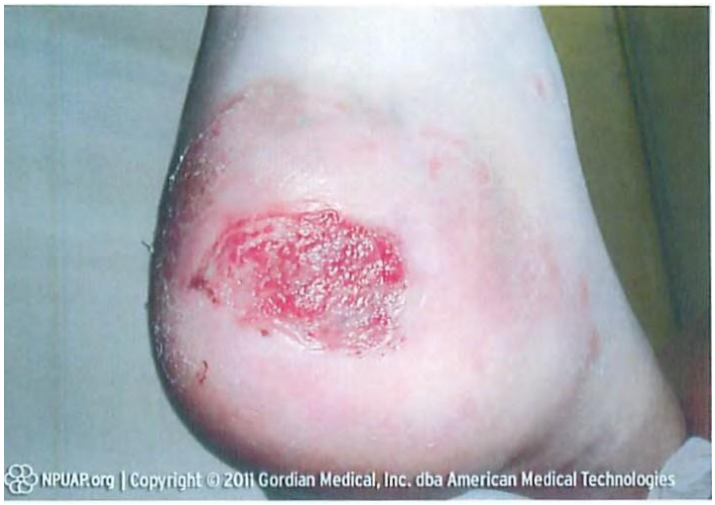
- *For decubitus wounds*
  - ***AKA: Pressure sores, Bedsores***

- *4 Stages*

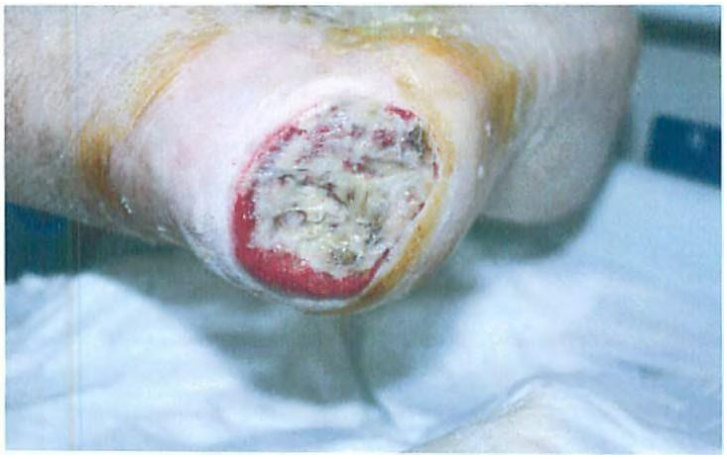
  - *Stage 1: Intact skin with non-blanchable erythema*
    - *Usually located over a bony prominent region*



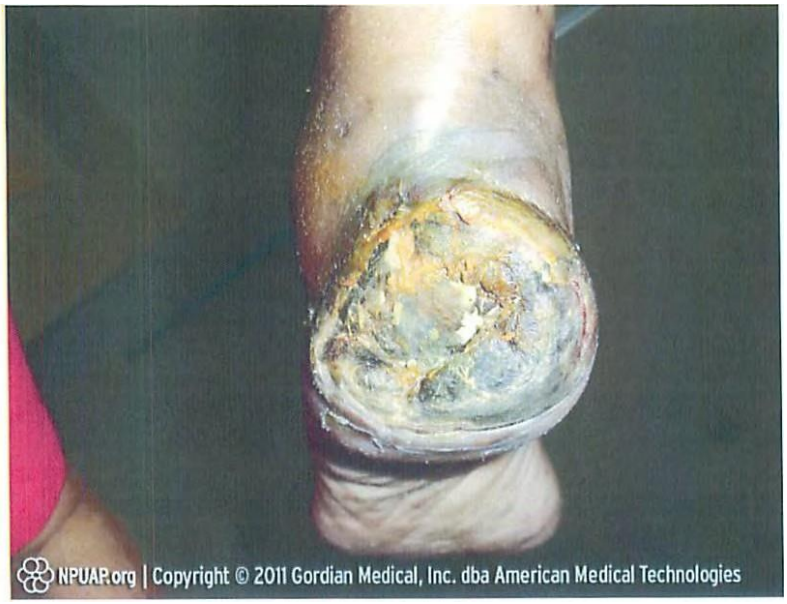
- ***Stage II: Partial thickness/ full thickness wound with loss of dermis***
  - *Presents as a shallow open ulceration with a red/pink wound base*



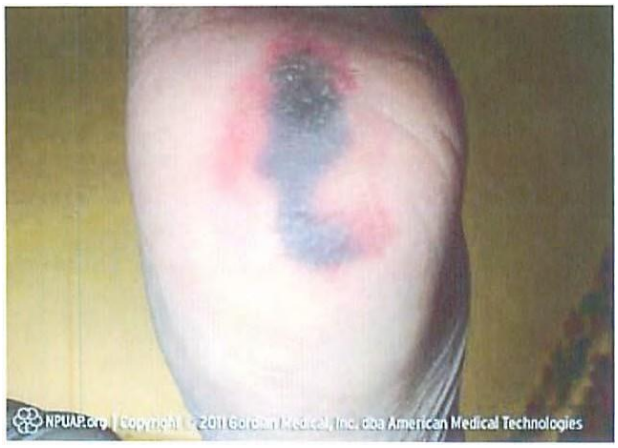
- *Stage III: Deep full thickness wound with exposed subcutaneous tissue*
  - *May include undermining and/or tunneling*



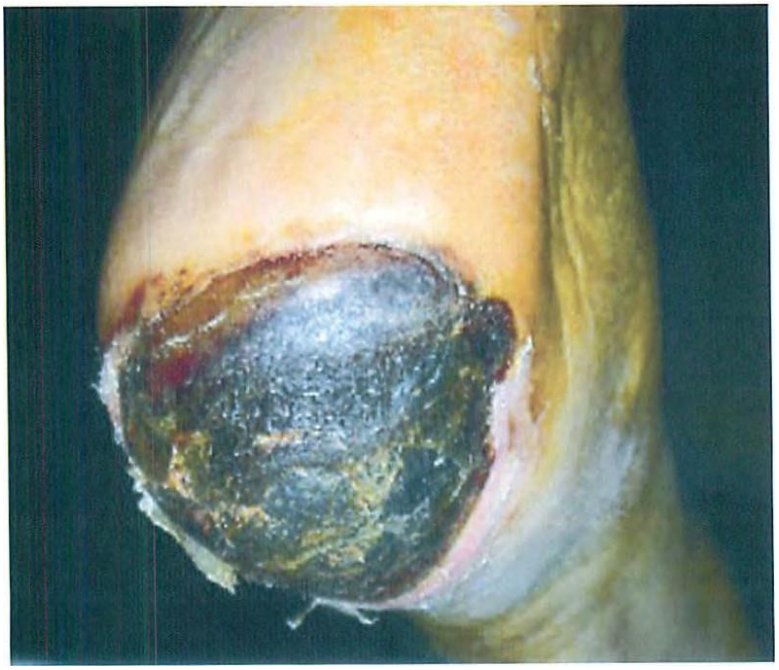
- *Stage IV: Deep full thickness wound with exposed tendon, muscle, or bone*
  - ***Often includes undermining and/or tunneling***



- *Suspected Deep Tissue Injury (DTI)*
  - ***Purple or maroon discolored area of tissue that is intact or may present as a blood filled blister due to damage of underlyingsoft tissue from pressure and/or shear***


NPUAP.org | Copyright © 2011 Gordon Medical, Inc. dba American Medical Technologies

- *Unstageable decubitus wound*
  - ***Full thickness tissue loss in which the base is covered with a yellow, tan, gray, green, brown, or black discolored tissue/eschar formation***



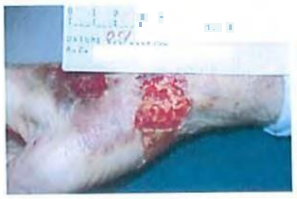
A Closer Look At The NationalPressure Ulcer Advisory Panel Classification System	
Staging	Description
1	Non-blanchable erythema purple hue of skin. changes In temperature and sensation
2	Partial-thickness skin loss (I.e.blister or shallow crater)
3	Full-thickness skin loss involving necrosis of subcutaneous tissue
4	Full-thickness skin loss with extensive necrosis to tendon. muscle.bone. or Joint
Unstageable	Ulcer with eschar.Wound base cannot be assessed.
DTI	Purple non-blanchable area of intact skin t11at demarcates between 24-48 1,ours clue to deep tissue destruction

Payne-Martin Classification of Skin Tears

- *3 Categories*
    - *Category I: Skin tear without tissue loss*
        - *Linear: Epidermis and dermis are pulled apart*
        - *Flap: Epidermal flap completely covers the dermis within 1 mm of the wound margin*
    - *Category II: Skin tear with partial tissue loss*
        - *Scant Tissue Loss: <25% of the epidermal flap is lost*
        - *Moderate to Large Tissue Loss: >25% of epidermal flap is lost*
    - *Category III: Skin tear with complete tissue loss where the epidermal flap is absent*

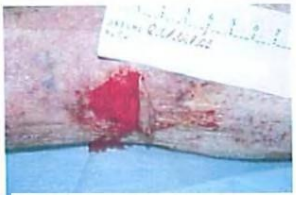
Category I. Without tissue loss either linear, or with a flm2. that closes the tear to within an approximation of 1mm of the v'bund edges.

C:llegory I .Itll'nr Typr

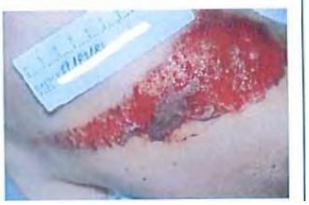


Category I - Flap Type

Category II. Partial tissue loss. considered scant when the loss is 25% or less and moderate or large when the ti loss is more than 25%.



Catl'gory 11 .'>cnllt. tl\,llt loss le,s th:lll 2!-0 o



Cn le2ory II .Lnrgt>. tissue loss mo, t lhtl 2:0 0

Category III Complete tissue loss or no epider - mal flap covering the injury.

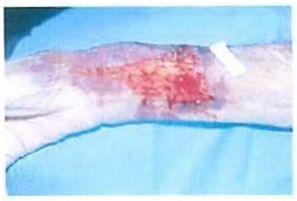


Figure 3. Payne·Mutln Method of Skin Tear Classilieatlon .lm19eo provided courtesy of Frans Mculcncirc, RN , ind the Journal of V/ound Care. Reproduced with pcrmlnlon .

Proper Documentation for Dictating Consultations/Progress Note

Louis J. Geller, D.P.M. Michael W. Kruplc, D.P.M.
Anthony LaLama, D.P.M
Geller Foot Clinic Foot and Ankle Specialists 20555 West 12 Mile Road
Southfield, Michigan 48076
Phone: 248-353-0096
Fax: 248-809-6255

Proper Documentation for Dictating Consultations/Progress Notes

Our notes are like stories; they need to tell about what is wrong with a patient and his or her foot, ankle or leg. When asked to see a patient, the Internist or Family Practitioner is consulting us for our expertise of the lower extremity. Just because something seems easy to us, may not be as clear cut for other medical specialties, and that is why they are asking us to partake in the care of their patients. Please, when dictating or typing out a note, do so as if you were speaking to someone. The consults and progress notes are viewed by many medical specialties and the attending sign their names to these documents. All notes should be correctly written/dictated in proper English with no spelling mistakes. **Spelling mistakes are unacceptable!!!**

When dictating a consultation, the subjective portion or the chief complaint should follow NLDOCATS (Nature, Location, Duration, Onset, Course, etc.)

When dictating a progress note, the subjective portion should state that you saw the patient at bedside. Make sure you document if the patient is in any pain. How is the patient doing? Is the patient on IV/oral antibiotics? Is the patient eating and drinking okay? If the note is a post-op note, is the patient urinating or having regular bowel movements? Does the patient have nausea, vomiting, fever, chills, etc.? Can the patient perform his or her own wound care?

You must then include for all consultations,

- Past medical history
- Past surgical history
- Medications
- Allergies
- Social history
- Family history
- Review of systems- for podiatry consult, the review of systems should be pertinent to lower extremity issues

For the Objective and Treatment portions of the chart note, use these clinical findings:
Abbreviations: are acceptable for all consults and subsequent hospital visit notes, however, you must use the standard abbreviations that are well known to all medical specialties. The following are the acceptable abbreviations that we commonly use. Please document them appropriately:

Alert and oriented xl,2,3:A&O x1,2,3
In no apparent distress: INAD
Sign of active infection: SOAI
Nausea, vomiting, fever, chills: N/V/F/C

Dermatological Exam: Skin temperature is warm to warm, warm to cool, cool to cooler from the patella proximally to the distal ends of all digits. Please also note if there is hair present or absent to the toes. Is there hair present or absent to the legs? This must be listed as well. You will also need to document skin hydration/turgor. It should state skin hydration/turgor is within normal limits or skin hydration/turgor is decreased. Please document the location of any callosities/hyperkeratotic lesions/pre-ulcerative lesions/ulcerations. Please document the appearance of the nails. Check for any signs of tinea pedis or dermatitis- the documentation for this should state if there is: There is extensive, eczematous, peeling, scaling, infected skin noted to the (list the location of the tinea pedis). You must check the interspaces as well. If they are clean, please state that interspaces 1through 4 bilateral foot are clean and free of maceration. If they are not, you must list the exact interspaces that exhibit eczematous, peeling, scaling skin and interdigital maceration. If there are no open wounds or any clinical signs of infection noted to either foot dermatologically speaking, the last 2 sentences should state no cellulitis is noted to either of the lower extremities. No open wounds are noted to either of the lower extremities.

Onychomycosis: Nails x _ are mycotic appearing, elongated, thickened, deformed, discolored yellow gray or yellow, or brownish yellow, are dystrophic/crumbly with distal lysis and distal subungual debris. You need to list which nails are painful to direct pressure and painful with ambulation. If none are painful, you need to mention that none of the toenails are currently symptomatic with shoe pressure, with ambulation or to direct pressure.

For the treatment plan for Onychomycosis if any of the nails are painful: Mycotic nails x were sharply excisionally debrided, both in length and thickness, using manual excisional debridement to aid ambulation, control infection and prevent further morbidity. If the patient is non-ambulatory, take out the wording that says to aid ambulation.

For the treatment plan for Onychomycosis if the nails are non-painful- Mycotic nails x were sharply excisionally reduced, both in length and thickness, using manual excisional reduction, to aid ambulation, control infection and prevent further morbidity. Again, if the patient is non-ambulatory take out the wording that says to aid ambulation.

Ingrown Toenails: You need to list the border of the exact toe that is ingrown. If it is ingrown and noninfected, the documentation should be as follows as an example: The medial nail border of the right great toenail is deformed, incurvated and embedded in the skinfold. It is extremely tender to light direct pressure. The medial skinfold of the right great toe is erythematous and edematous. It is not hypertrophic or fleshy. No proximal ascending cellulitis is noted. No granuloma formation Is noted.
Ingrown Toenail Treatment Example: I discussed with the patient his/her condition and treatment options. Alcohol prep. I injected 5 cc 1% plain lidocaine in right hallux block fashion. I partially avulsed the offending, deformed, incurvated medial nail border 1right past the eponychium. I cleansed the

region with peroxide. Topical antibiotic ointment (your choice) and a Band-Aid was applied. No abnormal incidents were encountered.

A topical antibiotic ointment or cream will need to be ordered and be applied to the affected toenail once daily and covered with a Band-Aid over the next 5-7 days.

Infected Ingrown Toenail/Paronychia: Again, like I discussed in the ingrown toenail section, you need to list the border of the exact toe that is ingrown and infected. The documentation should be as follows as an example: The medial nail border of the right great toenail is deformed, incurvated and embedded in the skinfold. The medial skinfold of the right great toe is erythematous, edematous, hypertrophic and fleshy. It is extremely tender to even light direct pressure. You must list the amount of purulence or seropurulent discharge expressed (a small amount, a moderate amount, a scant amount, etc.) Was it creamy yellow, was it yellowish-green, was it seropurulent drainage? Make sure you also note if there is a granuloma formation or any proximal ascending cellulitis. If there is proximal ascending cellulitis, you must trace, date and time the proximal margins of the cellulitis as well as list where it is located (E.g., proximal ascending cellulitis was noted to the level of the right hallux IP joint region. This area was traced, dated and timed.)

Paronychia Treatment Example: I discussed with the patient his/her condition and treatment options. Alcohol prep. I injected 5 cc 1% plain lidocaine in right hallux block fashion. Incised and drained the paronychia 1right medial with a (tissue nipper, #15 blade, #10 blade, etc.). A small/scant/moderate amount of seropurulent drainage/creamy yellowish purulent drainage/yellowish-green drainage was expressed. I then partially avulsed the offending, deformed, incurvated nail border 1right medial past the eponychium. I cleansed the region with peroxide. A topical antibiotic ointment (your choice) and a Band-Aid was applied. No abnormal incidents were encountered.

A topical antibiotic ointment or cream will need to be ordered and be applied to the affected toenail once daily and covered with a Band-Aid over the next 5-7 days.

IMPORTANT: If there is cellulitis and gross Infection, you need to culture the region for Gram stain and aerobic culture and sensitivity.

Diabetic Ulcerations: Please remember that diabetic ulcerations are graded using the Wagner Classification. When describing the ulceration in the objective section of the dermatological exam, you muscle list the following characteristics.

- Wagner Classification of the ulceration
- Size of the ulceration
    a. You must list pre-excisional wound debridement measurements and post-excisional wound debridement measurements
        i. Measurements are performed in cm
    b. Measurements are done as follows: length-width-depth
        i. Think of a clock:
            1. Length: 12 o'clock to 6 o'clock position of the wound
               Width: 3 o'clock to 9 o'clock position of the wound
               Depth: How deep does the wound probe
- Location of the ulceration
- You need to mention if the wound is painful or if it is nontender
- You need to describe the wound tissue (necrotic, slough tissue; devitalized subcutaneous tissue; devitalized deep fibrous tissue; is there a surrounding hyperkeratotic rim?, etc.)
- You need to describe the wound base as well (is it moist?,is it dry?)
- You need to mention if there is any active drainage, purulence, frank pus or malodor
- You need to mention if there is any undermining, sinus tracts or tunneling
- You need to mention if there are any palpable crepitations or fluctuations
- You need to mention if the wound probes deeply to bone
- Is there any periwound erythema or periwound maceration?
- Is there cellulitis noted surrounding the wound? **If there is, you must note what level it extends to and place In the note that thepro1tlmalmargins of the cellulitis were traced, dated and timed.**

E.g : A 5.5 cm x 3.2 cm x 0.4 cm Wagner Grade 2 ulceration is noted sub-1st metatarsal head right foot. This measurement was taken both pre- and post-excisional debridement. The wound is nontender secondary to neuropathy. There is necrotic, slough tissue and some devitalized subcutaneous tissue interspersed throughout a mild, red, granular wound bed. The wound base is moist in its appearance. A moderate amount of clear, serous drainage is noted from the wound. There is no purulence, frank pus or malodor. There are no palpable crepitations or fluctuations. There is no undermining, sinus tracts or tunneling. The wound does not probe deeply to bone. There is slight periwound erythema. There is mild periwound maceration. No cellulitis is noted to the right lower extremity. No other open skin sores are noted to either of the lower extremities.

Diabetic Ulceration Treatment Plan: (Do not use Betadine as wound dressings)

For a Wagner Grade 1 ulceration: Utilizing topical lidocaine anesthesia, I sharply, selectively, actively, surgically, excisionally debrided the necrotic, slough tissue from the Wagner Grade 1 ulceration on the plantar aspect of the right forefoot with a #10/#15 blade. (Mild, Minima/, Some, Good, Adequate, No) bleeding was noted. Hemostasis was achieved with manual compression. I cleansed the wound with (saline, chlorhexidine). Then, you must list what wound care product you applied to the wound and you must cover the foot with a bulky dry dressing.

IMPORTANT: If the patient has neuropathy, you do not have to use topical lidocaine anesthesia prior to doing an excisional wound debridement. In the note, you must include in the treatment plan for the

excisional debridement that no topical anesthesia was used due to a documented history of neuropathy.

Please also note that you must list in the treatment plan as well, what wound care product you are ordering for the patient to be applied daily to the wound. You will also need to order **PRADO's** to properly offload the wound. If the patient is a diabetic, make sure you order an **HbA1c** if one has not been ordered. If the patient has a wound, make sure you order prealbumin and transferrin labs as well as a **dietary consult**. For the dietary consult, please list the reason why you are ordering it- ***nutritional supplementation to aid/enhance wound healing. Request Juven as well.*** If the patient is older and cannot move on his or her own, please make sure you also order turning instructions. The reason that should be listed for turning instructions should say: **Turn the patient every 2 hours when lying in bed to offload and protect multiple bony prominent regions from skin breakdown/from further skin** breakdown.

If ordering a wound care consult for a wound VAC, make sure the wound VAC orders are as follows: Please apply the wound VAC (to the appropriate location of the wound) every Monday-Wednesday-Friday. It should be set at 125 mmHg on a continuous setting.

Venous Ulcerations: Venous ulcerations are described as full-thickness and deep full-thickness to subcutaneous tissue or deep devitalized fibrous tissue. Please follow the same characteristics that need to be described as above in the Diabetic Ulceration section. You need to add these further characteristics to describe a venous ulceration.

- Wound Margins- for all venous ulcerations, wound margins are **irregular**
- You also need to mention that there is hyperpigmentation to the lower extremity/lower extremities
- In the vascular section of the objective findings, when you describe edema in a patient with a venous ulceration, you need to mention that there is brawny +1pitting edema, brawny +2 pitting edema, etc.

Venous Ulceration Treatment Plan:
For a Full-Thickness Venous Ulceration: Utilizing topical lidocaine anesthesia, I sharply, selectively, actively, surgically, excisionally debrided the necrotic, slough tissue from the full-thickness venous ulceration on the lateral aspect of the right leg with a #10 blade. (Mild, Minimal, Some, Good, Adequate, No) bleeding was noted. Hemostasis was achieved with manual compression. I cleansed the wound with (saline, chlorhexidine). Then, you must list what wound care product you applied to the wound and that you covered the lower extremity with: an Unna boot compression dressing or a multilayered compression dressing system. If it is both lower extremities, you must document Unna boot compression dressings or multi layer compression dressing systems.

IMPORTANT: You need to list at all times for the Dermatological, Vascular, Neurological and Musculoskeletal examinations If you are examining the right lower extremity ,the left lower extremity or both lower extremities.
Assessment: When dictating the assessment, make sure the 1st few diagnoses are relevant to the patient's condition. If the patient is diabetic and has peripheral arterial disease, these should be the 1st 2 diagnoses. The next few diagnoses should be what you are treating i.e., a Wagner ulceration, a venous ulceration, tinea pedis, onychomycosis, etc.

E.g.: Type 2 diabetes mellitus with no neurological or vascular
manifestations Type 2 diabetes mellitus with vascular manifestations
Type 2 diabetes mellitus with vascular manifestations and neurological manifestations
Type 2 diabetes mellitus with renal manifestations
Polyneuropathy secondary to diabetes Diabetic peripheral neuropathy
Venous insufficiency, etc.

Plan: The 1st sentence of every treatment plan should say: "Patient was seen and evaluated at bedside today." Then, the plan should include your treatment course that was performed at the visit and recommendations. Make sure you are not cutting and pasting the previous treatment plan if you're doing a progress note from a previous visit and using it in its entirety. Many times, we make changes to the treatment plan.

Always end the Plan with the following sentence:

"Patient was seen with Dr who is In agreement with the above assessment and plan."

If there are any questions or concerns regarding proper documentation, please feel free to call me on my cell phone for clarification or contact the attending for whom you are doing the consultation for.

Louis J. Geller,DPM
Cell:248-89o-&828

For a Deep Full Thickness Venous Ulceration: Utilizing topical lidocaine anesthesia, I sharply excisionally debrided the necrotic, slough tissue, the devitalized deep fibrous tissue and/or the devitalized subcutaneous tissue from the deep full thickness venous ulceration on the lateral aspect of the right leg with a #10 blade. (Mild, Minimal, Some, Good, Adequate, No) bleeding was noted. Hemostasis was achieved with manual compression. I cleansed the wound with (saline, chlorhexidine). Then, you must list what wound care product you applied to the wound and that you covered the lower extremity with: an Unna boot compression dressing or a multilayered compression dressing system. If it is both lower extremities, you must document Unna boot compression dressings or multi layer compression dressing systems.

Venous ulceration dressing changes should be performed on Mondays and Thursdays, Tuesdays and Fridays, Wednesdays and Saturdays.

Vascular Exam: Palpable/Faintly palpable/Nan-palpable DP/PT pulses. Describe CFT as: CFT < 3 seconds, < 5 seconds, CFT is delayed: to digits 1-5 of the right foot, 1-5 of the left foot or to all digits on each foot. Is there edema? If there is, you need to describe it as non pitting, +1pitting, +2 pitting, +3 pitting, brawny +1pitting, brawny +2 pitting, brawny +3 pitting, etc. Is there calf tenderness, lymphangitis, lymphadenopathy? This all needs to be listed as well.

Neurological Exam: The patient exhibits grossly intact sensation, diminished sensation or absent sensation to sharp/dull, light touch and proprioception to the left foot, to the right foot, to both feet. If the patient has had a stroke, he or she may be hypersensitive. If the patient is a diabetic, you need to also note if the patient has intact sensation, diminished sensation or absent sensation via the S-W 5.07 monofilament and you must list the location where the sensation is intact, diminished or absent. Please also list if you've checked the Achilles and patellar deep tendon reflexes. Also, if you've checked for a Tinel's sign or a Babinski test, you need to list this as well.

E.g.: The patient exhibits absent protective sensation via the S-W5.0 7 monofilament distal to the plantar midfoot bilaterally. **Remember, diabetic neuropathy Is always symmetrical.**

Musculoskeletal Exam: The 1st thing to list is muscle strength. Next you list if there are any musculoskeletal foot deformities (i.e., HAV deformities, bunion deformities, hallux limitus, hallux rigidus, contracted digits, hammertoe deformities, claw toe deformities, mallet toe deformities, tailor bunions, osseous hypertrophy to the dorsal aspect of the midfoot, osseous hypertrophy to the posterior aspect of the calcaneus, osseous hypertrophy to the plantar aspect of the hallux IPJ, osseous hypertrophy to the medial aspect of the hallux IPJ, etc.). You can also document if they have adequate range of motion, diminished/decreased range of motion or no range of motion to particular joints that you check. If the patient is a diabetic and has a forefoot or midfoot wound, they most likely have an equinus deformity. You need to list this as well. Please do not dictate in your note that there are no musculoskeletal foot deformities noted.

Performance Improvement Process (PIP)

If your Clinical Competency Committee (CCC) reports that a trainee is not performing to their expected level and improvements need to be made, the Program Director (PD) must give the trainee an in-person consultation. The steps are as follows:

- Complete a Consultation Form, signed by the program director.
- Keep the consultation form internally and have the Program Coordinator (PC) upload it into New Innovations under Files and Notes in the confidential section.
- This is not reportable to the GME office unless the resident is put on an official Performance Improvement Plan (PIP).

Should the performance consultation not be resolved by the due date and need to move to an official Performance Improvement Plan, (PIP) follow these steps:

- Complete a Performance Improvement (PIP) form, signed by the program director and the trainee, with a copy given to the trainee, and sent to the Director of Medical Education/DIO (DME/DIO) within five days, along with the original consultation form.

If the PIP has been resolved, follow this step:

- Complete a Resolution Letter signed by the program director, the trainee, and the DME/DIO. Copies are to be given to the trainee and the DME/DIO. This letter will indicate that the PIP has been successfully completed.

If the PIP was not successfully completed, one of the following must be indicated on the PIP Resolution Letter:

- Re-Implementation of the Performance Improvement Plan
- The trainee will be placed on Probation
- The trainee will be terminated if there are unresolved or egregious issues.

If the PIP leads to Probation this procedure must be followed:

- The Program Director will consult with the CCC and the DME/DIO separately to discuss placing a trainee on probation.
- The DME/DIO may involve Human Resources and the Legal Department during the initiation of probation.
- Complete a Probation Form signed by the program director, the trainee, and the DME/DIO.
- Give copies of the Probation Form outlining the Performance Improvement Plan and the GME policies on Performance Improvement, Due Process, and Grievance Procedures to the trainee being placed on probation. They are entitled to Due Process if they want to contest Probation. A copy is also to be given to the DME/DIO.
- Probation is reportable as official remediation in all future verifications for the trainee.

If the Probation has been resolved by the end date on the form, follow this step:

- Complete a Probation Resolution Letter signed by the program director, the trainee, and the DME/DIO. Copies are to be given to the trainee and the DME/DIO. This letter will indicate that the Probation has been successfully completed.

If the Probation was not successfully completed, one of the following must be indicated on the Probation Resolution Letter:

- Re-implementation of probationary status
- Termination, if there are unresolved or egregious issues.

Should the result of Probation end in Termination or Non-Renewal, follow these steps:

- Complete a Termination or Non-Renewal Letter, filled out and signed by the program director and the DIO, and given to the trainee and the DME/DIO.
- Document all dates of the remediation process.

Tips:
All forms must be documented.
All steps must be dated and signed by the individuals indicated in each form.
Problem Issues: be specific as it pertains to the competency, but not too detailed.
Fulfillment Criteria: Make sure you use a SMART format.
Expected completion date should be no more than 3 months and use a specific date (i.e. start 1/1/2023 completion 4/1/2023).
Notes: Should be included if there is additional information that adds value and further clarification as to any consequence to the trainee.

Resident Academic Performance Policy

Henry Ford Providence Hospital (APH) Medical Education
Resident Academic Performance Policy

I. Purpose

This policy establishes procedures covering informal and formal discipline. It covers several distinct levels of discipline and a subsequent right of the house officer to initiate the Appeal Procedures outlined below. This policy and the procedures provided herein comprise the exclusive remedies available to House Staff who are appealing discipline, including formal discipline or nonrenewal of appointment or whose contract of appointment is modified or terminated.

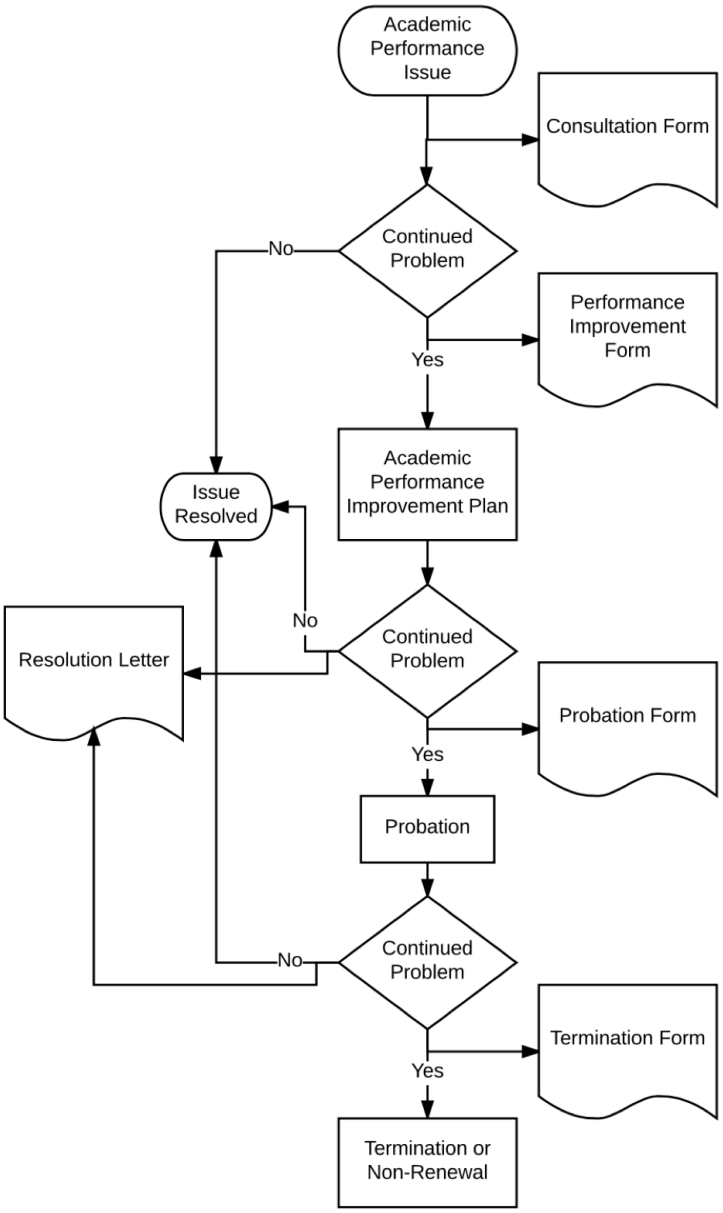
This policy does not and is not intended to constitute an employment contract or alter any house officer agreement, nor is it intended to create for House Staff any legally enforceable contractual right.

II. Policy Statement

Following the receipt of reliable information that the house officer's clinical judgment or proficiency in clinical skills, medical knowledge, or patient care necessary to the practice of medicine is deficient or impaired, or the house officer is deficient in any of the six Accreditation Council for Graduate Medical Education (ACGME) core competencies (patient care, medical knowledge, practice based learning and improvement, systems based practice, professionalism, and interpersonal and communication skills) or in the case of misconduct, policy violation, neglect of duty, violation of the house officer contract, failure to maintain a valid license to practice medicine, threat to patient safety, or any other malfeasance, misfeasance, or misconduct the following disciplinary procedures shall be implemented until the deficiency is corrected or the house officer is terminated from the program. Please note, there are two distinct pathways by which these issues shall be pursued. These problems are divided into Academic and Non-Academic problems with pathways for each type of issue.

III. Academic Flowsheet

On the next page is a generalized outline of the process when an academic performance issue occurs, including documentation requirements. Following this is a detailed description of each step in the process.


Academic Performance Issue
Consultation Form
Continued Problem
No
Performance Improvement Form
Yes
Academic Performance Improvement Plan
Issue Resolved
No
Continued Problem
Resolution Letter
Probation Form
Yes
Probation
Continued Problem
No
Termination Form
Yes
Termination or Non-Renewal

IV. Level I-Consultation-Non-reportable

a. If a department chair, program director, the Graduate Medical Education Committee, (GMEC) or the director of GME deems a house officer's performance or conduct to be deficient and the ordinary elements of the educational program or evaluations appear to be unavailing, the program director should informally counsel a resident, utilizing the Consultation Form.

b. This consultation should include a description of the issues that have occurred. The resident should be made aware of what the expected standard of performance should be with a clear plan to address the issues. This plan should include a goal date for achievement of the improvement goals.

c. At the conclusion of the consultation, the resident and director will both sign the form. This will be kept in the resident's personnel file in New Innovations. If the resident achieves the expected performance standards by the goal date, no further action is required. The documentation will be stored in the event of similar problems in the future.

d. Consultation is distinct from the categories of formal discipline set forth below, and accordingly, should not be cited as disciplinary in the event a reference, credentialing, or training verification is requested.

V. Level II – Performance Improvement Plan – Not Reportable

a. If performance fails to improve after a Consultation, the Program Director may elect to initiate a Performance Improvement Plan. The purpose of an Performance Improvement Plan is to clearly define Academic Performance issues and create a specific plan to address those deficiencies.

b. An Academic Improvement Plan will be documented on a Performance Improvement Form. This form will document the Plan and be signed by the Program Director and the Resident. The plan will clearly delineate the problem and the expected standard of performance using specific language and goals (e.g. SMART). There will be clear goals to document fulfillment of expected performance with a specific completion date.

c. After the Performance Improvement Form is signed, it will be scanned into the resident's personnel file in New Innovations. A copy will be given to the resident and another MUST be forwarded to the Director of Medical Education (within 5 days). If training to be extended the GME specialist must be notified so a training record will be adjusted in New Innovations.

d. Upon the successful completion of the criteria set forth in the Plan by the completion date, the Program Director will complete a Performance Resolution Letter. A copy of this letter will be scanned into the residents New Innovations personnel file, one sent to the resident and a final MUST be forwarded to the Director of Medical Education (within 5 days).

e. Academic Improvement Plans are distinct from the categories of formal discipline set forth below, and accordingly, should not be cited as disciplinary in the event a reference, credentialing or training verification is requested.

VI. Level III – Probation – Reportable

a. If the informal measures of Consultation and Performance Improvement Plan fail to resolve the performance issues, the resident may be placed on Probation. Probation is a formal disciplinary action that should serve as notice to the resident that failure to achieve expectations may result in dismissal from the program.

b. For a resident to be placed on probationary status, the Program Director must complete the Probation Form and submit it to the Director of Medical Education (within 5 days). It is preferred that the terms of the Probation be defined by the Program Director in consultation with the Clinical Competency Committee and the Director of Medical Education. The areas of deficiency and expected standard with its fulfillment criteria must be clearly defined on the Probation Form using specific language and goals (e.g. SMART). In addition, there needs to be a specific completion date.

c. The Program Director will meet with the resident and present the terms of the Probation. They shall both sign the Probation form. The Director of Medical Education will also sign the form. Copies will be given to the resident, Director of Medical Education and scanned into the resident's New Innovations personnel file (within 5 days).

d. Since this represents a reportable event, the resident must be given a copy of the appeals policy within 14 days of the initiation of Probation. The resident has a right to appeal under the Appeals/Grievance policy. In the event that a resident is placed on Probation, the 120-day notification of termination will be waived until the completion of the Probationary period.

e. At the end of the Probationary period, the Program Director, in consultation with the Clinical Competency Committee and Director of Medical Education, will determine if the performance has sufficiently improved. If so, the Program Director will complete a Probation Resolution Letter. This will be signed by the Program Director and Director of Medical Education. Copies will be sent to the Director of Medical Education and the resident, and a copy will be scanned into the resident's New Innovations Personnel file (within 30 days).

f. If the resident has not achieved sufficient improvement, the Program Director, in consultation with the Clinical Competency Committee, will make a recommendation to the Director of Medical Education for either continued Probation or dismissal (within 30 days). Another Probation Form must be completed for additional Probation as defined above. Dismissal may either be immediate or non-renewal of contract for the subsequent year of training. The Director of Medical Education will make the final determination.

g. Probation is formal discipline. It should be cited as disciplinary in the event a reference, credentialing or training verification is requested.

Approved by GMEC 6/23/16
Revised: 5/23/2019
Revised and approved:8/10/2020

Trainee Appeal Policy

Ascension Providence Hospital (APH) Medical Education
Trainee Appeal Policy

I. **Purpose**

To establish a policy for the Ascension Providence Hospital (APH) Graduate Medical Education Department to use for the trainee appeal process.

II. **Scope**

This policy will apply to the Ascension Providence Hospital (APH) Graduate Medical Education Department. All information contained in this policy shall be used as complete criteria for appeal.

III. **Definitions**

Trainee - refers to all interns, residents, fellows, and scholars enrolled in an Ascension Providence Hospital (APH) post-graduate training program.

IV. **Procedure**

A. Trainees may request an appeal in circumstances where the Trainee has a pending action placing them on academic probation, suspension, non-renewal, non-promotion or dismissal.

B. The Trainee has a right to request an Appeal, but this request must be in writing and received by the Department of Medical Education within five (5) working days after being notified of the pending action.

C. Primary Appeal: Program Director and Clinical Competence Committee

1. Within five (5) working days of the Appeal request, the Trainee shall meet with the program's Clinical Competence Committee and Program Director to reconsider the action.

2. The purpose of this meeting is for all parties to review the pending action and give the Trainee the ability to directly address identified concerns.

3. At the conclusion of the meeting, the Clinical Competence Committee will make a recommendation to the Program Director that; 1) affirms or rejects the factual basis of the concerns and 2) upholds or revokes the action.

4. The Program Director will then make a final decision to uphold or revoke the action and will notify the Trainee and the Chair of the Graduate Medical Education Committee within one (1) working day.

D. Secondary Appeal: Graduate Education Appeal Committee

1. If the Primary Appeal upholds the pending action, the Trainee has the right to request a Secondary Appeal. This request must be in writing and received by the Department of Medical Education within five (5) working days of being notified of the Primary Appeal decision.

2. The scope of the Secondary Appeal will be limited to confirm or deny that the Program followed the Institutional Policies related to the proposed action, including those listed above in this policy.

3. The Chair of the Graduate Medical Education Committee shall, within ten (10) working days, appoint a Secondary Appeal Committee composed of three members: The DIO or designee, the CMO or designee, and a Program Director from a different specialty than the Trainee.

4. The Secondary Appeal Committee shall meet and hear the Trainee's Appeal within ten (10) working days after the committee is appointed.

5. The Trainee's Program Director shall present the Department's position regarding the adverse action, including all supporting documentation. The Trainee shall present his or her position. Neither the Program Director nor the Trainee shall be represented by legal counsel at the hearing.

6. Following the hearing, the Committee has five (5) working days to affirm or reject the action. The decision of the committee must be a majority decision, or the action is rejected. The decision will be communicated in writing to the Trainee, Chair of the Graduate Medical Education Committee and the Trainee's Program Director.

7. If a trainee is dismissed from their program prior to completing their full training, a letter will be given to the Trainee upon their leaving, stating that they served a specific amount of time in the program.

Approved GMEC: 2/26/03, 3/27/14, 1/27/2022

Coaching Feedback

Commented [4]: I am not sure where this form came from as it is not in our policies

Success for an Associate requires a wide-range of social skills and behaviors to build collaborative and effective relationships with our fellow associates and the community that we serve. Effective communication practices and personal habits are not skills we learn once and quickly master. Rather, these talents and attributes are ones we continue to evaluate and develop throughout our careers to be most successful.

This Coaching Feedback is being provided to ensure we have open lines of communication regarding performance expectations and to further support growth and development in our roles.

Area(s) of focus:

Why changes are important:

Specific skills or behaviors to work on:

Plan for follow-up:

Employee's Name (Print) Employee ID# (Print)

Employee's Signature Date

Supervisor's Signature Date

Counseling Session

Success for an Associate requires a wide-range of social skills and behaviors to build collaborative and effective relationships with our fellow Associates and the community that we serve. Effective communication practices and personal habits are not skills we learn once and quickly master. Rather, these talents and attributes are ones we continue to evaluate and develop throughout our careers tobe most successful.

This Counseling Session is the first step in the formal corrective action process. Please be advised that nothing will be sent to your personnel file, provided the performance area and/or behavior identified as needing improvement is immediately corrected and no further corrective actions occur within one(1) year. If improvement does not occur, further corrective action may be taken and this document willbe transferred to your personnel file.

Area(s) for improvement:

Why changes are important:

Specific skills or behaviors to work on:

Plan for follow-up: Immediate and sustained improvement is required.

Employee's Name (Print) (Print)	**Employee ID#**
Employee's Signature	**Date**
Supervisor's Signature	**Date**

This Counseling Session document must be signed by both parties and a copy given to the Associate and one copy kept in the Associate's departmental file.

Appearance and Image Standards

INTENT

To enhance a culture of Service Excellence and professionalism at Ascension SE Michigan and establish guidelines for appropriate appearance.

DEFINITIONS

Direct Care Provider: All associates in the following or similar departments/units that are responsible for direct patient care, sterilization/disinfection or food preparation: All inpatient units, Emergency Services, Surgical Services, Endoscopy, Food and Nutrition, Sterile Processing, Laboratory, Physical Medicine, Respiratory Care, Cardiopulmonary, Radiation Oncology, Anesthesia, Cardiac Cath, Non Invasive Cardiology, Breast Care Center, IV Therapy, Cancer Center, and Imaging Services. Departments not mentioned should assess risk in their area and develop an appropriate policy.

Individuals – Associates, members of the Medical Staff, Residents, Volunteers, contractors and students

POLICY STATEMENT

1. Ascension SE Michigan attracts people from varied ages, cultures and backgrounds. Customers are more comfortable in an environment that conveys an image of competence and professionalism. Appearance makes that first visual impression to customers and "there is only one chance to make a first impression." That first impression should be a great one. All individuals should "dress to impress."

2. Certain departments, for reasons of hygiene, safety, uniformity, patient care, etc. may have specific requirements for appearance beyond those stated in this policy. In such departments, the departmental policies take precedence over the Appearance and Image Standard Policy.

3. Department management is responsible to communicate and enforce appearance standards. An associate considered by the manager to be in violation of the appearance standards should be counseled and may be required to meet the standard before being permitted to continue work. Violations of this policy or related department policies may result in corrective action up to and including discharge.

4. Clothing and uniforms must be neat, clean, in good repair and appropriately sized. They must also be job appropriate, which is determined by each individual department.

5. For the comfort of patients and associates, Ascension SE Michigan strives to be a fragrance free environment.

6. Individuals required to leave their work site to change to appropriate, acceptable attire may have their pay docked.

UNIFORMED ASSOCIATES

1. Ascension SE Michigan has implemented a standardized dress code for hospital based direct inpatient care departments:

RNs: Navy blue (tops & pants) or white scrubs (top & pants); solid navy, white or professional print smocks with predominant colors of navy/white (NO characters except in pediatrics); white or navy turtleneck may be worn under the scrub top.

PCTs/Nurse Assistants/Nurse Techs/Nurse Externs/Assistive Personnel: Burgundy scrubs (top & pants); solid burgundy or professional print smocks with predominant color of burgundy. (NO characters except pediatrics).

Licensed Practical Nurse (LPN): Olive Green scrubs (top and pants)

Health Unit Coordinators (HUCs): Business casual with khaki jacket and pants or khaki scrub jacket and pants or multi-color jacket with predominant color of khaki. Any coordinating solid color top may be worn. Associates working in sterile areas (Labor and Delivery, OR) will continue to wear hospital-acquired scrubs.

2. Ascension SE Michigan encourages standardized uniform colors by job classification. However, classifications other than those listed above should not select the standardized uniform colors already established.

3. Hospital issued Surgical Scrubs are Ascension SE Michigan property and must not be removed from or worn when leaving at the end of the shift.

CASUAL DAYS

1. Operating Units/Management may approve "casual days" in their departments, if appropriate. This is more commonly acceptable in a business office environment than in a patient care area. Casual day apparel must be consistent with the provisions of this policy.

EXPECTATIONS RELATED TO RELIGIOUS OBSERVANCE

No part of this policy is intended to hinder diversity in Ascension SE Michigan. Flexibility will be shown in relation to religious or ethnic apparel. If an individual makes an appearance related request in conflict with Ascension SE Michigan and/or department appearance policy(s) based on religion, she/he must provide documentation of the religious requirement to management. Requests are subject to review and approval of the department management and Human Resources. **Item**	**Appearance Standard**	**Unacceptable**
Identification Badge	• Identification badges must be worn above the waist and clearly visible while at work. The badge may be attached to clothing or hung on a chain or lanyard of appropriate length. • Approved cards which may be attached behind the ID Badge include Service Excellence, Emergency Codes, Security Access Cards and any other authorized attachments. • Pins related to recognition awards, professional affiliations and other service excellence related items are permitted but should not be attached to ID badge. Pins maybe worn on clothing and an approved attachment card identified above.	• Attaching a badge to a belt or below-waist pocket. Stickers or other attachments • Anything which obscures identifying information. • Anything that impairs the usage of magnetic strip or Security Access Card.
Personal/Oral Hygiene	• Personal and oral hygiene must be maintained.	• Odors or fragrances including body, breath, perfumes,

	• Individuals should be fragrance free.	cologne, scented hair products, lotions and tobacco smoke. • Extreme make-up.
Hair	• Hair must be neat and clean. • Hair must be confined to not interfere with customer service. This includes beards, mustaches, and sideburns.	• Extreme styles/Hair color, i.e., blue, orange, pink.
Fingernails	• Fingernails must be clean, trimmed and not to exceed ¼ inch and must not distract or interfere with work performance. Nail color and style must be consistent with a professional environment. • Direct care providers, nail polish permissible but intact, no chips, decals or jewelry.	• Direct care providers must not wear anything on top of the nails other than nail polish. This would include all artificial fingernails, wraps, extenders, gels, acrylics, or any similar coating or nail appliqués.
Jewelry/Body Piercing/Tattoos	• Jewelry is acceptable in moderation and must not pose a hazard or interfere in work performance	• Body piercing with visible jewelry, excluding ears. • More than 2 earrings per ear. • Visible tattoos may be offensive to patients/visitors and therefore need to be covered by clothing, bandage or make up.
Undergarments	• Appropriate undergarments must be worn at all times.	• Must not be visible. • Patterned/colored undergarments visible through light-colored uniforms.
Footwear	• Footwear must be worn at all times. • Footwear must be neat, clean, in good repair and job appropriate, as determined by individual departments.	• Open toe shoes in clinical/patient care settings. • Extreme Footwear, i.e. Flip flops, military combat boots

Vacation and Conference Request Form and Policy

Vacation Policy

Residents are eligible for three weeks vacation with pay. This will be assigned as 15 working days of PTO (paid time off). Vacations may be taken according to individual program policies with the prior approval of your Program Director. All PTO must be recorded in New Innovations as M-F at 8 hours per day. DO NOT record weekends as vacation.

Residents must complete a Resident Vacation/Conference Request form prior to taking any time off and is up to the discretion of the Chief Resident and Program Director.

Fellowship Interviewing Policy

Each resident will be allowed a maximum of 5 days for fellowship interviews in the 3rd year of residency. If more than 5 days are needed, it should be discussed with and approved by the Program Director in advance and will come out of the resident's vacation bank.

Conference Funding Form

All academic travel (conferences, meetings) must have funding approved. Residents return a completed Pre-Application for Research Travel Funding form and wait for approval by the Program Director/Program Coordinator. Estimate all costs and include on form, including $50/day for food during the trip.

Ascension
Providence Hospital
Department of Podiatry

RESIDENT VACATION/CONFERENCE REQUEST FORM

RESIDENT NAME: _____

DATES(S) REQUESTING OFF: _____

TOTAL AMOUNT OF DAYS: _____

ROTATION DURING TIME OFF REQUEST:

REASON FOR REQUEST (CHECK ONE) ___CONFERENCE
___VACATION
___NO CALL

(If conference, registration information must be provided upon registering)
Any other information regarding time needed please write on the back of the form. If you have a request for dates that you would like to be on call, please right on the back of the form also.

TODAYS DATE: _____

APPROVED: ___YES	___NO	_____ Chief Resident Signature
APPROVED: ___YES	___NO	_____ Program Director Signature
APPROVED: ___YES	___NO	_____ Resident Coordinator Signature

House Staff Leave Policy

I. Purpose

The purpose of this policy is to establish the parameters of all possible types of leave for house staff.

II. Scope

This policy will apply to the Ascension Providence Hospital (APH) Medical Education Department. All information contained in this policy shall be used as complete criteria for leave requirements.

III. Definitions

House Staff - refers to all interns, residents and fellows enrolled in an APH post-graduate training program.

IV. Policy

A. All Leaves of Absence

a. House Staff must notify their program office regarding absence for any reason. Illness causing absences for three days or more requires a physician's note or clearance from Ascension Occupational Health Services to return to work.

b. It is the resident/fellow's responsibility to work with their program director to notify the preceptor of any rotation affected by the absence. Any make-up required should be arranged between the resident and their program director.

B. Vacation Leave

a. House Staff are eligible for three weeks' paid time off or leave. This will be assigned as 15 working days of paid time off. Vacations may be taken according to individual program policies with the prior approval of your Program Director. **DO NOT record weekends as vacation**.

b. Specific vacation scheduling is discretionary, and requests for vacation must be approved in writing by the program director of the department to which resident/fellow is assigned. Requests, which will be reviewed in the context of the teaching requirements of the affected department and anticipated staffing shortages, may be denied. No vacations or absences for attendance at medical meetings will be allowed between June 15th and July 31st without the Program Director's approval because of changes in personnel which occur during that period.

c. Requests for vacation should be submitted to comply with program-specific vacation policies.

d. Vacation time not used during the contract period will be forfeited. No payment in lieu of actual time off will be made.

C. Extended Leave and Effect of Leave on Program Completion

a. An extended leave of absence might delay graduation from a program.The amount of additional time of training to meet requirements for graduation will be determined by the clinical competency committee, and the program director, based on fulfillment of requirements of the appropriate accrediting body and the appropriate certifying Board.

b. If a resident physician requests the opportunity for extended leave, he/she shall so advise the (CCC). The Program Director's recommendation shall include an individualized learning plan, and the resident physician's Program Director as early as possible. The Program Director shall then make a

recommendation on make-up to the department's Clinical Competency Committee that will be developed in consultation with the resident physician and approved by the CCC.

D. Bereavement Leave Policy

a. Bereavement Leave is intended to allow associates paid time off from scheduled work to attend to needs that may arise as a result of the death of a family member.

b. All house staff are eligible to receive three (3) working days off with pay per occurrence for the death of an immediate family member.

c. Immediate family members include only the following: Mother/Father, Spouse, Child, Sister/Brother, Grandparent, Grandchild, Stepmother/Father, Mother/Father-in-law, Stepchild, Sister/Brother-in-law, Daughter/Son-in-law and Stepbrother/Sister.

d. Ascension Providence Hospital reserves the right to ask house officers to provide proof of the relationship.

E. Jury Duty

a. A resident/fellow who is summoned for jury duty must provide notice to her/his program director as soon as possible.

b. The resident/fellow must keep her/his program director apprised of jury service obligations as information becomes available, including breaks in obligations. Residents/fellows released from work to provide jury service are expected to do so in good faith and are expected to minimize time lost from work while serving.

c. In the case of extended jury duty service, the Program will determine the need, if any, for make-up time.

F. Parental, Caregiver, and Medical Leave During Training

1. House Staff in training programs of two (2) or more years in duration are eligible for up to a **maximum of six (6) weeks' paid** time off **only once during each training program**, without exhausting all other allowed time away from training, for purposes of parental, caregiver and medical leave, and without extending training.

a. Leave can be taken as one time in one training year or be divided between years of training as needed over the course of a training program, (without exceeding 6 cumulative weeks total) after approval from the program and clinical competency committee.

b. For parental leaves, the first day is to be the day of birth or adoption, unless otherwise specified by a doctor's note.

c. The Program Director and clinical competency committee may limit the maximum amount of time away from training a house staff may take in any single year or level of training.

d. House staff will receive full pay and benefits during this approved leave of absence.

e. Leave includes personal or familial needs, including the birth and care of a newborn, adopted, or foster child ("parental leave"); care of an immediate family member (child, spouse or parent) with a serious health condition ("caregiver leave"); or the trainee's own serious health condition ("medical leave").

f. The Clinical Competency Committee and Program Director of the home program will assess how individual trainees' clinical experiences and educational objectives will be met, or to attest that competency has been achieved without an extension of training.

g. The program director, in consultation with the clinical competency committee, will determine the need for extending the training of the resident/fellow if it is determined that they did not meet the criteria of graduation due to this additional leave of absence.

h. Failure to provide adequate documentation to the program and/or GME administration as requested can result in the use of personal time off and/or the placement on non-paid leave.

i. For any additional time to the first six-week leave of absence, or for any subsequent leaves of absence, the following applies:

.All leaves of absence require advance notice to the program director and the GME administrative office whenever possible.

i.A formal leave of absence request must be filed by the house staff through the Ascension Portal per the Ascension leave policy. The first day absent is to be the day after the initial six weeks off. The percentage of pay that you will receive while on leave is dependent on your benefits package selection.

ii.It is the resident/fellow's responsibility to work with their program director to notify the preceptor of any rotation affected by the absence. Any make-up required should be arranged between the resident and their program director.

0. House Staff in training programs of less than two (2) or more years' duration, the following applies:

a. All leaves of absence require advance notice to the program director and the GME administrative office whenever possible.

b. A formal leave of absence request must be filed by the house staff through the Ascension Portal per the Ascension leave policy.

c. Vacation time will be exhausted, and additional time will be unpaid, per Ascension policy.

Ascension Providence Hospital (APH) Medical Education

Leave of Absence Procedure

A. Resident/fellow is to use the Leave of Absence Request form to notify the Program Director of the need to take a leave which includes the day it starts and how much time is being requested.
   a. The Program Director will approve and coordinate coverage if applicable.
   b. The Program Director along with the Program Coordinator must ensure that the Leave of Absence Request form is submitted to the Medical Education Manager.

B. Resident/Fellow contacts Sedgwick to start Leave Claim.
a. MyAscension > MyHR > Left hand side, File a Leave Claim
b. Work with Sedgwick on the claim by submitting requested documentation.

C. The Program Coordinator will add a rotation to the New Innovations block schedule using MEDED:LOA-ABMS PAID for the amount of time being requested, up to the initial six weeks. For any additional time the coordinator will use MEDED:LOA-Extended.

D. Resident/fellow contacts Associate Health at 248.849.3195 to make an appointment to be cleared to return to work.
This appointment must be at least 2 business days prior to returning to work.

E. If a resident/fellow takes more than the allowed six weeks, Medical Education Administration along with Program leadership will determine the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s).

Leave of Absence Request Form

Resident Name: _____

Program: _____

I hereby request a leave of absence effective_____(first day of absence) and anticipate returning

on_____.

If the request is longer than allowed six weeks:

☐ I will use vacation time

☐ I will file a medical leave request through the Ascension Portal (MyHR) that begins the day after my initial six weeks ends.

_____

Resident Signature Date

Program Director Authorization

☐ Approved as requested

☐ Approved with the following modifications:

☐ Permission withheld

_____

Program Director Signature Date

☐ Submitted to GME Administration

_____

GME Manager Signature Date

Podiatric Foot and Ankle Surgery Residency House Rules

Surgery

- Resident should contact attending to discuss case 1-2 days before elective surgery
- Prepare for case via reading, ACFAS surgery videos must be watched and studied prior to given case
- Dr. Nwosu requires minimum of 2 articles per case sent in advance preferably several days prior
- Residents arrive at least 30-45 minutes prior to scheduled surgery
- H&P can be performed by students but ultimately resident responsibility and must be checked
- Prepare the Room including having gloves, local and any instrumentation needed ready for the case
- Obtain XR prior to case if possible; have them on wall or large screen/ computer
- Inpatient surgery should be dictated ASAP, complete operative progress note in ECARE
- Outpatient surgeries must be dictated within 24 hours of the case
- Must notify chief resident of any cases boarded immediately
- Google drive surgery schedule must be checked every night prior to sleeping and early in am for changes
- Communicate if there are changes to surgery schedule or any issue directly with chief resident
- Help each other with cases, 3rd year teaches 2nd years who will teach 1st years and should give tips and pearls
- **EVERY CASE SHOULD BE PRESENTED IN RADIOLOGY GRAND ROUNDS**

On Call

- The on-call resident is responsible for seeing all progress and consults patients on the floor, as well as cover any on-call or floor cases. The on-call must start early to pre-round/prepare all patients for attending AM rounds which will be 0630 daily unless otherwise told by the rounding Attending. It is the on-call person's responsibility to find out what time Attending round will take place
- HELP EACH OTHER! When you help your co-residents on the floor, you will appreciate it when they help you back!
- Consults in the ER must be seen ASAP within 20-30 min. You should discuss the case with a senior resident prior to signing out the case with the attending until you are comfortable doing so
- **DO NOT CALL** attending without all HPI, Medical History, Physical exam and objective findings if available such as vitals, labs, cultures, pathology, imaging studies
- No procedures are to be performed without discussion with attending or senior resident if attending not available /no response
- Consults that come in after 6 PM may be seen next day EARLY/ FIRST thing in AM ONLY IF OK WITH ATTENDING
- If patient is known to an attending, that attending must be consults unless otherwise instructed by that particular attending
- When performing new consults, ALWAYS look back 10 years to read about the history of the patient and have an idea of who has been treating the patient, previous surgeries,

vascular and general medical status, prior surgeries by Podiatry/Vascular teams.

- When communicating with ER physicians, PA, primary admitting doctors, Infectious disease physician, vascular residents/ PA: make sure to communicate effectively and have as much of a plan from Podiatry attending/senior resident as possible
- Once a patient is seen, an assessment and plan should be immediately formulated and must include weight bearing status, Antibiotic status… if no definitive plan has been decided or have not been able to reach attending on the case write further Podiatry recs to follow

FULL CONSULTATION DICTATIONS/NOTES MUST BE COMPLETED WITHIN 12 HOURS

- Any Surgery plans must be discussed with the primary or ER physicians
- Google drive list should be updated daily
- If other resident performs surgery on an admitted patient, google drive list must be updated and on call resident must receive sign out on the procedure plan regarding the patient

Other

- Residents are expected to be present at all academic lectures even if off-service when possible
- Any changes to Surgery schedule/ boarding cases must be discussed immediately with surgery chief
- Any changes in call schedule/ call switches or vacation requests must be discussed immediately with schedule chief
- Any questions/ concerns should be discussed with senior residents
- Residents are responsible for attending ½ day per week clinic- this must be logged into PRR

Deadlines/assignment:

- PRESENT lecture certificates (1 per week) due Friday by 3pm to program coordinator
- 2 Biomechanical forms/evaluations due weekly , logged into PRR , and forms turned into program coordinator by Friday 3pm
- All logging for the week must be completed by Friday 3pm including clinic days

Research assignments and deadlines will be discussed separately

OR Locker Assignments

The podiatry residents are assigned one locker to share in each of the OR Locker rooms.

OR Locker Room	Locker #	Locker Combination
Women's	81	7-17-13
Men's	1	18-42-12

American Podiatric Medical Association, Inc.
Code of Ethics

PREAMBLE

All podiatrists have the responsibility of aspiring to the highest possible standards of conduct and ethical behavior, assuring that the best care is provided for the individuals and groups whom they serve. As members of the American Podiatric Medical Association (APMA), podiatrists accept and take seriously the common values and principles established within this code of ethics. This code applies to all aspects of professional life of podiatrists as they go about the implementation of their work within a variety of contexts as health care providers, administrators, educators, researchers, consultants, and employers.

The following statements and precepts are considered to be dynamic and may be interpreted and applied to an ever changing society.

Podiatrists who are members of the American Podiatric Medical Association (APMA) are bound to abide by the APMA Code of Ethics. APMA expects its members to adhere to the provisions in this document, but the document is not meant to be used in legal proceedings to establish a "Standard of Care."

MEDICAL ETHICS (ME)

ME1.0 Professional Judgment

The podiatrist has an obligation to facilitate patient care, placing the welfare and rights of the patient above all other considerations. The competence of a podiatrist extends beyond technical skills alone. Recognizing the extent of one's ability to perform and knowing when it is appropriate to seek consultation or make referrals is imperative.

ME1.1 National Standards (Representing a Model to be Used by Individual States)

ME1.11 The podiatrist strives to maintain the highest standards of practice in accordance with the responsibilities conferred by the state, profession, and society. *(See interpretive guideline.)*

ME1.12 The podiatrist recognizes their competencies and strives to practice in an environment that is consistent with those competencies.

ME1.13 The podiatrist freely utilizes the expertise of other podiatric physicians and professionals of other disciplines to enhance the welfare of the patient.

ME1.14 The podiatrist maintains continuing competence by participating in professional study and lifelong learning activities designed to ensure that their skills and knowledge are consistent with ongoing developments in the art and science of podiatric medicine and surgery.

ME1.15 The podiatrist has the responsibility to accurately and honestly report compliance with any Continuing Medical Education (CME) requirements for licensure, certification, and credentialing.

ME1.2 Practice Guidelines

ME1.21 The podiatrist strives to provide care consistent with established practice guidelines adopted by recognized podiatric medical organizations that utilize the opinions of authoritative experts. *(See interpretive guideline.)*

ME1.3 Patient Management

ME1.31 Within the responsibility of a podiatrist is the need to evaluate the patient, initiate care decisions, and decide on the best treatment plan. The plan should encompass the entirety of the patient and utilize appropriate consultation or referral. *(See interpretive guideline.)*

ME1.32 The podiatrist is responsible for ensuring appropriate follow-up care for their patient when they are not directly available to render such care. *(See interpretive guideline.)*

ME1.33 The podiatrist should refrain from providing care for any individual with whom he/she has a relationship of a nature that may cause them to provide care with reduced objectivity, interfering with the exercise of sound medical judgment.

ME2.0 Informed Consent

The doctrine of informed consent is premised upon the right of the patient to exercise control over their body by deciding whether or not to undergo a proposed treatment regimen. The duty of the podiatrist is always to disclose relevant information to the patient and obtain the consent of a competent patient or someone legally authorized to give consent on behalf of the patient before initiating treatment. *(See interpretive guideline.)*

ME2.1 What a Patient Needs to Know About the Proposed Treatment

ME2.11 The podiatrist strives to ensure that the patient is cognizant of the nature of the illness or condition, the treatment proposal or its alternatives with reasonable explanations of expected outcomes, potential complications, and length of recovery.

ME2.2 Disclosure of Experience and Outcomes

ME2.21 The podiatrist provides truthful representations of their experience and outcomes.

ME2.3 Economic Interests

ME2.31 The podiatrist strives to ensure that any economic benefit involving services, materials, medications, or facilities shall not interfere with their primary responsibility for the welfare of the patient and shall comply with applicable legal requirements.

ME3.0 Confidentiality

The podiatrist and their staff must maintain strict confidentiality (subject to federal and state laws) as to the condition and treatment of all patients. Release of any information must be premised on the consent of the individual patient, unless otherwise mandated by law. *(See interpretive guideline.)*

ME3.1 Medical Records

ME3.11 The podiatrist acts in a manner that protects the confidentiality of the patient and the records of the patient.

ME3.12 The podiatrist ensures that the staff over which they have responsibility or supervises, have an essential knowledge of the duty to maintain the confidentiality of the patient records.

ME3.13 The podiatrist will take all reasonable means necessary so that confidentiality of patient medical records and conversations are strictly maintained in the use of any on-line, website, or social networking communication medium.

ME3.2 Diagnosis

ME3.21 The podiatrist respects the confidentiality of the patient's diagnosis and does not release the diagnosis without the consent of the patient unless mandated by law.

ME3.3 Treatment

ME3.31 The podiatrist respects the confidentiality of the patient treatment information and does not release the treatment information without the consent of the patient unless mandated by law.

ME4.0 Patient Respect/Advocacy

Respect for the patient and advocating for the welfare of the patient should be the supreme concern of the podiatrist. A podiatrist should acknowledge cultural, individual, and ethnic differences of patients and the podiatrist has an obligation to set aside personal biases that could result in potentially discriminatory practices.

ME4.1 Do No Harm

ME4.11 The podiatrist will evaluate the patient and use appropriate treatments in the care of the patient, taking into consideration any physical, financial, cultural, or emotional limitations that may result in harm during the treatment process. *(See interpretive guideline.)*

ME4.2 Nondiscrimination

ME4.21 The podiatrist shall not discriminate against any patient because of race, religion, ethnicity, gender, sexual orientation, disability, socioeconomic status, or health status.

ME4.3 Harassment

ME4.31 The podiatrist shall not engage in any deliberate act of emotional abuse, physical abuse, sexual abuse, sexual misconduct, or sexual exploitation related to the podiatrist's position as a health care provider, administrator, educator, researcher, consultant, or employer. *(See interpretive guideline.)*

ME4.4 Patient Abandonment

ME4.41 The podiatrist shall not cease to provide care or to be available to provide care without giving the patient sufficient notice and/or the opportunity to seek continuing treatment from another health care practitioner.

ME5.0 Professionalism

The podiatrist should, at all times, act in a professional manner before patients, colleagues, and the general public. This conduct should extend not just to the podiatrist's professional life but should encompass his/her public and private lives as well.

ME5.1 Compassion, Respect, Honesty, and Integrity

ME5.11 The podiatrist has the responsibility to carry out all aspects of their career with compassion, respect, honesty, and integrity.

ME5.2 Accountability in Providing Expert Testimony

ME5.21 The podiatrist providing expert testimony is expected to have relevant experience, training, and knowledge in the area in which the podiatrist has agreed to testify. Testimony must be objective and be limited to the area of expertise held by the podiatrist. Expert testimony should be based upon recognized medical and scientific principles, theories, facts, and standard of care.

ME5.22 The podiatrist serving as an expert witness shall offer testimony that is honest and truthful. A breach of these ethics would exist if a podiatrist knowingly provides false or misleading testimony.

ME5.23 The podiatrist may accept compensation for testimony offered but such compensation should not in any way be related to or based upon the outcome of the litigation.

ME6.0 Physician Health Responsibilities

The podiatrist has the obligation to act upon the recognition of impairment(s) and/or health risks in themselves and in other health care providers and to ensure that the treatment and safety of patients is not compromised because of such impairments and/or health risks.

ME6.1 Physical, Mental, Chemical, or Emotional Impairment

ME6.11 The podiatrist who is physically, mentally, chemically, or emotionally impaired should withdraw from those aspects of practice that could be detrimentally affected by the impairment. If the podiatrist does not withdraw, other podiatrists who know of the impairment have the duty to take action to prevent the impaired podiatrist from harming themselves or others. *(See interpretive guideline.)*

ME6.2 Practice and Blood Borne Pathogens

ME6.12 The podiatrist should exercise in his/her practice all appropriate preventive strategies to preclude the spread of blood borne pathogens.

ME7.0 Research Ethics

Research conducted by podiatrists must be scientifically based with data, results, and outcomes reported in an accurate and truthful manner. Support for research may be obtained from any source but should not influence or bias the outcomes.

ME7.1 Integrity and Concern for Participants

ME7.11 The podiatrist shall maintain the integrity of the study to ensure that decisions by participants and subjects are made in an unbiased and fully informed manner.

ME7.12 The podiatrist shall not subject any patient to an experimental diagnostic modality or treatment method without prior review of the experiment protocol by their peers and with full disclosure to the patient. *(See interpretive guideline.)*

ME7.13 The podiatrist conducts research competently with due concern for the dignity and welfare of the participants.

ME7.2 Reporting

ME7.21 The podiatrist shall report truthfully in scientific and scholarly papers, lectures, accounts, and communications. *(See interpretive guideline.)*

ME7.22 The podiatrist shall avoid all forms of plagiarism, or otherwise taking credit for the work or ideas of others, by properly acknowledging the source.

BUSINESS ETHICS (BE)

BE1.0 Advertising

The podiatrist has the responsibility to properly represent themselves in advertisements and other forms of communications to the public, including, but not limited to, statements about training, ability, board certification, and scope of practice.

BE1.1 Communications with the Public

BE1.11 The podiatrist shall ensure that communications to the public are accurate and do not convey false, untrue, deceptive, or misleading information. The

podiatrist shall provide truthful and accurate representations of his/her credentials, training, experience, or ability. The podiatrist shall not communicate claims of superiority that cannot be substantiated.

BE1.12 The podiatrist, in connection with their name, must use the title(s), degree(s), or designation(s) authorized by state law. The title "doctor" or any abbreviation cannot be used without the qualification "podiatrist," "podiatric physician," or "Doctor of Podiatric Medicine," or other appropriate designation. The podiatrist who is certified by a specialty board may use the appropriate term in connection with their specialty.

BE1.2 Direct Solicitation of Referrals

BE1.21 The podiatrist shall not solicit patients in a manner that impairs their objectivity regarding the selection of diagnostic or therapeutic methods. The podiatrist shall provide realistic expectations as to outcomes, or utilization of diagnostic or therapeutic methods that may be employed in the care of the patient.

BE1.22 The podiatrist shall not offer gifts as an inducement to secure patient patronage. *(See interpretive guideline.)*

BE1.3 Free Foot Screenings

BE1.31 The podiatrist, as an inducement to provide additional services for a fee, may advertise and offer free examinations or free podiatric medical services. The podiatrist shall not, however, charge a fee to any patient or any third party payer for any podiatric medical service provided at the time that such free examination or free podiatric medical services are provided. *(See interpretive guideline.)*

BE2.0 Business Transactions

The podiatrist has the responsibility to maintain high moral, ethical, and legal standards in business transactions. Claims, bills, statements, and records must accurately reflect the services provided. *(See interpretive guideline.)*

BE2.1 Fee Splitting

BE2.11 The podiatrist neither accepts nor offers commissions in any form or manner on fees for professional services, referrals, consultations, pathology services, radiology services, prescriptions, or other services or article supplied to patients. Division of professional fees or acceptance of rebates from fees paid by patients to radiological, pathological, laboratory, shoe stores, or other establishments is inappropriate. *(See interpretive guideline.)*

BE2.2 Medically Unnecessary Procedures

BE2.21 The podiatrist shall perform services of a diagnostic or therapeutic nature that can reasonably be expected to benefit the patient. *(See interpretive guideline.)*

BE2.3 Economic Interest

BE2.31 The podiatrist shall not promote the sale of drugs, devices, appliances or goods to a patient, which are offered in such a manner as to exploit the patient for the financial gain of the podiatric physician.

BE2.32 The podiatrist shall not use their position to exert undue influence on patient treatment choices that are, or may be, physically, psychologically, or economically detrimental to the patient.

BE2.33 The podiatrist shall not base treatment decisions on managed care incentives/disincentives when such decisions are, or may be, detrimental or when they are not in the best interest of the patient.

BE2.4 Conflict of Interest

BE2.41 The podiatrist shall provide truthful disclosure of actual and potential conflicts of interest in the recommendation and/or prescription of services, materials, medications, and facilities that may be utilized in the care of a patient.

BE2.42 The podiatrist shall provide truthful disclosure of actual or potential conflicts of interest in communication with patients, potential patients, colleagues, and others. Such communication includes, but is not limited to, lectures, published material in peer review and other publications, and advertisements.

BE2.43 The podiatrist shall provide full public disclosure of financial relationships that constitute a conflict of interest, including any in which remuneration is expected to be awarded on an annual basis or any equity holding in a related company (excluding mutual funds and blind trusts).

BE3.0 Inter-professional Referrals

The podiatrist has the obligation of seeking consultation when the health and welfare of a patient would be advanced by referral to a health care provider with special skills, knowledge, or experience.

BE3.1 Referrals to Other Podiatrists

BE3.11 The podiatrist shall refrain from inducing a patient of a fellow practitioner

to become their patient either by belittling the ability of the fellow practitioner or by the promise of better service at a lower fee.

BE3.12 The podiatrist providing a second opinion is obligated to return the patient to the referring practitioner, unless that patient exercises free choice in selecting the use of the second opinion practitioner to provide further care, or unless otherwise prohibited.

BE4.0 Employees/Associates

The podiatrist reasonably delegates aspects of medical care to auxiliary health care personnel. The podiatrist shall ensure that such personnel are qualified and adequately supervised.

BE4.1 Duty of Supervision

BE4.11 The podiatrist has a duty to supervise their employees and confirm that they are performing in an ethical and appropriate manner. *(See interpretive guideline.)*

BE4.2 Delegation of Authority

BE4.21 The podiatrist delegating authority to an employee, associate, or to another physician for the care of their patient, shall ensure that the activity complies with professional standards and applicable laws.

BE4.3 Duty to Comply with Professional Standards

BE4.31 The podiatrist strives to practice podiatric medicine consistent with the standards of care established within their community.

BE5.0 Respect for Law

The podiatrist is obliged to comply with the letter of all applicable laws and regulations. *(See interpretive guideline.)*

BE5.1 Duty to Report Violation

BE5.11 The podiatrist is obliged to report known violations of conduct by providers to the appropriate authority.

BE5.2 Medical Records

BE5.21 The podiatrist is obliged to maintain documentation of patient encounters that is legible, complete, accurate, and patient specific. *(See interpretive guideline.)*

BE6.0 Staff Respect/Advocacy

The podiatrist has a duty to avoid interaction that would impair the physical and psychological health of those with whom they interact on a professional basis.

BE6.1 Harassment

BE6.11 The podiatrist shall not engage in any deliberate act of emotional abuse, physical abuse, sexual misconduct, or sexual exploitation related to the podiatrist's position as an employer, employee, partner, or associate. *(See interpretive guideline.)*

BE6.2 Nondiscrimination

BE6.21 The podiatrist shall not discriminate against any employee, partner, or associate because of race, religion, ethnicity, gender, sexual orientation, disability, socioeconomic status, or health status.

BE7.0 Managed Care/Insurance Issues

In the light of reimbursement issues, the podiatrist shall focus on patient care and patient advocacy.

BE7.1 Patient Advocacy

BE7.11 The podiatrist has the obligation to advocate for the health of their patients in negotiating with managed care organizations and other third party payers.

BE7.2 Financial Incentives/Disincentives

BE7.21 The podiatrist shall not use insurance coverage/reimbursement levels as the substantive determination of the treatment plan.

BE7.22 The podiatrist shall not accept financial incentives to withhold care or referrals that are appropriate for the care of the patient.

ASSOCIATION ETHICS(AE)

AE1.0 Conflict of Interest

The podiatrist rendering volunteer or compensated services to the American Podiatric Medical Association or its component association(s) provides truthful disclosure of actual and potential conflicts of interest and recused themselves from discussion and action on all issues relevant to the actual or potential conflict. Failure to recuse oneself

is considered a violation of the Code of Ethics. *(See interpretive guideline.)*

AE2.0 Confidentiality

The podiatrist rendering volunteer or compensated services to an organization(s) shall adhere to the rules of confidentiality of the organization(s).

AE3.0 Commercial Relationships

The podiatrist rendering volunteer or compensated services to the American Podiatric Medical Association or its component association(s) is obliged to disclose all significant commercial relationships with other organizations, businesses, or entities that have a relationship with podiatric medicine.

AE4.0 Association Conduct

An officer or elected representative of the American Podiatric Medical Association or its component society is obligated to abide by the Constitution and Bylaws of their respective organization(s), when not in conflict with this document.

INTERPRETIVE GUIDELINES

The following interpretive guidelines are provided to further elaborate upon the Code of Ethics.

ME1.11 A function of state licensing agencies is to establish standards of competency for members of the profession within their respective jurisdictions.

ME1.21 Practice guidelines suggest and recommend modalities for patient care as correlated to various diagnoses that may be encountered. They should not be construed to constitute unalterable treatment strategies. Recognized podiatric medical organizations may include, but are not limited to, specialty colleges and boards and other such agencies that formulate practice guidelines based upon well-grounded scientific and educational precepts. The guidelines recommended by such organizations are often useful but have no legally binding effect on members of the Association.

ME1.31 Treatment decisions, including surgery, should relate to the consideration of the physical, emotional, social, and occupational needs of the patient. All treatment regimens should include appropriate documentation of the indications for treatment. The performance of any unnecessary treatment is considered a serious ethical violation.

Consultation and referrals should be sought when:

1.) the patient can benefit from the care of a provider with different training and/or experience, or

2.) when the patient requests a consultation or referral.

No compensation shall be claimed for the referral of patients for care and/or evaluation.

ME1.32 Follow-up care should be provided by a qualified podiatrist or other appropriate health care professional until the patient has fully recovered. If the podiatrist is unable to personally provide the follow-up care, then the podiatrist shall make arrangements with another qualified podiatrist or qualified healthcare professional to provide continuing care, and properly notify the patient of discontinuation of care and arrangements for follow-up care in accordance with prevailing law.

ME2.0 The doctrine of informed consent is usually defined as a duty to warn a patient of

1.) possible complications expected;

2.) sequelae of the treatment;

3.) unexpected risks of the proposed treatment;

4.) reasonable alternative to the treatment;

5.) risks and comparative benefits of the alternatives;

6.) in most cases, the effects of non-treatment; and,

7.) economic interests that have the potential to influence judgment.

ME3.0 A patient has the right to have all identifiable medical and health information treated in strict confidence. This right includes the right to control the dissemination of such information. A patient must be secure in the expectation that medical information disclosed to the podiatrist will remain confidential. Failure to respect the right of privacy may cause patients to withhold important information vital to their care. Unauthorized release of confidential material may result in embarrassment, stigma, discrimination, and possible legal liability.
Common types of disclosure pose a threat to medical data privacy:

1.) The purposeful or repeated disclosure of confidential patient information on computer screens or by the inappropriate utilization of on-line communication

capability.

2.) The routine release of information; Health information is often shared without the specific knowledge of the patient based on blanket consent. The patient may not know that the information is sensitive when they sign the consent. Consent should be obtained knowingly.

ME4.11 Podiatrists have a duty to do all in their power to avoid actions that would cause harm. Physical harm may be the result of poor professional judgment in the diagnosis and treatment of the patient's medical condition, including treatment beyond the scope of competency, and/or experimental procedures without the full consent of the patient. Financial harm may be the result of inappropriate and misleading advertising, unnecessary procedures, and/or inappropriate and/or fraudulent billing procedures. Emotional harm may result from harassment and/or the undertaking of a personal relationship with a patient.

ME4.31 Sexual harassment, whether verbal, physical, or arising out of the patient-care, education, or work environment, is illegal, as it violates Title VII of the Civil Rights Act of 1964 and many state laws. Sexual harassment is unwelcome sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature that occurs within the podiatrist's role as a health care provider, administrator, educator, researcher, consultant, employee, or employer. Other harassment includes demeaning behavior directed towards others in the patient-care, education, or work environment.

Podiatrists at no time should abuse the authority figure they present as a means of fostering sexual relations with a patient, student, resident, fellow, or employee. A podiatrist may not employ sexual favors in bartering for professional services.

Sexual intimacy with patients, students, residents, fellows, or employees is inappropriate unless the personal relationship precedes the professional relationship.

ME6.11 Physical disability includes but is not limited to, deterioration through the aging process, or loss of motor skill that results in the inability to practice the profession with reasonable judgment, skill or safety.

Mental disability is any psychological condition or habitual or excessive use of alcohol, narcotics, stimulants, or other chemical agents or drugs that results in the inability to practice podiatric medicine with reasonable judgment, skill, or safety.

Addressing the problem of impairment includes several steps:

1.) The podiatrist recognizes the problem.

2.) The podiatrist seeks help within the profession.

3.) The podiatrist seeks active treatment of the impairment.

4.) The podiatrist seeks evaluation of their capacity to provide patient care.

ME7.12 The podiatrist shall subject all research projects involving human or animal subjects to the scrutiny of an independent body whose function is to review such projects for appropriateness and for protection of the human or animal subjects.

ME7.21 The podiatrist shall not intentionally mislead professional or lay audiences through scientific and scholarly papers, lectures, accounts, and communications, whether or not personal gain may accrue from such action.

BE1.22 Promotional gifts of nominal value may be offered.

BE1.31 In the event that an urgent condition presents at the time of a free examination, reasonable charges for the treatment may be allowed upon written consent from the patient for the services and related charges.

BE2.0 Fraud includes but is not limited to knowingly presenting (through actual knowledge, deliberate ignorance or reckless disregard) or causing to be presented a false or fraudulent claim.

Fraudulent acts include but are not limited to:

1.) Willfully making or filing false records or reports within the scope of practice.

2.) Gross, willful, and continued overcharging for professional services including filing false statements for collection of fees for those services, including, but not limited to, filing false statements for collection of monies for services not rendered or not provided as claimed.

3.) Routine waiver of deductibles and copayments that may lead to artificial inflation of the reported charges.

4.) Billing for supplies, equipment, or services is not reasonable and necessary.

5.) Repeat billing (double billing) for the same service that was not provided on repeat visits.

6.) Billing for non-covered services as covered services.

7.) Using an improper modifier to increase or allow inappropriate reimbursement.

8.) Billing for component parts of a procedure rather than the inclusive global procedure (i.e., a-la-carte).

9.) Billing at a higher more intensive level to increase reimbursement.

In addition, the following conditions and issues must be considered:

1.) Services billed should reflect the care provided as deemed medically necessary by the podiatric physician.

2.) Reasonable efforts should be made to inform the patient of costs for services or treatments that they will be directly responsible to pay.

3.) The podiatrist must be able to provide documentation to support appropriateness of care.

4.) Remunerations (e.g., kickbacks, inducements and self-referrals) for referrals are inappropriate and illegal. Such remunerations include knowingly and willfully giving or receiving anything of value to induce referrals.

BE2.11 Fee splitting is defined as sharing of fees for the purpose of referrals where one entity provides no service for its portion of the fee. Such sharing of fees is considered unethical and potentially illegal.

BE2.21 Documentation must be complete and legible, encounter specific, and should state the reason for the encounter. If not specifically documented, the rationale should be readily inferred.

Documentation also should identify any health risk, patient progress, and revisions to the treatment plan. Evaluation and Management (E and M) guidelines should be followed.

The podiatrist should be aware of the following risk areas:

1.) Financial arrangements with entities that may involve referrals.

2.) Joint ventures with entities supplying goods or services to providers or patients.

3.) Consulting contracts or medical directorships.

4.) Office or equipment leases with entities that could involve referrals.

5.) Soliciting, accepting, or offering any gift or gratuity of more than nominal value to or from an entity or person who may benefit from any referral in a federal program.

BE4.11 The podiatrist shall provide appropriate supervision of the activities of employees in the course of their podiatry-related activities to ensure the safety of the patient, other employees, and visitors to the clinical facility in which podiatric services are rendered.

The podiatrist shall provide appropriate supervision of the activities of employees in the course of their podiatry-related activities to ensure the accuracy of documentation, claims, and other communications made by the employee.

The podiatrist shall provide appropriate supervision of employees and others contracted by the podiatrist, who in the course of their employment or by reason of their contract, have, or reasonably may have, contact with the patients, other employees, or visitors to the clinical facility in which podiatric services are rendered.

BE5.0 Failure to be informed of applicable laws and regulations may constitute deliberate ignorance or reckless disregard and, therefore, is an ethical violation.

BE5.21 The podiatrist has a duty to maintain complete and legible medical records to ensure future continuity of care by other professionals, to ensure accountability, to meet the requirements of the healthcare system, and to meet legal requirements.

BE6.11 Sexual intimacy with any employee, associate, or business partner is inappropriate unless the personal relationship precedes the business relationship.

AE1.0 Association decisions and actions must not be based on personal interests or relationships. Relationships, including any ownership interests with suppliers, contractors, or any groups with competing

interests with the American Podiatric Medical Association must not influence the independent and sound judgment of an individual who serves the APMA or its component associations. Any situation that is or may be a conflict of interest must be avoided. To avoid a conflict of interest one must disclose any relationship(s) that others might misinterpret. An individual who is in a position to actually or potentially influence decisions has a duty of full disclosure. If in doubt about a relationship, it should be disclosed. A conflict of interest may arise through a family relationship. When an extended family member has a relationship or ownership interest with an entity that may conflict with the APMA, it must be disclosed. Extended family members shall mean spouse, domestic partner, parents, child, brother, sister, aunt, uncle, or anyone living with the individual.

Conflicts of interest may be present when one or more of the following situations exist:

1.) A podiatrist with an economic interest, a material financial interest or material financial relationship with any business or in an organization that is the subject of consideration. A "material financial interest" includes a financial ownership interest of 5% or more, a financial ownership interest which contributes materially to a member's income, or a position as proprietor, director, managing partner, or key employee. A "material financial relationship" would be present if a member or a member of his or her immediate family receives monetary compensation (including honoraria and grants) in an amount equal to or greater than $2,000 per year or $5,000 over three years.

2.) A podiatrist with a position of leadership (i.e., a director, trustee, or officer) in an organization, or an employee of an organization that is the subject of consideration.

3.) A podiatrist with a family member who is an owner, director, trustee, or employee of an organization that is the subject of consideration.

4.) A podiatrist having a business or personal relationship with an individual who is the subject of consideration.

5.) A podiatrist having an existing or prior relationship with an individual(s) or organization(s), which precludes the rendering of an impartial consideration.

6.) A podiatrist having information that was obtained under an agreement or assumption of confidentiality in an activity or relationship external to the consideration, but regarding or bearing on the subject of the consideration.

7.) A podiatrist serving on a board of directors of an organization with a competing or conflicting interest to the APMA.

8.) Gifts, favors, travel, and entertainment may rise to a level of a conflict of interest. Gifts of nominal value, given in the normal course of business are acceptable. Gifts received on a regular or continual basis, gifts of more than nominal value ($100), or gifts of money or cash equivalents are indications of a potential conflict and must be disclosed.

Even if a conflict does not exist in fact, the appearance of a conflict to others can be damaging to the reputation of the association. Whether or not an interest is conflicting will depend on the particular circumstances of the conflict, including the nature and relative importance of the interest.

WELLNESS QUICK REFERENCE GUIDE

YOU HAVE QUICK ACCESS TO MANY SUPPORT SERVICES TO HELP YOU MAINTAIN HEALTH AND WELLNESS IN YOUR CAREER AT PROVIDENCE

Wellness Line - available 24/7 through PERFECT SERVE

a. Help in navigating the hospital system, resources for finding ongoing counseling and therapy, advice in responding to family emergencies.

b. Guidance for Academic Issues, preliminary evaluation re. learning difficulties and assistance with study issues, test anxiety and test taking issues, writing issues, psychological testing referral - Paul Lessem at 248-849-8395 or the WELLNESS LINE

c. Help in finding a psychiatrist or psychotherapist or emergency mental healthcare

DETAILED DESCRIPTION OF WELLNESS SERVICES - GME Wellness Manual - New Innovations

3. **DIRECT MENTORING SUPPORT IN YOUR PROGRAM** - Program Wellness Plan -
Located under Program Resources on New Innovations > *More > Resources*

PSYCHOTHERAPY - this will be your most current list

a. Wellness Manual list of resources. Updated periodically

b. Mel Bornstein Clinic (A treatment clinic of Michigan Psychoanalytic Institute offering a variety of types of psychotherapeutic care): This clinic has a single intake number 248-851-7739. Leave a message for the intake worker, Marla McCaffrey. She will call you back and either leave you a referral number for a therapist who will take your insurance or may be able to see you on a sliding scale or she may call you to ask you for additional information. She will then give you the name and phone number for a therapist to contact with whom you will be able to meet and begin care.

c. Eastwood Clinic: schedule after-hours intake appointment i. Southfield - Nikki Dummond 248-849-3301, Thursdays 7 PM

ii. Novi - Judith Malinowski 248-465-4336, will arrange an after-hours intake

d. If you are having trouble getting help, please let us know on the Wellness Line. If contact information for a therapist is out-of-date or the therapist is not available, please inform Dr. Lessem.

RELIEF MEASURES are mandated by ACGME for fatigue mitigation, medical and emotional care. Consult your DEPARTMENT WELLNESS PLAN in New Innovations for details

LACTATION SUPPORT and LACTATION ROOM AVAILABILITY*

CHILD DAYCARE SUPPORT* a. Childtime 10% discount and assistance with facility locations
b. SHUTTLE SERVICE if your child is at Childtime

WOMEN'S support programs*
a. Women in Medicine Wellness Subcommittee
b. Women's Mentoring Program – Dr. Debra Hollander & Dr. Tania Little

WELLNESS COMMITTEE INFORMATION ext. 8395, 5322
*Indicates program in transition and development. Contact the Wellness Line for details