GRADUATE MEDICAL EDUCATION

PODiatric resiDENCY
TRAINING PROGRAM
HOUSESTAFF MANUAL
2011-2012

ACCREdITEd bY THE COUNCIL oN PODiatric MEDICAL EDUCATION (CPME)
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LBMMC HOUSESTAFF POLICIES
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Welcome!

At Long Beach Memorial Medical Center (LBMMC), we believe in training and graduating competent, compassionate, high quality, caring physicians while improving the health status of the communities we serve. We are committed to excellence in all our endeavors within medical education.

LBMMC is a professional teaching hospital accredited by the Accreditation Council of Graduate Medical Education (ACGME) to sponsor post-MD medical training programs. LBMMC is also accredited by the Council on Podiatric Medical Education, an independent accrediting agency for podiatric medical education. Our institution plays a vital role in the training of physicians from several universities. We currently have 23 programs with about 150 residents and residents. Approximately 15 medical students are here each month in addition to short-term medical students, residents, residents, research residents, and visiting professors.

LBMMC Master Affiliation Agreement is with the University of California Irvine (UCI) School of Medicine who sends residents from Anesthesiology, Emergency Medicine, Internal Medicine, Obstetrics, and Gynecology, Pathology, Pediatrics, Physical Medicine, and Rehabilitation, Radiation Oncology, and General Surgery to train at our facility. UCI Residency programs include Maternal/Fetal Medicine, Gynecology Oncology, Urogynecology, Cardiology, and Critical Care/Pulmonary.

From the University of Southern California, LBMMC has residents in Emergency Medicine and Pediatric Dentistry. From Downey Regional Medical Center, LBMMC receives residents in Family Medicine; from Harbor-UCLA, LBMMC receives residents in Emergency Medicine and Orthopaedics; and residents in Vascular Surgery. From UCLA, LBMMC receives residents in Anesthesiology/OB.

LBMMC contracts with a number of residents for specific residencies including Surgical Pathology. LBMMC sponsors and contracts with residents for specific training in Podiatric Medicine and Podiatric Surgery. Our Family Medicine program is affiliated with UCI, but is also sponsored by LBMMC.

If you are looking for a personalized, innovative, cutting edge, prestigious, quality educational environment where you can not only learn to become an excellent physician, but make a difference, we are your educational home of the future.

Graduate Medical Education Administrative Team

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HOUSE STAFF OFFICE TEAM

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EPIC Usernames/Passwords & Classroom Scheduling  
Sabrina Sadler  
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Contact any house staff office team to check-in or obtain information on the following specialties: Anesthesiology/OB, Emergency Medicine, Family Medicine, OB/GYN, Pathology, Pediatrics Dental, Radiation Oncology, Physical Medicine and Rehabilitation and Sports Medicine.

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Dermatology
Edward Glassbery, M.D.
Bryna Kane, M.D.

Emergency Medicine
Gary Moreau, M.D.

Endocrinology/Diabetes Education
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General Surgery
Steven Grant, M.D.

Hyperbaric
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Infectious Disease
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Radiology
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Vascular Surgery
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Podiatry Residency Program

A residency is a postgraduate educational program conducted under the control and sponsorship of a hospital or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges and schools of podiatric medicine through clinical and didactic experiences.

LBMMC offers an approved three (3) year residency in Podiatric Medicine and Surgery (PM&S-36), which is fully accredited by the Council on Podiatric Medical Education (CPME). We are approved for six (6) residents and allow one to two students to rotate through our program each month.

The residency program is based on the resource-based, competency-driven, assessment-validated model of training:

- **Resource-based** implies that the Podiatry Residency Program Director constructs the residency program based upon the resources that are available. While the Council recognizes that available resources may differ among institutions, the director is responsible for determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.

- **Competency-driven** implies that the Podiatry Residency Program Director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the sponsoring institution as having successfully completed the residency program.

- **Assessment-validated** implies that the serial acquisition and final achievement of the competencies are validated by assessments of the resident’s knowledge, attitudes, and skills. To provide the most effective validation, assessment is conducted both internally (within the program) and externally (by outside organizations).

Dedicated to excellence in patient care; resident and student education, the Podiatric Residency program has been functioning since 1994. Residents work with a dedicated podiatric and medical staff. Our base hospital, Long Beach Memorial Medical Center, offers a broad range of patient encounters. Resident also train at the St. Mary Medical Center, Community Hospital of Long Beach, Healthcare Partners and Veteran Affairs Hospital of Long Beach.

The program offers opportunities for independent growth, while providing the required supervision and mentoring needed to become an excellent podiatrist. You will have the opportunity to be completely responsible for the care of your patients while under direct supervision of a senior resident and attending physicians. Additionally, you will serve as a mentor for medical students who are an integral part of the training program.

You will also assume an active and integral role in shaping the program. You will share primary involvement in the process of interviewing and selecting candidates, in curriculum development, and in on-going education and research. Your input is vital to maintaining the high standards of the residency.

We greatly appreciate your interest in our program.
Curriculum

The curriculum is the residency program’s unique organization and utilization of its clinical and didactic training resources to assure that the resident achieves the competencies identified by the Council and is prepared to enter clinical practice upon completion of the residency.

All required curricular elements must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. If your residency is extended beyond 36 months, there will be a clear educational rationale consistent with program requirements. The program director must obtain the approval of Long Beach Memorial and the Graduate Medical Education Committee prior to implementation and at each subsequent approval review of the program.

The Council and the Resident Review Committee (RRC) view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

1) Clinical experience, providing an appropriate opportunity to expand the resident’s competencies in the care of diseases, disorders, and injuries of the foot and ankle, and their governing and related structures by medical, biomechanical, and surgical means.

2) Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident’s competencies in the perioperative care of diseases, disorders, and injuries of the foot and ankle, and their governing and related structures.

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

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

TRAINING RESOURCES

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medical and surgical subspecialties.

COMPETENCIES

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and American Board of Podiatric Surgery (ABPS) have identified competencies related to certification pathways.

The curriculum provides the resident with a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.
1) Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.

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

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

4) Communicate effectively and function in a multi-disciplinary setting.

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

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

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

**RESIDENT SELECTION POLICY /PROCESS**

To be eligible for appointment to the Podiatric Residency Program at LBMMC, an applicant must:

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

2. Be a US citizen.

3. All residents must be certified in basic life support for the duration of residency training.

4. All PGY1 positions will be offered through the Centralized Application Service for Podiatric Residencies (CASPR) following their established guidelines and policies. All interviewing will be done through the Centralized Residency Interview Process (CRIP) at the central CRIP.

5. All PGY1 applicants must pass Parts I and II of the National Boards of Podiatric Medical Examiners prior to beginning the Residency.

6. All PGY1 must have a California medical license.

7. All PGY2 and above applicants must pass Parts I, II and III of the national boards prior to the time they begin training.

8. All PGY1 must apply through CASPR. The program requires applicants who are currently in podiatry colleges to be in the upper 50% of their class. The program at its discretion may waive this requirement for students who participated in a clerkship program at the institution.

9. Notarized proof of graduation from podiatry school with date of graduation; Curriculum Vitae (CV) and Application, Podiatry College Transcripts, letter from current/former program director, three (3) letters of recommendation. National Board part I, II and III scores.

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

11. Application packets are reviewed via criteria set forth by the CPME Program Requirements, the COTH (CASPR) and this institution. A designated committee member reviews applicants who meet
the criteria. Based on the quality of the application packet and academic credentials, the applicant is subsequently invited, if appropriate, for an interview. At the central CRIP, applicants receive an informational packet and interview with members of the Resident Selection Committee including the Program Director whenever possible. At the conclusion of the interview, the interviewers complete a standard evaluation form for each applicant they interviewed. The results are tallied and form the basis of the preliminary rank order. The Resident Selection Committee bases final match rank order on preliminary ranking and review. A match list is developed and submitted to CASPR. Strict conformance with the rules of the match is maintained throughout the selection process.

In the event that we fail to match all PGY1 positions in a given year. The program will open up recruitment to all remaining applicants in the CASPR system under the “scramble” system they have developed. All that will be required of the applicants is a copy of their CASPR application package. Interviewing protocols and timing will be determined at the time in this event. Qualified individuals who did not participate in the CASPR process by providing the information listed for “PGY-2” applicants.

Appointees to the Residency must fulfill the current licensing requirements for podiatric residents in the State of California and must obtain a license as soon as possible during their PGY-2 year. Part III of the boards must be taken in December of PGY-1 and Resident must have passed exam to have renewal of contract.

**RENEWAL OF RESIDENT AGREEMENTS**

Residents performing satisfactorily may have the resident agreement renewed for the subsequent year. The resident agreement is renewable annually as agreed among the resident, the program director, and DIO. Issuance of an agreement for one year does not imply the resident will complete the training program. Agreements for succeeding years of training will be issued only after specified conditions have been met.

**JOB RESPONSIBILITIES**

**Podiatry Residency Program Director**

- The responsibility of the Podiatry Residency Program Director is to oversee the general administration of the residency. It is the Director's responsibility to insure that the residents follow the guidelines established for them within their contracts and within this manual.

- The Program Director is certified in the appropriate specialty areas by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and/or the American Board of Podiatric Surgery or possess similar qualifications.

- The Program Director is responsible for maintenance of records related to the educational program, communication with the Joint Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

- The Program Director must ensure resident participation in training resources and didactic experiences (e.g., lectures, journal review sessions, conferences, and seminars).

- The Program Director participates at least annually in faculty development activities (i.e.,
administrative, organizational, teaching, and/or research skills for residency programs).

- The Program Director coordinates with attending podiatrists at the various outside rotations. The Director ensures that each resident receives equitable training experiences.

- The Program Director directly responsible to the Residency Committee.

- The Program Director holds appropriate clinical administrative and teaching qualification suitable for implementing the residency and achieving the stated competencies of the residency.

- The Program Director serves as the liaison with the Council on Podiatric Education.

- The Podiatry Residency Program Director must be a member in good standing of the American Podiatric Medical Association and meet all relevant CPME requirements for Directors.

**House staff: Resident**

Under the supervision of assigned attending physicians and residency program directors, and in compliance with pertinent educational objectives, participates in clinical medical education concerned with the diagnosis, treatment and management of patients in both and in inpatient and outpatient setting in the following specialties and patient populations: anesthesia, emergency medicine, family practice, internal medicine, obstetrics and gynecology, pathology, pediatrics ophthalmology, orthopaedics, podiatry, radiation oncology, radiology, physical medicine and rehabilitation, surgery and urology.

**Essential Job Outcomes & Functions**

- Meet specific educational objectives as required by the program or rotation

- Participates in scheduled unit/patient population rounds on a regular basis

- Presents rounds cases, conferences, educational programs as assigned and as appropriate in a timely, concise, articulate manner

- Attends seminars, conferences and lectures pertinent to the resident’s specialty

- Manages, diagnoses and treats patients in a comprehensive, timely, caring and ethical manner

- Develops an understanding of ethical socioeconomic and medical/legal issues that affect graduate medical education and of how to apply cost containment measures in the provision of patient care

- Participates in the educational activities of the training program and, as appropriate, assumption of responsibility or teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff

- Participates in institutional committees and councils to which the house staff physician is appointed or invited

- Establishes and maintains respectful, cooperative relations when interfacing with physicians, nurses, patients, families, employees and the public

**Job Specific Competencies**

Non-Management: Performs these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which
the house staff physician is assigned; including, among others, state licensure requirements for physicians in training, where these exist

**Minimum Requirements / Work Experience**

Acceptance by university into applicable subspecialty residency program and scheduled by university department to train at Long Beach Memorial Medical Center. Must have a valid California license and be credentialed at LBMMC or through the University of California, Irvine. Completion of medical school accredited by LCME (Liaison Committee on Medical Education) and/or graduates of foreign medical schools who have entered into a residency through the ECFMC (Educational Commission for Foreign Medical Graduates)

**Education / Licensure / Certification**

Must meet the qualifications for subspecialty resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory.

Important Notice: The competencies listed here are assessed using a separate competency assessment tool. The organization-wide Threshold and Generic Competencies are required for all employees and are on a separate list available from Human Resources and all departments.

**COMMITTEES**

1. **Graduate Medical Education Committee (GMEC)**

   The Graduate Medical Education Committee is responsible for the overall direction and regulation, as well as the day by day functioning of the residency training program. It is composed of the:

   a. Podiatry Residency Program Director  
   b. Executive Director of Medical Education,  
   c. Podiatry Residents - Chief  
   d. Appropriate representatives of the Medical Teaching Staff,  
   e. A representative of the GME Administration of LBMMC,  
   f. Other members as deemed appropriate by the Committee and/or the affiliated institutions.

   Appointments from the podiatry residency to this committee are made by the Director and the Executive Director of Medical Education/DIO annually. Appointments to this committee should be made as soon as possible following the appointment of the Directors by their respective centers.

   a) **Purpose of Committee**

      The function of this committee is to set policies for the program, develop the curriculum of the training program and review overall resident and program performance. In addition, this committee will mediate conflicts arising within the teaching program, whether they are generated from the residents, podiatry staff, medical staff, nursing staff or administration. This committee will have the power to recommend the dismissal of the resident should the situation arise. Each member of the Committee will have one vote unless stated otherwise below.

   b) **Chairman of Committee**

      The GMEC Chair will be the chairman of this committee and will be responsible to schedule the meeting dates of the committee at least quarterly.

2. **Residency Selection Committee**
The Residency Selection Committee will be made up of a subcommittee appointed by the Program Director. The Program Director shall chair the Committee unless the Director has appointed another committee member to assume chairmanship. It will be the responsibility of all Committee members to screen each application prior to attending the final selection meeting. During the final meeting the applicants under consideration will be discussed in detail. The current Residents may be asked to comment on the applicants. If the committee can not reach a consensus, a final vote by the Committee members will be held by closed ballot. The committee members are:

a) Pedram Aslmand, DPM  
b) Resident – PGY 3  
c) Resident – PGY 3  
d) Resident – PGY 2

The Residency Evaluation/Grievance Committee

The Residency Evaluation Committee will be made up of the Director, the Chief Resident(s) and at least one other members of the residency training committee appointed by the Program Director and the GMEC Committee members. The Program Director shall chair the Committee unless the Program Director has appointed another committee member to assume chairmanship. The committee will review the progress of the residents at least annually to determine the promotion status of each resident. The committee will also review (self assess) the program on an annual basis and make recommendations to the Graduate Medical Education Committee regarding any needed changes or program enhancements. The committee will meet more frequently in cases where residents are having academic problems and will meet at least monthly when a resident is on academic probation. The committee will serve as the initial hearing body for any appeal of a resident evaluation.

PHYSICAL FACILITIES

The physical plant will be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources and a health information management system will be available for resident training. These facilities will have sufficient library resources including electronic retrieval capabilities, and personnel.

CONDUCT OF RESIDENT

A. Orientation

At the beginning of the residency year, a period of orientation and instruction in duties, responsibilities and privileges of the Podiatric resident is provided so that each resident may attain a working knowledge of the function and administration of the podiatry residency program and its affiliated institutions.

The following subjects are included in this period of instruction:

1. LBMMC new hire orientation,  
2. House staff new hire orientation  
3. Salary and benefits  
4. BCLS/ACLS  
5. EPIC training  
6. Residency Resource proper logging techniques
Demonstrations and lectures covering the various phases of clinical podiatry are given to the newly appointed podiatric resident throughout the year.

B. Dress Code: (Podiatry Program and LBMMC Guidelines)

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

Policy: Resident appearance and conduct should at all times reflect the dignity and standards of the medical profession. Dress guidelines for residents assist in achieving this goal while also acknowledging individual desires for diversity and self-expression. Following are guidelines for professional attire. It is recognized that each department or specialty may have requirements which are more specific or less rigorous than the guidelines outlined herein. It is the purpose of this policy to provide general guidelines to assist each department or specialty in developing its own dress code policy to meet its specific needs. These guidelines apply to each work day, including days with no patient care responsibilities. Maternity clothes are not exempt from these guidelines.

Specific Standards:

- Name Badge: Proper identification as required by each training site must be worn and clearly displayed at all times while on duty.

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

- Scrubs: Scrubs should not be worn outside of the hospital premises. Scrubs are expected to be clean and pressed. Scrubs may be worn in the operating room, delivery areas, or on the following rotations only unless otherwise delineated by departmental policy: Emergency room, AO, and all ICUs. In patient care areas, it is recommended that a coat with name tag be worn over the scrubs.

- Scrubs may not be worn in hospitals that they don’t belong to. Clinic attire must be worn from institution to institution. This includes all rotations.

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

- Each rotational director has the authority for specific attire guidelines related to their rotation

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

- Style: No tank or halter tops, midriffs or tube tops. No sweatshirts or shirts with messages, lettering or logos (except MCH or LBMMC). No shorts. Jeans are discouraged. A tie is recommended for men on weekdays and recommended on weekends unless described as optional.
in the specific department policy.

- Fragrance: No strong colognes or perfumes as patients may be sensitive to strong fragrances.

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

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

- Jewelry: Should not be functionally restrictive or excessive.

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

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

C. Relation to Staff and Personnel

Supervision, control and discipline of the resident is vested in The Graduate Medical Education Committee. The resident will make careful notes of orders given by the staff. In no case will the resident change the treatment plan without the knowledge of the staff members. Disagreement with or criticism of any member of the nursing staff must be discussed with the Program Director who will take any necessary action. Questions or criticisms relating to general hospital operation or personnel may be brought to the Program Director who may discuss them with the hospital administrator. Those questions relating to the podiatric residency training program will be discussed with the Podiatry Residency Program Director and/or the Executive Director of Medical Education/DIO.

Residents are expected, while in the hospital, to conduct themselves with professional dignity in the relationship not only with patients, but also with nurses and other hospital employees, both on and off duty. Cooperate in every way possible, and maintain friendly relations with all professional services, administrative departments, and other hospital personnel. You have no disciplinary jurisdiction over nurses or other hospital employees. If any personnel difficulties arise, talk them over with the Program Director.

Remember, always, that the attending physician is in full charge of the patient. Inform them promptly of any major change in the patient's condition. Work closely and conscientiously under their direction, and let them know that you want to learn from them.

Holidays Observed By Hospital

Long Beach Memorial observed holidays are New Years, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas. Coverage must be arranged.
Housestaff Leave

MemorialCare policy is to grant leaves of absence to all eligible residents on a nondiscriminatory basis and in compliance with all applicable collective bargaining agreements, and state and federal laws.

This policy is not intended to address every possible leave of absence that may be available to House staff. If you have any questions about a leave of absence, please contact the Graduate Medical Education Office.

1. **Vacation Leave**
   Each resident is entitled to use the defined number of vacation days established by the policies of each resident’s department. Vacation time does not accrue from year to year and must be scheduled and taken in the same academic year (July 1 – June 30) the vacation is earned. In addition to any department regulations concerning vacations, all vacation time must be scheduled with the prior approval of the designated department faculty member and/or administrator.

2. **Educational Leave**
   Resident’s are entitled to two week paid educational leave. The educational leave may be utilized for independent research, study or to attend an educational conference approved by the program director. To the extent that a resident’s department does not include educational leave as a portion of one’s annual vacation leave, each resident is entitled to use the department educational leave days consistent with the policies and procedures of his/her department.

3. **Total Leave**
   The total number of annual vacation/educational leave days for all Housestaff members is 30 days or 4 weeks per academic year. The department allocates the distribution of vacation and educational leave. All residents receive a minimum of two (2) weeks of vacation leave.

4. **Sick Leave**
   There is no formal sick leave allotment. Sick leave is deducted from the resident’s accrued Paid Time Off benefit hours during this absence from work.

5. **Jury Duty**
   It is the policy of LBMMC/MCH to allow residents who are required to serve on jury duty to fulfill their civic obligation, with up to 5 days pay at their regular hourly rate to offset regular pay which could be lost in the service of this jury duty. Leave of absence for jury duty will normally be granted. When granted, no loss of pay will occur.
   
   1. The resident must notify their program director and the GME office upon receipt of the notice to serve.
   2. The resident is excused from work on the day of service, unless released from service for the day.
   3. The resident must provide official court documentation for all days of service, including but not limited to days for which jury duty compensation is expected.
   4. Daily court fees paid to the resident are to be remitted and signed over to LBMMC/MCH in order to receive jury duty compensation. It is not the intent of this policy that the resident receives remuneration for a day of jury duty service at a rate greater than that which he/she would have received if they had performed actual work.
   5. Jury duty pay will equate to the residents regular hourly rate for non-exempt residents.
   6. An exempt resident will receive his or her full salary for any week in which he or she performs any work without deduction for absences caused by jury duty.
7. The resident is responsible for telling the judge that he/she is a resident physician and are only allowed thirty (30) days away from their residency program per year; are scheduled for night call; and patient care.

8. If a resident is assigned to a lengthy trial, graduation will be delayed.

6. Maternity/Paternity/Adoption Leave

The residency program supports a six-week unpaid maternity/paternity/adoption leave for the birth of the resident’s own child, for the placement of an adopted or foster child with the resident. Such leave must include use at the beginning of the leave of any remaining unused accrued Paid Time Off benefit hours. Before returning to work from a maternity leave of absence, the resident must provide a written verification from her health care provider indicating that she is fit to return to work. Requests for extensions of a maternity/paternity/adoption leave of absence will be considered if they are received by the Program Director in writing before the expiration of the approved leave. The leave may result in extending time in the residency training program. The time added to the residency post the normal June 30 graduating date is without pay.

7. Family & Medical Leave

A resident may request from his/her department an extended unpaid family and medical leave for, for the resident’s own serious health condition, or for the serious health condition of the resident’s parent, spouse, or child. Such leave must include use at the beginning of the leave of any remaining unused vacation leave. The duration of the family medical leave must conform to one’s departmental and American Board requirements together with applicable state and federal law. (California Family Care and Medical Leave Act of 1993, and the Federal Family and Medical Leave Act of 1993).

8. Bereavement Leave

In the event of a death in the immediate family of an eligible resident, up to three (3) working days off will be granted to arrange and/or attend the funeral. For purposes of this policy, a resident's immediate family is defined to include the resident's current spouse, father, mother, sister, brother, child (inclusive of unborn children after the first trimester of pregnancy), stepchild, grandparents, grandchildren, mother-in-law, father-in-law, and domestic partner (as defined by California Family Code, Section 297). Eligible full-time residents will be paid their straight-time (benefit) hourly rate up to a maximum of twenty-four (24) hours. Residents may be asked to provide satisfactory evidence to support their request. Residents who require more than these maximum time periods may request the opportunity to use any accrued Paid Time Off benefit hours, or a personal leave of absence. This requires the approval of the program director and GME office.

Leave cannot be carried over from one academic year to the next. Holiday, weekend days or three-day weekends will be counted against the total allowable leave for residents on rotations that require or expect weekend availability.

How The Rotation Schedule Works

Working Hours and Working Conditions

The Long Beach Memorial Medical Center and Miller Children’s Hospital Working Hours and Working Conditions are as follows:

1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
2. Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

a) In preparing request for exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

b) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

3. Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by the residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit. PGY 1 residents are not permitted to moonlight. Note: The Podiatry Program does not permit residents to moonlight. For more information regarding moonlighting, please refer to Graduate Medical Education moonlighting policy.

3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

4. Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 pm and 8:00 am is strongly suggested.

- It is essential for patient safety and residential education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

- Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

- In usual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

- Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

- Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

5. **Minimum Time Off between Scheduled Duty Periods**

Pgy-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty period.

Immediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

- This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
  - Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

6. **Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float.

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

7. **Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

8. **At-Home Call**

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

a) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
**Back-Up System:**

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

**Conflict/Complaints Resolution**

If the complainant is a resident, a member of the teaching staff, or other person affiliated with the program or institution in question, the following steps should be taken before submitting a complaint to the ACGME:

3. Contact the Program Director to discuss the problem.

4. If the issue either involves the Program Director or is not resolved by meeting with the Program Director, contact LBMMC Graduate Medical Education office or LBMMC DIO.

5. If the efforts above do not resolve the issue, contact the CPME Complaint Officer to discuss submitting a formal complaint. If the complainant is someone outside the institution, the CPME Complaint Officer may be contacted as the first step in the process.

**MISCELLANEOUS RESPONSIBILITIES**

While your obligation to yourself, your profession, your hospital and patients will be expressed by implication throughout this manual, the following reminders are added as a guide and check list and are intended to summarize many of the details not specifically mentioned. Members of the resident staff are expected to abide by the policies at all times.

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

2. Cooperate in the conservation of supplies.

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

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

5. Smoking in the hospitals is prohibited.

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

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

8. Provide complete privacy for each patient during dressings and examinations in which he or she might be exposed. Curtains are furnished in the multiple-bed rooms.

9. Do not sit on the patient's bed unless it is necessary for examination.
10. Protect your patient by refusing information about him to lawyers, insurance-men and newspapermen. Refer such inquiries to the appropriate individual at the institution.

11. Refer any questions about your patient's financial arrangements to the appropriate individual at the institution.

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

13. Report promptly on the Incident Report Form any unusual occurrences in the hospital; such as accidents, fire or a disturbed patient.

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

15. Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he has been the victim of malpractice.

16. Resident will not order materials, supplies or surgical equipment directly from outside vendors unless directed to by an appropriate individual.

17. Fraternization with patients is prohibited.

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

**Evaluations**

The Graduate Medical Education Committee of Long Beach Memorial Medical Center has responsibility for the overall academic quality of the Podiatry Residency Program. A part of that quality can be measured by the performance of the residents. The program expects a progression of knowledge in the specialty area from beginning to end of training, and such progress is monitored. It is further expected that residents will be eligible for the specialty board examination upon completion of the training program, with an overall goal that all residents will pass the examination and become board certified.

In addition to achieving board certification, the training of effective and competent physicians is the goal of the training program, and all evaluations will be directed at that ultimate objective. The podiatry residency program conducts self-assessment and assessment of the resident based upon the competencies.

**Faculty Evaluations**

Faculty will be evaluated and assess by each resident training under their supervision on an ongoing bases. The evaluation will be completed at the end of each rotation to improve the performance and teaching of the clinical faculty.

**Resident Evaluations**

1. In addition to regular contact with the teaching staff, each resident will be evaluated in writing at least
monthly, or at the end of each rotation. Rotations longer than one month will have an interim evaluation, if resident progress is not satisfactory.

2. The written evaluations will be placed in the resident's file, and will be available for review by the resident upon request.

3. Residents new to a training program need special monitoring during the first six months of the program. The teaching staff and Program Director are responsible for early detection of problems, and remedial programs must be established by each program.

4. For any evaluation of less than satisfactory performance, for whatever reason,
   a. Discuss the evaluation with the resident immediately.
   b. Outline in written form and in the discussion any corrective action to be taken to remedy the deficiency, and how the resident will be evaluated to determine if the problem has been corrected.
   c. Notify the program director of the unsatisfactory evaluation.

5. The resident will be allowed to refute in writing any evaluation, which will be placed in the resident's file along with the evaluation.

**Semi-Annual Meeting/Assessment Evaluation (formerly Quarterly Evaluations)**

The Program Director will conduct a semi-annual meeting with each resident to review the extent to which the resident is achieving the competencies. The written assessment will indicate the dates covered and will be validated by the resident, the Program Director and the Executive Director of Medical Education/DIO. The assessment will cover areas such as communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency will allow sufficient opportunity for remediation. Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

**Program Self-Assessment Evaluation**

The Program Director will conduct an annual self-assessment of the program’s resources and curriculum. The self-assessment form will be completed by program director, faculty and residents at the end of the academic year and shall be used in improving the program.

**Final Exit Evaluation**

The program director will provide a final exit evaluation for each resident who completes the program. This evaluation will include a review of the resident’s performance during the final period of education, and will verify that the resident had demonstrated sufficient professional ability to practice competently and independently. The final evaluation will be part of the resident’s permanent record maintained by Long Beach Memorial Graduate Medical Education Office.

**Competencies Evaluation/Review**

Each year the program’s competencies are reviewed by the program director and podiatric medical faculty. The review determines the extent to which the competencies need to be enhanced, modified, or reallocated to assure that the competencies can be achieved.

**In-Training Exam**

The residency program requires that all residents take in-training examinations as prescribed by the relevant specialty board. The examination results will be used as a guide for resident remediation and as part of the annual self-assessment of the program.
Promotion/ Graduation

The resident is eligible for promotion/graduation upon the satisfactory completion of the training program. During his residency program the resident shall maintain satisfactory academic performance, demonstrate clinical competence, complete responsibilities as outlined by the Residency Program, fulfill all the requirement set forth in CPME 320 for the appropriate category of residency training and fulfilled all financial obligations to all institutions affiliated with the program.

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

Remediation

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

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

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

2. Extra clinical and/or didactic work in the area will be assigned. The clinical work if needed will be worked into the resident's schedule. The resident must obtain a satisfactory rating on the work assigned.

3. The resident will be assigned to repeat the rotation or an equivalent rotation (as defined by the Director). This rotation may be added to the end of the training program and may or may not be the same length as the original rotation (at the discretion of the residency training committee). Training beyond the end of the standard 36 month training period will be without compensation.

If the grade of deficient is received remediation method will used:

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

2. Remediation will not extend beyond 3 months. Any resident still failing after that period will be dismissed without a certificate. A resident’s contract will not be renewed if failed/incomplete
rotations constitute 25% or more of the year’s training, except where this percentage is exceeded because of leave under the Family Medical Leave Act, or if the committee deems that remediation attempts have failed (in any case a second failure of any rotation will constitute failure of remediation). Training beyond the end of the standard 36 month training period will be without compensation.

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

### Due Process

Any resident who has a complaint, disagreement or expression of dissatisfaction with his/her training, assessment of abilities or matters related to Resident’s activities which could result in Resident’s dismissal, suspension, demotion or otherwise significantly threaten his/her intended career development has a right to request an informal review.

- **Informal Review**
  A Resident who has a complaint shall discuss it with the program director and/or the Executive Director for Medical Education. If the complaint cannot be resolved through informal discussion within 30 days, the resident may pursue the formal review process.

- **Formal Review**
  Grievances shall be submitted in writing to the office of Graduate Medical Education and to the Executive Director for Medical Education and must be received within 30 days of the date on which the Resident could be expected to know of the event of action which gave rise to grievance or within 30 days of the date of a separation or whichever occurs first. The written grievance shall describe the specific actions that are requested for review, how the Resident was adversely affected and the remedy requested. The Program Director who wishes to contest the allegations and the grievance shall have 15 days to respond after receiving the written grievance from the Resident.

An informal resolution to the grievance may be agreed upon by the Resident and the Executive Director of Medical Education. If a resolution is not achieved than a hearing must be scheduled.

- **Hearing Process**
  The Chair of the GMEC shall appoint a Hearing Committee. The Hearing Committee shall include two or three faculty members from departments other than the one in which the program is located, three residents, one who is in a program other than the department from which the Resident making the complaint is from, and an at-large member from the Medical Staff.

  The hearing shall be closed unless both parties agree to an open session. The hearing shall be recorded by the Office of Graduate Medical Education.

  No new issues may be introduced by the Resident that were not included in the original grievance unless both parties agree.

  **The responsibility and authority of the Hearing Committee:**

  1. Identify the grievance issues submitted in the original written grievance or hearing.
2. Conduct a hearing to determine the facts and whether the Chair’s and/or Program Director’s action was in violation of the Resident’s rights or if the grievance involves corrective action or dismissal, whether the action taken by the Chair and/or Program Director was reasonable under the circumstances.

3. Submit a report, in writing, to the Executive Director of Medical Education and the Chair of the GMEC.

   The Hearing Report Shall Include:
   a. Description of each issue under submission
   b. The positions of the parties on each issue
   c. The findings of facts and policy violation, if any
   d. A recommendation for resolution of each issue

- **Decision**
  The decision of the Hearing Committee will be sent to the Executive Director for Medical Education at LBMMC.

  The recommended decision of the Hearing Committee shall be accepted, rejected or modified within 15-calendar days after receipt. The decision of the Executive Director for Medical Education is final. The decision shall be in writing and forwarded, with a copy of the hearing report, to the respective parties.

- **Remedy**
  If the Chair’s or Program Director’s action is determined to be in violation of the Resident’s rights or if the corrective action or dismissal is determined by the Executive Director for Medical Education not to be reasonable under the circumstances, the remedy shall not exceed restoring the Resident’s pay, benefits, or rights lost as a result of the action less income earned from any other employment in the meantime.

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**Resident Supervision Policy**

I. **Key Principles**

1. An attending physician must be identified for each episode of patient care involving a resident.
2. The attending physician is responsible for the care provided to these assigned patients.
3. The attending physician is responsible for determining the level of supervision required to provide appropriate training and to assure quality of patient care.
4. Resident supervision must be documented.
5. Program directors direct and supervise the program.

II. **Key Supervision Issues**

1. Attending physician/staff practitioner responsibilities
   a. Inpatient
      i. Attending physician is identified in the chart.
      ii. Meet with the patient within 24 hours of admission
      iii. Document supervision with progress note by the end of the day following admission.
iv. Follow local admission guidelines for attending notification.
v. Ensures discharge is appropriate.
vi. Ensures transfer from one inpatient service to another inpatient service is appropriate.

b. Outpatient
i. Attending physician is identified in the chart
ii. Discuss patient with resident during initial visit -- Document attending involvement by either an attending note or documentation of attending supervision in the resident progress note.
iii. Countersign note

c. Emergency Room
i. An attending physician must always be physically present.

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

e. Surgery/Procedures
i. Attending physician is identified
ii. Attending meets with the patient before procedure/surgery
iii. Documents agreement with surgery/procedures
iv. Countersign procedure note

2. Program Director/GME Administrator
a. Establish and write program specific supervision policy
b. Orientation for residents
c. Education of attending physicians
d. Implementation and follow—up of policy

Policy For Supervision Of Podiatry Trainees (Affiliated Hospital and Non-Hospital Sites)

I. Definitions

a. Affiliated Training Site. An affiliated training site is an institution or facility that provides a rotation(s) for residents. Examples of sites include: a college of podiatric medicine, a teaching hospital including its ambulatory clinics and related facilities, a private medical practice or group practice, a skilled nursing facility, a federally qualified health center, a public health agency, an organized health care delivery system, or a health maintenance organization (clinical facility).

b. Graduate Medical Education. Postgraduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire those skills, knowledge, and attitudes, which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitate the resident’s professional and personal development, and ensure safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty.
c. Program Director. The Program Director is responsible for the quality of the overall affiliated education and training program in Podiatric Medicine & Surgery and for ensuring the program is in compliance with the policies of the Council on Podiatric Medical Education.

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

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

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

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

h. Supervising Practitioner. Supervising Practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the patients' health care needs.

II. Policies

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

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

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

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

e. The principles of good training and educational supervision are not likely to change radically over time. Rules governing billing and documentation, however, will inevitably evolve. This policy focuses on resident supervision from the educational perspective.
f. The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences. This process is the underlying educational principal for all podiatric residents. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident.

III. Responsibilities

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

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

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

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

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

b. Attending physician. The attending physician is responsible for and must be personally involved in the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible attending physician must continue to maintain a personal involvement in the care of the patient. The attending must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the patient's health care needs. The procedures through which the attending physician provides and document appropriate supervision is outlined below in section 5.

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

IV. Procedures

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

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

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

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

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

v. Intensive Care Units (ICU), including Medical, Cardiac and Surgical ICUs. For patients admitted to, or transferred into an ICU the attending physician must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays.
vi. **Night Float Admissions.** For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for the night float must be clearly designated by local policy.

vii. **Out Patient clinic.** An attending physician must be physically present in the clinic area during clinic hours. All patients to the clinic for which the attending physician is responsible should be supervised by the attending physician. This supervision must be documented in the chart via a progress note by the attending physician or the resident's note and include the name of the attending physician and the nature of the discussion. New patients should be supervised as dictated by graduated level of responsibility outlined for each discipline. The supervision for new patients should be documented by either independent attending physician note or an addendum to the resident note. Unless otherwise specified in the graduated levels of responsibility, new patients must be seen by and evaluated by the attending physician at the time of the patient visit. Return patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective and appropriate. This supervision must be documented in the record via a note by the attending physician or the resident's note that indicates the nature of the discussion with the attending physician. The medical record should reflect the degree of involvement of the attending physician, either by staff physician progress note or the resident's description of attending involvement. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement. All notes must be signed, dated, and timed by the resident. The Attending's co--signature of the resident's note is an acceptable method for the attending physician to document resident supervision.

viii. The attending physician is responsible for official consultations on each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these residents. The supervision of residents performing consultation will be determined by the graduated levels of responsibility for the resident. Unless otherwise stated in the graduated levels of responsibility, the attending physician must meet with each patient who received consultation by a resident and perform this personal evaluation in a timely manner based on the patient's condition. The patients seen in consultation by residents must be discussed and/or reviewed with the attending physician supervising the consultation within 24 hours of initial consultation by the resident. The attending physician must document this official consultation supervision by writing a personal progress note or by writing his/her concurrence with the resident consultation note by the close next working day. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement.

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

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

xi. Assure all Do Not Resuscitate (DNR) orders are appropriate and assure the supportive documentation for DNR orders are in the patient's medical record. All DNR orders must be signed or countersigned by the attending physician.

b. Assignment and Availability of Attending Physicians.

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

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

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

c. Graduated Levels of Responsibility.

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

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

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

d. Supervision of Procedures.

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

ii. Attending physicians will provide appropriate supervision for the patient's evaluation, management decisions and procedures. For elective or scheduled procedures, the attending physician must evaluate the patient and write a pre-procedural note or addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be done. A pre-procedure note may also serve as the admission note if it is written within 1 calendar day of admission by the attending physician with responsibility for continuing care of the inpatient, and if the notes meet criteria for both admission and pre-operatives’ notes. Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by JCAHO, but such documentation does not replace the pre-operative documentation required by the surgery attending physician.

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

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

f. Evaluation of Residents and Supervisors.

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

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

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

iv. All written evaluations of residents and attending physicians will be kept on file by the Residency Program Director in an appropriate location and for the required time frame according to the guidelines established by CPME.

g. Monitoring Procedures.

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

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

TEACHING CONFERENCES/SEMINARS/JOURNAL CLUBS

Didactic Activities

The didactic experience emphasize a scholarly approach and include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds and/or continuing education. The teaching faculty is included in the majority of didactic activities at LBMMC.

Research Methodology
The resident curriculum includes instructions in research methodology. Residents will participate in research activities to broaden their scope of training. The Program Director may appoint a faculty member to coordinator this activity.

**Journal Review Session**

A journal review session, consisting of faculty and residents will be held at least monthly to facilitate reading, analyzing, and presenting medical and scientific literature.

**Noon Conferences**

Noon conferences start at 12:00 p.m. and are held every Tuesday. All noon conferences are mandatory.

**Seminars**

The third (3) year residents are encouraged to attend a seminar from the approved list below and will be reimbursed for educational experience up to $1000.

1. Approved Seminars:
2. National APMA
3. ACFAS
4. ACFOAM
5. Super Seminar
6. Midwest Seminar

Additional programs are also options but must be approved by the Program Director.

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**VOLUME AND DIVERSITY REQUIREMENTS**

**A. Patient Care Activity Requirements**

( Abbreviations are defined in section B below )

<table>
<thead>
<tr>
<th>Case Activities</th>
<th>MAV</th>
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</thead>
<tbody>
<tr>
<td>Podiatric clinic/office encounters</td>
<td>1000</td>
</tr>
<tr>
<td>Podiatric surgical cases</td>
<td>300</td>
</tr>
<tr>
<td>Trauma cases</td>
<td>50</td>
</tr>
<tr>
<td>Podopediatric cases</td>
<td>25</td>
</tr>
<tr>
<td>Biomechanical cases</td>
<td>75</td>
</tr>
<tr>
<td>Comprehensive medical histories and physical examinations</td>
<td>50</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First and second assistant procedures (total)</td>
<td>400</td>
</tr>
</tbody>
</table>

First assistant procedures, including:

<table>
<thead>
<tr>
<th>Digital</th>
<th>80</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Ray</td>
<td>60</td>
</tr>
<tr>
<td>Other Soft Tissue Foot Surgery</td>
<td>45</td>
</tr>
<tr>
<td>Other Osseous Foot Surgery</td>
<td>40</td>
</tr>
</tbody>
</table>
C. Definitions

1. Levels of Resident Activity for Each Logged Procedure

First assistant: The resident participates in the procedure. Participation may include retracting and assisting, or performing limited portions of the procedure under direct supervision of the attending.

2. Minimum Activity Volume (MAV)

MAVs are patient care activity requirements that assure that the residents has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. For some residents, the minimum repetitions may be higher or lower than the MAVs. It is incumbent upon the program director and the faculty to assure that the resident has achieved a competency, regardless of the number of repetitions.

3. Required Case Activities

a) A case is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

b) Podiatric clinic/office encounters. This activity includes direct participation of the resident in the clinical evaluation and management of patients with foot and ankle complaints. LBMMC must document the availability of at least 1,000 encounters per resident.

c) Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.

d) Trauma cases. This activity includes resident participation in the evaluation and/or management of patients who present immediately after traumatic episodes. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Medical histories and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

e) Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.

f) Pedopediatric cases. This activity includes resident participation in the evaluation and/or management of patients who are less than 18 years of age.

g) Biochemical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of locomotor disorders caused by congenital, neurological, and heritable factors. These experiences include, but are not limited to, performing
comprehending the processes related to the examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders.

h) Comprehensive medical history and physical examinations: Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P. A focused history and physical examination does not fulfill this requirement.

The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

4. Required Procedure Activities

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable. For example, if a surgical procedure employed to correct a hammertoe includes a proximal interphalangeal joint component and a metatarsophalangeal joint component, these components cannot be counted as separate procedures.

Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies.

D. Assuring Diversity of Surgical Experience

The construct of the procedure categories assures some degree of diversity in the resident’s surgical training experience. The two paragraphs below relate to first assistant procedures only.

To assure proper diversity within each procedure category and subcategory, at least 33 percent of the procedure codes within each category and subcategory must be represented with first assistant procedures. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedures codes must have at least one activity as first assistant.

To avoid overrepresentation of one procedure within a category and subcategory, one procedure code must not represent more than 33 percent of the total number of procedures logged in each procedure category and subcategory. This statement applies more to a resident just meeting the minimum procedure requirement in a procedure category than to a resident significantly exceeding the procedure requirement in a procedure category. For example, the number of partial ostectomies must not exceed 26 when the minimum of 80 required Digital procedures are logged.

E. Programs with Multiple Residents or Fellows

1. Only one resident may take credit for first assistant participation on any one procedure.

2. More than one resident may take credit for second assistant participation.
3. The activity of a fellow should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

4. When multiple procedures are performed on a single patient, more than one resident or fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

**CERTIFICATION OF COMPLETION**

Certification is a process to provide assurance to the public that a podiatric physician has successfully completed an approved residency and an evaluation, including an examination process designed to assess the knowledge, experience, and skills requisite to the provision of high quality care in a particular specialty.

Resident completion of the Podiatric Medicine and Surgery-36 program leads to the foot surgery certification and reconstructive rearfoot and ankle surgery certification pathways of the American Board of Podiatric Surgery (ABPS) and certification pathway of the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).

Certification of completion of the residency will be made by an approval vote from the Graduate Medical Education Committee. Following approval the Program Director will cause to be issued to the resident a certification or diploma evidencing the successful completion of the residency.