

Coney Island Hospital (CIH)  
Podiatric Medicine and Surgery Residency (PMSR)  
Residency Training Program Manual

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***Attachment A: CPME Standards and Requirements***

## **I. Purpose**

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

1. Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot and ankle, by medical, biomechanical, and surgical means.
2. Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident's competencies in the peri-operative care of diseases, disorders, and injuries of the foot and ankle.
3. Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.
4. Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

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

1. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means.
2. Assess and manage the patient's general medical status.
3. Practice with professionalism, compassion, and concern, in a legal, ethical, and moral fashion.
4. The ability to communicate effectively and function in a multidisciplinary setting.
5. Has the capacity to manage individuals and populations in a variety of socioeconomic and health care settings.
6. Has the capacity to manage a podiatric practice in a multitude of health care delivery settings.
7. Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice.

## **II. Committees**

### A. Residency Training Committee

This committee is responsible for the overall direction, regulation and functioning of the residency training program. It is composed of the Director of Podiatric Medical Education, the Rotation Directors, appropriate representatives of the Medical Teaching Staff, a representative of the Administration of CIH, and other members as deemed appropriate by the Committee and/or affiliated institutions. The Committee should not exceed 15 members. Appointments to this committee are made by the Director and include the Rotational Directors following their appointment by their respective centers.

The function of this committee is to set policies for the program, develop the curriculum of the training program and review overall resident and program performance. In addition, this committee will mediate conflicts arising within the teaching program, whether they are generated 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. The Director of Podiatric Medical Education will be the chairman of this committee and will be responsible to schedule the meeting dates of the committee at least semi-annually. The committee may serve as the Evaluation/Grievance committee (see below)

The responsibility of the Director of Podiatric Medical Education is to oversee the general administration of the residency. It is the Director's responsibility to insure that the residents follow the guidelines established for them within their contracts and within this manual. If the need arises the Director of Podiatric Medical Education appoints individuals or committees to assist him in his responsibilities as Director. The Director or Rotation

Director will coordinate the various rotations. If a conflict should arise in respect to the curriculum and/or management of a rotation, the Residency Committee in consultation with the staff of the involved rotation will make the final decision regarding the rotational structure. The Director of Podiatric Medical Education is directly responsible to the Residency Committee. The Director serves as the liaison with the Council on Podiatric Education. The Director may only vote to break a tie. The Director may hold additional positions on the committee including their voting rights. The Coney Island Hospital GME committee appoints the Director. The choice of appointee should be based heavily on the individual's ability to do the job and the availability of the 20+ hrs per week it requires. CIH upon 30 days written notice may revoke the appointment.

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

The position of Rotation Director at the affiliated institution will be held by a member of the staff from that institution as long as the affiliation between the residency and institution is in force. The affiliated institution may choose that individual by any method they wish as long as the term of office is at least one year. The Rotation Director will be responsible for the day by day functioning of the residents at their institutions. The Rotation Director will serve as an advisor to the residents and a liaison with the heads of the various rotations and departments affiliated with the residency at their institution.

#### B. Residency Selection Committee

The Residency Selection Committee will be made up of a subcommittee of the residency training committee appointed by the Director. The Director shall chair the Committee unless the Director has appointed another committee member to assume chairmanship. It will be the responsibility of all Committee members to screen each application prior to attending the final selection meeting. During the final meeting the applicants under consideration will be discussed in detail. The current Residents 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.

#### C. 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 member of the residency training committee appointed by the Director. The Director shall chair the Committee unless the 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 Residency Training Committee regarding any needed changes or program enhancements. The committee will meet more frequently in cases where residents are having academic problems and will meet at least monthly when a resident is on academic probation. The committee will serve as the initial hearing body for any appeal of a resident evaluation.

### **III. Podiatric Resident Selection Policy / Process**

To be eligible for appointment to the Podiatric Housestaff at CIH, an applicant must:

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

All PGY1 positions will be offered through the Centralized Application Service for Podiatric Residencies (CASPR) following their established guidelines and policies.

All PGY1 applicants must pass Parts I and II of the national boards prior to the time they begin training.

**All applicants must obtain a New York State Permit prior to the start of residency regardless of PGY level.**

All PGY1 must apply through CASPR. The program prefers applicants who are currently in podiatry colleges to be in the upper 50% of their class.

D.P.M.s (applicants who have already graduated from podiatry school must provide the following items in addition to their CASPR application):

Letter from current program director or a letter detailing what they have done since graduation instead of residency training

Notarized proof of graduation from podiatry school with date of graduation

All PGY2 and above (including Fellowship) applicants must provide the following:

- \_ Curriculum Vitae and Personal Statement
- \_ National Board part I and II scores
- \_ Podiatry College transcripts
- \_ Three letters of recommendation
- \_ Letter from current/former program director
- \_ Notarized proof of graduation from podiatry school with date of graduation
- \_ **All applicants must obtain a New York State Permit prior to the start of residency regardless of PGY level.**

The Program will provide applicants the following information on request:

- \_ Instructions for submitting the application and required documentation (PGY-2 and above)
- \_ Program training and policy manuals
- \_ A statement that “IMC does not discriminate on the basis of sex, race, age, religion, color, national origin, disability, or veteran’s status.”

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

Application packets are reviewed via criteria set forth by the CPME Program Requirements, 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 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 obtain a New York State Permit prior to the start of residency. Residents are strongly encouraged to complete Part III of the boards as soon as possible.

#### **IV. Physical Facilities**

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

Mon-Thu 8:00 AM- 8:00 PM

Fri 8:00 AM- 4:00 PM

Sat 9:00 AM- 1:00 PM

Sun 1:00 PM- 5:00 PM

The library is available after hours by contacting the Hospital Police Supervisor at extension 4422

#### **V. Conduct of the 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 hospital podiatry department and its affiliated institutions.

The following subjects are included in this period of instruction:

1. New hire orientation
2. Committee of Interns and Residents (CIR) benefits
3. Salary and benefits
4. BCLS/ACLS
5. Residency Resource proper logging techniques
6. Residency schedule.
7. Policies manual
8. Program Competencies
9. Demonstrations and lectures covering the various phases of clinical podiatry are given the newly appointed podiatric resident throughout the year. These lectures and demonstrations are so presented that the new podiatric resident will adapt to the hospital atmosphere.
10. Orientation for Winthrop Hospital

##### **B. Dress Code**

Podiatry Department guidelines in addition to all CIH Guidelines

##### **Purpose**

To present a professional appearance to patients, staff, and the public at all training sites, and comply with Joint Commission 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 Tags:** Proper identification as required by each training site must be worn and clearly displayed at all times while on duty.

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

**Scrubs:** Scrubs should not be worn outside of the hospital premises. Scrubs 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 and 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.

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 permitted in patient care areas for safety and infection control reasons.

**Style:** No tank or halter tops, midriffs or tube tops. No sweatshirts or shirts with messages, lettering or logos. No shorts. Jeans are discouraged. A tie is recommended for men on weekdays and recommended on weekends.

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

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

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

**Jewelry:** Should not be functionally restrictive or excessive.

**Piercings:** There should be no visible body piercings, 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 Residency Committee. The resident will make careful notes of orders given by the staff. In no case will the resident change the treatment plan without the knowledge of the staff members. Disagreement with or criticism of any member of the nursing staff must be discussed with the appropriate Rotation Director who will take any necessary action. Questions or criticisms relating to general hospital operation or personnel may be brought to the appropriate Rotation Director who may discuss them with the hospital administrator. Those questions relating to the Podiatric Medicine and Surgery Residency training program will be discussed with the appropriate Rotation Director or Director of Podiatric Medical Education.

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

Remember, always, that the attending physician is in full charge 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.

All complaints must be in writing and presented to the Rotation Director, Program Director or the Training Committee as appropriate.

### D. Leave Policy

Vacation Leave: Each resident directly employed by CIH is allotted 20 days of vacation per year. The resident must request their vacation at least 30 days in advance. The request must be made in writing and the Chief of the rotation involved must approve the leave prior to submission to the Program Director for final approval. Residents may not take vacation in July or June. Vacation will be limited to 10% of any assigned rotation unless arrangements for making the time up are made in advance. No more than 1 week may be taken at any one time. If a rotation is not in session because the primary faculty is on vacation the resident must request and take leave for that period or make arrangements to be at an alternate rotation site. Unused vacation is lost at the end of each year.

Authorized leave: Each resident will be eligible for 5 days of leave to attend seminars. The leave must be approved 30 days in advance (see vacation above). A maximum of one travel day will be allowed.

Sick leave: Each resident must report sick days taken to the rotation involved at the beginning of the day of the absence and an email also at the beginning of the day sent to the Director's attention. A Doctor's note is required for absences greater than 4 successive days. All sick time occurring during the day must be reported to Surgery department and Occupational Health Services.

Any resident failing to abide by these policies after progressive discipline will be placed on corrective action with loss of all leave privileges (first offense) and suspended for 30 days without pay with makeup at end of program (second offense) or terminated (third offense).

Leave taken for medical reasons falls under The Family Medical Leave Act of 1993: The Family and Medical Leave Policy for housestaff at CIH meets the requirements of the Family Medical Leave Act of 1993, allowing up to 12 weeks of leave per year for eligible employees. To be eligible for FMLA leave, a houseofficer must have been employed for at least 12 months and must be requesting leave for a serious medical condition (birth or adoption of a child; serious medical condition of a spouse, parent, or child; serious medical condition of the employee).

Illness which result in a periods of absence longer than a week will be handled under the Family Medical Leave Act. House staff must inform the program director and the GME Office immediately about any needed medical leave to allow time to arrange clinical coverage. Upon learning that a house officer is requesting FMLA leave, the program director or program coordinator will contact the GME Office with the information, and will require that the house officer contact a Benefits Office representative to apply for FMLA. Employees are required to provide the Benefits Office with at least 30 days notice before FMLA is to begin, or within two (2) business days in the case of an unforeseen emergency. The Benefits Office will approve or disapprove the FMLA leave.

Emergency leave: On a case by case basis emergency leave may be granted (with or with out make up) at the discretion of the Program Director, the Rotation Director at the institution where the resident is rotating or if they are unavailable any member of the residency committee. The definition of emergency will be at the discretion of the program and the resident agrees to abide by the decision of the committee, whose available members will be polled in the case of a disagreement. Failure to abide by the decision will result in termination of the resident.

Unused leave is lost annually and will not be paid at the end of training. **Leave taken for any reason that exceeds 30 days in any year must be made up (without compensation unless prior arrangements have been made) in order to complete the program.** No more than 1 resident may take leave at the same time. Preference goes to authorized leave requests and order of request submission.

Unexcused absences: Any unexcused absence will be treated as a violation of the sick leave policy above with the same penalties applying. An unexcused absence is defined as anytime a resident is not in attendance at a scheduled rotation, conference or other residency function or is unavailable when on call without prior arrangements being made.

## E. Podiatric Resident Work Hours

### 1. Work Hours

1. Work hours are defined as all clinical and academic activities related to the residency or fellowship program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Work hours do not include reading and preparation time spent away from the work site.

2. Work hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

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

4. A 10-hour time period for rest and personal activities will be provided between all daily work periods.

5. Resident may be required to periodically track their work hours so they can document that the number of hours residents works on various rotations doesn't violate these rules.

2. At Home On-Call Activities:

1. At-home call (pager call) is defined as call taken from outside the assigned institution.

a. The frequency of at-home call is not subject to the every-third-night limitation. However, at-home call will not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call will be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a four-week period.

b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

c. The program may monitor the demands of at-home call by reviewing resident work hour on a periodic basis, a separate category of hours will be recorded as called to hospital.

3. Moonlighting of Residents and Fellows in Podiatric Programs

1. Professional and patient care activities that are external to the educational program are called "moonlighting." The Podiatry Program permits moonlighting in the 3<sup>rd</sup> year. However, hours are closely monitored to ensure compliance with the duty hour regulations.

4. Back-Up System:

1. 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.

5. Employment Hours:

Each resident is responsible to be prepared to start the day at 8AM and finish when all tasks for the day are completed and in compliance with residency by-laws. Sign in sheets will be monitored and must have time in/out. On call resident will carry the long range beeper and will be responsible for all Emergency Room consults. Any UN-excused lateness and/or absence will become part of the resident's file and will be reflected in any letter of recommendation. Chronic lateness and/or absenteeism will not be tolerated and will be referred to Department of Human Resources. Residents may not leave the premises without specific permission from Director of Podiatric Medical Education or designee. A resident will be considered Absent Without Leave (AWOL) if said permission is not granted and subject to suspension from program.

F. Miscellaneous Responsibilities

While your obligation to yourself, your profession, your hospital and patients will be expressed by implication through out 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. Resident shall report to the Director as a member of the house staff on or before the Monday of the last full week of June or sooner if informed in writing by the program.
3. Cooperate in the conservation of supplies.
4. Residents are not to accept fees or gratuities from patients, their relatives or friends. You will not practice your profession or assist any physician outside the affiliated institutions
5. No alcoholic beverages are permitted in the hospitals. No person who has been drinking may attend a patient.
6. Smoking in the hospitals is prohibited.
7. At **all** times, your patients are to be your first consideration.
8. Visit each of your inpatients 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 the case.
9. 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.
10. Do not sit on the patient's bed unless it is necessary for examination.
11. Protect your patient's privacy. Refer information release inquiries to the appropriate department at the institution.
12. Refer any questions about your patient's financial arrangements to the appropriate individual at the institution.
13. Refer any requests for extra visiting privileges to the Director of Nurses, requests for transfers to other accommodations to the Admitting office, and inquiry about discharge from the hospital, etc., to the patient's attending physician or chief resident.
14. Report promptly on an Incident Report Form any unusual occurrences in the hospital; such as accidents, fire or a disturbed patient.
15. Guard against unnecessary or unwise talking in the hearing of a patient coming out from anesthesia or from alcoholic or other stupor. Patients sometimes hear, and remember, surprisingly well.
16. Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he has been the victim of malpractice.
17. Resident will not order materials, supplies or surgical equipment directly from outside vendors unless directed to by an appropriate individual.
18. Fraternalization with patients is prohibited.
19. **Communication:** Pagers must be answered within 5 minutes. Batteries shall be checked at the beginning of each transfer of long range beeper. Not answering a page in a timely fashion will be considered a dereliction of duty and subjected to immediate suspension from the program.
20. Each resident must have an official HHC e-mail and all notices, journals and schedule changes will be communicated through this media.

21. 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 director.*

## **VI. Supervision/Evaluation**

The Residency Training Committee expects all residents to observe such rules of decorum and order in the hospitals, clinics, and/or private podiatric offices as are becoming to professional men and women. In the event that the resident fails to fully and faithfully perform each and all of his obligations as stated in his contract and as contained in this manual or conducts himself in a manner objectionable to the hospital, the attending staff or the administration of the hospital, it is understood and agreed that the hospital may suspend the resident's contract immediately and without prior notification to the resident subject to appeal (see below). In the event that the resident's contract is terminated, the same shall be of no further force or effect and each of the parties hereto shall be relieved and discharged of any and all further obligations pertaining to the residency program. It is clearly understood that any contract between a resident and the program may be terminated at any time by mutual consent.

### *Grievance Policy (Due Process Policy)*

The grievance procedure for the Podiatry Residency Program at Coney Island Hospital is determined by the programs representation by the committee of Interns and Residents.

#### **Section 1.**

The term "grievance" shall mean:

- a. A dispute concerning the application or interpretation of the terms of this collective bargaining agreement;
- b. A claimed violation, misinterpretation, or misapplication of the rules or regulations, authorized existing policy, or orders of the Corporation affecting the terms and conditions of employment;
- c. A claimed regular or recurrent assignment of House Staff Officer's to duties substantially different from those stated in their job specifications;
- d. A question regarding the non-renewal of the appointment of a House Staff Officer.
- e. The provisions of this Article XIV shall not apply to a grievance under Article VII, Section 1 and 2.

#### **Section 2.**

**Step I.** The Employee and/or the Committee shall present the grievance in writing to the Chief of Service or to the Executive Director or the Director's designee no later than 90 days after the date on which the grievance arose, and in grievances brought under Section 1(D) the grievance shall be presented no later than ninety (90) days after the date on which written notice of non-renewal is received. The individual to whom the grievance was presented shall take any steps necessary to a proper disposition of the grievance and shall reply in writing by the end of the tenth (10<sup>th</sup>) work day following the date of submission, except for grievances brought under Section 1(D), where the reply shall be in writing by the end of the fifth (5<sup>th</sup>) working day following the date of submission.

For all grievances as defined in Section 1 (c), no monetary award shall in any event cover any period prior to the date of the filing of the Step 1 grievance unless such grievance has been filed within thirty (30) days of the assignment to the alleged out-of-title-work.

**Step IIa.** An appeal from an unsatisfactory determination at Step I, except for an appeal brought under Section I(d), shall be presented in writing to the Corporation's Director of Labor Relations. The appeal must be made within ten (10) working days of the receipt of the Step I determination. The Corporation's Director of Labor Relations or his designated representative, if any, may meet with the Employee and/or the Committee for review of the grievance and shall in any event issue a determination in writing by the end of the tenth (10<sup>th</sup>) workday following the date on which the appeal was filed.

**Step II(b).** An appeal from an unsatisfactory determination at Step I in regard to a grievance brought under Section I(d) must be brought within fifteen (15) days of the receipt of the Step I determination to the Housestaff Affairs Committee of the Medical Board for evaluation and determination. A House Staff Office and/or CIR appealing to the Housestaff Affairs Committee shall be given advance written notice of when the Housestaff Affairs Committee will consider the appeal. The Housestaff Affairs Committee will render a written decision and provide it to the House Staff Office and/or CIR. All decisions of the Housestaff Affairs Committee may be reviewed by the Medical Board. If the Medical Board reviews the case, advance notice and a written decision will be provided the House Staff Officer and/or CIR. The decision of the Medical Board in all such matters shall be final.

**Step III.** An appeal from an unsatisfactory determination at Step II(a) may be filed by the Committee with the Office of Collective Bargaining for impartial arbitration within thirty (30) days of receipt of the Step II(a) decision. The Corporation shall have the right to appeal any grievance determination under Section I, except for grievances brought under Section I(d) directly to arbitration. Such appeal shall be filed within thirty (30) days of the receipt of the determination being appealed. The Committee and/or Corporation shall commence such arbitration by submitting a written request therefore to the Office of Collective Bargaining. A copy of the notice requesting impartial arbitration shall be forwarded to the opposing party. The arbitration shall be conducted in accordance with the Consolidated Rules of the Office of Collective Bargaining, except that each party shall be separately responsible for any costs or fees of any member of the arbitration board selected by such party, other than the impartial arbitrator. The cost and fees of such arbitration shall be borne equally by the Committee and the Employer. The determination or award of the arbitrator or the arbitration board noted in Section 8 of this Article shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section I (b) and I(c) of this Article existing at the time the grievance arose.

### **Section 3.**

As a condition to the right of the Committee to invoke impartial arbitration set forth in this Article, the Employee or Employees and the Committee shall be required to file with the Director of the Office of Collective Bargaining a written waiver of the right, if any, of the Employee or Employees and the Committee to submit the underlying dispute to any other administrative or judicial tribunal except for the purpose of enforcing the arbitration's award.

### **Section 4.**

Any grievance of a general nature affecting a large group of House Staff Officers and which concerns the claimed misinterpretation, inequitable application, violation, or failure to comply with the provisions of this Agreement shall be filed at the option of the Committee at Step II(a) of the grievance procedure, without resort to the previous step.

### **Section 5.**

If the Employer exceeds any time limit prescribed at any step in the grievance procedure, the grievant and/or the Committee may invoke the next step of the procedure, except, however, that only the Committee may invoke impartial arbitration under Step III.

## **Section 6.**

The Employer shall notify the Committee in writing of all grievances filed by House Staff Officers, all grievance hearings, and all determinations. The Committee shall have the right to have a representative present at any grievance hearing and shall be given forty-eight (48) hours' notice of all grievance hearings.

## **Section 7.**

Each of the steps in the grievance procedure, as well as time limits prescribed at each step of this grievance procedure, may be waived by mutual agreement of the parties.

## **Section 8.**

At the request of both parties, after the appointment of an arbitrator, or at the request of one party and the arbitrator, there shall be constituted a tripartite arbitration board consisting of the impartial arbitrator, a physician or dentist designated by the Committee, and a physician or dentist designated by the Corporation. The arbitrator shall be the chairperson and presiding member of the arbitration board and shall be the only voting member of the arbitration board. The determination or award of the arbitration board shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section I(b) and I(c) of this Article existing at the time the grievance arose.

## **Section 9.**

The grievance and arbitration procedure contained in this agreement shall be the exclusive remedy for the resolution of disputes defined as "grievances" herein. This shall not be interpreted to preclude either party from enforcing the arbitrator's award in court.

## **Section 10.**

House Staff Officers may be assisted at all stages of the procedures herein set forth in this Article by representatives of the Committee.

## **Section 11.**

The institutional Grievance Committee will consist of the following members of the Graduate Medical Education Committee (GMEC): Director of Medical Education, Chairmen of the Departments of Medicine, Surgery, Pediatrics, Obstetrics and Gynecology and Psychiatry (excluding the Chairman of the affected House Officer's Department), Representative of the Committee of Interns and Residents (CIR), Representative of the Human Resources Department and Representative of the Hospital Administration and/or Corporation

### *Grievance Policy II (Discipline and Dismissal Policy)*

Proposed disciplinary actions against a resident in the Podiatry Residency Program at Coney Island Hospital are adjudicated through representation of the house officer by the committee of Interns and Residents.

## **Section 1.**

House Staff Officers shall have the right to a hearing before being subject to disciplinary action except as hereinafter provided. There shall be no disciplinary action taken against a House Staff Officer except for cause

and pursuant to and after the completion of the procedures herein provided. Notwithstanding the provisions of Section 6(d) below, when a charge of failure to complete delinquent charts is sustained following proper notice and hearing as below, the proposed discipline may be implemented before the completion of those procedures by the Hospital Medical Director when it is a reprimand or by the Corporate Director of Labor Relations when it is other than a reprimand.

## **Section 2.**

It is understood that a House Staff Officer may be reassigned from medical responsibilities without a hearing when the House Staff Officer's continued presence is deemed to risk the successful operation of the hospital. Following such reassignment by either the Chief of Service or the Medical Director of the hospital, the Committee shall have the right to an immediate appeal to an arbitrator or arbitration board as hereinafter provided.

## **Section 3.**

When disciplinary action against a House Staff Officer is contemplated either by a Chief of Service or Medical Director, written charges and proposed disciplinary action shall be presented by the Medical Director to the Committee and to such House Staff Officer, who shall be notified of the House Staff Officer's right to appear before the Medical Director or duly designated representative for the purpose of an informal hearing before such Medical Director or designee. The Medical Director shall have the right to affirm, rescind, or modify the charges and/or proposed action after such informal hearing.

## **Section 4.**

The House Staff Officer or Committee shall be entitled to a conference with the Corporation Director of Labor Relations or the Director's designee in the event that the Medical Director does not rescind the charges and proposed disciplinary action, and the said Director of Labor Relations shall be authorized to affirm, rescind, or modify said charges and/or proposed action after such conference.

## **Section 5.**

The written charges and proposed disciplinary action shall become final unless: (i) rescinded by the Medical Director; or (ii) rescinded by the Corporation Director of Labor Relations; or (iii) the Committee requests in writing to the Office of Collective Bargaining, with simultaneous notice to the Corporation and the Medical Director, within fifteen (15) days after the receipt by the Committee of the original written charges and proposed disciplinary action, that said charges and action be submitted to arbitration pursuant to this Article XV.

## **Section 6.**

- a. Arbitration hereunder shall determine whether just cause or basis exists to sustain the charges and, if so, whether there is just cause or basis for the proposed disciplinary action. The arbitrator shall be authorized to accept, reject or modify the charges or proposed disciplinary action. The determination or award of the arbitration shall be final and binding and shall not add to, subtract from, or modify any contract, or any rule, regulation, existing authorized policy, or order mentioned in Section 1 (B) and (C) of Article XIV existing prior to the notice provided by Section 3 thereof.
- b. Arbitration hereunder shall be conducted in accordance with the Consolidated Rules of the Office of Collective Bargaining, except as modified in (c ) of this Section. The costs and fees of such arbitration shall be borne by the Committee and the Corporation as provided in Article XIV, Section 2.

- c. At the request of both parties after the appointment of an arbitrator, or at the request of one party and the arbitrator, there shall be constituted as tripartite arbitration board consisting of the impartial arbitrator, a physician or dentist designated by the Committee, and a physician or dentist designated by the Corporation. The arbitrator shall be the chairperson and presiding member of the arbitration board and shall be the only voting member of the arbitration board. The determination or award of the arbitration board shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section 1(B) and (C) of Article XIV existing prior to the notice provided by Section 3 hereof.
- d. No disciplinary action shall be imposed upon a House Staff Officer until said action has become final pursuant to Section 5 hereof or said action has been subject to a determination and award in arbitration pursuant to Section 6 hereof.

## **Section 7.**

The Hospital will arrange the schedules of House Staff Officers who are involved in disciplinary or grievance procedures so as to permit reasonable time off.

\*Refer to CIR Policy

### *Resident Evaluation Policy*

#### I. Purpose:

A. The Graduate Medical Education Committee of CIH has responsibility for the overall academic quality of each of the graduate medical training programs. A part of that quality can be measured by the performance of the residents (a term used to identify interns, residents, and clinical fellows in CPME accredited training programs). The program expects a progression of knowledge in the specialty area from beginning to end of training, and such progress needs to be monitored. It is further expected that residents will be eligible for the specialty board examination upon completion of the training program, with an overall goal that all residents will pass the examination and become board certified.

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

### Standards of Performance

#### I. Policy:

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

1. Appropriate behavior by the resident, towards patients, colleagues and staff while attaining the following competencies (see rotation specific competencies and indicators later in this manual)
  - a. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
  - b. Assess and manage the patient's general medical status.
  - c. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.

- d. Communicate effectively and function in a multi-disciplinary setting.
- e. Manage individuals and populations in a variety of socioeconomic and healthcare settings.
- f. Understand podiatric practice management in a multitude of healthcare delivery settings.
- g. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

## 2. Promotion/Graduation

The resident is eligible for promotion/graduation upon the satisfactory completion of the training program. During his residency program the resident shall maintain satisfactory academic performance, demonstrate clinical competence, complete responsibilities as outlined by the Residency Rotation/Training Manual, fulfill all the 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) (for 3<sup>rd</sup> year residents). 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.

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

## 3. Remediation

Any resident who fails to perform satisfactorily in a rotation will be given the opportunity to remediate the 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 below average 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 the following 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.

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

A written copy of these standards will be given to each resident on or before the first day of training in that 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.

#### 4. Renewal of House Officer Agreements

Residents performing satisfactorily may have the resident agreement renewed for the subsequent year. The resident agreement is renewable annually as agreed among the resident, the program director, and CIH. 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.

#### 5. Academic Evaluation

A. In addition to regular contact with supervisors, each resident will be evaluated in writing at least quarterly, or at the end of each rotation. Rotations should have an interim evaluation, if resident progress is not satisfactory.

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

C. Residents new to a training program need special monitoring during the first six months of the program. Supervisors are responsible for early detection of problems, and remedial programs must be established by each program.

D. For any evaluation of less than satisfactory performance, for whatever reason, the program director will:

a. Discuss the evaluation with the resident.

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 evaluation committee of the unsatisfactory evaluation.

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

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

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

G. It is the responsibility of each resident to secure evaluation forms and submit them to their supervisors at the end of each rotation. Failure to complete the evaluation form at the end of each rotation will result in disciplinary action

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

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

## 6. Academic Probation

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

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

1. Allow the resident to complete the remainder of the training year
2. Offer a house officer agreement for the next agreement year.
3. Not offer an agreement for the coming year.

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

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

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

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

## 7. Resident Supervision Policy

### Resident Supervision Policy -- Summary of Main Points

#### Key principles

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

#### 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 available.

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

f. Sign initial DNR orders and document compliance with local DNR policies

2. Program director/program coordinator

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 Podiatric Postgraduate Trainees*

#### I. Definitions:

a. 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.

b. Program Director. The Program Director is responsible for the quality of the overall affiliated education and training program in Podiatric Medicine & Surgery and for ensuring the program is in compliance with the policies of the Council on Podiatric Medical Education.

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

d. Attending Physician. Attending physician refers to licensed, independent physicians, who have been formally credentialed and privileged at 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.

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

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

g. 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. Policy:

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 accreditation standards of the Joint Commission and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide patient care and 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. CPME requirement: 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.

g. The Podiatry program must be approved by CPME (Council for Podiatric Medical Education) or have special approval by the Graduate Medical Education (GME) committee.

#### 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.

### III. 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 in 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 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. Out Patient clinic. 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 or cosigned by the attending. 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, an addendum to the resident note or attending co-signature. Unless otherwise specified in the graduated levels of responsibility, new patients should 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. The attending physician must document this official consultation supervision by writing a personal progress note, by writing his/her concurrence with the resident consultation note or by co-signature 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) 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. 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.

f. 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.

g. 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 six 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 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 Administrator and summary results will be given to 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.

h. Monitoring Procedures.

i. 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.

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

## VII. Sexual Harassment

Sexual Harassment will not be tolerated by the residency program. Sexual Harassment will be dealt with by the method prescribed in the sexual Harassment policy of the institution where the problem occurred (policies available on request). At any site where no such policy exists the VA policy will be followed. In this case any complaints must be filed with the residency training committee through one of its members.

## VIII. Resident logs

*Clinical log - Must be kept on Residency Resource ([www.podiatryrr.com](http://www.podiatryrr.com)) and each Monday must be current through the previous Friday. The program requires that all surgeries (all types) and at least one case from each ½ day clinic session (all specialties) be logged. The resident is required to log all cases, which would count toward an MAV requirement. Random audits of resident's logs are conducted by the Program Director. The director at his/her sole discretion will determine the adequacy and completeness of the log. **Repeated/chronic logging delinquency is grounds for dismissal without appeal. Any resident not completing their logs at the end of each quarter will be suspended without pay until the logs are completed.***

Activity log (didactics only) – Are kept on PRESENT ([www.podiatry.com](http://www.podiatry.com)) and each Monday must be current through the previous Friday. Failure to complete the assigned lectures for the week will result in suspension from program until assigned lecture is completed

## **IX. Teaching conferences/Seminars**

*Coney Island Hospital*

Wound Care Multidisciplinary Rounds (Podiatry, Vascular, Wound Care Team):

8am Every Tuesday

Journal Club

3pm Every Thursday

Guest Lecturer

5pm First Monday of Every Month

The residents shall also participate in the teaching conferences and rounds provided by the services they rotate on (i.e., medicine, orthopedics, endocrinology).

Seminars: Residents are encouraged to attend seminars from the approved list below.

Approved Seminars:

National APMA

Local APMA

Residency Summit

Additional programs are also options but must be approved by the Training Committee.

## **X. Academic requirements for residents**

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

1. One paper on a podiatry related subject of a quality consistent for publication. Completed by prior to the end of the 3<sup>rd</sup> year of residency.
2. Two formal (including audiovisuals and all relevant data) presentations of cases seen in the clinics suitable for inclusion in a teaching file.
3. Two lectures per year on topics in Podiatry suitable for presentation at Journal Club (including audiovisual aids etc.).
4. A minimum of twelve case presentations for Podiatry conferences (short audiovisuals optional).
5. One research project to be approved by residency committee. Section of project for which the resident is responsible completed by the end of the final year of training The program will assign a mentor. The purpose of this exercise is to teach research methodology to the resident.
6. Residents are provided funds for educational purposes through CIR.
7. Each resident must take the yearly American Board of Podiatric Surgery (ABPS) Exam exam with expectation of attaining at least the mean when compared to the peer group. Unsatisfactory grades will be subject to academic probation and recorded accordingly.

## **XI. Policies for Patient Relation**

### **A. Admission Procedure**

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

### **B. In Regard to Transfer of Patients**

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

### **C. History and Physical Examination:**

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

- a. Chief complaint
- b. History of present illness
- c. Past medical history
- d. Social history
- e. Review of systems

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

### **D. Progress Notes**

Progress notes are specific statements by the physician relative to the course of the disease, special examinations made, response to treatment, new signs and symptoms, complications, and surgical cases, removal of drains, splints, and stitches, abnormal laboratory and X-ray findings, condition of surgical wound, development of infection and any other data pertinent to the course of the disease. The frequent use of general statements such as "condition fair", "general condition, good", and "no complaints", is valueless. Progress notes should be written by the resident or if by a student reviewed by the resident. A note should be written at least once a day on all patients. An admitting progress note is to be written by the attending physician. A resident leaving the service should be sure that the progress notes are up-to-date and should summarize the condition of the patient on the day he leaves the case. The person coming on the service should carry on the progress notes from that time. All notes should be signed by the person writing the note and cosigned as necessary.

### **E. Orders**

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

## F. Consultations

Any podiatric consultation requested by the medical staff is to be handled directly by the resident in consultation with an attending. Residents will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders. In accordance with the resident's contract, the resident shall not be permitted to participate in professional or clinical work wherein others collect compensation for the resident's services.

## G. Discharges

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

1. Post-operative instructions.
2. Post-operative shoes, walker, or crutches.
3. Instructions to call the doctor's office for an appointment
4. Prescriptions for necessary medications. The resident should check with the attending podiatrist for types of medications preferred and/or special instructions. The resident is to dictate or record a discharge summary following the discharge.

### Discharge Medications:

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

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

The resident must in every case of discharge against medical advice do the following, which should be noted on the discharge summaries:

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

## H. Completeness and Accuracy

The value of the medical record is directly proportional to the thoroughness and accuracy with which it is written. It should be remembered that any record may be summoned for legal use. All entries in the medical record must be complete and accurate. Both the efficient of handling patients and good teaching and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than none.

## I. Corrections

Erasures and blanked-out alterations on records are illegal and make the record valueless to the patient or the hospital in case of litigation. If corrections are necessary, a single line should be drawn through the words to be

deleted, and the new entry should be made. Correction to electronic medical records shall be made as an addendum to the note being corrected. Chart entries are permanent and must be in permanent ink. The original reports, not copies, of special examinations, such as X-ray and Pathological examinations, are incorporated into the medical record. Neat, well kept, complete records may help to advance medical knowledge, and the condition of our records is one of the factors determining our approval by certifying committees.

Not only is the patient's record a permanent reference file for subsequent admissions and for medical research, it is also a legal document and should be regarded as such. Notations tinged with frivolity, inappropriate remarks, or implied criticisms have no place in these documents. Notes or messages for attending physicians or other members of the house staff should not be written on the permanent record; these may be written and attached to the outside of the chart, if desired.

#### J. Legibility

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

#### K. Rules for Patient's Records

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

1. Must not be removed from the hospital.
2. Must not be taken to Resident's quarters.
3. Must not be kept in desks or file drawers outside of the Medical Records Department.
4. Must not be kept in locked offices.
5. Electronic charts must be closed if you walk away from them.

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

1. For use by the physicians upon re-admission to the hospital or return to the hospital for out-patient care.
2. For use by the Resident or attending staff for reference or study with the Medical Records Librarian's knowledge and permission and in the case of research an IRB approval or waiver..
3. For use by other authorized hospital personnel upon request.
4. For use in court upon subpoena (copies only).
5. Never give a patient or anyone else a copy of any part of a medical record. The patient should be sent to medical records to sign an appropriate release form.

Any record may be requisitioned by a resident or attending staff for use within the hospital building for teaching purposes only. No record should be removed from Medical Records without the knowledge of that department. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

## **XII. Basic Hospital Charting**

### *Admitting Orders*

1. Admit Mrs. H, A. Smith to Hospital.
2. List diagnosis including medical diagnosis when appropriate.
3. Labs: SMA 12, CBC with differential, PT, UA, others as appropriate.
4. Chest X-rays, PA and lateral (as necessary).
5. Foot X-rays (as desired).
6. EKG (as necessary).
7. H & P and medical consult by Dr. Jones Admit.
8. Diet
  - a. Regular diet.
  - b. Special instructions to dietician (eg: 1800 calorie ADA diet for diabetics).
9. Dalmane 30 mg po hs sleep (or sleep medication of choice).
10. NPO after midnight.
11. Sterile below the knee bone prep.
12. Dr. (list names of resident and assistant surgeon) may write orders and assist in management.
13. Signature and degree

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

### *Admitting Note*

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

1. Date of admission, time.
2. Mrs. I.P. Smith, age 54, is admitted to Hospital for surgical/medical treatment of (list admitting diagnosis).
3. History of present illness/chief complaint. (HPI of C/C)
  - a. Chief complaint
  - b. Location and duration
  - c. Previous therapy with effect
  - d. Type of conservative treatment and proposed surgery.
4. Past medical history (PMH)

- a. Include serious illnesses-injuries
  - b. current medications
  - c. allergies.
  - d. past surgical history
  - e. review of systems
5. Full body examination including.
- a. vital signs
  - b. biomechanical exam
6. Assessment and plan for all current medical and podiatric problems
7. Note any contraindications or state that no contraindications to surgery are evident.
8. Signature and degree.

*Postoperative Note*

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

1. Surgeon, 1st assistant, 2nd assistant
2. Pre-operative diagnosis
3. Post-operative diagnosis
4. Procedures performed
5. Primary anesthetic: agents, route of administration, and amount.
6. Injectable: (steroid, type of local at close of case).
7. Hemostasis: type (thigh cuff), pressure (250 mm Hg), time.
8. Materials: type of sutures, pins or wire, implants, drains.
9. EBL (estimated blood loss).
10. Pathology (eg: soft tissue sent for gross and micro).
11. Dressing, splint, or cast.
12. Complications.
13. The patient tolerated the procedure well and left the OR for the R.R. in apparent satisfactory condition (this summary statement should be altered if the procedure was not well tolerated or the patient was not in satisfactory condition). Note on new vascular status.
14. Signature and degree.

### *Post-Operative Orders*

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

1. Monitor vital signs q 15 min. until stable, then q shift.
2. Activity level (CBR - complete bed rest, BRP - bathroom privileges).
3. Diet (liquid to regular diet as tolerated).
4. Elevate FOB, dispense foot cradle.
5. I.M. analgesic (Demerol 50mg/Vistaril 50mg I.M. q 3-4h prn severe pain).
6. Oral analgesic (Tylox caps, po q 3-4h prn moderate pain).
7. Antiemetic (Trilafon 5 mg I.M. TID prn N/V).
8. Sleep medication (Dalmane 30 mg po hs prn sleep).
9. P.O. X-rays
10. Orders for any I.V., antibiotics, anti-inflammatories, or other medications.
11. Therapeutic adjuncts such as mini-heparinization, incentive spirometry, breathing exercises, physical therapy.
12. Notify Dr. of any unusual circumstances.
13. Signature and degree.

### *Operative Report*

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

1. Name - Spell out completely for identification and clarification.
2. Hospital number - This is also important for identification and clarification.
3. Surgeon - The actual surgeon who performed the procedure.
4. First assistant/other assistant - Mention of these names will insure that these individuals receive copies of the report for the records.
5. Type of anesthesia - Local or general.
6. Date - Actual date of surgery.

7. Preoperative diagnosis

8. Postoperative diagnosis

9. Procedure - The exact operative procedures used during surgery, designated by the site. For example: arthroplasty, left foot, 5th digit. Include all procedures.

10. Operation and findings - This, which is the main body of the report, should be concise but must be complete to alleviate confusion and verbose reports. It describes the following:

- a. The prepping and draping.
- b. Administration of local anesthesia including type and amount and manner, or administration of general anesthesia.
- c. Type of hemostasis (cuff, etc.)
- d. Type and length of incision.
- e. The procedures used in relationship to the disease entity, using correct medical terminology.
- f. Any pathology related to the disease entity, using correct medical terminology
- g. All methods of closure, including type and suture material.
- h. Dressing.
- i. Condition of patient upon completion of surgery. The information on this report must be consistent, i.e., the post-operative original reports must be signed by the surgeon. To insure that a report has been dictated accurately, listen to the entire report before signing off or re-read the entire report before signing.

### *Progress Notes*

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

1. Date

2. Time

3. Patient's general condition or comments.

4. Medications/Allergies

5. Vital signs

6. Condition of bandages

7. LE exam

- a. Neurovascular status of feet

b. Evaluation for DVT

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

8. Condition of lungs

9. Assessment of patient's progress

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

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

12. Sign with name and degree.

### **XIII. Medical Permit Information**

All residents must obtain a New York State Permit prior to the start of the program. [www.op.nysed.gov](http://www.op.nysed.gov). **Podiatry Resident cannot start their program without an official affidavit from NYS permitting a resident to practice Podiatry in NYS.** It is the Resident's responsibility to procure this document and the required signatures. In addition, annual renewals are the responsibility of resident. A resident may not continue to practice at the hospital without this document. Any resident, knowingly practicing without this document will be immediately terminated from the program and have the results of their termination be part of their permanent file and letters sent out to any entities

You are also required to have an NPI number You must apply for you NPI number at the beginning of your 1<sup>st</sup> year. Put “Resident” and/or “Pending” for your license number.

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

### **XIV. Additional Program Information**

CPME requirements, APBS, Residency Review, PRESENT (diabetic lectures)

[CPME 320 – www.cpme.org](http://www.cpme.org)

[CPME 330 – www.cpme.org](http://www.cpme.org)

American Board of Podiatry Surgery – [www.abps.org](http://www.abps.org)

Residency Resource – [www.podiatryrr.com](http://www.podiatryrr.com)

Case logging, evaluations, competencies

PRESENT – [www.podiatry.com](http://www.podiatry.com)

Didactic lectures

## XV. Rotation Information and Competencies

The following rotations are designed to give the resident graded experiences and responsibility in the management of patients and recognition and understanding of clinical entities (this will have reference particularly to the field of foot surgery, but will also refer to all related medical and surgical areas). Included are the competencies to be achieved in each training experience. The resident will be responsible to the attending physician(s) and the chief resident (where applicable).

### **Goals and Competencies**

The program has written goals constituting a realistic overall mission for the residency program as well as specific objectives for each experience which are appropriate for each core and clinical rotation. Copies of these goals and competencies are contained within this manual. These goals and competencies focus on the educational development of the resident and do not place emphasis on service responsibility to individual faculty members.

At the completion of each block experience, the resident shall be evaluated by the rotation director. It shall be the responsibility of the resident to present to the director of podiatric medical education, the completed and signed evaluation forms for each rotation within two weeks of completion of the rotation unless extenuating circumstances exist.

All of the evaluation forms, including those from members of each rotations teaching faculty, will be submitted to the residency director within two weeks of completion of the rotation. Each evaluation performed shall be signed by the rotation director, the resident, and the director of podiatric medical education. All evaluation forms indicate the dates of the rotation.

If any competency is not met, the director of podiatric medical education will arrange for additional time to be spent in that rotation. The resident will be given additional teaching in the forms of lectures, assigned self-study, or clinical experiences as determined appropriate and necessary by the rotation director. The resident will then be reevaluated. Failure to pass a core experience after two consecutive attempts will result in dismissal.

Each rotation director will also report any attendance, disciplinary, or behavioral difficulties to the director of podiatric medical education.

### **a. Comprehensive Goals of the Program**

To graduate fully, a competent podiatric physician will:

1. Demonstrate proficiency in the evaluation and surgical treatment of commonly and uncommonly encountered foot and ankle disorders;
2. Demonstrate proficiency in the palliative and biomechanical management of foot and ankle disorders;
3. Demonstrate technical operative proficiency in the performance of office based and hospital based podiatric surgery
4. Demonstrate proficiency in the evaluation and treatment of
  - a. traumatic disorders of the foot and ankle;
  - b. infectious disorders of the foot and ankle;
  - c. congenital/pediatric disorders of the foot/ankle;
  - d. adult/geriatric disorders of the foot/ankle;
  - e. dermatologic disorders / wound management of the foot/ankle;
  - f. vascular/diabetic disorders of the foot/ankle;
  - g. neurologic disorders of the foot/ankle;

- h. rheumatic disorders of the foot and ankle;
- 5. Demonstrate proficiency in the interpretation of medical/bone and joint imaging techniques relevant to the management of the patient with a foot or ankle disorder
- 6. Demonstrate an understanding of the ethical practice of podiatry;
- 7. Demonstrate proficiency in the performance of a complete medical history and physical examination
- 8. Demonstrate the ability to evaluate, manage, or appropriately refer for treatment problems or concerns which occur in the peri-operative patient
- 9. Demonstrate an understanding of the "business" of podiatry, including practice management
- 10. Demonstrate proficiency in the utilization of special techniques, including but not limited to laser surgery, application of external fixation, arthroscopic surgery, internal fixation techniques, implant and biomaterial utilization.

## **b. Specialty Goals and Competencies**

### ***Anesthesia Competencies***

#### **Competency:**

- 1 Perform and interpret the findings of a pre-anesthetic evaluation including:
  - 1.1 Evaluation of anesthetic risk factors and ASA rating
- 2 .Demonstrates knowledge of fluid and electrolyte concerns in the perioperative period
- 3. Demonstrates knowledge of appropriate intraoperative monitoring of patients including:
  - 3.1 Patient positioning, establishing and assessing patient monitors
- 4. Demonstrates knowledge and ability to establish and maintain an airway and appropriate means and devices of doing so.
- 5. Demonstrates knowledge and indications for different anesthetic techniques:
  - 5.1 General, sedation, spinal, epidural, regional
- 6. Demonstrates awareness of the pharmacologic agents used in general, spinal, local, and conscious sedation techniques.
- 7. Perform and interpret the findings of a post-anesthetic evaluation and recognizes appropriate care measures including:
  - 7.1 Monitor vital signs, recovery techniques, airway maintenance, drug reversal, management of nausea and pain, resuscitation techniques

### ***Behavioral Science Competencies***

#### **Competency :**

- 1. Has the capacity to manage individuals and populations in a variety of socioeconomic and health care settings.
- 2. Demonstrates an awareness of how to manage a patient who refuses a recommended intervention or requests ineffective or harmful treatment.
- 3. Recognizes interview techniques in identifying patient behavior. Able to perform a mental status exam.
- 4. Utilizes effective methods to modify behavior and enhance compliance.
- 5. Demonstrates an awareness of the signs and symptoms of common psychological/psychiatric conditions and accepted treatment options
- 6. Demonstrates an awareness of the various medications employed in the treatment of mental illness and their common side effects..

### ***Dermatology Competencies***

#### **Competency:**

- 1. Utilizes the correct technique for performing each of the components of a problem-focused dermatologic examination.

2. Recognizes (correctly interprets) the normal or abnormal findings of each of the dermatologic exam components when performed upon a patient.
3. Utilizes appropriate dermatologic exam components indicated by patient's chief complaint.
4. Performs the problem-focused dermatologic exam in an appropriate period of time.
5. Utilizes proper technique while injecting the local anesthetic.
6. Utilizes adjunctive topical agents, as needed.
7. Utilizes universal precautions and appropriate needle precautions.
8. Monitors for, recognizes, and manages adverse reactions to the local anesthetic
9. Generates/revises treatment plan based on diagnostic and therapeutic results

### ***Emergency Department Competencies***

#### **Competency:**

1. Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination, HEENT, vital signs, chest, heart, lungs, abdomen, neurologic and extremities
2. Diagnose and manage diseases, disorders, and injuries by non-surgical and/or surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam:
  - 2.1 Problem-focused neurologic examination.
  - 2.2 Problem-focused vascular examination.
  - 2.3 Problem-focused dermatologic examination.
  - 2.4 Problem-focused musculoskeletal examination.
3. Perform (and/or order) and interpret appropriate diagnostic studies, including medical imaging
  - 3.1 radiographic contrast studies
  - 3.2 stress radiography
  - 3.3 fluoroscopy
  - 3.4 bone scans, CT, MRI
4. Perform (and/or order) and interpret appropriate diagnostic laboratory tests including: hematology, serology, toxicology, and microbiology
5. Perform (and/or order) and interpret appropriate diagnostic studies, including non-invasive vascular or invasive studies.
6. Formulate an appropriate diagnosis and/or differential diagnosis
7. Appropriate management when indicated of closed fractures and dislocations of pedal/ankle fractures and dislocations and cast/brace management
8. Appropriate indications and use of injection or aspiration techniques.
9. Formulate and implement appropriate plan of management including: consultation and/or referrals.
10. Recognize the need for (and/or orders) additional diagnostic studies when indicated including: EKG, chest x-ray, nuclear medicine , blood work etc
11. Appropriate pharmacologic management [IV , PO, or topical] including the use of : NSAID, narcotics, muscle relaxants, antibiotics, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents tetanus toxoid/immune globulin
12. Appropriate management of fluid and electrolyte agents when required
13. Formulate and implement appropriate plan of treatment for the management of : superficial ulcers or wound.
14. Formulate and implement an appropriate plan of management including appropriate medical/surgical management of: repair of simple laceration
15. Maintains appropriate medical records
16. Is able to partner with health care managers and health care providers to assess, coordinate and improve health care.

## ***Endocrinology Competencies***

### **Competency:**

1. Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: comprehensive medical history.
2. Understands the logical organization of a comprehensive history to include:
  - chief complaint.
  - history of chief complaint (history of present illness).
  - past medical history.
  - illnesses.
  - medications.
  - allergies.
  - past surgical history.
  - hospitalizations.
  - social history.
  - family history.
  - review of systems.
3. Charts most likely diagnosis appropriately as well as other possible diagnoses.
4. Reassesses and revises differential diagnosis as indicated during the course of patient evaluation and management
5. Recognizes when test values indicate further history, physical exam, diagnostic studies, consultation or repeat/serial analysis
6. Understands the indications for general medical health promotion and education, when appropriate
7. Understands the natural history of diseases, including etiologic and contributory factors and associated preventive measures
8. Demonstrate the ability to communicate effectively and function in a multidisciplinary setting. Is able to partner with health care managers and health care providers to assess, coordinate and improve health care

## ***General Surgery and Vascular Competencies***

### **Competency:**

1. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examinations).
  - 1.1 vital signs
  - 1.2 head, eyes, ears, nose, and throat (HEENT)
  - 1.3 chest
  - 1.4 heart/lungs
  - 1.5 abdomen
  - 1.6 genitourinary
  - 1.7 rectal
  - 1.8 musculoskeletal
  - 1.9 neurologic examination
2. Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).
3. Recognize the need for and the appropriate timing of additional diagnostic studies when needed, including:
  - 3.1 EKG
  - 3.2 Medical imaging studies including plain radiography, nuclear medicine imaging, CT, MRI, diagnostic ultrasound
  - 3.3 Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, urinalysis

4. Understands principles of perioperative management including fluid and electrolyte balance, pain management and blood and/or component therapy
5. Recognizes and demonstrates knowledge of conditions and problems that may be encountered in the management of the patient postoperatively including assessment of fever, postoperative infection, pulmonary function, fluid management, and gastrointestinal function
6. Understands management of the preoperative and postoperative surgical patient with an emphasis on complications.
7. Able to recognize intra-operative and/or postoperative complications and treatments available.
8. Understands surgical principles and procedures applicable to common pathologies of the human body.
9. Demonstrates proficient sterile techniques within the operating room.
10. Recognizes **at-risk surgical patients** and be knowledgeable of necessary precautions which should be employed.
11. Perform and interpret the findings of a thorough problem-focused vascular history and physical examination
12. Perform (and/or order) and interpret appropriate diagnostic studies including: vascular imaging and/or non-invasive vascular studies.
13. Perform (and/or order) and interpret appropriate diagnostic laboratory tests, including: hematology, blood chemistries, coagulation studies
14. Understands appropriate pharmacologic management in vascular surgery/medicine including peripheral vascular agents and anticoagulants
15. Understands the role of minimally invasive techniques such as angioplasty, stenting and atherectomy.
16. Formulate and implement an appropriate plan of management, including appropriate medical/surgical management when indicated for ulcerations or wounds.
17. Understands and develops knowledge regarding amputations of when/why to perform and at what level best performed.
18. Demonstrates an understanding of the diabetic patient and the effect of vascular disease in this patient population.
19. Understands the indications and different means of lower extremity bypass surgery in the vascular compromised patient.

### ***Infectious Disease Competencies***

#### **Competency:**

1. Performs and interprets the findings of a problem focused medical examination
2. Understands the indications and interpretation of common laboratory tests used to assess and manage patients with infectious diseases.
3. Demonstrates knowledge of the clinical signs and symptoms of infections in different parts of the body
4. Recognizes and understands the diagnosis and management of osteomyelitis.
5. Recognizes and understands the diagnosis and management of HIV and related pathology.
6. Understands the means of evaluating patient with hepatitis through clinical and laboratory methods.
7. Understands the means of evaluating clinically and through laboratory methods patients with other viral illnesses.
8. Demonstrates knowledge of the use, selection, indications, and adverse reactions of antibiotics
9. Appropriately interprets bacterial cultures, sensitivities, MIC/MBC studies

### ***Internal Medicine Competencies***

#### **Competency:**

1. Perform and interpret the findings of a comprehensive medical history and physical examination
  - 1.1 Vital signs
  - 1.2 HEENT
  - 1.3 Chest
  - 1.4 Heart / Lungs

- 1.5 Abdomen
  - 1.6 Genitourinary
  - 1.7 Gastrointestinal
  - 1.8 Endocrine
  - 1.9 Neurologic
2. Formulate an appropriate differential diagnosis of the patient's general medical problem.
  3. Recognize the need for and knowledge of the appropriate timing of additional diagnostic studies when needed such as EKG, chest x-ray, nuclear medicine, standard radiographs
  4. Recognize the need for and the appropriate timing of additional laboratory studies when indicated
    - 4.1 EKG
    - 4.2 Medical imaging studies including plain radiography, nuclear medicine imaging, CT, MRI, diagnostic ultrasound
    - 4.3 Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, urinalysis, synovial fluid analysis
  5. Recognizes the appropriate pharmacologic management of patients, including the use of :
    - 5.1 Antibiotics / Antifungals
    - 5.2 Narcotic analgesics / NSAID
    - 5.3 Sedative/hypnotics
    - 5.4 Anticoagulants and other vascular medications
    - 5.5 Medications for hyperuricemia
    - 5.6 Laxatives/cathartics
    - 5.7 Fluid and electrolyte agents
    - 5.8 Corticosteroids
    - 5.9 Management of hyper/hypoglycemia
  6. Assess and manage the patient's general medical status.
  7. Formulate and implement an appropriate plan of management, when indicated, including appropriate:
    - 7.1 therapeutic intervention,
    - 7.2 consultations and/or referrals, and
    - 7.3 general medical health promotion and education.

### ***Neurology Competencies***

#### **Competency:**

1. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform (and/or order) and interpret appropriate diagnostic studies, including: other diagnostic studies, including: electrodiagnostic studies.
2. Utilizes the correct technique for performing each of the components of a problem-focused neurologic examination.
3. Recognizes (correctly interprets) the normal or abnormal findings of each of the neurologic exam components when performed upon a patient.
4. Utilizes appropriate neurologic exam components indicated by patient's chief complaint.
5. Performs the problem-focused neurologic exam in an appropriate period of time.
6. Generates/revises treatment plan based on diagnostic and therapeutic results

### ***Orthopedic Competencies***

#### **Competency:**

1. Perform and interpret the findings of a comprehensive medical history and physical examination including preoperative history and physical examination
2. Diagnose and manage diseases, disorders, and injuries of the lower extremity by nonsurgical and surgical means.

3. Perform and interpret the findings of a thorough problem-focused history and physical exam in foot/ankle orthopedics.
4. Perform and interpret the findings of a thorough problem-focused history and physical exam, including:
  - 4.1 neurologic examination
  - 4.2 vascular examination
  - 4.3 musculoskeletal examination
5. Perform (and/or order) and interpret appropriate diagnostic studies including:
  - 5.1 plain radiography
  - 5.2 radiographic contrast studies
  - 5.3 fluoroscopy
  - 5.4 nuclear medicine imaging
  - 5.5 MRI
  - 5.6 CT
6. Formulate an appropriate diagnosis and/or differential diagnosis in non-surgical and surgical orthopedic patient.
7. Perform (and/or order) and interpret appropriate diagnostic studies including hematology, pathology, serology, microbiology, and synovial analysis as it pertains to the orthopedic patient.
8. Understands and recognizes the management of trauma including splinting, casting, along with other immobilization techniques.
9. Recognizes knowledge of anatomy and physiology of various structures associated in Orthopedics.
10. Appropriate pharmacologic management of the orthopedic patient including: NSAIDS, narcotics, sedatives/hypnotics, anticoagulants, laxatives/cathartics.
11. Appropriate assessment and management of foot and ankle trauma including:
  - 11.1 Closed management of fractures/dislocations of the foot
  - 11.2 Closed management of fractures/dislocations of the ankle
  - 11.3 Open management of fractures/dislocations of the foot
  - 11.4 Open management of fractures/dislocations of the ankle
12. Demonstrates knowledge and techniques in internal and external fixation especially as it applies to the foot and ankle.
13. Demonstrates knowledge and the treatment in infections in orthopedics including soft tissue, osseous, bacterial and fungal.
14. Formulate and implement appropriate surgical management when indicated including **digital surgery**.
15. Formulate and implement appropriate surgical management when indicated, including **first ray surgery**.
16. Formulate and implement appropriate surgical management when indicated, including **soft tissue foot surgery**.
17. Formulate and implement appropriate surgical management when indicated for **osseous foot surgery distal to the tarsometatarsal joints**.
18. Formulate and implement appropriate surgical management when indicated for **osseous foot surgery at the midtarsal level**.
19. Formulate and implement appropriate **reconstructive rearfoot /ankle surgical** management when indicated.
20. Demonstrates ability to understand and perform a lower extremity biomechanical examination as it pertains to foot and ankle orthopedics

### ***Pathology Competencies***

#### **Competency:**

1. The indications and interpretations of results from the clinical laboratory.
2. Understands collection methods for specific tests in pathology.
3. Understands general principles in the evaluation of gross pathology.
4. Recognize the need for (and/or orders) additional diagnostic studies when indicated.

5. Demonstrates knowledge and understanding of basic histopathology including:
  - 5.1 review and recognition of lower extremity surgical specimens
  - 5.2 review and identification of common benign lesions
  - 5.3 differentiation of benign and malignant neoplasia

### ***Pediatric Competencies***

#### **Competency:**

1. Ability to perform and interpret a physical examination on child and infant
2. Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: comprehensive physical examination, including: physical examination, including: head, eyes, ears, nose, and throat (HEENT).
3. Derives a treatment plan based upon a thorough history, physical examination, and appropriate diagnostic tests.
4. To be familiar with common pediatric drugs and dosages
5. To understand normal and abnormal gait patterns in children
6. To understand how to prioritize and manage pediatric emergencies
7. To be familiar with common pediatric neurological and orthopedic diseases
8. Demonstrates compassion, sensitivity, and respect in interactions with patients and families
9. Adheres to the principle "above all else, do no harm" in formulating and applying a treatment plan.
10. Uses a treatment approach that logically progresses from less interventional (conservative) to more interventional (surgical) when applicable.
11. Uses a treatment approach that considers cost-to-benefit and chooses the least costly, most effective therapeutic approach when applicable.
12. Uses a comprehensive treatment approach that responds to the etiologic factors as well as resultant pathology when applicable.

### ***Radiology Competencies***

#### **Competency:**

1. Recognize basic chest film pathology including: pulmonary edema, cardiomegaly, pneumonia, atelectasis, neoplasia
2. Recognize basic components of skeletal radiology via different imaging techniques including: Neoplasms, fractures, anatomic variants
3. Recognize the indications for additional imaging studies when indicated.
4. Understands the indications and advantages of different imaging modalities MRI vs. CT.
5. Recognizes the indications for CT and MRI imaging with and without contrast.
6. Recognize the principles and basics of interpreting MRI and CT images.
7. Recognizes the indications for and interprets nuclear medicine studies.
8. Recognizes the indications for and interprets diagnostic ultrasound studies.
9. Recognize the principles and basics of interpreting angiographic studies.

### ***Podiatric Medicine and Surgery Competencies***

#### **Competency:**

1. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means.
2. Perform and interpret the findings of a thorough problem-focused history and physical exam including:
  - 2.1 Vascular evaluation,
  - 2.2 Neurologic evaluation,
  - 2.3 Dermatologic evaluation,

## 2.4 Biomechanical/musculoskeletal evaluation

3. Perform and interpret the findings of a comprehensive medical examination (including preoperative H&P) that includes: vital signs, HEENT, chest, heart, lungs, abdomen, genitourinary, rectal, neurologic, and musculoskeletal.
4. Perform (and/or order) and interpret appropriate diagnostic medical imaging studies including: plain radiography, nuclear medicine, CT/MRI.
5. Perform (and/or order) and interpret appropriate diagnostic laboratory tests including: hematology, pathology/microbiology [anatomic and cellular], serology, synovial analysis
6. Perform (and/or order) and interpret appropriate diagnostic studies including: electrodiagnostic and vascular studies.
7. Perform (and/or order) and interpret appropriate examinations including: biomechanical examination of the podiatric patient.
8. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means.
9. Formulate an appropriate diagnosis and/or differential diagnosis
10. Formulate and implement an appropriate plan of management with regards to anesthesia: Local, MAC, General for the podiatric surgical patient.
11. Appropriate closed management of pedal fractures and dislocations.
12. Appropriate closed management of ankle fracture/dislocation.
13. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
14. Appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals, sedatives/hypnotics, muscle relaxants, laxatives, corticosteroids [ all either PO, IV/IM, Topical]
15. Formulate and implement appropriate medical/surgical management when indicated of an ulcer or wound
16. Formulate and implement appropriate medical/surgical management for skin lesions, including: excision or destruction of skin lesion (including skin biopsy and laser procedures).
17. Formulate and implement appropriate medical/surgical management for nail disorders including: nail avulsion or matrixectomy (partial or complete, by any means).
18. Formulate and implement appropriate medical/surgical management including repair for: **simple laceration** (no neurovascular, tendon, or bone/joint involvement) or **complex** ( neurovascular, tendon, or bone/joint involvement).
19. Formulate and implement an appropriate plan of management in **digital surgery** including appropriate surgical management when indicated.
20. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **first ray surgery**
21. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **soft tissue foot surgery**
22. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **osseous foot surgery (distal to the tarsometatarsal joints).**
23. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **osseous foot surgery of the midfoot.**
24. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **reconstructive rearfoot and ankle surgery.**
25. Demonstrates knowledge and techniques in **internal and external fixation** especially as it applies to the foot and ankle
26. Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals.
27. Able to assess the treatment plan and revise it as necessary including appropriate lower extremity health promotion and education.

## ***Podiatric Office/Clinical Competencies***

### **Competency:**

1. Performs appropriate palliative management when indicated for: keratotic lesions and nail disorders.
2. Formulate and implement an appropriate plan of management including: footwear and padding when indicated for the podiatric patient
3. Formulate and implement an appropriate plan of management when indicated, including: orthotic, brace, prosthetic, and custom shoe management.
4. Formulate and implement an appropriate plan of management in the care of foot/ankle fractures/dislocations and sprains including: immobilization techniques of casting, splinting, and taping
5. Formulate and implement appropriate medical/surgical management when indicated including: debridement of ulcer or wound
6. Formulate and implement appropriate medical/surgical management when indicated, including: excision or destruction of skin lesion (including skin biopsy and laser procedures).
7. Formulate and implement appropriate medical/surgical management when indicated, including: nail avulsion or matrixectomy (partial or complete, by any means).
8. Appropriate management when indicated for manipulation/mobilization of the foot/ankle joint to increase range of motion/reduce associated pain.
9. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
10. Recommends appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals
11. Formulate and implement an appropriate plan of management in **digital surgery** including appropriate surgical management when indicated.
12. Formulate and implement an appropriate plan of management in **first ray surgery**, including appropriate surgical management when indicated.
13. Formulate and implement an appropriate plan of management for **osseous surgery of the midfoot**, including appropriate surgical management when indicated.
14. Formulate and implement an appropriate plan of management for **reconstructive rearfoot and ankle surgery**, including appropriate surgical management when indicated.
15. Formulate and implement an appropriate plan of management, including appropriate: consultation and/or referrals.
16. Demonstrate understanding of common business and management practices as they relate to the podiatry office, including: understands health care reimbursement.

## ***Wound Care Management Competencies***

**Competency:** To include *Knowledge* and *proficiency*

### **The resident shall be *Knowledgeable* for the following:**

1. Performing complete patient evaluation including:
  - 1.1 history and physical examination,
  - 1.2 differential diagnosis, and
  - 1.3 rationale for proposed intervention.
2. Ordering laboratory and special examinations and interpretation of the results
3. Biomechanical evaluation of patients when appropriate.
4. Completion of charting and dictation.
5. Appropriate management of diabetic foot complications, including ischemic, neuropathic, and infectious processes.
6. Indications for total contact casting, use of Plastizote orthoses, and therapeutic splints and shoes
7. Indications for surgical management in diabetic or other ulcerative infections.
8. Indications for amputations such as partial foot amputation.
9. Debridement techniques and indications.
10. Wound care products, dressings and biologicals.

**The resident shall demonstrate *proficiency* for the following:**

11. Application and removal of total contact casts
12. Performance of complete physical examination of the lower extremity in diabetic patients to include orthopedic, vascular, neurologic, and dermatologic examinations.
13. Formulation of treatment plans for diabetic foot care patients.
14. Fabrication and adjustment of Plastizote insoles and fitting them to therapeutic shoes and splints.
15. Apply various compressive bandages.
16. Ordering and interpretation of the appropriate laboratory tests and results to include:
  - 16.1 complete blood count,
  - 16.2 chemistry profile , and
  - 16.3 urinalysis.
17. The ability to recognize ulcerative processes independent of diabetes such as:
  - 17.1 venous stasis,
  - 17.2 sickle cell anemia,
  - 17.3 lupus, and
  - 17.4 other vascularitic conditions.
18. Debridement technique.

**c. Attitudinal and Other Non-Cognitive Competencies**

There are several competencies that by their very nature fit into the overall practice of medicine and do not reside in any one rotation. The content of this material is delivered and will be evaluated in the following areas. *These competencies apply to ALL rotations.*

**Competency:**

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

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.
2. Practice and abide by the principles of informed consent.
3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.
4. Demonstrate professional humanistic qualities.
5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of healthcare costs.

**Communicate effectively and function in a multi-disciplinary setting.**

1. Communicate in oral and written form with patients, colleagues, payors, and the public.
2. Maintain appropriate medical records.

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

1. Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

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

1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand healthcare reimbursement.

3. Understand insurance issues including professional and general liability, disability, and Workers Compensation.

4. Understand medical-legal considerations involving healthcare delivery.

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

1. Read, interpret, and critically examine and present medical and scientific literature.

2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.

3. Demonstrate information technology skills in learning, teaching, and clinical practice.

4. Participate in continuing education activities.

## VI. Rotation Schedule

The following are the basic rotation schedules.

### PGY-1 schedule

<b>Date</b>	<b>Resident 1</b>	<b>Resident 2</b>
July	Podiatry	Podiatry
Aug	Podiatry	Internal Medicine
Sept	Internal Medicine	Podiatry
Oct	Podiatry	Emergency Room
Nov	Emergency Room	Podiatry
Dec	Podiatry	Anesthesia
Jan	Anesthesia	Podiatry
Feb	Podiatry	Pathology/Radiology
March	Pathology/Radiology	Podiatry
April	Podiatry	Dermatology
May	Dermatology	Podiatry
June	Podiatry	Podiatry

## PGY-2 Schedule

<b>Date</b>	<b>Resident 1</b>	<b>Resident 2</b>
July	Podiatry	Podiatry
Aug	Podiatry	Pediatrics
Sept	Pediatrics	Podiatry
Oct	Podiatry	Vascular
Nov	Vascular	Podiatry
Dec	Podiatry	Behavioral Science
Jan	Behavioral Science	Podiatry
Feb	Podiatry	General Surgery
March	General Surgery	Podiatry
April	Podiatry	Endocrine
May	Endocrine	Podiatry
June	Podiatry	Podiatry

## PGY-3 Schedule

<b>Date</b>	<b>Resident 1</b>	<b>Resident 2</b>
July	Research	Podiatry
Aug	Orthopedics	Infectious Disease
Sept	Orthopedics	Dermatology
Oct	Orthopedics	Research
Nov	Orthopedics	Podiatry
Dec	Orthopedics	Podiatry
Jan	Orthopedics	Orthopedics
Feb	Orthopedics	Orthopedics
March	Orthopedics	Orthopedics
April	Neurology/Derm	Orthopedics
May	Infectious Disease	Orthopedics
June	Podiatry	Orthopedics

## **XVII. Evaluations**

Evaluations need to be obtained at the end of each rotation. Residents need to make sure that the correct individual has an evaluation form and that they are willing to complete it. The evaluator may return the form to the resident or send it to the address on the bottom of the form.

At the end of the evaluation section is the form for these evaluations. You must fill out at least one for each rotation. Please fill out additional ones where you work extensively with more than one faculty member. These forms are due 2 weeks after the end of a rotation. If you wish them to be anonymous please return them to the Department of Surgery office.

Coney Island Hospital Podiatry Residency PMSR

Rotation: Anesthesiology

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Formulate and implement an appropriate plan of management, including: appropriate anesthesia management when indicated						
local anesthesia						
general anesthesia						
spinal anesthesia						
epidural anesthesia						
regional anesthesia						
conscious sedation						
Perform and interpret the findings of an appropriate medical history and physical examination						
Recognize the need for additional laboratory and diagnostic studies, when indicated						
Demonstrate ability to perform intravenous placement						
Demonstrate ability to manage an airway including intubation						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Behavioral Science

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages						
The podiatric resident will be able to discuss and describe the psychological issues related to the management of :						
Obesity						
Smoking cessation						
Behavior modification						
Dependency/addiction						
Describe the treatment strategies for these conditions						
Obesity						
Smoking Cessation						
Behavior modification						
Dependency/addiction						
Be able to identify patients who require referral to Mental health						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Dermatology

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult by nonsurgical and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including dermatologic examination.						
Order and interpret appropriate diagnostic studies, including anatomic and cellular pathology						
Formulate an appropriate diagnosis and/or differential diagnosis						
Formulate and implement an appropriate plan of pharmacologic management, including the use of:						
antibiotics						
Antifungals						
Corticosteroids						
Topical preparations						
Formulate and implement an appropriate plan of management, including: excision or destruction of skin lesion (including skin biopsy and laser procedures)						
Formulate and implement an appropriate plan of appropriate anesthesia management when indicated, including: local anesthesia						
Assess the treatment plan and revise it as necessary						
Recognize the need for (and/or orders) additional diagnostic studies, when indicated						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Emergency Medicine

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem-focused history						
Perform and interpret the findings of a thorough problem focused history and physical exam, including: neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Order and interpret appropriate diagnostic studies, including: medical imaging, plain radiography, stress radiography, MRI, CT						
Order and interpret appropriate diagnostic studies, including: laboratory (blood) tests, non-invasive vascular studies, compartment pressure studies						
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Formulate an appropriate diagnosis and/or differential diagnosis						
Appropriate non-surgical management when indicated, including: closed management of fractures and dislocations: closed management of pedal fractures and dislocations, closed management of ankle fracture/dislocation, cast management injections and aspirations, pharmacologic management						
Formulate and implement an appropriate plan of management, including: appropriate medical/surgical management when indicated, including: repair of simple laceration (no neurovascular, tendon, or bone/joint involvement).						
Appropriate anesthesia management when indicated, including: local anesthesia						
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals						
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: Problem focused medical history.						
Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: problem focused physical examination, including: vital signs, head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination						
Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s)						
Assess and manage the patient's general medical status. Recognize the need for (and/or orders) additional diagnostic studies, when indicated, including: EKG, plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, other diagnostic studies						
Assess and manage the patient's general medical status. Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic intervention						
Assess and manage the patient's general medical status. Formulate and implement an appropriate plan of management, when indicated, including: appropriate consultations and/or referrals						
Demonstrate the ability to communicate effectively and function in a multidisciplinary setting						
Maintains appropriate medical records						

Rotation: Emergency Medicine

Resident: \_\_\_\_\_

**Legend for Attitudinal Assessment**

1 - Never                      2 - Some of the Time                      3 - Most of the Time                      4 - Always                      N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Endocrinology

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: comprehensive medical history						
Understands the logical organization of a comprehensive history to include: chief complaint, history of chief complaint (history of present illness), past medical history, illnesses, medications, allergies, past surgical history, hospitalizations, social history, family history, review of systems						
Charts most likely diagnosis appropriately as well as other possible diagnoses						
Reassesses and revises differential diagnosis as indicated during the course of patient evaluation and management						
Recognizes when test values indicate further history, physical exam, diagnostic studies, consultation or repeat/serial analysis						
Understands the indications for general medical health promotion and education, when appropriate						
Understands the natural history of diseases, including etiologic and contributory factors and associated preventive measures						
Demonstrate the ability to communicate effectively and function in a multidisciplinary setting. Is able to partner with health care managers and health care providers to assess, coordinate and improve health care						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: General Surgery

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 2 - Demonstrates knowledge but is unable to perform
- 3 - Performs only with constant direction.
- 4 - Performs with minimal direction
- 5 - Performs the entire task independently
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: Problem focused medical history.						
Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: problem focused physical examination, including: vital signs, head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination						
Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s)						
Assess and manage the patient's general medical status. Recognize the need for (and/or orders) additional diagnostic studies, when indicated, including: EKG, plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound						
Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic intervention. Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem-focused history						
Understands principles of perioperative management including fluid and electrolyte balance, pain management and blood and/or component therapy						
Recognizes and demonstrates knowledge of conditions and problems that may be encountered in the management of the patient postoperatively including assessment of fever, postoperative infection, pulmonary function, fluid management, and gastrointestinal function						
Understands management of the preoperative and postoperative surgical patient with an emphasis on complications						
Able to recognize intra-operative and/or postoperative complications and treatments available						
Understands surgical principles and procedures applicable to common pathologies of the human body						
Demonstrates proficient sterile techniques within the operating room						
Recognizes at-risk surgical patients and be knowledgeable of necessary precautions which should be employed						
Formulate and implement an appropriate plan of management, including appropriate medical/surgical management when indicated for ulcerations or wounds						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

Rotation: General Surgery

Resident: \_\_\_\_\_

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Infectious Disease

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Evaluation and management of patients with the following disorders: Skin and soft tissue infection, bone and joint infections, infections of prosthetic devices, infections related to trauma, sepsis syndrome, nosocomial infection						
Basic knowledge of hospital epidemiology and infection control						
Basic knowledge of clinical microbiology						
Knowledge of dosing and monitoring of antibiotics						
Exposure to the techniques in the evaluation and management of the following disorders: Infections of reproductive organs, infections in solid organ transplant patients, infection in bone marrow transplant recipients, sexually transmitted diseases, viral hepatitis, including hepatitis B and C, infections in travelers, pleuropulmonary infections, cardiovascular infections, central nervous system infections, gastrointestinal and intra-abdominal infections, urinary tract infection, HIV infected patients with major impairment of host defenses						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Internal Medicine

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 2 - Demonstrates knowledge but is unable to perform
- 3 - Performs only with constant direction.
- 4 - Performs with minimal direction
- 5 - Performs the entire task independently
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Assess and manage the patient's general medical status as inpatients						
Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), comprehensive medical history, vital signs, head, eyes, ears, nose, and throat exam, neck exam, chest/breast exam, heart exam, lung exam, abdomen exam, GU/rectal exam, upper extremity exam, neurologic exam						
Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s), with particular emphasis on the following diagnoses: Diabetes mellitus, Hypertension, Coronary artery disease, Kidney disease, Liver disease, Common Gastrointestinal disorders, Common genitourinary disorders, Infectious disease processes, Common oncology disorders						
Assess and manage the patient's general medical status. Recognize the need for (and/or orders) additional diagnostic studies, when indicated: EKG, medical imaging						
Order and interpret appropriate laboratory tests: hematology, serology/immunology, blood chemistries, microbiology, synovial fluid analysis, urinalysis, anatomic and cellular pathology						
Assess and manage the patient's general medical status. Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic intervention, appropriate consultations and/or referrals, appropriate general medical health promotion and education						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Neurology

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform (and/or order) and interpret appropriate diagnostic studies, including: other diagnostic studies, including: electrodiagnostic studies						
Utilizes the correct technique for performing each of the components of a problem-focused neurologic examination						
Recognizes (correctly interprets) the normal or abnormal findings of each of the neurologic exam components when performed upon a patient						
Utilizes appropriate neurologic exam components indicated by patient's chief complaint						
Performs the problem-focused neurologic exam in an appropriate period of time						
Generates/revises treatment plan based on diagnostic and therapeutic results						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Acceptable for level of training
- Minimally acceptable: some remediation needed
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Orthopedics

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means						
Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Interpret appropriate medical imaging: plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, CT						
Interpret appropriate laboratory tests						
Interpret appropriate other diagnostic studies: electrodiagnostic studies, non-invasive vascular studies						
Formulate an appropriate diagnosis and/or differential diagnosis						
Formulate and implement an appropriate plan of management: cast management, physical therapy						
Perform appropriate pharmacologic management, when indicated, including: NSAIDs, antibiotics, narcotic analgesics, corticosteroids						
Formulate and implement an appropriate plan of management, when indicated, including: digital surgery, first ray surgery, other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints and exostectomies), reconstructive rearfoot and ankle surgery, hand surgery, other orthopedic surgery						
Formulate and implement an appropriate plan of management including: appropriate consultation and/or referrals, appropriate health promotion and education						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

Rotation: Orthopedics

Resident: \_\_\_\_\_

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency

Rotation: Pathology

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Completed and understands microbiology orientation in proper methods of specimen collection and transport						
Has an adequate fund of knowledge in anatomy & histology						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Acceptable for level of training
- Minimally acceptable: some remediation needed
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Pediatrics

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Ability to perform and interpret a physical examination on child and infant						
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: comprehensive physical examination, including: physical examination, including: head, eyes, ears, nose, and throat (HEENT)						
Derives a treatment plan based upon a thorough history, physical examination, and appropriate diagnostic tests						
Familiar with common pediatric drugs and dosages						
Understands normal and abnormal gait patterns in children						
Understands how to prioritize and manage pediatric emergencies						
Familiar with common pediatric neurological and orthopedic diseases						
Demonstrates compassion, sensitivity, and respect in interactions with patients and families						
Adheres to the principle "above all else, do no harm" in formulating and applying a treatment plan						
Uses a treatment approach that logically progresses from less interventional (conservative) to more interventional (surgical) when applicable						
Uses a treatment approach that considers cost-to-benefit and chooses the least costly, most effective therapeutic approach when applicable						
Uses a comprehensive treatment approach that responds to the etiologic factors as well as resultant pathology when applicable						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Acceptable for level of training
- Minimally acceptable: some remediation needed
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Podiatry PGY 1

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Perform (and/or order) and interpret appropriate medical imaging: plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, CT						
Perform (and/or order) and interpret appropriate laboratory tests: hematology, serology/immunology, blood chemistries, microbiology, synovial fluid analysis urinalysis, anatomic and cellular pathology						
Perform (and/or order) and interpret appropriate other diagnostic studies: electrodiagnostic studies, non-invasive vascular studies						
Formulate an appropriate diagnosis and/or differential diagnosis						
Perform appropriate non-surgical management when indicated: palliation of keratotic lesions, palliation of toenails, manipulation/mobilization of foot/ankle joint(s), closed management of pedal fractures and dislocations, closed management of ankle fracture/dislocation						
Formulate and implement an appropriate plan of management: cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, physical therapy						
Perform appropriate pharmacologic management when indicated, including: NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, corticosteroids, antirheumatic medications, topicals						
Formulate and implement an appropriate plan of management, when indicated, including: debridement of superficial ulcer or wound, excision or destruction of skin lesion including skin biopsy, nail avulsion (partial or complete), matrixectomy (partial or complete), repair of simple laceration, digital surgery, first ray surgery other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints, and exostectomies), reconstructive rearfoot and ankle surgery						
Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, reassessment of the treatment plan with revision as necessary						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

Rotation: Podiatry PGY 1

Resident: \_\_\_\_\_

**Legend for Attitudinal Assessment**

1 - Never      2 - Some of the Time      3 - Most of the Time      4 - Always      N/A - Not Applicable

<b>Attitudinal Assessment</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>N/A</b>
Accepts criticism constructively					
Acts as a patient advocate, involving the patient/family in the decision-making process					
Communicates effectively with colleagues and staff					
Communicates effectively with the patient/family, recognizing their concern for safety, comfort, and medical necessity					
Provides high quality, comprehensive care in an ethical manner					
Demonstrates moral and ethical conduct					
Respects and adapts to cultural differences					
Establishes trust and rapport with patients and peers					
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Podiatry PGY 2

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Perform (and/or order) and interpret appropriate medical imaging: plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, CT						
Perform (and/or order) and interpret appropriate laboratory tests: hematology, serology/immunology, blood chemistries, microbiology, synovial fluid analysis urinalysis, anatomic and cellular pathology						
Perform (and/or order) and interpret appropriate other diagnostic studies: electrodiagnostic studies, non-invasive vascular studies						
Formulate an appropriate diagnosis and/or differential diagnosis						
Perform appropriate non-surgical management when indicated: palliation of keratotic lesions, palliation of toenails, manipulation/mobilization of foot/ankle joint(s), closed management of pedal fractures and dislocations, closed management of ankle fracture/dislocation						
Formulate and implement an appropriate plan of management: cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, physical therapy						
Perform appropriate pharmacologic management when indicated, including: NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, corticosteroids, antirheumatic medications, topicals						
Formulate and implement an appropriate plan of management, when indicated, including: debridement of superficial ulcer or wound, excision or destruction of skin lesion including skin biopsy, nail avulsion (partial or complete), matrixectomy (partial or complete), repair of simple laceration, digital surgery, first ray surgery other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints, and exostectomies), reconstructive rearfoot and ankle surgery						
Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, reassessment of the treatment plan with revision as necessary						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

Rotation: Podiatry PGY 2

Resident: \_\_\_\_\_

**Legend for Attitudinal Assessment**

1 - Never                      2 - Some of the Time                      3 - Most of the Time                      4 - Always                      N/A - Not Applicable

<b>Attitudinal Assessment</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>N/A</b>
Accepts criticism constructively					
Acts as a patient advocate, involving the patient/family in the decision-making process					
Communicates effectively with colleagues and staff					
Communicates effectively with the patient/family, recognizing their concern for safety, comfort, and medical necessity					
Provides high quality, comprehensive care in an ethical manner					
Demonstrates moral and ethical conduct					
Respects and adapts to cultural differences					
Establishes trust and rapport with patients and peers					
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Acceptable for level of training
- Minimally acceptable: some remediation needed
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Podiatry PGY 3

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Perform (and/or order) and interpret appropriate medical imaging: plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, CT						
Perform (and/or order) and interpret appropriate laboratory tests: hematology, serology/immunology, blood chemistries, microbiology, synovial fluid analysis urinalysis, anatomic and cellular pathology						
Perform (and/or order) and interpret appropriate other diagnostic studies: electrodiagnostic studies, non-invasive vascular studies						
Formulate an appropriate diagnosis and/or differential diagnosis						
Perform appropriate non-surgical management when indicated: palliation of keratotic lesions, palliation of toenails, manipulation/mobilization of foot/ankle joint(s), closed management of pedal fractures and dislocations, closed management of ankle fracture/dislocation						
Formulate and implement an appropriate plan of management: cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, physical therapy						
Perform appropriate pharmacologic management when indicated, including: NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, corticosteroids, antirheumatic medications, topicals						
Formulate and implement an appropriate plan of management, when indicated, including: debridement of superficial ulcer or wound, excision or destruction of skin lesion including skin biopsy, nail avulsion (partial or complete), matrixectomy (partial or complete), repair of simple laceration, digital surgery, first ray surgery other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints, and exostectomies), reconstructive rearfoot and ankle surgery						
Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, reassessment of the treatment plan with revision as necessary						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

Rotation: Podiatry PGY 3

Resident: \_\_\_\_\_

**Legend for Attitudinal Assessment**

1 - Never      2 - Some of the Time      3 - Most of the Time      4 - Always      N/A - Not Applicable

<b>Attitudinal and Regulatory Assessment</b>	1	2	3	4	N/A
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					
Practices and abides by the principles of informed consent					
Acts as a leader for the rest of the team					
Demonstrates a desire to teach junior residents and students					

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Coney Island Hospital Podiatric Residency PMSR

Rotation: Vascular Surgery

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: Problem focused medical history.						
Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: problem focused physical examination, including: vital signs, head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination						
Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s)						
Assess and manage the patient's general medical status. Recognize the need for (and/or orders) additional diagnostic studies, when indicated, including: EKG, plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound						
Assess and manage the patient's general medical status. Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic intervention. Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem-focused history						
Perform and interpret the findings of a thorough problem-focused history and physical exam, including: vascular examination						
Order and interpret appropriate diagnostic studies, including: medical imaging, including: vascular imaging						
Perform (and/or order) and interpret appropriate diagnostic studies, including: laboratory tests, non-invasive vascular studies, appropriate non-surgical management when indicated, including: pharmacologic management						
Formulate and implement an appropriate plan of management, including: appropriate medical/surgical management when indicated						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

Rotation: Vascular Surgery

Resident: \_\_\_\_\_

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Podiatric Residency PMSR

Rotation: Wound Care Management

Rotation Dates: \_\_\_\_\_

Resident: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluator Date & Signature: \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Performs complete patient evaluation including: history and physical examination, differential diagnosis, and rationale for proposed intervention						
Performs complete physical examination of the lower extremity in diabetic patients to include orthopedic, vascular, neurologic, and dermatologic examinations						
Orders laboratory and special examinations and interpretation of the results						
Biomechanical evaluation of patients when appropriate						
Appropriate management of diabetic foot complications, including ischemic, neuropathic, and infectious processes						
Understands indications for total contact casting, use of Plastizote orthoses, and therapeutic splints and shoes						
Understands indications for surgical management in diabetic, other ulcerative infections, and amputations such as partial foot amputation						
Knows debridement techniques and indications						
Formulates treatment plans for diabetic foot care patients						
Completes charts and dictation in a timely manner						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

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

**Please rate this resident's overall competence.**

- Deficient: should repeat rotation
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

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

\_\_\_\_\_

Resident response (Circle one)    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Rotation Evaluation - Coney Island Hospital Podiatric Residency PMSR**

Resident's name \_\_\_\_\_

Dates of Rotation \_\_\_\_\_

Check one of the following:      PGY 1                      PGY 2                      PGY 3

**Name of Rotation**\_(check appropriate box)

- |   |   |
|---|---|
| <input type="checkbox"/> Foot and Ankle Orthopedics     | <input type="checkbox"/> Infectious Disease           |
| <input type="checkbox"/> Podiatric Medicine and Surgery | <input type="checkbox"/> Internal Medicine            |
| <input type="checkbox"/> Behavioral Health              | <input type="checkbox"/> Radiology                    |
| <input type="checkbox"/> Anesthesiology                 | <input type="checkbox"/> Emergency Department         |
| <input type="checkbox"/> Pathology                      | <input type="checkbox"/> General Surgery and Vascular |
| <input type="checkbox"/> Podiatric office and Clinical  | <input type="checkbox"/> Wound Care                   |

Please evaluate this rotation based on the criteria below.

1. The goals and competencies in relation to the practice of podiatric medicine were:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

2. The extent to which the content stated competencies were covered:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

3. The extent to which rotation was supplemented with clinical lectures, journal clubs, or clinical pathology conferences was:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

4. The supervision by faculty was:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

5. The patient exposures in regard to accomplishing rotation competencies were:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

6. The organization of this rotation was:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

7. The program director's administration was:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

**What are the strengths of the experience? (Circle all that apply)**

- |                       |                                    |             |                    |
|-----------------------|------------------------------------|-------------|--------------------|
| Diversity of workload | Journal Club                       | Conferences | Out-patient clinic |
| Inpatient service     | Hospital rotation (specify below): |             |                    |

other: \_\_\_\_\_

Resident's name \_\_\_\_\_ Rotation \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are the weaknesses of the experience? (Circle all that apply)**

Diversity of workload    Journal Club    Conferences    Out-patient clinic  
Inpatient service        Hospital rotation (specify below):  
other: \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident's Signature \_\_\_\_\_ Date \_\_\_\_\_

Residency Director's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Glenn Donovan, DPM

**Program Evaluation - Coney Island Hospital Podiatric Residency PMSR**

The resident will evaluate the effectiveness and organization of the program.

Resident's name \_\_\_\_\_ Date \_\_\_\_\_

Check one of the following:      PGY 1              PGY 2              PGY 3

1. The planning and organization of the program is appropriate for the goals and competencies.

**5**                      **4**                      **3**                      **2**                      **1**  
**Excellent**        **Very Good**        **Good**                **Fair**                **Poor**  
\*\*\*\*\*

2. The resources of the program are adequate to accomplish the program goals and competencies.

**5**                      **4**                      **3**                      **2**                      **1**  
**Excellent**        **Very Good**        **Good**                **Fair**                **Poor**  
\*\*\*\*\*

3. The program is having a positive effect on students and residents.

**5**                      **4**                      **3**                      **2**                      **1**  
**Excellent**        **Very Good**        **Good**                **Fair**                **Poor**  
\*\*\*\*\*

4. The program is having a positive effect in the care of patients.

**5**                      **4**                      **3**                      **2**                      **1**  
**Excellent**        **Very Good**        **Good**                **Fair**                **Poor**  
\*\*\*\*\*

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the strengths of the program? (Circle all that apply)

Diversity of workload      Journal Club      Conferences      Out-patient clinic      Clinical rotation

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the weaknesses of the program? (Circle all that apply)

Diversity of workload      Journal Club      Conferences      Out-patient clinic      Clinical rotation

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations for improvement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident's Signature \_\_\_\_\_ Date \_\_\_\_\_

Residency Director's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Glenn Donovan, DPM

## Coney Island Hospital - Podiatric Medicine and Surgery (PMSR)

### Self Assessment Evaluation

DATE:

Scale: 1 lowest, 4 highest

Name:

PGY:

Program Name: Podiatric Medicine and Surgery (PMSR)

#### Patient Care

1. I provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Not Applicable 1 2 3 4

#### Medical Knowledge

2. I know and apply the basic and clinically supportive sciences which are appropriate to Podiatry

Not Applicable 1 2 3 4

#### Practice Based Learning

3. My learning and improvement involves investigation and evaluation of my patient's care, appraisal and assimilation of scientific evidence and improvements in patient care

Not Applicable 1 2 3 4

#### Interpersonal and Communication Skills

4. I possess skills that result in effective information exchanges and teaming with patients, their families and other health care professionals

Not Applicable 1 2 3 4

5. I communicate with my co-residents we work as part of a team

Not Applicable 1 2 3 4

#### Professionalism

6. I am committed to carrying out my professional responsibilities, adhere to ethical principles, and the sensitivity of a diverse patient population

Not Applicable 1 2 3 4

#### System Based Practice

7. There is an awareness and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Not Applicable 1 2 3 4

**Faculty Evaluation - Coney Island Hospital Podiatric Residency PMSR**

Resident's name \_\_\_\_\_ Dates of Rotation \_\_\_\_\_

Name of facility member \_\_\_\_\_

Check one of the following:      PGY 1                      PGY 2                      PGY 3

**Name of Rotation**\_(check appropriate box)

- |   |   |
|---|---|
| <input type="checkbox"/> Foot and Ankle Orthopedics     | <input type="checkbox"/> Infectious Disease           |
| <input type="checkbox"/> Podiatric Medicine and Surgery | <input type="checkbox"/> Internal Medicine            |
| <input type="checkbox"/> Behavioral Health              | <input type="checkbox"/> Radiology                    |
| <input type="checkbox"/> Anesthesiology                 | <input type="checkbox"/> Emergency Department         |
| <input type="checkbox"/> Pathology                      | <input type="checkbox"/> General Surgery and Vascular |
| <input type="checkbox"/> Podiatric office and Clinical  | <input type="checkbox"/> Wound Care                   |

Please rate faculty member(s) involved in this rotation on the following criteria:

1. Teaching Ability:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

2. Rapport with Patients:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

3. Rapport with Residents:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

4. Availability to Resident:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

5. Amount of questioning and discussion toward learning:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

6. Amount of constructive criticism and feedback:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

7. Qualification as a positive role model:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

Resident's name \_\_\_\_\_ Name of facility member \_\_\_\_\_

Circle as many of the following descriptors to define your relationship with the faculty member:

- |             |                 |               |             |            |
|-------------|-----------------|---------------|-------------|------------|
| Helpful     | Confrontational | Professional  | Enjoyable   | Respectful |
| Challenging | Valuable        | Waste of Time | Educational | Unhelpful  |

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident's Signature \_\_\_\_\_ Date \_\_\_\_\_

Residency Director's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Glenn Donovan, DPM

**Coney Island Hospital Podiatric Residency PMSR**

**Resident Acknowledgement**

I have received and read the Coney Island Hospital Podiatric Medicine and Surgery Residency (PSMR) manual. I understand that the manual is subject to change annually and at other times given reasonable notice and I agree to abide by the policies and procedures delineated in the manual and any subsequent changes.

Please sign that you have received the manual.

Received Date: \_\_\_\_\_

Podiatric Resident

Signature: \_\_\_\_\_

Please sign that you have read the manual (it is expected that this is done no later than 2 weeks from the date of receipt of the manual).

Verification Date that manual has been read:

\_\_\_\_\_

Podiatric Resident

Signature: \_\_\_\_\_