

**STANDARDS AND REQUIREMENTS  
FOR APPROVAL OF RESIDENCIES  
IN PODIATRIC MEDICINE AND SURGERY**

**COUNCIL ON PODIATRIC MEDICAL EDUCATION**

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# INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency training programs that are conducted under the control and sponsorship of healthcare institutions. Residencies afford these individuals structured learning experiences in medical patient management along with training in the diagnosis and care of podiatric pathology. The individuals involved in these training programs are referred to as “residents” and are recognized as such by the institutions sponsoring the programs.

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council’s approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of doctoral education, postdoctoral education, certification, and continuing education. By confirming that these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council has been authorized by the APMA to approve institutions that sponsor residency training programs that demonstrate and maintain compliance with the standards and requirements in this publication. Podiatric residency approval is based on programmatic evaluation and periodic review by the Joint Residency Review Committee (JRRC) and the Council.

Standards and requirements in this publication are divided into institutional standards and requirements and program standards and requirements. Standard 6.0 and the associated requirements were developed as a collaborative effort of the Council on Podiatric Medical Education, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), and the American Board of Podiatric Surgery (ABPS).

Under no circumstances may the standards and requirements for approval by the Council supersede federal or state law.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council’s community of interest may be affected.

The Council formulates and adopts its own approval procedures. These procedures are stated in CPME 330, *Procedures for Approval of Residencies in Podiatric Medicine and Surgery*. This document, as well as CPME 320, may be obtained on the Council’s website at [www.cpme.org](http://www.cpme.org) or by contacting the Council office.

## ABOUT THIS DOCUMENT

This publication describes the standards and requirements for approval of podiatric residency programs. The standards and requirements, along with the procedures for approval, serve as the basis for evaluating the quality of the educational program offered by a sponsoring institution and holding the institution and program accountable to the educational community, podiatric medical profession, and the public.

The **standards** for approval of residency programs serve to evaluate the quality of education. These standards are broad statements that embrace areas of expected performance on the part of the sponsoring institution and the residency program. Compliance with the standards ensures good educational practice in the field of podiatric medicine and thus enables the Council to grant or confirm approval.

Related to each standard is a series of specific **requirements**. Compliance with the requirements provides an indication of whether the broader educational standard has been satisfied. During an on-site evaluation of a residency program, the evaluation team gathers detailed information about whether these requirements have been satisfied. Based upon the extent to which the requirements have been satisfied, the Council determines the compliance of the sponsoring institution and the residency program with each standard. In the requirements, the verb “shall” is used to indicate conditions that are imperative to demonstrate compliance.

The **guidelines** are explanatory materials for the requirements. Guidelines are used to indicate how the requirements either must be interpreted or may be interpreted to allow for flexibility, yet remain within a consistent framework. The following terms are used within the guidelines:

- The verbs “must” and “is” indicate how a requirement is to be interpreted, without fail. The approval status of a residency program is at risk if noncompliance with a “must” or an “is” is identified.
- The verb “should” indicates a desirable, but not mandatory, condition.
- The verb “may” is used to express freedom or liberty to follow an alternative.

Throughout this publication, the use of the terms “institution” and “program” is premised on the idea that the program exists within and is sponsored by an institution.

## **GLOSSARY**

**The Council strongly encourages sponsoring institutions and directors of podiatric medical education to become familiar with the following definitions to ensure complete understanding of this publication.**

### **Academic Health Center**

Academic health centers bring together programs of instruction and research in the health sciences and the delivery of health services. The Association of Academic Health Centers (AAHC) defines an academic health center as consisting of an allopathic or osteopathic school of medicine, at least one other health professions school or program, and one or more teaching hospitals, health systems, or other organized health care services. The AAHC also notes that the organization and structure of these institutions may vary. Academic health centers function either as component units of public or private universities, of state university systems, or as free-standing institutions.

### **Accreditation**

Accreditation is the recognition of institutional or program compliance with standards established by the Council on Podiatric Medical Education, based on evaluation of the institution's own stated objectives. Accreditation is a voluntary process of peer review. The Council is responsible for accreditation of colleges and schools of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

### **Approval**

Approval is the recognition of a podiatric residency program, podiatric fellowship program, or sponsor of continuing education that has attained compliance with standards established by the Council on Podiatric Medical Education. Approval is a program-specific form of accreditation.

### **American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)**

ABPOPPM is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric medicine and orthopedics. The ABPOPPM maintains one certification pathway leading to certification in podiatric medicine and orthopedics.

### **American Board of Podiatric Surgery (ABPS)**

ABPS is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric

surgery. The ABPS maintains two certification pathways: foot surgery and reconstructive rearfoot and ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot and ankle status.

## **Centralized Application Service for Podiatric Residencies (CASPR)**

CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to entry-level podiatric residency programs approved by the Council. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

## **Competencies**

Competencies are those elements and sub-elements of practice that define the full scope of podiatric competence. The Council has identified competencies that must be achieved by the resident upon completion of the 24- and 36-month residencies in Podiatric Medicine and Surgery. ABPS and ABPOPPM have identified competencies related to certification pathways; these competencies are published in *Components of Podiatric Competence*.

## **Council of Teaching Hospitals (COTH)**

COTH is a membership organization comprised of institutions sponsoring Council-approved podiatric residency programs (including programs holding provisional and probationary approval). The goals of COTH include fostering excellence in residency training, promoting a code of ethics, developing policy, and serving as a forum for the exchange of ideas on residency education. COTH is a component of the American Association of Colleges of Podiatric Medicine (AACPM). The Council on Podiatric Medical Education and the JRRC encourage sponsoring institutions to participate in COTH.

## **Curriculum**

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

## **Due Process**

Due process is a defined procedure established by the sponsoring institution that is utilized whenever any adverse action is proposed or taken against a resident. All parties to a residency program are protected when there is a reasonable opportunity provided to present pertinent facts.

## **External Assessments**

External assessments are standardized assessments of residents that are monitored and/or delivered by organizations external to the residency program for the purpose of validating the resident's experiences and development. Examples include an annual in-training examination conducted by the specialty board and/or a standardized attitudinal assessment of the resident.

## **Healthcare Institution**

A healthcare institution is an organization or corporation (such as a hospital or academic health center) established under the control and direction of a governing board. The mission of such an institution includes the evaluation, diagnosis, and treatment of disease and injury. Private individuals and/or groups of private individuals are not viewed to be healthcare institutions.

## **Hospital**

A hospital is an institution suitably staffed to provide diagnosis and treatment of a variety of medical conditions in inpatient and outpatient settings. The institution may provide training in the many special professional, technical, and economic fields essential to the discharge of its proper functions.

## **Internal Assessments**

Internal assessments are those assessments of residents that are conducted within the residency program by faculty, staff, peers, and/or patients for the purpose of validating the serial acquisition of necessary knowledge, attitudes, and skills by the residents. Knowledge, attitudes, and skills should be evaluated separately. Knowledge may be assessed with internal modular testlets. Attitudes may be assessed with an attitudinal assessment form. Skills may be assessed by utilizing a standardized technical skills assessment form and observing a particular skill set.

## **In-Training Examination**

Administered by the specialty board, the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification with the specialty board.

## **Joint Committee on the Recognition of Specialty Boards (JCRSB)**

The JCRSB is a committee established by the Council on Podiatric Medical Education on behalf of the podiatric medical profession to recognize specialty boards. The recognition of a specialty board by the JCRSB serves to provide important information to the podiatric medical profession, healthcare institutions, and the public about the sound operations and fair conduct of the board's certification process. The Council and JCRSB are committed to a process that assures the public that those podiatric physicians who are certified have successfully completed the requirements for certification in an area of specialization. The Council's authority for the recognition of

specialty boards through the JCRSB is derived solely from the House of Delegates of the American Podiatric Medical Association. The JCRSB recognizes the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and the American Board of Podiatric Surgery.

## **Joint Residency Review Committee (JRRC)**

The JRRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in residency positions, authorizing resident transfers, and recommending to the Council approval of residency programs. The JRRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The JRRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

Composition of the JRRC includes two representatives from each specialty area in which residency training occurs, one representative from COTH, one representative from residency programs at large (selected by the Council), and at least two Council members.

Although the JRRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of the JRRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the JRRC.

## **Residency**

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

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

- Resource-based implies that the director of podiatric medical education constructs the residency program based upon the resources that are available. While the Council recognizes that available resources may differ among institutions, the director is responsible for determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.
- Competency-driven implies that the director of podiatric medical education assures that the resident achieves the competencies identified by the Council for successful completion of the Podiatric Medicine and Surgery-24 and Podiatric Medicine and Surgery-36 residencies. Each of these specific competencies must be achieved by every

resident identified by the sponsoring institution as having successfully completed the residency program.

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

## **Training Resources**

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medical and surgical subspecialties. The resources may be defined as either essential or complementary to the achievement of the competencies expected to be achieved within a specific program category.

## **STANDARDS FOR APPROVAL OF PODIATRIC RESIDENCY PROGRAMS**

The following standards pertain to all residency programs for which initial or continuing approval is sought. The standards encompass essential elements including sponsorship, administration, program development, clinical expectations, and assessment.

### **INSTITUTIONAL STANDARDS:**

- 1.0** *The sponsorship and control of a podiatric residency program are under the specific administrative responsibility of a healthcare institution that develops, implements, and monitors the residency program.*
- 2.0** *The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.*
- 3.0** *The sponsoring institution formulates, publishes, and implements policies affecting the resident.*
- 4.0** *The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.*

### **PROGRAM STANDARDS:**

- 5.0** *The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.*
- 6.0** *The residency program in either Podiatric Medicine and Surgery–24 (PM&S-24) or Podiatric Medicine and Surgery–36 (PM&S-36) is a resource-based, competency-driven, assessment-validated program that consists of two or three years, respectively, of postgraduate training in inpatient and outpatient medical and surgical management. The program provides training resources that facilitate the resident’s sequential and progressive achievement of specific competencies.*
- 7.0** *The residency program conducts self-assessment and assessment of the resident based upon the competencies.*

# INSTITUTIONAL STANDARDS AND REQUIREMENTS

**1.0** *The sponsorship and control of a podiatric residency program are under the specific administrative responsibility of a healthcare institution that develops, implements, and monitors the residency program.*

**1.1** **The sponsor shall be a hospital or academic health center. Hospital facilities shall be provided under the auspices of the sponsoring institution or through an affiliation with an accredited institution(s) where the affiliation is specific to residency training.**

A college or school of podiatric medicine may co-sponsor a residency with a hospital and/or academic health center but cannot be the sole sponsor of the program. A surgery center may co-sponsor a residency with a hospital and/or academic health center but cannot be the sole sponsor of the program.

Institutions that co-sponsor a residency program must define their relationship to each other to delineate the extent to which financial, administrative, and teaching resources are to be shared. The document defining the relationship between the co-sponsoring institutions and the resident contracts must describe arrangements established for the residency program and the resident in the event of dissolution of the co-sponsorship.

**1.2** **The healthcare institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or the American Osteopathic Association.**

**1.3** **The sponsoring institution shall formalize all arrangements with affiliated institutions and/or facilities by means of written agreements that clearly define the roles and responsibilities of each institution and/or facility involved.**

When training is provided at a secondary institution or facility, the participating institutions must:

- Indicate their respective training commitments through a memorandum of understanding or contract that is reaffirmed at least once every five years.

This document must:

- Acknowledge the affiliation and delineate financial support (including resident liability) and educational contributions of each training site.
- Be signed and dated by the chief administrative officer of each participating institution or facility.

- Be forwarded to the director of podiatric medical education.

If the director of podiatric medical education does not participate actively at the affiliated institution or facility, or if a significant portion of the program is conducted at the affiliated institution or facility, an on-site coordinator must be designated formally to ensure appropriate conduct of the program at this training site. The on-site coordinator must hold a staff appointment at the affiliated site and be a faculty member actively involved in the program at the affiliated institution or facility.

The entirety of training experiences provided at sites located beyond daily commuting distance from the sponsoring institution and/or co-sponsor must not exceed one-twelfth of the residency.

## ***2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.***

### **2.1 The sponsoring institution shall ensure that the physical facilities, equipment, and resources of the primary and affiliated training site(s) are sufficient to permit achievement of the stated competencies of the residency program.**

The physical plant must 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 must be available for resident training.

The sponsoring institution must have been in operation for at least 12 months before submitting an application for approval to assure that sufficient resources are available for the residency program. The institution should have had an active podiatric service for at least 12 months prior to submitting an application for approval.

### **2.2 The sponsoring institution shall afford the resident ready access to adequate library resources, including a diverse collection of current podiatric and non-podiatric medical texts and other pertinent reference resources (i.e., journals and audiovisual materials/instructional media).**

Library resources should be located on-site or within close geographic proximity to the institution(s) at which the resident is afforded training. Library services must include the electronic retrieval of information from medical databases.

### **2.3 The sponsoring institution shall afford the resident ready access to adequate information technologies and resources.**

Computer hardware, software, and related resources must be readily available and utilized to further the resident's training.

- 2.4 The sponsoring institution shall afford the resident ready access to adequate office and study spaces at the institution(s) in which residency training is primarily conducted.**
- 2.5 The sponsoring institution shall provide adequate support staff to ensure efficient administration of the residency program.**

The institution must ensure that neither the director of podiatric medical education nor the resident assumes the responsibility of clerical personnel. The institution must ensure that the resident does not assume the responsibilities of nurses, podiatric medical assistants, or operating room or laboratory technicians.

**3.0 *The sponsoring institution formulates, publishes, and implements policies affecting the resident.***

- 3.1 The sponsoring institution shall utilize a residency selection committee to interview and select prospective resident(s). The committee shall include the director of podiatric medical education and individuals who are active in the residency program.**
- 3.2 The sponsoring institution shall conduct its process of interviewing and selecting residents equitably and in an ethical manner. The sponsoring institution shall inform the prospective resident in writing of the selection process and conditions of appointment established for the program.**

The sponsoring institution must make a written copy of the residency curriculum available to the prospective resident.

- 3.3 The sponsoring institution shall participate in a national resident application matching service. The sponsoring institution shall not obtain binding commitment from the prospective resident prior to the date established by the national resident matching service in which the institution participates.**
- 3.4 Application fees, if required, shall be paid to the sponsoring institution and shall be used only to recover costs associated with processing the application and conducting the interview process.**

The sponsoring institution must publish its policies regarding application fees (i.e., amount, due date, uses, and refunds).

- 3.5 The sponsoring institution shall inform all applicants as to the completeness of the application as well as the final disposition of the application (acceptance or denial).**
- 3.6 The sponsoring institution shall accept only graduates of colleges or schools of podiatric medicine accredited by the Council on Podiatric Medical Education.**
- 3.7 The sponsoring institution shall ensure that the resident is compensated equitably with and enjoys the same rights and privileges as other residents at the institution and/or in the geographic area.**

The stipend offered by the institution is determined as an annual salary. The amount of resident compensation must not be contingent on the productivity of the individual resident.

The sponsoring institution should disclose annually to the director of podiatric medical education the current amounts of direct and indirect graduate medical education reimbursement received by the sponsoring institution.

When practitioners collaborate to fund a residency stipend, a corporation should be formed.

- 3.8 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall state the category and length of the residency program to which the resident is appointed and the amount of the resident stipend. The contract or letter shall be signed and dated by the chief administrative officer of the institution or appropriate senior administrative officer, the director of podiatric medical education, and the resident.**

When a letter of appointment is utilized, a confirmation of acceptance must be put in writing by the prospective resident and forwarded to the chief administrative officer or appropriate senior administrative officer. In the case of a co-sponsored program, the contract or letter of appointment must be signed and dated by the chief administrative officer of each co-sponsoring institution, the director of podiatric medical education, and the resident.

- 3.9 The sponsoring institution shall include or reference the following items in the contract or letter of appointment:**

- a. resident duties and hours of work.**

The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident's ability to function in the training program.

**b. duration of the agreement.**

**c. health insurance benefits.**

The sponsoring institution must provide health insurance coverage for the resident for the duration of the training program. The resident's health insurance coverage must be at least equivalent to that afforded other entry-level professional employees at the sponsoring institution.

**d. professional, family, and sick leave benefits.**

The resident's leave benefits must be at least equivalent to those afforded other entry-level professional employees at the sponsoring institution.

**e. leave of absence.**

The sponsoring institution must establish a policy pertaining to leave of absence or other interruption of the resident's designated training period. In accordance with applicable laws, the policy must address continuation of pay and benefits and the effect of the leave of absence on meeting the requirements for completion of the residency program.

**f. professional liability insurance coverage.**

The sponsoring institution must provide professional liability insurance for the resident that is effective when training commences and continues for the duration of the training program. This insurance must cover all training experiences at all training sites and must provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution must provide the resident with proof of coverage.

**g. other benefits if provided (e.g., meals, uniforms, vacation policy, housing provisions, payment of dues for membership in professional organizations, and disability insurance benefits).**

**3.10 The sponsoring institution shall ensure that the following written policies and mechanisms are distributed to and acknowledged in writing by the resident prior to the start of the training program and following any written revisions to these policies and mechanisms:**

**a. the mechanism of appeal.**

The sponsoring institution must establish a written mechanism of appeal that ensures due process for the resident and the sponsoring institution, should there be a dispute between the parties. Any individual possessing a conflict of

interest related to the dispute, including the director of podiatric medical education, must be excluded from all levels of the appeal process.

**b. the remediation methods established to address instances of unsatisfactory resident performance.**

The sponsoring institution must establish remediation methods to address instances of unsatisfactory resident performance (academic and/or attitudinal). Remediation methods may include requiring that the resident repeat particular training experiences, spend additional hours in a clinic, or complete additional assigned reading to facilitate achievement of the stated competencies of the curriculum. Remediation should be completed no later than three months beyond the normal length of the residency program.

**c. the rules and regulations for the conduct of the resident.**

**3.11 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements. The certificate shall state the category of the training program (i.e., Podiatric Medicine and Surgery-24 or Podiatric Medicine and Surgery-36) and the date of completion of the resident's training.**

The certificate must indicate that the residency program is approved by the Council on Podiatric Medical Education.

**3.12 The sponsoring institution shall ensure that the residency program is established and conducted in an ethical manner.**

The conduct of the residency program must focus upon the educational development of the resident rather than on service responsibility to individual faculty members.

***4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.***

**4.1 The sponsoring institution shall report annually to the Council office on institutional data, residents completing training, residents selected for training, changes in the curriculum, and other information requested by the Council and/or the Joint Residency Review Committee.**

**4.2 The sponsoring institution shall inform the Council office in writing within 30 calendar days of substantive changes in the program.**

The sponsoring institution must inform the Council of changes in areas including,

but not limited to, sponsorship, affiliated training sites, appointment of a new director of podiatric medical education, curriculum, and resident transfer.

**4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, current and incoming residents informing them of denial of eligibility for initial on-site evaluation, probation, administrative probation, withholding of provisional approval, withdrawal of approval, denial of an increase in positions, or voluntary termination of the program. Program applicants shall be notified prior to the interview.**

The institution must submit either the program applicant's and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicant's and the current and incoming residents' receipt of the institution's letter (i.e., signed copies of return receipts for certified mail). These materials must be received in the Council office within 50 calendar days of the director's receipt of the letter informing the institution of the action taken by the Joint Residency Review Committee or the Council on Podiatric Medical Education.

## PROGRAM STANDARDS AND REQUIREMENTS

**5.0** *The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.*

**5.1** **The sponsoring institution shall designate one podiatric physician as director of podiatric medical education to serve as administrator of the residency program. The director of podiatric medical education shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.**

Because of the potential of creating confusion in the leadership and direction of the program, co-directorship is specifically prohibited; however, the director of podiatric medical education may appoint an assistant director to assist in administration of the residency program. A residency training committee also may be established to assist the director of podiatric medical education in the administration of the residency program.

The sponsoring institution should provide an orientation when the director of podiatric medical education is new to this position. A consultant may be utilized to present or participate in this orientation.

The sponsoring institution should provide compensation to the director of podiatric medical education. This compensation should be commensurate with that provided other residency directors at the institution and/or in the geographic area.

**5.2** **The director of podiatric medical education shall possess appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and achieving the stated competencies of the residency.**

The director of podiatric medical education should be certified in the appropriate specialty area(s) by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and/or the American Board of Podiatric Surgery or possess similar qualifications.

**5.3** **The director of podiatric medical education shall be responsible for the administration of the residency in all participating institutions. The director of podiatric medical education shall be able to devote sufficient time to fulfill the responsibilities required of the position. The director of podiatric medical education shall ensure that each resident receives equitable training experiences.**

The director is responsible for maintenance of records related to the educational program, communication with the Joint Residency Review Committee and Council

on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

The director must not delegate to the resident maintenance of records related to the educational program, communication with the Joint Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

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

**5.4 The director of podiatric medical education shall participate at least annually in faculty development activities (i.e., administrative, organizational, teaching, and/or research skills for residency programs).**

The faculty development activities should be approved as continuing education programs by the Council on Podiatric Medical Education or another appropriate agency.

**5.5 The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident.**

The complement of faculty relates to the residency category, number of residents, institutional type and size, organization and capabilities of the services through which the resident rotates, and training experiences offered outside the sponsoring institution.

Faculty members must take an active role in the presentation of lectures, conferences, journal review sessions, and other didactic activities. Faculty members must supervise and evaluate the resident in clinical sessions and assume responsibility for the quality of care provided by the resident during the clinical sessions that they supervise. Faculty members must discuss patient evaluation, treatment planning, patient management, complications, and outcomes with the resident and review records of patients assigned to the resident to ensure the accuracy and completeness of these records.

**5.6 Podiatric and non-podiatric medical faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible.**

The podiatric faculty must include sufficient representation by individuals certified by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. The podiatric faculty must include sufficient representation by individuals certified

by the American Board of Podiatric Surgery.

Faculty members should participate in faculty development activities to improve teaching, research, and evaluation skills.

**6.0 *The residency program in either Podiatric Medicine and Surgery–24 (PM&S-24) or Podiatric Medicine and Surgery–36 (PM&S-36) is a resource-based, competency-driven, assessment-validated program that consists of two or three years, respectively, of postgraduate training in inpatient and outpatient medical and surgical management. The program provides training resources that facilitate the resident’s sequential and progressive achievement of specific competencies.***

To receive approval, a residency in Podiatric Medicine and Surgery must train the resident in the breadth of podiatric healthcare. Resident completion of a Podiatric Medicine and Surgery–24 leads to the foot surgery certification pathway of the American Board of Podiatric Surgery (ABPS) and the certification pathway of the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM). Resident completion of a Podiatric Medicine and Surgery–36 leads to the foot surgery certification and reconstructive rearfoot and ankle surgery certification pathways of the ABPS and the certification pathway of the ABPOPPM.

The curriculum of a PM&S-24 must be completed within 36 months, and the curriculum of a PM&S-36 must be completed within 48 months.

The Council and the JRRC view the following experiences to be essential to the conduct of a residency in Podiatric Medicine and Surgery (although experiences need not be limited to the following):

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

- 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.

**6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council for completion of a 24- or 36-month residency in Podiatric Medicine and Surgery.**

The curriculum must be distributed at the beginning of the training year to all individuals involved in the training program including residents and faculty.

The curriculum must provide the resident appropriate and sufficient experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

**A. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity.**

1. 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.
2. Perform (and/or order) and interpret appropriate diagnostic studies, including:
  - Medical imaging, including plain radiography, radiographic contrast studies, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, vascular imaging.
  - Laboratory tests in hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis.
  - Pathology, including anatomic and cellular pathology.
  - Other diagnostic studies, including electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies.
3. Formulate an appropriate diagnosis and/or differential diagnosis.
4. Formulate and implement an appropriate plan of management, including:
  - Appropriate management when indicated, including
    - palliation of keratotic lesions and toenails.
    - manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
    - management of closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation.
    - cast management.
    - tape immobilization.
    - orthotic, brace, prosthetic, and custom shoe management.
    - footwear and padding.
    - injections and aspirations.

- physical therapy.
  - pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications.
  - Appropriate surgical management when indicated, including Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, Reconstructive Rearfoot and Ankle Surgery (PM&S-36 only), Other Procedures (see Appendix).
  - Appropriate anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia.
  - Appropriate consultation and/or referrals.
  - Appropriate lower extremity health promotion and education.
5. Assess the treatment plan and revise it as necessary.

**B. Assess and manage the patient’s general medical status.**

1. Perform and interpret the findings of a comprehensive medical history and physical examination (including pre-operative history and physical examination), including (see Appendix):
  - Comprehensive medical history.
  - Comprehensive physical examination.
    - vital signs.
    - physical examination including head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination.
2. Formulate an appropriate differential diagnosis of the patient’s general medical problem(s).
3. Recognize the need for (and/or order) additional diagnostic studies, when indicated, including (see also section A.2 for diagnostic studies not repeated in this section).
  - EKG.
  - Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound.
  - Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis.
  - Other diagnostic studies.
4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.

**C. 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.

**D. 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.

**E. 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.

**F. 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.
5. Demonstrate understanding of common business practices.

**G. 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.

- 6.2 The sponsoring institution shall require that the resident maintain logs documenting participation in all relevant podiatric medical and podiatric surgical activities. Logs shall be maintained in formats approved by the JRRC. Logs shall be submitted at least quarterly to the director of podiatric medical education for review, evaluation, and verification.**
- 6.3 The program shall establish a formal schedule for clinical training. The schedule shall be distributed at the beginning of the training year to all individuals involved in the training program including residents, faculty, and administrative staff.**

The schedule must reflect the experiences provided the resident at all training sites. Resident participation in training resources may be scheduled in several formats including blocks (e.g., two weeks, four weeks), sequential (e.g., one day per week, two afternoons per week for eight weeks), or case-by-case.

The director of podiatric medical education is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

Unless extenuating circumstances are present, the training period should be continuous and uninterrupted.

Twenty percent is the maximum proportion of residency education that is acceptable to be conducted in a podiatric private practice office-based setting.

- 6.4 The residency program shall provide the training resources required to enable the resident to achieve the competencies identified by the Council. These training resources shall include: diagnostic modalities; medicine and medical subspecialties; general surgery and surgical subspecialties; anesthesiology; emergency medicine; podiatric surgery; and podiatric medicine. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.**

The director of podiatric medical education must, in collaboration with appropriate individuals, construct the program curriculum based on available resources.

In developing the curriculum, the director of podiatric medical education must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

Additional resources may be utilized to complement the training resources listed

above. When these resources are available, they should be utilized to enhance the training experiences of the resident.

The resident must spend a greater proportion of his or her time in training resources that contribute to achievement of the competencies.

**6.5 Diagnostic modalities: This training resource shall include direct participation of the resident in ordering or performing (where applicable) and interpreting a variety of pertinent medical/surgical diagnostic modalities. Training experiences shall include, but not be limited to, the following areas:**

- a. Medical imaging, including plain radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, ultrasonography, and vascular imaging.**
- b. Laboratory studies in hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, and urinalysis.**
- c. Anatomic and cellular pathology.**
- d. Non-invasive vascular studies.**

**6.6 Medicine and medical subspecialties: This training resource shall include direct participation of the resident in the medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status. Training experiences in medicine and medical subspecialties shall include, but not be limited to, the following areas:**

- a. Performing a minimum of 25 comprehensive medical histories and physical examinations.**
- b. Formulating appropriate differential diagnoses.**
- c. Ordering and interpreting diagnostic studies, including EKGs, chest radiographs, and laboratory studies.**
- d. Formulating and implementing appropriate plans of management.**

Training resources that satisfy the medicine requirement must include at least one of the following: internal medicine or family practice. Training resources that satisfy the medical subspecialty requirement must include behavioral science and at least one of the following: physical medicine and rehabilitation, neurology, dermatology, infectious disease, rheumatology, sports medicine, pain management, or wound care.

A comprehensive history and physical examination (H&P) generally includes chief complaint, history of present illness, medical history, social history, family history, review of systems, and a physical examination including vital signs, HEENT, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, extremities, and neurologic examination. The resident must complete the comprehensive H&P in its entirety. Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P.

The resident must demonstrate competency in this area through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. Examples of how to meet this requirement can include, but not be limited to, H&Ps performed during medical, surgical, and emergency medicine training experiences.

The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

**6.7 General surgery and surgical subspecialties: This training resource shall include direct participation of the resident in surgical evaluation and management of non-podiatric patients. Training experiences in general surgery and surgical subspecialties shall include, but not be limited to, the following areas:**

- a. Understanding management of preoperative and postoperative surgical patients with emphasis on complications.**
- b. Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.**
- c. Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.**

Training resources that satisfy the surgical subspecialty requirement must include at least one of the following: orthopedic, plastic, or vascular surgery.

**6.8 Anesthesiology: This training resource shall include direct participation of the resident in pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences shall include, but not be limited to:**

- a. Local anesthesia.**
- b. General, spinal, epidural, regional, and conscious sedation anesthesia.**

**6.9 Emergency medicine: This training resource shall include the direct participation of the resident in urgent and/or emergent evaluation and management of podiatric and non-podiatric patients.**

Training resources may include emergency room service, urgent care center, trauma service, and critical care unit service.

**6.10 Podiatric surgery: This training resource shall include direct participation of the resident in the treatment of lower extremity pathology. Training experiences that emphasize evaluation, diagnosis, selection of appropriate treatment, and avoidance of complications shall be structured to achieve the competencies identified by the Council. This training resource shall provide an acceptable volume and diversity of operative cases, techniques, and procedures, and include direct participation of the resident as the surgeon or primary assistant under faculty instruction and guidance. The resident shall demonstrate a progressive development of knowledge, attitudes, and skills leading to competency in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, the following (see Appendix):**

- a. Digital Surgery.**
- b. First Ray Surgery.**
- c. Other Soft Tissue Foot Surgery.**
- d. Other Osseous Foot Surgery.**
- e. Reconstructive Rearfoot and Ankle Surgery (PM&S-36 only).**
- f. Other Procedures.**

The residency must refer to the information following requirement 6.11 regarding the volume and diversity of cases and procedures to be performed by the resident.

**6.11 Podiatric medicine: This training resource shall include direct participation of the resident in the evaluation and management of patients in a clinic/office setting. Training experiences shall include, but not be limited to, the following areas (see Appendix):**

- a. Performing problem-focused histories and physical examinations.**
- b. Performing biomechanical evaluations and managing patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.**
- c. Interpreting diagnostic studies, including imaging, laboratory tests, pathology, or other diagnostic studies.**
- d. Formulating appropriate differential diagnoses.**
- e. Formulating and implementing appropriate plans of management.**
- f. Assessing treatment plans and revising them as necessary.**
- g. Providing podiatric services in community and/or other healthcare settings.**

The following information pertains to requirements 6.10 and 6.11:

**A. Patient Care Activity Requirements**

(Abbreviations are defined in section B.)

	<u>MAV</u>	
	<u>PM&amp;S-24</u>	<u>PM&amp;S-36</u>
<u>Case Activities</u>		
Inpatient cases (podiatric or non-podiatric)	50	75
Podiatric clinic/office encounters	750	1000
Podiatric surgical cases	150	300
Trauma cases*	25	50
Podopediatric cases	25	25
Biomechanical cases	150	150

\* Trauma cases must be capable of being verified by patient name and/or medical record number, diagnosis, and attending's name in the resident log. In a PM&S-24, trauma cases can be satisfied with podiatric or non-podiatric cases. In a PM&S-36, at least 25 of the 50 required cases must be foot and/or ankle trauma.

	<u>MAV</u>	
	<u>PM&amp;S-24</u>	<u>PM&amp;S-36</u>
<u>Procedure Activities</u>		
B- and C-level procedures (total)	350	525
C-level procedures, including (see Appendix):		
Digital procedures	80	100
First Ray procedures	60	80
Other Soft Tissue Foot Surgery procedures	45	65
Other Osseous Foot Surgery procedures	40	60
Reconstructive Rearfoot and Ankle procedures	0	50
Other Procedures	0	0

**B. Definitions**

**1. Levels of Resident Activity for Each Logged Procedure**

A-level: The resident observes the case but is not participating actively. While clinical exposure of this kind may provide some useful experience to the resident, A-level procedures **cannot** be counted towards the resident minimum procedure requirements.

B-level: The resident participates actively in performing the procedure. Participation may include retracting and assisting, or performing limited portions (less than 50%) of the procedure **under direct supervision of the attending**.

C-level: The resident participates actively in performing the procedure. Participation includes performing at least the majority (greater than 50%) of the procedure **under direct supervision of the attending**.

## 2. **Minimum Activity Volume (MAV)**

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

## 3. **Required Case Activities**

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

- a. Inpatient cases. This activity includes podiatric or non-podiatric inpatient evaluation and/or management. The resident may gain this activity while participating on an inpatient medical/surgical/podiatric service or on a consultation service. Nail and callus debridement on an inpatient does **not** fulfill this requirement.
- b. Podiatric clinic/office encounters. This activity includes direct participation of the resident in the clinical evaluation and management of patients with foot and ankle complaints.
- c. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle surgery during a single patient encounter.
- d. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients who present immediately after traumatic episodes. In a PM&S-24, trauma cases can be satisfied with podiatric or non-podiatric cases. In a PM&S-36, at least 25 of the 50 required trauma cases must be foot and/or ankle trauma.
- e. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of patients who are less than 14 years of age. The cases may be generated while on podiatric service, pediatric

service, family practice service, emergency medicine service, or other clinical services that provide pediatric encounters.

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

#### **4. Required Procedure Activities**

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

- a. B- and C-level procedures (total). This activity includes the total of all surgical procedures of the foot and ankle performed by the resident in which the resident was afforded either B- or C-level activity.
- b. C-level procedures. This activity includes only those procedures performed by the resident at C-level activity, itemized in the following categories: Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, and Reconstructive Rearfoot and Ankle Surgery. Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies in the Other Soft Tissue Foot Surgery or Other Osseous Foot Surgery categories and the resident has performed the required respective C-level RRA procedures.

#### **C. Assuring Diversity of Surgical Experience**

The construct of the procedure categories assures some degree of diversity in the resident's surgical training experience.

To assure proper diversity within each procedure category and subcategory, at least 33% of the procedure codes within each category and subcategory must be represented with C-level experience. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedure codes must have at

least one C-level activity.

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

**D. Programs with Multiple Residents or Fellows**

1. Only one resident may take credit for C-level participation on any one procedure.
2. More than one resident may take credit for A- or B-level participation on the same procedure.
3. The activity of a fellow should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.
4. When multiple procedures are performed on a single patient, more than one resident or fellow may participate actively, but C-level activity may be claimed by only one resident or fellow per procedure.

**6.12 The residency program shall ensure that the resident is certified in basic life support for the duration of residency training.**

Resident certification must be obtained as early as possible during the training year but no later than six months after the resident's starting date. The resident should be afforded training in advanced cardiac life support.

**6.13 The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.**

The director of podiatric medical education must assure that the patient records accurately document the resident's participation in performing history and physical examinations and recording of operative reports, discharge summaries, and progress notes. The resident should participate in quality assurance and utilization review activities.

**6.14 Didactic activities that complement and supplement the curriculum shall be available at least weekly.**

Didactic activities must be provided in a variety of formats. These formats may include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

The majority of didactic activities must include participation by faculty.

The residency curriculum must include instruction in research methodology. The resident should participate in research activities to broaden the scope of training. The director of podiatric medical education may appoint a faculty member to coordinate didactic activities.

**6.15 A journal review session, consisting of faculty and residents, shall be scheduled at least monthly to facilitate reading, analyzing, and presenting medical and scientific literature.**

The residency curriculum must afford the resident instruction in the critical analysis of scientific literature. The resident should present current articles and analyze the content and validity of the research.

**6.16 The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.**

**7.0 *The residency program conducts self-assessment and assessment of the resident based upon the competencies.***

**7.1 The faculty and director of podiatric medical education shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.**

The director of podiatric medical education must conduct a formal quarterly meeting with the resident to review the extent to which the resident is achieving the competencies.

The assessments must be written or completed in an electronic format. The assessment instrument must indicate the dates covered and must be validated by the faculty member, the resident, and the director of podiatric medical education. The instrument may include assessment of the resident in areas such as communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency must allow sufficient opportunity for remediation.

Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

The residency program should require that the resident take in-training examinations as prescribed by the relevant specialty board if such examinations are available. The sponsoring institution is encouraged to pay any fees associated with the examinations. The examination results should be used as a guide for resident remediation and as part of the annual self-assessment of the program.

**7.2 The director of podiatric medical education, faculty, and resident(s) shall conduct an annual self-assessment of the program's resources and curriculum. Information resulting from this review shall be used in improving the program.**

The review must include evaluation of the program's compliance with the current standards and requirements of the Council, the resident's formal evaluation of the program, and the director's formal evaluation of the faculty.

The curriculum must be assessed to determine if it is relevant to the competencies. The review must determine the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved. The review also must determine the extent to which didactic activities complement and supplement the curriculum. The review must use performance data such as resident performance on external exams, including board qualifying exams, to support the program's goal of assuring that the resident achieves the competencies.

The review should include measures of program outcomes such as success of previous residents in private practice and teaching environments, attainment of board certification, state licensure, hospital appointments, and publications.

## APPENDIX

### CASE ACTIVITY AND SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

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

#### **1 Digital Surgery** (lesser toe or hallux)

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

#### **2 First Ray Surgery**

##### Hallux Valgus Surgery

- 2.1.1 bunionectomy (partial ostectomy/Silver procedure)
- 2.1.2 bunionectomy with capsulotendon balancing procedure
- 2.1.3 bunionectomy with phalangeal osteotomy
- 2.1.4 bunionectomy with distal first metatarsal osteotomy
- 2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
- 2.1.6 bunionectomy with first metatarsocuneiform fusion
- 2.1.7 metatarsophalangeal joint (MPJ) fusion
- 2.1.8 MPJ implant
- 2.1.9 MPJ arthroplasty

##### Hallux Limitus Surgery

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

### Other First Ray Surgery

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

### **3 Other Soft Tissue Foot Surgery**

- 3.1 excision of ossicle/sesamoid
- 3.2 excision of neuroma
- 3.3 removal of deep foreign body (excluding hardware removal)
- 3.4 plantar fasciotomy
- 3.5 lesser MPJ capsulotendon balancing
- 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
- 3.7 open management of dislocation (MPJ/tarsometatarsal)
- 3.8 incision and drainage/wide debridement of soft tissue infection (including plantar space)
- 3.9 plantar fasciectomy
- 3.10 excision of soft tissue tumor/mass of the foot (without reconstructive surgery)
- 3.11 external neurolysis/decompression (excluding tarsal tunnel)
- 3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
- 3.13 microscopic nerve/vascular repair (forefoot only)
- 3.14 other soft tissue procedures not listed above (limited to the foot)

### **4 Other Osseous Foot Surgery**

- 4.1 partial ostectomy (distal to and including the talus)
- 4.2 lesser MPJ arthroplasty
- 4.3 bunionectomy of the fifth metatarsal without osteotomy
- 4.4 metatarsal head resection (single or multiple)
- 4.5 lesser MPJ implant
- 4.6 central metatarsal osteotomy
- 4.7 bunionectomy of the fifth metatarsal with osteotomy
- 4.8 open management of lesser metatarsal fractures
- 4.9 harvesting of bone graft distal to the ankle
- 4.10 amputation (lesser ray, transmetatarsal amputation)
- 4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
- 4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)

- 4.13 open management of tarsometatarsal fracture/dislocation
- 4.14 multiple osteotomy management of metatarsus adductus
- 4.15 tarsometatarsal fusion
- 4.16 corticotomy/callus distraction of lesser metatarsal
- 4.17 revision/repair of surgical outcome in the forefoot
- 4.18 other osseous procedures not listed above (distal to the tarsometatarsal joint)

## **5 Reconstructive Rearfoot and Ankle Surgery**

### Elective - Soft Tissue

- 5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
- 5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
- 5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
- 5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
- 5.1.5 delayed repair of ligamentous structures
- 5.1.6 ligament or tendon augmentation/supplementation/restoration
- 5.1.7 open synovectomy of the rearfoot/ankle
- 5.1.8 tarsal tunnel decompression
- 5.1.9 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

### Elective - Osseous

- 5.2.1 operative arthroscopy
- 5.2.2 detachment/reattachment of Achilles tendon with partial ostectomy
- 5.2.3 subtalar arthroeresis
- 5.2.4 midfoot, rearfoot, or ankle fusion
- 5.2.5 midfoot, rearfoot, or tibial osteotomy
- 5.2.6 coalition resection
- 5.2.7 open management of talar dome lesion (with or without osteotomy)
- 5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
- 5.2.9 ankle implant
- 5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
- 5.2.11 other elective rearfoot reconstructive/ankle osseous surgery not listed above

### Non-Elective - Soft Tissue

- 5.3.1 repair of acute tendon injury
- 5.3.2 repair of acute ligament injury
- 5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
- 5.3.4 excision of soft tissue tumor/mass of the foot (with reconstructive surgery)
- 5.3.5 excision of soft tissue tumor/mass of the ankle (with or without reconstructive surgery)
- 5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
- 5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above

### Non-Elective - Osseous

- 5.4.1 open repair of adult midfoot fracture
- 5.4.2 open repair of adult rearfoot fracture
- 5.4.3 open repair of adult ankle fracture
- 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
- 5.4.5 management of bone tumor/neoplasm (with or without bone graft)

- 5.4.6 management of bone/joint infection (with or without bone graft)
- 5.4.7 amputation proximal to the tarsometatarsal joints
- 5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above

**6 Other Procedures** (these procedures **cannot** be counted toward the minimum procedure requirements)

- 6.1 debridement of superficial ulcer or wound
- 6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
- 6.3 nail avulsion (partial or complete)
- 6.4 matricectomy (partial or complete, by any means)
- 6.5 removal of hardware
- 6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)
- 6.7 biological dressings
- 6.8 extracorporeal shock wave therapy
- 6.9 other clinical experiences

**7. Biomechanics**

- 7.1 taping/padding
- 7.2 orthotics
- 7.3 prosthetics
- 7.4 biomechanical examination
- 7.5 other biomechanical experiences not listed above

**8. History and Physical Examination**

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