

# CPME 320

## STANDARDS AND REQUIREMENTS FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

COUNCIL ON PODIATRIC MEDICAL EDUCATION

**Approval Categories: PMSR and PMSR/RRA**

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# INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency programs conducted under sponsorship of health-care institutions and colleges of podiatric medicine. Residencies afford these individuals structured learning experiences in 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 graduate education, postgraduate education, certification, and continuing education. By confirming 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 APMA to approve institutions that sponsor residency 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 Residency Review Committee (RRC) 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 Foot and Ankle Surgery (ABFAS), and the American Board of Podiatric Medicine (ABPM).

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 Podiatric Residencies*. 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 extend 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.

- 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.

The terms “college” and “school” are used interchangeably throughout this document.

# GLOSSARY

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

## **Academic Health Center**

An academic health center is the entire health enterprise at a university including health professions, education, patient care, and research. An academic health center consists of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association, one or more health profession schools or programs (such as podiatric medicine, dentistry, allied health, nursing, pharmacy, public health, graduate studies, or veterinary medicine), and one or more owned and affiliated teaching hospitals or health systems.

## **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 accrediting colleges of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

## **Affiliated Training Site**

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

## **American Board of Foot and Ankle Surgery**

ABFAS is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards (JCRSB) to certify in the specialty area of podiatric surgery. ABFAS maintains two certification pathways: foot surgery and reconstructive rearfoot/ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot/ankle status.

## **American Board of Podiatric Medicine**

ABPM 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. ABPM maintains one certification pathway leading to certification in podiatric orthopedics and primary 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.

### **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 podiatric residency programs approved by the Council. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

### **Certification**

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

### **Collaborative Residency Evaluator Committee (CREC)**

CREC is an effort of ABFAS, ABPM, and the Council to improve the methods by which residency evaluators and team chairs are selected, trained, assessed, remediated, and dismissed. The composition of the Committee includes three individuals from each organization, one of whom must be the executive director or that individual's designee, who must be an employee of the organization represented.

### **Competencies**

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. ABFAS and ABPM have identified competencies related to certification pathways.

## **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. The Council on Podiatric Medical Education and RRC 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 in a residency program are protected when there is a reasonable opportunity provided to present pertinent facts.

## **Duplication**

Duplication occurs when a resident enters the same case and procedure on the same day of surgery more than once in clinical/patient logs.

## **External Assessments**

External assessments are standardized evaluations 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. An example is an annual in-training examination conducted by a specialty board.

## **Fragmentation**

Fragmentation occurs when a specific surgical procedure in clinical/patient logs is unbundled or fragmented inappropriately into its individual component parts.

## **Health-care Institution**

A health-care 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 health-care institutions.

## **Hospital**

A hospital is an institution that provides 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 evaluations of residents that are conducted within the residency program by faculty, staff, peers, and 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(s), the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification by the specialty board(s).

## **Joint Committee on the Recognition of Specialty Boards**

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 JCRSB serves to provide important information to the podiatric medical profession, health-care 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 JCRSB is derived solely from the House of Delegates of the American Podiatric Medical Association. JCRSB recognizes the American Board of Foot and Ankle Surgery and the American Board of Podiatric Medicine.

## **Podiatric Medicine and Surgery**

Podiatric medicine and surgery is the profession and medical specialty that includes the study, prevention, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.

## Miscategorization

Miscategorization occurs when a surgical procedure in patient/clinical logs is misclassified into an incorrect procedure code.

## Residency

A residency is a postgraduate educational program conducted under the sponsorship of a hospital, college of podiatric medicine, or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges 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 program director constructs the residency program based upon the resources available. While the Council recognizes that available resources may differ among institutions, the program 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 the program director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the sponsoring institution as having successfully completed the residency program.
- Assessment-validated implies 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).

## Residency Review Committee

RRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in and reclassification of residency positions, and recommending to the Council approval of residency programs. RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. RRC 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 RRC includes two representatives each from ABFAS and ABPM, one representative from COTH, one representative from residency programs at large (selected by the Council), and at least two Council members.



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

## **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.

## **Verification**

Verification is the process by which the program director reviews resident clinical/patient logs to ensure resident attainment of the Minimum Activity Volume (MAV) requirements and for accuracy to ensure there is no duplication, miscategorization, and/or fragmentation of procedures.

## **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 of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine 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 podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution 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 of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.*

**1.1** **The sponsor shall be a hospital, academic health center, or college of podiatric medicine. 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 surgery center may co-sponsor a residency with a hospital, academic health center, and/or college of podiatric medicine 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 health-care institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission, the American Osteopathic Association, or a health-care agency approved by the Centers for Medicare and Medicaid Services. The college of podiatric medicine shall be accredited by the Council on Podiatric Medical Education.**

**1.3** **The sponsoring institution shall formalize arrangements with each training site by means of a written agreement that defines clearly the roles and responsibilities of each institution and/or facility involved.**

When training is provided at an affiliated training site, the participating institutions must:

- indicate their respective training commitments through an affiliation agreement 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 by the chief administrative officer or designee of each participating institution or facility;
- include an effective date; and
- be forwarded to the program director.

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

The expected daily commute to each sponsoring and affiliated training site must not have a detrimental effect upon the educational experience of the resident. Training provided abroad may not be counted toward the requirements of any training resource.

## ***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.**
- 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 designated support staff to ensure efficient administration of the residency program.**

The institution must ensure that neither the program director 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 program director 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 must provide the prospective resident information describing the selection process and conditions of appointment established for the program. Interviews must not occur prior to, or be in conflict with, interview dates established by the national resident application matching service with which the residency program participates. The sponsoring institution must make 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 a 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 of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed the Parts I and II examinations of the National Board of Podiatric Medical Examiners.**
- 3.7 The sponsoring institution shall ensure that the resident is compensated equitably with and is afforded the same rights and privileges as other residents at the institution.**

If the sponsoring institution does not offer other residency programs, then the resident must be compensated equitably with other residents 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 resident cannot be hired as an independent contractor.

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

- 3.8 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall state whether the reconstructive rearfoot/ankle credential is being offered 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 designated senior administrative officer, the program director, and the resident.**

When a letter of appointment is utilized, a written confirmation of acceptance must be executed by the prospective resident and forwarded to the chief administrative officer or designated 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 or designated senior administrative officer of each co-sponsoring institution, the program director, and the resident.

Programs approved by the Council to exceed 36 months of training must state the extended program length in the contract.

**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 for the resident for the duration of the training program. The resident's health insurance must be at least equivalent to that afforded other 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 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 rotations 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 upon request.

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



**3.10 The sponsoring institution shall develop a residency manual distributed to and acknowledged in writing by the resident at the beginning of the program and following any revisions. The manual shall include, but not be limited to, the following:**

**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 program director, 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 and delineate remediation methods to address instances of unsatisfactory resident performance (academic and/or attitudinal) and that identify the time frame allowed for remediation. Remediation methods may include, but not be limited to, 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**

**d. Competencies specific to each rotation (refer to requirements 6.1 and 6.4)**

**e. Training schedule**

The schedule must be for the length of the residency (36 or 48 months, if applicable), reflect the number of approved residency positions, and clearly identify the rotation, location, format, and date of each rotation. (refer to requirement 6.3)

**f. Schedule of didactic activities (refer to requirement 6.7)**

**g. Journal review schedule (refer to requirement 6.8)**

**h. Assessment documents (refer to requirement 7.2)**

**i. CPME 320 and CPME 330**

These documents may be provided within the manual or the manual may include links to the residency section of CPME's website.

**3.11 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements. The certificate shall identify the program as a Podiatric Medicine and Surgery Residency and shall state the date of completion of the resident’s training.**

The certificate must include the following:

- The statement “Approved by the Council on Podiatric Medical Education”
- At a minimum, the certificate must be signed by the program director and the chief administrative officer, or designated senior administrative officer. In the case of a co-sponsored program, the certificate must be signed by the chief administrative officer or designated senior administrative officer of each co-sponsoring institution and the program director.
- Date of completion
- Identification of the residency as a “Podiatric Medicine and Surgery Residency”
- If applicable, the certificate must identify the added credential as “with the added credential in Reconstructive Rearfoot/Ankle Surgery”

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

The conduct of the residency 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 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, resignation or termination of the program director, appointment of a new program director, curriculum, a significant increase or decrease in faculty, and resident resignation, termination, or transfer.

**4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, and current and incoming residents informing them of adverse actions or voluntary termination of the program.**

**Program applicants shall be notified prior to the interview.**

The institution must submit either the program applicants' and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicants' and the current and incoming residents' receipt of the institution's letter. These materials must be received in the Council office within 50 calendar days of the program director's receipt of the letter informing the institution of the action taken by the Review Committee or the Council.

Adverse actions include, probation, administrative probation, withholding of provisional approval, and withdrawal of approval.

## 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 program director to serve as administrator of the residency program. The program director shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.**

The sponsoring institution must provide compensation to the program director. This compensation must be commensurate with that provided other residency directors at the institution. If the sponsoring institution does not offer other residency programs, then the program director must be compensated equitably with other program directors in the geographic area.

The program director must be a member of the medical staff of the sponsoring institution, or in the case of a co-sponsorship, at one of the sponsoring institutions. The program director must be a member of the graduate medical education committee or equivalent within the institution. The program director should be a member of national, state, and/or local professional organization(s).

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

The sponsoring institution must provide an orientation when the program director is new to this position. A consultant may be utilized to present or participate in this orientation.

Co-sponsoring institutions must designate one program director responsible for the entire co-sponsored residency. This individual must be provided the authority and have the ability to oversee resident training at all sites.

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

The program director should be certified in the specialty area(s) by the American Board of Foot and Ankle Surgery and/or the American Board of Podiatric Medicine.

**5.3 The program director shall be responsible for the administration of the residency in all participating institutions. The program director shall be able to devote sufficient time to fulfill the responsibilities required of the position. The program director 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 Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, review and verification of logs, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. In a co-sponsored program, the director is responsible for ensuring that the Council is provided requested information for all residents at all training sites, not just at one of the co-sponsoring sites (e.g., the institution at which the director is based).

The director must not delegate to the resident maintenance of records related to the educational program, communication with the Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, verification of logs, 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 program director 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. Formal faculty development programs provided by teaching hospitals and colleges that do not offer continuing education activities also will be acceptable if appropriate documentation is provided of the program's nature, duration, and attendance.

**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 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 active podiatric faculty must include sufficient representation by individuals certified by each board recognized by the Joint Committee on the Recognition of Specialty Boards, or by individuals possessing other specialized qualifications acceptable to the Residency Review Committee.

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

**6.0 *The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.***

The resident must be afforded training in the breadth of podiatric health care. Completion of a podiatric residency leads to the following certification pathways – the American Board of Podiatric Medicine and foot surgery of the American Board of Foot and Ankle Surgery.

Completion of a podiatric residency with the added credential in reconstructive rearfoot/ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of ABFAS.

All required curricular elements must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. Programs that extend the residency beyond 36 months must present a clear educational rationale consistent with program requirements. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee prior to implementation and at each subsequent approval review of the program.

The Council and RRC view the following experiences to be essential to the conduct of a residency (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, ankle, and their governing and related structures 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, ankle, and their governing and related structures.
- 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.**

At the beginning of the training year, all individuals involved in the training program must be provided the training schedule, competencies, and assessment documents for their respective rotations.

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

**A. Prevent, diagnose, and medically and surgically 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, biomechanical examination, and gait analysis.
2. Formulate an appropriate diagnosis and/or differential diagnosis.
3. Perform (and/or order) and interpret appropriate diagnostic studies, including:
  - Medical imaging, including plain radiography, 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.
4. Formulate and implement an appropriate plan of management, including:
- Direct participation of the resident in the evaluation and management of patients in a clinic/office setting.
    - perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
  - Management when indicated, including
    - dermatologic conditions.
    - manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
    - 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.
  - Surgical management when indicated, including
    - evaluating, diagnosing, selecting appropriate treatment and avoiding complications.
    - progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, the following: Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, Reconstructive Rearfoot/Ankle Surgery (added credential only), Other Procedures (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
  - Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia.



- Consultation and/or referrals.
  - Lower extremity health promotion and education.
5. Assess the treatment plan and revise it as necessary.
- Direct participation of the resident in urgent and emergent evaluation and management of podiatric and non-podiatric patients.

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

1. Perform and interpret the findings of comprehensive medical history and physical examinations (including pre-operative history and physical examination), including (see Appendix A):
  - 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.3 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.
5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.
6. Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to:

- Understanding management of preoperative and postoperative surgical patients with emphasis on complications.
  - Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
  - Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.
7. Participate actively in an anesthesiology rotation that includes 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 must include, but not be limited to:
    - Local anesthesia.
    - General, spinal, epidural, regional, and conscious sedation anesthesia.
  8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.
  9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:
    - Recognizing and diagnosing common infective organisms.
    - Using appropriate antimicrobial therapy.
    - Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring.
    - Exposure to local and systemic infected wound care.
  10. Participate actively in a behavioral science rotation that includes, but is not limited to:
    - Understanding of psychosocial aspects of health care delivery.
    - Knowledge of and experience in effective patient-physician communication skills.
    - Understanding cultural, ethnic and socioeconomic diversity of patients.
    - Knowledge of the implications of prevention and wellness.

**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 health-care costs.

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

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

**E. Manage individuals and populations in a variety of socioeconomic and health-care settings.**

1. Demonstrate an understanding of the psychosocial and health-care 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 health-care delivery settings.**

1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand health-care reimbursement.
3. Understand insurance issues including professional and general liability, disability, and Workers' Compensation.
4. Understand medical-legal considerations involving health-care 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 web-based logs in formats approved by RRC documenting all experiences related to the residency.**

**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 identify the rotations and document clearly the dates, length, format, and location of each rotation provided the resident. The program director 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.

The residency must be continuous and uninterrupted unless extenuating circumstances are present.

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 rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include: medical imaging; pathology; behavioral sciences; internal medicine and/or family practice; medical subspecialties; infectious disease; general surgery; 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 program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources. In developing the curriculum, the program director 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.

In addition to podiatric medicine and podiatric surgery, the following rotations are required:

- a. Medical imaging
- b. Pathology
- c. Behavioral sciences
- d. Infectious disease
- e. Internal medicine and/or family practice
- f. Medical subspecialties. Rotations that satisfy the medical subspecialty requirement include at least two of the following: dermatology, endocrinology, neurology, pain management, physical medicine and rehabilitation, rheumatology, wound care, burn unit, intensive/critical care unit, pediatrics, and geriatrics.
- g. General surgery
- h. Surgical subspecialties: Training resources that satisfy the surgical subspecialty requirement must include at least one of the following: orthopedic, plastic, or vascular surgery.
- i. Anesthesiology
- j. Emergency medicine. Training resources may include emergency department, urgent care center, and trauma service.

The time spent in infectious disease (d) plus the time spent in internal medicine and/or family practice (e) plus the time spent in medical subspecialties (f) must be equivalent to a minimum of three full-time months of training.

**6.5 The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of 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.

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

The program director must assure that patient records document accurately the resident's participation in performing comprehensive 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.

**6.7 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 didactic schedule must include instruction in research methodology. The resident should participate in research activities to broaden the scope of training.

The program director may appoint a faculty member to coordinate didactic activities.

**6.8 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 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.

**6.9 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 program director shall review, evaluate, and verify resident logs on a monthly basis.**

The program director must review the logs for accuracy to ensure that there is no duplication, miscategorization, and/or fragmentation of procedures into their component parts. Procedure notes must support the selected experience.

The program director must monitor resident logs to ensure resident attainment of the Minimum Activity Volume (MAV) and diversity requirements prior to completion of training.

**7.2 The faculty and program director shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.**

**a. Faculty Assessment of the Resident**

Assessment forms must be completed for all rotations identified in the curriculum. The document must specify the dates covered, the name of the resident, and the name of the faculty member. The assessment must be signed (signature and printed name) and dated by the faculty member, the resident, and the program director. The document must assess competencies specific to each rotation including communication skills, professional behavior, attitudes, and

initiative. The timing of the assessment for each competency must allow sufficient opportunity for remediation.

b. Program Director Assessment of the Resident

The program director must conduct and document a semi-annual meeting with the resident to review the extent to which the resident is achieving the competencies. Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

c. In-training examinations

The program should require that the resident take in-training examinations as prescribed by JCRSB-recognized specialty boards. If the resident is required to take an in-training examination(s), the sponsoring institution must pay any fees associated with the examinations. Examination results are used as a guide for resident remediation and as part of the annual self-assessment of the program.

**7.3 The program director, 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 the following:

- a. Identification of individuals involved (e.g. program director, faculty, and residents)
- b. Performance data utilized (e.g., evaluation of the program's compliance with the standards and requirements of the Council, the resident's formal evaluation of the program, the director's formal evaluation of the faculty, and the extent to which the didactic activities complement and supplement the curriculum)
- c. Measures of program outcomes utilized (e.g., in-training examination results, success of previous residents in private practice and teaching environments, board certification pass rates, hospital appointments, and publications)
- d. Results of the review (i.e., whether the curriculum is relevant to the competencies, the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether the resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved)

# APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

## A. Patient Care Activity Requirements MAV (Abbreviations are defined in section B.)

### Case Activities

Podiatric clinic/office encounters	1000
Podiatric surgical cases	300
Trauma cases	50
Podopediatric cases	25
Biomechanical cases	75
Comprehensive history and physical examinations	50

### Procedure Activities

First and second assistant procedures (total)	400
First assistant procedures, including:	
Digital	80
First Ray	60
Other Soft Tissue Foot Surgery	45
Other Osseous Foot Surgery	40
Reconstructive Rearfoot/Ankle (added credential only)	50

## B. Definitions

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

First assistant: The resident participates actively in the procedure **under direct supervision of the attending**.

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

### 2. Minimum Activity Volume (MAV)

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



### 3. Required Case Activities

A 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. 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. The sponsoring institution must document the availability of at least 1,000 encounters per resident.
- b. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.
- c. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients in the acute phase of a traumatic episode. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Comprehensive history and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

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

- d. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of patients who are less than 18 years of age.
- e. Biomechanical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by biomechanical means. These experiences include, but are not limited to, performing comprehensive lower extremity biomechanical examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders.
- f. Comprehensive history and physical examinations. Admission, preoperative, and outpatient H&Ps may be used as acceptable forms of a comprehensive H&P. A problem-focused history and physical examination does not fulfill this requirement.

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

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

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable. For example, a bunionectomy that has been fragmented into an osseous procedure and an adjunctive soft tissue procedures, creating two separate procedures.

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

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

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

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

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

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

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

## **APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS**

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

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

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

### **2 First Ray Surgery**

#### Hallux Valgus Surgery

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

### Hallux Limitus Surgery

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

### Other First Ray Surgery

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

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

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

- 3.15 procedure code number no longer used
- 3.16 external neurolysis/decompression (including tarsal tunnel)
- 3.17 decompression of compartment syndrome (includes foot or leg)

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

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

#### **5 Reconstructive Rearfoot/Ankle Surgery**

##### Elective - Soft Tissue

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

##### Elective - Osseous

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

#### Non-Elective - Soft Tissue

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

#### Non-Elective - Osseous

- 5.4.1 open repair of adult midfoot fracture
- 5.4.2 open repair of adult rearfoot fracture
- 5.4.3 open repair of adult ankle fracture
- 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
- 5.4.5 management of bone tumor/neoplasm (with or without bone graft)
- 5.4.6 management of bone/joint infection (with or without bone graft)
- 5.4.7 amputation proximal to the tarsometatarsal joints
- 5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above
- 5.4.9 application of multiplanar external fixation midfoot, rearfoot, ankle (does not include mini or mono rails)

**6 Other Podiatric 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 matrixectomy (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 taping/padding (limited to the foot, and ankle)
- 6.10 orthotics (limited to the foot, and ankle casting for foot orthosis and ankle orthosis)
- 6.11 prosthetics (including prescribing and/or dispensing toe filler and prosthetic feet)
- 6.12 other biomechanical experiences not listed above (may include, but is not limited to, physical therapy, shoe prescription shoe modification)
- 6.13 other clinical experiences
- 6.14 percutaneous procedures, i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma.

**7 Biomechanics**

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

**8 History and Physical Examination**

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

**9 Surgery and surgical subspecialties**

- 9.1 general surgery
- 9.2 orthopedic surgery
- 9.3 plastic surgery
- 9.4 vascular surgery

**10 Medicine and medical subspecialty experiences**

- 10.1 anesthesiology



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

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