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GENERAL INFORMATION
A. Administrative Chain of Command - Department of Anesthesiology

The Department of Anesthesiology “chain of command” chart is found on page 12.

B. Book and Educational Fund

Book allowance: $500 for residency
In addition residents receive the book: Basics of Anesthesiology by Stoelting
Educational Meeting Support (one week/year): $2,000 for residency
Society Memberships:
- American Society of Anesthesiologists Membership $25/year (includes journal)
- Colorado Society of Anesthesiology Membership $35/year
- International Anesthesia Research Society Membership $75/year (includes journal)

C. Case Documentation

Residents are required to document their cases and procedures each month through a web-based documentation program provided by the ACGME (www.acgme.org). At the end of each academic year, an Annual Training Report (a record of your O.R. cases) is submitted to the ABA. Instructions on how to access this program will be provided at orientation. See pages 5-6 for a sample documentation form.

D. Complaints, Grievance Procedures for Housestaff

Residents who wish to communicate complaints or resolve issues within the program or department may bring them up at our monthly Resident/Chair Forum or meet with their Faculty Advisor, the Residency Director or the Chairman at any time. In addition, Complaints, and Grievance Procedures are described on pages 31, 36-38 of the 2009-2010 Graduate Medical Education Manual and is also available online at www.uchsc.edu/gme.

E. Colorado Physician Health Program (CPHP)

Office: 303-860-0122 Fax: 303-860-7426

The Colorado Physician Health Program (www.CPHP.org) is a not-for-profit organization, independent of other medical organizations and the government. CPHP provides peer assistance services at no cost for licensed physicians and physician assistants of Colorado. CPHP clients are assured confidentiality as required by law or regulation. Peer assistance services aid individuals who have difficulties or problems such as emotional, psychological or medical issues. CPHP assists its clients with medical and/or psychiatric conditions (e.g. Alzheimer’s disease, HIV infection, depression or substance abuse) as well as psychosocial conditions (e.g. family problems or stress related to work or professional liability difficulties).

CPHP provides diagnostic evaluation, treatment referral as well as treatment monitoring and support services. CPHP believes that early intervention and evaluation offer the best opportunity
for a successful outcome and preventing the health condition from needlessly interfering with medical practice.

CPHP does not (with rare exceptions regarding safety) disclose the identity or information about any current or former participant without a written release of information. CPHP maintains records on participants by code number; thus appointment schedules, file folders, etc. are recorded by number. This number is used in lieu of a client name to assure anonymity within the program. Any identifying information is kept in locked files. Only CPHP staff are aware of the individual identify of a participant. Staff members sign a formal confidentiality agreement that specifies the confidentiality requirements and imposes consequences should a breach occur. CPHP participants are not identified to the CPHP Board of Directors.

F. DEPARTMENT OF ANESTHESIOLOGY FACULTY AND RESIDENTS

A list of our program faculty and residents/fellows can be found on pages 7-9. In addition, a roster of departmental employees is listed on the Intranet at www.uchsc.edu/anes under “Directory”.

G. E-MAIL ACCOUNTS

Residents are provided with a UCD e-mail address. Instructions on how to access your e-mail is provided in your orientation packet. You are required to use your UCD e-mail address as email cannot be forwarded to outside email accounts.

H. EMERGENCY CONTACT INFORMATION

It is essential that we have correct information from you in case of an emergency. Please inform Jan Ratterree of address or phone number changes and the person to contact in case of an emergency.

I. HEALTH, DENTAL, LIFE AND DISABILITY INSURANCE

Please refer to the 2009-2010 Graduate Medical Education Manual, pages 12-16 or online at www.uchsc.edu/gme for a description of your coverage.

J. MEAL TICKETS

Meal tickets are provided for residents at all hospitals. At UCH each meal ticket has a value of $8.00. The department is allotted a fixed number of meal tickets per month. If lost, they cannot be replaced!
K. **MOONLIGHTING**

The Department of Anesthesiology prohibits moonlighting.

L. **PAYROLL**

Payday is the last working day of the month. Automatic deposit is mandatory. If you have not completed an automatic deposit form, please do so as soon as possible to avoid delay of your July paycheck.

M. **SUBSTANCE ABUSE/IMPAIRED PHYSICIAN POLICY**

The Substance Abuse/Impaired Physician Policy can be found on page 56 of the 2009-2010 Graduate Medical Education Manual. In addition, the UCH Anesthesia Operating Room Pharmacy Controlled Substances Policy and Procedure is included in the Policies section of this manual (see page 56).
## Resident Training Report

**Program ID:** 0400721028  **Program Name:** University of Colorado Denver Program

### Anesthesia Administration

<table>
<thead>
<tr>
<th>At - Region</th>
<th>CAI</th>
<th>CA 2</th>
<th>CA 3</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intra-Thoracic with CPB</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Intra-Thoracic without CPB</td>
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<tr>
<td>Major Vascular (e.g. carotid, aorta, iliac)</td>
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<tr>
<td>Intracranial Vascular</td>
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<tr>
<td>Vaginal Delivery</td>
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<td>0</td>
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<tr>
<td>C-Section</td>
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</tr>
<tr>
<td>Other (Region)</td>
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<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td>0</td>
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### A2 - Situation Ambulatory, Same day

<table>
<thead>
<tr>
<th></th>
<th>CAI</th>
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<tr>
<td>Trauma</td>
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### A3 - Technique for anesthesia (not pain)

<table>
<thead>
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<tr>
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<td>0</td>
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<td>Epidural</td>
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</table>

### A4 - Procedures/Techniques

<table>
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<tbody>
<tr>
<td>Deliberate hypotension</td>
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<tr>
<td>Insertion of pulmonary artery catheters</td>
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<td>Insertion of central venous catheters</td>
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<tr>
<td>Fiberoptic intubation of the trachea</td>
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<tr>
<td>Transesophageal echocardiography</td>
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<td>Double lumen endotracheal tube placement</td>
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<tr>
<td>CA 1</td>
<td>CA 2</td>
<td>CA 3</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td><strong>AS - Age group of patient</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Under 45 weeks post-conceptual age (PCA)</td>
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<td>45 weeks PCA to one year</td>
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</tr>
<tr>
<td>&gt;1 year-12 years</td>
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<td>0</td>
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<tr>
<td>Older than 65 years</td>
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<td>0</td>
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<td>0</td>
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<td><strong>Total</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| B1 - Pain Management Consultations Acute | | | |
| Chronic | 0 | 0 | 0 | 0 |
| Cancer | 0 | 0 | 0 | 0 |
| **Total** | 0 | 0 | 0 | 0 |

| C1 - Pain Procedures Spinal (pain procedures) | | | |
| Epidural (pain procedures) | 0 | 0 | 0 | 0 |
| Nerve Block (pain procedures) | 0 | 0 | 0 | 0 |
| Other (pain procedures) | 0 | 0 | 0 | 0 |
| **Total** | 0 | 0 | 0 | 0 |

| Grand Totals | (A1 + B1 + C1) | | |
| 0 | 0 | 0 | 0 |

Signature of Resident:   
Signature of Program Director.

Date: ______________________

NOTE: The Program Director is responsible for validating the accuracy of the data in this record. Records signed by both the resident and Program Director must be kept on file in the Program Office. Records sent to the Residency Review Committee Office MUST be signed by the Program Director.
UNIVERSITY OF COLORADO DENVER, SCHOOL OF MEDICINE
ANESTHESIOLOGY RESIDENTS/FELLOWS
2009-2010

Cardiothoracic Anesthesiology Fellows

Prairie N. Robinson, M.D.
James J. Sederberg, II, M.D.

CA-3

Bryan S. Ahlgren, M.D.
Stephanie R. Atencio, M.D.
Jeromy M. Cole, M.D.
Anh Q. Dang, M.D.
Jay G. Hacking, M.D.
Kellie C. Hancock, M.D.
Christopher W. Harper, M.D.
Michael A. Heller, M.D.
Brian P. Matthews, M.D.
Gregory J. Myers, M.D.
Estee A. Piehl, M.D.
Joel E. Wilson, M.D.

CA-2

Gregory W. Berman, M.D.
Rachel L. Boggus, M.D.
Haley G. Hutting, M.D.
Ryan D. Lutz, M.D.
Matthew T. Maloney, M.D.
Aaron T. Murray, M.D.
Quinn J. Stevens, M.D.
Jill D. Stovall, M.D.
Gregory A. Wolff, M.D.
Cristina L. Wood, M.D.
Andrea Zatlin, M.D.

CA-1

Kevin T. Arnold, M.D.
Trenton D. Bryson, M.D.
Kristin A. Berger, M.D.
Angelo Dilullo, M.D.
Bethany J. Gannon, M.D.
Heidi B. Green, M.D.
Natalie B. Hamilton, M.D.
Jeremy L. Hansen, M.D.
Olivia B. Romano, M.D.
Rachael S. Rzasa-Lynn, M.D.
Justin K. Smith, M.D.
Barbara J. Wilkey, M.D.
Margaret (Megan) P. Zanger, M.D.
<table>
<thead>
<tr>
<th>NAME</th>
<th>SPECIALTY</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heidi Aasheim, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Rita Agarwal, MD</td>
<td>Pediatric Anesthesia, Pain Management</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>John Armstrong, MD</td>
<td>General Anesthesia, Regional Anesthesia, Liver Transplant</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Fareed Azam, MD</td>
<td>Critical Care Medicine, General Anesthesia</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Mike Bertz, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Adria Boucharel, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Michelle Browne, MD</td>
<td>Trauma Anesthesia</td>
<td>Denver Health Medical Center</td>
</tr>
<tr>
<td>Brenda Bucklin, MD</td>
<td>Obstetric Anesthesia</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Mark Chandler, MD</td>
<td>Trauma Anesthesia</td>
<td>Denver Health Medical Center</td>
</tr>
<tr>
<td>Charles Carter, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Uwe Christians, MD, PhD</td>
<td>Research, Clinical Pharmacology</td>
<td>University of Colorado Denver</td>
</tr>
<tr>
<td>Christopher Ciarallo, MD</td>
<td>Pediatric Anesthesia</td>
<td>Denver Health Medical Center</td>
</tr>
<tr>
<td>Randall Clark, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Patty Coughlin, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Brian Davidson, MD</td>
<td>General O.R. Anesthesia</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Colleen Dingmann, RN, PhD</td>
<td>Clinical Research and Development</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Morris Dressler, MD</td>
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<td>The Children’s Hospital</td>
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<tr>
<td>James Duke, MD</td>
<td>Trauma Anesthesia</td>
<td>Denver Health Medical Center</td>
</tr>
<tr>
<td>Tobias Eckle, M.D.</td>
<td>Clinical Research</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Holger Eltzschig, MD, PhD</td>
<td>Clinical Research</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Debra Faulk, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Lisa Faberowski, MD</td>
<td>Research, Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Ana Fernandez, MD</td>
<td>General O.R. Anesthesia</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Matthew Fiegel, MD</td>
<td>Regional Anesthesia; Transplant Anesthesia</td>
<td>University of Colorado Hospital</td>
</tr>
<tr>
<td>Jacob Friedman, MD</td>
<td>General O.R. Anesthesia</td>
<td>VA Medical Center</td>
</tr>
<tr>
<td>Robert Friesen, MD</td>
<td>Pediatric Anesthesia</td>
<td>The Children’s Hospital</td>
</tr>
<tr>
<td>Peter Fritz, MD</td>
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<tr>
<td>Andrea Fuller, MD</td>
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<tr>
<td>Glenn Gravlee, MD</td>
<td>Cardiothoracic Anesthesia</td>
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<td>Joy Hawkins, MD</td>
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<td>Richard Hendershot, MD</td>
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<td>Adrian Hendrickse, MD</td>
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<tr>
<td>Thomas Henthorn, MD</td>
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<td>University of Colorado Hospital</td>
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<tr>
<td>Lynn Hornick, RN, MP</td>
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<tr>
<td>Jack Humphrey, DO</td>
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<td>Leslie Jameson, MD</td>
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<td>University of Colorado Hospital</td>
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<td>Daniel Janik, MD</td>
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<tr>
<td>Mohammad Javed, MD</td>
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<td>VA Medical Center</td>
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<tr>
<td>Alma Juels, MD</td>
<td>Trauma Anesthesia</td>
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<td>Lyle Kirson, DDS</td>
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<td>Thomas Majcher, DO</td>
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<tr>
<td>Susan Mandell, MD</td>
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<td>University of Colorado Hospital</td>
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<td>Scott Markowitz, MD</td>
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<td>Roger Mattison, MD</td>
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<td>Theresa Michel, MD</td>
<td>Trauma Anesthesia</td>
<td>Denver Health Medical Center</td>
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<tr>
<td>Jose Melendez, MD</td>
<td>O.R. Management, Cardiothoracic Anesthesia</td>
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<td>Glenn Merritt, MD</td>
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</tr>
<tr>
<td>Howard Miller, MD</td>
<td>Trauma Anesthesia, Airway Management</td>
<td>Denver Health Medical Center</td>
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<tr>
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<td>Specialties</td>
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<td>-----------------------------</td>
<td>------------------------------------------</td>
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<td>Pierre Moine, MD</td>
<td>Critical Care Medicine, Liver Transplantation</td>
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<td>Paul Mongan, MD</td>
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<td>Cardiothoracic Anesthesia/O.R. Management</td>
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<td>Thomas Notides, MD</td>
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<td>The Children’s Hospital</td>
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<td>Luke Osborne, MD</td>
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<td>James (Mac) Packer, DO</td>
<td>Pediatric Anesthesia</td>
<td>Denver Health Medical Center/The Children’s Hospital</td>
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<td>David Polaner, MD</td>
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<tr>
<td>Ferenc Puskas, MD</td>
<td>O.R. Management, Cardiothoracic Anesthesia</td>
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<td>Peter Rowe, MD</td>
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<tr>
<td>Natalie Serkova, PhD</td>
<td>Research, Biomedical MRI/MRS Center</td>
<td>University of Colorado Denver</td>
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<td>Jeffrey Shifrin, MD</td>
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<td>Marina Shindell, MD</td>
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<td>Tod Sloan, MD</td>
<td>Neuroanesthesia, Intraoperative Neurophysiologic Monitoring</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Robin Slover, MD</td>
<td>Pain Management</td>
<td>VA Medical Center</td>
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<td>Scott Stenquist, MD</td>
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<td>Gee Mei Tan, MD</td>
<td>Simulation; Pediatric Anesthesia</td>
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<td>Nathaen Weitzel, MD</td>
<td>Cardiothoracic Anesthesia, TEE</td>
<td>University of Colorado Hospital</td>
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CALL SCHEDULES AND RESPONSIBILITIES
A. **Call Schedule Preparation**

Call schedules for all hospitals are prepared during the prior month by the chief residents. All call requests should be submitted via email to the Chief Residents at least 6 weeks before the start of the month. The Chief Residents will send an email reminder for monthly requests. Residents making multiple requests each month are not likely to receive all of their requests. Changes in the published schedules will be made only when absolutely necessary and then only with approval of the chief residents and relevant O.R. director.

Call responsibilities differ among various hospitals, but in general the call person will pre-op evening add-ons, be available for resuscitations, consultations, and after hour’s cases. Specific policies at VA and Denver Health Medical Center should be examined at the time the resident is rotating there.

Residents on back-up call from home should always check with the first call in-house attending before leaving. Residents who are not on call should also check with the charge anesthesiologist prior to leaving for the day.

B. **Call Schedule Changes**

The chief residents spend significant time creating the monthly resident call schedule within some very tightly defined parameters. We endeavor to provide the appropriate level of coverage on any given shift, and this means usually a resident and a CRNA will share 1st call and 2nd call responsibilities. Therefore, any changes of call that are made between residents after that schedule has been finalized must not adversely affect the level of call capability. Should a specific change in schedule be desired, it is the resident’s responsibility (not the Chief Resident’s) to find a suitable exchange with another resident. All changes in the call schedule, including vacations, should then be verified and approved through the chief residents. The change will not be considered "official" until you have it in writing signed by the O.R. Director and one of the chief residents.

The following is a more detailed list of call responsibilities.

C. **University of Colorado Hospital**

At the University of Colorado Hospital a minimum of two residents are in house each night. One covers the general O.R. and one the OB service. The OB call resident is one of the three assigned to OB that month. Some days there will also be a resident covering the SICU.

There are two CT residents available every night and on weekends.

1. **R1 Resident** - Taken by all residents from the general O.R. pool (this includes AOP, Neuro, and Senior OR). Responsible for overnight general O.R. cases and occasional pain call. Call usually starts at 3 p.m. weekdays, but the resident may be called in early by the anesthesiologist in charge and must, at most, be 30
minutes from the hospital by pager. If you are called in early (between 11 and 3) on a R1 day, you will receive an extra $50. If you are required to come in between 7 and 11, you will receive $100. If you are required to stay after 7 pm on a regularly scheduled day, you will receive $50 (this does not apply to CT or Transplant cases). Please inform Jan Ratterree by email what day and time you are called in. She will process the necessary paperwork for you to get paid. The extra pay will be included in your monthly paycheck.

2. C2 Resident - (Weekends only; C2 coverage by CRNA during week). The resident is responsible for cases when more than one room is running. On Saturdays between 7am and 5pm the C2 call shift is a moonlighting shift. Residents that have completed 6 months of residency (and at least 1 month and UH) are eligible to volunteer to work the C2 shift on Saturdays. Compensation is $100 for being on pager call for the C2 shift and $50/hour for each additional hour past the first 2 hours worked. For example: if you take the C2 shift and do not get called in you receive $100, if you work 2 hours during the shift you still get $100; if you work 4 hours you would receive $200 (100 + 50 x 2). After 5pm on Saturdays and Sundays, the C2 resident usually comes from the Acute Pain or Chronic Pain service and will also be carrying the acute pain pager and be required to round on those patients each day of the weekend.

3. R2/R3 Resident - (Weekdays). This resident is from the general O.R. pool. This resident is responsible in the general O.R. until only four/five rooms are running, all dinners have been given, all add-on pre-ops for next day have been seen, and until the C1 attending has given permission to leave. The R2 resident should check with the overnight call resident before leaving for the day to see if there is anything that needs to be done.

4. CT1/CT2 residents are responsible for CT cases at University of Colorado Hospital and occasionally at the VA.

Note: All residents must check out with the charge attending before leaving for the day. The first call resident needs to check out the morning after call with the attending in charge for that day.

5. General O.R. Resident - The resident should call his attending the night before to discuss the cases for the following day. This should be done for every case. If a pre-op on a presumed outpatient cannot be found, it is the resident's responsibility to be sure that the patient has not been admitted pre-op. Almost every patient will have some information on-line in Clinical Workstation. The O.R. schedule begins at 7:30 a.m. or sooner. The patient should be in the room at this time. Post-op checks need to be completed at all hospitals on all inpatients within 24 hours with a note left in the chart.

6. Acute Pain Resident – Make sure the attending in charge is always aware of your whereabouts during the day, especially when leaving the O.R. area. Never leave the hospital without first notifying the attending in charge.

7. Relief – Throughout the course of the day, you should have a morning break for 15 minutes, a lunch break for 30 minutes, and an afternoon break for 15 minutes. Usually these breaks are covered by the CRNA’s or an available resident. If the
O.R. schedule is busy for that day, the breaks may be shorter and the relief person will inform you of this. Your attending should try to get you out for lunch if no relief is available. The cardiac residents and attendings are responsible for providing their own breaks. In the afternoon relief personnel should see post-op checks from the previous day, as well as giving afternoon breaks.

8. Information Exchange

AM Information Exchange - (AM add-ons and TBA's) will be made between the previous 1st call resident and the Acute Pain or PACU resident immediately before morning conference.

Late AM to Mid Afternoon Add-ons - Responsibility for these work-ups will be apportioned by the attending in charge according to resident/CRNA availability.

After 5 p.m. Add-ons - The first call resident will be notified of these by the surgical resident scheduling the case, the O.R. charge nurse if it is an evening case, or the anesthesia attending if there are problems concerning the patient.

If you are on call during a time when no cases are running, you can help the OR run more smoothly if you make sure all pre-ops and consents are done for add-on cases scheduled for the next day.

9. CT Call at the University and VA consists of a CT1, CT2, CT3, and the Senior OR resident. The law of averages states that the CT1 will be called back once every three calls. CT1 and CT2 should be available within 30 minutes by pager. The call schedule is made by the Chief Resident at University Hospital and will vary month by month depending on the number of residents and their level.

10. A Hepatobiliary Survival Manual is available and should be reviewed before doing a liver transplant. The CA 2 resident on their Transplant Rotation will be responsible for Liver call. Liver call is home call, and the resident should be within 30 minutes of the OR after receiving a page. When the Transplant resident has the weekend off, transplant call is generally covered by the on-call CT residents.

11. Chronic Pain Residents are responsible for cases in the Chronic Pain Clinic until all the patients have been seen. In addition each Chronic Pain resident will take some C2 weekend call with acute pain responsibilities.

12. OB Residents (CA 2 or CA 3) - OB call will run from 7 a.m.-7 p.m. & 7 p.m.-7 a.m. weekdays and weekends, except on Saturdays when residents do not cover the 7 a.m. – 7 p.m. shift. You will receive an OB anesthesia syllabus defining the specific responsibilities prior to starting on the service.

13. SICU Resident (CA 2 or CA 3) - Responsible for all patients in the SICU, to be divided among him/herself, one other anesthesia resident and two surgery residents. Call is every fourth night.
14. Acute Pain Resident - Responsible for all patients on the Acute Pain Service. The Acute Pain residents will also take some C2 weekend calls with acute pain responsibilities.

15. Ambulatory Surgery – Two to three residents are assigned at the Anschutz Outpatient Pavilion (AOP). Their daily responsibilities will be assigned by the ambulatory O.R. director and may occasionally involve O.R. coverage at University Hospital and possibly R1 call. Mondays are generally spent at the AIP, with the remaining weekdays at the AOP.

D. VA MEDICAL CENTER

One resident is on call each night at the VAMC. Call is taken from home. The VA resident will also cover the pain service.

E. DENVER HEALTH MEDICAL CENTER

First call is taken in house. The first call resident will begin call at 3:00 p.m. on weekdays depending on the caseload. Saturday and Sunday calls are 12-hour shifts (7 a.m.-7 p.m. and 7 p.m.-7 a.m.). The first call resident will take over a room at 3 p.m., help finish all the scheduled cases, and then be available at night for traumas, emergent cases, and COR’s.

Second call is taken by a CRNA. This individual is responsible for the second room when there are only two rooms running, or to open a second room for emergencies. There is also a backup covering the labor deck.

Late call begins at 7 a.m. and works until typically 6 p.m.-8 p.m. This call is basically C4 coverage. Late call will finish their room or be relieved by C1, C2, or Float.

Float call arrives at Denver Health at 11 a.m. and will usually give lunches until 1 p.m. At that point float will take over a room, start emergent cases, or any other duties assigned by Anesthesia Charge. This call is basically C3, which will be relieved by C1 or C2. Float call is a dynamic call that will end at varying times each day, usually 7 p.m. - 8 p.m.

Pre/Post

Each resident will be assigned to a one month rotation of pre and postoperative care. This will occur at Denver Health. During this rotation, you will spend two weeks in the preop clinic and two weeks in the PACU. In the preop clinic, you will be doing preoperative evaluations of patients scheduled for surgery. You will be learning to appropriately assess a patient’s risks and administer any appropriate tests that need to be done prior to administering an anesthetic. In the PACU, you will be responsible for the care of the patients recovering from anesthesia, help with pain control, which may involve regional anesthesia techniques, and assist with any acute issues that may arise.

You will be given a syllabus prior to starting this month. In general, call is very limited during this month.
F. **THE CHILDREN'S HOSPITAL**

One resident or fellow is on call each night. Call averages 5-6 in-house calls per month. CA 2/CA 3 residents rotating at Children’s share C1 call responsibility with pediatric anesthesia fellows. Weekday call starts at noon; weekends are 7 a.m.-7 a.m. The C1 resident will additionally carry the acute pain phone and will be responsible for rounding on these patients during the evening and again in the morning before leaving the hospital when a pain nurse is not available. Specifics of the rotation will be provided in a packet given to you at your initial orientation.

G. **ANSCHUTZ OUTPATIENT PAVILLON (AOP)**

1. **Ambulatory Anesthesiology Rotation**

   The ambulatory anesthesiology procedure rooms are located at the Anschutz Outpatient Pavilion (AOP). These include four traditional operating rooms, an In Vitro Fertilization procedure room, an Endo-Urology Room and a Gastroenterology procedure room.

   **CA-1**

   Residents are assigned to the ambulatory operating at various times while assigned to UCH. This experience will be an orientation to sedation, regional and general anesthesia in an ambulatory setting, though you can expect your time spent at the AOP to be limited during this first year. Skills taught in the CA1 year include:

   - Rapid preanesthesia evaluation of patients who are generally healthy and have not been evaluated prior to the day of surgery
   - Conduct of anesthesia in patients who are expected to be discharged to home at the end of the procedure

   **CA-2, 3**

   Residents in the last 24 months of residency are assigned to 1-2 months of Ambulatory Anesthesia as a required subspecialty assignment. Skills taught in this assignment are:

   - Rapid preanesthesia assessment on the day of surgery
   - Various techniques for conscious and deep sedation in the OR context
   - Expert use of the LMA
   - Application of various techniques for regional anesthesia for intraoperative anesthesia and acute postoperative pain management
   - Rapid emergence techniques for general anesthesia
   - Efficient room turnover

2. **Pain Medicine Practice**
a. Acute Pain Services, CA1

The Inpatient Pain Service offered by the University of Colorado Hospital is responsible for the administration and supervision of the inpatient Acute Pain Service and regional anesthesia in the operating room. *The Inpatient Acute Pain Service will also handle ALL CONSULTS ON INPATIENTS AT UNIVERSITY OF COLORADO HOSPITAL, even if the consult is in regards to a chronic pain management problem.* To contact the Acute Pain Service, please use the following number: 303-266-6493.

The Pain Medicine Practice in the Anschutz Outpatient Pavilion will see all outpatient pain medicine consultations.

b. Chronic Pain Medicine, CA2, CA3

This resident is responsible for seeing patients in clinic as well as assisting with O.R. and pain procedures. The chronic pain resident will also carry the pain pager and take C2 and acute pain call.
DIDACTIC PROGRAM
A. **CORE LECTURE SERIES**

During July and August a series of Core Lectures are offered which are especially oriented to the needs of new anesthesia residents. Such topics as preoperative evaluation, anesthesia equipment, monitoring techniques, blood transfusion, and basic pharmacology of anesthetic drugs are included. The July lecture schedule is included in your orientation materials.

B. **ANESTHESIOLOGY LECTURE SCHEDULE**

The skeleton schedule for the overall didactic program of the anesthesia department is shown on page 25. Grand Rounds are held on Monday mornings. Tuesday afternoons are reserved for Clinical Case Conferences, Research Conferences, Resident/Chair Forum followed by Journal Club, or Practice Sessions for the ABA Oral or Written Examinations. These conferences begin at 3:30 pm.

C. **GRAND ROUNDS**

Grand Rounds is the featured lecture of the week, and it is organized around a system of “blocks,” or rotating themes. Each block of lectures lasts several weeks, and the blocks are rotated on a 2-3 year basis to ensure coverage of most of the topics in the Content Outline of the Joint Council on In-training Examinations. This Content Outline contains all topics from which the questions on Part I (written multiple choice questions) of the certifying examination of the American Board of Anesthesiology are chosen. The speakers at Grand Rounds include outside visiting professors, departmental faculty, UC faculty from other departments, and senior residents giving their senior lecture.

D. **CLINICAL CASE CONFERENCES**

Clinical Case Conferences are discussions of patient cases involving interesting management problems in anesthesiology. Often the cases presented involve morbidity or mortality, so the conference is sometimes called “M&M.” These cases are contributed by residents, CRNA’s and faculty based on perioperative, critical care, or pain management experiences. These cases can be about unexpected (or expected) difficulties encountered or just about interesting patient management problems. The goal is a free-wheeling discussion between the moderator, presenters, and attendees that educates everyone. Since these conferences also review events surrounding complications and deaths that required UCHSC peer review, trends and patterns discovered through the peer review process will also be discussed. Discussions are aimed at developing strategies that will lead to successful problem management. These conferences emphasize complete discussion of alternate methods of care and the suitability of those methods for specific cases.
E. **ITE Resident Lecture/PBLDs**

Conferences designed to complement Grand Rounds by covering additional aspects of the Content Outline are presented on Thursday mornings (6:30-7:00 a.m.). These sessions are facilitated by Drs. Adrian Hendrickse, Marina Shindell and Glenn Gravlee. The format ranges from lectures to workshops, and is typically interactive in nature. Typically either Dr. Hendrickse or Dr. Gravlee assigns two topics to residents for each conference, and the resident prepares a brief handout on that topic and leads the discussion of his or her topic. Sometimes specific board preparation sessions are conducted in this time slot as well, consisting of multiple choice question review or practice oral examinations.

F. **Journal Club**

Journal Club is held monthly (4:30-5:30 p.m.) and is organized by Suzanne Bullard and facilitated by Dr. Henthorn. Each CA-2 resident leads one Journal Club during the year. It follows the Resident/Chair Forum. Discussions emphasize critical review of the scientific literature including study design, statistical analysis, and interpretation of results. The resident is responsible for picking the topic, obtaining approval from Dr. Henthorn, and then preparing a PowerPoint presentation.

G. **Senior Lectures**

Senior residents are required to prepare a formal lecture. These lectures will be given as part of the Grand Rounds program on Monday mornings and can coincide with the monthly block schedule of topics. Residents participate in choosing their topics and choose a faculty advisor to assist them as needed in preparing this presentation.

H. **Resident/Chair Forum**

The Resident/Chair Forum is held once a month, from 3:30-4:30 p.m. Drs. Henthorn, Hawkins and Jameson meet with the residents to discuss any problems and to answer any questions. If there is a particular subject you wish to have discussed, please contact Dr. Henthorn (303-724-1750), Dr. Hawkins (303-724-1757) or one of the Chief Residents; Mike Heller (303-266-5594) or Joel Wilson (303-266-0931). Topics can also be suggested by email to any of these individuals or Jan Ratterree.

I. **Daily Chapter Reviews**

A chapter is assigned daily from Faust’s 3rd Edition of *Anesthesiology Review*. These are brief chapters on a variety of topics suitable for relatively fast (5-10 minutes) reading and discussion each day in the operating rooms. The idea is that this will provide a specific subject each day for the attending anesthesiologists and residents to discuss at the bedside. This reading assignment and discussion is expected of all residents and attending staff on all clinical OR rotations at University Hospital, the VA Hospital, The Children’s Hospital, and Denver Health Hospital.
J. **Research Conference**

A departmental research conference is conducted once or twice each month. Various faculty members from within and outside the department present current research topics at this conference. Ongoing projects are discussed in a brainstorming and/or didactic format. Residents are encouraged to attend.

K. **Cardiac Lecture**

A cardiothoracic anesthesia conference is held from 6:30 to 7:00 am on Friday mornings. This conference is led by a faculty member from the cardiothoracic anesthesia team and includes a variety of cardiac anesthesia, thoracic anesthesia, and transesophageal echocardiography topics. Residents on the cardiothoracic anesthesia rotation are expected to attend. Others are welcome as well. The cardiac anesthesia team also conducts a monthly journal club.

L. **Conferences at VA, DHMC and Children’s Hospital**

Residents at the VA Hospital and Denver Health are expected to attend University Hospital Grand Rounds through a video link. These hospitals also have their own didactic conferences. At Denver Health, there is a conference on Wednesday through Friday at 6:30 am that includes a resident presentation (Wednesday) and assigned attending anesthesiologist conferences on Thursday and Friday. The Children’s Hospital has its own comprehensive conference calendar designed to cover the important topics in pediatric anesthesia on a rotating basis. Conferences are conducted on Tuesdays through Fridays from 6:45 to 7:15 am, and there is a morbidity and mortality conference on Mondays from 7:15 to 8:00 am.

M. **Resident Attendance at Conferences**

Resident attendance at Grand Rounds, Clinical Case, ITE Resident Lecture, Resident Chair, and Journal Club conferences is expected unless geographic issues (e.g., rotation at Denver Health), clinical duties in the operating rooms, or post-call status precludes it. Consequently, resident attendance at conferences is monitored and those who are not present at conferences without an apparent rationale will often receive a notice from the program director, and unsatisfactory attendance will be reflected in evaluations of resident performance. The Accreditation Council for Graduate Medical Education requires that attendance records be kept for residents. An attendance sheet is prepared for each conference; it is the responsibility of each resident to sign this sheet.

*Please note:* Residents are given an optional 5 days per year for educational travel with approval from Dr. Hawkins. As a department, we feel it is inconsistent to allow a resident to travel away from the department to attend an educational meeting if he/she does not avail him/herself of the departmental conferences. The attendance record of
each resident at departmental conferences will be taken into consideration when
deciding if an application for educational travel should be honored.

N. RECOMMENDED READING LIST

There are a variety of good basic texts available for reading. We suggest that you
consider purchasing some of the following books during your residency:

Introductory Textbooks and general references:
Morgan, Mikhael, Murray: Clinical Anesthesiology
Hurford, WE: Clinical Anesthesia Procedures of the Massachusetts General Hospital
Stoelting RK: Pharmacology and Physiology in Anesthesia Practice
Jaffe RA, Samuels SI: Anesthesiologist’s Manual of Surgical Procedures (editorial
comment: better information in general about the surgical procedures than about the
anesthetic implications)
Faust RJ: Anesthesiology Review

Comprehensive Anesthesiology Textbook -purchase one or the other:
Miller RD: Anesthesia
Barash, Cullen, Stoelting: Clinical Anesthesia

Anesthetic Implications of Specific Disease States (can often be obtained in Barash
Or Miller as well):
Stoelting RK: Anesthesia and Co-Existing Disease (good for common diseases)
Fleischer LA: Anesthesia and Uncommon Diseases (good for rare conditions)

Journals:

Residents are advised to stay abreast of current journals: Anesthesiology and Anesthesia
and Analgesia are both recommended for regular reading. You will receive these journals
as a result of your membership in the ASA and IARS which is a paid benefit.

Subspecialty Rotations have their own reading lists

Reading non-medical material during cases in the O.R. appears non-professional and
is not appropriate! Reading medical material should be limited to issues relevant to
direct patient care and should not be done if it distracts from patient care.
<table>
<thead>
<tr>
<th>DAY/TIME</th>
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<tr>
<td><strong>MONDAY</strong></td>
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<tr>
<td>7:00-8:00 a.m.</td>
<td>Grand Rounds and Senior Lectures</td>
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<tr>
<td>4:00-5:00 pm</td>
<td>Research Seminar (Once a month)</td>
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<tr>
<td><strong>Tuesday</strong></td>
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<tr>
<td>4:00-5:00 p.m.</td>
<td>Research Seminar (Once a month, clinical or translational research)</td>
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<tr>
<td>3:30-4:30 p.m.</td>
<td>Clinical Case Conference (2-3x/month)</td>
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<tr>
<td>3:30-4:30 p.m.</td>
<td>Board Preparation Conference (once a month)</td>
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<tr>
<td>3:30-4:30 p.m.</td>
<td>Resident/Chair Forum (3rd week)</td>
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<tr>
<td>4:30-5:30 p.m.</td>
<td>Journal Club (3rd week)</td>
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<td><strong>THURSDAY</strong></td>
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<td>6:30-7:00 a.m.</td>
<td>In-Training Exam Lecture Series</td>
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<td><strong>FRIDAY</strong></td>
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<tr>
<td>6:30-7:00 a.m.</td>
<td>Cardiac Lecture (Every Friday – attendance is mandatory for residents rotating on the cardiothoracic service.)</td>
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Attendance at Grand Rounds, ITE Resident Lectures, Resident Chair/Journal Club and Clinical Case Conferences is considered mandatory if you are rotating at University of Colorado Hospital! If you are rotating at our satellite locations (DHMC, VAMC), they are teleconferenced in the assigned conference room location(s). You will be expected to sign in.

*Note: Each year, at the annual graduation dinner, conference attendance awards are given out to the top 3 residents who have attended the most conferences during the year.*
EVALUATION, EXAMINATION AND PROMOTION
A. **Clinical Competence Committee (CCC)**

Every six months, all of the evaluation forms received on each resident during the previous six-month period are tabulated and the numerical scores from each category are graphed. In addition, comments made on each resident are summarized and test scores are reviewed. The Clinical Competence Committee meets three times a year (or more often as specific resident needs dictate) to review these evaluation forms. Residents receive a copy of every CCC report. Currently, the membership of the CCC is:

Dr. Joy Hawkins, Committee Chair  Dr. Rita Agarwal (Children’s)
Dr. Thomas Henthorn  Dr. John Lockrem (DHMC)
Dr. Leslie Jameson  Dr. Jake Friedman (VA)
Dr. Fadi Nasrallah (UCH)  Dr. Fareed Azam (ICU)
Chief Residents  Dr. Randall Clark (Children’s)

Twice a year, in January and July, a Record of Training Report on each resident is submitted to the American Board of Anesthesiology (ABA). The information used to complete these reports comes from the recommendations of the Clinical Competence Committee. The ABA uses these reports as the basis for granting credit toward its Clinical Anesthesia training requirements.

B. **Evaluation and Promotion Policy**

**Purpose**

The program recognizes the need to provide a structure by which performance related to the training program will be assessed and consideration given for promotion to the next level of training. Evaluation will be provided in accordance with Graduate Medical Education Committee policy and ACGME common program requirement V.A.c: which says “a process involving use of assessment results to achieve progressive improvements in residents' competence and performance”.

Note: This policy addresses performance relating to academic program requirements and does not supersede other institutional or legal requirements that must be met by the resident to remain in a training program.

**Policy**

Any resident participating in training will be provided, at a minimum, a semi-annual formal evaluation developed by the Program Director. Residents shall be allowed to review semi-annual evaluations contained in permanent records and other evaluations as determined by program policy. The formal written evaluation shall:

- Address each of the six ACGME core competencies.
- Include well defined scoring and rating criteria that seek to minimize subjective assessment of performance.
- Include language indicating satisfactory performance, advancement to the next level of training (if applicable) or provide specific actions and performance requirements by the resident to return to a level of satisfactory performance or advancement to the next level of training.
- Be signed and dated by the resident and Program Director.
- Become a part of the permanent record file for the resident.

In the event that academic status of a resident is changed to Probation or Termination a letter of notification to the resident will be co-signed by the Associate Dean for GME. Additional information is provided in the institutional policy titled “Grievance Policy and Procedure”.

C. **Evaluation of Residents and Faculty**

Evaluation of residents and faculty are done monthly through the on-line evaluation program, New Innovations. See pages 30-32. Residents are able to view their evaluations on line at any time by logging on to [www.new-innov.com/suite](http://www.new-innov.com/suite). Residents are encouraged to discuss their evaluations frequently with their advisors (at least semi-annually). In addition, residents are required to complete evaluations on faculty members they have worked with during the month. These evaluations are anonymous. The process for completing and reviewing evaluations will be discussed at orientation. Similarly, faculty members are required to complete monthly evaluations on each resident they work with during the month. They are able to view their evaluations on line but are not able to see who completed the evaluation.

D. **Rotation Evaluation**

At the end of each rotation you will receive an email asking you to complete an evaluation form. This evaluation form can be accessed through the on-line evaluation program, New Innovations. You will receive automatic email reminders from New Innovations (see page 33).

E. **Program Evaluation**

Once a year in May, you will be asked to complete a program evaluation. This evaluation form can be accessed through the on-line evaluation program, New Innovations. As with the other evaluations you will receive automatic email reminders from New Innovations (see pages 34-36).

F. **Examination**

1. **Department of Anesthesiology Expectations**
   
   a. All residents, upon graduation, should successfully pass both written and oral portions of the examinations of the American Board of Anesthesiology on the first attempt.
   
   b. No resident at any time should score below the 50th percentile on the annual In-Training Examination or AKT exams when compared with other residents nationally that are at a comparable level of training.

2. **The ABA-ASA In-Training Examination**
The ABA-ASA In-Training Examination is given annually in March. This examination is required for all residents. The time and place will be announced later in the year.

We treat the ABA-ASA In-Training Examination with a great deal of importance and use it not only to know how we as a department are performing, but also how each resident is performing. One can usually predict from the examination results whether a resident will pass the written Board exam on first attempt. It is the goal of our training program to enable 100% of graduates to obtain Board certification on their first attempt. The Clinical Competence Committee has established a policy regarding resident performance on the In-Training Examinations. Our goal is to have our residents perform well above the national average on this examination. However, as a minimum score acceptable to the department, we expect all residents to score at least at the 50th percentile nationally. A performance below the 25th percentile will result in a resident being placed on "academic notice", a form of probation.

As a reward for passing at the 50th percentile, the Department of Anesthesiology will reimburse the CA 2 residents for their initial $750 application fee to take the written Boards.

3. Anesthesia Knowledge Test (AKT)

CA I (PGY II) residents will be given the Anesthesia Knowledge Test (AKT) on three occasions during the year - in early July (before receiving any anesthesia training), again after 1 month of training, and finally after 6 months of training. The purpose of this test is to help identify as early as possible residents who may experience difficulty in their testing. Again, you are expected to score at least at the 25th percentile. CA II residents will take an AKT exam after 18 months of anesthesia training.

4. Mock Oral Examinations

Mock oral exams are offered throughout the year and follow the ABA format.

5. BLS/ACLS

BLS/ACLS certification is required of all residents. Classes for residents are offered through the Anesthesiology department.

6. USMLE and COMLEX Examinations

All residents in GMEC approved programs are required to successfully complete the USMLE Step 2 (CS and CK) or COMLEX Part 2 (CE and PE) examination, as evidenced by obtaining a passing grade for that examination, prior to the mid-point in the first post-graduate year (PGY1). Failure to demonstrate passage within the stated timeline may result in termination from the training program at the end of the academic year.

All residents in GMEC approved programs are required to successfully complete the USMLE Step 3 examination or COMLEX Part 3 examination, as evidenced by obtaining a passing grade for that examination, prior to the mid-point of the second post-graduate year (PGY2). Failure to demonstrate passage within the stated timeline may result in termination from the training program at the end of the academic year.
ANESTHESIOLOGY FACULTY EVALUATION OF RESIDENT

Evaluator: Subject: Rotation:

Enter H (3) for Honors, S (2) for Satisfactory or U (1) for Unsatisfactory for each category. Keep in mind the Residents’ level of training. Provide constructive comments and examples of behaviors or incidents in each area.

**PROFESSIONALISM**

- Respectful of patients, families and other members of the health care team
- Responsible; punctual, responds to pages or messages promptly
- Acknowledges errors, self-asesses
- Honest; adheres to a code of moral and ethical values; a “role model”
- Respects ethical and personal values of others
- Communicates effectively with appropriate self-confidence
- Reacts to stressful situations in an appropriate manner

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**Medical Knowledge**

- Exhibits knowledge that is up to date and appropriate to level of training
- Investigates topics needed for clinical assignments
- Considers range of potential anesthetic plans

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**PATIENT CARE**

- Gathers appropriate pre-op information, orders tests and interprets properly
- Evaluates risks, benefits and formulates effective anesthetic plan
- Obtains necessary consent to proceed
- Responds appropriately to changes in patients’ conditions

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**CLINICAL/TECHNICAL SKILLS**

- Applies didactic knowledge to current clinical situation
- Appropriate and rapid room preparation and machine testing
- Safe performance of general anesthesia
- Demonstrates appropriate airway management skills
- Performance of regional anesthesia including drug and technique selection
- Placement of invasive monitors
- Plans for acute pain management and post-anesthesia care

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**INTERPERSONAL AND COMMUNICATION SKILLS**

- Communicates effectively with colleagues and other health care professionals
- Counsels and communicates effectively with patients
- Engaged; demonstrates active listening skills
- Medical records are legible, comprehensive and timely

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**PRACTICE-BASED LEARNING AND IMPROVEMENT**

- Uses information technology effectively
- Constant self-evaluation; uses feedback and data-gathering
- Demonstrates knowledge of study design and statistical methods to analyze evaluate scientific studies
- Facilitates the learning of students and other professionals
- Understands and incorporates principles of evidence-based medicine into their practice

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**SYSTEMS-BASED PRACTICE**

- Practices cost-effective medicine that does not compromise quality of care
- Uses resources and consultants appropriately
- Uses protocols and practice guidelines to reduce error, improve outcome

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**OVERALL**

Overall clinical competence for their level of training

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Comments

Remaining Characters: 5000

Return to Questionnaire
## ANESTHESIOLOGY RESIDENT EVALUATION OF FACULTY

Evaluator: Subject:

Your comments and ratings will be anonymous to the individual faculty. If you have questions, please contact Jan Ratterree at 303-724-1758.

### MEDICAL KNOWLEDGE
1) Knowledge of specialty
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### CLINICAL TEACHING
2) Quality of clinical teaching
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### AMOUNT OF CLINICAL TEACHING
3) Amount of clinical teaching
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### QUALITY OF DIDACTICS
4) Quality of didactics
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### CLINICAL/TECHNICAL SKILLS
5) Ability to teach procedures
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### AVAILABILITY
6) Availability
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### INTERPERSONAL AND COMMUNICATION SKILLS
7) Interpersonal skills
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### PATIENT CARE
8) Patient interaction
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### PROFESSIONALISM
9) Role model
   - Below Expectations
   - Effective
   - Exceeds Expectations
   - Outstanding

### GENERAL
10) Overall Constructive Comments (Please provide additional comments for any of the above questions or items that were not covered in this evaluation. This information is strictly confidential).

Comment
1) What was the best thing about this rotation?
Comment

Remaining Characters: 5000

2) If you could change one thing about this rotation, what would it be?
Comment

Remaining Characters: 5000

3) During this rotation, did you:
   Work more than 80 hours per week averaged over four weeks?
   Yes □ No □

4) During this rotation, did you:
   Take in-house call more often than every third day/night?
   Yes □ No □

5) During this rotation, did you:
   Not receive one day off per week averaged over four weeks?
   Yes □ No □

6) During this rotation, did you:
   Not receive a 10-hour break between the end of one work period and the beginning of the next work period?
   Yes □ No □

Return to Questionnaire

New Innovations, Inc. ©1995-2009
ANESTHESIOLOGY PROGRAM EVALUATION
BY FACULTY & RESIDENTS

Evaluator:  Subject:
Status:

This anonymous evaluation will be used for the continuing process of improvement of our Residency Program. Please be candid and constructive.

1) If Faculty, primary working location:

- UCH
- VAMC
- DHMC
- TCH

2) Overall, the quality of clinical training provided by the Residency Program is:

- Poor
- Fair
- Average
- Good
- Outstanding

3) Departmental support for faculty and resident scholarly activity is:

- Poor
- Fair
- Average
- Good
- Outstanding

4) Faculty availability, bedside teaching, and supervision is:

- Poor
- Fair
- Average
- Good
- Outstanding

5) Overall, the residents' clinical workload is:

- Light
- Average
- Heavy

6) Program Director (Dr. Hawkins) availability, involvement, and coordination of Residency Program:

- Poor
- Fair
- Average
- Good
- Outstanding
- N/A

7) Chair (Dr. Henthorn) availability, involvement, and coordination of Residency Program:

- Poor
- Fair
- Average
- Good
- Outstanding
- N/A

8) Program Coordinator (Jan Rattherree) availability, involvement, and coordination of Residency Program:

- Poor
- Fair
- Average
- Good
- Outstanding
- N/A

9) Please give an example of unsatisfactory or nonproductive aspects of the training program:

Comments

Remaining Characters: 5000

10) Please give an example of the most beneficial aspects of the training program:

Comments

Remaining Characters: 5000
11) I have the following suggestions for improving the Anesthesiology Residency Program at the University of Colorado Denver:

Comments

Remaining Characters: 5000

12) The written goals (Level specific goals received with your contract) for the program are appropriate.

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13) The written goals for the program are clear.

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14) The online process of evaluation is fair.

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15) The online process of evaluation is anonymous.

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16) DHMC service provides exposure to a breadth of clinical cases.

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17) DHMC service provides adequate supervision.

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18) DHMC service provides an important learning experience for the program.

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19) VAMC service provides exposure to a breadth of clinical cases.

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20) VAMC service provides adequate supervision.

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21) VAMC service provides an important learning experience for the program.

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22) UCH services provides a breadth of clinical cases.

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23) UCH services provides adequate supervision.

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24) **UCH services provides an important learning experiences for the program.**

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25) **TCH service provides exposure to a breadth of clinical cases.**

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26) **TCH service provides adequate supervision.**

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27) **TCH service provides an important learning experience in the program.**

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28) **The Grand Rounds didactic conferences provide important education.**

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29) **The Journal Club conferences provide important education.**

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30) **The ITE conferences provide important education.**

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31) **The DHMC morning conferences provide important education.**

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32) **The TCH morning conferences provide important education.**

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33) **Undue fatigue is a problem in this program.**

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34) **The workload in this program is excessive.**

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35) **The Faculty in this program are supportive of Resident education.**

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36) **I am confident I will be able to practice competently and independently after completion of the program.**

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*Return to Questionnaire*
ABSENCE FROM TRAINING - VACATION AND APPROVED CONFERENCES
A. A BSENCE FROM TRAINING (VACATION/EDUCATION LEAVE)

The policy of the American Board of Anesthesiology regarding absence from training states:

“The total of any and all absences may not exceed 60 working days (12 weeks), during the Clinical Anesthesia 1-3 years of training. Attendance at scientific meetings, not to exceed five working days per year, shall be considered a part of the training program. Duration of absence during the Clinical Base year may conform to the policy of the institution and department in which that portion of training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

A lengthy interruption in training may have a deleterious effect upon the resident’s knowledge or clinical competence. Therefore, when there is an absence for a period in excess of six months, the Credentials Committee of the ABA shall determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.” (ABA Booklet of Information, February 2009, page 13).

Vacation and education time cannot be carried over from one academic year to the next and will be forfeited if not taken during the academic year. All vacation/educational leave requests need to be approved by the individual hospital service chief and the chief resident in charge of vacation leave.

DO NOT purchase plane tickets or make reservations until your vacation/educational has been approved; otherwise, you may have to forfeit. Vacations officially start on Monday, although every attempt is made to give residents the preceding weekend off. Before making any plans to leave prior to Monday, check with the Chief Residents!

Each hospital will be responsible for 4 weeks of leave per resident FTE (3 weeks of vacation and 1 week of education time). No more than that number of weeks of leave time will be allowed at that hospital.

University of Colorado Hospital: 4 x 25 FTE = 100 weeks
No leave will be granted while on SICU or OB as these residents would have to be covered from the operating room residents to prevent excessive call. Leave time will otherwise be allotted proportionally to each service at UCH.

Veterans Affairs Medical Center: 4 x 4 FTE = 16 weeks

The Children’s Hospital: 4 x 4 FTE = 16 weeks

Denver Health: 4 x 7 = 28 weeks

No more than 1 person per week may be gone from VAMC, TCH and DHH. Vacations in excess of the institutional allotment will be approved and covered by the Institution of record. Leave during July can only occur under extraordinary circumstances with special permission from the Chairman or his designee.
The Director at each hospital must approve in writing all non-vacation absence requests (i.e. job interviews). All requests should be submitted and approved as early as possible, preferably 2 weeks in advance.

B. APPROVED EDUCATIONAL CONFERENCES

Attendance at scientific meetings is optional and must be approved by the program director prior to making travel arrangements. The department provides you with money (a total of $2,000 of meeting expenses for each resident during the 3-year residency period) and up to 5 days per year if you wish to attend a scientific meeting. We must document that you are actually attending a meeting, however, or it will be treated no differently than vacation time. You may not use this time for reading at home or self-study. We will be asking you for the title of the meeting and a copy of the program.

You will also be given education time only for the days the meeting is actually ongoing. For example, if the meeting is from Friday through Tuesday, you will be using 3 days of educational time (Friday, Monday and Tuesday) and will be expected to be back at work on Wednesday unless you plan on using vacation days to extend your time away. Some meetings may require a travel day, but those will be dealt with on an individual basis.

1. ASA Conferences

To select a conference, go to the ASA website and click on Calendars for Meetings (www.asahq.org). Select the meeting you would like to go to and print the syllabus for the meeting and the registration form.

2. CRASH

Every year, the department sponsors a national review course in Vail, the Colorado Review of Anesthesia and Ski Holiday (CRASH) www.cucrash.com. CA3 residents are excused from their clinical duties for part of the week to attend this conference.

3. Western Anesthesia Residents Conference (WARC)

This organization was developed as a result of the residents in the Midwest, especially in the Iowa area, meeting once a year to present ongoing research. When Bill Hamilton became chairman of the department of anesthesia at the University of California, San Francisco some years ago, he brought the idea of a regional residents' meeting with him and began the Western Anesthesia Residents Research Conference. It has been ongoing for a number of years now and it is not only enjoyable but also allows residents to meet and compare notes with residents throughout the Western U.S. Also, it allows the residents the opportunity to meet at close range many of the notable faculty from this part of the U.S. Many of the key academic anesthesiologists in the U.S. attend this annually held meeting. We encourage residents who have research to present or have an unusual case presentation to submit it for consideration for presentation at this meeting. The meeting site moves around from year to year.
D. **Family/Medical Leave**

Please refer to the Policy on Family/Medical Leave and Leave of Absence in the GME 2009-2010 Housestaff Manual on pages 40-42 or online at [www.uchsc.edu/gme](http://www.uchsc.edu/gme).

E. **Military Leave**

Legislation exists which requires all employers to permit its employees two weeks per year military leave without loss of any other privileges. We as a department will meet those requirements. However, residents who have a military reserve or National Guard obligation must also understand the current guidelines from the ABA. See page 13 in the ABA Booklet of Information, February 2009.

If the resident feels that while fulfilling military reserve activity he or she will be performing the duties of an anesthesia resident (as an elective rotation at a military hospital), he/she may receive credit for this rotation by petitioning the Credentials Committee of the ABA for prospective approval prior to taking the rotation.

F. **Guidelines for Travel Arrangements and Reimbursement**

*Very important – Please contact your Program Coordinator before making travel arrangements for conferences so that we are able to reimburse your expenses!*

1. **Travel Arrangements**

   **Conference Registration Fees:**

   Conference registration fees are reimbursable. Complete the conference registration form and give it to your Program Coordinator at least two months prior to the meeting. A check will be mailed directly to the conference.

   **Airline Tickets:**

   Please let your Program Coordinator know 6 weeks in advance what dates you want to travel and the times you want to leave and return. She will then request a Travel Authorization number for you. You will need to make your plane reservations through a University designated travel agency using your TA#. The tickets will automatically be paid for by the department and mailed to you. If you are traveling with a spouse or significant other, they can be included also, however the travel agency will need a personal credit card number for the extra ticket(s).

   **Hotel and Car Rental:**

   Expenses for hotel and car rental need to be paid by your before your trip but will be reimbursed after the meeting.
2. **Travel Reimbursement**

ORIGINAL receipts are needed for reimbursement, i.e., original airline ticket stub or e-ticket receipt, original hotel receipt (itemized bill), original car rental receipt, itemized meal receipt, etc.

All receipts need to show HOW the bill was paid (cash, credit card or check) and WHO paid the bill. Reimbursement can only be made to the person whose name appears on the receipt or bill, i.e., if you share a hotel or car rental with someone else, reimbursement will be paid to the person listed on the receipt.

UCD provides a daily per diem rate for meals: you will receive 75% of the maximum per diem rate for the first and last day of travel. The days in between you will receive the maximum per diem. The per diem rate will depend on the city you are staying in.

**Note:**

*Even though you are allocated money for travel and books, please understand that there are guidelines that need to be followed in order for you to be able to use these funds.*

*The deadline for using your travel funds is May 30th of your graduating year. Please submit all receipts for books and travel prior to that date.*
PROFESSIONAL AFFILIATIONS
A. **American Board of Anesthesiology (www.abahq.org)**

1. **Booklet of Information** - The Booklet of Information can be found on the American Board of Anesthesiology’s website and explains the following:
   
   a. The American Board of Anesthesiology
   b. Primary Certification in Anesthesiology
   c. Application Procedure
   d. The Examination System
   e. Board Policies
   f. Important Dates

B. **American Society of Anesthesiologists (ASA) and Colorado Society of Anesthesiology (CSA)**

Membership for the ASA and CSA is paid by the Department of Anesthesiology. Membership in the ASA includes the journal ANESTHESIOLOGY. ASA Standards and Guidelines are available on their website along with other useful information – [www.asahq.org](http://www.asahq.org).

C. **International Anesthesia Research Society (IARS)**

Membership in the IARS is paid by the department and includes a subscription to the journal ANESTHESIA AND ANALGESIA.

D. **American Society of Regional Anesthesia (ASRA)**

CA I residents are provided with a one year complimentary membership to ASRA. This membership includes receipt of the ASRA Newsletter, the journal REGIONAL ANESTHESIA, and all meeting notices. If you wish to continue your subscription after your first year, the cost is $25. You may use your book fund for this purpose.

E. **Colorado State Board of Medical Examiners**

1. **Physician Training Licenses**

   The Colorado General Assembly passed into law House Bill 02-1278, which grants the Colorado Board of Medical Examiners the authority and requires the Board to license all physicians enrolled in training programs in the state. Therefore, as of August 7, 2002, all physicians enrolled in a training program must either hold a physician training license or an active Colorado medical license.

   *Note: You will need a new training license for the Anesthesiology program regardless of whether or not you have a training license from another specialty.*
2. Permanent Licensure

After USMLE Part III has been taken and passed, an application for permanent state licensure can be obtained from the Colorado State Board of Medical Examiners (address listed below). Permanent Colorado licensure is not required during residency; however, CA 3 residents must obtain a state licensure for ABA Board eligibility prior to graduation.

Board of Medical Examiners
1560 Broadway
Suite 1300
Denver, CO 80202-5140
(303) 894-7690
www.dora.state.co.us/medical
GOALS FOR RESIDENCY TRAINING IN ANESTHESIOLOGY
GOALS FOR RESIDENCY TRAINING IN ANESTHESIOLOGY
CLINICAL ANESTHESIA 1 (PGY 2)

DEPARTMENT OF ANESTHESIOLOGY
UNIVERSITY OF COLORADO DENVER

1. All residents, upon graduation, should successfully pass both written and oral portions of the examinations of the American Board of Anesthesiology on the first attempt.

2. The ABA-ASA In-Training Examination (ITE) is given annually in July, and one can predict from the examination results whether a resident will eventually pass the written Board exam. The ITE is required for all residents. No resident at any time should score below the 25th percentile when compared with other residents nationally that are at a comparable level of training. A performance below that level will automatically result in resident placement on "academic notice", a form of probation. It is for this reason that we strongly encourage each resident to read daily in a regimented fashion so that your performance will not only meet our minimums, but that you will eventually be a well-read, knowledgeable and safe clinical practitioner who competes favorably against a very bright pool of Anesthesiology trainees nationally.

3. In general, the three-year Clinical Anesthesia curriculum consists of experience in basic anesthesia training, subspecialty training, and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

4. The Clinical Anesthesia (CA) I year is devoted to basic anesthesia training. It will emphasize basic and fundamental aspects of anesthesia such as airway management, vascular access, pharmacology of anesthetic agents, perioperative management of co-existing medical problems, and acute pain management. This will be accomplished during a broad range of general operating room cases and recovery room care.

5. All CA-I residents are required to have ACLS certification. A course is offered in August.

6. All CA-I residents will take the three Anesthesia Knowledge Tests (AKT 1, 2, and 6) upon entry into the program, after one-two months, and after six months of training. A minimum score of 25%ile is required as on the In-Training Exam.

END OF FIRST 6 MONTHS, CA1 YEAR

Knowledge
- Understand basic anesthesia machine and routine monitors (pulse oximetry, capnography, circuits, oscillometric blood pressure cuffs, electrocardiogram)
- Understand basics of neuromuscular blockade (relaxants, train-of-four monitoring, reversal)
- Understand use of routine vasoactive drugs
- Understand the indication for commonly used anesthetic drugs
- Understand major hemodynamic and respiratory effects of routine anesthetic agents and their indications
- Understand comprehensive examination and classification of the airway
- Understand key preoperative findings in history, physical, and laboratory work
- Understand application of "Universal Precautions" and aseptic technique
- Advanced Cardiac Life Support certification

**Case Management**
- Manage ASA physical status 1 patients with minimal assistance for uncomplicated surgery, including induction, maintenance, emergence, and transport to the post anesthesia care unit
- Accurately estimate fluid (blood/colloid/crystalloid) requirements in routine cases
- Identify basic intraoperative problems (hyper-/hypotension, hypoxia, hypercapnia, arrhythmias, anuria, acidosis, laryngospasm) and formulate differential diagnosis and treatment plans

**Technical Skills**
- Set up a case in reasonable time (machine check, drugs, airway equipment)
- Ventilate lungs via mask, and intubate trachea of patients with easy to moderately difficult airways
- Place peripheral intravenous and arterial catheters with minimal assistance
- Keep legible and accurate intra-, pre-, and postoperative records, either written or EMR
- Operate basic technical monitors and pressure transducers and trouble-shoot simple technical malfunctions

**Oral Skills**
- Communicate effectively with patients
- Deliver concise, organized case presentation to staff that includes important pre-anesthetic concerns
- Formulate and describe in detail a plan for anesthetic management of ASA physical status 1-3 patients including anticipated problems and their solutions

**Knowledge**
- Understand physiology of significant cardiovascular events (compression of vena cava by surgeons, hypovolemia, hypervolemia, pulmonary embolism, ischemia, myocardial depression)
- Understand aspects of neuroanesthesia (management of increased intracranial pressure for craniotomy), vascular anesthesia (changes with aortic cross clamp), and orthopedic anesthesia (fat emboli)
- Understand choice of regional versus general anesthesia and need for selective invasive monitoring
- Understand how to obtain and apply information from a pulmonary artery catheter

**Case Management**
- Manage, under supervision, patients with difficult airways who are undergoing elective surgery
- Perform emergency airway management with reasonable skill (rapid sequence vs. awake intubation) in the operating room and the intensive care unit
- Manage ASA physical status 3 patients for uncomplicated surgery with assistance
- Initiate management of trauma cases and other emergencies in proper sequence (airway, intravenous access, monitoring)
- Recognize key anatomic landmarks, indications/contraindications, and potential complications of regional blocks (spinal, epidural, axillary, intravenous regional)
- Manage patients in the post anesthesia care unit with assistance (assure adequacy of airway or adjust ventilation; manage pain, hemodynamics and fluids, and determine readiness for
• Develop and implement a rational plan for tracheal intubation of patients in the intensive care unit

*Technical Skills*
• Insert central and arterial catheters with minimal assistance
• Insert a pulmonary artery catheter with direction
• Perform aforementioned regional blocks on suitable patients with assistance
• Perform spinal and lumbar epidural anesthesia without assistance in most patients
• Perform fiberoptic or awake intubation with assistance

*Oral Skills*
• Cogently discuss management plan with anesthesiology staff or surgeon for ASA physical status 3 patients
• Defend choice of monitoring
• Defend choice of anesthetic technique and drugs used with discussion of options
• Recognize when to proceed, investigate further, or cancel a case
• Participate actively in teaching medical students

*Number of Hours Worked*
While the actual number of hours worked by residents may vary, residents should have sufficient off-duty time to avoid undue fatigue and stress. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house activities. Residents should be allowed to spend, on average, at least 1 full day out of 7 away from the hospital, and participate in on-call duty in the hospital no more frequently than on average every third night. There should be a 10-hour time period provided between all daily duty periods and after in-house call. The program director must monitor on-duty assignments for residents to assure adherence to this recommendation.
1. All residents, upon graduation, should successfully pass both written and oral portions of the examinations of the American Board of Anesthesiology on the first attempt.

2. The ABA-ASA In-Training Examination (ITE) is given annually in July, and one can predict from the examination results whether a resident will eventually pass the written Board exam. The ITE is required for all residents. No resident at any time should score below the 25%ile when compared with other residents nationally who are at a comparable level of training. A performance below that level will automatically result in resident placement on "academic notice", a form of probation. It is for this reason that we strongly encourage each resident to read daily in a regimented fashion so that your performance will not only meet our minimums, but that you will eventually be a well-read, knowledgeable and safe clinical practitioner who competes favorably against a very bright pool of Anesthesiology trainees nationally.

3. In general, the three-year Clinical Anesthesia curriculum consists of experience in basic anesthesia training, subspecialty training, and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

4. The Clinical Anesthesia (CA) II year emphasizes subspecialty anesthesia training accentuating the theoretical background, subject material and practice of subdisciplines of anesthesiology. These subspecialty areas include obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuroanesthesia, pain management, and critical care in the form of concentrated subspecialty rotations.

5. During general operating room rotations additional training will occur in outpatient anesthesia, advanced airway management, regional anesthetic techniques, and techniques of sedation and anesthesia for diagnostic and therapeutic procedures outside the operating room.

END OF CA2 YEAR

Knowledge

- Understand physiology and anesthetic concerns associated with pediatric anesthesia
- Understand obstetric syndromes and their anesthetic implications
- Understand routine open heart procedures, including pre-bypass, and separation from cardiopulmonary bypass
- Understand pharmacology of a variety of vasoactive and anesthetic drugs in depth
- Know how to perform emergency airway maneuvers, including cricothyroidotomy
- Understand basics of obstetric anesthesia (physiologic changes of pregnancy, techniques for analgesia and cesarean section)
Case Management

- Manage medical disease in surgical patients (pulmonary, cardiovascular, hepatorenal, endocrine)
- Manage routine pediatric, vascular, thoracic, and neurosurgical cases with assistance
- Manage neuraxial labor analgesia and cesarean section by general or regional anesthesia with assistance.

Technical Skills

- Perform spinal and lumbar epidural anesthesia in patients with extremes of body habitus
- Insert peripheral intravenous catheters in pediatric patients older than 2 yr
- Perform a variety of regional blocks with frequent success
- Insert a pulmonary artery catheter with minimal assistance
- Assemble and calibrate transducers without assistance
- Manage acute postoperative pain (patient-controlled analgesia, continuous infusions of epidural opioids and/or local anesthetics)

Oral Skills

- Cogently discuss management plan with attending and surgeon for ASA physical status 4 patients
- Review literature and participate in discussion for "Journal Club"
- Perform reasonably on oral board-style examination
- Lecture to faculty and residents at teaching conferences
- Actively teach medical students

Number of Hours Worked

While the actual number of hours worked by residents may vary, residents should have sufficient off-duty time to avoid undue fatigue and stress. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house activities. Residents should be allowed to spend, on average, at least 1 full day out of 7 away from the hospital, and participate in on-call duty in the hospital no more frequently than on average every third night. There should be a 10-hour time period provided between all daily duty periods and after in-house call. The program director must monitor on-duty assignments for residents to assure adherence to this recommendation.
1. All residents, upon graduation, should successfully pass both written and oral portions of the examinations of the American Board of Anesthesiology on the first attempt.

2. The ABA-ASA In-Training Examination (ITE) is given annually in July, and one can predict from the examination results whether a resident will eventually pass the written Board exam. The ITE is required for all residents. No resident at any time should score below the 25%ile when compared with other residents nationally who are at a comparable level of training. A performance below that level will automatically result in resident placement on "academic notice", a form of probation. It is for this reason that we strongly encourage each resident to read daily in a regimented fashion so that your performance will not only meet our minimums, but that you will eventually be a well-read, knowledgeable and safe clinical practitioner who competes favorably against a very bright pool of Anesthesiology trainees nationally.

3. In general, the three-year Clinical Anesthesia curriculum consists of experience in basic anesthesia training, subspecialty training, and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

4. The Clinical Anesthesia 3 year may include the more difficult or complex anesthetic procedures and care of the most seriously ill patients so that you exhibit sound clinical judgment in a wide variety of clinical situations and can function as a leader of perioperative care teams.

END OF CA3 YEAR

Knowledge
- Understand principles of all major subspecialties (ambulatory, cardiac, critical care, endocrine, neurosurgical, obstetrics, pediatrics, acute and chronic pain, thoracic, trauma, vascular) in depth
- Know and address important articles in recent literature

Case Management
- Manage independently, with staff availability:
  - ASA physical status 4 patients with multisystem diseases for complex elective and emergency surgery
  - Acute and chronic pain
  - Recovery room care

Technical Skills
- Perform all aforementioned anesthetic and invasive monitoring procedures independently
**Oral Skills**

- Attain the qualities and attributes fundamental to performance as a consultant anesthesiologist (according to the American Board of Anesthesiology):
- Ability to organize and express thoughts clearly
- Sound judgement in decision-making and application
- Ability to apply basic science principles to clinical problems
- Adaptability to rapidly changing clinical conditions
- Supervise and mentor medical students
- Participate actively in teaching fellow residents

**Number of Hours Worked**

While the actual number of hours worked by residents may vary, residents should have sufficient off-duty time to avoid undue fatigue and stress. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house activities. Residents should be allowed to spend, on average, at least 1 full day out of 7 away from the hospital, and participate in on-call duty in the hospital no more frequently than on average every third night. There should be a 10-hour time period provided between all daily duty periods and after in-house call. The program director must monitor on-duty assignments for residents to assure adherence to this recommendation.

Revised 3/2008
INSTITUTIONAL POLICIES
Policy
The program policy on duty hours for residents follows the intent and language found in the Accreditation Council for Graduate Medical Education (ACGME) guidelines addressing this topic and is consistent with policy adopted by the Graduate Medical Education Committee. The program director and faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Duty Hours
a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. {The “80” may be changed to reflect RRC requirements for <80 hours per week or RRC approval for > 80 hours per week}

c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.

d. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-Call Activities
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements).

c. An individual resident may accept no new patients after 24 hours of continuous duty.

d. At-home call (pager call) is defined as call taken from outside the assigned institution.
   1) The frequency of at-home call is not subject to the every third night limitation.
      However, at-home call must not be so frequent as to preclude rest and reasonable
personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

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

3) The program director and faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

**Monitoring Fatigue and Stress**

All residents are required to complete the module, Sleep Deprivation and Fatigue. This module can be accessed through the department’s Intranet at [www.uchsc.edu/anesthesia](http://www.uchsc.edu/anesthesia). The link is found under “Residents”.
Residency and Fellowship
POLICY ON CONTROLLED SUBSTANCES
Department of Anesthesiology
University of Colorado Denver, School of Medicine

Related Policies and Procedures:  
Drug and Alcohol Free Workplace  
Fitness for Duty  
Employee/Volunteer Health Screen  
Employee Discipline

Description: University of Colorado Hospital Operating Room and the Department of Anesthesiology are committed to a safe, healthy, and productive work environment for all employees, free from the effects of substances that impair employee judgment, and could result in increased safety risks, injuries, and faulty decision-making.

Accountability: All anesthesia care providers that handle controlled substances.

Definitions:

- **Impaired Employee:** Alterations in behavior, cognitive abilities, physical agility, and dexterity due to the ingestion of ethyl alcohol or drugs, including substances with known mind or function altering effects on the person.

- **Controlled Substance/Drug:** Any substance that has known mind or function-altering effect on a person, including psychoactive substances and including but not limited to, substances prohibited or controlled by state and federal laws. Drugs may include prescription or nonprescription, and legal or illegal substances.

- **Discrepancy:** A variation from a quantity expected. An OR pharmacy employee will compare the distribution/administration records(s) [narcotic return bag] with the anesthesia record. The amount dispensed should equal the amount given, plus the amount to credit, if any, plus the amount to waste. Any differences found versus what was expected in quantities returned or charted, will be considered discrepant.

- **Deviation:** Not following established procedures in the handling, charting or safe keeping of controlled medications, resulting in lost or uncharted medications.

Policies/Procedures:

1) The OR Pharmacy shall have locked storage for all controlled substances. All records for controlled substances shall be maintained in a readily retrievable manner for five years. Controlled substances records will be maintained in a manner to establish receipt and distribution of all controlled substances. Records of all controlled substances will be
maintained separately from non-controlled medication records. The OR pharmacist will maintain a perpetual inventory of all controlled substances used in the operating room setting. Administration and wasting records will be maintained separately from the patient charts. An OR pharmacy employee will compare the distribution/administration records(s) [narcotic return bag] with the anesthesia record.

a) If any discrepancy is found in checking the narcotic bag against the anesthesia record, the anesthesiologist, resident, CRNA, or SRNA that signed for the controlled substances will be questioned about the discrepancy. If there is no legitimate and verifiable accountability of the controlled substances after twenty four hours, please refer to the protocol of section 4.

b) Poorly documented transactions, illegible handwriting or failure to document doses/ incomplete records will be subjectively deemed as non-compliant and follow the protocols of section 4.

2) Controlled substances procedure during satellite hours (06:30-17:00)

a) The anesthesiologist, resident, Certified Registered Nurse Anesthetist (CRNA), or Student Registered Nurse Anesthetist (SRNA) will come to the OR Pharmacy to request specific controlled drugs for each case or they may obtain the controlled drugs from the Pyxis Medstation.

b) The requested drug order is filled by the Pharmacist or Technician and placed in a narcotic return bag with the patients name, date, drug, quantity, and the anesthesiologist’s, resident’s, CRNA’s, or SRNA’s name written on the bag.

c) Each line on the controlled drug daily record (CDDR) must be filled out with the patient's name, (last name first, first name last). The operating suite number and time can be added if known. The record is signed by the anesthesiologist, resident, CRNA, or SRNA and initialed by the pharmacist or technician.

i) As each drug is dispensed, the quantity dispensed is subtracted from the previous total, so that a continuous inventory is maintained. Enter only one drug per line.

ii) If the anesthesiologist, resident, CRNA, or SRNA obtains controlled medication from the Pyxis Medstation, the individual fills in the required information on the bag.

d) The amount of drug that is administered to the patient will be recorded by the anesthesiologist, resident, CRNA, or SRNA on the patient’s anesthesia record. The drug amounts administered, returned for credit, and amount to be wasted is recorded on the narcotic return bag. All unused drug to waste or to credit, is placed inside the bag and returned to the pharmacy satellite at the end of the case.

e) When the bag is returned to the Pharmacy, the Pharmacist or Technician receiving the bag will initial the narcotic return line(s) on the CDDR sheet indicating that the narcotic bag has been returned.

f) When the pharmacy receives a copy of the anesthesia record, all doses of controlled drugs charted are checked against the return bag. The amount dispensed should equal the amount given, plus the amount to credit, if any, plus the amount to waste.
i) If any discrepancy is found in checking the narcotic bag against the anesthesia record, the anesthesiologist, resident, CRNA, or SRNA signing for drug will be questioned about the discrepancy. If there is no resolution for the discrepancy after twenty four hours, please refer to the protocol of section 4.

ii) A discrepancy record will be kept in the pharmacy, along with a file including a photocopy of the narcotic bag, a photocopy of the anesthesia record and an explanation of the discrepancy.

iii) If the anesthesiologist, resident, CRNA or SRNA fails to return the bag after the case, the pharmacy will question the anesthesiologist, resident, CRNA or SRNA about the missing bag. The anesthesiologist, resident, CRNA, or SRNA will write an explanation resolving the discrepancy on the photocopy. If, after a day, the discrepancy has not been resolved and/or the anesthesiologist, resident, CRNA or SRNA is unavailable, please refer to the protocol of section 4.

g) In the morning the Pharmacist will waste the previous day's narcotic bags. The OR Pharmacist will cosign the return bags with another available Pharmacist or Technician prior to being wasted. The bag label will be kept in the OR Pharmacy for approximately one month and filed in the Central Pharmacy and then eventually stored at the warehouse on file for 3 years.

3) Controlled substances procedure when satellite is not open

   a) After 1700 when the satellite is not open, the resident, CRNA, SRNA, or anesthesiologist will pick up controlled drugs from the Pyxis Medstation located in the sterile cores of the OR.

   b) The resident, CRNA, SRNA, or anesthesiologist will fill in the patient's name, date, and the amount of each controlled drug signed out on the narcotic return bag.

   c) The narcotic return bag is returned to the Pharmacy drop box at the end of the case. The drop box is located outside of the operating room.

   d) The Pharmacist collects all narcotic return bags from drop box the next "open" morning and checks them against the inventory record and Pyxis receipt tapes and reconciles any discrepancies according to the procedures when the OR Pharmacy is open.

   e) Poorly documented transactions, illegible handwriting or failure to document doses/incomplete records will be subjectively deemed as non-compliant and follow the protocols of section 4.

4) Deviations from the Anesthesia Operating Room Pharmacy Controlled Substances Policy and Procedure

   a) Non-reconciled controlled substance doses, as described below, will be recorded on a discrepancy tracking form and immediately investigated. If the discrepancy cannot be resolved within 24 hours of discovery, the following protocol will be put into action:

      i) The first incident of deviation from the controlled substances policy and procedure will result in reporting the incident to the Department of Anesthesiology Quality Assurance Committee and the Senior Medical Director
of Perioperative Services. The anesthesia care provider must submit within twenty four hours of being requested to do so a written explanation and a documented action plan to assure total compliance with controlled substances in the future.

ii) If a second unresolved discrepancy (or deviation) by the same provider occurs within one year, it will result in suspension from the OR schedule and the anesthesia care provider will be sent to Concentra Clinic Labs for the purpose of obtaining a urine/blood sample to test for controlled substances. They will also personally appear before an emergency meeting of a quorum of the Department of Anesthesiology Quality Assurance Committee to explain the discrepancies. If and when the testing results are returned negative for controlled substances the provider will then be immediately returned to the OR schedule.

iii) The third unresolved discrepancy (or deviation) will result in suspension from the operating room and referral to Colorado Physician Health Program (CPHP). Reinstatement to the operating room will be based on a written action plan for return to work agreed upon by CPHP, the referred individual, and the Department of Anesthesiology.

In addition, please review the policy on Substance Abuse/Impaired Physician in the 2009-2010 Housestaff Manual on page 56.
Supervision:

The attending provider is responsible for all care delivered by trainees. Trainees shall always be appropriately supervised and the supervision of trainees is ultimately the responsibility of the attending provider, who is accountable to the Medical Board. Each department shall have a mechanism in place that communicates to the trainees the identity of the attending provider and back-up coverage by another faculty member in the event that the attending provider is not immediately available. Refer to the University of Colorado Hospital (UCH) Medical Staff Bylaws, Section 2.10 for hospital specific Resident Supervision guidelines.

In the Department of Anesthesiology, residency training is 3 clinical years. Candidates begin at the PGY-2 level and complete training at the PGY-4 level. Fellowship or subspecialty training begins at the PGY-4 level and finishes at the PGY-5 level.

If your program does NOT begin at the PGY1 level, in what specialty do your residents train for the first year(s)?

The American Board of Anesthesiology allows almost any medical or surgical specialty. Many do their PGY-1 year as a Transitional Internship.

Please provide a narrative description of the ongoing resident evaluation and promotion process for both cognitive and procedural skills. This should include the faculty evaluation process, in-service examination, and residency/promotions committee process:

Anesthesiology residents are evaluated by the faculty at the completion of each rotation. The Clinical Competence Committee meets three times each year to review resident performance and make decisions regarding resident progression through the program. These decisions are based on the residents’ clinical and technical skills, professionalism and results on the American Board of Anesthesiology In-Training examinations as well as other standardized tests administered during the CA-1 (PGY-2) and CA-2 (PGY-3) years.

Definitions:

Resident: The term resident refers to individuals who are engaged in graduate medical education training, including interns, residents, and fellows.

Fellow: any individual engaged in any training period after already taking or qualifying for Board Certification in their specialty.

Supervision: Refers to the authority and responsibility that a staff practitioner, as attending, exercises over the care delivered to a patient by a resident or fellow.
Direct Supervision: Requires the presence of the attending faculty or supervising resident, appropriate record keeping, and direct involvement of the attending faculty or supervising resident during follow-up.

Indirect Supervision: Requires appropriate record keeping and discussion with attending faculty or supervising resident either before or after the procedure.

**LEVELS OF SUPERVISION**

<table>
<thead>
<tr>
<th>The trainee will not be performing the procedure</th>
<th>Faculty Present (Direct)</th>
<th>Faculty in hospital and available for consultation (Indirect)</th>
<th>Faculty out of hospital but available by phone (Indirect)</th>
<th>Supervising Resident Present (Direct)</th>
<th>Supervising Resident in hospital and available for consultation (Indirect)</th>
<th>Supervising Resident out of hospital but available by phone (Indirect)</th>
<th>The trainee may perform the procedure without any supervision or oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>IND</td>
</tr>
</tbody>
</table>

Assign a supervisory level (NA, 1 – 6, or IND) to every procedure for every level of trainee.

**NON-PROCEDURAL ACTIVITIES**

<table>
<thead>
<tr>
<th>NON-PROCEDURAL ACTIVITIES</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit patients to this service</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Perform History and Physical Examination for patients on this service</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Treat and Manage patients on this service</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Make referrals and request consultations</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provide consultations within the scope of his or her expertise</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Use all skills normally learned during medical school</td>
<td>IND</td>
<td>IND</td>
<td>IND</td>
</tr>
<tr>
<td>Render any care in a life-threatening emergency</td>
<td>IND</td>
<td>IND</td>
<td>IND</td>
</tr>
<tr>
<td>Supervise Allied Health Professionals on this service</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**GENERAL PROCEDURES**

<table>
<thead>
<tr>
<th>GENERAL PROCEDURES</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of surgical anesthesia</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**SPECIAL PROCEDURES**

<table>
<thead>
<tr>
<th>SPECIAL PROCEDURES</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insertion of peripheral arterial catheters</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pulmonary artery catheterization</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Endotracheal intubation</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Insertion of central venous catheters</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pain Management:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Epidural analgesia</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nerve block analgesia</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
ENTRY REQUIREMENTS

The Department of Anesthesiology at the University of Colorado Denver does not discriminate with regard to age, sex, race, religion, national origin, disability, or Veteran status.

The Department of Anesthesiology at UCD is an advanced program. Therefore applicants need to complete a PGY 1 year prior to entering the program. For most applicants this means that they will need to match for their PGY 1 and 2 years at the same time. The PGY 1 year must be in direct patient care. Training that is limited to pathology, radiology or psychiatry is not acceptable. We suggest that applicants complete either a transitional or an Internal Medicine internship.

Certification by the National Board of Medical Examiners (NBME), the National Board of Osteopathic Medicine (NBOME), or the Educational Commission for Foreign Medical Graduates (ECFMG) is required.

International medical graduates must hold a valid ECFMG (Educational Commission for Foreign Medical Graduates) certificate, or have a full, unrestricted license to practice medicine in a U.S. licensing jurisdiction, or have completed a Fifth Pathway program provided by an LCME-accredited medical school.

The University of Colorado School of Medicine recognizes that housestaff enrolled in its program are trainees, not employees. As such, applicants also must be able to meet the conditions of the school’s Houseofficer Training Agreement. Specifically, they must:

1. Be a U.S. citizen or hold a valid U.S. resident alien card;

2. Possess (or be eligible to obtain) all three of the following:
   a) valid passport;
   b) valid 1-94 card (obtained upon entry to the U.S.) that indicates D/S J-1 (Duration of Status for J-1 visa);
   c) J-1 visa sponsorship from the ECFMG to train at the University of Colorado School of Medicine in the Department of Anesthesiology.
The Department of Anesthesiology has adopted the University of Colorado Sexual Harassment Policy. The policy is listed below:

INTRODUCTION

This administrative policy statement implements Regent Policy 2-J, Sexual Harassment Policy.

POLICY STATEMENT

The University of Colorado is committed to maintaining a positive learning, working and living environment. The University does not discriminate on the basis of race, color, national origin, sex, age, disability, creed, religion, sexual orientation, or veteran status in admission and access to, and treatment and employment in, its educational programs and activities. (Regent Law, Article 10, amended 11/8/2001). In pursuit of these goals, the University will not tolerate acts of sexual harassment or related retaliation against or by any employee or student. This Policy (1) provides a general definition of sexual harassment and related retaliation; (2) prohibits sexual harassment and related retaliation; and (3) sets out procedures to follow when a member of the University community believes a violation of the Policy has occurred. It is also a violation of this Policy for anyone acting knowingly and recklessly either to make a false complaint of sexual harassment or to provide false information regarding a complaint.

Robust discussion and debate are fundamental to the life of the University. Consequently, this policy shall be interpreted in a manner that is consistent with academic freedom as defined in Regent Law, Article 5 D (amended 10/10/02). It is intended that individuals who violate this Policy be disciplined or subjected to corrective action, up to and including termination or expulsion.

DEFINITIONS

Appointing authority/disciplinary authority: an appointing authority is the individual with the authority or delegated authority to make ultimate personnel decisions concerning a particular employee. A disciplinary authority is the individual who has the authority or delegated authority to impose discipline upon a particular employee.

Complainant: a complainant is a person who is subject to alleged sexual harassment.

Respondent: a respondent is a person whose alleged conduct is the subject of a complaint.

Sexual harassment: sexual harassment consists of interaction between individuals of the same or opposite sex that is characterized by unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, living conditions and/or educational evaluation; (2) submission to or rejection of such conduct by an individual is used as the basis for tangible employment or educational decisions affecting such individual; or (3) such conduct has the purpose or effect
of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive working or educational environment.

**Hostile environment sexual harassment:** (described in subpart (3) above) is unwelcome sexual conduct that is sufficiently severe or pervasive that it alters the conditions of education or employment and creates an environment that a reasonable person would find intimidating, hostile or offensive. The determination of whether an environment is "hostile" must be based on all of the circumstances. These circumstances could include the frequency of the conduct, its severity, and whether it is threatening or humiliating. Examples which may be Policy violations include the following: an instructor suggests that a higher grade might be given to a student if the student submits to sexual advances; a supervisor implicitly or explicitly threatens termination if a subordinate refuses the supervisor's sexual advances; and a student repeatedly follows an instructor around campus and sends sexually explicit messages to the instructor's voicemail or email.

**Retaliatory Acts:** It is a violation of this policy to engage in retaliatory acts against any employee or student who reports an incident of alleged sexual harassment, or any employee or student who testifies, assists or participates in a proceeding, investigation or hearing relating to such allegation of sexual harassment. Students and employees who believe they have been retaliated against because of testifying, assisting or participating in a proceeding, investigation, or hearing relating to an allegation of sexual harassment, should meet with and seek the advice of their campus sexual harassment officer, whose responsibilities include handling retaliation.

**POLICIES AND PROCEDURES**

**A. Obligation to Report**

In order to take appropriate corrective action, the University must be aware of sexual harassment or related retaliation. Therefore, anyone who believes that s/he has experienced or witnessed sexual harassment or related retaliation should promptly report such behavior to a campus sexual harassment officer (see campus Appendix discussed below) or any supervisor (see section B below).

**B. Supervisor's Obligation to Report**

Any supervisor who experiences, witnesses or receives a written or oral report or complaint of sexual harassment or related retaliation shall promptly report it to a campus sexual harassment officer. This section of the Policy does not obligate a supervisor who is required by the supervisor's profession and University responsibilities to keep certain communications confidential (e.g., a professional counselor or ombudsperson) to report confidential communications received while performing those University responsibilities. Each campus shall have an appendix to this Policy designating the supervisory positions that qualify under this exception.

**C. Investigation Process**

1. Reports or complaints under this Policy shall be addressed and resolved as promptly as practicable after the complaint or report is made. Ordinarily, investigations shall be concluded and reports submitted to the reviewing committee no later than 90 days following the receipt of a complaint. Ordinarily, the final report shall be sent to the Chancellor or President no later than 30 days after the committee's receipt of the draft report of the investigation.

It is the responsibility of the sexual harassment officer(s) to determine the most appropriate means for addressing the report or complaint. Options include: 1) investigating the report or complaint in accordance with paragraph C.3. Below, 2) with the agreement of the parties, attempting to resolve the report or complaint through a form of alternative dispute resolution (e.g., mediation), or 3) determining that the facts of the complaint or report, even if true, would not constitute a violation of this Policy. The campus sexual harassment officer(s) may designate another individual (either from within the University, including an administrator, or
from outside the University) to conduct or assist with the investigation or to manage an alternative dispute resolution process. Outside investigators shall have training, qualifications and experience as will, in the judgment of the sexual harassment officer, facilitate the investigation. Anyone designated to address an allegation must adhere to the requirements of this Policy and confer with the sexual harassment officer(s) about his or her progress. (See campus appendix for a list of resources for further assistance or additional information.)

2. All reports or complaints shall be made as promptly as feasible after the occurrence. (A delay in reporting may be reasonable under some circumstances, as determined on a case-by-case basis. An unreasonable delay in reporting, however, is an appropriate consideration in evaluating the merits of a complaint or report.)

3. If an investigation is conducted: The complainant and the respondent shall have the right to:
   a. Receive written notice of the report or complaint, including a statement of the allegations, as soon after the commencement of the investigation as is practicable and to the extent permitted by law;
   b. Present relevant information to the investigator(s); and
   c. Receive, at the conclusion of the investigation and appropriate review, a copy of the investigator's report, to the extent permitted by law.

4. The Chancellor, the respondent's appointing authority and the respondent's supervisor shall be notified that an investigation is taking place. The sexual harassment officer shall advise the respondent's supervisor whether the respondent should be relieved of any supervisory or evaluative authority during the investigation and review. If the respondent's supervisor declines to follow the recommendation of the sexual harassment officer, s/he shall send a letter explaining the decision to the Chancellor with a copy to the sexual harassment officer.

5. At the conclusion of an investigation, the investigator shall prepare a written report which shall include a statement of factual findings and a determination of whether this Policy has been violated. The report shall be presented for review to the standing review committee designated by the Chancellor, or, in the case of System Administration, the President.

6. The standing review committee may consult with the investigator, consult with the parties, request that further investigation be done by the same or another investigator, or request that the investigation be conducted again by another investigator. The standing review committee may adopt the investigator's report as its own or may prepare a separate report based on the findings of the investigation. The standing review committee may not, however, conduct its own investigation or hearing. Once the standing review committee has completed its review, the report(s) shall be sent to the campus sexual harassment officer(s), the complainant and the respondent, to the extent permitted by law. The report shall also be sent to the Chancellor, or, in the case of System Administration*, to the President. If a Chancellor is the respondent or complainant, the report shall be sent to the President. If the President or the Secretary of the Board of Regents is the respondent or complainant, the report shall be sent to the Board of Regents.

*For the purposes of this Policy, System Administration includes the Office of the Secretary of the Board of Regents and Internal Audit.

D. Reporting Process

1. A. If a Policy violation is found, the report(s) shall be sent to the disciplinary authority for the individual found to have violated the Policy, and the disciplinary authority must initiate a disciplinary process against that individual. The disciplinary authority shall have access to the records of
the investigation. If disciplinary action is not taken, the appointing authority and the Chancellor, or in the case of System Administration, the President, shall be notified accordingly.
b. Following a finding of violation of the Policy, the disciplinary authority shall forward to the sexual harassment officer and to the Chancellor, or in the case of System Administration, the President, a statement of the action taken against an individual for violation of this Policy.
c. If a Policy violation is not found, the appointing authority and the Chancellor, or in the case of System Administration, the President, shall be notified accordingly.

2. The sexual harassment officer shall advise the complainant and respondent of the resolution of any investigation conducted under this Policy.

3. A copy of the investigator's written report as approved by the standing review committee shall be provided to: (1) the complainant; (2) the respondent; and (3) the respondent's appointing authority.

4. In all cases, the sexual harassment officer shall retain the investigator's report, as approved by the standing review committee, for a minimum of three (3) years or for as long as any administrative or legal action arising out of the complaint is pending.

5. All records of sexual harassment reports and investigations shall be considered confidential and shall not be disclosed publicly except to the extent required by law.

6. Complaints Involving Two or More Campuses: When an alleged Policy violation involves more than one campus, the complaint shall be handled by the campus with disciplinary authority over the respondent. The campus responsible for the investigation may request the involvement or cooperation of any other affected campus and should advise appropriate officials of the affected campus of the progress and results of the investigation.

7. Complaints By and Against University Employees and Students Arising in an Affiliated Entity: University employees and students sometimes work or study at the worksite or program of another organization affiliated with the University. When a Policy violation is alleged by or against University employees or students in those circumstances, the complaint shall be handled as provided in the affiliation agreement between the University and the other entity. In the absence of an affiliation agreement or a provision addressing this issue, the University may, in its discretion, choose to 1) conduct its own investigation, 2) conduct a joint investigation with the affiliated entity, 3) defer to the findings of an investigation by the affiliated entity where the University has reviewed the investigation process and is satisfied that it was fairly conducted, or 4) use the investigation and findings of the affiliated entity as a basis for further investigation.

E. No Limitations on Existing Authority
No provision of this Policy shall be construed as a limitation on the authority of a disciplinary authority under applicable policies and procedures to initiate disciplinary action. If an individual is disciplined for conduct that also violates this Policy, the conduct and the discipline imposed shall be reported to a campus sexual harassment officer. If an investigation is conducted under this Policy and no Policy violation is found, that fact does not prevent discipline of the respondent for inappropriate or unprofessional conduct under other applicable policies and procedures.

F. Information and Education
The President's office shall provide an annual report documenting: (1) the number of reports or complaints of Policy violations; (2) the categories (i.e., student, employee, or other) and sexes of the parties involved; (3) the number of Policy violations found; and (4) examples of sanctions imposed for Policy violations.
Each campus shall broadly disseminate this Policy, distribute a list of resources available on the campus to respond to concerns of sexual harassment and related retaliation, maintain the campus appendix to the sexual harassment policy, and develop and present appropriate educational programs. Each campus shall maintain information about these efforts, including a record of how the Policy is distributed and the names of individuals attending training programs.

G. Oversight Committee
There shall be an oversight committee consisting of campus and system representatives appointed by the President. No one shall serve on this committee who has been involved with a sexual harassment case in any capacity during the previous two years. The oversight committee shall annually gather and review information regarding investigations conducted under this Policy and the ultimate actions taken as a result of such investigations. The oversight committee shall be responsible for making confidential findings and recommendations to the University Counsel for the purpose of enabling the University Counsel to provide legal advice to the Board, the President, the campus Chancellors, and other University officials, as appropriate concerning the equitable, effective and lawful implementation of the policy.

H. Review of the University Policy
Pursuant to the University Policy on Sexual Harassment, effective July 1, 1999, the Policy underwent review and revision in 2000-2003. In accordance with this Policy as reviewed and revised in 2003, the President shall periodically have this Policy reviewed.

RELATED POLICIES
Administrative Policy Statement, "University Policy on Amorous Relationships Involving Evaluative Authority," provides that an amorous relationship between an employee and a student or between two employees constitutes a conflict of interest when one of the individuals has direct evaluative authority over the other and requires that the direct evaluative authority must be eliminated.

For related complaint, grievance or disciplinary processes refer to Regent Policies under 5. Faculty, 5. H. Faculty Senate Grievance Process and 5. I. Faculty Dismissal for Cause Process (for faculty), State Personnel Board Rules (for classified employees), and campus student disciplinary policies and procedures (for students).

UCD Sexual Harassment Policy Campus Appendix

Campus Resources:
If you wish to report sexual harassment or need additional information, contact the UCD Sexual Harassment Officer at (303) 315-2724; send correspondence to PO Box 173364, Campus Box 130, Denver CO 80217-3364; or email richard.webbuchse.edu.
The Ombuds Office is a resource available to all members of the University community. It is an independent entity which will provide informal, confidential and neutral services to members of the university community in resolving conflicts, complaints, and disputes. For the downtown Denver campus office call (303) 556-4493. For the office serving the AMC call (303) 724-2950.

UCD Department of Human Resources is located on the downtown Denver campus. The Department provides services to faculty, exempt professional and classified staff. Phone: (303) 315-2700.

The emergency phone number for police serving all campuses is 911.

The CU-Denver Student and Community Counseling Center serving the downtown Denver campus is located in room 4036 of the North Classroom Building. (303) 556-4372.
Exception to the Obligation to Report:

The Sexual Harassment Policy obligates supervisors who experience, witness or receive written or oral reports or complaints of sexual harassment or related retaliation to promptly report the information to a campus sexual harassment officer. The policy also requires that exceptions to this requirement be identified. The Ombuds Office at UCD is not required to inform the sexual harassment officer of confidential communications, including information regarding sexual harassment.

Source: President’s Office
Prepared by: Associate Vice President for Human Relations and Risk Management
Approved by: Elizabeth Hoffman
Application: All Campuses and System Administration
Effective Date: July 1, 2003
Replaces: University Policy on Sexual Harassment dated July 1, 1999
ACGME Program Requirements for Graduate Medical Education in Anesthesiology

Common Program Requirements are in BOLD

Effective: July 1, 2008

Introduction

A. Definition and Scope of the Specialty

The Review Committee representing the medical specialty of anesthesiology exists in order to foster and maintain the highest standards of training and educational facilities in anesthesiology, which the Review Committee defines as the practice of medicine dealing with but not limited to the following:

1. assessment of, consultation for, and preparation of patients for anesthesia;
2. relief and prevention of pain during and following surgical, obstetric, therapeutic, and diagnostic procedures;
3. monitoring and maintenance of normal physiology during the perioperative period;
4. management of critically ill patients;
5. diagnosis and treatment of acute, chronic, and cancer-related pain;
6. clinical management and teaching of cardiac and pulmonary resuscitation;
7. evaluation of respiratory function and application of respiratory therapy;
8. conducting of clinical and basic science research; and,
9. supervision, teaching, and evaluation of performance of personnel, both medical and paramedical, involved in perioperative care.
B. Duration and Scope of Education

1. Length of Program

A minimum of four years of graduate medical education is necessary to train a physician in the field of anesthesiology. Three years of the training must be in clinical anesthesia. The Review Committee for Anesthesiology and the Accreditation Council for Graduate Medical Education (ACGME) accredit programs only in those institutions that possess the educational resources to provide three years of clinical anesthesia training. The capability to provide the Clinical Base Year within the same institution is desirable but not required for accreditation.

2. Program Design

The continuum of education in anesthesiology consists of four years of training, the Clinical Base Year (CBY) and 36 months of clinical anesthesia training (CA-1, CA-2, and CA-3 years).

a) Clinical Base Year

(1) One year of the resident’s total training must be the Clinical Base Year, which should provide the resident with 12 months of broad education in medical disciplines relevant to the practice of anesthesiology. The Clinical Base Year usually precedes training in clinical anesthesia. It is strongly recommended that the Clinical Base Year be completed before the resident begins the CA-2 year; the Clinical Base Year, however, must be completed before the resident begins the CA-3 year.

(2) If an accredited anesthesiology program offers this year of training, the Review Committee will verify that the content and oversight for the year are acceptable. If the year is judged to be in substantial compliance with the requirements for the Clinical Base Year (as defined below), the Review Committee will accredit the residency as a four-year program. When the Clinical Base Year is approved as part of the accredited anesthesiology residency program, the program director must maintain oversight for all rotations on the services that are used for the Clinical Base Year and must approve the rotations for individual residents.
(3) When the resident obtains the CBY in another accredited program (e.g., a Transitional Year program or a PGY-1 experience in another specialty), the anesthesiology program director must receive from the CBY program director the resident’s written performance evaluation quarterly during the CBY. Acceptance into the CA-1 year depends on the resident demonstrating satisfactory abilities on these written evaluations. This requirement pertains to the resident who has been accepted into an anesthesiology program before starting the CBY. For information concerning residents who transfer from a residency in another specialty or from another anesthesiology residency, refer to Sec. III.C. Resident Transfers.

(4) At least six months of the Clinical Base Year rotations must include experience in caring for inpatients in internal medicine, pediatrics, surgery, or any of the surgical specialties, obstetrics and gynecology, neurology, family medicine, or any combination of these. In addition, there should be rotations in critical care and emergency medicine, with at least one month, but no more than two months, devoted to each. Up to one month may be taken in anesthesiology. Rotations should ensure continuity of teaching and clinical experience. Each month of training may be counted only once. For example, a rotation in a pediatric intensive care unit may count as either a month in pediatrics or a month in critical care medicine.

(5) The development of clinical skills and mature clinical judgment requires that residents be given responsibility, under proper supervision and commensurate with their ability, for decision-making and for direct patient care in all settings. The resident’s patient care responsibilities should include the planning of care, and the writing of orders, progress notes and relevant records, subject to review and approval by senior residents and attending physicians.
The resident should develop the following fundamental clinical skill competencies during the Clinical Base Year:

(a) obtain a comprehensive medical history;

(b) perform a comprehensive physical examination;

(c) assess a patient's medical conditions;

(d) make appropriate use of diagnostic studies and tests;

(e) integrate information to develop a differential diagnosis; and,

(f) implement a treatment plan.

Each clinical service on which the Clinical Base Year resident rotates must provide written evaluation of the resident's performance at the end of the rotation. The Anesthesiology program director is responsible for reviewing these written evaluations on a quarterly basis.

b) Clinical Anesthesia Training: CA-1 through CA-3 Years

These three years consist of training in basic and advanced anesthesia. They must encompass all aspects of perioperative care to include evaluation and management during the preoperative, intraoperative, and postoperative periods. The clinical training must progressively challenge the resident's cognitive and technical skills, and must provide experience in direct and progressively responsible patient management. As the resident advances through training, she or he should have the opportunity to learn to plan and to administer anesthesia care for patients with more severe and complicated diseases, as well as patients who undergo more complex surgical procedures. The training must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations.
and can function as a leader of perioperative care teams.

(2) The program should provide initial rotations in surgical anesthesia, critical care medicine, and pain medicine. Experience in these rotations must emphasize the fundamental aspects of anesthesia, preoperative evaluation and immediate postoperative care of surgical patients, and assessment and treatment of critically ill patients and those with acute and chronic pain. Residents should receive training in the complex technology and equipment associated with these practices. There must be documented evidence of direct faculty involvement with tutorials, lectures, and clinical supervision.

(3) Clinical experience in surgical anesthesia, pain medicine, and critical care medicine should be distributed throughout the curriculum in order to provide progressive responsibility to trainees in the later stages of the curriculum.

(4) During the 36 months of clinical anesthesia training, there must be a minimum of two identifiable one month rotations in each of obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. If the program director judges that a resident has gained satisfactory skills and experience in clinical anesthesia in any of these subspecialties before completion of the second required month, the resident may pursue other experiences that augment learning of perioperative care in the subspecialty during the time remaining in the second month. For example, a resident who has gained sufficient experience in cardiac anesthesia (see IV.A.5.a) Patient Care) before completion of the second month of a cardiac anesthesia rotation may benefit from other perioperative experiences such as caring for patients in a cardiac angiographic suite or learning the basics of performance and interpretation of transthoracic or transesophageal echocardiograms.

(5) Additional subspecialty rotations are encouraged, but the cumulative time in any one subspecialty may not exceed six months during the CA-1 through CA-3 years. Curricula specific to all subspecialty rotations
must be on file in the department. Advanced subspecialty rotations, including those in critical care medicine and pain medicine, must reflect increased responsibility and learning opportunities. These assignments must not compromise the learning opportunities for residents participating in their initial subspecialty rotations.

(6) Experiences in perioperative care must include rotations in critical care medicine, acute perioperative and chronic pain management, preoperative evaluation, and postanesthesia care. These experiences must consist of at least four months of distinct progressive rotations in critical care medicine; at least three months in pain medicine that may include one month in an acute perioperative pain management rotation, one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain problems, and one month of regional analgesia experience in pain medicine; one month in a preoperative evaluation clinic; and 0.5 month in a postanesthesia care unit. The Review Committee will allow two months of critical care medicine and one month of pain medicine experiences to occur during the Clinical Base Year. The Review Committee anticipates that rotations in preoperative evaluation clinics, acute perioperative pain management, and postoperative care units may occur in divided rotations. However, the rotation unit may not be less than one week. Successive experiences must reflect increased responsibility and learning opportunities.

(7) During the 36 months of training residents may select additional focused educational experiences in advanced clinical anesthesiology subspecialties and/or related activities, remaining CBY required rotations, or research. For example, residents seeking broad exposure in critical care-related specialties may choose to take one or more rotations in echocardiography, nutrition, infectious diseases, or nephrology. Some may wish to gain experiences in pain medicine-related specialties such as physical medicine & rehabilitation, neurology, or psychiatry. Others may wish to choose advanced clinical anesthesiology subspecialty rotations or unique
anesthesia-related experiences.

Introduction.B.2.b) (8) The program director must determine the sequencing of the rotations.

(9) All residents must hold current certification as providers for advanced cardiac life support (ACLS).

C. Program Objectives

1. An accredited program in anesthesiology must provide education, training, and experience in an atmosphere of mutual respect between instructor and residents so that residents will be stimulated and prepared to apply acquired knowledge and talents independently. The program must provide an environment that promotes the acquisition of the knowledge, skills, clinical judgment, and attitudes essential to the practice of anesthesiology.

2. In addition to clinical skills, the program should emphasize interpersonal skills, effective communication, and professionalism. The residency program must work toward ensuring that its residents, by the time they graduate, assume responsibility and act responsibly and with integrity; demonstrate a commitment to excellence and ethical principles of clinical care, including confidentiality of patient information, informed consent, and business practices; demonstrate respect and regard for the needs of patients and society that supersede self-interest; and work effectively as members of a health-care team or other professional group. Further, residents are expected to create and sustain a therapeutic relationship with patients, engage in active listening, provide information using appropriate language, ask clear questions, provide an opportunity for comments and questions, and demonstrate sensitivity and responsiveness to cultural differences, including awareness of their own and their patients’ cultural perspectives.

3. These objectives can be achieved only when the program leadership, faculty, supporting staff, and administration demonstrate a commitment to the educational program and provide appropriate resources and facilities. Service commitments must not compromise the achievement of educational goals and objectives.
I. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

1. The institution sponsoring an accredited program in anesthesiology must also sponsor or be affiliated with ACGME-approved residencies in at least the specialties of general surgery and internal medicine.

B. Participating Sites

1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

   The PLA should:

   a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

   b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

   c) specify the duration and content of the educational experience; and,

   d) state the policies and procedures that will govern resident education during the assignment.

2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data
A participating site may be either integrated or non-integrated with the parent institution:

a) An integrated site must formally acknowledge the authority of the core program director over the educational program in that hospital, including the appointments of all faculty and all residents. Integrated sites should be in geographic proximity to the parent institution to allow all residents to attend joint conferences. If a site is not in geographic proximity and joint conferences cannot be held, an equivalent educational program in the integrated site must be fully established and documented. Rotations to integrated sites are not limited in duration. It is expected, however, that the majority of the program will be provided in the parent institution. Prior approval of the Review Committee must be obtained for participation of a site on an integrated basis, regardless of the duration of the rotation.

b) A non-integrated site is one that is related to the core program for the purpose of providing limited rotations that complement the experience available in the parent institution. Assignments at non-integrated sites must be made for educational purposes and not to fulfill service needs. Rotations to non-integrated sites may be no more than a maximum of 12 months during the three years of clinical anesthesia. Prior approval of the Review Committee must be obtained if the duration of a rotation at a site will exceed six months.

II. Program Personnel and Resources

A. Program Director

1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

a) When the program director is not the department chair, the department chair must be an anesthesiologist who also meets the qualification criteria found below in III.A.3.a)-e).
b) Frequent changes in leadership or long periods of temporary leadership may adversely affect an educational program and may present serious cause for concern. The Review Committee may initiate an inspection of the program in conjunction with this change when it deems it necessary to ensure continuing quality.

2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

3. Qualifications of the program director must include:

   a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

   b) current certification in the specialty by the American Board of Anesthesiology, or specialty qualifications that are acceptable to the Review Committee; and,

   c) current medical licensure and appropriate medical staff appointment.

   d) licensure to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)

   e) faculty experience, leadership, organizational and administrative qualifications, and the ability to function effectively within an institutional governance. The program director must have significant academic achievements in anesthesiology, such as publications, the development of educational programs, or the conduct of research.

4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

   a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

   b) approve a local director at each participating site who is accountable for resident education;
c) approve the selection of program faculty as appropriate;

d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e) monitor resident supervision at all participating sites;

f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

g) provide each resident with documented semiannual evaluation of performance with feedback;

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of residency education for all residents, including those who leave the program prior to completion;

j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

   (1) distribute these policies and procedures to the residents and faculty;

   (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

   (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

   (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities
are unusually difficult or prolonged;

II.A.4. I) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

(1) all applications for ACGME accreditation of new programs;

(2) changes in resident complement;

(3) major changes in program structure or length of training;

(4) progress reports requested by the Review Committee;

(5) responses to all proposed adverse actions;

(6) requests for increases or any change to resident duty hours;

(7) voluntary withdrawals of ACGME-accredited programs;

(8) requests for appeal of an adverse action;

(9) appeal presentations to a Board of Appeal or the ACGME; and,

(10) proposals to ACGME for approval of innovative educational approaches.

o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
(1) program citations, and/or

(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

p) confirm that all residents completing the program have met the requirements of the 48-month continuum, i.e., the Clinical Base Year and the 36-month anesthesiology residency;

q) regularly review the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee;

r) ensure that the residency program has a written policy and an educational program regarding substance abuse as it relates to physician well-being that specifically address the needs of anesthesiology;

s) require residents to maintain an electronic record of their clinical experience. The program director or faculty must review the record on a regular basis. It must be submitted annually to the Review Committee office in accordance with the format and the due date specified by the Review Committee. The logs must be reviewed for accuracy and completeness before they are submitted to the Review Committee; and,

t) have the means for monitoring the appropriate distribution of cases among the residents.

B. Faculty

1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and
b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

2. The physician faculty must have current certification in the specialty by the American Board of Anesthesiology, or possess qualifications acceptable to the Review Committee.

   a) The number of faculty must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. In the clinical anesthesia setting, faculty members should not direct anesthesia at more than two anesthetizing locations simultaneously.

   b) Faculty who are not ABA-certified should be in the process of obtaining certification.

3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

   a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

   b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

      (1) peer-reviewed funding;

      (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

      (3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

      (4) participation in national committees or educational organizations.
All above scholarship components must be present in the program.

Il.B.5. c) Faculty should encourage and support residents in scholarly activities.

6. The faculty should have varying interests, capabilities, and backgrounds, and must include individuals who have specialized expertise in the subspecialties of anesthesiology, which includes but is not limited to critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine. Didactic and clinical teaching must be provided by faculty with documented interests and expertise in the subspecialty involved. Fellowship training, several years of practice (primarily within a subspecialty), and membership and active participation in national organizations related to the subspecialty may signify expertise.

7. Teaching by residents of medical students and junior residents represents a valid learning experience. The use of a resident as an instructor of junior residents, however, must not substitute for experienced faculty.

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

1. Space and Equipment

There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for teaching staff, diagnostic and therapeutic facilities, laboratory facilities, and computer support. The institution must provide appropriate on-call facilities for male and female residents and faculty.
E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of residents appointed to the program.

1. General issues considered by the Review Committee include the adequacy of resources for resident education such as volume and variety of patients and related clinical material available for education, faculty-resident ratio, institutional funding and support of education, the quality of faculty teaching, and scholarship. Specific criteria evaluated when establishing numbers of residents for programs include:

   a) ABA certification rate of program graduates during the most recent applicable five-year period;

   b) Current accreditation status and duration of review cycle;

   c) Most recent accreditation citations, especially any relating to adequacy of clinical experience and/or faculty coverage; and,

   d) Clinical volumes demonstrating that there will be sufficient experience for all residents.

2. Appointment of a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2 and CA-3 years is required. Any proposed increase in the number of residents must receive prior approval by the Review Committee.
III.  Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

1. The integration of nonphysician personnel into a department with an accredited program in anesthesiology will not influence the accreditation of such a program unless it becomes evident that such personnel interfere with the training of resident physicians. Interference may result from dilution of faculty effort, dilution of the available teaching experience, or downgrading of didactic material. Clinical instruction of residents by nonphysician personnel is inappropriate, as is excessive supervision of such personnel by resident staff. Additional necessary professional, technical, and clerical personnel must be provided to support the program.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;
3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

a) Patient Care

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

(1) must have a wide spectrum of disease processes and surgical procedures available within the program to provide each resident with a broad exposure to different types of anesthetic management within the anesthesiology residency program. The following list represents the minimum clinical experience that should be obtained by each resident in the program. Care should be provided for:

(a) 40 patients undergoing vaginal delivery. There must be evidence of direct resident involvement in cases involving high-risk obstetrics;

(b) 20 patients undergoing cesarean sections;

(c) 100 patients less than 12 years of age undergoing surgery or other procedures requiring anesthetics. Within this patient group, 20 children must be less than three years of age, including five less than three months of age;

(d) 20 patients undergoing cardiac surgery. The majority of these cardiac procedures must involve the use of cardiopulmonary bypass;
20 patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery. Excluded from this category is surgery for vascular access or repair of vascular access;

20 patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures;

20 patients undergoing intracerebral procedures. These patients include those undergoing intracerebral endovascular procedures. However, the majority of these twenty procedures must involve an open cranium;

40 patients undergoing surgical procedures, including cesarean sections, in whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for perioperative analgesia. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;

20 patients undergoing procedures for complex, life-threatening injuries. Examples of these injuries include trauma associated with car crashes, falls from high places, penetrating wounds, industrial and farm accidents, and assaults. Burns covering more than 20% of body surface area also are included in this category;

40 patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;

40 patients undergoing surgical procedures in whom peripheral nerve blocks are used as part
of the anesthetic technique or perioperative analgesic management;

(l) 20 new patients who are evaluated for management of acute, chronic, or cancer-related pain disorders. Residents should have familiarity with the breadth of pain management including clinical experience with interventional pain procedures;

(m) Patients with acute postoperative pain. There must be documented involvement in the management of acute postoperative pain, including familiarity with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities;

(n) Patients scheduled for evaluation prior to elective surgical procedures. There must be documented involvement for at least four weeks in preoperative medicine;

(o) Patients who require specialized techniques for their perioperative care. There must be significant experience with a broad spectrum of airway management techniques (e.g., performance of fiberoptic intubation and lung isolation techniques such as double lumen endotracheal tube placement and endobronchial blockers). Residents also should have significant experience with central vein and pulmonary artery catheter placement and the use of transesophageal echocardiography and evoked potentials. The resident must either personally participate in cases in which EEG or processed EEG monitoring is actively used as part of the procedure or have adequate didactic instruction to ensure familiarity with EEG use and interpretation. Bispectral index use and other similar interpolated modalities are not sufficient to satisfy this requirement;

(p) Patients immediately after anesthesia. There must be a postanesthesia care experience of 0.5 month involving direct care of patients in
the postanesthesia-care unit and responsibilities for management of pain, hemodynamic changes, and emergencies related to the postanesthesia-care unit. The Review Committee expects resident clinical responsibilities in the postoperative care unit to be limited to the care of postoperative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. Designated faculty must be readily and consistently available for consultation and teaching.

(q) Critically ill patients. There must be a minimum of four months of critical care medicine distributed throughout the curriculum in order to provide progressive responsibility to trainees in the later stages of the curriculum. No more than two months of critical care medicine will be credited for training that occurs before the CA-1 year. Each critical care medicine rotation should be at least one month in duration, with progressive patient care responsibility in advanced rotations. Overall, this training must take place in units providing care for both men and women in which the majority of patients have multisystem disease. The postanesthesia-care unit experience does not satisfy this requirement. Anesthesia residents must actively participate in all patient care activities and as a fully integrated member of the critical care team. During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically ill patients and the educational activities of the residents.

(r) Patients undergoing diagnostic or therapeutic procedures outside of the surgical suites. There must be appropriate didactic instruction and sufficient clinical experience in managing the specific needs of patients undergoing these procedures.
b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

(1) should have didactic instruction that encompasses clinical anesthesiology and related areas of basic science, as well as pertinent topics from other medical and surgical disciplines. Didactic presentations related to the specific issues noted in section IV.A.5.b) (Medical Knowledge) are required. Practice management should be included in the curriculum, and should address issues such as operating room management, types of practice, job acquisition, financial planning, contract negotiations, billing arrangements, professional liability, and legislative and regulatory issues. The material covered in the didactic program should demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held teaching conferences. The number and types of such conferences may vary among programs, but there must be evidence of regular faculty participation. The program director should also seek to enrich the program by providing lectures and contact with faculty from other disciplines and other institutions;

(2) must have appropriate didactic instruction and sufficient clinical experience in managing problems of the geriatric population; and,

(3) must have appropriate didactic instruction and sufficient clinical experience in managing the specific needs of the ambulatory surgical patient.
c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;
(2) set learning and improvement goals;
(3) identify and perform appropriate learning activities;
(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
(5) incorporate formative evaluation feedback into daily practice;
(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
(7) use information technology to optimize learning; and,
(8) participate in the education of patients, families, students, residents and other health professionals.

d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

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(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

(2) communicate effectively with physicians, other health professionals, and health related agencies;

(3) work effectively as a member or leader of a health care team or other professional group;

(4) act in a consultative role to other physicians and health professionals; and,

(5) maintain comprehensive, timely, and legible medical records, if applicable.

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;

(2) responsiveness to patient needs that supersedes self-interest;

(3) respect for patient privacy and autonomy;

(4) accountability to patients, society and the profession; and,

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
work effectively in various health care delivery settings and systems relevant to their clinical specialty;

(2) coordinate patient care within the health care system relevant to their clinical specialty;

(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

(4) advocate for quality patient care and optimal patient care systems;

(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

(6) participate in identifying system errors and implementing potential systems solutions.

B. Residents’ Scholarly Activities

1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

2. Residents should participate in scholarly activity.

3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

4. Each resident must complete an academic assignment. This assignment usually occurs during the final 24 months of training, but it may, at the program director’s discretion, occur earlier. Academic projects may include grand rounds presentations, preparation and publication of review articles, book chapters, manuals for teaching or clinical practice, or similar academic activities. Alternatively, a resident may elect to develop and perform or participate in one or more clinical or laboratory investigations. The Review Committee expects that the outcomes of resident investigations will be suitable for presentation at local, regional, or national scientific meetings and that many will result in peer-
reviewed abstracts or manuscripts. A faculty supervisor must be in charge of each project and investigation.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

b) The program must:

(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

(3) document progressive resident performance improvement appropriate to educational level; and,

(4) provide each resident with documented semiannual evaluation of performance with feedback.

c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
V.A.2. 

a) document the resident’s performance during the final period of education, and

b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

B. Faculty Evaluation

1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

   a) resident performance;

   b) faculty development;

   c) graduate performance, including performance of program graduates on the certification examination; and,

   d) program quality. Specifically:

      (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

      (2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.

2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance.
in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C. 3. As part of the overall evaluation of the program, the Review Committee will take into consideration the information provided by the ABA regarding resident performance on the certifying examinations over the most recent five-year period. The Review Committee will also take into account noticeable improvements or declines during the period considered. Program graduates should take the certifying examination, and at least 70% of the program graduates should become certified.

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

3. Didactic and clinical education must have priority in the allotment of residents’ time and energy.

4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

1. Supervision shall not vary substantially with the time of day or day of the week. In the clinical setting, faculty members should not direct anesthesia at more than two anesthetizing locations simultaneously.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to
prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

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

2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

   a) The Review Committee will not consider requests for a rest period of less than 10 hours.

E. On-call Activities

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

   a) During the six additional hours, residents may not administer anesthesia for a new operative case or manage new admissions to the intensive care unit.

3. No new patients may be accepted after 24 hours of continuous duty.

   a) A new patient is defined as any patient for whom the
resident has not previously provided care.

4. **At-home call (or pager call)**

   a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

   b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

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

5. On-call activities present the resident with the challenges of providing care outside regular duty hours. Therefore, on-call activities, including those that occur throughout the night, and on weekends and holidays, are necessary components of the education of all residents.

F. **Moonlighting**

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

G. **Duty Hours Exceptions**

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

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

3. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.
4. The RRC for Anesthesiology will not consider requests for an exception to the limit to 80 hours per week, averaged monthly.
VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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