TABLE OF CONTENTS

I. GENERAL INFORMATION .................................................................................................. 2

II. CALL SCHEDULES AND RESPONSIBILITIES ............................................................... 20

III. DIDACTIC PROGRAM ................................................................................................. 27

IV. EVALUATION/EXAMINATION AND PROMOTION PROCESS ................................. 33

V. ABSENCE FROM TRAINING - VACATION AND APPROVED CONFERENCES .......... 45

VI. PROFESSIONAL AFFILIATIONS ................................................................................. 49

VII. GOALS FOR RESIDENCY TRAINING IN ANESTHESIOLOGY ................................. 52

VIII. DEPARTMENT AND INSTITUTIONAL POLICIES .................................................... 60

   A. Policy on Duty Hours/Monitoring Fatigue and Stress ............................................. 61
   B. Policy on Controlled Substances .......................................................................... 63
   C. Policy on Supervision ........................................................................................... 67
   D. Policy on Entry Requirements and Selection Criteria ......................................... 69
   E. Policy on Sexual Harassment – University of Colorado Denver ......................... 71
GENERAL INFORMATION
A. **EDUCATIONAL FUND**

Travel/Educational Fund (books, journals, conferences)

Department of Anesthesiology provides: $2000/residency
GME provides $150/year

Society Memberships:
- American Society of Anesthesiologists Membership $25/year (includes the journal *Anesthesiology*)
- Colorado Society of Anesthesiology Membership $35/year
- International Anesthesia Research Society Membership $75/year (includes the journal *Anesthesia and Analgesia*)

In addition residents receive the book:
*Manual of Clinical Anesthesiology* by Chu & Fuller

*Your book and travel funds are given to you by the Department of Anesthesiology. Even though you are allocated money for travel and books, please understand that there are guidelines that must be followed to use these funds. You are not required to use the allotted money. Unused money is returned to the department’s general fund. These funds may not be used for computers, lap tops, I-phones or hardware of any kind.*

The deadline for using your book and travel fund is **May 30th of your graduating year.** Please submit all receipts for books and travel prior to that date.

*How to Order and Get Reimbursed for Books:*

1. The preferred method: To order a book(s), send an email to your Program Coordinator indicating which book(s) you want to order. She will order the book(s) for you. The cost of the book is automatically subtracted from your educational fund.
2. If you would prefer to purchase books on your own, give your itemized receipt (not the credit card statement) to your Program Coordinator and she will process the reimbursement.

*How to Schedule and Get Reimbursed for Travel:*

Conference Registration Fees:
Many conferences have online registration. To use this method, you need to register for the course from the computers in the Anesthesiology Library (AO1 Building). The Program Coordinator can pay the fee with a department credit card. If the conference does not have online registration, complete the registration and give it to the Program Coordinator who will fax the form along with payment.

*Airline Tickets and Hotel:*
You are encouraged to book airline tickets through the University of Colorado’s Travel and Expense System.

1. Log on to [https://my.cu.edu](https://my.cu.edu). Your username and password is the same as your email’s login information.
2. Click on “My Tools”
3. Click on “Open CU Travel and Expense System”
4. Complete your information under “Trip Search”
5. You will need to pay for your hotel first, but will be reimbursed after the trip.
6. Bring a copy of your conference brochure, all receipts, including travel itinerary, to your Program Coordinator for reimbursement.

*Mileage:*
If you choose to drive to a conference that is out of state, you are either reimbursed the mileage rate (.50/mile) or the cost of round trip airfare, whichever is lower. Driving to an out-of-state conference is highly discouraged; you are using your own vehicle, your own insurance and if you are in an accident, you will receive no compensation from the Department of Anesthesiology or from the State of Colorado for injury or damages to person or vehicle.

*How to Submit Receipts for Reimbursement:*
1. You must submit original receipts. You must also provide a copy of the meeting flyer. You do not need to save meal receipts. You will be paid a daily meal per diem, the amount of which depends on the city you are visiting. You receive 75% of the total meal per diem on the first and last day of travel and a full per diem for the days in between.
2. Your Program Coordinator will submit your expenses through the University of Colorado’s online finance system. Once the reimbursement is submitted, you will receive an email from AutoNotification@concursolutions.com asking you to log on to the system to certify and submit the reimbursement. (Instructions below).
3. Your reimbursement is deposited directly into your checking account, usually within 3 days of your approval.

*How to Approve Reimbursements:*
First you will receive an email from AutoNotification@concursolutions.com entitled “Report Read for Submission”
1. Log on to MyCU - Use the link in the email or open your browser to the my.CU portal (my.cu.edu). Log in using the same credentials used to access your campus email. Select the MY.TOOLS tab and click the Open CU Travel and Expense System.
2. Review the Expense Report – In the Active Work section, select the appropriate report. On the Expense List page, review the transactions included in the report.
3. Certify and Submit Expense Report – Click the Submit Report button. A pink window will pop up. Type an asterisk (Shift 8) in the box. Two names will appear in the box. Click on Jeanette Leeser. Then click Submit Report.
4. Log out.

**B. COLORADO PHYSICIAN HEALTH PROGRAM (CPHP)**

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

The Colorado Physician Health Program ([www.CPHP.org](http://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 clients are not identified to the Board of Medical Examiners.

C. **CONTROLLED SUBSTANCES POLICY AT UCH**

The UCH Anesthesia Operating Room Pharmacy Controlled Substances Policy and Procedure is included in the Policies section of this manual (see page 63). In addition, The Impairment Physician Policy can be found on page 73 of the 2012-2013 Graduate Medical Education Manual.

D. **HEALTH, DENTAL, LIFE AND DISABILITY INSURANCE**

Please refer to the 2012-2013 Graduate Medical Education Manual, pages 13-14 for a summary of your benefits.

E. **E-MAIL ACCOUNTS**

Residents are provided a University e-mail address, which you are encouraged to use. Instructions on how to access your e-mail is provided in your orientation packet.

F. **MEAL TICKETS**

See the 2012 Hospital Meal Policy on page 7.

G. **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.
H. **Case Documentation**

Residents are required to document their cases and procedures through the ACGME web-based documentation program (www.acgme.org). Residents are encouraged to enter cases daily to avoid getting behind. At the end of your residency a Resident Training Report (a record of your O.R. cases) is submitted to the ACGME. Instructions on how to access this program will be provided at orientation. See pages 8-13 for a sample documentation form.

I. **Moonlighting Policy**

The Department of Anesthesiology adheres to the Graduate Medical Education’s policy on Moonlighting. Please review pages 68-71 of the GME Housestaff Manual.

J. **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 36 and 61 of the 2012-2013 of the Graduate Medical Education Manual.

K. **Accreditation Council for Graduate Medical Education (ACGME)**

The ACGME Program Requirements for Graduate Medical Education in Anesthesiology are listed on their website. To access this document, log on to www.acgme.org; click on Review Committees; click on Anesthesiology; Click on Program Requirements; then click on the PDF link for Anesthesiology.

L. **Department of Anesthesiology Faculty and Residents**

A list of our program faculty and residents/fellows can be found on pages 14-19. In addition, a roster of departmental employees is listed on the Intranet (http://virtue.ucdenver.edu/) under “Directory”.

M. **Emergency Contact Information**

It is essential that we have current information on file for you in case of an emergency. Please inform your Program Coordinator –{ Kay Oliver, 303-724-1758 or kay.oliver@ucdenver.edu} of address or phone number changes and the person to contact in case of an emergency.
ANESTHESIOLOGY RESIDENTS/FELLOWS 2012-2013

Cardiothoracic Anesthesiology Fellows (PGY 5)

Kevin Arnold, MD – University of Tennessee
Barbara Wilkey, MD – University of Florida

PGY 4 Jen Appelman, MD – University of Colorado
   Allison Losey, MD – University of Texas, Houston
   Jonathan Mayles, MD – University of Colorado
   Tony Oliva, MD – University of Colorado
   James Ryan, MD – Medical University of South Carolina
   Marshall Stafford, MD – University of Texas, Houston
   Carrie Stair, MD – University of Nebraska
   Andrew Sullivan, MD – Indiana University
   Sarena Teng, MD – University of South Alabama
   James Thomas, MD – University of Tennessee
   Matthew Uhlenkott, MD – University of Washington
   Amanda Wallace, MD – Florida State University

PGY 3 David Abts, MD – Northwestern University
   Zach Bryan, MD – Ohio State University
   Meghan Furlong, MD – University of Wisconsin
   Gina Haussner, MD – University of Colorado
   Shin Kamaya, MD – University of Utah
   Chase Kelly, MD – University of Colorado
   Sarah Milliken, MD – University of Colorado
   Joseph Peetz, DO – Kansas City University of Medicine
   Matthew Rowan, MD – Medical College of Wisconsin
   Anne Rustemeyer, DO – Chicago College of Osteopathic Medicine
   Matthew Victor, MD – Ohio State University
   Sukhi Walha, MD – Virginia Commonwealth University
   Jessica Yanosik, MD – Ohio State University

PGY 2 Grant Armouro, MD – University of Colorado
   Timothy Casias, MD – University of Colorado
   Samuel Gilliland, MD – University of Kansas, Kansas City
   Neena Gupta, MD – Virginia Commonwealth University
   Ross Hanson, MD – University of Rochester
   Brian Johnson, DO – Western University of Health Sciences
   Sarah Killeen, MD – University of South Alabama
   Mike Kim, DO – Touro University
   Emily McQuaid-Hanson, MD – University of Rochester
   Neil Mehta, MD – University of Chicago
   Carolyn Mohr, MD – East Carolina University
   Benjamin Snyder, MD – University of Colorado
   Mario Villasenor, MD – University of Texas – San Antonio
   Matthew Wyatt, MD – University of Colorado
PGY 1  Kerry Bigelow, DO – Rocky Vista University College of Osteopathic Medicine
   Ann-Kathrin Riegel, MD – University ofTuebingen, Germany
   Justin Schulte, MD – University of South Dakota
   Scott Vogel, DO – Oklahoma State University College of Osteopathic Medicine
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<thead>
<tr>
<th>NAME</th>
<th>SPECIALTY</th>
<th>HOSPITAL</th>
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<tbody>
<tr>
<td>Heidi Aasheim, MD</td>
<td>Pediatric Anesthesia</td>
<td>Children’s Hospital Colorado</td>
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<tr>
<td>Henri Acosta, MD</td>
<td>General O. R. Anesthesia</td>
<td>VA Medical Center</td>
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<tr>
<td>Rita Agarwal, MD</td>
<td>Pediatric Anesthesia, Pain Management</td>
<td>Children’s Hospital Colorado</td>
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<tr>
<td>John Armstrong, MD</td>
<td>General Anesthesia, Regional Anesthesia, Liver Transplant</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Fareed Azam, MD</td>
<td>Critical Care Medicine, General Anesthesia</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Daniel Beck, MD</td>
<td>General O.R. Anesthesia</td>
<td>VA Medical Center</td>
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<tr>
<td>Bethany Benish, MD</td>
<td>Pediatric Anesthesia</td>
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<td>Alan Bielsky, MD</td>
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<td>Allison Brainard, MD</td>
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<td>Jason Brainard, MD</td>
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<td>Adria Boucharel, MD</td>
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<td>Megan Brockel, MD</td>
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<td>Melissa Brooks, MD</td>
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<td>Brenda Bucklin, MD</td>
<td>Obstetric Anesthesia</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Mark Chandler, MD</td>
<td>Trauma Anesthesia</td>
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<td>Debnath Chatterjee, MD</td>
<td>Pediatric Anesthesia</td>
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<tr>
<td>Sara Cheng, MD</td>
<td>Transplant; Clinical Research</td>
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<td>Charles Carter, MD</td>
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<td>Randall Clark, MD</td>
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<td>Mindy Cohen, MD</td>
<td>Pediatric Anesthesia</td>
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<td>Patty Coughlin, MD</td>
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<td>Tobias Eckle, M.D.</td>
<td>Clinical Research</td>
<td>University of Colorado Hospital</td>
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<td>Holger Eltzschig, MD, PhD</td>
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<td>Debra Faulk, MD</td>
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<td>Ana Fernandez, MD</td>
<td>General O.R. Anesthesia</td>
<td>University of Colorado Hospital</td>
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<td>Matthew Fiegel, MD</td>
<td>Regional Anesthesia; Transplant Anesthesia</td>
<td>University of Colorado Hospital</td>
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<td>Jacob Friedman, MD</td>
<td>General O.R. Anesthesia</td>
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<td>Peter Fritz, MD</td>
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<td>Joy Hawkins, MD</td>
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<td>Adrian Hendrickse, MD</td>
<td>Simulation; General O.R. Anesthesia</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Thomas Henthorn, MD</td>
<td>Clinical Pharmacology, Research</td>
<td>University of Colorado Hospital</td>
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<tr>
<td>Michelle Herren, MD</td>
<td>Pediatric Anesthesia, Trauma Anesthesia</td>
<td>Denver Health Medical Center</td>
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<td>Jack Humphrey, DO</td>
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<td>Dominique Schiffer, MD</td>
<td>Ambulatory Anesthesia; Regional Anesthesia</td>
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<td>Benjamin Scott, MD</td>
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<td>University of Colorado Hospital</td>
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<td>Jeffrey Shifrin, MD</td>
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<td>Marina Shindell, DO</td>
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<tr>
<td>Tod Sloan, MD</td>
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<td>Robin Slover, MD</td>
<td>Pain Management</td>
<td>Children's Hospital Colorado</td>
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<tr>
<td>Scott Stenquist, MD</td>
<td>Pediatric Anesthesia</td>
<td>Children's Hospital Colorado</td>
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<tr>
<td>Quinn Stevens, MD</td>
<td>General O.R. Anesthesia</td>
<td>VA Medical Center</td>
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<tr>
<td>Breandon Sullivan, MD</td>
<td>General O.R. Anesthesia</td>
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<td>Judit Szolnoki, MD</td>
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<td>Gee Mei Tan, MD</td>
<td>Simulation; Pediatric Anesthesia</td>
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<td>Mark Twite, MD</td>
<td>Pediatric Anesthesia</td>
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<td>Ronald Valdivieso, MD</td>
<td>Acute Pain Management</td>
<td>Denver Health Medical Center</td>
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<td>Brett Wallen, MD</td>
<td>Pediatric Anesthesia</td>
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<td>Jennifer Wallen, MD</td>
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<td>Kim Weigers, MD</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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<td>Cristina Wood, MD</td>
<td>OB Anesthesia</td>
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<td>Jennifer Zieg, MD</td>
<td>Pediatric Anesthesia</td>
<td>Children's Hospital Colorado</td>
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CALL SCHEDULES AND RESPONSIBILITIES
A. CALL SCHEDULE PREPARATION

Call schedules for all hospitals are prepared during the prior months by the chief residents. All call requests should be submitted via email to the Chief Residents when requests are called for by the chiefs for that specified 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. All inpatients should be seen and consented the night BEFORE surgery.

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. 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 Kay Oliver 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 7pm 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 $400 for being on pager call for the C2 shift and $50/hour for each additional hour past the first 8 hours worked. After 7pm 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. 12 hour Resident - (Weekdays). This resident is from the general O.R. pool 7a-7p. 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 12 hour 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 add-ons will be made between the previous 1st call resident and the resident taking over the case immediately before morning conference when appropriate.

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 1, CA 2, or CA 3) – Two residents are responsible for all patients in the SICU, to be divided among him/herself. The third anesthesia resident will be designated as the CT resident, who will share responsibility for the CT patients in the ICU with a surgical resident. Call in the ICU involves covering all general and CT patients in the ICU, and is shared with two surgery residents. Call is every fifth 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. As the AOP resident, you are responsible for staying until all cases are completed for the day, this includes reliving CRNAs.

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 patients with epidural catheters. You must be within 30 minutes of the hospital when on call.

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.

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. **Children's Hospital Colorado**

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 3 p.m.-7 a.m. There are C2 late shifts that start at 7a and continue until there is only one room running. As a C2 this shift varies widely, you can be finished at 5p or stay until midnight or later as needed. These weekend call shifts are provided a stipend at a rate of $200 for being on home call and $50 hour beyond 4 hours of time in the hospital. The 10 hour rule applies, you will not return to the hospital until 10 hours have passed. Specifics of the rotation will be provided in a packet given to you at your initial orientation.

G. **Anschutz Outpatient Pavilion (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 CAI 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, typically not more than once per month.
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 32. Grand Rounds are held on Monday mornings. Research Conferences are held on Monday afternoons. Tuesday afternoons are reserved for Clinical Case Conferences, Senior Lectures, Resident/Chair Forum followed by Journal Club, or Practice Sessions for the ABA Oral or Written Examinations. ITE Lectures are held on Thursday mornings.

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 UCH 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, Alison Brainard, Christopher Lace, 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 Kathy Riggs 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 on Tuesday afternoons 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; Allison Losey (303-266-1012) or Jonathan Mayles (303-266-4774). Topics can also be suggested by email to any of these individuals.

I. **Daily Chapter Reviews**

A chapter will be assigned daily from The Manual of Clinical Anesthesiology. 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 COLORADO**

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. 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:**
Chu, Fuller: *Manual of Clinical Anesthesiology* (Provided by the department)  
Morgan, Mikhail, Murray: *Clinical Anesthesiology*  
Longnecker, DE, Brown DL, Newman MF: *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.*
### DIDACTIC PROGRAM
**DEPARTMENT OF ANESTHESIOLOGY**  
**UNIVERSITY OF COLORADO SCHOOL OF MEDICINE**

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<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</td>
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<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 /Senior Lectures (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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<td>6:30-7:00 a.m.</td>
<td>Cardiac Lecture Series (Every Friday – attendance is <strong>mandatory</strong> 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.
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. Scott Markowitz (Children’s)
Dr. Thomas Henthorn        Dr. Glenn Gravlee (UCH)
Dr. Leslie Jameson          Dr. Jake Friedman (VA)
Dr. Fadi Nasrallah (UCH)    Dr. Fareed Azam (ICU)
Dr. Jack Humphrey (DHHA)    Dr. Randall Clark (Children’s)
Dr. Jason Krutsch (Pain Medicine)    Dr. Ferenc Puskas (Cardiothoracic Anesthesia)
Dr. Christopher Lace (UCH)   Chief Residents

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**

**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, MedHub. See pages 38-40. Residents can view their evaluations on line at any time by logging on to [www.ucdenverMedHub.com](http://www.ucdenverMedHub.com). 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 can view their evaluations on line but cannot see which resident completed the evaluation.

D. **Multi-Source Evaluation**

Residents are evaluated by nursing personnel from the operating room/PACU, the critical care unit, labor and delivery and the pain medicine clinic. These evaluations are done on line through MedHub. A sample evaluation form can be found on page 41.

E. **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, MedHub. A sample evaluation form can be found on page 42.

F. **Program Evaluation**

Once a year in May, you will be asked to complete a program evaluation/program survey. This evaluation/survey is completed through Survey Monkey, an online survey tool. Samples of the form can be found on pages 43-44.

G. **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 $950 application fee to take the written Boards. Application to the Written Boards is a continuing process. You can register online at www.theaba.org. We encourage you to register during your last year of residency. The fee of $950 goes up to $1425 after July 1st and then up to $1900 after November 1st.

3. Anesthesia Knowledge Test (AKT)
CA I (PGY 2) 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 (PGY 3) residents will take an AKT exam after 24 months of anesthesia training.

4. Mock Oral Examinations
Mock oral exams are offered twice a year, in November and May, 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 on an as needed basis.

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.
ABSENCE FROM TRAINING - VACATION AND APPROVED CONFERENCES
A. **Absence 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.”

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

**Children’s Hospital Colorado:** 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, CHC 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 a scientific meeting is optional. If ITE < 50%, choice of meeting must be approved by the program director, and a review course will be recommended. The department provides each resident financial support and up to 5 days per year during the 3-year residency period for attendance at scientific meetings. We must provide documentation to the GME office 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.

Suggested conferences:

1. ASA Sponsored Conferences
   The ASA website (www.asahq.org) has a list of meetings that are approved by the department. Go to the main page and click on Calendars for Meetings. The meetings are listed chronologically.

2. Colorado Review of Anesthesiology for Surgicenters and Hospitals (CRASH)
   Every year, the department sponsors CRASH, a national review course, in Vail, Colorado. Visit the CRASH website (www.cucrash.com) for detailed information about this conference. Only 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 WARC conference is held at a different western anesthesiology program each year.
C. **FAMILY/MEDICAL LEAVE**

Please refer to the Policy on Family/Medical Leave and Leave of Absence in the GME 2012 - 2013 Housestaff Manual on page 64.

D. **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.

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.
PROFESSIONAL AFFILIATIONS
A. **AMERICAN BOARD OF ANESTHESIOLOGY (www.theaba.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.

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 SCHOOL OF MEDICINE

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 early in the academic year as well as several times throughout the year.

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

END OF CA1 YEAR

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 discharge)
• 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.
GOALS FOR RESIDENCY TRAINING IN ANESTHESIOLOGY

CLINICAL ANESTHESIA 2 (PGY 3)

DEPARTMENT OF ANESTHESIOLOGY
UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

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.
GOALS FOR RESIDENCY TRAINING IN ANESTHESIOLOGY
CLINICAL ANESTHESIA 3 (PGY 4)

DEPARTMENT OF ANESTHESIOLOGY
UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

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.
DEPARTMENT OF ANESTHESIOLGY AND 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. For call from home, only the hours spent in the hospital after being called in count toward duty hours.

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.

e. All residents will report duty hour compliance in their end-of-rotation evaluation forms. Residents will all participate in the MedHub program for duty hour compliance. All residents are responsible for reviewing their schedules at the beginning of rotations and checking them for assignments that would cause a duty hour violation. If a problem exists, it must be reported to the program coordinator and to the chief resident of the rotation. If residents discover that daily assigned workloads create a situation where duty hour violations occur, they must take immediate action to correct the situation. They must notify their attending that a potential problem exists. A plan to address the problems must be established at that time which may involve the residents in charge of the service and/or the attending physician responsible for overseeing the service. When necessary, this program’s residency leadership will assist in ensuring that a resolution to the problem is accomplished.

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. Residents are permitted to trade call. All call trades must be done in a fashion that neither resident will violate any of the duty hour standards. All call trades must be reported to the chief residents.

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 during their orientation process. Residents are encouraged to talk to their Program Director if they are experiencing excessive fatigue and sleep deprivation. Residents are responsible for tracking their level of fatigue. If they find that lack of adequate rest is interfering with their ability to provide proper care for patients, the program’s chief resident in charge of the hospital schedule must be contacted to arrange coverage in consultation with the Program Director.
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.
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.

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. We initiated a PGY-1 year in 2010 that includes 9 months of rotations in Internal Medicine, 2 months Emergency Medicine, and 1 month Anesthesiology. Only 4 out of 12 residents in each class come through our PGY-1 year.

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.

<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>
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<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>
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</table>

<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>

Rev. 4/2011
ENTRY REQUIREMENTS

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

The Department of Anesthesiology has both advanced and categorical positions. Therefore applicants may need to complete a PGY 1 year prior to entering the program. The PGY 1 year must be in direct patient care in accordance with RRC specifications (review the ACGME website for more information (www.acgme.org).

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.

SELECTION CRITERIA

1. We look for ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty.

2. To determine the appropriate level of education for individuals wishing to transfer from another training program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to acceptance into the program.
3. We will review and select applicants in a manner consistent with provisions of equal opportunity employment and will not discriminate with regard to sex, race, age, religion, color, national origin, disability or any other applicable legally protected status.

4. We participate in the National Resident Matching Program (NRMP).

5. The application deadline, except for the MSPE letter, is October 1st. Interviews are scheduled from November through January.
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.webb@uch.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.

The Associate Dean in the GME Office is also a resource for assistance in resolving complaints of sexual harassment. The supervisor who receives the complaint is obligated to report it to the UCD Sexual Harassment Officer. The Resident should also inform the UCD Sexual Harassment Officer.

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