ANESTHESIA HOUSESTAFF MANUAL

Department of Anesthesiology & Perioperative Medicine

July 2016 – June 2017
Residency Program

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GENERAL INFORMATION:

Mission Statement

It is the mission of the Anesthesiology residency at the Medical College of Georgia at Augusta University (AU) to provide education, training, and experience in an atmosphere of mutual respect between instructor and resident so that the resident will be stimulated and prepared to apply his acquired knowledge and talents independently as a certified consultant in the practice of anesthesiology.

Statement of Objectives

The Department of Anesthesiology and Perioperative Medicine (Department) embraces the concept that postgraduate medical education is an integral component of the continuum of medical education. It is the objective of this program to provide education, training, and experience in an atmosphere of mutual respect between instructor and resident so that the resident will be stimulated and prepared to apply his/her acquired knowledge and talents independently in the practice of anesthesiology.

THE BASICS:

You have a mailbox in the Residents lounge. Check it frequently and also keep it cleaned out. Frequently there are things that you need to sign and return to the program coordinators that are time sensitive. Your radiation badge will also be posted in the Residents lounge at the beginning of each month. Please make sure you return your radiation badge to the envelope posted in the Residents lounge when you pick up your new badge.

If there is a problem with scheduling, call, vacations, or anything else please notify your Chief Residents (see below), and your Program Coordinator, Karen McDaniel, by email, office phone and/or cell phone:

Karen:        Cell - 706-284-9154
               Office - 1-4544
               Email - kmcdani5@augusta.edu

Dr. Michael Drinkwater and Dr. Scott Medearis are the Chief Residents:

Mike:         Cell - 803-998-6047
              Pager - 1094
              Email - mdrinkwater@augusta.edu

Scott:        Cell - 720-236-6258
              Pager - 5891
              Email - rmedearis@augusta.edu

In case of an emergency you may also reach the Residency Program Director, Dr. Mary Arthur, via email at marthur@augusta.edu, via office phone at 1-7748, or by cell phone at 706-627-1126.
RESIDENT RESPONSIBILITIES:

Anesthesiology residents are expected to:

1. Develop a personal program of self-study and professional growth with guidance from the teaching staff.
2. Acquire the knowledge, skills, and expertise to be able to meet the standards of the ABA board certification examination upon completion of their residency.
3. Participate in safe and effective patient-sensitive care under supervision, commensurate with their level of advancement and responsibility.
4. Participate fully in the educational activities of the program and, as required, assume responsibility for teaching and supervising students and other residents.
5. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
6. Participate in institutional committees and state and national councils, especially those that relate to patient care review activities.
7. Apply cost containment measures in the provision of patient care.

SELF-STUDY RESPONSIBILITIES:

Residents are responsible for reading about their cases for the following day and completing the reading assignments for the assigned textbook. If a resident has difficulties with subject matter or completion of assignments for any reason, they should contact their advisor, chief resident or program director.

ORIENTATION PERIOD:

The orientation period consists of the first month of CA-1 training. Each new CA-1 resident receives a packet containing learning objectives, competency assessment forms, and deadlines for accomplishing the competencies. Orientation period objectives are related to specific skill sets that form the basis of further education in anesthesia. The didactic conference schedule and faculty teaching are coordinated to facilitate timely achievement of the skill sets and procedure competencies. Competencies are assessed by the resident’s preceptor and through direct observation of the performance of the skills and procedures by an attending Anesthesiologist.

Competency is documented as follows:

1. Structured Observation Competency Assessment Forms: A packet of Competency Assessment forms are provided at the beginning of training. It is the resident’s responsibility to have the preceptor and anesthesiology attending preceptor assess each competency at the required time. The form is completed immediately following performance of the skill or procedure, and is then handed to the Program Coordinator by the end of the deadline date.

2. Resident Procedure Record (RPR): Each resident receives an RPR at the beginning of training. The RPR documents a series of procedures to be completed within the first month of training. It is the resident’s responsibility to record in the RPR each directly supervised procedure, including the supervising physician’s signature, until the required number of supervised procedures have been
documented. The resident must meet the specified deadlines for becoming credentialed in each procedure. The RPR must be turned in to the Program Coordinator when requested and for the final time at the end of the one-month orientation period.

Procedures requiring credentialing and the deadlines for credentialing are listed below. It is the responsibility of the resident to take advantage of opportunities to document procedures. The deadlines for becoming credentialed in each procedure are easily achievable. **Failure to meet the deadlines** will result in assignment of additional clinical time (i.e., late call and/or weekend call) to facilitate achieving credentialing requirements. Assessment forms are located at the end of this handbook.

**WEEK ONE:**

**Day 1:**
- All Day Orientation
- **AKT PRE-TEST**

**Day 2:**
- OR set up
- Sim Center
- IV placement with task trainers
- Intro to Sim Mannequin

**Day 3:**
- Introduction to General Anesthesia
- Induction agents & Basic Pharmacologic Principles

**Day 4:**
- The Anesthesia Machine (will take apart and examine a machine)

**Day 5:**
- Mechanical Ventilation Modes - Simulation

**WEEK TWO:**

**Day 1:**
- OR scavenger hunt
- Thermacor in-service
- Positioning and Nerve Injury
- Pre-anesthesia Evaluations

**Day 2:**
- Intra-op Monitors
- Record Keeping

**Day 3:**
- Medication Safety and Anesthesia Errors - Simulation

**Day 4:**
- Autonomic nervous system
- Neuromuscular blocking drugs
- Reversal Agents
- Choice of anesthetic plans

**Day 5:**
- Anesthesia for Laparoscopic Procedures - Simulation
**WEEK THREE:**

*Day 1:* Common intra-op events and how to manage them – Simulation  
Fluid Management & Blood Transfusion  
Trip to blood bank  

*Day 2:* Practical Keywords & Basics of Acid/Base & Blood Gas Analysis  
Inhalational agents  

*Day 3:* Aline placement with task trainers  
NPO guidelines, Anesthesia for obese patients - Simulation  

*Day 4:* Local Anesthetics  
Spinal/epidural anesthesia  

*Day 5:* Anesthesia for patients with cardiac disease  
When/How to use pressors & anti-hypertensives  
Learn to program a pump  

**WEEK FOUR:**

*Day 1:* Airway workshop #2  
Difficult airway techniques & algorithm  
Pulmonary & Cardiac Physiology  
In-service for fiber optic  

*Day 2:* Tentative Full Day of Simulation – Check offs of skills and common intra-op events, patient handoffs, getting anesthesia consent.  

*Day 3:* CA1 Jeopardy  
Narcotics and non-opioid adjuncts  

*Day 4:* Your Safety in the OR Ethics, Professionalism, Sleep Deprivation, and the Impaired Physician  
Care of the PACU patient  

*Day 5:* AKT POST-TEST  

**Throughout July and August, no later than the first week of August:**

- Emergency airway management [3]  
- Perform elective induction of general anesthesia and tracheal intubation [25]  
- Manage emergence from general anesthesia, including tracheal extubation [25]  
- Perform emergency preanesthetic evaluation [1]  
- Peripheral IV cannulation [3]  
- Maintain (reinject medication) epidural (thoracic or lumbar) anesthesia [3]
RESIDENT DIDACTIC SCHEDULE, 2016–2017:

<table>
<thead>
<tr>
<th>DAY</th>
<th>CONFERENCE</th>
<th>TIME</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Residents Didactic Conference</td>
<td>6:00–7:00 a.m.</td>
<td>Small Auditorium</td>
</tr>
<tr>
<td>Monday</td>
<td>Grand Rounds (including M&amp;M)</td>
<td>7:00–8:00 a.m.</td>
<td>Small Auditorium</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Lecture Series for BASIC exam or Mock Oral prep</td>
<td>6:00–6:45 a.m.</td>
<td>Anesthesiology classroom</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Board Review or Keywords</td>
<td>6:00–6:45 a.m.</td>
<td>Anesthesiology classroom</td>
</tr>
<tr>
<td>Thursday</td>
<td>Pediatric/Chronic Pain Lectures</td>
<td>Varies</td>
<td>CHOG library or Chronic Pain library</td>
</tr>
<tr>
<td>Various days</td>
<td>Surgical ICU Lecture Series for SICU residents</td>
<td>12:00–1:00 p.m.</td>
<td>Small Anesthesia conference room</td>
</tr>
</tbody>
</table>

CONFERENCE ATTENDANCE POLICY:

- Residents should make every effort to attend all the didactic sessions unless on leave, post-call, or serving clinical duties.
- A 65% attendance for didactics is mandatory.

CONFERENCE RESPONSIBILITIES:

- Residents are required to document attendance at each conference. Documentation is via the web-based One45 system as well the “sign-in” sheet provided for every session.
- All resident presentations will be supervised by staff. Conferences may be led by a resident under the direction of faculty.
- All keyword presentations will be by residents. It is the resident’s responsibility to follow his/her assigned presentation. In the event of conflicting schedule it is the resident’s responsibility to either swap assignments with his/her peers or bring it to the attention of the Program Director or supervising attending in a timely manner.
- A nondisclosure and course objectives must be completed prior to the Grand Round presentations. This can be obtained from the Program Coordinator.

DAILY RESPONSIBILITIES:

- Residents are required to arrive in the hospital early enough each day to set up their work area, operating room (OR), or block area before the start of the day. Residents should complete their OR setup and patient interviews by 7:00 a.m.
• In the event of not being assigned to a room, the resident is still expected to be available for clinical duties at 7:00 a.m. and should report to the Clinical Director for the day.

• The expected start times for General OR is 7:30 a.m. and for Cardiac/Thoracic OR is 7:00 a.m. Residents should confirm the start times the day prior.

• Residents are expected to be available for duty until 5:00 p.m. each day or until off duty. Residents must talk with the Clinical Director or on-call attending each day for permission to leave the hospital, unless already advised by another attending anesthesiologist. Permission will be given depending upon the work load.

PRE- AND POST-ANESTHETIC EVALUATIONS:

Pre-anesthesia

• Evaluations are to be made daily prior to administering anesthesia, including weekends, holidays and emergencies, unless time does not allow in the instance of level one cases.

• All outpatients and AM admits will be seen in the Preoperative Clinic but in-patients should be seen by the resident assigned to the case, unless completed by another resident. Residents will discuss all patients with the assigned attending. If the assigned attending is not readily available, then the patient should be discussed with the on-call attending.

• Pre-operative evaluations can be found in Cerner Power Note.

Post-anesthesia

• Post-op evaluations should be done in the Cerner post-op note. There are also paper-based forms in PACU that can be completed in lieu of a note in Cerner.

• Post-anesthesia follow-up on patients will be performed, within 48 hours, by the resident performing the anesthesia or another qualified anesthesia provider. Pre-op residents will perform post-ops on CRNA cases on the morning following surgery. If a resident will be unavailable for 48 hours after surgery, the resident should request that the pre-op team perform the post-op visit. If a significant complication is noted, the pre-op resident will notify the provider for further follow-up.

• If a complication occurs or the patient is transferred to the ICU during/after the anesthetic, then the provider should follow up personally for as long as needed and make the attending anesthesiologist aware of the complication.

ANESTHETIC RECORD:

• All anesthesia records will be recorded on the automated record keeper, CompuRecord. Residents will be required to learn how to use the record keeper during the first week of residency. Manual records will be kept when the record keeper is not available. Knowledge of manual record keeping is also important and should be mastered.

• Charting technique will be taught during the month of July at which time junior residents will be paired with seniors. Both manual and computer documentation will be discussed.

• Certain aspects of the anesthetic record are relatively constant. Examples are the manner in which blood pressure is recorded, symbols for certain manipulations, and certain abbreviations.
• Other aspects are less constant but of equal importance, such as the monitors used, patient position, anesthetic techniques used. These must also be appropriately charted on the anesthetic record. Incomplete or faulty completed records will be returned to the resident for completion.

• Documentation for anesthesia care is important for billing and hospital reimbursement and must be mastered by the prospective successful practitioner.

• **QA and billing are part of the anesthesia record and must be completed.** Repeated incomplete records may be used as an indication for remediation.

• **Complications should be thoroughly and appropriately documented.** If the resident has questions or concerns, he/she should involve the attending anesthesiologist or senior resident to ensure adequate documentation has occurred.

**POST-ANESTHESIA ROUNDS AND RECORDS:**

• The Joint Commission on Accreditation of Hospitals and our own hospital regulations insist on proper completion of patient records. In order for our department and training program to retain its accreditation, it is imperative that notes be placed on the patient's chart by the anesthesiologist reflecting pre-op and PACU care.

• Appropriate post-operative notes should be made in the patients chart about problems relating to anesthetic management. Every attempt should be made to see the patient post-operatively within the first 48 hours.

• A follow-up note should be documented in the Cerner Power Note. Residents will be required to make their own post-op rounds if the patients are still in-house the next day.

**RECOVERY ROOM:**

• Personally evaluate vital signs and general condition of any patient before turning patient over to the Recovery Room nurse.

• Give pertinent instructions concerning the patient to the nurse. Any patient discharged by you must be discharged in person and a note is to be placed on the anesthesia record, recording time, condition of patient and any other pertinent information.

• Always make a written note stating whether there is any evident anesthetic complication noted. This duty can neither be delegated to a medical student nor done over the telephone.

• The resident on PACU rotation should also be given a hand-off regarding the patient.

**CLINICAL COMMITMENTS:**

The Residency Review Committee for Anesthesiology requires clinical experience that is listed on the ACGME website ([www.acgme.org](http://www.acgme.org)) under Program Requirements for Anesthesiology, Section F, Number 1, labeled “Clinical Experience.” This section describes, for each category, the case numbers that our program is required to provide to our residents. These numbers are not required by the RRC for a resident to graduate. They are the recommended numbers that we provide to allow the resident to be proficient in management of all types of cases and procedures.
## RESIDENT ROTATIONS

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>CA-1</th>
<th>CA-2</th>
<th>CA-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASMP</td>
<td>1 month</td>
<td></td>
<td></td>
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<tr>
<td>Preoperative clinic</td>
<td>1 month</td>
<td></td>
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<tr>
<td>General Anesthesia</td>
<td>8-9 months</td>
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<tr>
<td>Neuroanesthesia</td>
<td>0-2 months</td>
<td></td>
<td></td>
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<tr>
<td>SICU</td>
<td>0-2 months</td>
<td></td>
<td></td>
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<tr>
<td>Acute Pain</td>
<td>1 month</td>
<td></td>
<td></td>
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<tr>
<td>CT/Vascular</td>
<td></td>
<td>2 months</td>
<td></td>
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<tr>
<td>Neuroanesthesia</td>
<td></td>
<td>2 months</td>
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<tr>
<td>Pediatrics</td>
<td></td>
<td>2 months</td>
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<tr>
<td>Obstetrics</td>
<td></td>
<td>2 months</td>
<td></td>
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<tr>
<td>Chronic Pain</td>
<td></td>
<td>1-2 months</td>
<td></td>
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<tr>
<td>Surgical ICU</td>
<td></td>
<td>2 months</td>
<td></td>
</tr>
<tr>
<td>General Anesthesia</td>
<td></td>
<td>0-2 months</td>
<td></td>
</tr>
<tr>
<td>PACU</td>
<td></td>
<td>1 month</td>
<td></td>
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<tr>
<td>VA</td>
<td></td>
<td>1 month</td>
<td></td>
</tr>
<tr>
<td>Acute Pain</td>
<td>1-2 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SICU</td>
<td>1-2 month</td>
<td></td>
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<td></td>
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<tr>
<td>Obstetrics</td>
<td>1-2 months</td>
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<tr>
<td>Electives</td>
<td>6 months</td>
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</tbody>
</table>

- Cumulative time in any one subspecialty is not to exceed 6 months over 3 years, per ABA policy.
- Changes in rotation schedule cannot be made unless approved by the Program Director. After approval is received, the resident will notify the Chief Resident and Program Coordinator.

## CASE REQUIREMENTS DURING RESIDENCY:

- Experience with a wide spectrum of disease processes and surgical procedures is available within our program to provide each resident with a broad exposure to different types of anesthetic management. The following list represents the minimum clinical experience that should be obtained by each resident in the program. Although the minimum requirements are for the CA-1 through CA-3 years, the majority should be accomplished in the CA-1 and CA-2 years.

- **Residents are expected to complete case logs on at least a monthly basis. This log (found on ACGME website and on One45, can be accessed using login and password provided by the Program Coordinator.**

- Residents must maintain a comprehensive anesthesia record for each patient as an ongoing reflection of the drugs administered, monitoring employed, techniques used, physiologic variations observed, therapy provided as required, and fluids administered. The patient’s medical record should contain evidence of preoperative and postoperative anesthesia assessment.

**Specific Requirements**

1. Forty anesthetics for vaginal delivery; evidence of direct involvement in cases involving high-risk obstetrics, as well as a minimum of 20 cesarean sections.
2. Anesthetic management, including care for: patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; care for 100 patients younger than 12 years of age; within this patient group, 20 children must be younger than three years of age, including five younger than three months of age.

3. Anesthesia for 20 patients undergoing cardiac surgery of which 10 must involve cardiopulmonary bypass.

4. Twenty other major vascular cases (including endovascular cases).

5. Twenty intrathoracic (thoracotomy, thoracoscopy) noncardiac cases.

6. Twenty intracerebral cases, 10 of which must include open cranium.

7. Forty epidural anesthetics for patients undergoing surgical procedures, including cesarean sections.

8. Twenty cases involving life-threatening pathology.


10. Forty peripheral nerve blocks for patients undergoing surgical procedures.

11. Twenty new patient evaluations for management of patients with acute, chronic or cancer pain disorders. Residents should have familiarity with the breadth of pain management including clinical experience with interventional pain procedures.

12. Documented involvement in the management of acute postoperative pain, including familiarity with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities.

13. Documented involvement in the systematic process of the preoperative management of the patient.

14. Significant experience with certain specialized techniques for airway management (such as fiberoptic intubation, double lumen endotracheal tube placement, and laryngeal mask airway management), central vein catheter placement, pulmonary artery catheter placement, peripheral artery cannulation, transesophageal echocardiography, evoked potentials, and electroencephalography.

15. A postanesthesia care experience of two contiguous weeks which must involve direct care of patients in the post-anesthesia care unit and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit. Designated faculty must be readily and consistently available for consultation and teaching.

16. Critical care rotation, including active participation in patient care by anesthesia residents in an educational environment in which participation and care extend beyond ventilatory management, and active involvement by anesthesiology faculty experienced in the practice and teaching of critical care. This training must take place in units in which the majority of patients have multisystem disease. The post-anesthesia care unit experience does not satisfy this requirement.
<table>
<thead>
<tr>
<th>Rotation (Responsible faculty)</th>
<th>Required duration</th>
<th>Prerequisites</th>
<th>Earliest start date</th>
<th>Skills to be acquired</th>
<th>Call pool</th>
</tr>
</thead>
</table>
| Acute Pain/Regional (Varies)                   | 1-2 mo*           | OB rotation   | March of CA-1 year  | • 40 peripheral nerve blocks for surgical patients  
• 20 new patient evals for acute, chronic or cancer disorders  
• Management of acute postop pain                                                                                                                     | Pain Main OR (Fri/Sat only) |
| Ambulatory/ ASMP (Dr. Donald)                 | None              | None          | N/A                 | • Significant experience with specialized airway management techniques                                                                                                                                             | Main OR  (Fri/Sat only) |
| Cardiothoracic/ Cardiovascular (Castresana, Agarwal) | 2 mo              | SICU rotation or at the discretion of CT faculty | May of CA-1 year | • Anesthesia for 20 pts undergoing surgical procedures involving CPB  
• 20 other major vascular cases (including endovascular cases)  
• 20 intrathoracic noncardiac cases  
• Significant experience with specialized airway management techniques, central venous catheter placement, pulmonary artery catheter placement, peripheral artery cannulation, TEE | CT/ICU (home) |
| Chronic Pain (Martin)                         | 1-2 mo*           | 6 mo General  | Jan of CA-1 year    | • New patient evals for acute, chronic, or cancer disorders  
• Familiarity with the breadth of pain management, including interventional pain procedures                                                                                                         | Main OR  (Fri/Sat only) |
| Critical Care (Castresana)                    | 2-4 mo**          |               |                     | • Significant experience with specialized techniques  
• Active participation in patient care in educational environment; participation and care extend beyond ventilatory management; active involvement by anesthesiology faculty experienced in the practice and teaching of critical care in a unit which the majority of patients have multi-system disease. | SICU     |
| General/Main OR (Castresana, Core Section Chiefs) | N/A               | Completion of Orientation | July–Aug of CA-1 year | • 20 life threatening cases  
• Epidural anesthetics for surgical patients  
• Subarachnoid blocks for surgical patients                                                                                                             | Main OR   |
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Duration</th>
<th>Rotation</th>
<th>Month</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroanesthesia (TBD)</td>
<td>2 mo</td>
<td>6 mo General</td>
<td>Jan of CA-1 year</td>
<td>Significant experience with specialized airway management techniques, central venous catheter, pulmonary artery catheter, peripheral artery cannulation, evoked potentials, EEG</td>
</tr>
<tr>
<td>Obstetric &amp; Gynecologic Anesthesia (TBD)</td>
<td>2 mo</td>
<td>6 mo Main OR</td>
<td>Jan of CA-1 year</td>
<td>20 intracerebral cases, 10 of which are open, 40 anesthetics for vaginal delivery, 20 anesthetics for cesarean section, 40 epidural anesthetics for surgical patients, including C-section, 40 subarachnoid blocks for surgical patients</td>
</tr>
<tr>
<td>PACU (Clinical Director)</td>
<td>2 weeks</td>
<td></td>
<td></td>
<td>Direct care of patients in the PACU management of pain, hemodynamic changes, emergencies related to PACU with designated faculty readily available for consultation and teaching</td>
</tr>
<tr>
<td>Pediatric Anesthesia (Weatherred)</td>
<td>2 mo</td>
<td>4 mo CA-1</td>
<td>March of CA-1 year</td>
<td>Anesthesia for 100 children under age 12, including 15 infants &lt;1yr, infants &lt;45 weeks post conceptual age</td>
</tr>
<tr>
<td>Preoperative Clinic (Schwartz)</td>
<td>1 mo</td>
<td>2 mo General</td>
<td></td>
<td>Involvement in systematic process of preoperative patient management</td>
</tr>
</tbody>
</table>

* ACGME pain rotation requirement “... at least three months in pain medicine that may include one month in an acute perioperative pain management rotation, one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain problems, and one month of regional analgesia experience in pain medicine.” One month of pain may be done during CB year

** Four months of an ICU rotation is required. Two of these months may be done during the CB year.
**PORTFOLIO:**

- The ACGME resident learning portfolio is an interactive professional development tool that residents can use throughout their residency to record and organize their learning activities and to reflect and receive feedback on their skills as physicians, building evidence that allows you to chart your own progress over time.
- The portfolio is a learning tool for residents that enable them to track their experiences, self-reflect on those experiences, share insights for further discussion with faculty or mentors, and receive real-time, formal feedback on designated learning experiences.
- The portfolio also serves as a repository for resident work products and professional documents, which ultimately will serve the needs of many groups, including licensing bodies and certification boards.
- An e-portfolio is available on One45. The portfolio will be reviewed quarterly by faculty mentor and/or Program Director.

**SENIOR PROJECT:**

- CA-3 residents are required to complete an academic assignment in order to graduate. This assignment is also listed on the ACGME website under section (B) Duration and Scope of Education, # 2 - Program Design, (B) Clinical Anesthesia Training, CA-1 through CA-3 years.
- Academic assignments may include special training assignments, grand round presentations, preparation and publication of review articles, book chapters, presentations at national/international conferences, manuals for teaching or clinical practice, or similar academic activities.
- Senior projects must be determined by June 15 of the CA-2 year and approved by the Residents Education Committee. Once approved the senior resident will be assigned a mentor who will oversee the project.

**CALL SCHEDULE:**

- A call schedule is posted in the Clinical Director’s (CD) book at the front desk of the OR. Each faculty member, resident, and intern also receives the schedule by email.
- It is requested that changes in the schedule be kept to a minimum. Residents can exchange call time only with others at their level (e.g., short-term residents only with other short-term residents). If a resident makes a change, he/she needs to let the telephone operator know of the change, as well as update the call schedule in the CD’s book.
- Residents need to let the Chief Resident and the CD know about all changes and get approval before changing the schedule. The Department strives for on-call frequency to be less than every third day. Also, it is expected that at least one day out of seven the resident will be free from hospital activities.
**WORK HOURS:**

The Department follows the guidelines for work hours as outlined by the ACGME. Duty hours are to be documented on a weekly basis in One45.

**Duty Hours**

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both 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. See **Attachment A**, Duty Work Hours Policy.

**FYI:** MCG/AU GME website can be found at [www.augusta.edu/mcg/residents/](http://www.augusta.edu/mcg/residents/)

**ON-CALL ACTIVITIES:**

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period, provided the resident is CA-1 or higher. 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.

- In-house call must occur no more frequently than every third night, averaged over a 4-week period.
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours (PGY-2 and above).
- Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.
- No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- Strategic napping, especially after 16 hours of service, is strongly suggested when clinical responsibilities permit. As such, if a resident is not required for clinical duty as determined by the attending anesthesiologist, that resident should make every effort to sleep in the call room provided.
- In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
- Under those circumstances, the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director.
The Department complies with any and all requirements outlined in Common Program Requirements as defined by the ACGME. If any resident becomes aware of an infraction of these requirements either by himself/herself or another resident, they are asked to notify the chief resident, advisor, Program Director, or Chairman to remedy the circumstances in order to attain compliance.

1. At-home call (pager call) is defined as call taken from outside the assigned institution.
   a. The frequency of at-home call is not subject to the every-third-night limitation. However, at-home call must not be as frequent as to preclude rest and reasonable personal time for each resident.
   b. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a 4-week period.
   c. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
   d. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

IN-TRAINING EXAMINATION (ITE):
Residents are required to take the annual in-service anesthesiology examination (ITE). The progress shown by the resident is an important part of the evaluation of the knowledge base of each resident. All residents are required to score > 30th percentile on this exam. Failure to do so may require the residents to present their keywords from ITE to a selected panel of attendings. See Commencement and Graduation Policy for further details.

- A score in the 30th percentile for each class is the Program’s accepted pass rate on the ITE and AKT.
- If a resident fails the ITE, he or she will have a chance to redeem him/herself by achieving a better score on the AKT.
- A resident who fails to meet the minimum score will be expected to present his/her keywords to a panel of three attendings.
- The three-member panel will then make a recommendation to the CCC.
- If a resident fails the keyword presentation, no extension will be granted.
- The decision of the CCC will be final.

ANESTHESIA KNOWLEDGE TEST (AKT):
All incoming residents will take the AKT pre-test during their first days. This assessment is used to help, not hinder, the resident. The AKT post-test is taken after one month to allow us to evaluate their progress during the month-long orientation. This test will again be given after 6 months and 24 months of residency. It will be used to gauge progress and determine if deficiencies are present. The 6 and 24 month exams will be used in a similar fashion to the ITE. See Commencement and Graduation Policy for further details.
ABA BASIC EXAM:

The ABA is transitioning to a new assessment program that will complement the movement of the Accreditation Council of Graduate Medical Education (ACGME) toward competency-based training and promotion.

Rather than taking the Part 1 Examination at the conclusion of residency, ABA candidates who will complete residency training on or after June 30, 2016, will take a staged Part 1 Examination that will consist of two separate examinations. The first of these examinations, the BASIC Examination, will be offered beginning in July 2014. It will be followed by the ADVANCED Examination after the conclusion of residency training in 2016.

The ABA’s current Part 2 (Oral) Examination will become the APPLIED Examination. Beginning in 2017, its content and format will change to include elements of Objective Structured Clinical Examinations (OSCEs) in addition to the traditional oral examination questions. For more details, visit www.theaba.org.

The Department will reimburse residents for the ABA BASIC examination fee. Each resident is responsible for registering for the BASIC examination. Submit receipt to Program Coordinator for reimbursement processing. Department will not pay any late registration fee. The Department does not reimburse the fee for the ABA primary certification for CA-3 residents, however, resident book/travel allotment may be used to pay for this fee.

Procedure for Those Who Do Not Pass ABA BASIC Examination

- For each failed attempt at the BASIC exam, the Program will assign a “U” (unsatisfactory) for Medical Knowledge on the Clinical Competency Committee (CCC) report for the reporting period in which exam was taken.

- **NOTE:** All Residents MUST pass their BASIC Examination prior to starting their CA-3 year. Any resident who has attempted and failed the BASIC Examination three (3) times prior to the end of their CA-2 year will be REQUIRED to extend their CA-2 year by six (6) months. Residents MUST pass the BASIC Examination to qualify for the ADVANCED Examination. Any resident who has been granted an additional six (6) month extension to their CA-2 year, and who does not pass the BASIC Examination by the end of the extension period, will be terminated from the Program.

- Continuation of the residency training is at the discretion of the Program

- Registration for the BASIC exam is at the discretion of the Program Director.
Diagram for Those Who Do Not Pass ABA Basic Examination

- **FAIL**
  - **ATTEMPT 1**
    - **Prepare for Attempt 2 in 6 months**
    - **Finally, Attempt 1 MUST be completed by the end of your CA-1 year**
  - **ATTEMPT 2**
    - **Prepare for Attempt 3 prior to the end of your CA-2 year**
    - **ATTEMPT 3**
      - **Extended CA-2 year by 6 additional months**
      - **Finally, Attempt 3 MUST be taken prior to the end of your CA-2 year**
  - **TERMINATION**

- **PASS**
  - **ATTEMPT 1**
    - **Continue with the Program on Schedule**
    - **Finally, Attempt 1 MUST be completed by the end of your CA-1 year**
  - **ATTEMPT 2**
    - **Continue with the Program on Schedule**
    - **Finally, Attempt 2 MUST be taken 6 months after failing (halfway mark of your CA-2 year)**
  - **ATTEMPT 3**
    - **Continue with the Program on Schedule**
    - **Finally, Attempt 3 MUST be taken prior to the end of your CA-2 year**
  - **GRADUATION**

**Additional Notes:**
- **ATTEMPT 1**
  - Must be completed by the end of your CA-1 year.
- **ATTEMPT 2**
  - Must be taken 6 months after failing (halfway mark of your CA-2 year).
- **ATTEMPT 3**
  - Must be taken prior to the end of your CA-2 year.
- **TERMINATION**
  - Extended CA-2 year by 6 additional months.
- **GRADUATION**
  - Progress to CA-3 year.
USMLE STEP 3:

- **NOTE:** Residents are strongly advised to take Step 3 during their internship year. However, Step 3 MUST be completed no later than the December 31 of the CA-1 year of training.
- If a resident fails to complete Step 3 by December 31 of their CA-1 year of training, they will receive an unsatisfactory on the ABA Essential Attributes semiannual evaluation for the 6-month period.

RESIDENT EVALUATION:

- The Clinical Competence Committee evaluates residents semiannually. The faculty member that a resident works with during a particular month submits evaluations. The faculty member should discuss the evaluation with the resident each month. The resident’s assigned faculty mentor will review and discuss his semiannual Clinical Competence Report and evaluations. The resident’s evaluations can be viewed on the One45 system after the resident has completed evaluations of faculty on the service just finished. The resident will also have an opportunity to respond to faculty evaluations at that time.
- The Department abides by the policies of the American Board of Anesthesiology as indicated in the American Board of Anesthesiology Booklet of Information (Policy 2.02, The Continuum of Education in Anesthesiology).
- However, please note that as of July 1, 2014, the Department will not extend training in the event that a resident receives three consecutive unsatisfactory evaluations.

FACULTY EVALUATION:

Residents are encouraged to evaluate faculty members monthly via the One45 web-based program. These evaluations are confidential. Synopses of the evaluations are reviewed by the individual faculty member and the Chairman.

PROGRAM EVALUATION:

Residents are given an opportunity to evaluate the residency program on an annual basis. These evaluations are reviewed by the Chairman. Residents will have the opportunity to evaluate each lecture as it is presented.

CRITICAL INCIDENTS:

All critical incidents must be recorded in the Quality Improvement section of the anesthesia record for each case. A dedicated tab exists on the CompuRecord with pre-populated list of common incidents. This reporting of critical incidents is a requirement of the residency program and failure to do so can result in unsatisfactory evaluations. Selected cases will be presented at the M & M conference every other month and residents will be required to present the case with the faculty member involved. Presenting a case is not to be considered punitive, but an opportunity to improve an individual’s and the department’s practice.
**DRUG POLICY:**

The Department adheres to the institution’s drug-free work place policy. See AU House Staff Policy No. HS 1.0, Chemical/Substance Abuse, which can be found at: [http://www.gru.edu/mcg/residents/hspolicies/documents/hs1chemicalsubstanceabuse.pdf](http://www.gru.edu/mcg/residents/hspolicies/documents/hs1chemicalsubstanceabuse.pdf).

The Department reserves the right, at the Chairman’s discretion, to randomly drug test, with or without cause, any resident with urine or blood samples.

**DELINQUENT MEDICAL RECORDS:**

House officers are required to complete medical records at all participating institutions in order to avoid delinquency as outlined in AU House Staff Policy No. M.4.0, Housestaff Delinquent Records, which can be found at: [http://www.gru.edu/mcg/residents/hspolicies/documents/delinquentmedicalrecord2014.pdf](http://www.gru.edu/mcg/residents/hspolicies/documents/delinquentmedicalrecord2014.pdf)

**LIBRARY:**

The library is available for the benefit of all in the department. Books are not for loan but are for references purposes. Please return any books you have taken from our departmental library and leave them on the table in the library. No books are to be taken to or used in the operating room (OR). Please cooperate!! Short-term residents can arrange for a loan of Stoelting’s *Basics in Anesthesia* for the duration of their rotation on anesthesiology through the Program Coordinator. No food or drink is allowed in the library. Online access to some reference books is available via the Resource page of the Department’s intranet (PAWS), which can be found at: [https://paws.gru.edu/pub/anesthesia/resources/Pages/default.aspx](https://paws.gru.edu/pub/anesthesia/resources/Pages/default.aspx). Surgeons’ anesthetic preference cards are also located on that page.

**CARDIOPULMONARY RESUSCITATION:**

**Code 99**

1. During orientation the chief resident will give instructions concerning proper procedures to follow in answer to "Code 99." The new resident is responsible for knowing this information on the first day of Clinical Anesthesia.

2. A resident will be assigned the code beeper during the day and will be responsible for responding to all codes and unstable traumas. The “code bag” is kept at the front of the OR for rapid response. At night the first call resident is assigned the code beeper and is responsible for responding to all codes and unstable traumas.

3. Whether this occurs in the OR, Recovery Room, X-ray, or Nursing Unit, the resident will document the diagnosis and treatment on a consult sheet for the patient's charts, including elective intubations.
Please familiarize yourself with the protocol for handling code boxes

- Each code box will be numbered. (We have six so far – 4 in the main OR, 1 in SICU, 1 in preop.)
- Each code box will have checklist of items present in the box (unnecessary items have been removed and only the most relevant intubating aids should be in the box).
- The anesthesia provider (resident, AA, or CRNA) on returning the box back to the OR will make sure to circle the items that have been used and sign and print his/her name.
- The anesthesia provider (resident, AA, or CRNA) would then page/contact the anesthesia tech or extern to facilitate restocking of the box.
- The anesthesia provider (resident, AA, or CRNA) would take a new medication bag from the pyxis and place in the code box. (Dr. Crane can send an email to everyone and along with Dr. Mark Banks, can train the residents and CRNAs how to get the new meds from the Pyxis on weekends.
- There will be a sign-in sheet on the wall close to OR board where the anesthesia provider (resident, AA, or CRNA) will sign his/her name to document using the box.
- The anesthesia tech or intern will restock the box, make sure that the medication bag is in there, will sign, print his/her name, and date and time the checklist.
- The anesthesia tech or intern will also sign the sheet on the wall next to the box # that has been used.

NEWBORN RESUSCITATION:

1. In the delivery room the first duty of the anesthesiologist is to the parturient.
2. The anesthesiologist should assist the pediatrician during resuscitation of the newborn, as needed.
3. In the event of a conflict concerning whether the anesthesiologist, pediatrician, or obstetrician is in charge of newborn resuscitation, the physician with the most expertise to handle the problem at hand should take charge.

BLOOD AND FLUID PRECAUTIONS:

Detailed information regarding blood and fluid precautions can be found on AU’s web page under Policy and Procedures.

CONSULTS/INTUBATIONS:

The responsible resident and attending faculty should complete anesthesiology consults promptly. In the event that a resident or attending is not able to attend immediately due to imminent clinical duties, the person or service that sent the page must be notified. Do not hesitate to ask for any member of the departmental faculty to assist. An attending must actively contribute to the consult and sign the consultation. For intubations, the consult form must be completed and signed by resident and attending. The form must be completely filled out by primary team including requesting attending name, PPG #, and pager number.
**CODE PAGER:**

The resident carrying the code pager is responsible for the following:

1. Immediate response to CODE 99, level one trauma, or unstable trauma.
   a. For patients who are unstable and/or unresponsive, residents should intubate and perform ACLS protocols as appropriate. In these circumstances, an attending presence is not required, however, the attending anesthesiologist should be notified as quickly as possible.

2. Immediate response to text or number pages for intubation consults.
   a. If intubation is requested, the following minimum information must be obtained over the phone:
      i. Patient location, name, MRN
      ii. Brief HPI including pertinent comorbidities
      iii. Weight, potassium level, current vital signs including FIO$_2$.
   b. This information is then immediately given to the CD or on-call attending who will give instructions on the appropriate course of action. The resident is responsible for ensuring that all necessary equipment is present prior to induction for intubation, including accessory airway equipment or medications.
   c. ***Residents are not permitted to administer medications unless an anesthesia attending is present. There are no exceptions to this rule. Noncompliance may result in disciplinary action.***
      i. This rule is for the protection of the patients and for the residents’ and anesthesia attendings’ professional liability.

**MISCELLANEOUS:**

The Department will endeavor to consider the religious and/or moral objections of residents so as not to require participation in elective procedures which the resident believes violate his/her ethical values.

**BENEFITS:**

Please review the benefit package information by reviewing the Graduate Medical Education website at http://www.gru.edu/mcg/residents.

Prescription expenses are reimbursed by PPG. Prescription receipts should be submitted to Tammy Trenary at PPG or given to the Program Coordinator who will submit them to PPG.

**ABSENCES FROM TRAINING:**

Residents are allowed three weeks (defined as 15 clinical days) of vacation during the academic year. Two to three weeks will be assigned in one-week blocks at the beginning of the year. The third week may be split into multiple separate days. This assignment will be based upon requests and seniority. In other words, seniors will get their first choice, then second years and then first years. After all first choices are filled, then the second week will be filled, again based upon seniority.
VACATION:

ONLY CA-3s CAN TAKE VACATION THE LAST TWO (2) WEEKS OF JUNE (through June 30th including the 5th week, if applicable). There will be a maximum of six (6) CA-3s per week allowed to take vacation the last two (2) weeks of June. Approval will be determined by the Program Director and based upon distance to move for a job or fellowship.

NO VACATION IS ALLOWED IN THE MONTH OF JULY

NO VACATION IS ALLOWED IN THE MONTH OF JUNE FOR ANY CA-1

Vacation request process:

- All vacation requests are to be submitted via QGENDA to the program coordinator for approval with backup approval by the Program Director and Dr. Vikas Kumar. All three (3) weeks granted by the hospital will be assigned based upon request and seniority at the beginning of the year. Due to limitation of vacation during certain subspecialty rotations, CA-3s and CA-2s will have first pick of vacation slots. Three (3) residents will be allowed to be off on any given week during this process.

- Institutional policies concerning any or all absences from training supersede department policies. It is a general and accepted departmental policy that in consideration of our colleagues and the call schedule, terminal leave will not be allowed.

- CA-3s and CA-2s will be granted three (3) days for interviews. If appropriate, extra time can be scheduled if coverage can be arranged in collaboration with colleagues. AU House Staff Policy No. HS 4.0, House Office Leave, can be found at: [http://www.gru.edu/mcg/residents/hspolicies/documents/hs4houseofficerleave.pdf](http://www.gru.edu/mcg/residents/hspolicies/documents/hs4houseofficerleave.pdf).

- The ABA policy regarding absence from training mandates that the total of any and all absences may not exceed 60 working days (12 weeks) during Clinical Anesthesia years 1-3 of training. Attendance at scientific meetings, not to exceed 5 working days per year (CME), shall be considered a part of the training program. CME time is defined as organized attendance at a conference, meeting, or educational program. Duration of absence during the Clinical Base year may conform to the policy of the institution and department in which that portion of the training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence. A lengthy interruption in training may have a deleterious effect upon the resident’s knowledge or clinical competence. Therefore, when there is an absence for a period in excess of six months, the Credentials Committee of the ABA shall determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system. (ABA Booklet of Information, February 2012, Policy 2.03, page 16.)

- All absences from residency training must be approved by the Program Director and/or Clinical Director.

- ABA Policy regarding absence from training:

  Policy 2.03 The American Board of Anesthesiology, Inc. Booklet of Information.
“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 the 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.”

- The amount of paid vacation time, sick disability leave within a contract year is determined by the Hospital. After paid vacation time, sick, disability or maternity leave are used, the remainder of time will be categorized as leave without pay.

Please become familiar with the departmental policies for vacation as applicable to Residents, CRNAs, and AAs

Effective immediately all major holidays will be split between the residents/mid-levels (New Year’s, Master’s, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas).

A total of six (6) (Residents/CRNAs/AAs) allowed off per day. (Chronic Pain & CHOG residents can be off at the discretion of the service chief.)

July – A total of three (3) (CRNAs/AAs) are allowed off per day. No residents are allowed off during the month of July.

Vacation/CME request may be submitted no more than one (1) year in advance with the exception of the following holidays (New Year’s, Master’s, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas).

New Year’s, Master’s, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas – Vacation request may be submitted no more than 6 months in advance. If you had any of these holidays off within the past three (3) years you may submit your leave request only one (1) month in advance.

Consecutive weeks of vacation may not exceed four (4) weeks. If consecutive vacation starts or ends in the month of July it can only be one (1) week. Vacation requests that exceed four (4) weeks as a block will require Vice Chair/Chair approval.

Last two (2) weeks of June – six (6) slots reserved for CA-3 residents moving to fellowships/jobs with preference given for fellowships and distance.
Only residents will be allowed time off during the Annual ASA and GSA meetings. (No mid-level providers are allowed vacation/CME during this time.) (However, one (1) mid-level provider will be allowed to go to the Annual ASA meeting)

CME – Presenters and authors have priority over others requesting to go to the meeting.

ALL Annual ASA Meeting Requests may be submitted no more than two (2) months out.

Because of the large number of residents presenting at the Annual ASA meeting, the Friday before the meeting will be blocked for three (3) residents/one (1) mid-level going to the meeting.

Annual AANA meeting will be blocked for three (3) mid-levels.

All meetings outside of the country will be approved by the Chair after reviewing the meeting program unless you are presenting at the meeting.

SICK LEAVE:

All residents are required to follow the procedure listed below when calling in sick.

- Call the Clinical Director by 6:30 a.m., but preferably the night before. If you are unable to speak directly with the assigned CD, you must call your assigned attending. If you are unsuccessful in reaching your assigned attending call the OR front desk. In addition to speaking to the Clinical Director, attending, or the front desk, you must also send an email to Karen McDaniel and Angie Skinner notifying them of your absence.

- Sick and Disability Leave and Pregnancy and Maternity Leave:
  - While pregnancy is neither a disease nor an injury, Federal Law requires that pregnancy be treated as any other sickness or disability.
  - The duration of leave allowed before and after an illness or disability including pregnancy is determined individually by the Program Director in consultation with the resident’s physician.
  - In the usual case, the total duration of leave is expected to be no more than three months. Vacation time, sick leave, disability leave, and maternity leave may not be accrued from year to year or used in advance.

- Pregnancy and Maternity Leave:
  - Please see GRHealth Family Medical Leave Act (FMLA), Policy No. 4.60.0, at: https://paws.gru.edu/pub/hr/resources/policies/Documents/4_60_02_r3.pdf
  - Please also see: http://www.gru.edu/hr/benefits/university_benefits/fmlaforms.php
  - The American Board of Anesthesiology Booklet of Information.
The Department expects the resident to notify the Program Director as soon as pregnancy is suspected or determined so that appropriate scheduling is assured. Every attempt will be made to schedule the pregnant resident so as to avoid possible occupational hazards such as radiation and unscavenged anesthetic environments. Schedule accommodations such as reduced hours, no night call, and modified rotation schedules cannot be guaranteed but are considered on an individual basis. The influence of such accommodations on the education of the pregnant resident and on the workload of other residents is given careful consideration.

- **Child Care:**
  Each resident is expected to make suitable arrangements for child care so that absences because of child care are rare.

- **Paternity Leave:**
  Male residents will be allowed one week (5 work days) of family leave for the support and care of the pregnant spouse after delivery. Under unusual circumstances, additional days may be allowed for paternity leave, up to the maximum 20 days allowed by the ABA. It is understood that the exact timing of this leave can only be estimated and every effort will be made by the department to accommodate the timing of this leave. The resident should notify the Chief Resident and Program Director as to the progress of a pregnancy to enable them to make appropriate changes to the OR and call schedules. This leave is included in the 20 days allowed by the ABA.

**INTERVIEW DAYS:**

CA-3 & CA-2 residents are allowed 3 days for interviews. This must be coordinated with the Clinical Director.

The Department abides by the ABA policy which states "that 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 the training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence. (ABA Booklet of Information February 2012, Policy 2.03, page 16)

**TRAVEL AND BOOK ALLOWANCE:**

The Chairman makes decisions concerning travel and book allowances annually. Requests for leave to attend meetings must be approved by the Faculty Education Committee and made at least six weeks in advance of the meeting. Meeting expenses to be borne by the Department, travel time, and other demands will be considered by the Committee. Travel reservations are to be made through the Department. Amounts exceeding allotment will be paid out of pocket by the resident.

The Education Committee has allotted $1500.00 for CME and books. This allotment will begin in the PGY-2 year. *The Basics of Anesthesia* can be purchased during the internship if the resident does the PGY-1 year with our department. CME time is given preferentially to the residents with
the highest percentage of conference attendance or to the resident presenting at the conference. Conference attendance is tracked on a weekly basis by the education coordinator. At the Chairman’s discretion and, if budget allows, each resident in good academic standing is also allotted $300.00 toward attending the bi-annual Georgia Society of Anesthesiologists meeting. This is in addition to the $1500.00 allotment.

Additional funds for travel, for participation in political activities, and/or abstract presentation will be at discretion of the Chairman.

**MEDICAL LICENSURE:**

Temporary Postgraduate Training Permit is mandatory for participation in all postgraduate medical training programs in the State of Georgia, unless the individual holds a regular license to practice medicine in Georgia prior to participating in postgraduate medical training program. AU House Staff Policy No. 6.0, House Officer Licensure, can be found at: [http://www.gru.edu/mcg/residents/hspolicies/documents/hs6houseofficelicensure.pdf](http://www.gru.edu/mcg/residents/hspolicies/documents/hs6houseofficelicensure.pdf).

**ABA BOOKLET OF INFORMATION:**

The current ABA requirements are outlined in the February 2012 Booklet of Information. You may also view this on the ABA website under the Publications link ([www.theaba.org](http://www.theaba.org)). The individual resident should understand the requirements of the ABA and share with the Chairman and Program Director responsibility for fulfilling these requirements.

**REIMBURSEMENTS:**

Deductions for hospital insurance and parking fees will be made from the resident’s check, and will be reimbursed on a six-month basis from PPG.

**SOCIETY MEMBERSHIPS:**

Application for membership in the American Society of Anesthesiologists (ASA), the Georgia Society of Anesthesiologists (GSA), and American Medical Association (AMA) should be made as soon as possible. Membership to the ASA and GSA entitles the member to a subscription to the journal, *Anesthesiology*. The Department will pay membership dues to these societies. Forms are available from the Program Coordinator.

**BEEPERS:**

To minimize the difficulty we have with this equipment, please do the following.

Check equipment before use by calling "Pagemaster Operator" at extension 1-3893. DO NOT place a Pagemaster on a metal desk, in contact with keys or other metal objects, or directly under fluorescent lights as this interferes with its accuracy of function. If you have any problems with your beeper, replacements can be obtained from Telecommunications located on the 8th floor of the hospital. Lost or stolen beepers need to be reported to Public Safety.
DEPARTMENT COMMITTEES:
Each level of resident in Clinical Anesthesia is encouraged (with the approval of the Program Director to elect one resident to serve on the Department Education Committee. All residents will also vote to elect one representative to serve on the institutional Graduate Medical Education (GME) Committee.

MOCK ORAL EXAMINATION:
Mock Oral exams will be given to each resident in May and December. The CA-3 residents have an opportunity to another mock oral exam in the final months of training if they request this. The mock oral program is considered a very important part of the training program and is highly advised for all residents to participate. It consists of two 35-minute sessions given by two sets of attendings and is based on the actual American Board of Anesthesiology examination.

MOONLIGHTING:
Outside moonlighting is NOT allowed for any anesthesia residents.

SEXUAL HARASSMENT POLICY:
The Department abides by AU Anti-Sexual Harassment Policy, No. 8.3.3, which can be found at: http://policy.gru.edu/archives/651.

DUE PROCESS:
It is the intention of the Department to provide due process for residents, specifically in any action which could affect the resident’s career development or advancement or when there is a grievance against the program. AU House Staff Policy No. HS 13.0, House Officer Evaluation, Grievance, & Due Process, can be found at: http://www.gru.edu/mcg/residents/hspolicies/documents.hs13evaluationanddiscipline.pdf.

COMMENCEMENT AND GRADUATION POLICY:
All residents are required to take both the ITE and respective AKT exams during the CA-1 to CA-3 years as follows:

<table>
<thead>
<tr>
<th>Level</th>
<th>Month</th>
<th>Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA-1</td>
<td>July</td>
<td>AKT pre-exam</td>
</tr>
<tr>
<td></td>
<td>July</td>
<td>AKT post-exam</td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>ITE</td>
</tr>
<tr>
<td></td>
<td>June</td>
<td>AKT-6 exam</td>
</tr>
<tr>
<td>CA-2</td>
<td>March</td>
<td>ITE</td>
</tr>
<tr>
<td></td>
<td>June</td>
<td>AKT-24</td>
</tr>
<tr>
<td>CA-3</td>
<td>March</td>
<td>ITE</td>
</tr>
</tbody>
</table>
Residents are required to attend all lectures and educational meetings and are to engage in sufficient personal study in order to achieve a score of 30th percentile or higher on each of the ITE exams.

Residents who fail to score at least in the 30 percentile on any ITE exam will be required to present 1-2 paragraph summaries of each one of the keyword topics that the resident missed on the ITE exam to a panel of attendings selected by the PD. In addition, the resident will sit for an oral examination with three attending physicians. This examination will consist of questions from the residents keyword summaries and will last no longer than 3 hours.

The results of the examination will be reported to the Program Director and CCC. If the oral examination results are satisfactory, a satisfactory report will be submitted to the ABA for the six-month period.

CA-1 and CA-2 residents who have two ITE scores less than the 30th percentile may be subject to further disciplinary action involving extending residency or dismissal from the residency program.

Final approval for graduation will be decided by both the Program Director and Chairman.

**QUALITY IMPROVEMENT PROJECT:**

Each CA-3 resident must choose a quality improvement project to be completed within the CA-3 year. The project must be approved by the resident’s mentor and the Program Director before the project is started. This requirement can be fulfilled in many ways within Perioperative Services, ICU, and Pain Services.
DEPARTMENT OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

DUTY WORK HOURS POLICY:

The Department of Anesthesiology & Perioperative Medicine recognizes that education and patient care are integrally related. All graduate medical education programs have a responsibility to the resident to provide training in continuity of patient care. The Department of Anesthesiology & Perioperative Medicine Residency Training Program provides through its duty hours and call schedules an appropriate balance between patient care and teaching/training programs in an environment conducive to both resident education and patient care. This environment ensures wherever possible that undue stress and fatigue among residents is avoided. The Department of Anesthesiology & Perioperative Medicine fully supports the Resident Work /Hours policy established by the ACGME with the following requirements:

- Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both 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.
- A maximum of 80 hours per week averaged over four weeks, inclusive of all in-house activities.
- Adequate time for rest and personal activities must be provided. This should consist of a 10-hour period provided between all daily duty periods and after in-house call. If a resident is required to stay late for any reason, the on-call attending should be notified by the resident and arrangements made to accommodate the resident coming in the next day.
- House officers will be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as a continuous 24 hour period free from all clinical, educational and administrative duties.
- Twenty-four hours maximum continuous on-site duty with up to six additional hours permitted for patient transfer and other activities.
- No new patients after 24 hours of continuous duty.
- House officer time spent in the hospital during at-home call is to be counted toward the 80 hour maximum.
- In-house moonlighting to be counted toward the maximum 80 hours.

Adequate backup through resident physicians or supervising staff physicians will be available and utilized as needed to ensure that patient care is not jeopardized by resident stress or fatigue.

Resident training is a full-time responsibility. It encompasses the formal curriculum, the individual learning opportunity through independent study time, and clinical exposure including the service component of patient care.AU Institutional Policy (HS 16.0) states that the Program Director must be informed and approve of activities outside the educational program (i.e., moonlighting). Written permission for moonlighting must be obtained by the house officer from his/her Program Director with official notification of the GME Office of the moonlighting activity. Outside activities must not interfere with the resident’s performance in the educational process defined in the agreement between the institution and the resident.
It is a departmental policy that no moonlighting is allowed.

The facilities afforded the residents are there to ensure an appropriate environment for learning and providing patient care. This shall include food service capabilities during assigned duty hours and suitable on-call rooms suitable for each resident on night duty in the hospital.

If a resident has any problems with duty hours, either on anesthesia or off-service rotations, the chain of command for complaints are as follows:

- Chief Resident
- Dr. Mary Arthur, Residency Program Director
- Dr. Steffen Meiler, Department Chair
- Dr. Walter Moore, Graduate Medical Education, MCG
- ACGME