

**STATE UNIVERSITY OF NEW YORK - DOWNSTATE MEDICAL CENTER,
STATE UNIVERSITY OF NEW YORK AT LONG ISLAND COLLEGE HOSPITAL,
KINGS COUNTY HOSPITAL CENTER**



RESIDENT POLICY MANUAL

JULY 2011

**Policies and procedures contained within this manual have been reviewed and/or revised,
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DEFINITION OF ANESTHESIOLOGY

The medical specialty of anesthesiology establishes the highest standards for training and educational facilities through its Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME). The American Board of Anesthesiology (ABA) defines the field of Anesthesiology as the practice of medicine dealing with, but not limited to:

- Assessment of, consultation for, and preparation of patients for anesthesia.
- Relief and prevention of pain during and following surgical, obstetric, therapeutic, and diagnostic procedures.
- Monitoring and maintenance of normal physiology during the perioperative period.
- Management of critically-ill patients.
- Diagnosis and treatment of acute, chronic, and cancer-related pain.
- Clinical management and teaching of cardiac and pulmonary resuscitation.
- Evaluation of respiratory function and application of respiratory therapy.
- Conduct of clinical, translational, and basic science research.
- Supervision, teaching, and evaluation of performance of both medical and paramedical personnel involved in perioperative care.
- Administrative involvement in health care facilities and organizations, and medical schools necessary to implement these responsibilities.

In addition to medical knowledge and patient care, the program will emphasize interpersonal skills, effective communication, professionalism, systems-based practice and practice-based learning and improvement (PBLI) as part of a continuum of competency-based education.



FUNDAMENTAL CHARACTERISTICS OF A PHYSICIAN/ANESTHESIOLOGIST

A resident will, at all times, demonstrate the fundamental characteristics of a physician.

1. A physician is **TRUTHFUL**, to his patients, colleagues, professional co-workers, and to the public. He does not lie or evade or practice deception in his professional conduct.
2. A physician is **HONEST**, and does not cheat or steal or tolerate those who do.
3. A physician is **RELIABLE**. Realizing that the practice of medicine relies upon the integration of the activities of many people with many and diverse talents, all working toward the goal of optimal patient care, the physician carries his share of the burden willingly, appears on time for his assignments, does his share of work, and leaves only when his work is completed.
4. A physician is **KNOWLEDGEABLE**. Realizing that medicine is a learned profession, whose body of knowledge is constantly expanding, he studies diligently, frequently, and regularly. He demonstrates his knowledge by passing required examinations, especially, as an anesthesiologist,

the yearly In-Training Examination, and later, the written and oral examinations for Board certification by the American Board of Anesthesiology.

5. A physician is **CARING**. The physician is eager to apply his knowledge to patient care and seeks out opportunities to be of service.
6. A physician is **RESPECTFUL**. He respects the opinions of his teachers, co-workers, and peers, and treats their ideas with the respect they deserve. He is always willing to listen, and ever slow to criticize. His greatest respect is for his patients, those who have entrusted him with their good health and even their lives.



COMPETENCE OF PERSONNEL

A competent anesthesiologist is expected to be proficient in:

- **Technical Skills:** Proficiency in providing all technical services required in the practice of the specialty.
- **Medical Judgment:** The application of mature medical judgment in solving medical problems associated with patient care.
- **Scholarship:** The talent, training, and habits of study necessary for evaluating and appropriately applying new knowledge.



CORE COMPETENCIES

The anesthesiology residency training program is aligned with the changing needs of the health care delivery system. The core competencies are the vital structure upon which the program's core curriculum has been developed. The six general competencies endorsed by the ACGME are:

1. Patient care
2. Medical knowledge
3. Interpersonal and communication skills
4. Practice-based learning and improvement
5. Professionalism
6. Systems-based practice

These competencies have been incorporated into the department's overall core curriculum and subspecialty rotation learning objectives. The overall expectation is that graduating residents will satisfactorily complete the required training and demonstrate sufficient competence to enter practice without direct supervision.



FUNDAMENTAL CONSIDERATIONS FOR ALL ANESTHETICS

Prior to the induction of anesthesia:

1. A medical evaluation is made and recorded by a physician.
2. The individual responsible for the anesthetic is thoroughly familiar with the medical and surgical history of the patient.
3. Pertinent consultations are requested and obtained.
4. Provisions for continuity of care are established.
5. The physicians responsible for anesthetic management are identified to the patient. The attendings' availability for supervision and direction is established, if he/she is not personally administering the anesthetic.



BASIC GUIDELINES FOR ANESTHESIA CARE

I. Surgical Anesthesia

- A. Pre-anesthetic evaluation and preparation by a responsible physician means that he/she:
 1. Review the chart.
 2. Interview the patient to:
 - a. Discuss medical, anesthetic and drug history.
 - b. Perform any examinations that would prove useful in making decisions regarding risk and management.
 3. Order necessary tests and medication essential to the conduct of the anesthetic.
 4. Obtain consultations, as deemed necessary.
 5. Record impressions on the patient's chart or on the anesthetic record.
- B. Pre-anesthetic care means:
 1. Re-evaluation of the patient prior to induction.
 2. Careful, thorough preparation and check of equipment, drugs, fluids, and gas supplies.
 3. Availability of equipment and experience in its use when administering an anesthetic, including, but not necessarily limited to: functioning laryngoscope, endotracheal tubes, wide selection of airways and masks, artificial ventilation, defibrillator, and suction equipment.
 4. Proper application of monitoring equipment.
 5. Accurate documentation of all aspects of the anesthetic.
- C. Post-anesthesia care requires:
 1. Availability of nursing personnel and equipment necessary for safe post-anesthesia care.
 2. Awareness by responsible physician of competence level of personnel who administer post-anesthesia care.
 3. Informing post-anesthesia care personnel of any problems experienced by the patient.

4. That the individual who administered the anesthetic remain with the patient as long as necessary.
5. That a physician participates in establishing policies for the discharge of patients from any post-anesthesia care facility.
6. At least one visit with appropriate documentation on the patient's chart during the early post-anesthetic period.
7. Management of related anesthesia complications.

II. Obstetrical Anesthesia

Except in emergency or near-emergency situations; no difference in standard of care should exist between obstetrical and surgical patients as described above.

III. Resuscitation Procedures

Resuscitation procedures require the availability, teaching and coordinated participation of trained personnel as practiced in the particular hospital. Please refer to the hospital “Policy and Procedures.”

IV. Availability of best qualified personnel for:

- A. All patients in all anesthetizing areas at all times.
- B. Providing the same quality of care for both emergency and elective cases.

V. Reflective Practice and PBLI:

The department recognizes the need for education and departmental evaluation of quality of care, which includes regular meetings to review cases, anesthetic techniques, morbidity and mortality conferences, and continuous self-evaluation and evidence of professional growth.



THE CONTINUUM OF EDUCATION

Duration and Scope of Education

The continuum of education in anesthesiology consists of four years of full-time training subsequent to the date that the medical or osteopathic degree has been conferred. The continuum consists of a Clinical Base Year and 36 months of approved training in anesthesia (CA-1, CA-2, and CA-3 years). Prospective approval by the ABA is required for exceptions to ABA policies regarding the training planned for individual residents.

Program Design – Clinical Anesthesia Training (CA-1 YEAR)

- A. During the **clinical base year** the physician must be enrolled and training as a resident in a transitional year or primary specialty training program in the United States or its territories that is accredited by the ACGME or approved by the American Osteopathic Association, or outside the United States and its territories in institutions affiliated with medical schools approved by the Liaison Committee on Medical Education from the date the training begins to the date it ends.
Training as a fellow in a subspecialty program is not an acceptable Clinical Base experience.

The **clinical base year** must include at least six months of clinical rotations during which the resident has responsibility for the diagnosis and treatment of patients with a variety of medical and surgical problems, of which at most one month may involve the administration of anesthesia. Acceptable clinical base experiences include training in internal medicine, pediatrics, surgery or any of the surgical specialties, obstetrics and gynecology, neurology, family medicine or any combination of these as approved for the individual resident by the director of his or her training program in anesthesiology. The clinical base year should also include rotations in critical care and emergency medicine, with at least one month, but no more than two months, devoted to each. Other rotations completing the 12 months of broad education should be relevant to the practice of anesthesiology.

The resident must complete the clinical base year before beginning CA-3 year clinical rotations.

- B. The three-year **CLINICAL ANESTHESIA** curriculum (CA 1-3) consists of experience in basic anesthesia training, subspecialty anesthesia 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.
1. Experience in **BASIC ANESTHESIA TRAINING** is intended to emphasize basic and fundamental aspects of the management of anesthesia. It is recommended that at least 12 months of the CA-1 and CA-2 years be spent in basic anesthesia training with the majority of this time occurring during the CA-1 year.
 2. **SUBSPECIALTY ANESTHESIA TRAINING** is required to emphasize the theoretical background, subject material, and practice of subdisciplines of anesthesiology. These subdisciplines include obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuro anesthesia, anesthesia for outpatient surgery, recovery room care, regional anesthesia, and pain medicine. It is recommended that these experiences be subspecialty rotations and occur in the CA-1 and CA-2 years. The sequencing of these rotations in the CA-1 and CA-2 years is left to the discretion of the program director.

By the end of the CA-3 year, required experiences in perioperative care must include four months of distinct rotations in critical care medicine with progressive responsibility and three months in pain medicine that may include one month in an acute perioperative pain management rotation, one month in a rotation for assessment and treatment of inpatients and outpatients with chronic pain, and one month of regional analgesia experience in pain medicine. Experiences in these rotations must emphasize the fundamental aspects of anesthesia, preoperative evaluation, and immediate postoperative care of surgical patients, and assessment and treatment of critically-ill patients and those with acute and chronic pain. An acceptable critical care rotation should include active participation in patient care, active involvement by anesthesia faculty experienced in the practice and teaching of critical care, and an appropriate population of critically-ill patients. Experience in short-term overnight post-anesthesia units, intermediate step-down units, or emergency rooms, does not fulfill this requirement.

3. Experience in **ADVANCED ANESTHESIA TRAINING** constitutes the CA-3 year. Residents, in collaboration with the program director, will design their CA-3 year of training. The CA-3 year is a distinctly different experience than the CA-1 and 2 years, requiring progressively more complex training experiences and increased independence and responsibility for the resident.

Resident assignments in the CA-3 year should include the more difficult or complex anesthetic procedures and care of the most seriously ill patients. Residents must complete the Clinical Base Year, as well as the CA-1 and 2 years of training before they can begin clinical rotations in fulfillment of the CA-3 year requirement.

CA-3 residents are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining months in advanced anesthesia training, in one to three selected subspecialty rotations, or in research. Residents may train in one anesthesia subspecialty for, at most, six months during the CA-3 year and no more than 12 months during the CA 1-3 years. The training must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident demonstrates sound clinical judgment in a wide variety of clinical situations and can function as a leader of perioperative care teams.

4. There are **OPTIONS FOR RESEARCH** during the anesthesiology residency. Interested residents could spend approximately 25% of a 3- or 4-year training program, and 38% of a 5-year program, engaged in scholarly activities. Suggested templates for research during the anesthesiology residency are posted on the ABA website at www.theABA.org. The program director must develop a plan with strict guidelines for research activity and “work product” oversight, if a resident’s research activities will be more than six months. The resident must be enrolled in an ACGME-accredited anesthesiology program and remain active in the educational component of the program while pursuing research. Please refer to the February 2011 ABA booklet (p.12) for additional information on research options, scholarly activities and oversight by the Scholarship Oversight Committee.

A resident must have a satisfactory Core Competence Committee report for six months of Clinical Anesthesia training immediately preceding any research period unless prospectively approved by the ABA Credentials Committee.

For additional information on departmental requirements for research & scholarly activities, please refer to **pp. 24-26** of this manual.

- C. The ABA grants a resident **credit toward the CA 1-3 year requirements** for Clinical Anesthesia training that satisfy **all four** of the following conditions:
 1. The CA 1-3 years of training are spent as a resident enrolled with the ABA by no more than two ACGME-accredited anesthesiology residency programs in the United States or its territories. An ACGME-accredited program includes the sponsoring (parent) institution and major participating institutions (i.e. institutions that have an RRC-approved integration or affiliation agreement with the sponsoring institution).
 2. The period of Clinical Anesthesia training as an enrolled resident of any single program is at least six months of uninterrupted training.
 3. The six-month period of Clinical Anesthesia training in any one program ends with the receipt of a satisfactory Certificate of Clinical Competence. To receive credit from the ABA for a period of Clinical Anesthesia training that is not satisfactory, the resident must immediately complete an additional six months of uninterrupted Clinical Anesthesia training in the same program with receipt of a satisfactory Certificate of Clinical Competence. **If a resident receives consecutive**

Certificates of Clinical Competence that are not satisfactory, additional training is required. When a resident receives a satisfactory Certificate of Clinical Competence immediately following consecutive periods of training that are not satisfactory, the ABA will grant credit only for the period of satisfactory training and the most recent of the periods of unsatisfactory training immediately preceding it.

4. Training away from the resident's ACGME-accredited anesthesiology program cannot occur until completion of at least one year of Clinical Anesthesia or during the last three months of the CA-3 year, unless such training will be in another ACGME-accredited anesthesiology program.

Current Residency Review Committee requirements limit training in institutions not integrated with the resident's ACGME-accredited program to a maximum of 12 months throughout the CA 1-3 years. The ABA will accept no more than six of these months in institutions not affiliated with the ACGME-accredited program. Therefore, residents must complete a minimum of 24 months of Clinical Anesthesia training in their ACGME-accredited program's parent and integrated institutions and may complete at most six months of Clinical Anesthesia training away from their ACGME-accredited program.

The Credentials Committee of the ABA must prospectively approve Clinical Anesthesia training away from the ACGME-accredited program even if the training will occur in another ACGME-accredited program (see Section 2.02 E of the ABA booklet). The request for approval must include a chronological description of the rotations, information about the supervision of the resident, and assurances that the resident will be in compliance with the limits on training away from his/her ACGME-accredited program. Further, the resident must remain enrolled in his/her program while training away from the ACGME-accredited program, and his/her program must report the training on the Clinical Competence Committee report filed for the period involved.

- D. The Credentials Committee of the ABA will assess individual requests for part-time training. Prospective approval is required for alteration in the number of hours per week of training or alteration in the temporal distribution of the training hours (e.g. substantially different night and weekend hours) from other residents in the program. It is expected that residents will take not more than twice the "standard time" to achieve the level of knowledge and clinical experience comparable to a full-time resident completing the program in standard time. Residents who train on a part-time basis are expected to meet all the program's didactic requirements before training is complete.

Requests for part-time training must be in writing from the program director and countersigned by the department chair (if that is another person), the hospital's Designated Institutional Officer (DIO), and the resident. The letter must include: (1) the reason for the part-time training request, (2) documentation about how all clinical experiences and educational objectives will be met, (3) assurance that the part-time training program will teach continuity-of-care and professionalism, and (4) an explanation about how the part-time training program will maintain the overall quality, content and academic standards/clinical experiences of the training program required of a full-time trainee.

- E. **Prospective approval is required** for exceptions to ABA policies regarding the training planned for individual residents (see Sections 2.02.B (3) and 2.02.C (4) aforementioned February 2011 ABA booklet of information). The Credentials Committee of the ABA considers requests for prospective

approval on an individual basis. The ABA office must receive the request from the program director on behalf of a resident at least **four months** before the resident begins the training in question. It is the responsibility of the program director and the resident to assure that the request is received in a timely manner.

Educational Program

1. Educational Goals for the Program

The Anesthesiology department provides education, training, and experience in an atmosphere of mutual respect between instructors and residents so that the latter are stimulated and prepared to apply acquired knowledge and talents independently. The program provides an environment that promotes the acquisition of the knowledge, skills, clinical judgment, and attitudes essential to the practice of anesthesiology.

The primary goal of the residency training program in Anesthesiology is to provide an organized education program with guidance and supervision of the resident, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients. Throughout the course of training, the resident will assume progressively greater responsibility, consistent with individual growth in clinical experience, knowledge and skill. Each resident will be provided with a booklet containing the written competency-based goals and objectives for each anesthesiology rotation at each educational level. **PLEASE REFER TO THE CURRICULUM MANUAL.** The program distributes a hard copy of the Curriculum Manual during the CA-1 orientation program. It is updated annually and is available for review by all faculty and residents on the department website. Before the start of each rotation, all residents are reminded via e-mail to review their respective rotation's goals and objectives.

2. Program Objectives

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

ACGME Competencies

The program has integrated the following ACGME competencies into the curriculum:

A) Patient Care

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

- (1) A wide spectrum of disease processes and surgical procedures is available within

the program so as to provide each resident with a broad exposure to different types of anesthetic management. The following list represents the minimum clinical experience which should be obtained by each resident in the program. Although the minimum requirements are for the CA-1 through CA-3 years, the majority of these should be accomplished in the CA-1 and CA-2 years.

- (a) 40 patients undergoing vaginal delivery. There must be evidence of direct resident involvement in cases involving high-risk obstetrics;
- (b) 20 patients undergoing cesarean sections;
- (c) 100 patients less than 12 years of age undergoing surgery or other procedures requiring anesthetics. Within this patient group, 20 children must be less than three years of age, including five less than three months of age;
- (d) 20 patients undergoing cardiac surgery. The majority of these cardiac procedures must involve the use of cardiopulmonary bypass;
- (e) 20 patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery. Excluded from this category is surgery for vascular access or repair of vascular access;
- (f) 20 patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures;
- (g) 20 patients undergoing intracerebral procedures. These patients include those undergoing intracerebral endovascular procedures. However, the majority of these twenty procedures must involve an open cranium;
- (h) 40 patients undergoing surgical procedures, including cesarean sections, in whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for perioperative analgesia. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;
- (i) 20 patients undergoing procedures for complex, life-threatening injuries. Examples of these injuries include trauma associated with car crashes, falls from high places, penetrating wounds, industrial and farm accidents, and assaults. Burns covering more than 20% of body surface area also are included in this category;
- (j) 40 patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;

- (k) 40 patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or perioperative analgesic management;
- (l) 20 new patients who are evaluated for management of acute, chronic, or cancer-related pain disorders. Residents should have familiarity with the breadth of pain management including clinical experience with interventional pain procedures;
- (m) Patients with acute postoperative pain. There must be documented involvement in the management of acute postoperative pain, including familiarity with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities;
- (n) Patients scheduled for evaluation prior to elective surgical procedures. There must be documented involvement for at least four weeks in preoperative medicine;
- (o) Patients who require specialized techniques for their perioperative care. There must be significant experience with a broad spectrum of airway management techniques (e.g., performance of fiberoptic intubation and lung isolation techniques such as double lumen endotracheal tube placement and endobronchial blockers). Residents also should have significant experience with central vein and pulmonary artery catheter placement and the use of transesophageal echocardiography and evoked potentials. The resident must either personally participate in cases in which EEG or processed EEG monitoring is actively used as part of the procedure or have adequate didactic instruction to ensure familiarity with EEG use and interpretation. Bispectral index use and other similar interpolated modalities are not sufficient to satisfy this requirement;
- (p) Patients immediately after anesthesia. There must be a post-anesthesia care experience of 0.5 month involving 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. The Review Committee expects resident clinical responsibilities in the postoperative care unit to be limited to the care of postoperative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. Designated faculty must be readily and consistently available for consultation and teaching.
- (q) Critically-ill patients. There must be a minimum of four months of critical care medicine distributed throughout the curriculum in order to provide progressive responsibility to trainees in the later stages of the curriculum. No more than two months of critical care medicine will be credited for training that occurs before the CA-1 year. Each critical care medicine rotation should be at least one month in duration, with progressive patient

care responsibility in advanced rotations. Overall, this training must take place in units providing care for both men and women in which the majority of patients have multi-system disease. The post-anesthesia-care unit experience does not satisfy this requirement. Anesthesia residents must actively participate in all patient care activities and as a fully integrated member of the critical care team. During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients and the educational activities of the residents.

- (f) Patients undergoing diagnostic or therapeutic procedures outside of the surgical suites. There must be appropriate didactic instruction and sufficient clinical experience in managing the specific needs of patients undergoing these procedures.
- (2) Must maintain a comprehensive anesthesia record for each patient as an ongoing reflection of the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided as required, and the fluids administered. The patient's medical record should contain evidence of preoperative and postoperative anesthesia assessment.

Resident ACGME Caselog Requirement

Residents must maintain an electronic record (ACGME CASELOG) of their clinical experiences. The record is reviewed by the program director on a quarterly basis. Appended to this manual is a summary of the minimum clinical experiences which must be obtained by each resident.

B) Medical Knowledge

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

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

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

C) Practice-based Learning and Improvement

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

- (a) identify strengths, deficiencies, and limits in one's knowledge and expertise;
- (b) set learning and improvement goals;
- (c) identify and perform appropriate learning activities;
- (d) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- (e) incorporate formative evaluation feedback into daily practice;
- (f) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- (g) use information technology to optimize learning; and,
- (h) participate in the education of patients, families, students, residents and other health professionals.

D) Interpersonal and Communication Skills

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

- (a) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- (b) communicate effectively with physicians, other health professionals, and health related agencies;
- (c) work effectively as a member or leader of a health care team or other professional group;
- (d) act in a consultative role to other physicians and health professionals; and,
- (e) maintain comprehensive, timely, and legible medical records, if applicable.

E) Professionalism

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

- (a) compassion, integrity, and respect for others;
- (b) responsiveness to patient needs that supersedes self-interest;
- (c) respect for patient privacy and autonomy;
- (d) accountability to patients, society and the profession; and,
- (e) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

F) Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- (a) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- (b) coordinate patient care within the health care system relevant to their clinical specialty;
- (c) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- (d) advocate for quality patient care and optimal patient care systems;
- (e) work in professional teams to enhance patient safety and improve patient care quality; and,
- (f) participate in identifying system errors and implementing potential systems solutions.

Resident Job Description at Each Level of Training

CA-1 and CA-2 Years (Clinical Anesthesia 1 & 2)

Basic Anesthesia Training

Residents will gain experience in basic anesthesia, which emphasizes basic and fundamental aspects of the management of anesthesia. These initial rotations in surgical anesthesia, critical care medicine, and pain medicine will emphasize the fundamental aspects of anesthesia, preoperative evaluation and immediate postoperative care of surgical patients, and assessment and treatment of critically-ill patients and those with acute and chronic pain. Residents will receive training in the complex technology and equipment associated with these practices. As residents progress in clinical skills, they will be assigned to anesthesia subspecialty rotations.

Subspecialty Anesthesia Training

Residents will gain experience in the subspecialty areas of anesthesia, which emphasizes the theoretical background, subject material and practice of subspecialties of anesthesiology.

These subspecialties include cardiac and thoracic anesthesia, neurosurgical anesthesia, obstetrical anesthesia, pediatric anesthesia, pain medicine, regional anesthesia, and transplant anesthesia. These experiences will be in the form of subspecialty rotations.

ROTATION	LENGTH
CARDIAC	2 MONTHS
THORACIC	1 MONTH
NEUROSURGICAL	2 MONTHS
OBSTETRICAL	2 MONTHS
PEDIATRIC	2 MONTHS
PAIN MEDICINE	
ACUTE	1 MONTH
CHRONIC	1 MONTH
REGIONAL	1 MONTH
TRANSPLANT	1 MONTH

CA-3 (Clinical Anesthesia 3 Year)

Residents will gain experience in **Advanced Anesthesia Training**. They will collaborate individually with the Program Director to design their respective CA-3 year of training. The CA-3 year is a distinctly different experience from the CA 1-2 years with exposure to more complex training experiences and increased independence and responsibility. Resident assignments will include more difficult or complex anesthetic procedures and care for the most seriously ill patients.

Residents must complete the Clinical Base and CA 1-2 years of training before they begin CA-3 year clinical rotations. CA-3 residents are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining months in advanced anesthesia training, in one to three selected subspecialty rotations, or in research. Residents may train in one anesthesia subspecialty for at most six months during the CA-3 year and no more than 12 months during the CA 1-3 years. The training must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident demonstrates sound clinical judgment in a wide variety of clinical situations and can function as a leader of perioperative care teams.

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



USMLE PART III POLICY

The department of Anesthesiology follows the SUNY Downstate Medical Center's USMLE/COMLEX Part 3 policy. Successful completion of USMLE & COMLEX Part 3 is recommended before entry into the CA-1 year of the Anesthesia program.

The SUNY Downstate Medical Center USMLE/COMLEX Policy for entry into the PGY-3year is the following: "All residents in SUNY Downstate Medical Center GMCC-approved programs are required to successfully complete and pass USMLE Step 3 or COMLEX Part 3 examinations by November 1st in the second post-graduate year of training. Failure to demonstrate passage within the stated time line may result in termination of training at the end of the academic year." Exceptions to this policy will be considered after discussion with the Program Director and final approval from the Core Competency Committee (CCC) Members.



LICENSURE

Departmental Policy

In order to enter the examination process of the ABA, medical licensure is required. All residents are strongly urged to complete the necessary applications and obtain licensure, in any state, as soon as possible.

International Medical Graduates

International medical graduates (IMG), when eligible, are encouraged to obtain a permanent state license after completion of the required three (3) years of post-graduate residency training. During the first year of residency in Anesthesiology, IMGs should obtain a valid limited permit with a filed application for permanent licensure. In order to facilitate the licensure process with the New York State Education Department, timely validation of paperwork and credentials should be followed up with the Bureau of Comparative Education on an on-going basis until issuance of a limited permit and licensure. For a limited permit or license in another state, refer to the appropriate State Board of Medical Education or Division of Occupational and Professional Licensing.



BOARD CERTIFICATION

The most important evidence of competence in an anesthesiologist is certification by the American Board of Anesthesiology (ABA). All residents are urged to familiarize themselves with the requirements of the Board and to enter its examination process as soon as possible.

For certification purposes, the relationship between The American Board of Anesthesiology (ABA) and candidates is personal, with little direct involvement by the Department of Anesthesiology. The certification requirements of the ABA are described in the “ABA Booklet of Information” which is issued each year.

The Department of Anesthesiology certifies that candidates have fulfilled all the requirements of the continuum of education in anesthesiology. The residency training program submits an evaluation of clinical competence in January and July on behalf of each resident who has spent any portion of the prior 6 months in clinical anesthesia training in or under the sponsorship of the residency program and its affiliates.

The resident must sign his/her clinical competence report, prior to submission to the Board. Please refer to the “February 2011 ABA Booklet of Information” for specific details. The resident must apply for permission to take the examination, and pay the required fee. Please note that the CCC report from the department and the evaluation of the program director and others will be used as the basis for assessing admission qualifications to enter the examination system of the ABA.

The ABA recertification programs include a commitment to continuing education, an assessment of the quality of the practice in the local environment, and an evaluation of knowledge.

All certificates issued by the ABA will be valid for a period of ten (10) years after the candidate passed the certifying examination. For details of ABA policies and requirements, please refer to the Booklet of Information of the American Board of Anesthesiology. A copy of the “February 2011 ABA Booklet of Information” is provided by the department at orientation and can also be found at www.theaba.org.



ABA SUBSPECIALTY CERTIFICATION

The ABMS has authorized the ABA and other ABMS Member Boards to award certification in the subspecialties of Critical Care Medicine, Pain Medicine, and Hospice and Palliative Medicine. Please refer to section 3.01 of your “February 2011 ABA Booklet of Information” for additional information on Subspecialty Certificates.



DEPARTMENTAL PROGRAM ENTRANCE REQUIREMENTS

The department has a four-year continuum of education in anesthesiology. Applicants must be graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME). Exceptionally qualified graduates of foreign medical schools are eligible for appointment, provided they have been certified by the Educational Commission for Foreign Medical Graduates (ECFMG).

Prerequisites for application: Diploma from an ACGME-approved medical school or school of Osteopathic Medicine; International Medical Graduates must have a Standard ECFMG Certificate, have passed the CSA (clinical skills assessment), at minimum passed USMLE Steps 1 and 2, and obtained a clinical base year (PGY-1), if not admitted to our categorical program, which must be devoted to clinical training in a primary care specialty. Under special circumstances, and in accordance with the American Board of Anesthesiologists (ABA) regulations, an applicant can be accepted prior to completing a PGY-1 year, which then must be completed within the first two years of clinical anesthesia training.

Process for review of applications: Applications are accepted through the Electronic Residency Application Service (ERAS). Criteria determined by the Resident Selection Committee are applied and applications are retrieved by the administrator of the Resident Education Office. Applicants that meet the criteria are given appointments to be interviewed by members of the Resident Selection Committee, Chief Resident(s), the Program Director and, if available, the Chair of the Department. Applicant Assessment forms are completed by each interviewer.

For NRMP applicants, a special “ranking” meeting is held and committee members, the Program Director, and the Chairman rank the interviewed applicants. A similar process is conducted for applicants outside of the Match.



EDUCATION PROGRAM AT SUNY-DOWNSTATE MEDICAL CENTER

Recommended Reading

The goal of the educational program is to stimulate residents to learn by guiding and instructing them. At all times, that requires the commitment to learning, self-advancement, and self-evaluation which are characteristics of the mature physician. What will be taught in the operating room, recovery room, intensive care unit, or at conferences, journal clubs, and grand rounds will be only a fraction of the available information. Residents are also expected to devote themselves to mastery of their chosen career by reading the established journals and books in this area. The following journals should be read on a regular basis:

Anesthesiology
Anesthesia and Analgesia

British Journal of Anesthesia
The Canadian Anesthetist' Society Journal

Residents should also maintain his/her knowledge of other areas of medicine by regularly reading such general medical journals as:

The New England Journal of Medicine
Lancet

Critical Care Medicine
The Journal of Neurosurgical Anesthesia

Special attention should be given to pharmacology and such journals as: **Clinical Pharmacology & Therapeutics**

All of the above journals are available in the Anesthesia Department Library or the medical school library.

It is recommended that all residents read the following textbooks to become familiar and proficient with the basic concepts of Anesthesiology:

Miller's Anesthesia, 7th Edition, Volumes I and II, edited by Ronald D. Miller
Clinical Anesthesia, 6th Edition, edited by Paul G. Barash, et al.

During subspecialty rotations, advanced readings will be assigned to residents related to the respective subspecialty. The training program at SUNY is conducted at University Hospital, Long Island College Hospital, and Kings County Hospital Center. Each hospital has its own characteristics, philosophy and patient population, thus providing residents with ample exposure to a diverse patient population and clinical training challenges.

The 36 months of Clinical Anesthesia training will be spent at the three aforementioned sites. Elective rotations may be assigned to Maimonides Medical Center or Beth Israel Medical Center for one month of cardiothoracic anesthesia, Lutheran Medical Center for thoracic, neurosurgical and regional anesthesia, and Memorial Sloan Kettering for neurosurgical anesthesia.

The first month of training introduces residents to all aspects of anesthesia care. Under close supervision of the attending staff, residents will anesthetize all types of patients for all types of surgical procedures. The amount of care personally rendered by the residents, and the amount of responsibility assumed, will be determined by progress in developing the technical skills and judgment required of a specialist in anesthesiology.

After acquiring basic skills and knowledge, residents will rotate on a pre-determined basis through general surgical specialties such as urologic, gynecologic, ENT, trauma and vascular anesthesia. During the specialty rotations, the majority of the residents' time will be devoted to the particular areas of anesthetic management, although residents will anesthetize other patients as necessary. During the next twelve (12) months of Clinical Anesthesia training, residents will rotate through other specialty services - obstetrics, cardiac, thoracic neurosurgery, pediatrics, critical care, ambulatory surgery, pain management and regional anesthesia.

At all times during training, residents are expected to see and evaluate their patients preoperatively, to formulate a plan of anesthetic management, and to discuss this plan with the assigned attending. It is mandatory to discuss the anesthesia management with the assigned attending the evening before the scheduled O.R. date. Residents are then expected to supervise the Recovery Room progress of their patients by evaluating them postoperatively and providing postoperative patient care as needed.

The schedule for the didactic program is included in this manual. The didactic program has been structured to combine all aspects of Anesthesiology with the basic sciences and application of the basic sciences in Anesthesiology. Regularly scheduled teaching sessions will be held to supplement ongoing clinical instruction. The didactic program is organized to provide continuity and sequencing of anesthesia related topics. They include morbidity and mortality conferences, lectures, discussions and seminars. Residents participate in all aspects of the teaching program. Faculty from other disciplines and/or other institutions is invited to participate in various components of the didactic program.

The main components of the didactic program are Grand Rounds and Performance Improvement, Colloquia, Visiting Professor Program, Case-Based Discussions, Journal Clubs, Board Reviews, interviews, Morning Conferences, Subspecialty Conferences, Workshops and Competency lectures, and mock oral examinations.

The Didactic Program

- **Grand Rounds & Performance Improvement Conference** - Grand Rounds consists of cases covering topics or problems in anesthesiology. The cases are presented by residents every **Friday** at 7:15 a.m. whenever preceded by a colloquia session. However, whenever colloquia are electronic, Grand Rounds will start at 7:00 a.m. Each case presentation is followed by questions and discussions by faculty and residents. Grand Rounds are open to all practicing anesthesiologists in the Brooklyn, Queens and Staten Island areas. The Chairman of the Department or designee moderates all Grand Rounds sessions.
- **Colloquia** - The training and research colloquia consist of a three year rotating sequence of seminars which cover current anesthesiology topics. Faculty members are selected to lead the seminars and the discussion sessions that follow. Outlines, with objectives and reading lists are distributed before each colloquia. It is required that each participant be prepared to participate in the colloquium and the ensuing discussions. The colloquia are held every Friday from 6:25 a.m. to 7:10 a.m.

Beginning in July 2011, the program will make use of internet and technology to improve our teaching program. The traditional didactic colloquia session will evolve over time into an online delivery format.

Each faculty member will upload their colloquia lecture as a PowerPoint presentation with embedded audio files as well as flash media files. There will be an audio presentation to go along with the presentation that will last approximately 60 minutes total (including pre-test/lecture and post-test). Residents will be required to complete each session in one sitting within that week.

Attendings will be able to see class performance /distribution on each question of the pre- and/or post-tests. Residents will also see statistical breakdown of each test. Answer and explanations to quiz will be provided after the completion of the module.

Each resident can only see his/her score. After residents have finished with the post-test, an automatic email (without grades) will be sent to the Resident Coordinator. Results of the pre- and post-tests are confidential.

Our goal is to provide a supportive educational environment, where self-directed learning is encouraged and facilitated with the help of the faculty at SUNY Downstate's Anesthesia Program. The objective is to encourage learning and provide a worthwhile, rewarding experience for the learner and teacher.

- **Visiting Professor** - At least six times a year, a Visiting Professor of Anesthesiology visits the residency program. The professor participates in operating room teaching of the residents, mock oral examinations, luncheon discussions, meets with residents for a case discussion, and delivers a one-hour lecture during Grand Rounds.
- **Case-Based Discussions** - The case-based discussions are CA-1 study groups led by a faculty member. Four (4) residents are assigned each Friday between December and May to attend from 8:00 am-11:00 am. To accommodate a class of 20 residents, 5 weeks are scheduled for each module. Residents, in groups, will sequentially review Miller's 7th Edition, using the Content Outline as a guide for their notes and group presentations. At the end of the session, residents will be able to interpret and discuss, using physiologic concepts, the pathophysiology presented in clinical cases.
- **Journal Clubs** - Anesthesiology subspecialty directors conduct discussion groups focusing on current research articles reported in the subspecialty journals. These clubs are directed by faculty members in the subspecialty to promote continuous research in the field as well as assist the resident in developing proficiency in research methods and techniques. The journal clubs meet on a day and time selected by the faculty member.
- **ITE/Board Reviews:** Several months before the ABA In-Training Examination and again before the ABA Written Examination, faculty members give reviews to the residents in place of colloquia. These reviews are based on the subspecialty areas of anesthesiology. ITE and board review questions along with a lecture are used to assist the resident in successfully passing each exam.
- **Morning Rounds** - Morning rounds are conducted from 6:40 a.m. to 7:15 a.m. Mondays – Thursdays at UHB, KCHC, LICH, and LMC. The Chief Resident will generate the monthly resident assignments. **All residents** will participate in preparing these reviews.
- **Subspecialty Conferences** – The subspecialty Conferences occur in lieu of morning rounds at the designated hospitals. At SUNY, cardiac conferences take place on the first and third Wednesdays of

the month. At LICH, Neurosurgical Anesthesia board reviews and oral exams are scheduled and moderated by Dr. Gina Matei.

- **Mock Oral Exam Program** – Each month, two designated residents from the CA-2 and CA-3 classes will participate in practice mock oral board examinations. Selected faculty members from each hospital will serve as examiners and ask oral board practice questions. Residents are expected to respond based on their clinical experience and academic knowledge. The objective of the program is to introduce residents to the format of the ABA oral board exam in order to better prepare them to successfully pass the exam. The outcomes of the exams are not graded and will not be part of the semi-annual review process.
- **Simulation Activities** – As stated in the ACGME’s Common Program Requirements, residents must participate in at least one simulated clinical experience **each year**. For the CA-2 and CA-3 residents, the following simulation activities occur throughout the academic year:
 - Simulator workshop with I-Stan and Noell every Tuesday from 3 pm – 4pm at SUNY’s audiovisual center. Every scenario is mailed to the residents prior to the simulation. After the activity, residents will receive a complete discussion of the case and management issues that occurred during the simulation activity.
 - Difficult Airway Management workshop uses different airway management devices on a mannequin and cadavers.
 - Anatomy Cadaver Workshop- Ultrasound-guided regional anesthesia for all applicable regional procedures.

In addition, there are opportunities to learn percutaneous tracheostomy, ultrasound guided regional anesthesia for creation of vascular access in end stage kidney disease.

- **Workshops and Competency lectures** – **Specialty workshops**, such as, Airway Management, TEE, Regional, and Neuromonitoring, are held throughout the academic year to enhance faculty and resident education and clinical skills. In addition, **special competency-based educational lectures or workshops** are scheduled each academic year to educate faculty and residents on topics, such as, Professionalism and Cultural Diversity, Ethics, Resident Fatigue (identification and management), substance-abuse, practice management and other important topics.

Teaching Activity Attendance Policy

ATTENDANCE AT TEACHING ACTIVITIES IS REQUIRED FOR ALL RESIDENTS.

Residents on call the Thursday night before Friday morning Grand Rounds/Colloquia, are required to attend educational activities. The Resident Education Office will monitor all residents’ working hours to ensure compliance with both ACGME (www.acgme.org, link Resident Duty Hours) and NYS Title 10, Section 405.4 Regulations (Resident Duty Hours & Working Environment). Please refer to department policy, reviewed July 1, 2008, copy included in the appendices. Residents on sick leave who have notified their attending supervisor and the Resident Education Office of their absence will be excused from teaching activities. This policy is enforced to ensure attendance at all teaching activities. **Attendance at all academic events will be taken. The ACGME recommends that each resident attend a minimum of 75% of all teaching activities. Grand Rounds, Colloquia, Visiting Professor**

lectures, Orientation, and Workshops are required educational activities for all residents, unless they are on call, vacation, at a meeting, or excused by an attending that has informed the Resident Education Office.

Prior to Grand Rounds and colloquia, residents are provided, via email, with a protocol and a list of appropriate articles. Educational objectives, handout(s), and/or reading lists are distributed to the residents in advance of Grand Rounds, colloquia, Visiting Professors, and board review conferences. It is recommended that residents read all handout(s) and recommended articles in advance in order to make didactic sessions more meaningful and educational.

Residents' Scholarly Activities Requirement

- The curriculum is designed to advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
- All residents must participate in scholarly activity or research.
- Adequate educational resources to facilitate resident involvement in scholarly activities will be provided as necessary.
- All residents must complete one scholarly activity. Though this assignment usually occurs during the final 24 months of training, it may occur earlier, at the program director's discretion. Academic projects may include poster presentations at professional meetings, preparation and publication of review articles, book chapters, case report, manuals for teaching or clinical practice, or similar academic activities.

Alternatively, residents may elect to develop and perform or participate in one or more clinical or laboratory investigations. The outcomes of the investigation(s) should be suitable for presentation at local, regional, or national scientific meetings and that many will result in peer-reviewed abstracts or manuscripts. A faculty supervisor or mentor must be in charge of each project and investigation.

Departmental Scholarship Oversight Committee Procedures:

Objective: The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty. An active research component must be included within the program. Both faculty and residents must participate actively in scholarly activities.

Scholarship is defined as the following:

- The scholarship of discovery, as evidenced by peer-reviewed funding or publication of original research in peer-reviewed journals.
- The scholarship of dissemination, as evidenced by review articles or chapters in textbooks.
- The scholarship of application, as evidenced by the publication or presentation at local, regional, or national professional and scientific society meetings, for example, case reports or clinical series.
- Active participation of the faculty in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship.

To foster and develop an environment of inquiry and scholarship during residency and encourage further research experience and training, all residents will be required to participate in a scholarly activity as defined above.

Goals:

- Increased submission of scholarly activity at major national and specialty meetings.

- Increased participation in national resident research forums (e.g. ASA, PGA, FAER, SOAP, NYSCARF, New York Academy of Medicine).
- Increased resident interest in Research and fellowship training.
- Increased grant submissions.
- Increased involvement of faculty serving as mentors for basic science and clinical research.
- Increased publications in peer-reviewed journals.

Administrative Process

- Guidelines for conducting research and other scholarly activities are distributed to all residents at the beginning of each academic year in the Resident Research Handbook.
- All residents should select a faculty mentor from the Department List of Faculty Mentors. Faculty mentors will work with their team of residents to discuss proposed area of research, other scholarly activity, and define roles of team members.
- A Chief Resident for Research Activities will be designated each academic year and will serve as a liaison between faculty and residents. Additional resident research liaisons will be appointed for each CA year. After an introductory research seminar, CA-1 residents will be asked to submit their selected scholarly project and mentor to the Residency Education Office no later than **December 1st**. Resident liaisons will report to the Scholarship Oversight Subcommittee of the Research and Publications Committee.
- Residents may participate in multiple scholarly and research activities with a defined role.
- Residents will report any updates to their designated Resident Research Liaison on a monthly basis.
- Residents will present new proposals through the Scholarship Oversight Subcommittee of the Research and Publications Committee Meeting, which takes place on a monthly basis.
- Residents must complete their research/scholarly projects and submit a written summary to the Resident Education Office in their Resident Portfolio no later than **February 1st** of their **CA-3** year.
- Research colloquia will be scheduled throughout the academic year and will include lectures on statistics, research methodology, preparation for IRB, and research presentations (“colloquia style”). Outside seminars regarding grant writing, and other inter-departmental programs will be announced.
- Residents will be encouraged to submit their research/scholarly projects for presentation at scientific meetings, e.g., ASA, PGA Resident Research Forum, SUNY Research Day, specialty society meetings, etc. All abstracts must receive approval **PRIOR** to submission by either Dr. Rebecca Twersky or Dr. Audrée Bendo. Resident participation in Department Research Colloquia will be determined by the Vice-Chair for Research.
- Performance evaluation will be on a Pass/Fail basis, and Honors with Distinction. Competitive awards for “Excellence in Research” will be conferred on an annual basis. Residents will be selected to attend the ASA Celebration of Research and FAER Program at the Annual Meeting, and PGA Resident Research Component, and present the findings of these meetings at an appropriate department forum.

Acceptable Research Scholarly Projects

1. Case report on clinically relevant subject not previously reported in the literature.
2. Participation in active clinical project; this may include any of the following:
 - Protocol development
 - Literature Review
 - Recruitment of patients
 - Data Collection
 - Data Analysis
3. Manuscript preparation for peer-reviewed publication.

4. Writing book chapter.
5. Writing Review article.
6. Writing article for non-peer reviewed publication (e.g. Anesthesiology News, Sphere).
7. Submission of an abstract for presentation at ASA, PGA, IARS, NYSCARF or Subspecialty Society meetings.

Resident Evaluation of Educational Program

Evaluation is an important function of the anesthesia program. The department has developed processes for periodic and confidential written evaluation of:

- The educational experience and program performance (semi-annually)
- Faculty performance (monthly)
- Resident performance (monthly)
- Resident performance at completion of subspecialty rotations
- Resident self-evaluation (semi-annually)
- Core competency professional evaluation (semi-annually)

New Innovations, a web-based program, will be used to complete evaluations of the **educational experience, the anesthesia program, and faculty and resident performance**. The **program evaluation** is a mechanism designed to furnish the department with a method of assessing the on-going ability of the program to provide the foremost in educational training and experience. It specifically measures the quality of the curriculum in order to assure that the educational goals of the program are being met. The results of the program evaluation are reviewed by the Core Resident Education Committee on an annual basis to determine if any modifications are needed to improve the overall educational experience of the anesthesia residents in the upcoming academic year. The above is in addition to adjustments which may be made by the committee at any of their quarterly meetings.

Residents are encouraged **to evaluate each faculty member** that they have worked with on a monthly basis. To ensure anonymity, residents complete the evaluation onto a secured web site. The evaluations are analyzed by a program that generates individual faculty reports. Confidential reports are then forwarded to the Chairman for review on a quarterly basis. Faculty members meet with the Chairman of the department on an annual basis to discuss the computerized report of their individual evaluations.

The department's Core Competency Committee (CCC) evaluates **residents' performance** on a monthly or quarterly basis, according to necessity. The process for resident evaluations is detailed on **page 43** of the Policy and Procedure Manual. Residents receive information regarding their individual evaluations, semi-annually, and are also encouraged to personally review their evaluations a minimum of every three months. Residents also receive an evaluation of their performance at the completion of each subspecialty rotation by the director of service. A final summative evaluation is prepared for each resident completing the program.

ACGME RESIDENT SURVEY

Each spring, ACGME requires residents and fellows to complete an online survey that includes questions about residents' clinical and educational experiences, as well as duty hours worked. Detailed information for accessing the survey and the deadline for its completion is provided. Prior to release of the survey, the department meets with residents to make sure that the meaning of each survey question is understood.



RESIDENT RULES AND REGULATIONS

Anesthesiology residents are expected in the operating room promptly each morning. They will be expected to attend morning conferences with the attending-in-charge at 6:30 am everyday at all hospitals. They **must** be prepared to begin the administration of anesthesia to their patient at 7:30 a.m.

Preoperative and Postoperative Rounds

All residents who are assigned preoperative patients must assess each patient's status by history and physical examination, **write a preoperative note**, order any other laboratory tests deemed necessary, obtain consultations as indicated, write preoperative orders as thought proper, and discuss the patients with the attending anesthesiologist. If the attending is not in the hospital, he/she will be called at home. If for some reason the attending assigned to the case cannot be contacted, the in-house attending will be contacted.

When a resident sees a patient for another resident, he/she is to **call the resident who is assigned to administer anesthesia**. The resident assigned to administer anesthesia will also call the attending. **This is an important responsibility which must be met.**

Residents must also make postoperative rounds on all patients during the first postoperative day, with further rounds as the patient's condition warrants.

*****RESIDENT WRITTEN PERIOPERATIVE NOTES (PRE AND POST) ARE AN ACGME REQUIREMENT.*****

Resident On-Call Schedules & Hours

For State University Hospital, Kings County Hospital Center and University Hospital of Brooklyn at Long Island College Hospital, the call schedule will be made by the Administrative Chief Resident; any changes will be made through the Administrative Chief Resident and the Resident Education Office with final approval by the Program Director. On-call residents will assume their responsibilities after completing the normal day's activities. At University Hospital and Long Island College Hospital, the resident on call works under the direct supervision of the attending anesthesiologist.

At Kings County Hospital, the senior resident on-call works under the direct supervision of the anesthesiology attending on-call. However, the senior resident on-call may supervise the activities of the other residents and nurse anesthetists, under the general direction of the attending anesthesiologist on call.

Supervision of Residents

- All patient care will be supervised by qualified faculty. The clinical director at each facility will ensure and document direct supervision of residents at all times. The availability of faculty for supervision, direction and guidance will be established to provide residents with prompt and reliable systems for communicating with supervising faculty.

- Faculty assignment schedules will be structured to provide residents with continuous supervision and consultation.
- Faculty and residents will be trained to recognize signs of fatigue and sleep deprivation; please refer to the appendices for this policy. When the attending- in-charge observes that a resident is fatigued, the resident will be relieved from his/her assignment. The period of relief will be determined at the discretion of the attending in charge.

Duty Hours in the Learning and Working Environment

Providing residents with a sound academic and clinical education in a supportive educational environment is carefully planned and balanced with concerns for both patient safety and resident well-being. The program ensures that the educational objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. In this respect, didactic and clinical education has a priority in the allotment of residents' time and energies. Assignments of duty hours will be based on the recognition that faculty and residents collectively are responsible for the safety and welfare of patients. **The only exception to this rule is for emergency care during a disaster. For more information, refer to departmental policy: Disaster Plan Protocol Residents and Fellows, included in the appendices.**

- 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 (educational conferences).
- Duty hours will not exceed 80 hours per week, averaged over a four week period inclusive of all in-house call activities, clinic assignments and all moonlighting (if approved). Any exception to this maximum must be approved by the GMEC and DIO and then submitted for approval to the ACGME Review Committee. Activities, which count in the 80-hour work week and for the consecutive duty hours work rules, include inpatient assignments, outpatient clinic, emergency and acute care assignments, required conferences and other required educational activities, program required research activities and on-site activity/direct patient care that occurs when a resident/fellow is called back while on beeper call from home. In Emergency Medicine, residents should not work more than 60 hours per week seeing patients in the ED and no more than 72 hours per week.
- Residents shall have at least one 24-hour period of scheduled non-working time per week, averaged over a four-week period, free from all clinical, educational and administrative activities.
- Residents will not be permitted to work more than 24 consecutive hours, i.e. 7:00 a.m. to 7:00 a.m. However, transitional time of up to three (3) hours after a 24-hour call will be allowed, when appropriate, to endorse patient care activities, i.e. attending morning report, rounds and endorsing care of critically-ill patients. Under no circumstances may a resident be kept beyond a 24 hour on-call period to handle direct patient care activities. All sign outs from the PACU, preoperative evaluations and follow ups must be completed prior to 7:00 a.m.
- Residents will be provided with adequate time for resident and personal activities. This will consist of a 10-hour time period (as per ACGME rules/8 hours per NYS DOH regulations 6/2/98) provided between all daily duty periods and following an in-house call. If a resident is required to remain on duty post-call to handle the care of a critically-ill patient, then documentation must be provided of such circumstance. In the event that this emergency occurs in the morning, the resident will be excused from all evening academic activities in order to provide the resident with the required time for rest and personal activities.

- Assignment of residents should be limited to no more than 12 (twelve) consecutive hours per on-duty assignment, except under extenuating circumstances.
- Post-call residents are expected to attend morning conference and provide the clinical director with a sign out of cases. will be permitted to do so as a voluntary educational activity. This time will be included in the total number of duty hours worked.

The Resident Education Office will monitor all residents' working hours to ensure compliance with both ACGME (www.acgme.org, link Resident Duty Hours) and NYS Title 10, Section 405.4 Regulations (Resident Duty Hours & Working Environment).

Resident schedules will observe the limits on assigned responsibilities and hours on duty in compliance with the New York State Codes Rules and Regulations, Volume 10 Part 405.4 - Medical Staff. The daily clinical director in each O.R. is responsible for insuring compliance with the NYS Codes Rules and Regulations, Volume 10 Part 405.4 - Medical Staff. In accordance with 405 regulations and ACGME requirements, all residents will be free of program duties at a minimum of one (1) full day out of seven (7).

Department policy ensures compliance by setting on-call standards for each level of resident training. For example, CA-1 residents are assigned calls no more than 6-8 times per month and no more than two (2) twenty-four hour tours per week. CA-2 and CA-3 residents are assigned calls no more than 6-8 times per month. If, at any time, residents are assigned to take more than the designated calls, the total hours worked per month will be in compliance with NYS Codes Rules and Regulations, Volume 10, part 405.4.

At all institutions, residents on call, together with the attending, are responsible for patients in the Recovery Room, the Ambulatory Surgery "step-down" areas, and the in-house pain management service. After completing a night on call, the senior resident is responsible for completing a case report form indicating all cases treated during his on call period. In accordance with 405 regulations and the ACGME requirements, residents do not administer anesthesia on the day after in-house overnight call.

Weekend call begins at 7:00 a.m. and ends 24 hours later. **Call may not be split, nor are any changes allowed without prior written approval by the Program Director, the Chief Resident and the Clinical Directors of the involved hospitals.** All changes to the call schedule must be approved through the Resident Education Office and the Program Director. Call residents will be off the next day. **Only in an emergency** and at the discretion of the Clinical Director, can an on call resident, who has been relieved to rest from continuous assignment, be assigned clinical responsibilities the day after call. **All residents are responsible for pre- and post-operative patient visits, and must attend scheduled teaching activities (including the day after call).**



RESIDENT MOONLIGHTING

Departmental policy does not permit residents to moonlight outside of S.U.N.Y. Downstate Medical Center. With the approval of the Chairman/ Program Director, moonlighting may be permitted within

S.U.N.Y. Downstate Medical Center, and its affiliates - Long Island College Hospital, the Kings County Hospital Center, and Lutheran Medical Center, **but only when resident hours are in compliance with NYS Codes Rules and Regulations, Volume 10, part 405.4 - Medical Staff and ACGME regulations. Please note that only residents with satisfactory clinical and academic performance will be allowed to moonlight.**



FATIGUED RESIDENTS

When the attending-in-charge observes that a resident is fatigued, the resident will be relieved from his/her assignment. The period of relief will be determined at the discretion of the in-charge attending. **Refer to departmental policy on working hours to ensure compliance with both ACGME (www.acgme.org, link Resident Duty Hours) and NYS Title 10, Section 405.4 Regulations (Resident Duty Hours & Working Environment). Please refer to department policy, reviewed July 1, 2008, copy included in the appendices.**

All incoming residents are responsible to participate in the Resident Fatigue Lecture (LIFE Curriculum Tape) during the orientation program in July 2011. All faculty and residents attend various ACGME Workshop lectures on resident fatigue, stress management, and physician impairment. In addition, the LIFE Curriculum tape is distributed to all residents and faculty for education and review.



LIMITS ON ASSIGNED RESPONSIBILITIES – CRITICAL CARE

The Department of Anesthesiology respects the policy of each affiliate hospital with regard to limits for those anesthesia residents who are on the Critical Care service. Direct supervision is the responsibility of the critical care attending assigned to the specific ICU service (i.e., D-MICU, K-SICU, K-MICU).



ILLNESS

When ill, residents are responsible for directly informing the staff anesthesiologist on call, or in charge, as soon as possible, as well as the Resident Education Office. The anesthesiologist-in-charge should be notified by 2:00 p.m. of the day prior to returning to work. The direct dial telephone numbers for all O.R.s and the Resident Education Office are the following:

SITE	DIRECT DIAL NUMBER
SUNY	(718) 270-1910/2530
SUNY RESIDENT EDUCATION OFFICE	(718) 270-1926/1510/3075
SUNY at BAY RIDGE	(718) 567-1480/1229/1492
KCHC	(718) 245-4502
LICH	(718) 780-1740/1707
LMC	(718) 630-7476

When a resident is assigned to an elective rotation at Maimonides Medical Center, Memorial Sloan Kettering, Beth Israel Medical Center, or in Critical Care or Pain Medicine, the resident or designee **must** inform the department's Residency Education office at the phone numbers provided above.

If a resident is absent from duty on sick leave for a total period exceeding the guidelines of the American Board of Anesthesiology (ABA), he will be expected to make up this absence either at the **expense of annual leave or by changing his/her termination date at the end of residency training.**

Requests to be excused from duty for personal reasons will not be considered except in grave emergency. Permission for such absence must be obtained from the staff anesthesiologist-in-charge for the day. It is expected that residents will take care of their personal affairs on their days off.



VACATION

For annual leave, residents are entitled to **20 working days during each of the Clinical Anesthesia years.**

Vacations must be taken in the academic year earned; residents **MAY NOT** carry annual leave from one academic year to another. Kings County Hospital **WILL NOT** pay for any vacation time that residents elect not to take. The department's policy for annual leave is based on the American Board of Anesthesiology's Handbook of Information February 2011.

Vacations will be permitted throughout the year, **except** in July and the last month of the academic year. Terminal leave will only be granted under unusual circumstances. Please note that a maximum of six residents per week may be on vacation, **except** at the times of the American Board of Anesthesiology In-Training examinations (ITE). Limiting the number of residents on vacation each week allows flexibility in coverage in the event of illness, facilitates the scheduling of night calls, and avoids overburdening other residents with clinical duties.

Vacations will not be scheduled during major meetings, i.e., The American Society of Anesthesiologists in October, and the New York State Society of Anesthesiologists in December, in order to allow **maximum attendance by residents at these meetings.**

Requests for Absences

- All absences require the submission of a written request. Annual leave and conference forms (see attached) are available in the Resident Education Office and must be submitted to the Resident

Education Office at SUNY on or before **May 15th** of each academic year. Failure to do so will result in scheduling of time at the discretion of the department. Furthermore, in order to meet scheduling needs, not all requests can be honored.

- Annual leave requests must be submitted for one-week blocks beginning on Monday and ending on Friday. The only exception will be for religious holidays.
- Requests for sick leave or leaves of absence require the submission of a "Request for Sick Leave/Leave of Absence" form (see attached) accompanied by a doctor's note for sick leave, to the Vice-Chair of Education.
- The approval of all resident absences is provided by the Program Director. Written authorization with the signature of the Program Director is necessary for approval of all absences.

Time off that is not charged to vacation or sick leave is permitted **ONLY** for examinations pertaining to, or required by, anesthesiology. It is highly recommended that the USMLE be taken and completed prior to entry into the anesthesia training program. For further information, refer to USMLE Policy in Appendices. If this is not feasible, then the examination should be completed during the first six months of the CA-1 year. Time off for the USMLE examination must be requested in writing with the dates of the examination specified. This time will be charged to annual leave. In addition and, if feasible, the resident may be assigned on call with post call day prior to the examination date. The department must be given a copy of the completed approval notification (admission card) for the USMLE as soon as it is received.

Procedure for Returning From Absences

Residents returning from a leave of absence or extended sick leave must obtain a letter from their physician authorizing their return to work. That letter should then be brought to the Employee Health Service at their pay source, who will ultimately provide the final authorization to return to work. A copy of the Employee Health Service's authorization to return to work must be delivered to the Program Director/ Resident Education Office prior to returning to clinical duties.

Absence from Training – ABA Policy

The total of any and all absences may not exceed 60 working days (12 weeks) during the Clinical Anesthesia 1 to 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 compete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.

Policy on Professional Development and Conferences for Residents

I. General Meeting Requests by CA – level:

- As per ABA policy, residents are allowed to attend either one scientific meeting or one review course each year depending on scheduling availability. The meeting time may not exceed **5 days**

inclusive of weekends. (Meeting reimbursement is subject to departmental policy as described below.)

- All meetings are requested prior to the academic year and must be submitted to the Resident Education Office by **May 1**.
- **PGY-1 and CA-1 residents** are scheduled for the NYSSA – PGA meeting in December in New York City. The designated meeting days are scheduled in advance by the Chief Residents and Program Director. Residents scheduled to attend the PGA on designated dates are required to attend each day's entire activities, and they must provide proof of attendance. CA-2 and CA-3 year residents are encouraged to request a review course one year and a specialty course the other year.
- **CA-2 and CA-3 residents** are encouraged to request a review course one year and a specialty course the other year.
- To accommodate as many residents as possible, vacations are not scheduled during major meetings, i.e. the American Society of Anesthesiology (ASA) meeting in October, and the New York State Society (PGA) meeting in December.

II. Meeting Request for Research and Scholarly Activities:

- All abstracts or medically challenging cases must be reviewed and approved by the faculty mentor before requesting Program Director approval.
- All residents **must seek** approval from the program director prior to submitting their research/scholarly project for presentation at any meeting. **Please note:** Formal approval is required prior to submitting registration or obtaining airfare or reserving a room.
- All residents are encouraged to participate at SUNY's research day and resident meetings such as New York Academy of Medicine and New York State Conference for Anesthesia Residents and Fellows regardless of prior approval of a meeting or review course during that year.

III. For All Meetings:

- Those residents scheduled for conference time are required to provide **documentation of attendance (CME certificate)** to the Resident Education Office upon their return. **In the week following your conference, you will be scheduled during morning conference to present a summary of new clinical information and techniques you learned to your colleagues.**
- Partial attendance at any scheduled activity will be considered as non-attendance and the day will be charged to annual leave. Annual leave time will then be adjusted in keeping with ABA regulations as will the reimbursement.

IV. Stipends for Meetings with Official Functions:

The department of Anesthesiology provides CA-2 and CA-3 residents with a stipend to attend a meeting when:

- I. **The resident is presenting a paper as described in the following policy statement:** After prior approval by the program director, the resident can submit a paper, scientific abstract, poster and/or medically-challenging case to one of the following meetings in the continental U.S. – ASA, SAMBA, SNACC, ASRA, SOAP, SCVA, ASCCA, SPA, and IARS (domestic locations).

Reimbursement for presentations is as follows:

1. Official functions as defined by the following with reimbursement subject to a maximum of \$2,500.00:
 - Panel speaker
 - Problem-based learning discussion moderator
 - Poster presentation, poster discussion or oral presentation of original clinical trial or basic science investigation.
2. Official function designated as meeting time and eligible for a \$500.00 stipend:
 - Medically challenging cases.
 - **Please note:** Only one resident involved in the case submission will receive the stipend.

II. The resident has been delegated by the department to attend a meeting.

In such cases, the following reimbursement guidelines will apply:

- Air fare – coach;
- Lodging up to 5 days with a maximum reimbursement of \$275 per night;
- Per diem meal allowance: \$45.00
- Meeting registration fee in full;
- Total maximum reimbursement is \$2,500.00.
- No advanced payment will be provided.

For reimbursement, the resident must present originals of airline ticket stubs, hotel bill, taxi receipts, and proof of registration to obtain reimbursement. A letter or certificate of attendance and/or CME certificate must accompany the reimbursement request along with the required narrative (Meeting Policy Attachment A). If these documents are not submitted, the meeting time may be converted to Annual Leave and expenses may not be reimbursed.

Residents should bring their original receipts to the Resident Education Office to be copied and processed for reimbursement. The Resident Education staff will submit your official expense form with proof of payments attached for reimbursement.

CHIEF RESIDENTS

Every year, four CA-2 residents will be chosen by the Executive Committee to serve as Administrative Chief Resident, Chief Resident of Operations, Chief Resident of Education, and Chief Resident of Research in their final academic year. The Chief Residents are responsible for creating the resident on-call schedules with the Residency Education Office. Additionally, they will organize ITE/Board Review groups and monitor attendance at all academic functions. Designated Chief Residents are members of the Core Competency Committee (formerly Clinical Competency Committee), Core Residency Education Committee (CREC), Resident Selection Committee, Anesthesia Performance Improvement Committees at each hospital, and Institutional GME and hospital OR committees.

The Chief Residents also act as liaisons for communication departmental policies to residents. They also serve as resident advocates on all departmental and institutional committees.

The Chief Residents for 2011-2012 are:

Chief Position	Resident
Administrative	Alexander Rances, D.O.
Operational	Tom Kao, M.D.
Educational	Roxana Horczakiwskyj, M.D.
Research	Vitaly Kotlyar, M.D.

At least twice a year, the Chiefs will meet with all residents to provide them with the opportunity to address any concerns or issues they may have.



RESIDENT COMPLAINTS AND CONCERNS

SUNY Downstate residents have several avenues of communication to identify problems related to their work environment or issues related to the program or faculty without fear of intimidation or retaliation.

Residents are expected to address complaints and grievances to their Program Director and/or department Chair. However, if this fails to resolve the issue, or if the resident does not wish to address the matter within the program, the resident may directly and confidentially contact the Associate Dean/DIO who serves as the Ombudsman for GME. Residents are assured that nothing can be communicated about what they say to the Ombudsman without their express permission. Referrals, as well as problem-solving interventions, are provided in the strictest confidence. Residents can reach the Ombudsman by phone, email, or in person as is needed.

PROGRAM LEVEL:

Chief Residents(s)

Chief Residents serve effectively as liaisons advocating on behalf of their residents. Residents are encouraged to discuss all concerns or problems with the Chief residents. The Chiefs will address some concerns on their own and, when necessary, escalate to the Program Director.

Faculty Advisor or Mentor

Residents are asked to select a faculty member at the beginning of each academic year. The mentors assist the residents with issues related to performance in the program and often provide career guidance and help with both professional and personal concerns. In addition, many residents develop informal mentoring relationships with faculty, and these faculty [members] can be a very helpful resource.

Program Director

The Program Directors, along with the Associate Program Directors, are charged with the responsibility of looking after the welfare of their residents and assuring an appropriate environment for training and

patient care. The Program Directors are the principal advocate and should be consulted for any areas of concern. The Program Director has an open door policy for all residents and encourages them to speak with her regarding any issues or concerns.

Resident Review of Program and Faculty

The anesthesiology program provides residents with two survey opportunities (departmental mid-year and ACGME end of year) to review and evaluate their educational program and their faculty **anonymously** in writing.

DEPARTMENTAL LEVEL:

Educational Committee

The department has established a committee to address program outcomes, educational curriculum, resident concerns, and resident performance. The committee is called the Core Resident Education Committee (CREC). It is comprised of faculty, Chiefs, and resident representation from all PGY levels. Residents can raise concerns to their department's education committee or to peer-elected representatives who sit on this committee. The department has policies which describe the process and role of the Education Committee.

Department Chairperson

The Chairman of Anesthesiology has responsibility for oversight of the conduct, quality, and outcomes of all its training programs and clinical services. The Chairman is a very concerned, dedicated, and potent advocates for students, residents, and, of course, patients.

GME LEVEL

GME Office Staff

Many issues can be addressed by the GME Office staff. When necessary, referrals will be made to the DIO and Resident Ombudsman.

Chair of the resident Subcommittee

For educational, work environment, and institutional issues, residents from each department elect peer representatives to serve on the GMEC Resident Subcommittee. This committee meets, without program director or faculty present, monthly as a forum for communication and exchange about resident concerns.

Resident Ombudsman/DIO

Residents can speak directly and confidentially to the Associate Dean/DIO who serves as the Ombudsman for GME. Residents are assured that nothing is communicated about what they say to the Ombudsman without their expressed concern. Referrals as well as problem-solving interventions are provided in strict confidence.

Graduate Medical Education Committee (GMEC)

After consulting with the Associate or Vice Dean for GME, residents may formally seek adjudication through the GME Committee. (Please policy for Adjudication of Resident Complaints and Grievances). And ad hoc grievance subcommittee of the GMEC will be appointed to address the grievance or complaint.

Employer Level

Affiliated employing hospitals may provide additional avenues for you to raise concerns.

Union Representation

For residents assigned to Kings County Hospital Center pay lines, or other affiliated hospitals, where they are represented by the Committee of Interns and Residents (CIR), as well as residents represented by UUP, there are additional avenues for the redress of grievances within policies developed through collective bargaining.

Formal charges of discrimination based on race, sex, age, religion, national or ethnic origin, disability marital status, sexual orientation, or veteran status, should be filed with the campus' Office of Diversity and Affirmative Action and addressed as per institutional policy.



CLINICAL COMPETENCE EVALUATION AND ASSESSMENT

The clinical years in Anesthesiology provide the necessary time for achieving the technical skills and knowledge of a specialist. Residents will be guided in their acquisition of knowledge by the didactic program, which includes Morning Conference, Grand Rounds, Colloquia, Visiting Professor, Journal Clubs, and Board Reviews, etc. Residents' progress will be judged by a series of oral and written examinations. The test results will be discussed with the resident. Performance on oral and written examinations will be included in the final assessment for promotion to the next level of training. Please refer to Performance Improvement Policy on **page 41**. The technical skills will be taught in active patient care in the Operating Room, Post Anesthesia Care Unit, and Critical Care Units. Residents' progress in training will be discussed each month at meetings of the Resident Clinical Competence Committee.

If residents are found to be deficient in their duties, or are not meeting competency expectations for level of training, they are informed of the deficiencies and a remedial plan is set in place. All residents are invited to discuss problems with any member of the attending staff or resident program administrative staff, but especially with the Program Director and Chair of the Department. Residents will find the faculty receptive and eager to assist them in resolving problems.

When residents begin training, they will become familiar with the use of the anesthesia machine and learn how to maintain and intubate the airway. The techniques of spinal and epidural anesthesia will be taught early in the program, as will the commonly used nerve blocks, e.g., axillary block. **It is expected that within the first six months of training, residents will become adept at airway maintenance, endotracheal intubation, and general and regional anesthesia in patients without multisystem disease, i.e. ASA I/II patients.**

To ensure clinical competence in airway management, departmental policy requires CA-1 residents to satisfactorily complete **twenty (20) airway procedure forms**. Residents are required to submit to the Resident Education Office a completed airway form for each satisfactorily completed procedure. Residents shall be considered credentialed for **airway management and emergency airway**

management upon completion of these forms **and** the satisfactory completion of six months of anesthesia training. Copies of this form are available in the **Appendix**. Each airway procedure form must be signed by an attending.

In addition to the above, certifying checks for airway management and emergency airway management are logged in to *New Innovations*. Five (5) of each are required to be considered “Mastered.”



CORE COMPETENCY & SUBSPECIALTY EDUCATIONAL OBJECTIVES

Each resident is responsible for reviewing the written education goals and objectives **incorporating the core competencies** prior to rotating through each subspecialty. The resident will also be provided with reading lists and assignments as deemed necessary by the subspecialty director. In addition to the various general anesthesia rotations, the resident will rotate through the following subspecialty rotations:

- **Obstetrical Anesthesia:** The Obstetrical Anesthesia rotation provides an opportunity for reviewing the physiology of labor and delivery and pain relief. Regional Anesthesia will be stressed.
- **Pediatric Anesthesia:** The Pediatric Anesthesia rotation provides an opportunity for reviewing neonatal and developmental physiology and for learning how to maintain an airway and perform endotracheal intubation in a child. Fluid and electrolyte balance will be reviewed.
- **Cardiothoracic Anesthesia:** The Cardiothoracic Anesthesia rotation provides an opportunity for reviewing cardiac physiology and the pharmacology of cardioactive drugs. Cardiopulmonary bypass and thoracic anesthesia will be stressed. Invasive monitoring, Transesophageal Echocardiography (TEE) training, management of cardiopulmonary bypass, anesthesia for major vascular and thoracic procedures will be part of the curriculum during the resident’s rotation.
- **Neurosurgical Anesthesia:** The Neurosurgical Anesthesia rotation provides an opportunity for reviewing neuroanatomy and physiology and allows training in specialized techniques, such as awake craniotomy, electrophysiologic monitoring, and interventional neuroradiology endovascular procedures.
- **Vascular Surgery:** The Vascular anesthesia rotation exposes residents to patients with multisystem disease. During this rotation, the resident will acquire skills to manage the perioperative care of elderly, high-risk vascular surgical patients.
- **Transplant:** The Transplant rotation provides the opportunity to care for patients with end-stage kidney disease and those requiring kidney transplantation. During this rotation, the resident is expected to acquire clinical skills and knowledge about all transplant surgical procedures (e.g., liver, cardiac, kidney).

- **Ambulatory Surgery:** The Ambulatory Surgery rotation provides the resident with experience in dealing with the out-patient, and the particular needs imposed by the service. Administrative skills will be stressed.
- **Regional:** The Regional Anesthesia (RA) rotation provides the residents with an ideal environment for learning the technical and educational aspects of RA. At the end of the rotation, the resident should be able to identify patients suitable for RA, conduct RA techniques safely and proficiently, and use RA as a method for postoperative pain management.
- **Pain Medicine:** The Pain Service provides the opportunity to review the pathophysiology of pain, the diagnosis of pain syndromes, and the various therapeutic modalities available to treat acute and chronic pain patients.
- **Post Ambulatory Care Unit [PACU]:** The Post-Ambulatory Care Unit (PACU) rotation lasts two weeks, during which time residents will be involved in the direct care of patients in the unit. The rotation will provide opportunities for residents to gain experience in dealing with responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia unit.
- **Critical Care:** The Critical Care rotation provides an opportunity for learning how to manage the care of critically ill patients. In addition, residents learn how to insert and manage arterial lines, central venous pressure and pulmonary artery catheters.

There are members of the attending staff with special interest and expertise in each of these subspecialty areas. Residents are advised to review the goals and objectives and discuss educational content and any difficulties with comprehension of the material with the attending staff frequently. Attendings will assess residents' progress and send performance evaluations to the CCC.



EVALUATION OF RESIDENT PERFORMANCE

Resident evaluation is a component of the department's evaluation system. The process of resident evaluation is designed to provide the department with a method of measuring competency and appropriateness of performance of residents on a monthly basis.

It includes the assessment evaluation of performance of all residents by the members of the Resident Core Competency Committee. This committee meets on a monthly basis to discuss the performance appraisals of each resident according to the guidelines discussed previously on **page 52**.

If a resident is found deficient in his/her duties, he/she is counseled by the CCC Director, faculty advisor and/or a designee. Clinical deficiencies may require the appointment of a tutor to that resident for a specified period of time. The resident's performance will be discussed monthly at the Clinical Competence Committee and recommendations will be made accordingly. Disciplinary actions are outlined on **pages 43-44 herein**.

EVALUATION, PROMOTION & DISMISSAL GUIDELINES

Evaluation

The Department of Anesthesiology recognizes the importance of accurate assessment of each resident's abilities, capabilities, progress and potential. Hence, promotion is predicated upon achieving the various milestones in academic, clinical and administrative/professional performance. Residents will be evaluated by several mechanisms including formative evaluations (daily clinical OR and end of rotation), semi-annual core competency evaluations and performance on standardized tests. The Core Competency Committee (CCC) will provide the final summative evaluations every 6 months. The CCC chair will submit the Clinical Competency Report (included in the appendices) for each resident to the ABA at the end of six months based on the final Core Competency Committee's summative evaluations.

The criteria used by the Department of Anesthesiology are outlined below:

- **Formative daily operating room evaluations** of observed "clinical" performance of technical operative skills, application of knowledge, judgment and the core competencies will be made by faculty and senior residents. These evaluations are electronically submitted to the Core Competency Committee. At each hospital, residents will be evaluated at the end of each month by designated faculty (End of rotation/Core Competency Clinical evaluation). The **end of rotation** evaluations will include the formative daily evaluations as well as other Core Competency assessments.
- **Other formative written** evaluations by faculty include the end of rotation **Subspecialty Assessments and evaluations**. In addition, **360° evaluations** by auxiliary staff will be performed after selected rotations. All formative evaluations are included in the final Core Competency Committee's evaluation of resident performance. **Residents are required to review their CCC file at least quarterly.**
- **No less than 75% attendance is required at departmental conferences**, i.e., Grand Rounds, Colloquia, Journal Clubs, workshops, etc. with the exception of vacation and, when applicable, on-call or post-call residents. The objective of departmental workshops is to enhance education and technical skills in the respective subspecialties. The policy is that any residents that are unable to attend must inform the Resident Education Office of the reason for their absence. However, post-call residents are encouraged to attend on a voluntary basis, since there is a ten-hour time period between on-call clinical duties and the educational activities, as required by the duty hours policy. Attendance at workshops will be monitored separately from the colloquia/grand rounds series. Attendance at case-based discussions is **mandatory**.
- **Administrative Compliance:** Residents are required to complete the following, as designated for each training level: a) all required educational assignments; b) credentials (privileges); c) faculty evaluations; d) annual program evaluations; and surveys.
- **ACGME Caselog:** Residents are responsible for the timely entry and maintenance of their clinical experience logs using the ACGME website.
- Satisfactory performance is required on all written examinations (i.e. Pre-, Post-, 6 month and 24 month Anesthesia Knowledge Examinations (AKT), ABA In-Training Examinations), mock oral examinations and various subspecialty examinations. Please refer to the Performance Improvement

policy on the following page for additional information on examination performance criteria and passage rates.

- **USMLE, Step 3/COMLEX, Part 3, effective July 2006**, Institutional USMLE/COMLEX Policy requires that USMLE Step 3 or COMLEX Part 3, be completed **prior** to entering the PGY-3 Year (policy attached).
- **Curriculum Manual - Goals & Objectives:** It is the responsibility of all residents to read the curriculum manual. Additionally, residents are responsible for reading the goals and objectives prior to each rotation and successfully completing their assigned responsibilities, as defined for each rotation. The goals and objectives for each rotation are uploaded into *New Innovations* and, up to two weeks before the start of the rotation, an email is sent to all residents that this information is available to be reviewed. Residents should follow the link and confirm the curriculum wherever indicated.

Promotion Criteria as Defined by the ABA

In the Department of Anesthesiology resident training program, trainees will be promoted to the next level of training provided the resident has received a satisfactory Evaluation of Clinical Competence based on the essential attributes as defined by the ABA and the core competencies as defined by the ACGME. The ABA requires every residency training program to file, on forms provided by the Board, an Evaluation of Clinical Competence in January and July on behalf of each resident who has spent any portion of the prior six months in clinical anesthesia training in or under the sponsorship of the residency program and its affiliates. The CCC's recommendation to promote a resident to the next level of training depends on satisfactory performance, based on the essential attributes of the ABA and the Performance Improvement Policy for residents, as defined.



PERFORMANCE IMPROVEMENT POLICY (PIP) FOR RESIDENTS

The goal of the Performance Improvement Policy (PIP) for residents is to assist each resident by guiding them through their residency education and allowing each resident to achieve educational milestones at each level of training. During the resident's semiannual review of their performance, the program and resident will use the PIP to identify strengths and weaknesses. The resident will develop his/her individual learning plan using the information from the semiannual review and PIP in order to achieve optimal performance in all competencies. Ultimately, the final summative evaluation as defined by the ACGME Common Program Requirements for each resident's performance in the program is to demonstrate "sufficient competence to enter practice without direct supervision."

The following criteria for academic, clinical and professional performance will be determined and calculated for each resident's semiannual review:

- I. Academic Performance (33.3% of total grade):**
Includes performance on the ITE, AKT, and other formal exams using the following

grades based on percentile performance on the examination, when indicated:

Test Percentile	Grade	CCC Score
70 th and up	90-100	5
60-69	81-89	4.5
55-59	76-80	4
50 – 54	71-75	4
45-49	66-70	3.5
40 – 44	60-65	3
35 – 39	50-59	2.5
30 – 34	40-49	2
25 – 29	30-39	1.5
20 – 24	20-29	1
15 – 19	10-19	0
0 – 14	0-9	0

II. Clinical Performance* (33.3% of total grade):

The **End of Rotation evaluations** for the designated semester will be used to calculate the clinical performance grade. When applicable, 360° and subspecialty rotation evaluations will also be included.

III. Professional performance (33.3% of total grade):

The core competency professionalism evaluation and grade will be used to determine this vital component of the evaluation process. The evaluation form will be filled out semi-annually for each resident by the CCC and a grade will be assigned.

IV. Performance Improvement Grade:

At the semi-annual review, each resident will be provided with a grade based on their overall performance. Promotion will require a **mean passing grade of 70**. The grade will be an average of the grades obtained in each of the three components listed above.

For example, a resident may obtain the following grades:

Academic performance:	60
Clinical performance:	90
Professional performance	+ <u>80</u>
Total:	230 / 3 = 76.7 Passing score

Residents with an initial performance improvement score below 70 promotion score will receive counseling and a letter of warning; they will not immediately receive an unsatisfactory ABA report. Letters of concern will be sent to any resident with a score between 70-75.

For residents at risk of an unsatisfactory ABA report, the CCC will use the following time periods for clinical performance evaluations: July – December and January – June. Following the semi-annual reviews, the clinical performance scores will be re-calculated for residents who

score below 70 or within the 70-75 range. Therefore, their scores will reflect the ABA reporting periods.

Clinical Performance Evaluation Process

At each hospital site, the Director, Clinical Director and/or Site Director will organize and conduct a meeting of teaching faculty to review and evaluate each assigned resident's end of rotation clinical performance. All grades and comments for each assigned resident will be submitted to the Resident Education office in a timely manner. *The Resident Education office will tabulate the scores quarterly for each resident and submit them to the CCC for review and evaluation.*

Subspecialty Rotations

In addition to completing the standard end of rotation evaluation form for each residents, subspecialty directors, or a designee, will also complete a comprehensive **Subspecialty Rotation Evaluation form** for each CA-1/CA-2 resident that has completed the required number of block periods for the following rotations:

SUBSPECIALTY ROTATION	REQUIRED # OF BLOCK PERIODS
CARDIAC (SUNY and/or Maimo, BI)	2
NEUROANESTHESIA (KCHC, LICH, MSK)	2
OBSTETRICS (SUNY, LICH)	2
PEDIATRICS (SUNY, LICH)	2
ACUTE PAIN*/CHRONIC PAIN (KCHC)	1
REGIONAL (SUNY, Lutheran)	1
ICU** (SUNY, KCHC)	2
PACU (LICH)	0.5

* Acute Pain rotation may occur in the PGY-1 or CA-1 years; ** The ICU rotation is for CA-1 and CA-2 residents

The subspecialty director should include the subspecialty faculty as a group in the evaluation process. The final rotation evaluation will be submitted to the CCC for review and action as necessary. Residents must receive satisfactory performance evaluations in all subspecialty rotations to be promoted to the next level of training.

Please note that the performance improvement policy represents the internal policy of the department of Anesthesiology and will be subject to revisions based on recommendation(s) of the Core Resident Education Committee. Residents will be notified promptly in writing of any amendment to this document.

Resident Remediation and Dismissal

Residents who fail to demonstrate competence, as noted above, may be given a remedial period in which to demonstrate the ability to correct deficiencies. Residents who continue to show lack of progress and aptitude for the specialty will be dismissed from the program. The program will attempt to assist the resident in transferring to an area of medicine more suited for his/her ability. In accordance with GME policy, residents who demonstrate a complete lack of regard for professional, hospital or departmental policies, risk being dismissed from the program.

If the CCC recommends a resident's dismissal from the program, the resident will be advised in accordance with departmental policy and the Grievance Procedures and Due Process as described in the **Resident's Handbook**, Eighth Edition, 2010 - 2012, pgs. 34 - 37.



MENTORING PROGRAM

Function of a Mentor

A mentor is a trusted counselor that provides guidance and support. In an academic and medical setting, a mentor advises or guides junior faculty in matters relating to professional achievement and success. It is expected that the mentor will assist the mentee in formulating a plan toward his or her goal of professional development. A mentor will also provide the mentee with insight into the realities of a future career in his or her chosen specialty. As such, the mentor is an active participant in his or her mentee's academic development.

A good mentor will be perceived as a role model, providing a good example for his or her mentee. He or she should also be able to maintain privacy and confidentiality when a mentee shares information in confidence. Also, a mentor should be both unbiased and helpful when advising a mentee regarding the various aspects of their profession.

Resident Mentors

At the start of each base year, every Anesthesia resident will be assigned a senior resident mentor. Questions regarding training, and education, or personal issues can be addressed by this mentor at any time by the junior resident. Senior residents, who have already been a part of the program for 1 to 2 years, are a source of invaluable information regarding daily processes and adjusting to the newfound responsibilities of an anesthesia residency. Additionally, as this resident mentor-mentee relationship is informal, a mentee may ask any resident in the program for advice.

Faculty Mentoring Program

The function of the faculty mentors is to advise and assist residents in their academic, clinical and personal concerns regarding professional development and act as resident advocates if problems arise. After the first two months of residency training, each resident will be asked to request a faculty mentor. As the resident to faculty member ratio is disproportionate, each resident will submit three choices, in order of priority, to the Resident Education Office. The final selection is made at the discretion of the Program Director or a designee who will consider the number of requests for each faculty member, as well as the educational and/or professional compatibility between the advisor and the advisee.

A. Goals & Objectives of a Mentor

Both the mentor and the mentee should agree upon goals and objectives that will benefit the mentee. These will vary depending on the needs and desires of the mentee. The mentee should examine career goals and objectives and the mentor should help to clarify those goals. Together, the two should then establish a plan of action to achieve those goals. Specific strengths, weaknesses, and opportunities relating to achieving these goals should be discussed; this includes an objective

assessment of the mentee’s knowledge and skill base. A plan should be developed for any possible deficit.

Additionally, as the mentee nears the end of their training, they may look to the mentor for advice on life experience with job opportunities, career goals, resumes, and employment prospects.

B. Meeting with a Faculty Mentor

The faculty mentor and mentee are to meet once every three months to “check in” with each other and see how the latter is doing academically, clinically, and personally. This meeting will be informal; it will not be a judgment on how he or she is performing, but just an advising process. Questions regarding the resident’s future should be addressed, as well as basic questions that the resident has. If this meeting is not feasible due to scheduling limitations, an email thread or telephone conversation should take place.

The resident will be responsible to meet with their mentor before their semi-annual review. This can provide both parties with insight into the resident’s status within the program. There will be a record of the meeting with the mentor that will be included in each semi-annual review to document that the advisement process is taking place.

C. Changing a Mentor

At the beginning of each academic year, residents will be given the option to change their mentor or continue with the same one. The mentor-mentee relationship should never affect professional relationships. The mentee should be able to accept constructive criticism, if given, and use it for professional development. However, should the mentee wish to have a different mentor during their course of training, the relationship with the previous mentor may be terminated without fear of retribution by the faculty member.

Before a scheduled semi-annual review, residents should meet with and/or send via email their portfolio/learning plan to their mentor for review and/or comments. By doing so, the mentor is aware of their mentee’s progress and self-evaluation, and can provide assistance and/or guidance wherever necessary. The faculty mentor is responsible for reviewing the portfolio with the mentee, providing dated comments and forwarding the portfolio to the Resident Education Office with comments for inclusion in the semi-annual review.



RESIDENT CREDENTIALING

The system used by the anesthesiology department is coordinated by the Office of Graduate Medical Education at S.U.N.Y. Downstate Medical Center. Its purpose is to provide the hospital and the anesthesiology department with a system that ensures that residents in training have been credentialed and privileged to perform appropriate procedures. This policy applies to all physicians-in-training within the Department of Anesthesiology of S.U.N.Y. Downstate Medical Center and includes all affiliate institutions.

Policy Statements

- Every academic year, a Physician-in-Training Credentialing Profile will be completed for each resident in the anesthesia residency training program.
- Designated staff members who are involved in evaluating residents, coordinating education and maintaining credentialing, quality assurance and salary source data, will sign and attest to the information provided.
- A copy of each profile will be maintained in the individual resident's file at each hospital. The original profile will be maintained centrally in the Office of Graduate Medical Education at S.U.N.Y. Downstate Medical Center.
- Residents will be evaluated monthly by the anesthesia department's Resident Core Competency Committee. With the advice of members of the attending staff, the committee will recommend to the department Program Director the appropriate level of privileges for each resident.

Evaluation Objectives

Acquisition of technical skills must be established by **direct observation** by a teaching staff physician and must be certified in writing. Only after residents or medical student have demonstrated proficiency in performing a procedure, will they be granted the privilege to perform that particular procedure under **general supervision** by a physician.

Direct observation takes place when a teaching staff physician of appropriate expertise is present during examination or procedure to be certified. **General supervision** is when a teaching staff physician of appropriate expertise has ordered the procedure and is in the vicinity and immediately available to repeat the procedure or to consult. Procedures and limitations are described on **page 47**.

Evaluation Method

Only a teaching staff physician (attending or credentialed senior resident) may certify a resident or medical student's performance of a procedure. The physician must directly and personally observe the resident or student. Refer to attachment: Master List of Supervisory Residents.

Proficiency in performing a procedure is more important than the number performed. Residents are expected to acquire skills appropriate to their specialty. Students are expected to acquire skills appropriate for a primary care physician. When skills are appropriate, based on the quality and/or number of times a procedure is performed, residents or students may be certified by the department chair or designee, to perform the procedure under general supervision.

Institutional Policy for Credentialing Residents for Procedures

The credentialing of procedures has been designed to facilitate the process of procedure certification. The following steps must be followed in order to obtain privileges for the procedures outlined by your department. **Residents must input all completed procedures online into *New Innovations* for departmental processing.** Please refer to **page 94 in the appendices** for the instructions on how to do so.

Resident Privileges

The Resident Education office will routinely provide residents and students with an update of their privileging status. Requirements are as follows:

Procedure Name	PGY-Yr	# Required	Limitations
ABG Interpretation	1	5	Attending Supervision
Arterial Puncture	1	5	Attending Supervision
History Taking	1	10	Attending Supervision
Peripheral Intravenous Line Placement	1	5	Attending Supervision
Physical Exam	1	10	Attending Supervision
Management of Mechanical Ventilation	1	5	Attending Supervision
Nasogastric Intubation	1	2	Attending Supervision
Room Setup*	1-2	5	Attending Supervision
Airway Management*	2	5	Attending Supervision
Pre-Anesthetic Orders*	1-2	5	Attending Supervision
Anes. Management of Patients*	2	5	Attending Supervision
Emergency Airway Management*	2	5	Attending Supervision
Arterial Catheter Placement	1-3	5	Attending Supervision
Recovery Room Management	2-3	5	Attending Supervision
Pain Management	1-3	5	Attending Supervision
Spinals	2-3	5	Attending Supervision
Epidurals	2-3	5	Attending Supervision
Central Venous Cath.-Internal Jugular	2-4	5	Attending Supervision
Flow Directed Pul. Artery Catheter	2-4	5	Attending Supervision

*For these procedures, the submission of five (5) certifying checks (mastered) should be completed no later than the end of the CA-1 Year.

Direct observation is required for the performance of all procedures until five (5) certifying checks are submitted at the “mastered” level. Following credentialing, residents may then perform procedures for which they are credentialed under general supervision until graduation. The only exception to this rule is emergency airway management. For more information, please see the memo regarding the requirement for procedures in the appendices of this manual.



SUPERVISION

The Department of Anesthesiology complies with *ACGME* and New York State Department of Health Code Part 405 regulations. Appended to the **Rules and Regulations** is an abstract of the Part 405 regulations pertaining to Supervision, and a copy of the Department of Anesthesiology Policy: Resident Duty Hours & Working Environment (www.acgme.org, link Resident Duty Hours) and NYS Title 10, Section 405.4 Regulations (Resident Duty Hours & Working Environment). Please refer to department policy, copy included in the appendices.

In the Operating Room & PACU (Post Ambulatory Care Unit)

Residents are provided with the opportunity to achieve the technical skills and knowledge of a specialist and consultant. As residents progress through the program, they are given the opportunity to administer anesthesia care for patients with more severe and complicated diseases, as well as for those who undergo more complex surgical procedures. To ensure that residents acquire these skills, they are supervised by

attendings in the operating room at all times. There is 1:1 supervision for difficult or complex cases and 1:2 supervision for general surgical procedures. For additional information pertaining to resident supervision, refer to **pages 27-28** of the **Rules and Regulations**.

In the Critical Care Unit

Direct and general supervision is the responsibility of the attending-in-charge of the critical care unit (i.e. K-SICU, K-MICU, D-MICU). The subspecialty director of the critical care rotation is responsible for ensuring the educational component of this rotation. For additional information pertaining to resident supervision, refer to **pages 27-28** of the **Rules and Regulations**.



CLINICAL COMPETENCE/DISCIPLINE

The Anesthesiology resident is expected to adhere to all institutional and departmental rules. Clinical competence/discipline falls into two categories:

Administrative and Institutional

Conformity with the departmental rules and institutional policies and procedures, including documentation, is mandatory (see resident's handbook, SUNY and department orientation programs).

ABA Record of Training/Clinical Competence Report

Twice a year, the departmental Core Competency Committee Chair and Program Director submit a report to the ABA grading each resident's performance in the categories delineated by the ABA. Credit for each training period is then granted by the ABA. Adequate records of the evaluation process shall be maintained for each resident and shall be available for inspection by the resident as set for below. The resident's overall performance must be reported as unsatisfactory, if one of the ABA's essential character attributes is unsatisfactory. Behaviors including, but not limited to, lying, cheating, keeping incomplete records, lack of availability during day assignments and on call, pervasive interpersonal problems and substance abuse will not be tolerated.

The Core Competency Committee's Chair and its members are appointed by the Department Chair and/or Program Director. As a general rule, Vice-Chairmen, Service Directors, Clinical Directors, Subspecialty Directors as well as faculty members sit on the committee. Designated Chief Residents also serve as full members of the committee. This committee meets regularly, (quarterly or monthly as necessary) and its members and/or designated faculty members implement its recommendations regarding tutoring, counseling, remediation and incident investigation.

Chief Residents may only be asked to counsel CA-1 and CA-2 residents. They will submit a brief written report of the counseling session, signed by the counseled resident. If further counseling is recommended, the Core Competency Committee will appoint a faculty member and/or the faculty mentor to meet with the resident. The Chief Resident should be present during the second counseling session.

Faculty mentors will be informed in writing of any remedial/disciplinary actions taken by the Core Competency Committee. Similarly, the resident on whose behalf action is being taken will be informed in writing of the Core Competency Committee's decision as soon as is practical after the meeting.

All committee decisions affecting the resident's standing in the program (such as probation, suspension, termination, non-renewal of contract, and revocation) will be referred to the Department Chair/Program Director in the form of a written recommendation. The final decision rests with the Department Chairman.

The Core Competency Committee relies on performance evaluations by faculty members, site directors, subspecialty directors, standardized test results, (AKT, ITE, and others), documentation review, oral and/or written examinations as prescribed by the subspecialty directors and/or the Core Competency Committee, and conference attendance, participation and preparation. Semi-annually, the Core Competency Committee will review the resident's performance improvement profile to determine promotion to the next level of training. **In addition, residents will meet semi-annually with the Program Director or his/her designees to discuss their progress in the program and review of their performance improvement scores and prospects for promotion.**

Prior to the review, the resident will update his/her Resident Portfolio/Individual Learning Plan which allows the resident to reflect on their academic, clinical and professional performance and comment on their progress. This is reviewed and discussed with the Program Director or designee.

All formal meetings with residents pertaining to their performance evaluation will result in a written report, acknowledged in writing by the resident, and placed in the evaluation file. All adverse action notices will specify the problem areas of performance, delineate the recommended methods to correct the deficiencies, and determine the criteria and timetable for re-evaluation, removal of probationary status, suspension or re-appointment.

In the event of an adverse evaluation, the resident must be offered the opportunity to address judgments of academic deficiencies or misconduct before the Core Competency Committee or to assert the right to appeal such decisions in accordance with the due process provisions set forth herein.

Emergency Suspensions

- If a resident commits any action which, in the opinion of the attending anesthesiologist jeopardizes a patient's care, he/she may be suspended immediately by the attending-in-charge, or during off hours by the attending-on-call. Such suspension shall not exceed ten (10) days without review by the Core Competency Committee. Any continuing suspension must be determined by the Core Competency Committee in accordance with the provisions set forth herein.

Following this action, the Chairman/Program Director, the Clinical Director, and the Core Competency Committee Chairperson must be notified as soon as possible. An emergency hearing will be promptly scheduled to address the issue. The Department Chairman's decision will be binding.

- Persistent non-compliance with administrative program rules will result in referrals by the Residency Program Director to the Core Competency Committee for disciplinary action. Each case will be reviewed individually and the Core Competency Committee's decisions will be carried out as above.

Evaluation Files

To protect the integrity of the evaluation system, resident evaluation files will not be duplicated unless requested in writing by the resident. The request must specify the evaluation period to be copied. The resident must further acknowledge in writing the receipt of the copied evaluations. Notwithstanding the foregoing, the Department may comply with requests for reproduction of all or a portion of a resident's evaluation file if such request is pursuant to the rule of the GME Office, University or Hospital Policy or is required by court order, subpoena or other governmental authority.

Access to Resident Evaluation Files

The following individuals have access to residents' evaluation files: the Department Chairman or Program Director, Core Competency Committee Chairperson and secretary, and the specified resident. The faculty mentor may view the files only when the resident has signed a release form. Members of the Core Competency Committee may have access to selected files during committee meetings on a need-to-know basis.

Residents may review their evaluation files during Resident Education office hours. To prevent record alteration and ensure completeness, the file review must be witnessed. Notes may be taken, but no copies are allowed, except as above.

It is the resident's responsibility to review his/her evaluation file at least once every three months. This review will be documented on the face sheet of the file with date, signature, and last evaluation number. If the resident refuses to review/sign the file, he/she must sign a form indicating access to the file was granted. The resident evaluation files will be updated monthly within two weeks of the Core Competency Committee's meeting.

Due Process

The resident has the right to appeal any sanction imposed by the program. This must be done in writing within 15 days of receipt of the written sanction notice. In order to preserve the integrity of the academic self-governance, lawyers may not represent the resident during the departmental appeal process.

Actions not immediately affecting the resident's standing in the program (such as mandated tutoring, remediation, change of previously assigned rotations, mandated repeating of rotations, mandated referrals to support services) may be appealed to the Department Chairman/Program Director. The Department Chairman/Program Director may then ask for a review of the documentation and other evidence pertinent to the appeal by faculty members of his choice who will act as his advisors. The Chairman's/Program Director's decision will be binding and will be made within 30 days of the resident's appeal. Further appeal will occur according to the institutional due process rules. The department has the right to appeal the decision of the institutional review body.

Actions affecting the resident's standing in the program (such as suspension, non-renewal for performance reasons, overall unsatisfactory semi-annual ABA report) may be appealed to the Department Chairman/Program Director. The Department Chairman/Program Director may form a panel to re-examine the documentation and recommend the disposition of the appeal. The panel will be composed of the Chairman of the Core Competency Committee, a member of the Resident Education Committee, 1-3 faculty members appointed by the Chairman, a Chief Resident and a resident-advocate in good standing in this program. The resident-advocate will be selected by the appealing resident. The panel will create its own rules of procedure. The recommendation of the panel will be forwarded to the Chairman/Program Director within 21 days of the resident's appeal. The Department Chairman/Program Director will **inform the resident of the panel's recommendation** within 7 days. The resident has the right to appeal the department's decision to the GME office of the Medical School. The Department has the right to appeal the decision of the institutional review body.

Residents against whom no adverse action has been taken and who disagree with written documentation/evaluations in their file are encouraged to refute the charges by submitting a letter to the Core Competency Committee Chairperson **within 15 days from counseling or from the resident's review of the evaluation**. The resident's letter will then be discussed at the next Core Competency Committee meeting and will be placed in the evaluation file. This policy is subject to the policy of the Institutional GME Office and other institutional rules and procedures. This policy represents the internal policy of the Department of Anesthesiology and is subject to change periodically without prior notification to residents. However, residents will be notified promptly in writing of any amendments to this document.

CHEMICAL DEPENDENCE

The Department of Anesthesiology mandates staff compliance with the Drug-Free Schools and Communities Act Amendments of 1989, as set forth by the State University of New York/Downstate Medical Center's Policy Statement and Supplemental Policy, **dated June 16, 2006**, on Alcohol and Controlled Substances in the Workplace. This policy is in the 2010-2012 **Resident's Handbook** and in the Appendix of this manual.

The ABA requires indication of absence of chemical dependence in all candidates for board certification. Consult the ABA Handbook for details.

Substance Abuse Policy

Appended to the **Rules and Regulations** are the Department of Anesthesiology's policies of the Physician's Wellness Committee (formerly the Substance Abuse Committee).

ETHICS

The American Society of Anesthesiologists (ASA) has organized a Committee on Ethics, chaired by Gail Van Norman, M.D. The Accreditation Council for Graduate Medical Education (ACGME) acknowledged that a variety of factors - the ascendancy of patient rights, the technical advancements in medical care, the extension of both extremes of our patients' life span, the ever-expanding costs of providing care within a setting of limited national resources, to name a few - are bringing an enlarging list of ethical dilemmas to the arena of clinical practice. In order to empower physicians-in-training to better understand and manage the perplexing ethical problems inherent to our profession, the ACGME mandated that all accredited residency programs provide an education in the ethics of the practice of medicine.

The ASA's Committee on Ethics has prepared a curriculum for teaching ethics. The Committee has published a **Syllabus on Ethics** with a downloadable PDF file on the ASA website. (Please refer to the newsletter, ASA Syllabus on Ethics, in the appendix). Each chapter concentrates on one fundamental area of bioethics relevant to the anesthesiologist. The contents include anesthesia-specific educational material: informational backgrounds, references and guided case studies. Articles addressing the challenges that faculty encounter in the teaching of ethics to residents are included.

It is noted that a copy of the Syllabus on Ethics is available in the Anesthesia Library and in the Resident Education Office. The Syllabus on Ethics and certain references are available in the ASA website at <http://www.asahq.org/wlm/>. Residents are encouraged to review the syllabus.



RESIDENT PATIENT CARE QUALITY IMPROVEMENT EXPERIENCE

The resident quality improvement experience will consist of a two-month rotation in which a CA-2 or CA-3 resident will be assigned as an ad hoc member of the department's Quality Assurance Committee. The experience will enhance the residents' knowledge of the requirements of the ACGME general competency, practice-based learning and improvement as detailed in the **Curriculum Manual**. Please refer to the Curriculum Manual for a full description of the resident quality improvement experience.

The purpose of the Performance Improvement Program in Anesthesia is (a) to identify and resolve important problems in patient care as well as address issues where improvements are feasible; (b) to provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated privileges.

The Performance Improvement plan includes, but is not limited to, the following:

- Appropriateness of choice of anesthetic agent
- Proper recording on the anesthesia record
- Anesthesia equipment maintenance
- Routine case conference (non-complication and complication cases)
- Pre-op anesthesia evaluation
- Post-op anesthesia evaluation
- Morbidity and mortality conference

- Evaluation of clinical privileges, orientation, self education, continuing education and departmental in-service
- Infection control
- Utilization review/risk management

The Director of Anesthesia, at each hospital, is responsible for assuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients and the clinical performance of all individuals with clinical privileges in Anesthesia. The director or his/her designee is responsible for the everyday monitoring of all important aspects of anesthesia activities.

The director appoints departmental performance improvement committee members. This committee shall meet approximately once a month. Minutes of these meetings will be forwarded to the hospital's Director of Performance Improvement and the department Chairman.

Procedure

The Director or his/her designee collects data about important aspects of patient care in the department and about clinical performance of its members. This information is collected on an on-going basis using appropriate forms and any quality issues identified by Utilization Review, Infection Control, etc.

The information is assessed so as to identify important problems in patient care, as well as to identify the opportunities for improvement.

When important problems in patient care and clinical performance or opportunities to improve care are identified, the following is implemented:

- Actions are taken, and
- The effectiveness of the actions is evaluated
- A periodic assessment of evaluations and effectiveness of actions is performed to ensure the process is still appropriate.

The findings from, and conclusions of, monitoring, evaluating and problem solving activities are documented and brought to the attention of the department Quality Assurance Committee as well as the hospital's Director of Performance Improvement.

The departmental performance improvement program consists of the following components:

1. Monitoring system to identify problems
2. Analysis/Evaluation of problem
3. Corrective Plan/Action
4. Implementation of Plan/Action
5. Evaluation of effectiveness of Plan/Action

Monitoring Systems to Identify Problems

- Routine collection in the anesthesia department/service and the hospital performance improvement program of information about important aspects of anesthesia care.
- Monthly case review.
- Daily pre-anesthesia assessment.

- Monthly Mortality and Morbidity Conference.
- Review of Mortality and Morbidity in OR/PACU and within 24 hours.
- Post anesthesia rounds.
- Attendance at various committee meetings.
- Monthly staff meetings.
- Statistical review.
- Routine/non-complicated cases who remain intubated over 2 hours.
- Appropriateness of blood utilization.
- Drug utilization.
- Verbal communication when various staff members from other services keep us abreast of problem/issues relevant to patient care; this will be documented and discussed.
- There will be an on-going performance improvement review to monitor compliance with resident duty hours and working environment at each affiliate hospital. Monthly reports will be forwarded to the department's Performance Improvement Program.
- Patient records including documentation of preoperative and postoperative anesthesia assessments by residents.

Analysis/Evaluation of Problems

- A review committee has been established to analyze and evaluate the information collected through the monitoring system and random case audit by the type of procedures to identify important problems and improve care. The review committee meets quarterly.
- A departmental in-house committee has been established to evaluate and discuss collected data on a monthly basis.
- The results of the data collected, along with the minutes from each meeting, are forwarded to the hospital's director of performance improvement.
- The department has established criteria for all major clinical functions of the anesthesia department. These criteria are used by the department in the monitoring and evaluation of patient care.

Major Criteria

- Monthly on-going case review criteria.
- Monthly performance improvement criteria.
- Formalize a monitoring performance improvement activities form with written guidelines to be used for documenting monitoring and resolutions.

Corrective Plan/Action

When important problems in the quality of patient care are identified, the following steps are taken:

- Action is taken with the department.
- Recommendations for action are made by the Performance Improvement and Quality Care Committee of the Department of Anesthesiology of the SUNY Downstate Medical Center.
- Disciplinary action will be taken against residents who fail to comply with the department's "moonlighting" policy.
- Problems and issues that cannot be resolved at the departmental level through the established mechanism will be referred to the established multidisciplinary committees within the institution, i.e., OR, P&T, QA, Infection Control or Administration and/or Medical Board, etc.

Implementation of Plan/Action

Findings are to be discussed at departmental and multidisciplinary meetings and appropriate measures will be instituted and documented. This consists of guidelines for corrective action which are as follows:

- In-service training and lectures with in-house and guest speakers.
- Conference with individual staff members and Director of Department.
- Interaction and meetings/conferences with other disciplines and follow-up monitored.
- Monitoring of established criteria for pre, intra and post anesthesia care.
- Attendance at assigned hospital committees and contribution to issues discussed with recommendation for resolution and monitoring and follow-up of issues.
- Discussion on new/improved techniques for improvement of quality care.
- Attendance at outside seminars and workshops.
- Annual written evaluations on all staff in conjunction with re-credentialing process.
- Delineation and review special privileges as per established mechanism.
- Interaction with hospital-wide quality assurance program and risk management departments.
- Dissemination of departmental minutes and information to appropriate personnel, departments, committees, medical board and administration.

Follow-up

The effectiveness of the actions taken to resolve the problems will be evaluated on a periodic or ongoing basis depending on the nature of the issue.

Evaluation of Effectiveness of Plan/Action Taken

The effectiveness of the monitoring/evaluation/problem-solving activities in the Anesthesia Department is evaluated annually as part of the Program's Performance Improvement Problem.

The Director of Anesthesia, in monitoring patient care, is responsible for notifying the appropriate Chiefs of Service, department Heads, Chief(s), hospital-wide Quality Assurance program, of any adverse situations that impact on total patient care, but are outside of the scope of the department of Anesthesia.

PLEASE NOTE: RESULTS OF PERFORMANCE IMPROVEMENT MONITORING EVALUATIONS ARE PLACED IN THE APPROPRIATE ANESTHESIA PROVIDER'S PERSONNEL FILE.