

National Capital Consortium Anesthesiology Residency Manual

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I. Introduction

The National Capital Consortium welcomes you to the Anesthesiology Residency Program. Whether you have just completed your internship or an operational tour, we understand that a residency program may differ greatly from your previous experiences and hope to assist in making this transition as smooth as possible. You are not expected to master the field of anesthesiology immediately. Rather, this program offers three years of instruction in the theory and practice of anesthesiology, increasing levels of responsibility, and progressively more difficult and challenging cases in both general and subspecialty anesthesiology. Your training will prepare you for successful completion of the written and oral examinations of the American Board of Anesthesiology with the ultimate goal of evolving into a competent, knowledgeable, and safe clinical anesthesiologist that achieves the status of “consultant in anesthesiology”.

Anesthesiology Is an Evolving Specialty

Beyond the operating room, practice now encompasses ambulatory clinics, dedicated regional anesthesia and acute pain sections, intensive care units, and free standing pain centers. Consultant anesthesiologists today must be clinically skilled, as well as savvy about contemporary organizational management, medical leadership, legal issues, computer applications, and quality management. The curriculum here at the NCC Anesthesiology Residency incorporates hands-on training, didactics, tutorials, simulations, and problem-based learning to meet these needs. It is designed to prepare physicians in all aspects of today’s practice and to foster creativity so that one may prosper in an ever-changing health care environment.

Developing Competent Anesthesiologists

The goal for residency training in Anesthesiology at the NCC is to become a skilled, competent physician specializing in anesthesiology who is an asset to the Military Health Care System, the US healthcare system, and the profession.

II. Program Overview

The NCC Anesthesiology program is based on a system of graduated responsibility. Residents will receive extensive exposure to a diversity of cases that progressively expand their skills. Working closely with attending anesthesiologists, residents learn manual skills and are challenged to take increasing independence and responsibility for a wide variety of patients with disease processes in diverse settings.

While broad program goals and objectives can be found below, each clinical opportunity or rotation has a focused set of goals and objectives that outline the expected experience and set the expectations for resident learning. These should be reviewed prior to each rotation to maximize resident benefit.

Common Program Objectives for Residents

1. Develop a core competency of proficiency in the perioperative, critical care, and pain management of a wide range of patients (neonate to geriatric) in anesthesia subspecialties and diverse settings.
2. Acquire medical knowledge to pass the American Board of Anesthesiology written examination.
3. Develop technical skill and demonstrate judgment to practice anesthesia competently. This includes performing at least the minimum number of procedures required for board certification and demonstrating adequate skill level when performing these procedures with the faculty.
4. Develop a pattern of practice-based, life-long learning to maintain excellent skills and competency in the specialty of Anesthesiology.
5. Acquire / develop communication skills that facilitate effective and professional interaction with patients and other healthcare professionals, and develop verbal presentation skills that facilitate passage of the oral examination of the American Board of Anesthesiology.
6. Act and behave in a professional manner.
7. Become familiar with and be able to function as an Anesthesiologist in both the military medical systems and US medical system.

Program Educational Goals

1. To instruct the resident in the theory and scientific foundation of anesthesiology.
2. To develop each resident into a competent clinical anesthesiologist.
3. To allow each resident to achieve his/her full potential as an anesthesiologist.
4. To expose the resident to the full scope of clinical anesthesiology.
5. To provide the resident a progressive increase in the level of his/her responsibilities.
6. To develop the resident's ability to plan and manage a broad range of anesthetics, ranging from simple to complex, in all age ranges, and in patients with a wide spectrum of disease states.
7. To prepare each resident for a professional career in anesthesiology.
8. To prepare each resident for successful completion of both the written and oral examinations of the American Board of Anesthesiology.
9. To establish in each resident the motivation to maintain professional development in the field of anesthesiology after the completion of the residency.

Basic Domains of Learning

The NCC Anesthesiology residency program is designed to provide residents opportunities to succeed in all domains of learning. Residents will be expected to exhibit advanced affective behavior and technical skill as they learn through clinical exposure, while cognitive knowledge should continue to expand via self-initiated study with the assistance of a structured didactic schedule.

1. **Cognitive Knowledge** – What you know and how you think.
2. **Affective Behavior** – Your attitudes and how you treat others; specifically professionalism, communication, and patient management skills.
3. **Technical Skill** - What you can do with your hands.

Philosophical Steps of Learning

Growth and competency in the practice of anesthesiology will proceed through four phases. Throughout residency and one's professional career, movement in both the forward and reverse direction will occur. This is the essence of practice-based learning, the development of life-long learning skills, and the continued maintenance of professional competency. While location in the level of competence should be recognized to remain a safe anesthesiologist, difficulty at any time should not be thought of as failure, but rather an opportunity to expand your understanding of practice of the specialty.

1. **Reporter** – Accurately gather relevant patient information and communicate this information to others.
2. **Interpreter** – Interpret information in the context presented while remaining conscious that you are not facile with the independent management of many of the situations in which you are placed and tasks you may be asked to perform.
3. **Manager** – Consciously competent of your ability to manage patient care, critical situations, and procedures. During this phase confidence is reinforced through success in education.
4. **Educator** – Capability to effectively transfer knowledge to others.

III. Clinical Descriptions

Clinical Rotation Sites

Each Anesthesia department is comprised of approximately twenty to twenty five full time anesthesiologists. Teaching staff are either board certified or board eligible by the American Board of Anesthesiology. Subspecialty trained anesthesiologists in cardiovascular anesthesia, neurosurgical anesthesia, pediatric anesthesia, obstetrical anesthesia, regional anesthesia, intensive care medicine, and pain management are also active department members providing training to residents.

The primary academic hospital for the NCC Anesthesia Residency is the new Walter Reed National Medical Center (WRNNMC) at Bethesda (aka WRB), with a variety of academic, research, and staff educator opportunities available through the Uniformed Services University for the Health Sciences (USUHS). When fully completed, this facility will offer 20 main ORs and multiple remote locations (including pediatric and adult gastroenterology, oral maxillofacial surgery, urology, the maternal infant care center, one or more cystoscopy rooms), a pre-op holding area, the post-anesthesia care unit, and an outpatient surgical admitting area. WRB also provides regional anesthesia suites and pain clinic centers. Obstetrical anesthesia experiences occur in the Mother Infant Care Center (MICC) which has eight laboring beds and three operating rooms, while critical care rotations currently occur in the WRB SICU.

Clinical Experience

Clinical Anesthesia 1 (CA-1)

The first clinical academic year is designed to provide for the fundamentals required of a clinical anesthesiologist.

1. **General Operating Room (GOR)** – Defined as “basic anesthesia training”, these months that make up a large portion of the CA-1 year will provide the starting resident with adequate clinical material to learn the fundamentals of anesthesiology. Scheduling is designed to offer the resident the opportunity to achieve skill and confidence in the conduct of uncomplicated anesthetics.
2. **Critical Care** – Provide intensive care level management of critically ill patients in the perioperative period. A total of 3 months are required during the three year residency.
3. **Obstetrics** – 2 month rotation in the CA-1 or CA-2 year providing labor analgesia to laboring mothers and both routine and emergent anesthesia for surgical deliveries.
4. **Regional Anesthesia** – Insertion and management of both peripheral and neuraxial catheters for the management of acute pain from operative procedures and our war wounded.
5. **Chronic Pain Management** – Management of patients with chronic pain syndromes to include both medical management and procedure pain control.
6. **Preoperative Anesthesia Management** – Preoperative evaluation of patients to undergo surgery.
7. **Post Anesthesia Care Unit** – Management of postoperative patients to include both non-complicated management of same day surgery patients and treatment of postoperative complications.

Clinical Anesthesia 2 (CA-2)

The second clinical anesthesia year is almost completely divided into anesthesiology subspecialties to allow for focused study and clinical training in the theory and practice of subspecialty anesthetic management.

1. **Cardiovascular Anesthesia** – Single month rotation at WRB followed by a two month rotation at Washington Hospital Center, providing anesthesia for cardiovascular surgery to include CABG and valvular replacements.
2. **Neurosurgical Anesthesia** – Single month rotation at WRB followed by a one month rotation at Johns Hopkins Medical Institute, providing anesthesia for patients intracranial and spine surgery patients.
3. **Pediatric Anesthesia** – Two month rotation at the Children’s National Medical Center offering a large volume experience in pediatric anesthesia to patients ranging from premature neonates to teenagers undergoing both elective and complicated surgical interventions.
4. **Advanced Clinical Anesthesia** – Experience advanced anesthesia cases to include vascular and thoracic surgery.
5. **Advanced Regional Anesthesia (CA2 and CA3)** – Rotation in Landstuhl Germany providing regional pain management mostly to wounded warriors.
6. **Trauma (CA2 or CA3)** – Provide anesthesia management of acute trauma patients at Washington Hospital Center.
7. Rotations similar to CA-1 year (Regional, pain management, etc.)

Clinical Anesthesia 3 (CA-3)

Progressively difficult anesthetic cases are assigned as the resident shows more independent practice. Elective subspecialty training or research may be possible when appropriately scheduled via consultation with the director of residency training.

1. **Advanced Clinical Anesthesia**
2. **Cardiovascular Fairfax Elective** – Three month rotation at Fairfax hospital in Virginia.
3. **Trauma**
4. **Advanced regional Anesthesia**
5. **Obstetrical Anesthesia** (Washington Hospital Center)
6. Rotations similar to CA-1/2 year (Regional, pain management, etc.)

IV. Didactic Descriptions

Orientation Program

Under the direction of the Residency's Executive Education Committee (EEC), the residency organizes a comprehensive orientation program for all incoming residents during July of each year. The first week is structured assist residents in transitioning to the operating room environment, to introduce the residents to residency organization and expectations, and to cover the rules and regulations of the American Board of Anesthesiology.

Over the next month the introductory program period continues with daily reading assignments from a basic anesthesiology text and supplemented by daily departmental staff lectures (*Resident Didactic Series*). The Anesthesia knowledge test will be given before and after this orientation program to gauge resident progress.

2011-2012 Basic Text: Basics of Anesthesia, Fifth Edition.

Case Related Education

The backbone of our educational program is the learning experience associated with the conduct of each case. All aspects of the perioperative period offer a learning opportunity that should be seized by the resident. The resident will be expected to utilize information gathered from the preoperative examination and interview, knowledge of the case complexity and length, anticipated postoperative management, and any possible complications to carefully plan and implement an anesthetic plan. The resident is then expected to utilize the opportunity to contact their attending anesthesiologist to discuss their plan in detail.

Departmental Morning Report

Departmental morning conferences occur from 0630-0700 (except for the one hour Grand Rounds lecture) at WRB. These meetings are mandatory for all residents. The usual agenda follows:

Monday:	Resident Chapter Review
Tuesday:	Chief Resident Conference
Wednesday:	Morbidity & Mortality (M&M) / Quality Assurance (QA) Conference
Thursday:	Grand Rounds (0630-0730)
Friday:	Problem Based Learning or Oral Board Preparation

Resident Didactic Series

Staff anesthesiologists moderate several weekly didactic sessions to complete the resident didactic series. Over the first month of the academic year this will take the form of daily review of a basic anesthesiology text (*orientation program*). After completion of the orientation program, the didactic series follows and is composed of topic based chapter review, Morbidity & Mortality or QA conference, problem based learning, and oral board preparation.

- 2010-1011 Orientation Text: Basics of Anesthesiology, Fifth Edition. Stoelting, Miller.
- 2010-2011 Didactic Text: Clinical Anesthesiology, Fourth Edition. Morgan, Mikhail, Murray.

Residents are expected to attend a monthly academic day on the second Thursday of each month. These represent staff anesthesiologist moderated lectures, reviews, question and answer sessions, and participation in anatomical procedure-oriented labs.

Grand Round Lecture Series

The anesthesia departments at WRB, recognizing the need to introduce opinions and ideas from outside their respective departments, have integrated the Grand Round Lecture Series into the morning conference schedule. Topic-expert anesthesiologists and physicians from other fields are invited to lecture on a wide variety of topics. CA-3 residents are also expected to prepare a single grand round presentation (see *Scholarly Activity*).

Morbidity & Mortality / Quality Assurance

This forum is utilized to discuss cases deemed interesting on a clinical basis by the QA officer. These are often presented by residents with attending supervision and all trainees are expected to participate in the discussion.

Journal Club

Each month a staff anesthesiologist hosts the departmental journal club. During these conferences two to three articles from current anesthesiology journals are presented and discussed by the residents and staff sponsor.

Resident Self-Study

While the NCC Anesthesiology Residency Program provides a wide range of educational opportunities to its residents, EACH RESIDENT MUST UNDERTAKE A COURSE OF SELF STUDY to prepare for the vigorous ABA written and oral examinations. Each resident is expected to study a major anesthesiology textbook as well as subspecialty texts.

In addition, the journals, ***Anesthesiology*** and ***Anesthesia and Analgesia*** are highly recommended for information regarding current progress in the field. It should be noted that these are meant as supplements to expand ones knowledge but the focus should be on anesthesiology texts, especially during their CA-1 year.

Departmental Library

The department maintains a collection of past and current textbooks in all subspecialties of anesthesia both in the library and resident rooms. These texts should not be removed and should be available for all to use at all times. The department also maintains subscriptions to the major anesthesia journals (***Anesthesiology*** and ***Anesthesia and Analgesia***, ***Journal of Regional Anesthesia and Pain Medicine***) that are available for review.

Computers with graphics, slide production, and literature search capability are widely available for resident and staff use. Only software installed by the department is authorized for resident use. Many resources on CD ROM are also available and the internet is available for academic usage. Additional literature and interlibrary loan requests are available either through the main hospital libraries and the USUHS Learning Resource Center (LRC). Access to the WRB main library after hours can be obtained. Please note that all residents are eligible for free access to the electronic media of

the USUHS Learning Resource Center (LRC), which includes thousands of current medical journals and complete textbooks. Please contact the program coordinator for assistance in obtaining access to these electronic resources.

V. Examinations

Anesthesia Knowledge Test (AKT)

The AKT exists as a series of examinations that allow for establishment of a baseline of anesthesiology knowledge and to gain information regarding progress throughout residency. The testing occurs via the following schedule:

- Pre-Test – Given upon arrival to establish baseline.
- Post-Test – Given following the first month of training.
- AKT 6 – Given after 6 months of residency training.
- AKT 24 – Given after 24 months of residency training.

ABA In-Training Examination (ITE)

Residents are required to take the ABA/ASA In-Training Examination (ITE) annually. This examination is typically administered in March and represents testing similar to that of the anesthesiology board examination. Statistical breakdown of results allows for evaluation of residents progress regarding board certification as well as against their national cohort.

Mock Oral Board Examination

A mock oral board examination will be administered quarterly at NNMC and WRAMC. These will represent simulation of the ABA oral board exam and serve to introduce residents to the oral board process. Faculty will also evaluate a resident's taxonomic level of learning, academic progress, and verbal expression capability.

Examination Expectations

While strict standards concerning resident performance do not exist on any of the examinations utilized by the residents, the department expects improvement to be exhibited in both written and oral examinations over the course of the residency program. Each resident's progress is expected to be sufficient to reasonably expect a passing grade on the ABA Written Board Examination taken for credit after one's CA-3 year.

A resident who fails to meet these goals is in jeopardy of being placed on academic probation or discharged from the program. Towards this end, residents performing at a level less than the 25th percentile on either the AKT or ABA examination after the first six months of residency will be placed on non-adverse academic remediation.

VI. Scholarly Activity

Academic Project

Residents are expected to complete a scholarly project. While it is not a requirement to present nationally or to be published to meet this requirement, the completed scholarly project must be deemed by the Executive Educational Committee to be worthy of presenting or publishing. Examples of scholarly projects have included clinical or bench research, case reports, and literature reviews.

Grand Rounds

Residents are expected to present a one hour grand rounds to the WRB department of anesthesiology during their CA-3 year. This is a multimedia presentation on a topic that will educate and inform the staff at both hospitals. The resident is expected to be a subject matter expert; a basic anesthesia review will not suffice.

Scholarly/Academic Portfolio

Each resident will maintain an academic portfolio that will be reviewed periodically. It should contain copies of all presentations and projects during residency (lectures, morning reports, M&M, etc).

VII. Performance Evaluation

Evaluation of Resident Performance

The expectation is that each physician who enrolls in the residency will successfully complete the program. However, the department recognizes its responsibility to the profession, to patients, to society, and to the residents who should have the expectation of comprehensive graduate medical education leading to competency in the field of anesthesiology. Therefore, structured resident evaluations of all domains of learning are utilized to measure resident performance. Currently the “e-value” (www.e-value.net) system is utilized to document all written evaluations. Evaluations will include:

1. Written and informal verbal communication from the staff anesthesiologist on a daily basis.
2. Formal written end-of-month rotation evaluations.
3. Quarterly evaluation reviews with Program director.
4. Semiannual Clinical Competence Committee (CCC) meeting chaired by an Associate Program Director to review performance. Results are communicated to the residents and appropriate remedial actions are initiated if necessary.

Evaluation of Departmental Staff

Residents have the opportunity for written but anonymous evaluation of the departmental staff utilizing the “e-value” system. This information is utilized to improve the overall quality of residency education. Evaluations should be truthful and staff delinquencies documented with the same level of professionalism that residents should expect from their attending anesthesiologists in their evaluations of resident performance.

Evaluation of the Residency

Residents are expected to complete the annual evaluations of the residency program. Thoughtful completion of these evaluations allow for changes to the program that improve the experience and education of the residents.

VIII. Administrative Policies – Interactions, conflicts, and Grievances

Chief Resident

The Program Director, in consultation with the Associate Program Directors, will appoint four Chief Residents. Chief Residents serve at the discretion of the program director. The typical duration is six month period during the CA-3 year with roles divided between the administrative chief and academic chief. The Chief Residents serve as the administrative liaison between residents and staff. Residents should regard the Chief Residents as their advocate, and should seek counsel should problems arise with respect to the residency program.

The Chief Residents generate the monthly resident call schedule at WRB and assist in coordination of the weekly resident didactic series.

Staff-Resident Interaction

Staff anesthesiologists at the National Capital Consortium hospitals are graduates of an ACGME approved residency in anesthesiology or its international equivalent, and are either board certified or currently involved in the examination process. It is expected that all interactions between residents and staff will be carried out with mutual professionalism and respect within the scope of the following guidelines:

1. The staff anesthesiologist is the ultimate care provider, credentialed by the hospitals to provide anesthesia care to patients. Residents are credentialed to function *only under staff anesthesiologist supervision*.
2. The Staff anesthesiologist is ultimately responsible for preparation and completion of the anesthetic plan. Resident anesthetic plans are subject to approval and modification as the staff anesthesiologist deems fit. There are numerous appropriate anesthetic concepts and is the privilege and responsibility of the staff to finalize an anesthetic plan.
3. If a resident feels the patient management plan dictated by the staff to be unsafe, refusal to participate is warranted, and must immediately be brought to the attention of the Department Chairperson and the Residency Program Director. Residents should first attempt to resolve any conflicts with their staff prior to taking this action.
4. Resolution of less serious conflicts should initially be dealt with in a professional manner at the resident-faculty level. If unable to resolve the conflict or the resident feels uncomfortable in discussing the issues with their staff anesthesiologist, the residents may utilize their Chief Residents and Associate Program Directors. The Program Director may be asked to serve as the ultimate arbiter.
5. Residents may have some interaction with credentialed CRNA providers in the NCC hospitals. This relationship is governed by guidelines of mutual professional respect and military courtesy, but CRNA providers may not supervise residents in the delivery of an anesthetic per ACGME and Residency Review Committee mandate.

Harassment

Harassment, or discriminatory intimidation, may take many forms. It may be, but is not limited to, words, signs, jokes, pranks, intimidations, physical contact, or violence. Harassment may be related

to gender, race, religion, ethnicity, sexual orientation, age, marital status, health, or physical condition.

Sexual harassment may include unwelcome sexual advances, requests for sexual favors, or other verbal or physical behavior of a sexual nature that creates an intimidating environment or prevents an individual from effectively performing their duties.

All faculty and residents are responsible for keeping the work environment free of harassment. Any faculty member or resident who becomes aware of an incident of harassment, whether by witnessing the incident or being told of it, must report it to their supervisor, or if the supervisor is involved, to the next superior supervisor who is not involved in the incident. Harassment that occurs between fellow workers outside of the work place will be treated the same as an incident that occurs in the actual place of work. Incidents of harassment will be investigated and if deemed necessary referred to the command for action.

Adverse Actions and Due Process

A resident who is identified as having deficiencies in any of the basic domains of learning may receive either non-adverse or adverse remedial action.

Non-adverse remedial actions will be initiated in response to recurring evidence of deficiencies in Core Competencies as assessed through written evaluations by faculty, as reported by the Clinical Competency Committee (CCC), in response to examination scores that place residents below the twenty-fifth percentile nationally, or on a case-by-case basis at the discretion of the Program Director.

Non-Adverse remedial action typically consists of a remediation program containing the following:

1. Written and in-person counseling by the Program Director.
2. A 3-4 month academic remediation period guided by written goals and objectives agreed upon by the resident, resident mentor, and Program Director.
3. Periodic Assessments of progress by the educational committee.

Documentation of Non-Adverse remedial actions will include the following at a minimum:

1. Expectations – What is expected in terms of competencies
2. Deficiencies – Areas of resident failure
3. Improvement – Written plan for remediation
4. Consequences – Plan if remediation is not accomplished
5. Timeline – Length of anticipated remediation period.

Upon successful completion of the remediation period, documentation will remain at the level of the program director. In the event of unsuccessful remediation, documentation from that period may be included in adverse remedial actions. Policies and procedures guiding the implementation for adverse actions (probation, extension, or termination) and breaches of military professionalism are outlined in the NCC Administrative Handbook (available at <http://www.usuhs/mil/gme/>).

Conflict Resolution and Grievances

The resident occupies a position of subservience and dependency that makes him/her particularly vulnerable. This can discourage the type of frank dialogue necessary to address substantive issues of quality of training should such issues arise. This program has pathways by which complaints may be registered and mechanisms by which grievances may be resolved. The starting point is with any of the Chief Residents. However, if the problem cannot be resolved at that level, this program maintains an open door policy with respect to the program Director and Associate Program directors. If those methods prove ineffective then the resident may use the procedures outlined in the NCC Administrative Handbook (available at <http://www.usuhs/mil/gme/>).

IX. Administrative Policies – Substance Abuse

Each uniformed service has written policies concerning management of physician impairment and impaired residents are managed by their respective service. Details of the services' policies and management systems may be obtained from the Credentials offices. All policies concerning management of physician impairment include procedures for identification of impaired providers, limitation of privileges, surveillance, and rehabilitation. All residents have access to comprehensive rehabilitation services to include inpatient treatment.

Nonetheless, residents are subject to a **zero tolerance** policy for the use of illicit substances. All services maintain a "zero tolerance" with reference to use or abuse of controlled substances by officers. In the implementation of this policy, urine samples are obtained from all personnel on a random basis, and positive results are grounds for initiating an investigation by the service member's respective service investigative service. Any officer accused of using a controlled substance may be subjected to a felony court martial, and if found guilty will be subject to imprisonment and/or fines, notification of state medical license boards of conviction, and discharge from the military. This policy applies for even first time offenders.

Below are service specific links to Department of Defense policies regarding substance abuse:

U. S. Navy:

<http://doni.daps.dla.mil/Directives/05000%20General%20Management%20Security%20and%20Safety%20Services/05-300%20Manpower%20Personnel%20Support/5350.4D.pdf>

U. S. Army:

http://armypubs.army.mil/epubs/pdf/R600_85.pdf

<http://www.acsap.army.mil/sso/pages/public/laws/army.jsp>

U. S. Air Force:

<http://www.e-publishing.af.mil/shared/media/epubs/AFI44-121.pdf>

Department of Defense Instruction:

<http://www.dtic.mil/whs/directives/corres/pdf/101006p.pdf>

X. Administrative Policies – Leave and Meeting Policies

NCC Anesthesiology Resident Leave policies are guided by the requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Anesthesiology, and DOD leave policies. The structure of leave requests is attempted to make the process fair for all residents involved while maintaining our ability to meet our clinical needs.

1. Residents are allotted a total of 60 days out of training (average of 20 days per year) over the course of their residency. These so-called “ABA days” include absence from regular working days and typically will not include federal holidays or weekends.
2. Residents must be on leave with their respective service command. This is included in the 30 days allotted per year and includes any day away from the residency to include weekends and holidays.
3. The ACGME also allows Residents an additional five business days each year to attend an anesthesiology conference or meeting. While these days do not count as absence from the residency, they must be accounted for by either funded or unfunded TAD/TDY travel orders. By policy, all residents are allowed one funded TAD/TDY at the discretion of the program director. Furthermore, although the ACGME allows for a maximum of 15 meeting days during residency training, meeting attendance is a privilege and not an entitlement.
4. Leave requests are to be made to the Associate Program Director managing the “Leave Books” and must be approved prior to arrangements being made.
 - a. All non-emergency leave should be requested in at least the second calendar month before the leave start date (eg, March leave request must be submitted NLT 31 January).
 - b. Requests for full business week blocks are the expectation. Shorter blocks will be reviewed on an individual basis but are discouraged.
 - c. Leave is not permitted during rotations in the SICU, Children’s National Medical Center, Trauma, or Landstuhl rotations. Elective CA-3 out rotation leave is limited to a single week.
 - d. Due to shortage of staff (and inability of CA-1 residents to take call), leave in the month of July is extremely limited. The priority for June Leave is given to graduating CA-3 residents.
5. NCC guidance on the management of maternal, parental, convalescent, and religious leave policies can be found in the NCC Administrative Handbook (available at <http://www.usuhs/mil/gme/>).

XI. Administrative Policies – Resident Work Hours

Strict adherence to resident work hour requirements is mandated by the ACGME. If at any period these policies are believed to have been violated the incident must immediately be reported to the Chief Residents, Associate Program Director, and the Program Director. Residents are responsible for monitoring and submitting their duty hour statistics.

1. Residents are limited to an eighty hour weekly work limit averaged over a 4 week period.
2. Work hours are limited to twenty-four hours of continuous duty time with an additional period of up to four hours permitted for continuity of care and educational activities.
3. Residents will be allowed one day in seven free from all patient care and educational obligations when averaged over four weeks.
4. In-house call will not exceed every third night, averaged over a four week period.
5. Residents will not administer anesthesia on the day after an in-house overnight call.
6. Residents must be allotted an adequate rest period between shifts. Residents should have a ten hour break between shifts and a minimum 14 hour break after a 24 hour shift.

Further details regarding duty hour policies are available at www.acgme.org and policies will be modified as ACGME policy evolves.

XII. Administrative Policies – BLS and ACLS Certification

Residents are required to be current in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certifications at all times. Should a resident lapse in either of these certifications, they will be unable to continue residency training until that delinquent certification is achieved. Residents will forfeit a day of their allotted 60 leave days for each day of training missed. If the resident has no leave to forfeit, then residency training will be extended for one day for each training day missed.

XIII. Resident Clinical Duties

Main Operating Room Work Day

Operating Room Assignments

The operating room assignments are determined by the Chief Resident and Department Scheduling Officer. It is the responsibility of residents to review this published schedule (alternatively cases can be found on S3) for their room, case, and staff assignments

Preoperative Patient Evaluations

The Resident is responsible for the preoperative evaluation of all inpatients scheduled to have a procedure in their assigned room. This is to include patient interview and examination, review of appropriate labs or studies, and consultation with the surgical service if necessary. This preoperative encounter should be entered into the electronic medical record. Outpatient surgical candidates are typically evaluated in the Ambulatory Procedures Unit (APU) at WRB, respectively. An electronic medical record is often present and the patient's paper record can be found in these locations. It is the resident's responsibility to review the electronic medical record in order to become familiar with the patients, even if no preoperative evaluation is in place (day of surgery pre-op).

Staff Notification

The resident is responsible for notifying their assigned attending anesthesiologist of the proposed caseload the day before scheduled cases. Each case should be presented in a concise manner as if presented on morning rounds. An anesthetic plan should be presented and will be discussed and altered as necessary until a final plan created. Staff anesthesiologists will likely inquire about pertinent medical issues and the surgical procedure to be completed. It is therefore expected that the resident has reviewed this information prior to contacting their staff.

Room Preparation

On the morning of the procedure, the resident is responsible for setup of all anesthetic equipment necessary to appropriately manage the anesthetic for the first scheduled surgical procedure. Detailed setup plans are covered during orientation and a setup overview is included in this manual.

Operating Procedures

The resident is responsible for meeting the patient immediately following morning conference and confirming all preoperative information. Peripheral venous access should be accomplished in the holding area. The goal is to have the patients in their respective operating rooms by 0730 (except on grand rounds days when the expectation is 0800). Once in the operating room, the anesthetic plan and operative procedure should be completed. The patient is then taken to the Post-Anesthesia Care Unit (PACU) or ICU postoperatively. You will find it useful to have the majority of the setup for the next case completed prior to leaving the room to expedite room turnover. The process then repeats as the resident meets the next patient in anticipation of the next case.

Postoperative Evaluations

All patients that remain in-house should be evaluated with a postoperative visit within 48 hours of surgery completion. This should be documented in the electronic medical record. If a complication

is noted, the resident is then responsible for compilation of any quality assurance data deemed necessary as well as notifying the attending anesthesiologist of record.

Floor Runner Checkout

After 1500, and once the resident has completed all daily duties and compiled all relevant information for the next day's cases, the resident is responsible for check out with the daily Floor Runner regarding any tasks that require completion prior to resident dismissal for the day, i.e. RESIDENTS MUST CHECK OUT WITH THE FLOOR RUNNER BEFORE LEAVING EVERY DAY.

Call Responsibilities

The Primary Call Team

The main call team is composed of a single staff anesthesiologist with a senior and junior resident. The senior resident, in conjunction with the staff anesthesiologist, is responsible for acting as the primary anesthesia provider in the hospital and for coordinating all anesthesia activities. The junior resident works to assist the senior resident in completing all anesthesia requirements as outlined below. Call duties should be shared. The senior should not delegate all activities to the junior resident and retire to bed. This is bad form and reflects poorly on the resident.

Call Scheduling

The call schedule is produced by the Chief Resident on a monthly basis and outlines the call requirements for each resident.

Weekends and Holiday: 0600-0600

Weekdays: OB Call 0630 – 0630

Night Float: Monday through Friday from 1800 until the end of the morning's conference (0700 or 0730)

Main Operating Room Cases

The primary call team is responsible for completion of the days regularly scheduled and Time and Space Available (TSA) cases, as well as any emergent cases that arise. While the senior resident is responsible for coordinating activities, all members of the call team should work with ancillary OR personnel to move patients in and out of the OR in an expedited manner.

A pre-assigned operating room should be set-up at all times in preparation for emergent cases.

Hospital Codes & Airway Emergencies

Anesthesiology residents, acting as emergent airway consultants/experts, are responsible for responding to all "codes" to include both respiratory and cardiopulmonary arrest scenarios. The code bag should be checked and stocked prior to each call in anticipation of emergent use.

Regional Anesthesia / Pain Service Responsibilities

The pain service and regional service are both managed by the primary anesthesia call team during off hours to include nights and weekends. It is imperative that every effort is made to guarantee that pain patients (and our wounded warriors) are cared for expeditiously and are not allowed to remain unattended on the floor. Management of these pain catheters will be covered in resident orientation and senior residents are always available to assist in their management.

Preoperative Evaluations

The operating room schedule may change after hours with the addition of new TSA cases or changes in room assignments. The call residents are expected to review the OR assignments (S3) and are held responsible for the preoperative evaluation of all added cases.

Obstetrics Call (NNMC)

A single staff anesthesiologist and resident make up the obstetric anesthesia call team on the MICC at WRB. The resident is responsible for providing labor analgesia (epidurals) to laboring parturients and maintaining preparation for any emergent surgical deliveries.

XIV. Resident Supervision Policies

Every patient that receives care by an NCC anesthesiology resident is assigned an attending staff anesthesiologist. This anesthesiologist assumes complete responsibility for care rendered to the patient as dictated by customary practice, legal requirements, and standards of care. The following standards for resident supervision should act as guidelines as individual staff anesthesiologists will require varying levels of resident supervision. Residents should assume that their attending would like to be present for all invasive procedures to include induction and emergence unless directly instructed otherwise by staff.

Level I Procedures – Indirect supervision appropriate: Attending anesthesiologist is aware and immediately available but not present.

Clinical Anesthesiology Year 1	Clinical Anesthesiology Year 2 & 3
Routine Peripheral Intravenous Line Insertion	CA-1 Level Procedures
Arterial Line Insertion	Routine Labor analgesia for uncomplicated obstetrical cases
Arterial Blood Gas Sampling	
Preoperative Evaluations (includes APU)	Routine Placement and testing of perioperative lumbar epidural catheters
PACU Evaluations	
Routine Postoperative Pain Consultations	Moderate sedation and analgesia for minor procedures
Routine Labor analgesia for uncomplicated obstetric cases after completion of 15 supervised neuraxial anesthetics	
Other main OR procedures at the discretion of the staff anesthesiologist	Dosing of OB Epidural catheters for urgent/emergent obstetric surgical delivery
	Routine Placement and testing of perioperative thoracic epidural catheters
	Moderate sedation and analgesia for cardioversion
	Uncomplicated central lines
	Blood Product Administration
	Routine subarachnoid or epidural anesthesia
	Trigger point injections
	Lumbar epidural steroid injection
	Emergent intubations for codes
	Other main OR procedures at the discretion of the staff anesthesiologist

Level II Procedures – Indirect Supervision: Attending Anesthesiologist aware and immediately available WITH a CA-3 present (or CA-2 at discretion of attending anesthesiologist).

Clinical Anesthesiology Year 1	Clinical Anesthesiology Year 2 & 3
Routine Placement and testing of perioperative lumbar epidural catheters	Moderate sedation and analgesia for cardioversion
	Uncomplicated central lines
Routine Placement and testing of perioperative thoracic epidural catheters	Blood product administration
Moderate sedation and analgesia for minor procedures	Routine subarachnoid block or lumbar epidural anesthesia
	Trigger Point Injections
Moderate sedation and analgesia for cardioversion	Lumbar epidural steroid Injections
Uncomplicated central lines	Emergent intubation for codes
Blood Product Administration	Pulmonary artery catheterization
Routine subarachnoid or epidural anesthesia	Peripheral Nerve block & Regional Anesthesia Procedures
Chronic Pain Evaluations	
Trigger point injections	Endotracheal intubation
Lumbar epidural steroid injection	
Emergent intubations for codes	

Level III Procedures – Attending Anesthesiologist will provide direct supervision unless the attending specifically indicate that the procedure can be performed under indirect supervision.

ALL LEVELS OF TRAINING
All remaining procedures not detailed above to include but not limited to:
Induction of General Anesthesia
Emergence from General Anesthesia
Invasive Pain Management Procedures

**SUPPLEMENTAL
MATERIALS**

ANESTHESIA OPERATING ROOM SETUP

Machine
Low Pressure Check Turn on Machine, monitors, gas monitor Reserve O2 Check Main O2 check / O2 Pressure Alarm Check O2 sensor calibration CO2 sensor testing CO2 canister locked / fresh and Common gas outlet closed High pressure test Ventilator and disconnect alarm (end case to stop alarm) Flowmeters (N2O, O2) Vaporizers (opening, levels)

Suction
Canister with tubing & yankauer

Monitors
Age appropriate, Pulse-Oximetry, NIBP, ECG, Temp, twitch Optional: A-line, CVP, BIS

Airway
Laryngoscopes ET tubes w/ stylet & syringe Airway Adjuncts: Oral airways w/ tongue blade, Nasal airways Bite block Lube, gauze, NG/OGT, Temp probe Emergency Airways (LMA 3-5, Lightwand, Gum elastic Bougie, Cric Kit)

Intravenous Access
LR/NS with tubing IV start Kits: Catheters, prep, gauze, tourniquet, Local, occlusive dressing, tape, gloves Optional: Blood tubing or fluid warmer

Drugs	
100cc Saline bags	10cc Syringes
Phenylephrine (100mcg/cc) Flush	*Fentanyl (50mcg/cc) Succinylcholine (20mg/ml)
3cc Syringes	Vecuronium (1mg/ml) or Rocuronium (10mg/ml) Phenylephrine / neosynephrine (100mcg/ml) Ephedrine (5mg/ml)
*Midazolam (1mg/cc) **Ondansetron/Zofran (2mg/cc) **Dexamethasone/Decadron (4mg/cc)	20cc Syringes
5cc Syringes	Propofol (10mg/ml) or etomidate (2mg/ml)
*Fentanyl (50mcg/cc) *Midazolam (1mg/cc) Lidocaine (20mg/cc) Neostigmine (1mg/cc) Glycopyrrolate (0.2mg/cc)	*Multiple Syringe size options *Optional Medication for case setup

Stuff
Ambu-bag, Surgical airway kit (on back of machine) Transport O2, Jackson Rees, FM Stool Eye tape, tube tape, mask strap

Daily Assignment Sheet (located in Floor Runner's Office)

WRB Anesthesiology Schedule

Date: , July , 2011

Call	Staff Anesthesiologists	Staff CRNA's
PW	Angelo	Awunor
Latestay	Barrows	Bonds
	Beal	Cornett
	Bergstrom	Cox
MD	Berry	Davis,J
	Brown	Deloge
Consult	Dobson	Fuller
Regional	Fahlgren	Guzman
Pain Svc	Gatner	Holmes
	Hodgson	Jarvis
APU	Hudson	Siffes
Pain	Merrill	Thomas.E
OB /Figueroa/Johnson/Paul	Moore	Residents
	Nicodemus	Hansen
S (12-2230)	Outler	Hooks
SW (3-11)	Rotruck	Figueroa OB
SW (3-11)	Scheiner	Griffis
	Sipe	Hayes
1	Slovin	Jensen
2	Soni	Johnson OB
3	Stambaugh	Lammers
4	Thomas,B	McCormick
5	Williams	Mcguire
6		Paul OB
7		Bryant
		Ernst
MICC	Visiting MD's	Froehner
Urology	Dainer	Fura
OMF	Holt	Lizek
	Houston	Longwell
PACU	Upp	Parsons
GI	McDonald	Rios
Remotes	Verdun	Solla
Breaks	Szpisjak	Thomas,T
Post-ops		SRNAs
Deployed	Visiting CRNA	Boese
	Markell	Roadfuss
	Maye	Rotators/Students
	McGuire	Duarte (Intern)
	McKenna	Michalowicz (Intern)
	Todd	Sanou (MSIV)
	Delino	Baker (MSIII)
	Weisgerber	Charmforoush (MSIII)
		Cowart (MSIII)
		Davis (MSIII)
		Schiaretta (MSIII)