Welcome from the Chair and Residency Director

My staff and I wish to extend a cordial welcome to all of you. This booklet should serve to guide you in your course of study. Read it carefully and refer to it frequently.

My every good wish.

T. J. Gan, M.D., MHS, FRCA
Professor and Chairman
Department of Anesthesiology

June, 2015

Welcome to the 2015-2016 academic year. Here’s your guidebook for the year, including all our policies/expectation/guidance for the year. I’ve thrown in plenty of examples to make sure you know what we expect of you. Should be a great year! Let us know how we can improve this guidebook, as it’s always and forever a work in progress.

Christopher Gallagher, MD
Residency Director
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POLICY: COUNSELING AND SUPPORT SERVICES FOR PHYSICIAN IMPAIRMENT/SUBSTANCE ABUSE

PURPOSE
To establish an institutional policy regarding Counseling and Support Services to assist program directors and residents on finding resources for dealing with these important issues.

POLICY
Physician Impairment
Program directors and faculty are responsible for monitoring resident stress, including mental or emotional conditions inhibiting performance or learning and drug or alcohol-related dysfunction.

Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified.

Program directors and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents.

Substance Abuse:
In compliance with the Federal Drug-Free Workplace Act of 1988, the following policy must be adhered to as a condition of employment.

The unlawful use, possession, manufacture, dispensation or distribution of a controlled substance in all Stony Brook University Hospital work locations is prohibited. The term "controlled substance" means a controlled substance in Schedules I through V of the Section 202 of the Controlled Substances Act (21 USC 312).
Employees who unlawfully manufacture, distribute, dispense, possess or use a controlled substance will be subject to disciplinary procedures consistent with applicable laws, rules, regulations, and collective bargaining agreements. Penalties sought may include termination.

Any illegal activity involving drugs or alcohol is considered MISCONDUCT and may be reportable to the Office of Professional Medical Conduct.

Employees must notify their program director of any criminal drug statute conviction occurring in the workplace or at a worksite no later than five (5) days after such conviction.

**Counseling Services:**
An Employee Assistance Program (EAP) is available for employees who wish to seek assistance in dealing with drug or alcohol related problems. Call 632-6085 for additional information. Questions about this policy should be referred to the Human Resources Labor Relations section at 444-2596.

Further information can be found in:

1. The agreement between the State of New York and United University Professionals (dated 1988-91 and continued under the tentative agreement dated 1995-99 along with provisions of the Taylor Law) Article 39 provides for services for the treatment of alcohol or substance abuse. It provides for a revised program for managed care for psychiatric services and alcohol and substance abuse treatment implemented by the State and the Joint Committee on Health Benefits sometime after 1/1/89.
2. The Stony Brook University Hospital Faculty and Professional Employee Handbook offers information about the University Counseling Center as well as the Employees Assistance Program. This support and referral service is set up for employees and families facing health, emotional, alcohol, drug abuse, financial strain or legal problems. It is free and strictly confidential. The University has also established an Alcohol and Drug Abuse Advisory Panel composed of faculty, professional employees, and students to promote the ongoing education of the University community with regard to alcohol and drugs. For additional information call 632-6085.
3. Stony Brook University Hospital employs a full-time chaplain whose staff gives support to the human and emotional needs of the faculty, house staff and patients. Call 444-8157.
4. The Medical Society of the State of New York has recently expanded and revitalized their program called Committee on Physician's Health (CPH). This confidential organization is empowered to assist impaired physicians and is the only program exempted from the legal mandate of reporting impaired physicians to the Office of Professional Medical Conduct (OPMC) in the State of New York. This is available to any resident by calling 1-800-338-1833.

Reviewed: November 2003
Revised: March 10, 2004
Reviewed and Accepted: March 22, 2004
Supervision

The Education office.

Residents in anesthesia are to perform all invasive activities under direct faculty supervision. The only exception to this is emergent intubation by a CA-3 when the faculty member is unable to make it to the intubation immediately (for example, the faculty member is inducing in an OR on a call night).

In addition, in the OR's a specific set of guidelines is attached to the machine, detailing exactly when the faculty are to be advised.

**Stony Brook University Medical Center**
**Communication Regarding Patients**

Residents/Fellows-on-call are required to notify the Attending-on-call (or Surgeon or Medical Attending of record, if so directed) of any changes in any designated clinical or diagnostic parameters using the following criteria:

a. **Utilize the criteria from the Rapid Response Team or age appropriate acute changes.**
   1) Staff member is worried about the patient
   2) Acute change in heart rate to <40 or >130 bpm
   3) Acute change in systolic blood pressure to <90 mmHg
   4) Acute change in respiratory rate to <8 or >28 per min
   5) Acute change in saturation to <90% despite O2
   6) Acute change in conscious state
   7) Acute change in urinary output to <50 ml in 4 hours

Additionally EFFECTIVE MAY 2007:

- Residents/fellows shall utilize general Department or Division specific criteria developed by each program of the top 8-10 diagnoses (contact your program if you are not aware of the specific criteria by May).
- Utilize specific order sets which shall be developed by each residency/fellowship program based on specific cases that are not covered by the first two criteria.
If the resident/fellow contacts the attending of record for situations defined above, a note documenting the communication must be placed in the Medical Record by both the resident/fellow and the attending.
Grievance and Due Process

The grievance and due process is included in the resident’s contract. The specific area regarding grievance and due process is included below.

**Grievance/Due Process:** Dismissal, or any action, including non-renewal of agreement, which may significantly threaten a resident’s intended career development, may be recommended by a Program Director based on substantial non-compliance, egregious behavior or clinical or professional incompetence of a resident. An appeal process is available as described in the GME Policy and Procedures (Grievance Procedure/Due Process, revised 11/24/03). This policy also includes the process for a resident to have their complaints and grievances, related to the work environment and/or issues related to the program or faculty, addressed.

**Policy: Termination, Grievance and Due Process**

**PURPOSE**
To establish a policy for Termination, Grievance and Due Process as it relates to Residents

**POLICY**
1. During the course of training residents are to be evaluated by members of the teaching program at least semi-annually. More frequent evaluations may be undertaken at the discretion of the Program Director (PD) and should follow the policy and procedure on Substandard Resident Performance. The decision to renew a resident’s training program is at the discretion of the PD or Departmental Chairperson.

2. Termination without due process may be based upon a single significant event or a series of unsatisfactory evaluations and substandard performance. Single significant events include but are not limited to,
   1. Falsification of records
   2. Material omission of information on an application
   3. Conviction of a felony
   4. Loss of medical licensure
   5. Placement on a federal debarment list

3. The resident will be notified in writing of the disciplinary actions being instituted and the reasons for such actions. Any disciplinary action resulting in the suspension or termination, except as noted above, will entitle the resident to request a
review of that decision by a hearing panel in accordance with the following procedure:

1. Prior to suspension or dismissal the resident will be given written notice stating the basis for the suspension or termination and advising the resident of the right to request a review of that decision by the Chair of the Graduate Medical Education Committee (GMEC). A resident who wishes to request such a hearing must do so within five (5) business days after receipt of the decision.

2. The Chair of the GMEC will render a written determination after investigating the reasons for the PD or Departmental Chairperson’s decision.

3. If the resident is not satisfied with that determination s/he may request a review before an ad hoc committee appointed by the Chair of the GMEC. A request for such a review must be made within five (5) working days of receipt of the Chair of the GMEC determination.

4. The ad hoc committee comprises three (3) medical staff members of the GMEC. None of the appointed ad hoc committee members may have faculty appointment in the department of the named resident.

4. The ad hoc committee will conduct the hearing in the following manner:
   1. The named resident will be apprised of the nature of the charges and the supporting evidence. The resident may submit any documentation he/she believes to be relevant to a review of his/her record and may list individuals with whom he/she wishes the committee to speak. The committee is not bound to speak with all of the named individuals.
   2. The committee will review the resident’s records and program director documented reasons for the decision.
   3. The resident and PD shall present evidence as requested and deemed necessary by the ad hoc committee.
   4. Hearing proceedings shall be considered informal and non-adversarial. A resident may not be represented by counsel.
   5. The hearing proceedings shall be tape recorded.

5. The ad hoc committee will forward its recommendation to the Chair of the GMEC who will then convene a meeting of the GMEX to review the report of the ad hoc committee and make a final determination.

6. A resident’s failure to appeal an adverse determination by their training program to the next higher step within the time frame specified shall be deemed a waiver of the residents appeal rights and shall render the adverse determination as final and binding.

7. A resident with a complaint or grievance related to the work environment or issues related to the program or faculty may utilize the same procedure as outlined above to achieve resolution.

Reviewed and Accepted November 24, 2003
Selection and Promotion of Residents

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Eligibility, Selection and Appointment of Residents and Fellows

PURPOSE
To establish an institutional policy regarding the selection and appointment of residents and fellows.

POLICY
The University Hospital Graduate Medical Education programs share common criteria and processes for the recruitment and selection of residency and fellowship training candidates. The application process meets all requirements of the Equal Employment Opportunity and the Americans with Disability Act, in insuring that all qualified applicants are afforded a review without discrimination based on sex, race, age, religion, color, national origin, disability or veteran status.

Minimum requirements
General and minimum requirements for eligibility for consideration for a training program at University Hospital are:

1. graduation from an United States or Canadian Liaison Committee on Medical Education (LCME) accredited medical school, OR
2. graduation from an American or Canadian Osteopathic Association accredited medical school OR
3. graduation from a medical school outside of the United States and Canada AND meeting one of the following qualifications:
   1. holds a current valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG)
   2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction, or
4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
5. A US citizen, permanent resident or eligible for an appropriate visa to train in the United States.
6. Fellowship applicants must have successfully completed an ACGME accredited residency program.
The program director is responsible for verification of the applicants' credentials.

Applicants who do not meet the above criteria cannot be considered for any graduate medical educational programs at University Hospital, SUNY at Stony Brook.

Resident Selection
Stony Brook University Hospital Graduate Medical Education programs share common criteria and processes for the recruitment and selection of residency and fellowship training candidates. A selection committee exists within each program and consists of, at a minimum, the program director, and a faculty member. Additional members are included at the discretion of the program director. This committee reviews all applicants and is responsible for selection of applicants for interview, participation in the interview process and the final choice of applicants to be ranked in the NRMP match or offered contracts independent of the match when this option is allowed.

The selection committee members review all eligible applicants to the program. All applicants meeting the minimum criteria above, plus meeting program-specific criteria (such as requirements for prior training), will be reviewed by members of this committee. The relative academic aptitudes and credentials of the applicants and the candidate's personal characteristics such as motivation and integrity are evaluated in this phase of the process. Academic credentials include medical school grades and performance as reflected in documentation received directly from the school, United States Medical Licensing Examination (USMLE) scores. Prior graduate medical education training, where applicable will also be considered. Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators and peers, when appropriate, serve to provide additional information on personal characteristics are required and evaluated as well.

The selection committee then invites selected candidates for an individual interview, which may be conducted in person (preferred) or rarely by telephone if travel to this site presents a personal hardship to the applicant. The interview allows in person confirmation of information provided in the written application as well as an opportunity to assess communication skills.

Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee, and become part of the application file. The committee, with input from the department, is responsible for the final ranking of candidates for the NRMP. The committee will recommend the selection of qualified candidates for positions outside of the NRMP process when appropriate and allowable. All applicants for first year positions are strongly encouraged to participate in the NRMP. All current fourth year medical students from United States medical schools are required to apply through the NRMP process.

Applicants meeting the above eligibility requirements, and the required additional documentation (letters of reference and interview) will be considered by the selection committee for positions remaining open in the program after the NRMP match, and will be offered positions by the program director if considered qualified.

All candidates who are interviewed shall be given a copy of the SBUH contract and a copy of this policy. Programs will document
that the candidate has received a copy of the contract by obtaining their signature.

Purpose of the process
The components of the resident selection process have several general purposes:

**First**, a specific selection committee reviews all eligible applicants to insure that all eligible candidates' applications are given careful, fair, and consistent review.

**Second**, documentation of eligibility and successful performance at the medical school and on required licensure examinations is required to insure that applicants possess proper academic credentials and are sufficiently prepared to benefit from graduate medical education.

**Third**, letters of reference are required and reviewed to gain insight into the applicant's personal characteristics such as motivation, integrity, attitude, and ability to work with others, as viewed by a group of educators, mentors or peers.

**Fourth**, recognizing the central role of communication in providing medical care, a personal interview is required to further evaluate the applicant’s interpersonal skills, and ability to communicate both in an individual interview and in a group setting.

Appointment
The following is required before any resident can be officially appointed as a resident:

**Primary verification of all credentials is required. The Residency Program in conjunction with the Medical/House Staff office will conduct this verification. It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.**

At a minimum, Stony Brook University Hospital must be able to obtain primary source verification on the following:

1. Certification of graduation from any accredited medical school or ECFMG certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECGMG directly to the residency program.
2. Letter of recommendation
3. Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding 1 month that are not verifiable will disqualify candidates for consideration for a GME program
4. Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program
5. USMLE or COMLEX board scores demonstrating successful completion by the end of 3 attempts.
6. Passing a criminal background check

Applicants who do not meet the above criteria can not be appointed to any graduate medical educational program at Stony
Brook University Hospital. Completion of primary source verifications renders an applicant eligible for appointment, but does not in and of itself result in automatic appointment. Residents are eligible to proceed through the appointment process. Any exceptions may be brought to the GME Committee for consideration.

Once all information is completed and reviewed, the applicant will be sent a letter of appointment.

The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.) clearance by employee health service (resident must submit a complete history and physical form) and appropriate visa, if applicable.

Monitoring
This process has been reviewed by members of the Graduate Medical Educational (GME) Committee, and agreed upon as a uniform approach to evaluation and selection of residency applicants.

Insuring compliance with the eligibility and selection criteria as described above is the responsibility each program director. Oversight for GME is the responsibility of the Associate Dean for Medical Education, School of Medicine, i.e. chair of the GMEC, who reviews on an annual basis, the process for every GME program in the institution.

Compliance is monitored through the regular internal reviews conducted through the GMEC, through periodic review of resident qualifications by the Chair and at the time of the regular accreditation site visits and program reviews by ACGME.

Revised September 17, 1997
Reviewed November 18, 2003
Revised and Accepted November 24, 2003
Revised and Accepted: January 24, 2005
SUNY AT STONY BROOK UNIVERSITY HOSPITAL
AGREEMENT OF APPOINTMENT

The SUNY at Stony Brook University Hospital (SBUH) is committed to offering Graduate Medical Education (GME) training programs that meet the institutional and special requirements of the Essentials of Accredited Residencies adopted by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA) and the American Osteopathic Association (AOA).

The following is an agreement between SBUH and the undersigned Resident. This agreement outlines the terms and conditions of the appointment/reappointment (circle one) of house staff to these programs. The official letter of appointment states the salary, PGY level and dates of appointment.

I. **SBUH will provide an environment free of intimidation, and be responsible for the following:**
   a. Financial Support: an annualized salary will be paid in biweekly installments as per the schedule put forth by the SUNY Board of Trustees.
   b. Benefits: include but are not limited to:
      - Vacations* & **
      - Professional liability insurance*
      - Health insurance*
      - Parental leave of absence*
      - Sick leave* & **
      - Disability/maternity* & **
      - Leave of absence policy**
      - On-call meals, sleep rooms, laundry/linen*
      - Counseling, medical, psychological support services*
      - Policy on effect of leave for satisfying completion of program**
      - Policy on Physician Impairment and Substance Abuse**
      - Policies on Gender or Other Forms of Harassment**
      - Policy on Residency Closure/Reduction**
Policy on Duty Hours**

Restrictive Covenants – No resident will be required to sign a non-compete contract.

These fringe benefits are contingent on meeting the conditions of your appointment/reappointment as follows:

**Appointment:** Before beginning your employment, you shall have graduated from a school offering programs accredited by the Liaison Committee on Medical Education, American Osteopathic Association or American Dental Association, or a program registered with the NYS Education Department or accredited by an organization acceptable to the State Education Department. Additionally, you will need to provide SBUH with all credentialing information including, but not limited to, your medical school diploma, a completed health physical acceptable to the institution’s Employee Health Service and any documents required by the House Staff Office for processing. The duration of your temporary appointment is expected to be one year.

Graduates of foreign medical schools must have had at least four (4) credit years at a medical school listed in the World Directory of Medical Schools at the time of graduation and must have received a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).

If you are not a citizen of the United States, this agreement is contingent upon your having a visa with authorization to train in the United States during the term of your appointment.

**Reappointment:** For reappointment, you will be subject to satisfactory performance of your duties and educational progress as determined by your Program Director.

**Grievance/Due Process:** Dismissal, or any action, including non-renewal of agreement, which may significantly threaten a resident’s intended career development, may be recommended by a Program Director based on substantial non-compliance, egregious behavior or clinical or professional incompetence of a resident. An appeal process is available as described in the GME Policy and Procedures (Grievance Procedure/Due Process, revised 11/24/03). This policy also includes the process for a resident to have their complaints and grievances, related to the work environment and/or issues related to the program or faculty, addressed.

II. RESIDENT RESPONSIBILITIES: The resident/fellow will be responsible for the following:

  a. **Policies and Procedures.** I agree to be subject to the Policies of the Board of Trustees of the State University of New York and the Department that governs my appointment in my chosen academic training program. Furthermore, I understand that I will be subject to the policies and procedures of SBUH and its affiliates.

  b. **Professional Licensure Examinations.** I agree to take the USMLE Part 3 examination by the completion of my first PGY year at SBUH.
c. **Professional Conduct.** I agree to abide by the Code of Ethics set forth in the New York Public Officers Law, Section 74, and any other codes of ethics adopted by the School of Medicine.

d. **Fulfillment of Terms of Employment.** Temporary appointees to a residency program are reviewed on a yearly basis. I agree to remain employed for the full period of appointment unless suspended or terminated pursuant to due process procedures contained in the GME Grievance/Due Process policy, revised 11/24/03.

e. **Rotations to other services and other affiliates.** The residency rotation for the period of this agreement will be in accordance with the applicable Residency Review Committee of ACGME and the AOA/ADA with regard to standards, policies and procedures. I agree, when rotating to another service or affiliate institution, to be responsible to the service/affiliate to which I am assigned.

f. **Assignments.** I agree to accept all assignments of duty and to meet all academic responsibilities required by the Program Director and/or Chief of Service or their designee and shall perform my duties in a professional and satisfactory manner.

g. **Core Curriculum.** I agree to attend all graduate medical education committee “required” seminars as part of my educational program developing competencies in my profession.

h. **Medical Record Completion.** I agree to complete the medical record of each of my patients for whom I have medical responsibilities within three (3) days of the discharge or death of the patient. It is further understood that I have the responsibility to complete any other required medical record(s) in a timely fashion as required in the Medical Staff Bylaws, Rules and Regulations. I am aware that failure to comply with this provision may be cause for fines and/or disciplinary action.

i. **Moonlighting or any other professional activities outside the program.** Postgraduate trainees are prohibited from moonlighting unless expressly agreed to, in writing, by the GMEC. Any secondary employment or professional activities outside the program may not exceed duty hours prescribed in Section 405.4 (10NYCRR).

j. **Annual Training.** I agree to comply with all annual training requirements (i.e., fire safety, right-to-know, infection control, HIPAA, etc.).

k. **Annual Health Assessment.** I agree to obtain an annual health assessment including a PPD.

l. **Clearance Procedure.** I agree to return all hospital property and complete all medical records before the last day of employment.

Having read and understood the above information and read the designated passages in the appropriate manuals, I agree to accept the conditions for appointment/reappointment at SBUH. I understand that this agreement is in effect for one year. If any policies are revised, I understand I will be notified of the revisions and will be able to access them on the SBUH website.

Name of Resident/Fellow (Printed)  Signature  Date

Name of Program Director (Printed)  Signature  Date
There is an additional aspect of professionalism that is important to the functioning of the department – Vacation “Shaving”.

**Professionalism and Vacations – Don’t “Shave Vacations”**.

This is an extremely common problem that comes up when people try to “shave vacations” and end up putting a lot of stress and strain on the schedule.

You are going on vacation, so the chief residents cut you some slack and put you on call the Thursday before vacation. That means you’ll be post call Friday and can get an early jump on your vacation plans.

So you “shave the vacation” – you arrange a flight out at 6 AM on Friday. Wait a minute – to get to the airport on time, someone needs to come in at 4 AM, or the call team needs to be “short” for the last 2 hours of the call night so you can make the flight.

**Do not do this.** Do not make your vacation plans “push” the call team or the call schedule.

At the end of the vacation, people will sometimes “shave the schedule” the other way.

“My flight gets in at 1 AM the Monday I’m supposed to be back. Can I get some sleep then come in late on Monday?”

No! Unacceptable. You should come back in plenty of time to show up to work well-rested for work on Monday.

“My flight get bumped/delayed by weather on Sunday. So I couldn’t get back. It’s not my fault!”

Wrong, it is your fault. In this era of overbooked flights, delays, and weather-as-unknown, you should plan on the possibility of a missed flight. Come back from vacation on the Saturday before you’re due back at work on Monday. That way, if there’s a glitch in travel plans, you’re still able to get back to work.

Part of professionalism is doing whatever it takes to not impose on your colleagues. Respecting the vacation schedule, and refraining from “shaving the schedule” when you leave and when you return, is an important part of this professionalism.
Fatigue can be found on New Innovations in the Curriculum Section. All residents are required to complete this self-study program. The link is https://rms1.newinnov.com/2003/sunystonybrook/upload/10-27-2004-10-11-22-CURRIC-18-18-0-627.ppt.

All residents completed this program created by the American Society of Sleep Medicine.
Work environment

The contract signed by the residents details the work environment at Stony Brook. The contract is included below. Of note, specific issues addressed include:
- Details of getting an appointment
- Grievance and due process
- Professional conduct
- Moonlighting. You will note that moonlighting is not allowed.

SUNY AT STONY BROOK UNIVERSITY HOSPITAL
AGREEMENT OF APPOINTMENT

The SUNY at Stony Brook University Hospital (SBUH) is committed to offering Graduate Medical Education (GME) training programs that meet the institutional and special requirements of the Essentials of Accredited Residencies adopted by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA) and the American Osteopathic Association (AOA).

The following is an agreement between SBUH and the undersigned Resident. This agreement outlines the terms and conditions of the appointment/reappointment (circle one) of house staff to these programs. The official letter of appointment states the salary, PGY level and dates of appointment.

I. SBUH will provide an environment free of intimidation, and be responsible for the following:
   a. Financial Support: an annualized salary will be paid in biweekly installments as per the schedule put forth by the SUNY Board of Trustees.
   b. Benefits: include but are not limited to:
      Vacations* & **
      Professional liability insurance*
      Health insurance*
      Parental leave of absence*
      Sick leave* & **
      Disability/maternity* & **
Restrictive Covenants – No resident will be required to sign a non-compete contract.

These fringe benefits are contingent on meeting the conditions of your appointment/reappointment as follows:

**Appointment:** Before beginning your employment, you shall have graduated from a school offering programs accredited by the Liaison Committee on Medical Education, American Osteopathic Association or American Dental Association, or a program registered with the NYS Education Department or accredited by an organization acceptable to the State Education Department. Additionally, you will need to provide SBUH with all credentialing information including, but not limited to, your medical school diploma, a completed health physical acceptable to the institution’s Employee Health Service and any documents required by the House Staff Office for processing. The duration of your temporary appointment is expected to be one year.

Graduates of foreign medical schools must have had at least four (4) credit years at a medical school listed in the World Directory of Medical Schools at the time of graduation and must have received a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).

If you are not a citizen of the United States, this agreement is contingent upon your having a visa with authorization to train in the United States during the term of your appointment.

**Reappointment:** For reappointment, you will be subject to satisfactory performance of your duties and educational progress as determined by your Program Director.

**Grievance/Due Process:** Dismissal, or any action, including non-renewal of agreement, which may significantly threaten a resident’s intended career development, may be recommended by a Program Director based on substantial non-compliance, egregious behavior or clinical or professional incompetence of a resident. An appeal process is available as described in the GME Policy and Procedures (Grievance Procedure/Due Process, revised 11/24/03). This policy also includes the process for a resident to have their complaints and grievances, related to the work environment and/or issues related to the program or faculty, addressed.
II. RESIDENT RESPONSIBILITIES: The resident/fellow will be responsible for the following:

a. Policies and Procedures. I agree to be subject to the Policies of the Board of Trustees of the State University of New York and the Department that governs my appointment in my chosen academic training program. Furthermore, I understand that I will be subject to the policies and procedures of SBUH and its affiliates.

b. Professional Licensure Examinations. I agree to take the USMLE Part 3 examination by the completion of my first PGY year at SBUH.

c. Professional Conduct. I agree to abide by the Code of Ethics set forth in the New York Public Officers Law, Section 74, and any other code of ethics adopted by the School of Medicine.

d. Fulfillment of Terms of Employment. Temporary appoints to a residency program are reviewed on a yearly basis. I agree to remain employed for the full period of appointment unless suspended or terminated pursuant to due process procedures contained in the GME Grievance/Due Process policy, revised 11/24/03.

e. Rotations to other services and other affiliates. The residency rotation for the period of this agreement will be in accordance with the applicable Residency Review Committee of ACGME and the AOA/ADA with regard to standards, policies and procedures. I agree, when rotating to another service or affiliate institution, to be responsible to the service/affiliate to which I am assigned.

f. Assignments. I agree to accept all assignments of duty and to meet all academic responsibilities required by the Program Director and/or Chief of Service or their designee and shall perform my duties in a professional and satisfactory manner.

g. Core Curriculum. I agree to attend all graduate medical education committee “required” seminars as part of my educational program developing competencies in my profession.

h. Medical Record Completion. I agree to complete the medical record of each of my patients for whom I have medical responsibilities within three (3) days of the discharge or death of the patient. It is further understood that I have the responsibility to complete any other required medical record(s) in a timely fashion as required in the Medical Staff Bylaws, Rules and Regulations. I am aware that failure to comply with this provision may be cause for fines and/or disciplinary action.

i. Moonlighting or any other professional activities outside the program. Postgraduate trainees are prohibited from moonlighting unless expressly agreed to, in writing, by the GMEC. Any secondary employment or professional activities outside the program may not exceed duty hours prescribed in Section 405.4 (10NYCRR).

j. Annual Training. I agree to comply with all annual training requirements (i.e., fire safety, right-to-know, infection control, HIPAA, etc.).

k. Annual Health Assessment. I agree to obtain an annual health assessment including a PPD.

l. Clearance Procedure. I agree to return all hospital property and complete all medical records before the last day of employment.
Policy: Substandard Resident Performance

PURPOSE
To establish a policy for substandard resident performance

POLICY
1. Residents identified as not meeting the standards of training performance through mechanisms outlined in the Resident Evaluation and Promotion Policy and Procedure may be at risk for the following actions,
   1. Written warning/letter of counseling
   2. Probation
   3. Suspension
   4. Termination
   A decision to terminate a resident is subject to the due process procedure as outlined. A decision to provide a warning to the resident or place a resident on probation is not subject to the due process procedure.
2. The GMEC recognizes the following categories pertaining to substandard trainee performance,
   1. Professional misconduct
      1. Insufficient interest and/or participation in the required rounds and conferences
      2. Attendance-related infractions including excessive absenteeism or tardiness
      3. Failure to meet medical documentation requirements
      4. Failure to participate in credentialing processes
      5. Difficulties in functioning as a cooperative team member
      6. Recurrent complaints by patients and/or hospital/clinic staff as reflected by letters or evaluation forms
      7. Any misconduct defined as "professional misconduct" under NY education Law 8, 6530
   2. Academic deficiencies
      1. Failing performances in at least two (2) of the following
1. Rotation evaluation forms
2. Quizzes
3. Board exams
4. Composite evaluation forms
5. In training examinations
2. Chronic marginality
3. Lack of interest in the educational process
3. Residents identified as not meeting the standards of the training program or of the profession will receive written notice communicated by the PD. A warning letter serves as an alert that academic and/or professional performance are in need of remediation. Such notice will include,
   1. Specific reference to area(s) of deficiency
   2. Suggestions for improvement and time frame
   3. Mechanism of evaluation
   4. Consequences of unfulfilled/ unsatisfactory improvement (i.e. probation) which may adversely affect promotion, graduation credentialing and licensure.
   5. Acknowledgement of receipt by resident attestation and signature
4. Residents who have received a warning letter and have not demonstrated substantial improvement as previously outlined and communicated or incur repeat offenses shall be placed on academic or professional probation. Such notice will include and provide,
   1. Deficiencies that the individual has been counseled for and that no improvement has been made
   2. Explicit remediation plan with time frame not to exceed three (3) months
   3. A faculty advisor/educator to assist with successful completion of the remediation plan
   4. A mechanism of evaluation, which may included but is not limited to:
      1. 360 degree assessment
      2. Global assessment
      3. Mini-CEX
      4. Direct Observation
      5. Patient simulations
   5. Consequences of unsatisfactory improvement which may include termination
   6. Acknowledgement of receipt by resident attestation and signature
5. The chair of the GMEC will be notified, in writing of all residents placed on probation.
6. Residents who have not made satisfactory progress despite the above measures may be terminated under the due process procedure.
7. In the event that the resident's actions or performance are determined by the Department Chairperson to be of a nature such that it represents an imminent threat to patient care, the Department Chairperson may suspend the resident from patient care activities for a period not to exceed three weeks. The resident will be notified immediately in writing of such action and the reason for such action. Any disciplinary action resulting in suspension or termination is subject to
the due process procedures.
Sexual harassment

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Policy: Sexual and Other Forms Of Harassment

PURPOSE
To establish an institutional policy regarding sexual and other forms of harassment.

POLICY
Harassment is a form of sexual or other discrimination, and violates Title VII of the Civil rights Act of 1964 and Title IX of the Educational Amendments of 1972. Stony Brook University reaffirms the principal that students, faculty and staff have the right to be free from sexual discrimination and any other form of discrimination inflicted by any member of the campus community.

Unwelcome sexual advances or requests for sexual favors and verbal or physical conduct of an abusive, sexual nature, constitute sexual harassment when such conduct interferes with an individual’s work or academic performance or creates an intimidating, hostile or offensive work or academic environment.

Discrimination/harassment based upon race, creed, ethnic background, etc., is also not tolerated by the institution.

The Office of Affirmative Action/Equal Employment Opportunity (Administration Building, 632-6280) has professional staff trained to provide assistance with sexual harassment problems. All calls are confidential.

Any other forms of harassment/discrimination, not sexual in nature, should be reported to Labor Relations, HSC 3-040, 444-2528.

Additional information: refer to ADMINISTRATIVE POLICIES & PROCEDURES MANUAL CODE: LD: 0039

Revised: November 18, 2003  Reviewed and Accepted: November 24, 2003
# Policy: Resident Responsibilities

**PURPOSE**
To define resident responsibilities

**POLICY**
The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the attending physician. Such communication must be documented in the patient record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities.

Reviewed and Accepted: March 22, 2004
New Innovations

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Policy: Use Of Institutional Computer Tracking System for GME

PURPOSE
To ensure that all GME programs utilize and maintain data in the computerized residency management suite known as New Innovations

POLICY
Program directors and coordinators will be responsible for maintaining the accuracy and integrity of all data, its timeliness, evaluations, procedures, and schedules in the institutional computerized residency management suite known as New Innovations.

Faculty that supervise residents and fellows within an accredited training program will utilize the evaluation and verification of procedures tools by means of New Innovations.

Residents will be responsible for maintaining accurate case load, duty hours and schedules by means of New Innovations. Residents and fellows will be responsible for reviewing and completing evaluations via the New Innovations system.

Reviewed and Accepted: March 22, 2004
EOC Reference cards, covering safety management, fire safety, hazardous materials and waste management (including radiation protection services), security management, emergency management, medical equipment and utilities management

Stony Brook University Hospital Enviroment Of Care can be find on web page
www.stonybrook.edu/ehs/healthcare/

Environmental Health and Safety HSC, Level 1, Room 059 Stony Brook, NY
11794-8017

Radiation Protection Services (RPS): 4-3196
Policy: Supervision of Residents

PURPOSE
To establish an institutional policy regarding supervision for all graduate medical education training programs within the institution.

To outline guidelines for supervision for postgraduate trainees at Stony Brook University Hospital (SBUH). Each discipline will be responsible for the development of a policy for its program, which includes the principles stated in this document and outlines specific supervision issues distinctive to their training program. All supervision situations will be specialty specific.

Each program must provide appropriate supervision for all residents that is consistent with proper patient care, the educational needs of residents and the applicable program requirements.

Postgraduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire those skills, knowledge and attitudes which are important in the care of patients. The purpose of Graduate Medical Education (GME) is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitate the resident’s professional and personal development, and ensure safe and appropriate care for patients. GME programs focus on the development of clinical skills, attitudes, professional competencies and an acquisition of detailed factual knowledge in a clinical specialty.

POLICY
In a health care system where patient care and the training of health care professionals occur together there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. It is recognized that as resident trainees acquire the knowledge and judgment that accrue with experience, they will be allowed the privilege of increased authority for patient care.
The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently.

This policy focuses on resident supervision from the educational perspective. Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) state that "[medical] residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience." This process is the underlying educational principal for all graduate medical education, regardless of specialty or discipline. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident. All programs which include residents within SBUH must be approved by the appropriate ACGME or have special approval by the GMEC or the Associate Dean for GME.

All patient care must be supervised by qualified faculty. Each program director must ensure, direct and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervisory faculty.

Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

Program letters of agreement must identify the faculty who will assume educational and supervisory responsibility for residents and specify the faculty responsibilities for teaching, supervision and formal evaluation of resident performance.

**New York State Health code 405.4**
The medical staff monitors and supervises postgraduate trainees assigned patient care responsibilities as part of an approved medical training program including:

Providing written documentation of privileges granted to such individuals to appropriate medical and other hospital patient care staff;

Continuously monitoring patient care services provided by such individuals to assure provision of quality patient care services within the scope of privileges granted;

For acute care specialties of anesthesiology, family practice, medicine, obstetrics, pediatrics, psychiatry and surgery, supervision
shall be provided by physicians who are board certified or admissible in those respective specialties or who have completed a minimum of 4 postgraduate years of training in such specialty. There shall be sufficient number of these physicians present in person in the hospital 24 hours per day, 7 days per week to supervise the postgraduate trainees in their specific specialties to meet reasonable and expected demand. In hospitals that can document that the attending physicians are immediately available by telephone and readily available in person when needed, the on-site (supervising physicians) may be in their final year of postgraduate training supervision of routine hospital care and procedures may be carried out in accordance with paragraph (2) of this subdivision by postgraduate trainees who are in their final year of postgraduate training or who have completed at least 3 years of postgraduate training.

(iv) supervision by attending physicians of the care provided to surgery patients by postgraduates in training must include as a minimum:

- personal supervision of all surgical procedures requiring general anesthesia or an operating room procedure;
- preoperative examination and assessment by the attending physician; and
- postoperative examination and assessment no less frequently than daily by the attending physician;

RESPONSIBILITIES
The Associate Dean for GME is responsible for establishing local policy to fulfill the requirement of this policy and the applicable accrediting and certifying body requirements.

The Program Director is responsible for the quality of the overall affiliated education and training program in a given discipline and for ensuring the program is in compliance with the policies of the respective accrediting and/or certifying bodies. The Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. They are responsible for:

1. Assesing the attending physician's discharge of supervisory responsibilities. At a minimum this includes written evaluations by the residents and interviews with residents, other practitioners and other members of the health care team.
2. Arranging for all residents entering their first rotation to participate in an orientation to policies, procedures and the role of residents within the affiliated training program.
3. Ensuring that residents are provided the opportunity to contribute to discussions in committees where decisions being made may affect their activities.
4. Defining the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity.

The Attending Physician refers to licensed, independent physicians who have been formally credentialed and privileged at the
training site, in accordance with applicable requirements. The Attending may provide care and supervision only for those clinical activities for which they are privileged. The Attending is responsible for and must be personally involved in the care provided to individual patients in inpatient and outpatient settings and must continue to maintain this personal involvement when residents are involved in the care of these patients.

Residents refer to individuals who are engaged in a postgraduate training program in medicine. The term "resident" includes interns, residents and fellows. (See policy on Resident Responsibilities)

Supervision
The Attending physician has the responsibility to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. This responsibility is exercised by observation, consultation and direction. It includes the imparting of the practitioner’s knowledge, skills and attitudes by the practitioner to the resident and assuring that the care is delivered in an appropriate, timely and effective manner. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with teach patient and each resident who is providing care as part of the training experience. Each patient will be assigned an attending physician whose name will be clearly identified in the patient's record. It is recognized that other attending physicians may, at times be delegated responsibility for the care of a patient and provide supervision instead of or in addition to the assigned practitioner.

1. The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Medical, surgical or mental health services must be rendered under the supervision of the attending physician or be personally furnished by the attending physician. Documentation of this supervision will be by progress notes entered into the record by the attending physician or reflected within the resident's progress note at a frequency appropriate to the patient's condition. The medical record should reflect the degree of involvement of the attending physician, either by staff physician progress note, or the resident's description of attending involvement. The resident note shall include the name of the attending physician with whom the case was discussed as well as a summary of that discussion. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement and supervision.

2. For patients admitted to an inpatient team, the attending physician or covering attending physician must meet the patient early in the course of care (within 24 hours of admission including weekends and holidays). This supervision must be personally documented in a progress note no later than the day after admission. The attending physician’s progress note will include findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed (including physician identification number), dated, timed and reflect ongoing supervision of the residents. Attending physicians are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the trainee.

3. The attending physician will ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate,
based on the specific circumstances of the patient’s diagnoses and therapeutic regimen. This may include physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by the attending physician’s countersignature of the discharge summary or clinic discharge note.

4. For outpatients, all new patients to the clinic for which the attending physician is responsible should be supervised by the attending physician. This supervision must be documented in the chart via a progress note by the attending physician or the resident’s note and include the name of the attending physician and the nature of the discussion. New patients should be supervised as dictated by graduated level of responsibility outlined for each discipline. Unless otherwise specified in the graduated levels of responsibility, new patients should be seen and evaluated by the attending physician at the time of the patient visit. Return patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective, appropriate and appropriately documented by the attending or resident to reflect the degree of attending involvement and include the date, time and signature and physician identification number.

5. The attending physician is responsible for official consultations of each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these residents. The supervision of residents performing consultation will be determined by the graduated levels of responsibility for the resident. Unless otherwise stated in the graduated levels of responsibility, the attending physician must meet with each patient who received consultation by a resident and perform this personal evaluation in a timely manner based on the patient’s condition. The patients seen in consultation by residents must be discussed and/or reviewed with the attending physician supervising the consultation within the guidelines established in the medical staff rules and regulations. The attending physician must document this official consultation supervision by writing a progress note or by writing and addendum with his/her concurrence with in the consultation note by the close next working day.

6. Emergency room consultations by residents may be supervised by a specialty attending physician or the emergency room attending physician. All emergency room consultations by residents should involve the attending physician supervising the resident’s discipline specific specialty consultation activities for which the consultation was requested. After discussion of the case with the discipline specific attending physician, the resident may receive direct supervision in the emergency room from the emergency room attending physician. In such cases where the emergency room attending physician is the principal provider of care for the patient’s emergency room visit, the specialty specific attending physician’s supervision of the consultation should be documented in the medical record by co-signature of the consultation note or be reflected in the resident physician consultation note.

7. Assure all Do Not Resuscitate (DNR) orders are appropriate and assure the supportive documentation for DNR orders are in the patient’s medical record. All DNR orders must be signed or countersigned by the attending physician.

8. Assignment and availability of attending physicians

   1. Within the scope of training program, all residents, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed. Each discipline will publish, and make available "call schedules" through the SBUH switchboard indicating the responsible attending physician(s) to be contacted for each service.

   2. It is expected that an appropriately privileged attending will be available for supervision during clinic hours. Patients
followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

Graduate Levels of Responsibility

3. Each training program will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge and judgment.
4. As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.
5. The residency program director will define the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. The documentation of the assignment of graduated levels of responsibility will be made available to other staff as appropriate. These guidelines will include the knowledge, attitudes and skills which will be evaluated and must be present for a resident to advance in the training program, assume increased responsibilities (such as the supervision of lower level trainees), and be promoted at the time of the annual review.

9. Supervision of Procedures

1. Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents with the required knowledge/skill, and judgment and under an appropriate level of supervision by attending physicians. Examples include by are not limited to operative procedures performed in the operating suite, angiograms, endoscopy, bronchoscopy, and any other procedures where there is the need for informed consent. Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Examples are the placing of intravenous and arterial lines, thoracentesis, paracentesis, lumbarpuncture, routine radiologic studies, wound debridement, and drainage of superficial abscesses. Attending physicians will be responsible for authorizing the performance of such procedures and such procedures should only be performed with the explicit approval of the attending physician.
2. Attending physicians will provide appropriate supervision for the patient's evaluation, management decisions and procedures. For elective or scheduled procedures, the attending physician will evaluate the patient and write a pre-procedural note describing the finding, diagnosis, plan for treatment, and/or choice of specific procedure to be performed.
3. During the performance of such procedures, an attending physician will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending physician within the context of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and the complexity of the specific case.
10. Emergency Situation
An “emergency” is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient’s record.

EVALUATION OF RESIDENTS AND SUPERVISORS

1. Each resident will be evaluated according to accrediting and certifying body requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior and overall ability to manage the care of a patient. The evaluation will also include assessment of the general competencies, patient care, medical knowledge, practice-based learning and improvement, interpersonal skills and communication, professionalism and systems-based practice. Evaluations will occur as indicated by the accrediting or certifying body at the end of the resident’s rotation or every six months, whichever is more frequent. Written evaluations will be discussed with the resident.
2. If a resident’s performance or conduct is judged to be detrimental to the care of a patient(s) at any time, action will be taken immediately to ensure the safety of the patient(s).
3. At least annually, each resident will be given the opportunity to complete a confidential written evaluation of attending physicians and of the quality of the resident’s training. Such evaluations will include the adequacy of clinical supervision by the attending physician. The evaluations will be reviewed by the program director.
4. All written evaluations of residents and attending physicians will be kept on file by the residency program director in an appropriate location and for the required time frame according to the guidelines established by the respective ACGME Residency Review Committee or other accrediting and certifying agencies.

Revised: November 18, 2003
Reviewed and Accepted: November 24, 2003
Revised: March 10, 2004
Reviewed and Accepted: March 22, 2004
Program Curriculum Review

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Program Curriculum Review

PURPOSE
To establish an institutional policy and guideline for programs within the institution on the development and implementation of program curriculum.

POLICY
Program Directors are required to develop and implement the academic and clinical curriculum of resident education by:

- Preparing an outline of the educational goals and objectives of the program to include the knowledge, skills and other attributes of residents for each rotation and each level of the program. This outline must be distributed to residents and faculty and reviewed with residents prior to the assignment.
- Preparing and implementing a comprehensive, well-organized, and effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by the addition of current information. The residency program must require that residents obtain competence in the patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. Programs must define the specific knowledge, skills, behaviors and attitudes required and provide educational experiences as needed in order for residents to demonstrate these competencies.
- Providing residents with direct experience in progressive responsibility for patient management.
- Providing residents with the opportunity to:
  1. develop a personal program of learning to foster continued professional growth with guidance from the teaching staff;
  2. participate in safe, effective and compassionate patient care, under supervision, commensurate with their level of advancement and responsibilities;
  3. participate fully in the educational and scholarly activities of their program and as, required, assume responsibility...
for teaching and supervising other residents and students;
4. participate, as appropriate, in institutional programs and medical staff activities and adhere to established practices, procedures, and policies of the institution;
5. have appropriate representation on institutional committees and councils whose actions affect their education and/or patient care; and,
6. Submit to the program director, at least annually, confidential written evaluation of the faculty and of the educational experiences.

This curriculum must be developed with input from the teaching faculty and residents and must be evaluated by faculty and residents and continuously updated to reflect changes and improvements.

The curriculum, with the defined goals and objectives for each rotation, must be used for evaluation of residents and faculty. The curriculum shall be reviewed by the Chair of the GMEC annually and/or as changes occur. The author of the curriculum will utilize the Program's Special Requirements and the Institutional Requirements of the ACGME. The curriculum will also be reviewed at the time of the internal review.

Reviewed November 21, 2003
Revised and Accepted November 24, 2003
Counseling and Support for Impairment/Substance Abuse

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish an institutional policy regarding Counseling and Support Services to assist program directors and residents on finding resources for dealing with these important issues.

POLICY

Physician Impairment
Program directors and faculty are responsible for monitoring resident stress, including mental or emotional conditions inhibiting performance or learning and drug or alcohol-related dysfunction.

Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified.

Program directors and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents.

Substance Abuse:
In compliance with the Federal Drug-Free Workplace Act of 1988, the following policy must be adhered to as a condition of employment.

The unlawful use, possession, manufacture, dispensation or distribution of a controlled substance in all Stony Brook University Hospital work locations is prohibited. The term "controlled substance" means a controlled substance in Schedules I through V of the Section 202 of the Controlled Substances Act (21 USC 312).
Employees who unlawfully manufacture, distribute, dispense, possess or use a controlled substance will be subject to disciplinary procedures consistent with applicable laws, rules, regulations, and collective bargaining agreements. Penalties sought may include termination.

Any illegal activity involving drugs or alcohol is considered MISCONDUCT and may be reportable to the Office of Professional Medical Conduct.

Employees must notify their program director of any criminal drug statute conviction occurring in the workplace or at a worksite no later than five (5) days after such conviction.

**Counseling Services:**
An Employee Assistance Program (EAP) is available for employees who wish to seek assistance in dealing with drug or alcohol related problems. Call 632-6085 for additional information. Questions about this policy should be referred to the Human Resources Labor Relations section at 444-2596.

Further information can be found in:

1. The agreement between the State of New York and United University Professionals (dated 1988-91 and continued under the tentative agreement dated 1995-99 along with provisions of the Taylor Law) Article 39 provides for services for the treatment of alcohol or substance abuse. It provides for a revised program for managed care for psychiatric services and alcohol and substance abuse treatment implemented by the State and the Joint Committee on Health Benefits sometime after 1/1/89.
2. The Stony Brook University Hospital Faculty and Professional Employee Handbook offers information about the University Counseling Center as well as the Employees Assistance Program. This support and referral service is set up for employees and families facing health, emotional, alcohol, drug abuse, financial strain or legal problems. It is free and strictly confidential. The University has also established an Alcohol and Drug Abuse Advisory Panel composed of faculty, professional employees, and students to promote the ongoing education of the University community with regard to alcohol and drugs. For additional information call 632-6085.
3. Stony Brook University Hospital employs a full-time chaplain whose staff gives support to the human and emotional needs of the faculty, house staff and patients. Call 444-8157.
4. The Medical Society of the State of New York has recently expanded and revitalized their program called Committee on Physician’s Health (CPH). This confidential organization is empowered to assist impaired physicians and is the only program exempted from the legal mandate of reporting impaired physicians to the Office of Professional Medical Conduct (OPMC) in the State of New York. This is available to any resident by calling 1-800-338-1833.

Reviewed: November 2003
Revised: March 10, 2004
Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish a policy on Resident Evaluation and Promotion

POLICY

1. Each training program will adopt a policy specifying that written evaluation will be provided to each resident on a semi-annual basis.
2. A copy of the Program’s Evaluation policy will be provided to the Associate Dean for Graduate Medical Education and the Graduate Medical Education Committee (GMEC). The GMEC recognizes the following methods of resident evaluation:
   1. Direct observation
   2. Patient simulations
   3. Global assessments
   4. Mini-CEX
   5. Rotation evaluation forms
   6. Quizzes, Board exams and In training examinations
3. Each program should develop specific criteria for advancement/promotion to higher levels of medical training and graduation of its residents. The criteria for advancement shall be based upon competent demonstration of the general competencies as set forth by the Accreditation Counsel for Graduate Medical Education:
   1. Patient care
   2. Medical knowledge
   3. Practice-based learning and improvement
   4. Professionalism
   5. Interpersonal and communication skills
6. Systems-based practice
4. Each year the Program Director (PD) will provide to the GMEC a list of the residents in their program whose contract will be renewed with or without promotion
5. The decision to promote a resident shall be determined by the PD with the advice of the core faculty (employed by) of the training program
6. Residents who have not made satisfactory progress may be dismissed under the Due Process Procedure. Non renewal of contract may be based on documentation of inadequate progress as outlined in the Substandard Resident Performance Procedure
7. Programs should provide residents with four (4) months written notice of intention not to renew contract. If the reason for the non-renewal occurs within four months of the end of appointment the training program should provide written notice as the circumstances reasonably allow.

Reviewed and Accepted November 24, 2003
Substandard Resident Performance

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish a policy for substandard resident performance

POLICY

1. Residents identified as not meeting the standards of training performance through mechanisms outlined in the Resident Evaluation and Promotion Policy and Procedure may be at risk for the following actions,
   1. Written warning/letter of counseling
   2. Probation
   3. Suspension
   4. Termination

A decision to terminate a resident is subject to the due processes procedure as outlined. A decision to provide a warning to the resident or place a resident on probation is not subject to the due process procedure.

2. The GMEC recognizes the following categories pertaining to substandard trainee performance,
   1. Professional misconduct
      1. Insufficient interest and/or participation in the required rounds and conferences
      2. Attendance-related infractions including excessive absenteeism or tardiness
      3. Failure to meet medical documentation requirements
      4. Failure to participate in credentialing processes
      5. Difficulties in functioning as a cooperative team member
      6. Recurrent complaints by patients and/or hospital/clinic staff as reflected by letters or evaluation forms
7. Any misconduct defined as "professional misconduct" under NY education Law 8, 6530

2. Academic deficiencies
   1. Failing performances in at least two (2) of the following
      1. Rotation evaluation forms
      2. Quizzes
      3. Board exams
      4. Composite evaluation forms
      5. In training examinations
   2. Chronic marginality
   3. Lack of interest in the educational process

3. Residents identified as not meeting the standards of the training program or of the profession will receive written notice communicated by the PD. A warning letter serves as an alert that academic and/or professional performance are in need of remediation. Such notice will include,
   1. Specific reference to area(s) of deficiency
   2. Suggestions for improvement and time frame
   3. Mechanism of evaluation
   4. Consequences of unfulfilled/unsatisfactory improvement (i.e. probation) which may adversely affect promotion, graduation credentialing and licensure.
   5. Acknowledgement of receipt by resident attestation and signature

4. Residents who have received a warning letter and have not demonstrated substantial improvement as previously outlined and communicated or incur repeat offenses shall be placed on academic or professional probation. Such notice will include and provide,
   1. Deficiencies that the individual has been counseled for and that no improvement has been made
   2. Explicit remediation plan with time frame not to exceed three (3) months
   3. A faculty advisor/educator to assist with successful completion of the remediation plan
   4. A mechanism of evaluation, which may included but is not limited to:
      1. 360 degree assessment
      2. Global assessment
      3. Mini-CEX
      4. Direct Observation
      5. Patient simulations
   5. Consequences of unsatisfactory improvement which may include termination
   6. Acknowledgement of receipt by resident attestation and signature

5. The chair of the GMEC will be notified, in writing of all residents placed on probation.

6. Residents who have not made satisfactory progress despite the above measures may be terminated under the due process procedure.

7. In the event that the resident’s actions or performance are determined by the Department Chairperson to be of a
nature such that it represents an imminent threat to patient care, the Department Chairperson may suspend the resident from patient care activities for a period not to exceed three weeks. The resident will be notified immediately in writing of such action and the reason for such action. Any disciplinary action resulting in suspension or termination is subject to the due process procedures.

Reviewed and Accepted November 24, 2003
Termination Grievance and Due Process

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish a policy for Termination, Grievance and Due Process as it relates to Residents

POLICY

1. During the course of training residents are to be evaluated by members of the teaching program at least semi-annually. More frequent evaluations may be undertaken at the discretion of the Program Director (PD) and should follow the policy and procedure on Substandard Resident Performance. The decision to renew a resident’s training program is at the discretion of the PD or Departmental Chairperson.

2. Termination without due process may be based upon a single significant event or a series of unsatisfactory evaluations and substandard performance. Single significant events include but are not limited to,
   1. Falsification of records
   2. Material omission of information on an application
   3. Conviction of a felony
   4. Loss of medical licensure
   5. Placement on a federal debarment list

3. The resident will be notified in writing of the disciplinary actions being instituted and the reasons for such actions. Any disciplinary action resulting in the suspension or termination, except as noted above, will entitle the resident to request a review of that decision by a hearing panel in accordance with the following procedure:
   1. Prior to suspension or dismissal the resident will be given written notice stating the basis for the suspension or termination and advising the resident of the right to request a review of that decision by the Chair of the Graduate Medical Education Committee (GMEC). A resident who wishes to request such a hearing must do so within five (5)
business days after receipt of the decision.
2. The Chair of the GMEC will render a written determination after investigating the reasons for the PD or Departmental Chairperson’s decision.
3. If the resident is not satisfied with that determination s/he may request a review before an ad hoc committee appointed by the Chair of the GMEC. A request for such a review must be made within five (5) working days of receipt of the Chair of the GMEC determination.
4. The ad hoc committee comprises three (3) medical staff members of the GMEC. None of the appointed ad hoc committee members may have faculty appointment in the department of the named resident.

4. The ad hoc committee will conduct the hearing in the following manner:
   1. The named resident will be apprised of the nature of the charges and the supporting evidence. The resident may submit any documentation he/she believes to be relevant to a review of his/her record and may list individuals with whom he/she wishes the committee to speak. The committee is not bound to speak with all of the named individuals.
   2. The committee will review the resident’s records and program director documented reasons for the decision.
   3. The resident and PD shall present evidence as requested and deemed necessary by the ad hoc committee.
   4. Hearing proceedings shall be considered informal and non-adversarial. A resident may not be represented by counsel.
   5. The hearing proceedings shall be tape recorded.

5. The ad hoc committee will forward its recommendation to the Chair of the GMEC who will then convene a meeting of the GMEX to review the report of the ad hoc committee and make a final determination.
6. A resident's failure to appeal an adverse determination by their training program to the next higher step within the time frame specified shall be deemed a waiver of the residents appeal rights and shall render the adverse determination as final and binding.
7. A resident with a complaint or grievance related to the work environment or issues related to the program or faculty may utilize the same procedure as outlined above to achieve resolution.

Reviewed and Accepted November 24, 2003
Disruptive Resident Behavior

PurPOSE

To establish an institutional policy regarding disruptive resident behavior

To ensure residents conduct themselves in a professional, cooperative and appropriate manner while providing services as members of the medical staff.

To encourage the prompt identification and resolution of alleged disruptive behavior by all involved or affected persons through informal, collaborative efforts at counseling and rehabilitation.

To provide a formal process for the further investigation and resolution of disruptive resident behavior that has not been appropriately modified by prior informal efforts.

To provide for the appropriate discipline of residents only after the informal efforts and formal process described in this policy have been unsuccessful in causing the resident to appropriately modify behavior in compliance with this policy.

PROCESS

It is the policy of the Graduate Medical Education (GME) Committee and the Medical Staff Office of Stony Brook University Medical Center that all practitioners who are members of any resident training program at this facility shall conduct themselves in a professional, cooperative and appropriate manner, and shall not engage in disruptive behavior. It is expected that residents treat all staff and patients with courtesy and respect, show respect for patient autonomy and maintain confidentiality of patient information.
Disruptive behavior includes but is not limited to:

- Conduct that interferes with the provision of quality patient care
- Conduct that disrupts hospital operations
- Conduct that constitutes sexual harassment including sexual discussions or innuendos
- Making or threatening reprisals for reporting disruptive behavior
- Shouting or using vulgar, profane or abusive language
- Making racial or ethnic slurs
- Abusive behavior including threats of violence, retribution, or financial harm towards patients or staff
- Physical assault or inappropriate physical affection
- Behavior that is intimidating, belittling or implies incompetence
- Refusal to accept medical staff assignments or cooperate with other staff members
- Conduct that adversely affects the community’s confidence in the hospital’s ability to provide quality patient care

Residents are expected to:

- Accept and incorporate feedback in a non-resistant and non-defensive manner
- Address dissatisfaction through appropriate offices
- Cooperate and communicate with all providers displaying regard for their dignity
- Be truthful in all written and verbal communication

1. Residents identified as demonstrating disruptive behavior may be at risk for the following actions,

   - Written warning/ letter of counseling
   - Probation
   - Suspension
   - Termination

A decision to terminate a resident is subject to the due processes procedure as outlined. A decision to provide a warning to the resident or place a resident on probation is not subject to the due process procedure.

2. Any written or oral report of alleged disruptive resident behavior must be sent to the program director, who shall initiate an investigation as he/she deems appropriate to identify or rule out the existence of disruptive behavior. Issues not resolved at the program director level will be forwarded to the Chair of the GME Committee for resolution.

3. During the investigation, the program director will meet with the resident to review the alleged behavior and the requirements of this policy. Both the program director and the resident may be accompanied at this meeting by other practitioners that the program
director or resident feel are necessary to explain the disruptive behavior. The program director will also meet with the person(s) toward whom the disruptive behavior was directed.

4. At the completion of the investigation, the program director and department chair will make a determination as to whether the resident engaged in disruptive behavior. The written summary of the investigation will document the following:
   a.) the date and time of the questionable behavior
   b.) if the behavior affected or involved a patient, and the patient’s name and medical record number
   c.) the circumstances that precipitated the behavior
   d.) a factual, objective description of the behavior
   e.) the consequences of the behavior for patient care or hospital operations
   f.) the dates, times, and participants in any meetings with the resident, staff, etc. about the behavior.
   g.) acknowledgement of receipt by resident attestation and signature

5. If the program director determines that the resident has not engaged in disruptive behavior, he/she will advise the resident and the person(s) to whom the allegedly disruptive behavior was directed of such determination, and will prepare a written report (as outlined above) to be filed in the program director’s file, with a copy given to the resident.

6. If the program director and department chair determine that the resident has engaged in disruptive behavior, they will meet with the resident to counsel the resident concerning compliance with this policy and assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior. The program director will advise the person(s) to whom the allegedly disruptive behavior was directed of such determination. Depending on the nature of the behavior, the program director may refer the resident to the Committee on Physician Well-Being for assistance. A letter of warning will serve as an alert that this disruptive behavior has been documented and will include a plan for monitoring future compliance with and violation of this policy. This letter along with the written report (as outlined above) will be filed in the program director’s file, the resident’s file with a copy given to the resident.

7. Residents who have received a warning letter and have not demonstrated substantial improvement as previously outlined and communicated or incur repeat offenses shall be placed on academic or professional probation.

8. If a second report of alleged disruptive behavior is made concerning the same resident, the program director will confirm that this is a second incident of disruptive behavior and will refer the matter to the Chair of the GME Committee.

   a.) The Chair will make a determination based on the documentation from the program director. Referrals for counseling (to the MSSNY committee on Physician Health, the Medical Director of the hospital, and the Committee on Physician Well-being) may also be part of this process. The determination will be documented and filed in the program director’s file, the resident’s file with a copy given to the resident.
b.) The Chair may also appoint an adhoc committee to further investigate the issue. This adhoc committee will meet with the resident and attempt to further assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior. This committee will also develop a plan for monitoring future compliance with or violation of this policy. At its discretion, the committee may consult with the person(s) who was the object(s) of the disruptive behavior. The committee will send a written report to the program director and the Chair of the GMEC. The committee report shall remain in the program director's file, and the resident's file.

9. Failure of the resident to satisfactorily resolve the behavior problem will result in suspension and termination. If the resident is not satisfied with this determination, he/she can proceed with the grievance of this issue as outlined in the termination, due process and grievance policy.
Section and Appointment of Residents and Fellows

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish an institutional policy regarding the selection and appointment of residents and fellows.

POLICY
The University Hospital Graduate Medical Education programs share common criteria and processes for the recruitment and selection of residency and fellowship training candidates. The application process meets all requirements of the Equal Employment Opportunity and the Americans with Disability Act, in insuring that all qualified applicants are afforded a review without discrimination based on sex, race, age, religion, color, national origin, disability or veteran status.

The components of the resident Minimum requirements
General and minimum requirements for eligibility for consideration for a training program at University Hospital are:

1. graduation from an United States or Canadian Liaison Committee on Medical Education (LCME) accredited medical school, OR
2. graduation from an American or Canadian Osteopathic Association accredited medical school OR
3. graduation from a medical school outside of the United States and Canada AND meeting one of the following qualifications:
4. 1. holds a current valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG)
2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction, or
5. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
6. A US citizen, permanent resident or eligible for an appropriate visa to train in the United States.
7. Fellowship applicants must have successfully completed an ACGME accredited residency program.

The program director is responsible for verification of the applicants' credentials.

Applicants who do not meet the above criteria can not be considered for any graduate medical educational programs at University Hospital, SUNY at Stony Brook.

Resident Selection
Stony Brook University Hospital Graduate Medical Education programs share common criteria and processes for the recruitment and selection of residency and fellowship training candidates. A selection committee exists within each program and consists of, at a minimum, the program director, and a faculty member. Additional members are included at the discretion of the program director. This committee reviews all applicants and is responsible for selection of applicants for interview, participation in the interview process and the final choice of applicants to be ranked in the NRMP match or offered contracts independent of the match when this option is allowed.

The selection committee members review all eligible applicants to the program. All applicants meeting the minimum criteria above, plus meeting program-specific criteria (such as requirements for prior training), will be reviewed by members of this committee. The relative academic aptitudes and credentials of the applicants and the candidate's personal characteristics such as motivation and integrity are evaluated in this phase of the process. Academic credentials include medical school grades and performance as reflected in documentation received directly from the school, United States Medical Licensing Examination (USMLE) scores. Prior graduate medical education training, where applicable will also be considered. Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators and peers, when appropriate, serve to provide additional information on personal characteristics are required and evaluated as well.

The selection committee then invites selected candidates for an individual interview, which may be conducted in person (preferred) or rarely by telephone if travel to this site presents a personal hardship to the applicant. The interview allows in person confirmation of information provided in the written application as well as an opportunity to assess communication skills.

Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee, and become part of the application file. The committee, with input from the department, is responsible for the final ranking of candidates for the NRMP. The committee will recommend the selection of qualified candidates for positions outside of the NRMP process when appropriate and allowable. All applicants for first year positions are strongly encouraged to participate in the NRMP. All current fourth year medical students from United States medical schools are required to apply through the NRMP process.

Applicants meeting the above eligibility requirements, and the required additional documentation (letters of reference and interview) will be considered by the selection committee for positions remaining open in the program after the NRMP match, and will be
offered positions by the program director if considered qualified.

All candidates who are interviewed shall be given a copy of the SBUH contract and a copy of this policy. Programs will document that the candidate has received a copy of the contract by obtaining their signature.

Purpose of the process
selection process have several general purposes:

First, a specific selection committee reviews all eligible applicants to insure that all eligible candidates' applications are given careful, fair, and consistent review.

Second, documentation of eligibility and successful performance at the medical school and on required licensure examinations is required to insure that applicants possess proper academic credentials and are sufficiently prepared to benefit from graduate medical education.

Third, letters of reference are required and reviewed to gain insight into the applicant's personal characteristics such as motivation, integrity, attitude, and ability to work with others, as viewed by a group of educators, mentors or peers.

Fourth, recognizing the central role of communication in providing medical care, a personal interview is required to further evaluate the applicant's interpersonal skills, and ability to communicate both in an individual interview and in a group setting.

Appointment
The following is required before any resident can be officially appointed as a resident:

Primary verification of all credentials is required. The Residency Program in conjunction with the Medical/House Staff office will conduct this verification. It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.

At a minimum, Stony Brook University Hospital must be able to obtain primary source verification on the following:

1. Certification of graduation from any accredited medical school or ECFMG certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECGMG directly to the residency program.
2. Letter of recommendation
3. Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding 1 month that are not verifiable will disqualify candidates for consideration for a GME program
4. Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program
5. USMLE or COMLEX board scores demonstrating successful completion by the end of 3 attempts.
6. Passing a criminal background check

Applicants who do not meet the above criteria can not be appointed to any graduate medical educational program at Stony Brook University Hospital. Completion of primary source verifications renders an applicant eligible for appointment, but does not in and of itself result in automatic appointment. Residents are eligible to proceed through the appointment process. Any exceptions may be brought to the GME Committee for consideration.

Once all information is completed and reviewed, the applicant will be sent a letter of appointment.

The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.) clearance by employee health service (resident must submit a complete history and physical form) and appropriate visa, if applicable.

Monitoring
This process has been reviewed by members of the Graduate Medical Educational (GME) Committee, and agreed upon as a uniform approach to evaluation and selection of residency applicants.

Insuring compliance with the eligibility and selection criteria as described above is the responsibility each program director. Oversight for GME is the responsibility of the Associate Dean for Medical Education, School of Medicine, i.e. chair of the GMEC, who reviews on an annual basis, the process for every GME program in the institution.

Compliance is monitored through the regular internal reviews conducted through the GMEC, through periodic review of resident qualifications by the Chair and at the time of the regular accreditation site visits and program reviews by ACGME.

Revised September 17, 1997
Reviewed November 18, 2003
Revised and Accepted November 24, 2003
Revised and Accepted: January 24, 2005
Evaluation of Program Faculty and Rotations

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE
To establish an institutional policy on the evaluation of graduate medical education programs, faculty and rotations.

POLICY
The educational effectiveness of all graduate medical education programs, faculty and rotations of Stony Brook University Hospital evaluated at least annually in a systematic manner.

Programs
The overall program evaluation must include (but not be limited to) the following:

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Representative program personnel, i.e., at least the program director, representative faculty and at least one resident, must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The group must have regular documented meetings at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. The program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

**Faculty**
The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment of the educational program, clinical knowledge and scholarly activities. Annual written confidential evaluations by residents must be included in the process.

**Rotations**
Residents must be given the opportunity to evaluate the educational experiences at the end of each rotation and use the information to improve rotations.
Duty Hours

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

PURPOSE

To establish an institutional policy regarding duty hours for all graduate medical education training programs within the institution.

POLICY

Each residency/fellowship program must maintain and monitor the resident work hours as outlined in the New York State Health Code 405.4 established in July 1989 and ACGME requirements as of July 2003 with regard to resident duty hours. Each program will submit a departmental duty hour compliance plan to the GME office and update any changes as required.

A. Duty Hours
   1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
   2. Duty hours must be limited to 80 hours per week, averaged over a 4-week period.
   3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.
   4. Such trainees shall not be scheduled to work for more than 24 consecutive hours.
   5. On-duty assignments must be separated by not less than 10 non-working hours.
   6. Assignment of post-graduate trainees shall be limited to no more that 12 consecutive hours per on-duty assignment in the emergency service.
   7. Providing residents with a sound didactic and clinical education must be carefully planned and balanced with
concerns of patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

8. The GMEC has developed and implemented procedures to regularly monitor resident duty hours for compliance.
   a. All programs with the exception of Dental, Dermatology, Endocrinology, Pathology, Blood Banking, Preventive Medicine, Psychiatry, Child & Adolescent Psychiatry, Geriatric Psychiatry, Abdominal Radiology, Neuroradiology, Interventional Radiology and Musculoskeletal Radiology must track resident duty hours daily for a four (4)-week period, two (2) times per year, once during July - December and once during January - June.
   b. The listed programs will track resident duty hours daily for a four (4)-week period, one (1) time per year during July 1- June 30.
   c. It is the resident's responsibility to log duty hours daily for a four (4)-week period in the New Innovations tracking system as directed by the residency program.

B. On-Call Activities
   0. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.
   1. In-house call must occur no more frequently than every third night.
   2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 3 additional hours to participate in transfer care of patients and educational requirements which is included in the work time toward the 80-hour limit.
   3. No new patients may be accepted after 24 hours of continuous duty.
   4. Each program must have a departmental policy that will immediately relieve a postgraduate trainee from a continuing assignment when fatigue due to an unusually active "on-call" period is observed.
   5. At-home call (or pager call) is defined as a call taken from outside the assigned institution.
      i. The frequency of at-home call is not subject to the every-third-night limitation. At-home call however must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities.
      ii. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
      iii. The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Prescription Writing

PURPOSE
To establish an institutional policy regarding the medical records system for the graduate medical education programs within the institution.

POLICY
The medical record reflects the quality of patient care given in a hospital. The record is the basic tool for planning patient care and for communication between physicians and other persons contributing to patient care. The medical record must document the course of each patient's illness and care and must be available to the residents at all times. The medical records system must support the education of residents and quality assurance activities and provide a resource for scholarly activity.

Orientation regarding the institution's medical records systems may be found in program manuals. It is also delivered orally by the Director of Risk Management and Medical Records departments at the House Staff Orientation for all incoming trainees at Orientation, and in the Rules and Regulations of the Medical Staff Bylaws. In addition, the Medical Records Committee, established to monitor the quality of documentation in the medical record, has a resident representative.

Rules and Regulations regarding Delinquent Records. Section 9 (l)

Residents who do not complete their medical records within 30 days of discharge will receive a letter warning them that they have 14 days to complete their records or they will be suspended from clinical duties. 14 days later, any resident that has not completed all available incomplete charts will be automatically suspended. The suspension will remain in effect until all charts are completed. Suspensions will be reported on the resident final evaluation.

Fines will be imposed for all house staff suspensions as follows:
1st suspension - no fine
2nd suspension - $10
3rd suspension - $50

Residents are responsible for notifying the supervisor in the incomplete room (444-2854) once the records are complete. Additional information: Refer to ADMINISTRATIVE POLICIES & PROCEDURES MANUAL Management of Information (IM).

Reviewed: November 18, 2003
Revised and Accepted: November 24, 2003
Resident Participation in Institutional Programs

Stony Brook University Hospital
Graduate Medical Education
Policies and Procedures

Resident Participation in Institutional Programs

PURPOSE
To establish an institutional policy regarding resident participation in institutional programs, committees and medical staff activities, educational activities, including Quality Assurance, Research and Scholarly Activity. The purpose is also to provide a mechanism for the GMEC to ensure program compliance with ACGME requirements.

POLICY
All program directors must develop and implement a departmental/program policy regarding residents' participation in institutional programs, committees and medical staff activities, educational activities, including quality assurance, research, and scholarly activity. The GMEC will monitor these activities through regular review of the program.

GUIDELINES
Residents must be given the opportunity to participate in institutional and program committees, medical staff activities, educational programs, including quality assurance, research and scholarly activity that will enhance their knowledge, skills and attitudes essential to the practice of medicine.

INSTITUTIONAL PROGRAMS, COMMITTEES AND MEDICAL STAFF ACTIVITIES
Residents currently serve on the Graduate Medical Education, the Medical Board and Medical Records Committees. Residents are peer selected to serve on these committees. They are also invited to the Medical Quality Assurance Committee when they are involved in a case being reviewed in their specialty area. Program Directors must develop and implement departmental/program policies and procedures to ensure resident participation in the institutions' programs, committees and medical staff activities other than those listed above.

QUALITY ASSURANCE
Program Directors must develop and implement departmental/program policies and procedures to ensure resident participation in the institution's Quality Assurance program.

RESEARCH AND SCHOLARLY ACTIVITY
Resident scholarly activity should be a continuous activity. The program director and faculty must maintain an environment of inquiry and scholarship. Examples of scholarly activity may include, but are not limited to:

Research support; research design; hypothesis formulation; data collection methods; statistical analysis; data summary and presentation; application of computer software in medical research; critical reading of medical literature; and ethical issues related to the conduct of research; active participation in local, regional and/or national professional and scientific societies; case presentations, IRB Protocol, publication, journal clubs and conferences.

Revised: November 20, 2003
Reviewed and Accepted: November 24, 2003
Revised: March 10, 2004
Reviewed and Accepted: March 22, 2004
Stony Brook University Hospital
Graduate Medical Education Policies and Procedures

### Moonlighting

**PURPOSE**

To establish an institutional policy regarding dual employment (i.e. moonlighting) for all graduate medical education training programs within the institution.

**POLICY**

Stony Brook University Hospital residents are prohibited from moonlighting unless expressly agreed to, in writing, by the Program Director and the Graduate Medical Education Committee. Each residency program must maintain and monitor the resident work hours as outlined in the New York State Health Code 405.4 established in July 1989 with regard to dual employment [See "Duty Hours" in the GME Policy and Procedure Manual.] and be in compliance with ACGME requirements as outlined below.

**NYS HEALTH CODE 405.4**

Hospitals employing postgraduate trainees shall adopt and enforce specific policies governing dual employment. Such policies shall require at a minimum that each trainee notify the hospital of employment outside the hospital and the hours devoted to such employment. Postgraduate trainees who have worked the maximum number of hours permitted in subparagraph (i) and (iv) of the paragraph shall be prohibited from working additional hours as physicians providing professional patient care services. (10NYCRR)

Professional and patient care activities that are external to the educational program are called moonlighting. Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care. Therefore, the GMEC and program directors will closely monitor all moonlighting activities.
Additionally:

- residents are not required to engage in moonlighting;
- a prospective, written statement of permission from the program director must be obtained and will be made part of the resident's file; and, the residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.
- all residents engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. It is the responsibility of the institution hiring the resident to moonlight to determine whether such licensure is in place, adequate liability coverage is provided and whether the resident has the appropriate training and skills to carry out assigned duties.

Revised October 21, 2003
Review and Accepted: October 27, 2003
A legitimate question any resident may ask is, “Well, just what constitutes acceptable behavior? What constitutes unacceptable behavior?” Residents work in a kind of “splendid isolation” once they’re in a room alone. They may chug along, wondering if they’re doing better than their peers, doing worse, keeping up? Who’s to know?

And how does my behavior “shape up” in regard to the six core clinical competencies?

To clear this up, we include the following examples of expectation behaviors.

Examples of Expectation Behaviors

Patient Care:

Below expectations
- Does not identify patient’s allergies that are noted in chart and on bracelet
- Does not explain risks of anesthesia procedure as part of informed consent
- CA3 cannot intubate patient with Class 3 airway with minimal assistance
- CA1 at 6 months cannot identify vocal cords on Class 1 airway
- Does not perform airway assessment on H&P
- For emergencies, does not ask NPO status

Above expectations:
- Diagnoses remote disease process during H and P
- CA1 performs smooth, quick fiberoptic intubation on first fiberoptic case
CA1 places successful spinal on first attempt in morbidly obese pt

**Medical knowledge:**

**Below Expectations**
- Poor fund of knowledge of planned discussion topic
- CA1 does not know how Mac and Miller blades are used differently
- CA3 does not understand the physiology of cardiac Bypass
- CA2 cannot identify source of increased airway pressure during GA

**Above Expectations:**
- Can recite the Kreb Cycle
- Identifies unusual medical problem on H&P and comes prepared to the OR with articles
- CA1 at 6 months identifies the entire nerve distribution for an axillary block

**Practice Based Learning:**

**Below expectations**
- Did not read for case
- Does not change practice after directed to do so
- Does not engage student
- Does not attend journal club and offers no excuse

**Above expectations:**
- Reads Miller and brings in 4 papers on planned discussion topic
- Uses Internet to answer difficult question identified in the OR
**Interpersonal and Communication Skills:**

**Below expectations:**
- Does not follow directions
- Defensive with constructive criticism
- Does not call for attending when appropriate
- Did not help fellow residents on call
- Is not empathetic with anxious patient

**Above expectations:**
- Speaks to difficult surgeon and is able to work out a problem without the attending
- Returns a Pain call at night and remains polite even though it was a ridiculous call

**Systems Based Practice:**

**Below expectations:**
- Sloppy, illegible records
- Inaccurate record
- Slow turnover
- Does not properly account for narcotics
- Does not work with the OR team

**Above expectations:**
- CA3 rate of turnover by a CA1

**Professionalism:**

**Below expectations:**
- Does not admit to error
- Covers up error
- Leaves to go home before completing debriefing form
Leaves to go home before checking with coordinator

**Above expectations:**
Stays to care for pt after relieved to go home
Provides emotional support to awake pt that would make an observer cry

The following material provides more details about what is expected of you during each stage of your training.

The following details the overall educational goals by year, demonstrating iterative accumulation of knowledge and skills.

**First Month of Training:**

The goals of the curriculum for the first month of anesthesiology training are that all incoming anesthesiology residents (CA-1) develop and demonstrate the knowledge, skills, and attitudes necessary to administer an anesthetics to a healthy patient for an uncomplicated surgical procedure, and that they continue to develop and demonstrate competencies in the domain of the ACGME – medical knowledge (MK), patient care (PC), professionalism (PF), practice-based learning and improvement (PBLI), interpersonal and communication skills (ICS) and systems-based practice (SBP).

**Objectives**

I. Knowledge.
By the end of the first month of training each resident will demonstrate applied knowledge, as measured by acceptable scores on the AKT-1, in the following:
- Airway management (MK)
- Basic monitoring (MK)
- Anesthesia equipment (MK)
- Preoperative assessment (MK)
- Intraoperative fluid and electrolyte therapy (MK)
- Neuromuscular blockade use and monitoring (MK)
- Pharmacology and physiology of inhaled anesthetics, induction agents, opioids and amnestic (MK)
- Basic respiratory and cardiac physiology in the anesthesia setting (MK)
- Regional anesthesia (MK)
- Post-anesthesia care (MK)
- Dysrhythmias and principles of defibrillation/cardioversion (MK)

Program level: By the end of the first month, >50% of the residents will score at or above the national mean of the AKT-1.
II. Skills

Individual learning level: By the end of the first month of training all CA-1 residents will have demonstrated proficiency, as measured by an anesthesia attending, in the following skills:

- Perform a complete preoperative patient evaluation and discuss with the attending their evaluation and anesthetic plan in a cohesive and systematic manner (PC, ICS).
- Conduct a pre-use anesthesia workstation checkout procedure according to ASA guidelines (PC, SBP).
- Set up an anesthesia workstation in a safe, cost-effective manner (PC, SBP).
- Safely and effectively insert peripheral IV’s (PC).
- Perform airway management, including mask ventilation and intubation (PC).
- Position patient with regard to pressure points, in particular, eye and ulnar nerve protection (PC).
- Insert oro/nasogastric tubes (PC) and communicate effectively with surgical team if difficulty is encountered (ICS).
- Recognize and summon help immediately if light anesthesia, dysrhythmias, hypotension, hypertension, hypoxemia or hypercapnia occur (PC, ICS).
- Convey all essential information during case handover or PACU arrival (PC, ICS).
- Manage the end of a case, including discontinuation of anesthetics, emergence, and extubation (PC).
- Maintain a complete, accurate and legible anesthesia record that includes all relevant patient and billing information (PC, PF).
- Perform postoperative evaluation and complete all quality assurance documentation (PC, PF, PBLI).
- Demonstrate appropriate use of IV pumps, defibrillator, and airway equipment (SBP).
- Demonstrate operating room safety procedures including patient identification, time-out, correct site identification, medication labeling, narcotic disposition, and safe needle handling (PC, SBP).

Program Level: By the end of the first month of training, >80% of the residents will have demonstrated proficiency in these areas, either in the OR or in the simulator.

III. Attitudes

Individual learning level: By the end of the first month of training all CA-1 resident will routinely incorporate, as measured by those who surround them, the following behaviors:

- Caring and respectful behavior to patients and staff (PF, ICS).
- Sensitivity to patients’ culture, age, gender and disabilities (PF).
- Work effectively in a team (ICS).
- Use judgment to call for help (PC, ICS).
- Participate in all learning activities – journal club, grand rounds, morning report (PF, PBLI).
- Display willingness to acknowledge errors (PBLI).
- Wear appropriate ID and OR apparel (PF, SBP).
- Accept criticism as a means to improve patient care and personal growth (PBLI).
- Commit to patient confidentiality (PF).
-Complete rotation and faculty evaluations in timely manner (PF)
-Complete ACGME case log before end of each rotation (OF)
-Monitor department messages and web-site postings (PF)

In addition, by the end of the first month of training, all CA-1 residents will demonstrate understanding and beliefs in the following:
- Patients and health care organizations want physicians to have strong medical knowledge, demonstrate good communication skills, are professional, know the literature regarding patient illnesses, are reflective about their own practice, are able to act as an advocate in the health care system (MK, PC, PF, ICS, SBP, PBL)
- Patient safety is an essential element in all patient care and planning (PC, PF)

Program level: by the end of the first month of training, >80% of CA-1 residents will have a satisfactory rating in the above behaviors, as rated by perioperative staff, anesthesia faculty and simulation center personnel.

In addition,
- 100% of all CA-1 residents will believe that patients and health care organizations want physicians who are proficient in the core ACGME competencies.
- >80% of CA-1 residents will rate their competency in performing psychomotor skills as satisfactory.

CA-1 Summary List of Goals and Objectives

Educational Objectives: CA-1 graduates should be able to understand, discuss and apply knowledge of:

A. Anesthesia equipment and patient monitors, including data interpretation and appropriate clinical response.
B. Pharmacology and clinical use of all major anesthetic agents, IV and inhalational, used in all phases of perioperative patient care.
C. Physiology of all organ systems in ASA Class I and II patients.
D. Anesthesia directed H and P with interpretation and incorporation of all relevant lab data.
E. Appropriate preop testing for Class I and II patients.
F. Use and risks of monitored anesthesia care.
G. Basic concepts of airway management from evaluation, recognition of potentially difficulties, induction, emergence, extubation.
H. Knowledge of basic breathing circuits.
I. Essentials of fluid management and IV access.
J. Premedication and prophylaxis regimens for latex allergy, malignant hyperthermia, and medication allergies.
K. Basics of pain control theories and strategy.
L. Basic concepts of invasive monitoring.
M. Importance of accurate documentation, informed consent, notation of intraoperative events.
N. Knowledge of quality improvement issues such as postop follow-up, and follow-up of complications.
O. Basic concepts of positioning and padding patients for different operations as well as basic concepts of prevention of positioning complications.
P. Social issues regarding religious and ethnic diversity in physician-patient as well as personnel interactions.

Technical skills: CA-1 graduates should be able to perform:
A. Appropriate anesthesia directed H and P including a detailed airway exam.
B. Presentation of ASA Class I and II patients.
C. Be able to demonstrate the use of all routine anesthesia equipment and patient monitors, including safety systems, routine machine check-out, troubleshooting alarms and creating alternative plans in case of malfunction.
D. Set up an OR for a routine case without assistance.
E. Perform mask ventilation, and use oral and nasal airways, without assistance.
F. Intubate patients with normal anatomy with different blades.
G. Intubate patients with use of the intubating Bougie.
H. Perform a rapid sequence induction.
I. Display appropriate knowledge of the ASA difficult airway algorithm.
J. Display appropriate evaluation and preparation of patients for extubation, including appropriate monitoring of train of 4 twitch monitoring.
K. Place peripheral IV’s and arterial lines in timely and effective manner.
L. Be able to demonstrate proper functioning of an existing.
M. Be able to troubleshoot an improperly functioning IV.
N. Be able to document in legible, intelligible fashion all preop, intraop, and postop events in accordance with ASA and federal guidelines.
O. Demonstrate the ability to position and pad patients appropriately.
P. Demonstrate proper handling of medications including sterile technique, admixing, labeling, injecting and documenting.
Q. Perform a socially sensitive interview with patients including religious and ethnic concerns.
R. Conduct themselves with professionalism and respect for co-workers.

CA-1 Goals:
At the end of the CA-1 year, the anesthesia resident will have a basic understanding of anesthesia equipment and monitors, routine airway management, basic anesthetic and adjuvant drug pharmacology, as well as fundamental physiology in ASA I and II patients. The CA-1 graduate will be able to perform a routine H and P, plan for preop meds and testing, and discuss these with the patient in a sensitive and caring fashion including anesthesia risks and benefits. Maintenance of routine general anesthesia and MAC should be mastered by the end of CA-1 year. Residents will also master extubation and transport issues in ASA I and II patients. CA-1 residents should be able to document preop, intraop, and postop data in clear and concise fashion. The competent CA-1 resident should also understand and participate in quality assurance issues, including routine postoperative care. At all times, the CA-1 will conduct him/herself with ethical and professional conduct towards patients, nursing, technical, and surgical personnel. The CA-1 will respect patient privacy and will execute all house staff duties.
CA-2 Summary List of Goals/Objectives

Educational Goals/Objectives: CA-2 graduates should be able to understand, discuss, and apply the following:

A. Concepts of evaluation and care of subspecialty patient populations such as pediatric, obstetric, cardiac, neurosurgical, critical care, and ambulatory patients.
B. Strategies for preop testing of complex patients as well as the appropriate use of consultants in the preop assessment.
C. Physiology and pharmacology issues regarding subspecialty patient populations.
D. Knowledge of complications of pharmacologic treatment of subspecialty patients.
E. Advanced airway management strategies and preparations.
F. Advanced invasive monitoring strategies and data synthesis.
G. Acid-base physiology, electrolyte disturbances, and blood product use.
H. ACLS.
I. Concepts of patient care, assessment, and interventions in the PACU.
J. Pain management evaluation and treatment in both acute and chronic settings.
K. Concepts in regional anesthesia.
L. Transplant patient physiology and pharmacology for both donors and recipients.

Technical skills: CA-2 graduates should be able to perform the following:

A. Evaluation, preparation, induction and extubation of complex patients.
B. Advanced airway maneuvers such as double lumen, Univent, fiberoptic, LMA, Fastrach, and Bullard.
C. Place central access lines effectively and appropriately.
D. Evaluate blood loss and transfuse appropriately.
E. Demonstrate sterile technique.
F. Evaluate and treat acute and chronic pain.
G. Perform peripheral and central-neuraxial blocks for analgesia and anesthesia.
H. Set up and conduct complex anesthetics with minimal assistance.
I. Perform ACLS with minimal assistance.
J. Perform all procedures used in subspecialty rotations.

CA-2 goals:

CA-2 builds on the skills learned and knowledge acquired during the CA-1 year. Thus, a CA-2 must demonstrate mastery of all CA-1 skills prior to the start of the CA-2 year. The CA-2 graduate should be able to evaluate any patient of any ASA level for any operation. The CA-2 graduate should be able to order preop tests and ask for preop consults, as well as prescribe and administer appropriate preop medication for complex patients. The CA-2 graduate should be able to plan and execute advanced airway maneuvers, fluid management for unstable patients, invasive monitoring and master overall management of complex patients.
ACLS certification is required by the end of the CA-2 year.

Subspecialty rotations provide residents with experience in pediatric, obstetric, neurosurgical, cardiac, vascular, and outpatient anesthesia. Anesthetic in the ambulatory setting will emphasize SAFE (short-acting, fast-emergence) techniques. Rotations in pain management and obstetrics will introduce the resident to different regional techniques. ICU rotations will increase residents' knowledge and skills in handling complex patients in the postoperative setting. Cardiac will introduce the resident to complex physiology and techniques, including on-pump and off-pump cardiac surgery. Neurosurgical, ENT, GU/GYN rotations will round out the residents' experience. Residents are expected to behave with dignity and compassion in their interactions with patients, nursing, technical, and surgical staff. Residents must act as patient advocates and must demonstrate professionalism at all times.

CA-3 Summary List of Goals/Objectives

Educational Goals/Objectives: CA-3 graduates should be able to understand, discuss, and apply the following:

A. Advanced concepts of patient care including multisystem organ disease for complex operations, out of OR anesthesia (CT, MRI, ESWL, ER) and transplant anesthesia.
B. Acting as consultant to surgeons for anesthesia planning and care of a variety of patient types and surgical settings.
C. Directing junior residents by assisting faculty in clinical assignments, preop evaluations and case management.
D. Help teach medical students and allied health professionals.
E. Participate in teaching at academic presentations and conferences.
F. Gain experience in research by participating in journal clubs, grand rounds, and department research.
G. Gain experience in such issues as billing, medical economics, medicolegal aspects and social issues regarding medicine.

Technical Skills: The CA-3 graduate should be able to perform:

A. Complex airway management in a variety of settings.
B. Aid junior residents in complex airway management.
C. Complex and invasive monitoring, such as TEE, ICP, and SCC monitoring.
D. Effectively evaluate and treat complex patients with acute or chronic pain.
E. Perform complex peripheral nerve blocks, including use of ultrasound visualization.
F. Evaluate patients and perform anesthetics safely with little supervision.
G. Direct cardiac arrest resuscitation within acceptable ACLS guidelines with little supervision.

CA-3 Goals:

During the CA-3 year, the resident is to become a leader and supervisor, able to direct others in the planning and execution of anesthesia. The CA-3 year broadens the scope of knowledge, hones communication and technical skills, and prepares the
resident to become a consultant anesthesiologist, not just an anesthetist. During the CA-3 year, the resident acts as leader in various settings, including call nights and on OB. CA-3 residents assist the junior residents in evaluation and management of patients of all ASA classes. CA-3 residents assist junior residents to induce patients, perform advanced airway and monitoring techniques, and handle physiologic perturbations before, during, and after the case. CA-3 residents participate in teaching by their senior presentations on grand rounds, their participation in morning report, and by teaching junior residents during call duties. CA-3 year fosters research and academe by offering research opportunities with faculty. During the CA-3 year, the residents will be expected to perform anesthesia on a variety of patients, many of them extremely complicated patients. Cases that require expertise and experience will be assigned preferentially to CA-3 residents.

The main goal for all CA-3’s is to be consultants in anesthesiology, able to function with complete independence upon graduation.
How Attendings are Educated about Fatigue

All attendings are required to review the SAFER program about resident education. Thus, attendings get the same level of training regarding resident education as the residents get.
Attending faculty development

Residents may well ask the question, “How are the faculty encouraged to keep abreast of the latest developments?” “How are the faculty encouraged to develop professionally?” “How are the faculty encouraged to teach?”

From the Department of Anesthesiology, Policies and Procedures, last update, November 5, 2007.

Policy on Benefits, #11. “In general, all Attendings who are presenting at national meetings or are members of committees that meet at such are given time to attend. In addition, all Attendings are given a minimum of one day to attend the Post Graduate Assembly of the New York State Society of Anesthesiologists. It has also been customary to allow attendance at other meetings, such as ASA, IARS, SOAP, SAMBA, SCA, so long as you can be spared from your assigned clinical responsibilities.”

Policy on Departmental Reimbursement, #2, Incentive Plan. “The yearly recipient of the teaching award will be awarded (a certain number of incentive points). For those attendings in the top 25% on the Resident Evaluations of the Attendings (a certain number of incentive points). In addition, points are awarded for giving lectures and classes.

“Publications and other scholarly activity are also rewarded: for a study, special article, or review article appearing in a peer review journal: (incentive points) for first, second, third, and senior author. For a case report (incentive points). For an article in a non-peer review journal (incentive points). Such points are also given for abstracts, posters, and presentations.

Allocation of Academic Time: In this section, details of academic time are included, all with the same theme – more academic production results in more academic time.

Thus, the department clearly puts emphasis on scholarly and teaching activities, encouraging the professional development of the faculty.
How you evaluate the faculty

New Innovations has a mechanism for you to evaluate faculty. Your evaluations are kept anonymous. In addition, the evaluations are “held” for six months, so the faculty will not be able to tell who submitted their evaluations. All of this is done to make sure that you can write anything you would like on your evaluations.

If at anytime, you feel it necessary to contact the residency director or chairman, you can do that as well. You can contact them directly, have the chief resident “speak for you on condition of anonymity”, or any other method that makes you feel comfortable. For example, if a faculty member acts unprofessionally, you can contact us immediately, rather than waiting for a faculty evaluation to “make its way through the system”.

Faculty evaluations are taken very seriously, and constitute an important part of the faculty member’s overall evaluation and professional standing. So your evaluations are important. Also, as part of our continued effort to improve the teaching environment at Stony Brook, we consider these evaluations as we make resident assignments. If a faculty member is not a good teacher, as evidenced by poor resident evaluations, that faculty member will not get assigned to a resident.
How the faculty evaluate you

Faculty evaluate you both on a daily basis (the daily debriefing form) and on a monthly basis (the monthly evaluation form). You have access to these evaluations and can see them on a regular basis.

The daily debriefing forms are meant to be “formative”, that is, they should be used to help you shape and improve your practice. Ideally, you will have the opportunity to sit down with your attending and go over the evaluation together. You will have an opportunity to look over and reflect on the attending’s comments. It’s important to keep in mind that the daily debriefing forms are meant to help you improve, not to be punitive. If, for example, an attending says you are below expectations on patient care because you missed a central line, the idea is not to say “Shame on you!”, rather, the idea is to build the grounds for improvement. In this case, you might go over anatomical landmarks for central line placement and how ultrasound guidance can help you get the next central line.

The monthly evaluation is “summative”, that is, it goes over how you performed for the entire month. Care is taken to make sure you are evaluated in all areas of the core clinical competencies. As with the daily forms, the monthly evaluations are meant to direct you toward improvement. They also allow the department as a whole to follow your progress through the program.

The Clinical Competency Committee meets on a regular basis to evaluate the residents. At this meeting (held monthly), the committee looks over the residents, looking at daily evaluations, monthly evaluations, as well as direct feedback from attending physicians and the chief residents. The main idea of this committee is to do everything to assure success of our residents. If a problem is identified, then a plan for improvement is created and the department does everything to bring the resident to a satisfactory level. In a real sense “Your success is our success”. The Committee works diligently to help any resident who is having any problem in any area of their professional development.

The residency director will meet with you twice per year. At this time, all evaluations, test scores, and CCC input are reviewed. As before, the goal is to assure your professional development is proceeding in a satisfactory fashion.
How the Simulator sessions go

Each Wednesday from 8-11 AM, one class (CA-1, 2, or 3) will have a three hour educational session. The complete schedule for the year is included in the year long curriculum.

The sessions are broken into three components.

1. Didactic session, including review of material you have prepared ahead of time.
2. Simulator session to explore, in hands-on fashion, the major lessons of the day.
3. Wrap-up didactic session, including a debrief on the simulator episode, post-session discussion, and time to reflect and evaluate the session.

Here’s an example of how such a session might go.

Difficult airway

1. Review concepts of difficult airway management, go over the “pre-test”.
2. Simulator session where a difficult airway is encountered and managed.
3. Wrap-up didactic session where we go over the difficult airway algorithm, debrief the events in the simulator, take a post-test, and have time to reflect and evaluate the entire session.

A key element of this educational session is showing up prepared. By referring to the curriculum and seeing what’s coming, the resident can read and study prior to the educational experience and get a lot more out of it.
Preparation for Grand Rounds

As with the Simulator sessions, the key to getting the most out of Wednesday’s 7-8 AM Grand Rounds (or QA or Visiting Professorships) is to read and study on the subject prior to showing up. Active learning is better than just “showing up and seeing happens”. So, for example, if a Visiting Professor is going to show up and discuss “Uptake and Distribution of Anesthetics”, then the resident should read about this before the lecture. If the QA session is going to center on ACLS principles, then the resident should review current ACLS algorithms before showing up for the lecture.

We will make sure the residents “know what’s coming” so they can prepare ahead of time and get the most out of their 7-8 AM Wednesday educational experience.
5. Getting All Your Paperwork Done

Checklists and Tests

As adult learners, residents will need to “take charge” of their own education and make sure they are moving toward complete independence in the practice of anesthesia. To organize the learning, each rotation has a checklist of procedures and skills, as well as a post-rotation test, to make sure the resident has acquired the requisite knowledge from each rotation.

As part of the essential attribute of professionalism, the residents are required to complete their checklist and test during the last week of their rotation. All tests and checklists are available on-line through the Resident Portal.

Residents are encouraged to “work through the checklist” throughout their 4 week rotation, rather than waiting to the last day and trying to play “catch up”. Similarly, the residents have full access to the test questions, so can prepare well ahead of time for their end-of-rotation exam.

Make sure you keep up with these important aspects of your education, and don’t let them “accumulate”.
Completing competency cards

Getting All Your Paperwork Done

<table>
<thead>
<tr>
<th>Completing Competency Cards</th>
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<tr>
<td>At the center of current graduate medical education is the idea of the six core clinical competencies:</td>
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<tr>
<td>1. Patient Care</td>
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<tr>
<td>2. Medical Knowledge</td>
</tr>
<tr>
<td>3. Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>4. Systems-Based Practice</td>
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<tr>
<td>5. Professionalism</td>
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<tr>
<td>6. Practice-based Learning and Improvement</td>
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Each month, we have a “Competency of the Month”. This competency will be posted prominently around the department and the OR’s. As part of their essential attribute of professionalism, residents are required to fill out at least 2 competency cards each month and turn them into Joan Claeson.

Filling out your cards is a lot easier if you “buy in” to the idea of the core clinical competencies, so a little explanation here should suffice.

Learning anesthesia, or any specialty in medicine, is more than just “knowing the specialty”. We do not practice in a vacuum and we do not treat inanimate objects. We practice in teams, in complicated organizations, in an ever-changing environment, and we do all this to benefit a wide variety of human beings in need of medical help. The six core clinical competencies make sure that we realize this and “teach to these ideas”. A few examples:

1. Beta blocker recommendations change frequently. You can’t just “know today’s medicine” and leave it at that. You need to keep current. That links to the competency of Medical Knowledge.
2. In our multi-cultural society, different people from different backgrounds may respond differently to your medical explanations. Being sensitive to the cultural differences is part of the competency of Professionalism.
3. Handing off a complex patient to the ICU requires a complete delivery of all appropriate medical concerns, plus you need
to listen to nurse feedback in the ICU. This is part of the competency of Interpersonal and Communication Skills.

So the competencies are aspects of medical care you need to know, and we need to teach. Filling out those cards each month, every month, keeps those competencies “front and center” in the educational experience.
Getting All Your Paperwork Done

House Staff Paperwork – NPI, DEA, license

We are highly regulated and closely monitored by the state, by the federal government, by the insurance industry, by the drug enforcement agency. All of this translates into a lot of forms that need filling out, licenses that need to stay current, and the like. The House Staff office keeps track of all this material.

You ignore this at hazard to your career! If your license lapses, or you don’t have proper DEA clearance, or you forget some important documentation, you cannot practice medicine.

Lesson learned? Keep close track of all your “necessary documentation”. Contact the House Staff office and see if you’re missing anything. (Joyce Klein is the chief administrator and will be happy to help you fill out the necessary forms.) This is an extremely important lesson to learn during residency, because this same problem can appear after you graduate. If you don’t get enough CME credits or you let your license lapse or you let your DEA clearance outdate, you will get a call from your hospital’s administrator. “You can’t go to the OR today, Doctor!”

PAX certification – So you can look at X-rays online

Get your certification to be able to access X-rays as soon as possible. You don’t want to be on the PACU and be asked, “Check this CXR and see if there’s a pneumothorax” and you come back with a lame “Uh, I don’t have the necessary clearance”. It takes just a few minutes. You fill out a little paperwork, give it to either the chief resident Dr. Cohanim or else hand it directly to Radiology, or you can even fax it to them.

Joan Claeson has the necessary forms. A scanned image of one is included below.
You will need a valid E-mail account and must supply a user name and password. If you do not supply us with this information we will not be able to set up your account.

If you have any questions regarding this application, please call 4-HELP (444-4357)

Upon acceptance of my personal identification and password, which allows access to University Hospital Information System, I accept responsibility for their use and confidentially. I understand the need to maintain all patient information, as well as other financial and statistical information to which I have access, in the strictest of confidence. I also understand that any unauthorized use of this information or my password and identification will subject me to appropriate administrative disciplinary measures, in addition to possible criminal prosecution. The use of this I.D. is a privilege that will be revoked if abused. Passwords will be e-mailed within 48 hours. Due to HIPPA regulations, random audits will be performed to protect patient confidentiality.

Employee Signature

Date

Supervisor Name

Date

Supervisor Signature

Date

Supervisor Title

Date

Please use this area to indicate access request: (You must check the application.)

Attending

Nurse

PACS

Resident

Student

IDX

Nurse Practitioner

Other

Echo
6. Learning the Ropes for the New Resident (Advice for Beginners)

Here’s a few words of advice, gleaned from lots of experience with new residents. It’s a bit long winded, but new residents have found this very useful through the years.

Introduction

You’ve just finished internship and now it’s off to Anesthesialand. Just what are you supposed to do?

For the last year, you did the intern thing – H & P’s, gentamycin levels, blood cultures, admission orders, finding the X-rays, pushing the Gurneys.

Useful stuff.

Now you’re going to start an anesthesia residency and you don’t know from shine-o-la about it. Maybe anesthesia is a “good lifestyle” (you heard that and want to believe it), the dough is supposed to be good eventually (of course, that’s three years away, plus who knows what they’ll be paying anyone by then), and anesthesia can be, sort of, if you believe the Oprah specials, dangerous (hell, they use anesthesia drugs at state executions, just in case you had any doubt about their deadly potential). OK, that’s all just wonderful, but when July 1 comes around and you’re standing by that half-Rube Goldberg, half-rolling ICU of an anesthesia machine, just where precisely do you start this anesthesia odyssey?

Start here.

This is a starting guide, a jump start, a push out of the nest. This should get you through the first month or so, make you moderately non-lethal, and a tiny bit independent (at least until help arrives). I’ll start slow, real slow, assume total ignorance, and tell you everything from the ground up. Once you get this stuff down, and mid-August comes around, then you can move on to the more advanced stuff.

In this handout, I’ll go over 6 ideas to carry into your early residency:

1. The IV.
2. Common Sense.
3. Game Plan.
4. Attitude.
6. Reflexes.

Not a million things to know, just a few. Get a few ideas down now, there's time to fill in the details later. Hope this helps.

Welcome to Stony Brook.
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Idea 1

Idea 1: IV.

Right, give me a break. As if I need to hear about an IV. Get out.

Well, sports fans, believe it or not, reliable intravenous access is the thing you need to start most cases. Without an IV, that case ain't gonna happen. When you start a case, if the IV stinks and infiltrates, you are in deep kimchee. If a patient's blood pressure tanks, you're going to need that IV to save the day. And if the IV doesn't work, you ain't savin' anything. Unlike an infiltrated IV on your medical or surgical rotation, an infiltrated IV during an anesthetic case can spell D-I-S-A-T-E-R.

At the end of your case, when the patient rises from their anesthetic slumber, he or she may move their arms all over the place, knocking out their IV right when you need it most. As you move a patient from the OR table to the PACU or ICU bed, IV's pull out as if by magic.

The IV is important. Know how to get one in. Know how to keep one in. No joke. This focus on the IV may seem trivial; trust me, it's not. Let's go over a few IV considerations.

1. If someone comes from the floor with an IV, make sure it works well. Right away, right away, right away, just open the stopcock and see if the damn thing works! Those who put in floor IV’s are thinking of giving antibiotic, running a little maintenance fluids, whatever. A floor IV placer is not thinking of anesthetic induction, possible need for resuscitation, all the heroic things an anesthetic IV might have to do. Therefore “floor IV’s” tend to be small, poorly secured, and well infiltrated. No problem. Put in your own. But the time to find that out is right away, not later on when you've rolled into the room, are ready to induce, and THEN you find out you have no IV.
2. If you put in an IV, try to do it under good conditions. Place the IV in the holding area (where it tends to be warm) rather than the OR (which is cold enough to cure bacon). Get a real tourniquet, good lighting, and a chair to sit in. If you do all your IV’s hunched over, you'll eventually screw up your lower back.
3. Use local. If you have to dig around, the patient will appreciate it. If a patient is absolutely freak-o-matic about needles, use EMLA cream, making sure to place it on two sites, in case you miss the first time.
4. The biggest error beginners make is “getting the blood flow, but I couldn't advance it”. That happens because you pull
the skin back with one hand, get the flash of blood, then you RELEASE THE SKIN TO BRING YOUR SECOND HAND UP TO ADVANCE THE IV. In that moment, the skin springs forward just a millimeter or two, and the vein springs forward too. Voila, you’re out of the vein now and you can’t advance the IV. The cure to this is simple, keep holding the skin back and slide the IV catheter in with the same hand – the one-handed IV. Believe it or not, this simple technique will save you a million times. Learn the technique early, you won’t regret it.

5. What size IV? A smaller IV that is IN is far superior to a bigger IV that is NOT IN. So when you’re looking at a nice vein and you think, “Yeah, macho, I’ll slam in a 14 g!”, think again. A 16 g is as easy to put in as an 18 and it runs about as good as a 14. Be satisfied with a smaller IV that’s more of a sure thing. You can always put in another one after the patient is under anesthesia.

6. Taping the IV. Yes, this is important too. Don’t put in a big loop. That loop is GUARANTEED to get hooked on something and pull out. Keep your IV’s secured well. On the flip side, don’t fall prey to this mistake and wind the IV around so tight that there is a kink. Also, make sure all links are visible, so if there is a problem, you can fix it.

7. Straighten out all the IV lines so they’re easy to get at. If you do tape the IV down to the bed, tape it along tubing, not at a connection. Have an easy-to-get-at injection port. Finally, don’t tape it down to the bed real hard. If later on you forget, you would rather have the IV pull off the bed than pull out of the patient. (See diagram).

8. When you open up the IV to see it works, remember to slow it down again. Especially early on, you’re doing so many other things that you forget that your IV is running wide open. Then you end up with an “air bag” as well as an overloaded patient (see diagram).

9. When you induce, make sure the IV site is uncovered. A blanket over the IV (the nurse in the room will tend to do that) may hide an infiltrated IV. As much as possible, “see” your IV sites. If the case requires tucking the right arm, then put in a left arm IV. If they are going to tuck both arms, then put in an extra IV. If you just have one, and something goes wrong, then you are stuck. An extra IV always helps!

10. Just absolutely cannot get a peripheral IV? Go to a central line early. Better one stick in the neck than 50 sticks in the arms, followed by a stick in the neck anyway. Philosophy of your IV access should always be – Have enough. There is no worse feeling than being halfway through a case and sweating a lack of IV access. Get the lines you need, then you can relax during the case.

11. Get an IV, 1 is good, 2 is better. Practice, practice, practice. After the patient is asleep, put another one in.

12. You only get one chance to make a good impression, this is the first technical thing the patient sees, so make sure you get good at putting IV’s in. This may be the only thing the patient remembers about you because after the Versed, they forget stuff.
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Idea 3

Idea 3: Game Plan

Even though you are just starting, you should set up a game plan for your entire residency. Remember in college how you got a syllabus for each class at the beginning of the semester? The syllabus listed which books you needed to read, when the mid-terms and final exam were, and what you’d be expected to know. View residency as a three year semester, and map out what you need to know, what you need to read, what skills you need to have, and what tests you need to pass and when. The list may appear overwhelming at first, but make that list anyway. Then, as residency progresses, make sure you are making steady progress on that list.

Here’s a sample outline. You can modify it as you see fit.

(You will also get a nice booklet from us that outlines your goals for CA-1, CA-2, and CA-3 years. All the different rotations are included along with goals for each rotation. So you’ll have a good outline. View this as a “supplementary outline”.)

The Broad Outlook Synopsis for Residence

1. Clinical skills.
   Be able to handle any patient for any procedure under any circumstance.
2. Academic skills.
   Be able to handle any question about any aspect of anything related to anesthesia.
3. Interpersonal skills.
   Be able to handle the myriad personalities you will encounter in and around the OR.
4. Business skills.
   (An oft-overlooked aspect of your training) Be able to go out there and get a job once this is all done and not be an absolute idiot when it comes to money.

At first blush, this synopsis looks ridiculous. But if you sit down and think, it actually makes sense.
1. **Clinical skills.**

   From day one, you should make this your mantra, “When I’m out of this place in 3 years, I have to be the stopper. I have to be the one that makes it happen.” When the 400 pound uncooperative patient comes down to the OR desaturating, with a neck collar on and no IV access and a surgeon screaming “We gotta get going, he’s dying!”, you will need to know what to do.

   Your attending will not be there.
   Kid? You’ll need to know what to do.
   Pregnant patient? You’ll need to know what to do.
   Arterial line, central line, femoral line, awake intubation, arm block, thoracic epidural? No matter the procedure, you’ll need to know how to do it.

   Intracranial injury, asthma, heart disease, DKA?

   Learn from your fellow residents and attendings. Learn what to do and what not to do. Spend as much time in the OR as you can. There is no penalty for going into a room where something interesting is going on, for example a TEE in a heart room. Also, when there is a big monster of a case, you can always be a helping hand, for example, moving a patient prone is always a difficult task, so go ahead and BE that extra helping hand. No matter the condition, no matter the patient, you’ll need to know what to do and how to do it.

   Three years seems like a long time, but it will pass in a blur and then you are the one. From the beginning of residency, plan for how you will finish up your residency. Independent and able to handle it all.

   You may find yourself complaining that everyone ELSE gets the cool cases, but fear not, time has a way of evening things out. You’ll get your good cases.

   Once again, the more time you spend in the OR, the more stuff you’ll see.

   Who will keep track of this stuff?

   A. Your mentor.

   You will be assigned a mentor, and that mentor will meet with you twice a year. Approach that meeting with a “let’s make sure I’m on track” attitude.

   “Let’s see, you’re six months in, are you comfortable inducing a patient on your own? That was one of your six month goals.”

   “Here we are at a year and a half, how many central lines have you done? You should be pretty facile with them. Is that the case?”

   “2 years down. Does the thought of an awake intubation freak you out, or can you do one now with confidence?”
B. You.
It is a truism of the universe that no one cares about you so much as you care about you. You yourself should create and map out a syllabus, a check list. What does the broad outlook syllabus say about clinical skills?
   Any patient, any procedure, any circumstance.
   Even now, at the very beginning, you can make such a checklist (add to it as your depth of understanding increases).

   Any patient.
   Adult, kid, newborn, pregnant, old. That's a start.

   Any procedure.
   Go by body site on this one.
   Intracranial, around the airway, neck, intrathoracic including lung, esophagus, and heart, abdominal, peripheral.
   Anesthetic procedures – central lines from different approaches, arterial lines from different approaches, regional blocks such as the arm, spinal, epidurals (including thoracic), fiberoptic intubations. Rapid sequence inductions, deep extubations, LMA cases.

   Any circumstance.
   Healthy, full stomach, moribund, bleeding all over the linoleum, uncooperative.

   So you start your own, personalized road map that will eventually get you to, “I can handle any patient for any procedure under any circumstance.” Use this to steer yourself. For example, if you look at that checklist and you realize that your pediatric skills need brushing up, then look over your schedule. Get another peds rotation. Haven't done many spinal? Ask to go into the GU room so you can do more TURP's and cystoscopies under spinal.
   The best way to make sure you get good at everything is to be your own monitor.
   If, at the end of your residency, you are no good at, say, arm blocks, then what do you do? Whine? Say, “Nobody told me!” or “Why didn’t the residency take care of me better?” People might give you a little sympathy, but that won’t do you any good when you go out into the cold cruel world and do not have a required skill.
   Don’t rely on someone else to keep tabs on you.
   Keep tabs on yourself.

2. Academic Skills.
More or less the same deal here as with clinical skills. We will “keep tabs” on your progress by our in-service exams and our evaluations, but you are the one who should be keeping tabs yourself.
Where to start? One approach is the “keyword approach”. We can give you a list of the keywords that appear on the exams. Guess what? Those keywords are the very things you need to know to practice safe anesthesia. What a concept! We make you learn and test you on what you should know!
So, if you want to keep tabs on your progress, then work your way through the keywords. For example, make sure you know, say, 3 keywords a day. Read about:
- latex allergy
- barotrauma from PEEP
- MAC.

Make sure you have those ideas down cold today.

Tomorrow, read about:
- pulmonary embolus’ effect on end-tidal CO2
- CO2’s effect on intracranial pressure
- heparin resistance

When reading time is tight (which it always is), and you only have time to read about tomorrow’s case, then pick a keyword that relates to tomorrow’s case. Say you’re doing a TURP in the morning. Read about:
- spinals, complications
- TURP syndrome
- spinal, contraindications.

Just as you follow your checklist for clinical skills, so also you should follow your checklist for academic skills. No better list for this than the keyword list. Make a schedule, then stick to it.

“By six months in, I’ll be halfway through that list.”

Then, you look, and at 4 months, you’ve done a total of 2 keywords. OK, doesn’t take a rocket scientist to tell you that you should get your lazy tailbone in gear!

It’s worth noting when your tests will be, both your while-you’re-a-resident tests and your when-we-release-you-into-the-wild tests.

While-You’re-Still-Under-Our-Wing Test List

Anesthesia Knowledge Tests (AKT)

AKT-1
The exam is designed to allow an entering resident’s knowledge to be assessed (“Pre test”) and to determine the extent to which a resident has progressed in knowledge during the first month as an Anesthesiology resident (“Post test”). The exam items focus on knowledge concerning cardiopulmonary resuscitation and that necessary to administer an anesthetic to a healthy patient for an uncomplicated surgical procedure. Items that constitute the examination can be grouped under twelve major categories:
anesthesia technique and procedures, airway, cardiovascular, cardiopulmonary resuscitation, equipment, instrumentation and monitoring, neuromuscular blockade, pharmacology, preoperative assessment, respiratory, regional, and recovery room.

HINT: The introduction of any anesthesia text has all the info you need for the AKT 1.

AKT-6
Multiple choice question examination similar in length and style to the AKT-1, but intended to be taken by residents who are near completion of their sixth month of training. Items that make up the AKT-6 represent eight curriculum areas: anesthesia, cardiovascular, equipment, neuromuscular, pharmacology, regional anesthesia and pain therapy, respiratory and miscellaneous. HINT: The rest of any basic anesthesia textbook has all the info you need for the AKT-6 exam.

AKT-18
Designed to assess the subspecialty knowledge expected of a CA-2 resident. Examinees are scored on individual subspecialty areas for which they have indicated that they have had a rotation. In effect, the exam is a group of seven related, but separately scored subspecialty examinations. The subspecialty areas are perioperative, critical care, cardiovascular, neuroanesthesia, pain management, pediatrics and obstetrics. HINT: This test stems from the knowledge from a basic text plus your 18 months of clinical experience. (Learn something every day in the OR, read regularly, pay attention at Grand Rounds, M&M and your lectures, and you’ll do fine).

ABA/ASA In-Training Examination
Jointly sponsored by the American Board of Anesthesiology and the American Society of Anesthesiologists, the In-Training Examination is a multiple choice question written examination available to physician-trainees in approved anesthesiology residency programs. It also serves as the entry examination to the certification system of the American Board of Anesthesiology. Keyword feedback is supplied to examinees and program directors, and scores are provided to enable the examinees to compare their performances to that of all other residents at the same training level and to track their own growth in knowledge. Percent correct scores and percentile-ranking information is also provided. Each program director receives a summary of the performance of all trainees in that program, including every year each trainee has participated. Many training programs utilize the in-training examination as a tool to assess whether residents are eligible for advancement to the next level of training and/or to develop specialized educational programs and goals that residents must meet before advancement is considered. HINT: This is the real deal. This is the exact same as the written board that you will take. View this as a preview of coming attractions. Take this exam seriously. By the end of residency, you should be passing or near-passing this exam. That way, you will know that when you take it for real, you will be in clover.

ORAL PRACTICE EXAMINATIONS IN ANESTHESIOLOGY
Because oral examinations obtain trainee responses to a fairly standardized, real-life case scenario, they add to other evaluations by affording insight into trainees' clinical reasoning. In addition to providing practice opportunity for the ABA oral examination process, oral practice examinations (“Mock Orals”) may represent a useful tool for assessment of clinical performance and learning
process. Studies indicate that oral practice examinations can represent a reasonably valid tool for assessing resident performance and can serve effectively as one measure of the resident’s progress toward independent practice and specialty board certification.

Out-in-the-Wild Test List

You finish residency June 30.
That July (just a few weeks later) you take the written boards.
Once you pass that, you take your oral boards the following April.
So, to pace yourself, view your AKT tests and practice written tests as a “preview of coming attractions”. Your score should be creeping towards passing by the time you are a CA-3. If your scores aren’t up to snuff, don’t panic.
Just start studying more.

Here’s one formula for getting ready for the boards.

Important things to remember:

1. Board questions come from 3 books:
   o Miller (the big one you have access to through MD Consult)
   o Barash
   o Stoelting & Dierdorf’s Anesthesia and Co-Existing Disease

2. No board question has ever come from:
   o Baby Miller
   o Morgan & Mikhail

3. The ABA tells you exactly what you need to spend time studying when they send you the missed keyword list each year!

Study prescription:

1. CA-1 year:
   o Read Baby Miller during the first 6 months, cover to cover
   o Read Morgan & Mikhail during the 2nd 6 months, cover to cover

2. CA-2 year:
   o Read Barash over the course of the year, cover to cover
   o Read short and manageable subspecialty texts while on subspecialty rotations: (eg. Norris’ OB manual)
   o Study each and every keyword that is sent to you in October when you get your inservice results. Go to the section of Miller (the big one that’s online) and read about each...should take 15 minutes a piece.
3. CA-3 year:
1. Read Stoelting & Dierdorf’s Anesthesia & Co-Existing Disease during the first 6 months, cover to cover
2. Read Faust's Anesthesiology Review from January to March
   3. Read Board Stiff Too (by Gallagher and Lubarsky) in April just as a nice review
4. Study each and every keyword that is sent to you in October when you get your inservice results. Go to the section of Miller (the big one that's online) and read about each...should take 15 minutes a piece.
5. By May you should know exactly what your strong and weak points are.
Spend the next 2 months reading up on your weak topics in Barash or Miller.

And that’s it! If you do this and you do NOT improve your inservice scores each year and you do NOT pass the boards on your first try, there’s something inherently wrong with how your brain is wired, and you should submit an application for employment at McDonald’s.

What to study, you ask? There are million anesthesia books out there, and you can’t read them all, so where do you start? Talk with CA-2’s and CA-3’s, they’ll tell you which help the most. Believe it or not, Baby Miller actually has it all! Many a resident has studied just Baby Miller and passed his or her boards. Yes it’s true. (Note that what I just said is at variance with what Dr. Soto said. Alas, not the first time you’ll get conflicting information from different attendings! And by no means the last time, either!) You just want to make sure you go through Baby Miller with absolute meticulous attention to all the teeny tiny details. People will miss a test question, open Baby Miller and shout, “Damn, it was there all the time, I just glossed over it!”

Don’t gloss over Baby Miller.
Digest it, word by word.

You will also get an official reading list that has many more books on it. Read those, amen amen, read those. But keep in mind, “It’s all in Baby Miller”, so go back to that book again and again and get that baby down pat.

3. Interpersonal Skills.
   This may seem a bit fuzzy squishy, but this is a real-live skill you need to develop. Yes, anesthesia is about getting the tube in and placing the line and managing the arrhythmias, all true. But more than that, the OR is a collection of people with different agendas, a vast array of psychological baggage, and easily damaged egos. You will need to do your anesthetic “thing” and keep your cool in the face of:
   -screaming surgeons
   -pouting and reluctant OR/ICU/ER staff
- indifferent personnel from all departments
- blood banks who aren't as impressed by your needs as you are
- anxious parents
- did I say screaming surgeons?

And when you decide it's your turn to pull rank, beat your sternum, and say, “I am doctor, hear me roar!”, keep in mind the people you may be trampling. They're doing their job as best they can and don't like to hear your guff any more than you like to hear it.

No checklist here, no Baby Miller, no keywords. But you need to learn it. You need to learn to keep your cool, do what's right for the patient, ignore the static, and keep professional. All in a room that can become a snake-pit in the blink of an eye.

As for your fellow anesthesia residents, you are all in this together. If you show up late, if you don't come in, then all you are doing is imposing on your colleagues. We're not drowning in extra residents, so when you don't pull your weight, someone else does. And, lest we forget, what goes around, comes around.

4. **Business Skills.**

   It's heresy to mention this to starting residents, but it bears saying.

   Your job here is to learn the craft of anesthesia, and money should not be your biggest concern, especially now, when you don't even know how to unlock your locker. But we are all small business people selling “anesthesia”, just as the grocer sells apples and the used-car salesman sells cars. We do not make money, and we do not pay residents' salaries, by any other means than charging for anesthesia services.

   No anesthesia department has oil wells in the lounge. No anesthesia department supplements its income by valet parking for the patients coming to the endoscopy suite or by shining shoes in the hospital foyer, attractive though those options may seem.

   And when you go out into the world, you will go into private practice (85% or so of you) or academics (15%, plus or minus), and guess what? You'll make money the same way, by charging for what you do. (It sounds so “dirty”, doesn't it, actually getting money.) As noble a calling as medicine is, we do still have to charge. Until the landlord takes your “nobility” for rent and the Piggly Wiggly gives you free milk when you walk in with your white coat, you will have to make some money.

   Fill out the billing slips.

   While we're at it, fill in the anesthetic record completely too. If you were too busy during the case (that's fine, take care of the patient first), then, once the patient is safely in someone else's care, then make damn sure the record is complete.

   Know where your money comes from; know how you get it; know the screwups that can prevent you from getting it; and know what the law says.

   Penury is bad.
Jail is worse.
Know your money
Idea 4: Attitude

Hiding an 80 pound sarcoma on your nose is easier than hiding a bad attitude. More than anything else, a good attitude about work will make your life easier. Your attendings will love you, the staff will love you, you will love you. Nothing but good comes from a good attitude.

Cultivate that attitude early and hang onto it like a drowning person hangs onto a straw.

Out in the real world, same thing. A good attitude will keep you in a good job. Bad attitude? Out you go.

To best illustrate this, I'll draw up some mini-conversations (some real, some made-up), that show a winning attitude and a not-so-winning attitude. You may be rolling your eyes and saying, “Not more warm and fuzzy stuff, puh-leeze!”, but believe me, this stuff is important.


   Good attitude: (Dropping everything) “God all fishhooks, these folks look like they could use a hand! Even if just pushing stuff or helping move the patient over. The more people the better when the you-know-what hits the fan.”

   Bad attitude: (Sitting at the desk) “Glad it’s not my room.”

Believe it or not, I’ve seen this happen a dozen times.

2. “Can you give us a talk on MH next Wednesday?”

   Good attitude: “OK. Might not be the greatest, but if nothing else I can get some stuff off a Google search and give you guys the highlights.”

   Bad attitude: “Oh, I’m on call a lot, and besides…can’t someone else, I mean, is this fair, blah, blah, blah.”

3. “This guy looks tough, better do this intubation awake.”
Good attitude: “I’ll get the stuff. I need to do more awake intubations anyway.”

Bad attitude: “Do you really think so? Come on, how about you do it?”

You could make up a hundred of these little morality plays yourself. The point is always the same – a can-do, OK-how-can-I-help attitude will always, always, always serve you better than a weaselly, how-can-I-get-out-of-this approach. If you’re forever trying to get out of things:
- first of all, you probably won’t get out of it in spite of your efforts
- second, your attitude is plastered all over. You might just as well have a neon tattoo on your forehead saying, “I AM AN UNPLEASANT HUMAN BEING”.
Idea 5

Idea 5: Cyber-learning


Unless, of course, you want to look up something timely in anesthesia. Then it’s time to “go silicon”.

By the time a textbook gets on the shelf, it’s already at least a year old, more likely two. Then, the longer the books sits there, the more outdated it gets. So, for example, you want to look up something on Dexmedetomidine (an alpha-2 blocker with great sedative properties). You look in Miller – not much, Stoelting, ditto. Damn. This new drug just doesn’t seem to be out there!

Enter the world of the Google search engine.
Search – dexmedetomidine.
Voila! Anything and everything you’d ever want to know about it.
Need more detail? Off to our library, where you can look up articles and print them out in full.
Boom. Everything you need, always up-to-date. Ah, the wonderful world of computers.

Websites?
Great stuff. Below is a sampling of the websites that can answer any and all questions on any and all issues. Use them, look around for other websites and let us know about the good ones. We’ll keep adding to the list.

Keywords:
http://anesthesia.slu.edu

Demonstrations of regional blocks:
http://www.nysora.com/

Website on respiratory physiology with practice questions:
http://www.acbrown.com/lung/index.htm
manbit.com has echo questions

ABA: www.abanes.org
www.acc.org
www.theanswerpage.com - excellent for Palm
www.mypatient.com
www.digiscript.com
www.avantgo.com
www.arcstream.com
www.unboundmedicine.com
www.ovid.com
www.bmj.com
www.manbit.com
www.boardprep.com
http://pacep.org
www.netce.com
www.blackboard.com
www.webct.com
www.e4hats.com
www.nysora.com
www.anesthesiologynline.com
www.businessandhealth.com

One of the best websites with associated links is
http://anesthesiology.yale.edu/

metrohealthanesthesia.com is a good web site, funny too!

There is a nice Anesthesia History website on http://www.medicalassistantschools.org/resources/pain.html

Latest ACC/AHA Guidelines for periop CV eval of non Cardiac Sx patients
http://www.acc.org/clinical/guidelines/perio/update/V_supplemental.htm

FDA Anesthesia Machine Pre-Use Checkout
http://vam.anest.ufl.edu/fdacheckout.html
U of F website with many useful links
http://www.anest.ufl.edu

UNC website with many useful links
http://www.unc.edu/~rvp/RP_Anesthesia/

Medical Calculator
http://www.intmed.mcw.edu/clincalc.html

Fluid Therapy
http://www.fluidtherapy.net/

PDF Files of all gov. pt. safety guidelines
http://www.ahrq.gov/clinic/ptsafety

GLOSSARY OF LAY TERMS FOR USE IN PREPARING CONSENT FORMS FOR HUMAN SUBJECTS
http://ovcr.ucdavis.edu/HumanSubjects/HSDefinitions/HSGlossary.htm

Latex Allergy
http://allergy.mcg.edu/physicians/ltxhome.html

National Guideline Clearinghouse
http://www.guideline.gov/

Nerve Blocks Tutorials
http://www.nerveblocks.net/
http://regionalabc.org/

Medline
http://www.nlm.nih.gov/

Trauma Scoring
http://www.trauma.org/scores/index.htm

Why be an Anesthesiologist?
Here’s a theoretical question to bat around.
“Could a truly ‘wired’ resident learn everything on the Internet?”
Well, um, maybe! Of course, the Internet cannot replace doing procedures (intubating, placing lines and spinals), but I’ll bet you could look up just about everything on line and never crack a book. What a concept!
Keep in mind the usual caveat about the Internet, of course. Who wrote this? Do they know their stuff? Was there any kind of peer review or is this just someone’s opinion? The Internet is still the Wild West of Information, so caveat emptor. (Caveat Netsurfor?)

And as final note, you can look at gasnet.com to look over the job market. On your darkest day, you can see jobs that pay way more than what your attendings are making, so you'll get the last laugh.

As long as we’re on the subject of learning, let’s answer the burning question – just what should I be studying, and how should I study?
It seems a bit much to tell you how to study. You did, after all, make it through Medical School, so presumably you know a thing or two about studying. I’ll toss out some ideas and if any seem good, snap them up.

1. **Study something.**
   That may seem kind of obvious, but the point is this - learning material is like exercise equipment, for it to work, you have to work. The rowing machine that sits in the corner is a GREAT piece of equipment, but if you don’t get on it, then you won’t get any fitter. The anesthesia handbook/handout/website/textbook may be great, but unless you study it, then it doesn’t do you much good.
From another direction, you could say, “It doesn’t matter much what you study, just as long as you study it well.”

2. **Study from several places.**
   - In talking with residents over the years, I get a lot of different responses to this question, “Which book helped you learn the most?” Some love Baby Miller, some hate it. Some swear by Morgan, some think it’s awful. Some read only textbooks, some concentrate on review books that have lots of questions and answers. Some go to websites, some don’t bother.
   - But the brightest residents all have one thing in common, they diversify their portfolio. Just like a good investor, they don’t put all their eggs in one basket. They study a little from this book and a little from that book. They look at teaching videos and teaching cassettes. They go over websites. They read *Anesthesiology* and *Anesthesia and Analgesia*.
   - The best residents sample it all.
   - That’s your best bet too.

3. **Formulate a tough question, then don’t go home until you’ve answered that question.**
   - When, exactly, is the blood pressure so high that you would cancel a case?
   - Can you use Sux when a patient has an open eye?
   - If I can’t get the central line in, what is my next best step?
   - If you go in each day with one good question, one real brain-buster, then by the end of residency you should be a damned genius.
   - Who should you give this question to? Your attending, of course! This question will give them something to do other than yell at you and drink coffee.

4. **Don’t take my word for it. Find the proof.**
   - In the good old days, humankind used to burn witches at the stake, torture heretics on the rack, and treat veneral disease with mercury. If you asked anyone back then, “What evidence do you have that what you are doing is right?”, you yourself might have ended up at the stake, on the rack, or getting mercury.
   - But we live in more enlightened times, or so we think.
   - When your attending says, “I always use this technique” or “I never give that”, go ahead and ask the question, “Why do you say that? Is there any evidence for that? Is there a paper that backs your stance?” We should be more scientific than folkloric in our practice of medicine, so look for the science.
   - Start accumulating your own library of articles.
   - Open eye, full stomach? Get an article on that.
   - Which blood pressure is too high? Get an article on that.
   - Can you do a spinal if a patient is receiving Plavix? Get an article on it.
   - The sooner you start applying science to your practice, the better.
Idea 6: Reflexes

Reflexes keep you out of trouble. A reflex pulls your hand out of the fire before you feel the pain. Your pupil constricts in sunlight to protect your retina. You will need to develop a few reflexes in anesthesia to keep you out of trouble.

A few situations will scare hell out of you the first time, and your brain is likely to freeze up. That’s why you need to drill these situations ahead of time so you can keep the patient safe until help arrives. Those spooky situations are:

- patient bucks
- saturation drops
- blood pressure drops.

These are by no means the only things that can go wrong, but they are the most common ones that you will face on your own at the beginning of your residency. So let’s develop reflexes for these.

Reflexes are automatic and simple, nothing super complicated. At first blush, these may seem so obvious as to be ridiculous, but trust me, people forget what to do when the pressure’s on, so you really need to drill this. (I hope to bring all of you into the Simulator so we can practice these reflex maneuvers a few times.)

PATIENT BUCKS
1. Take off ventilator.
2. Give IV bolus of sedative (eg Propofol)
3. Gently hand ventilate until patient calms down.
4. Deepen anesthetic.
5. Recheck vital signs.
6. Put back on ventilator.

SATURATION DROPS
1. Go to 100% oxygen.
2. Get your attending.
3. Hand ventilate.
4. Auscultate to make sure tube is in and in correct position.
5. Suction ETT.
6. Check pulse oximeter.

**BLOOD PRESSURE DROPS**
1. Get your attending.
2. Decrease or turn off potent anesthetics.
3. Increase fluids.
4. Give appropriate pressor.

There are a thousand and one reasons/exceptions/explanations/variants for these three conditions. And yes, different attendings have different takes on these. But for now, stick with simplicity. Have a simple reflex plan for taking care of problems before they happen. Realize that you will freeze up in a jam, so you have to resort to reflex to keep the patient safe until help arrives and you can sort out what’s happening.

Over the course of your residence, you will learn those thousand and one things. Use these reflexes for now, while you’re still new to this.
Thrilling Conclusion

That's it, sports fans. Six ideas for you to ponder - IV, common sense, game plan, attitude, common sense, cyber-learning, reflexes. Hope this helps organize your thoughts a little as you roll into Anesthesialand.

Let us know how we can help. Glad to have you on board.
7. Additional Resident Guide Contents

To familiarize you with all the different forms, evaluations, and paperwork, examples of all the important ones are included below. Some are pretty small here, but are easy to read on New Innovations and on the actual forms. They’re included just to acquaint you with them and so that you know what goes into the educational evaluations.

1. Medical Student Education and Evaluation.
3. Evaluation that the resident does of his/her attending.
4. Monthly evaluation done by the attending.
5. 6 month evaluation form
6. Learning and evaluation form.
7. Mentor form.
8. Professionalism as spelled out by the National Board of Medical Examiners.
9.
10. Journal Club Evaluation
12. Attendings’ preferred call-at-home times (currently unavailable).
16. Pre-induction form.

The two pages below are a daily debriefing form. They’re small here, but easy to read on New Innovations.
Below, left, is an evaluation form that you fill out about your attending. As noted before, this is small, but on New Innovations these are easy to read. Below, right, is an evaluation form that the attending fills out about you. The details about what is below, what meets, and what exceeds expectations is included in Section 2, which starts on page 65 of this booklet.
Below are the rest of the pages of the monthly evaluation form that the attending fills out about you.

### ATTITUDE KNOWLEDGE

1. **Medical Knowledge**
   - Meets expectations
   - Exceeds expectations
   - Inadequate

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved goals and objectives in a timely manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls for help or advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responded appropriately to critical events</td>
<td></td>
<td></td>
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</tbody>
</table>

### MEDICAL KNOWLEDGE

1. **Medical Knowledge**
   - Below expectations
   - Meets expectations
   - Exceeds expectations

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of medical principles related to patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough case study in patient chart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggests appropriate questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies knowledge and asks for help when needed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PERSONALITY AND COMMUNICATION SKILLS

1. **Medical Knowledge**
   - Below expectations
   - Meets expectations
   - Exceeds expectations

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies knowledge and asks for help when needed</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### PRACTICAL LEARNING & IMPROVEMENT

1. **Practical Learning and Improvement**
   - Below expectations
   - Meets expectations
   - Exceeds expectations

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies knowledge and asks for help when needed</td>
<td></td>
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</tbody>
</table>

### SKILLS

1. **Medical Knowledge**
   - Below expectations
   - Meets expectations
   - Exceeds expectations

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of medical principles related to patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3. Nurses, caregivers and ancillary personnel

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give for help when needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows respect for nurses and ancillary personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets along well with nurses and others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsive to communications needs for nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows up at all times for nursing shift</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Deals with OH distinctive to being pushed into the scene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does correlate situations put with out patient's needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Professionalism

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the right thing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ticks theكبلاع</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows respect for others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes appropriate amount of time for breakfast</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Arrives on time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is respectful of others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is well groomed and neat in appearance</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Below is a 6-month evaluation form. These are filled out every six months by the residency director.
Below is the rest of the six month evaluation form.
Below is a learning activity evaluation form. You will fill one of these out after a Simulation session, lecture, morning report, PBLD discussion or written/oral board review session.

<table>
<thead>
<tr>
<th>Learning Activity Evaluation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Name/Topic of learning activity:</td>
</tr>
<tr>
<td>Type of learning activity:</td>
</tr>
<tr>
<td>Morning Report</td>
</tr>
<tr>
<td>PBLD</td>
</tr>
<tr>
<td>Presenter(s):</td>
</tr>
<tr>
<td>Evaluator:</td>
</tr>
<tr>
<td>Strongly disagree</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

1. The educational objectives were available & clear. 1 2 3 4 5
2. The objectives were met, i.e. I learned what was intended. 1 2 3 4 5
3. The content was clear and organized. 1 2 3 4 5
4. Active resident involvement was encouraged. 1 2 3 4 5
5. The content was useful and applicable to my practice. 1 2 3 4 5
6. I was satisfied with this learning session. 1 2 3 4 5
7. Overall, I was satisfied with this learning session. 1 2 3 4 5

Suggestions for improvement of this learning activity:

Additional comments:
Below is a mentor report. This is filled out when you meet with your mentors.
Below is a list of the behaviors of professionalism as described by the National Board of Medical Examiners.

The Behaviors of

PROFESSIONALISM

Accepts constructive feedback and modifies behavior appropriately
Accepts personal risk in provision of health care
Adapts style and content of communication appropriately for each patient
Adheres to institutional policies and procedures
Adheres to local dress code
Admits errors and assumes personal responsibility for mistakes
Advocates for changes in policies, procedures, or practices for the benefit of patients
Advocates for colleagues
Advocates for societal health issues
Advocates for the individual patient
Allocates health care resources without bias
Appropriately incorporates patient’s values, customs, and beliefs into management plan
Arrives on time for scheduled activities and appointments
Attributes ideas and contributions appropriately to others
Avoids gifts and remunerations that might be perceived as conflicts of interest
Balances personal needs and patient care obligations
Breaks bad news with compassion and appropriate candor
Collaborates with patients/designated representatives in decision making
Completes assigned share of team responsibilities
Conveys information and answers questions honestly and tactfully
Demonstrates appropriate boundaries for interprofessional relationships

Demonstrates appropriate boundaries for patient relationships
Demonstrates sensitivity to power asymmetries in professional relationships
Discloses errors to patients when appropriate
Discusses colleagues without using inappropriate labels or comments
Discusses patients without using inappropriate labels or comments
Displays compassion and respect for all patients even under the most difficult circumstances
Elicits patient’s understanding to ensure accurate communication of information
Endures inconvenience to meet patient needs
Engages in informal teaching and learning activities with colleagues as appropriate
Facilitates conflict resolution
Fulfills all clinical responsibilities in a timely manner
Fulfills all nonclinical responsibilities in a timely manner
Improves team effectiveness through motivation and facilitation
Intervenes immediately when unprofessional behavior presents clear and present danger
Maintains a positive attitude amidst increased and unanticipated additional work
Maintains composure during difficult interactions with colleagues
Maintains composure during difficult interactions with patients
Maintains confidentiality of patient information in public areas
Maintains thoroughness and attention to detail

Makes valuable contributions during class, rounds, or meetings
Offers advice when appropriate
Optimizes patient comfort and privacy when conducting history, physical examination, and procedures
Provides constructive and supportive feedback appropriately
Provides patient care without consideration of personal benefit
Provides patient information to team members in a timely and effective manner
Reacts appropriately to other’s lapses in conduct and performance
Requests help when needed
Responds appropriately to a distressing or impaired colleague
Responds promptly when paged or called
Serves as knowledge or skill resource for others
Signs over and ensures coverage of patients when unable to fulfill responsibilities
Solicits and values input from colleagues when appropriate
Takes on extra work when appropriate for the benefit of the patient
Takes on extra work when appropriate to help the team
Takes steps to prevent repetition of errors
Teaches and emphasizes tenets of professionalism when appropriate opportunities arise
Transmits accurate and detailed information for optimal transition of care
Upholds ethical standards in research projects and other scholarly activities
Uses resources effectively to ensure optimal patient care
Teaching medical students will be part of your daily duties as an anesthesia resident. Since we are affiliated with a medical school, it will seem that there are students everywhere. We have a responsibility to teach them, but you will personally benefit from teaching students as well. Answering questions and explaining concepts truly reinforces one's own fund of knowledge. It also fulfills one of the competencies that requires resident teaching others.

We have approximately 150 medical students rotate with us per year in addition to ER residents, orthopedic surgery residents, ENT residents, dental residents, pedidental residents and dental students, and periodontal residents.

In addition to teaching, you will be responsible for evaluating the student's performance based on your interactions and returning the forms to the dept. The students also evaluate each resident that he or she works with. These evaluations are reviewed by Drs. Glass and Steinberg and become part of your file. There is an annual resident teaching award given by the dept and quarterly resident recognition teaching awards(§) as selected by the medical students.

**General Info:** 3rd and 4th year medical students spend 2-4 weeks with our department. Some students are on the 2 week mandatory rotation. Others are on the 2 or 4-week elective. Some elective students are applying for an anesthesia residency here or elsewhere and are very, very eager to be actively involved. All students should be encouraged to participate no matter what their career choice might be. There should be no bias to only teach students going into anesthesiology. All specialties of medicine need to know the basics of airway management and anesthesia. If a student is not interested in learning despite your efforts, then please indicate this on his or her evaluation form.
Rotation structure: Students are assigned to residents and rotate through the OR, OB, Acute Pain Service, Chronic Pain Center, Cardiac, and ICU. They report to you at 7:00 a.m. and leave at 3:00 p.m. or 4:00 p.m. to attend their daily lecture. Their daily assignments are done by a resident assigned to do so. Dr. Miss Jakesaki is the resident coordinator responsible for these assignments this year. The students are given an exam at the end of the rotation and must complete a case write-up.

Clinical Teaching: The anesthesia resident (under the attending supervision) is responsible for teaching and directing clinical procedures. All medical students are allowed to do ANY procedure. The rotation is a "HANDS-ON" rotation for students and they are expected to be actively participating in patient care. Airway management should be the focus. Procedures to involve students include mask ventilation, intubation, oral and nasal airway and IV insertion, IV, CVP, a-line, spinal and epidural placement.

How do you teach procedures? It can be stressful teaching others new procedures. Nobody wants their patients to have a blown IV, wet tap, epiglottic intubation or missing teeth. Avoiding student participation (unless clearly not appropriate) avoids complications. But that is not an effective teaching approach. You effectively teach others by first doing the procedures with them. This is done by having your hand on the laryngoscope (hold it superior to student's head), epidural needle (let the student tap the syringe for LOR and advance it one or twice), spinal needle (let the student do the prep, subcutaneous local after you do the skin wheal, advance the needle after you place introducer). The student can even glove up for a CVP placement and can probe with the finder needle with you. advance the wire as you hold it with them, and suture it in place. If your hands are next to or on top of the students hands, then you will avoid any "student complication".
Some attendings are more reluctant than others in having students perform procedures and do not know the students as well because they are supervising 2 ORs. However, if you are doing the procedures with the students, it often reassures the attending, so that the student can really participate and not just observe all day. You can probably remember having no fun as a student when you spent an entire day watching procedures being performed by others. Even in an unexpected difficult satiation case, the student could pre-oxygenate, mask ventilate, insert the oral airway and then give the airway to you for the intubation. Students can tape the eyes, insert the O2 tube, empty the Foley, place the second IV, SIS monitor, switch monitor...

**Didactic Teaching:** Students are expected to learn more than just procedures during the anesthesia rotation. They are given a didactic topic checklist to review topics with you during a slow part of the case. If you talk about what you are doing when you do it, then you will be actively teaching the student. Another way to teach is to ask questions. You can ask them about medical diseases and treatments, ACLS, physiology and pharmacology. You can ask them to interpret the EKG, echo, BNT or lab tests. Interactive teaching is the best way to teach others.

**Evaluations:** Students evaluate the residents with whom they have worked, and you evaluate the students. They will give you a form to complete. Under the comments section, please write additional comments that made the student unique. Samples include:
- "came in early and stayed late"
- "excellent hands"
- "asked excellent questions"

Comments such as "going into medicine" do not say anything about the student. You will also need to check off their grade from you. Reserve "Honors" for the top 15-20% of all students. Please return the completed form to the student in the attached envelope or to the locked box in the ER office or to Dr. Schabel's mailbox. These forms are very important. If they are not returned, then the student cannot receive a grade. This becomes a big problem for the Department.
Below is the last page of the student teaching guide.

**Contacts:** Dr. Misa Sakamaki is the Medical Student Resident Coordinator this year and is responsible for the daily student assignments. Trish DeMartino is the administrative assistant responsible for the students and Dr. Joy Schabel is the Director of Medical Student Education for the department. Please contact them with questions or concerns. Please contact Dr. Schabel if you have an interest in student teaching and want to get more involved in the student program.

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Below is the form used to evaluate the Medical Students you have worked with.
Below is the front side of the Grand Rounds evaluation form:

Please fill out and hand in at end of session:

OFFICE OF CONTINUING EDUCATION
STONY BROOK SCHOOL OF MEDICINE/HEALTH SCIENCES CENTER
STATE UNIVERSITY OF NEW YORK AT STONY BROOK

EVALUATION OF PROGRAM: Senior Grand Rounds
PROGRAM TITLE: Case Review & PIF Discussion
SPAKER NAME(s): Christopher Gallagher, MD
DATE: April 25, 2018
TIME: 7:30am-8:30am

[ ] Physician  [ ] Resident  [ ] Other/Specify

1. The program addresses problems I face in my practice
   [ ] Very Well  [ ] Adequately  [ ] Poorly

2. This program met its objectives
   [ ] Excellent  [ ] Very Good  [ ] Good  [ ] Fair  [ ] Poor  [ ] Not Applicable

3. The presentation was
   [ ] Excellent  [ ] Very Good  [ ] Good  [ ] Fair  [ ] Poor  [ ] Not Applicable

4. The discussion was
   [ ] Excellent  [ ] Very Good  [ ] Good  [ ] Fair  [ ] Poor  [ ] Not Applicable

5. The illustrative/audio visual materials were
   [ ] Excellent  [ ] Very Good  [ ] Good  [ ] Fair  [ ] Poor  [ ] Not Applicable

6. Presentation was free of commercial bias (if no, specify):
   a. [ ] YES
   b. [ ] NO  If commercial bias indicated by:
      □ Unbalanced view or therapeutic options
      □ Failure to use generic names
      □ Use of single brand name vs. several
      □ Illustrative material (e.g., audio-visual) reflects company product promotion
      □ Failure to disclose that product recommended for off-label use or still investigational
      □ Other/Specify

7. THIS PROGRAM (please check all that apply):
   [ ] Will alter my practice performance
   [ ] Won't alter my performance, but convinced me I'm doing the right thing
   [ ] Will be relevant to my practice
   [ ] Will not be relevant to my practice
   [ ] Will result in better patient outcomes
   [ ] Did not satisfy my expectation
   [ ] Satisfied my expectation

8. The content covered will improve my following competencies, check all that apply:
   □ Patient care
   □ Medical knowledge
   □ Practice-based learning and improvement
   □ Interpersonal communication skills
   □ Professionalism
   □ Systems-based practice

Please use the space on the reverse side for other comments and suggestions for future programs.

(turned over)
9. From what you heard today:
   a. On which aspects of this clinical problem do you need more information before you feel you can change your approach to the diagnosis or management of this clinical problem?

   b. Which practice strategies can we help you develop or expand regarding this clinical problem?

   c. Upon reflection, how often do you approach a patient in the manner described in this presentation? What can this CME program do to help you change your practice?

   d. Do your patients get the best possible outcomes from your treatment as described in the presentation? What can this CME program do to help you change your patients' outcomes?

10. Other comments and suggestions:

     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
     __________________________________________________________
Below is the form used to evaluate Journal Club.

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**Medical Literature Critique/Evaluation Form**

Please fill out and hand in at end of session

Office of Continuing Medical Education
SUNY Stony Brook School of Medicine/Health Sciences Center
State University of New York at Stony Brook
Evaluation of Journal Club
Speaker:
Date:

1. The presentation was free of commercial bias (If no specify):
   a. Yes
   b. No
   c. Commercial bias indicated by:
      - Unbalanced view of therapeutic options
      - Failure to use generic names
      - Use of single brand name vs. several
      - Illustrative material (audio-visual) reflects company promotion
      - Failure to disclose that product recommended for off label use or still investigational
      - Other:

2. Article title and journal?

3. The presentation was ______ Excellent ______ Very Good ______ Good ______ Fair ______ Poor

4. This program met its objective ______ very well ______ Adequately ______ Poorly

5. What is the justification for the study?

6. What is the null hypothesis? (the two test parameters assumed to be the same)

7. Methods?
   - Design type:
   - Design features

8. Sample?
   - Number of data points (n)
   - Inclusion criteria
   - Exclusion criteria

9. Treatment allocation?
   - Describe each treatment group and indicate number (n) for each

10. Statistics?
    - What statistical tests are used?
    - Are the statistics used appropriate for the data?
    - Is there a type I or II error? (Type I: rejection of the null hypothesis when it is in fact true. Type II: acceptance of the null hypothesis when it is in fact false. Type II error occurs when a study has inadequate power to detect a true difference between samples.)

11. Results?
    - Is the null hypothesis accepted or rejected?
    - Does the study answer the question asked?
    - How could the study be redesigned to better answer the question?
    - Were adverse effects of treatment, limitations to the study, and intentions of the trial discussed?

12. Conclusions?
    - Is the study biased?
    - Are the authors' conclusions supported by the study?
Below are the Pre-op phone call guidelines.

**Resident Preoperative Phone Call Guidelines**

**Preoperative Phone Call Guidelines:**

1. Present case and management plan explaining why you chose the plan you did
2. Discuss reasons/indications for invasive monitoring if applicable
3. Discuss important case events (positioning concerns, blood loss, acute stimulation,) and pertinent management plans
4. Choose a discussion topic for the next day with attg, read about the topic prior to OR, and be prepared to discuss with attg.
5. Check “Attending Preferred Pre-Op Call Times” list for best time to call attending
Below are the times attendings would prefer to be called regarding preops. All times are PM.

Information not available.
Below is an anesthetic record. When you fill it in, be sure and be legible.

Below is another part of the OR paperwork, the narcotic sheet. This too, must be carefully and legibly filled out.
Part of Systems-based medicine is the billing aspect of anesthetic care. Below is the billing form you fill out for each case and procedure.
Below is the Pre-induction form. This, too, must be filled out for each case.
The mission of the Residency Program at Stony Brook University is to train and educate an elite generation of anesthesiologists who in the course of their career will be successful partners in the effort to raise the quality of health care in our nation.

The Department of Anesthesiology therefore aims for the residents to receive, and benefit from, an educational experience that is provided by a faculty excelling in Patient Care, Teaching and Research. The guiding philosophy sees residency training in anesthesiology as a process where the educational needs of the residents in-training go hand in hand with patient service.

The end-product of anesthesia residency education is a superbly trained consultant in anesthesiology, able to provide the highest quality of care to patients who may present the most challenging clinical conditions.
This University Hospital and Medical Center at Stony Brook, an academic and regional medical center, has a mission to provide excellence in PATIENT CARE, EDUCATION, RESEARCH and COMMUNITY SERVICE. Our mission is achieved through commitment to the core values of Quality/Excellence, Integrity/Honesty, and Respect.
10. Rules of the Road

Six things the good resident does.
- Pre-ops
- Post-ops
- Read for the case the night before
- Set up appropriately
- Clean up after the case
- Be on time

Things to make you more than adequate
- Call the attending the night before
- Ask questions (“What would you like to talk about tomorrow?”)
- Timely breaks – 15 minutes for break, 30 for lunch
- Use your resources: Chief residents and attendings
- Arrive by 6:15 AM even if you’re not on the schedule (changes come up!)
- Let OR coordinator (47481) know where you are if you leave the floor.

Things that will make you less than adequate
- Complaining in the workroom
- Ignoring instructions
- Starting cases without an attending – Absolutely forbidden
- Not answering your pages
- Calling in sick when you’re tired
- Not returning favors to the “favor bank”
- Dumping on your fellow residents
- Making personal plans on a call night.
- Arriving late
- Not filling out your necessary paperwork
ABA requirements
   20 days per year of vacation
   5 sick days per year
Sick days are taken seriously
Wrong Site Surgery

11. Wrong Site Surgery, Patient Identification

From a letter by Ken Rosenfeld, Clinical Coordinator of the OR, regarding wrong site surgery and patient identification. This letter was dated July 1, 2007 and applies today.

All patients will be identified by name and date of birth prior to any invasive procedure, medical or blood administration or phlebotomy.

Prior to entry into the OR, all patients must have their surgical site marked with the patient’s initials by the attending surgeon. Immediately prior to the procedure, a time-out must occur. The time out is to include:

- The patient’s name and procedure as written on the consent form
- A discussion of the preoperative antibiotics that were given. If antibiotics were not given, this, too, must be mentioned.
- A check that all three signatures (surgeon, anesthesiologist, circulating nurse) are on the back of the consent form.
12. Resident Manual

A lot of this ties in with Section 6 – Learning the Ropes, but this stuff bears repeating, as it's the "essence" of what you’ll be doing every day!
Preoperative Evaluation

There are several categories of patients for the OR: Inpatients (floor or ICU), same day admissions, outpatients with extended recovery and outpatient anesthesia. Some of these patients have been seen in the Pre-op clinic. Many have not been seen prior to the day of surgery (their preops are kept in a box to the right of the main scheduling board.

The resident is expected to see each elective inpatient he/she is schedule to anesthetize the following day. Review the chart and prior records and perform a directed history and physical exam. REMEMBER, THE AIRWAY IS PARAMOUNT, SO DO A GOOD AIRWAY EXAM.

You and the attending will decide which labs/studies/consults are necessary. Gone are the days of ordering “everything on everybody”. Only get those studies that are indicated. (Knowing what to order is an entire art in itself. In particular, which preop cardiac study to order is undergoing constant revision.) An article in Anesth and Analg takes on this very topic and you might as well start looking it over now, since it will form the backbone of “ordering cardiac stuff”. A and A, Vol 106, No 3, March 2008 pp 685 ff. ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery: executive summary.

Here’s a good habit to get into early on – Once you’ve done your preop, read about what you’re going to do the next day. After you’ve done your preop, call your attending and discuss the plan for the next day. If you can’t talk with your attending the night before (say it’s an emergency), still take time to talk over your anesthetic plan with your attending before the case starts.

Document your preop evaluation.

This obligation to see preops applies to Sundays and holidays, as well as weekdays, since the preop evaluation and plan are your professional responsibility and the preop discussion is one of the prime educational opportunities. Faculty “prefer to be called by” times are listed in this booklet.

If the preop is done by someone else, the resident assigned to the case is still responsible for ensuring the information is complete and available prior to discussing the case with the faculty.

Sometimes, for extremely complicated patients, the surgeon may request an anesthetic consultation in advance. A resident will be assigned to the consultation and the same “talk it over with the attending” applies. Document the consultation in the record. An attending will need to sign this.

Keep in mind, the last thing you want to get is “surprised” the day of surgery, so make sure you scour that chart well and know everything about the patient. Here’s a few “surprises” that have crept in through the years:
“Oh, what's this trach scar doing here?”
“I see there’s an AV fistula here. Um, is there something about his kidney function you might want to tell me about?”
“This lump in the patient’s left upper chest looks like an AICD. Am I mistaken?”
Patient and Room Preparation

b. Patient and Room Preparation

You have to be ready to launch the case on time, and that means showing up early enough to have the room/patient ready to go. In a practical sense, this means showing up by 6:30 AM when you’re starting out. Minimal elements of preparation include:

- Patient is NPO and took morning meds
- Review the H and P, labs, special studies, and consults.
- Consent
- Appropriate meds available (drips in room, antibiotics)
- **Immediately prior to surgery, identify the patient, check allergy and NPO status, proposed operation, availability of blood products and any interval change in the patient’s health.**
- Be wary of “relying blindly on routine”, as things change (people forget NPO instructions and eat breakfast, “Oh yeah, I’m allergic to Latex”, asthma worsens since the preop visit, patients develop chest pain in the holding area)

Room Preparation

The resident must make sure the OR is ready. Minimal elements of “room prep” include:

- Complete check of anesthetic equipment, monitors, room temp (warm the room up until the patient is in the room and covered up, you lose a lot of temperature in a few minutes in a “meat locker” cold OR). A complete anesthesia machine check following FDA guidelines will be performed prior to the first case of the day. Dr Moller is our best “machine expert” so don’t be afraid to go over the complicated machine check with him.
- Meds, IV fluids, monitors, prepared and drawn up.
- Make special requests (fiberoptic, pressure monitors, double lumen tubes) to the anesthesia technicians the night before, if possible.
- Check with the OR staff (techs and nurses) prior to bringing the patient in the room. Getting along well with the staff is crucial and is part of the core clinical competency of Professionalism.
- If the patient is to have a block or other procedure prior to surgery, make arrangements with the Acute Pain service ahead of time.
• If a block is planned and the patient has any bleeding dyscrasia or is on anti-platelet drugs (and a lot of people are), make sure the Pain service knows.
c. Starting Times

You will NEVER regret showing up too early. You can always get ready then read a little. You will ALWAYS regret showing up late. The best way to make sure the room starts on time (once you graduate and are in the real world, “starting late” usually translates into “losing job”) is to get there early, get set up, and fix problems. Little things always come up, and showing up early will ALWAYS help you iron out these things.

- Patient is a hard stick and you have to do a central line.
- The room is a mess.
- You forgot to request the fiberoptic.
- The blood warmer in your room is missing.

If you show up early, you can fix all this stuff and still get going on time. If you show up late, you look like a maniac running around trying to play catch up. You look bad to the staff, your attending, and the patient.

Patients in critical condition for whatever reason should be transported to the OR by the resident. The attending must be notified before going into the OR. In case of doubt or you are concerned about patient safety, the attending will accompany you from the ICU to the OR. In case of doubt, ask!

Get all paperwork, setup, and other preparations done well ahead of time so induction goes smoothly. This allows for an educational experience during induction.
Turnover

d. Turnover

As the case before is winding down, make sure you’re preparing for the next case. As you do this, keep facing the patient (don’t turn your back on the patient you’re taking care of) so you can see if there’s any change.

By getting ready for the next case, you assure prompt turnover between cases. This is a key element of Systems-based practice, as turnover time is a major economic factor in the OR environment. Looking ahead to when you graduate and go “out there”, your ability to ensure rapid turnover is extremely significant.

A partial anesthesia machine check, as outlined in FDA guidelines, is acceptable if you are using the same machine without major modifications.

The resident will help however he/she can to facilitate rapid turnover.

Prior to bringing in the next patient, the resident will make sure all preparations are complete (drugs drawn up, monitors set, airway and special equipment ready to go.)
Intraoperative Care

e. Intraoperative Care

This is the essence of the core clinical competency of Patient Care.

• The resident will provide continuous care of the patient from the time they enter the operating room until the patient’s care is turned over to another physician or nurse anesthetist as described below.
• Never interrupt this care.
• No resident may interrupt care by engaging in telephone conversations, text messaging, surfing the net, reading, or other activities not directly related to the care of the patient at hand unless relieved by another anesthesia resident, nurse anesthetist or faculty.
• The resident is responsible for secure handling of all controlled substances issued to their care and careful documentation of their administration. Controlled substances issued by the pharmacy are not to leave the OR suite. No controlled substances, including residual drugs in used syringes, may be left unattended in the OR.
Postoperative – Transport

f. Postoperative – Transport

   Notify the place you’re going with a patient so they’ll know you’re coming. So, before you go to the AICU, call the AICU. Before you go to the ICU, call the ICU.

   If you care for a patient off-site (CT, MRI, Angio, ED, a planetarium [who knows nowadays, we do anesthesia all over the place]), and the case is finishing, let “where you’re going” know that you are coming. Most of the time, this will mean notifying the AICU that you are coming.

   Effective and timely communication with “the receiving area” is part of the core clinical competency of Interpersonal and Communication Skills. And this just makes sense, because if you “appear out of nowhere” in the AICU, they may not have adequate staff or space for you.

   Be sure and let them know if you need a ventilator, and give them vent settings.

   Let them know all the pertinent data about the patient – pt name, condition, procedure, lines, blood given, infusions running, airway situation, special needs. In other words, let THEM know what YOU would want to know if you were going to take over care of the patient.

   Residents will accompany transport of any patient from the OR after a general anesthetic, MAC, or neuraxial block. Transport the patient with mask and oxygen.

   Unstable patients, patients being transported to ICU’s or outside sites (most often CT scan after a neuro procedure) should have, as a minimum, non-invasive monitoring for transport. In addition, at least one other person should accompany the resident. Have airway equipment and resuscitative drugs with you during transport.

   Transport can be quite hazardous, so think before you move. If the patient is rocky or the airway is iffy, stay in the OR (you have all your equipment there) before you head into the hallway (where you only have what you brought with you).
Postoperative care

g. Postoperative care

Upon arrival at your destination, give a full report to the nurse or physician who will take over care of the patient. Until report is given, you are still responsible for the patient. Stable patients may be left under the direct supervision of an RN, but if anything looks amiss, stick around until things are stable. This is part of the core clinical competency of Professionalism. Report must be given directly to the receiving physician for all unstable patients and to all patients sent to the ICU. So, for example, if you drop off a patient on a ventilator in the AICU or the ICU, make sure a physician gets report. The resident is responsible for making sure the patient gets adequate pain meds in the immediate postop period. Notify the Acute Pain service if appropriate (say, you have an epidural in).
h. Postoperative visit

The resident will see the patient within 48 hours of surgery to evaluate the condition of the patient and to ascertain any persistent anesthetic problems or complications.

Following up on anesthetic complications is part of Professionalism, and documenting these is part of Systems-based Practice. As you can see, the Core Clinical Competencies are part of everything we do every day.

Write a note, making special care to document fully any anesthetic related complications. Notify the faculty of any complications.

This is a good time to address the importance of “documentation after a complication”. Your notes are your ONLY DEFENSE if a medicolegal complication should arise. The single most common issue that comes up is “What was the doctor thinking?” and “This happened, did the doctor care?” So write extensive notes, being sure to explain exactly what happened, exactly what you were thinking, and how you followed up. Don’t imagine you can “sweep this under the rug” or ignore it. Document, document, and document again.
Resident on-call expectations

i. Resident on-call expectations

Residents will take a maximum of 7 calls per month. ACGME states a maximum of 1 call in 3 nights). If a resident is getting near the limit on total hours or on calls, he/she is to contact the Residency Director immediately as the Department has a zero tolerance for any duty hour or duty day violations.

Call responsibilities start at 17:00 during weekdays and 07:00 on weekends and holidays. Call ends at 07:00 the next day. Clinical call responsibilities are determined by the call faculty and include:

- Intraop care of patients
- Preop assessment
- Postop care and AICU coverage
- Pain consults and patient care
- Trauma room and code box setup
- Airway emergencies and codes

All add-on procedures added past 17:00 must be seen by a resident. Report to the on call attending with any issues. You will function as part of a team consisting of physicians and CRNA’s. Professionalism (a core clinical competency) is expected at all times. If disagreements arise, contact the call attending.
j. Post-call

Post-call residents are expected to attend Grand Rounds the morning after call. For all conferences, it is the coordinator's duty to assure all residents attend, since the department stresses resident education over service commitments.
All call residents will attempt to equitably distribute the workload in keeping with the skills and experience of the residents on the team.
The senior resident will assume an organizational role for resident activities. Being able to organize the team is part of the core clinical competency of Systems-based medicine.
**Pre-operative phone call**

**k. Pre-operative phone call**

Call your attending the night before the case, and have a brief, focused presentation ready. And don't ever forget to mention THE AIRWAY!

Here's a little cheat sheet for organizing your phone call:

- Procedure, room, time, surgeon.
- AIRWAY EXAM
  - Patient's age, height, weight and diagnosis
  - EXPLANATION OF POSSIBLE AIRWAY PROBLEMS
  - Physical Exam including airway
  - Your anesthetic plan (General, regional, MAC, nerve block)
- Describe your plans from holding area to induction to maintenance to special lines to emergence and postop care.
- Ask for a teaching plan. “Tomorrow, let's talk about awake intubations” or “I'll read about the machine tonight, can we talk about that tomorrow?”
- Part of Systems-based medicine is making sure you keep adding to your knowledge base, so make sure you always have a “what I'm going to learn tomorrow” in your anesthetic plan. You are adult learners now, and you have to “take charge” of your education.
Anesthesia Resident Rotations


AC – Advanced Clinical
AICU – Anesthesia Intensive Care Unit (known as the PACU in days of yore, and called the Recovery Room back when dinosaurs roamed the earth)
AMB – Ambulatory Surgery Center
AMB-P – Ambulatory Surgery Center, Pediatrics
AP – Acute Pain
G – General
GU/GY – Gynecology/Urology
H – Cardiac Anesthesia (the H stands for heart, not “this is a hard rotation”)
N/E – Neurology/ENT
NICU – Neonatal Intensive Care Unit
OB – Obstetrical Anesthesia. If the epidural doesn’t work, put a knife under the bed. According to legend, that “cuts the pain in half”.
OR/PL – Ortho/Plastics
PAT – Pre-admission Testing
PC – Pain Center
PICU – Pediatric Intensive Care Unit
SICU – Surgical Intensive Care Unit
VA – Veteran’s Hospital in Northport
VASC – Vascular Anesthesia (more accurately rendered avascular anesthesia, we try to provide vasculature)
19. Department Policies
   a. Resident vacation
   b. Patient evaluations and rounds
   c. Drug return procedure
   d. Chemical dependency and substance abuse among anesthesiologists
   e. Professional medical conduct policy for impaired physicians
   f. Dress code
   g. Personal religious beliefs and ethics
   h. Miscellaneous requests
   i. Sick call
   j. Call requests
   k. Anesthesia library
Resident vacation

The following applies to resident vacations.

1. No more than three residents will be allowed on vacation on any given day. Of these three, one may be from the VA and no more than two from the University Hospital.
2. Terminal vacation (vacation in the final weeks of June, 2009) will not be routinely allowed. Such vacation is at the discretion of the Chairman, the Clinical Coordinator and the Residency Director.
3. No resident vacation will be allowed in July or August, unless authorized by the Chairman, the Clinical Director and the Residency Director.
4. Residents will be asked to make vacation requests for the upcoming academic year in April of the prior year, eg April 2009 for the 2009-10 academic year. Residents are encouraged to minimize requests for one week vacation blocks, as this creates difficulties in making month long block assignments. Residents should indicate priority of requests. All attempts will be made to honor requests, but senior residents have priority.
5. In accordance with ABA requirements, residents are allowed a maximum of 20 work days off, on average, per academic year. Residents exceeding the allowable time may be asked to extend their residencies in order to make up this time.
6. The following is the vacation policy:
   - PGY-1 – 4 weeks
   - CA-1 – 3 weeks
   - CA-2 – 4 weeks
   - CA-3 – 5 weeks
   - The additional CA-3 week is to be used for interviews and/or Board Review Classes and should be left open (unscheduled) at this time.
Patient Evaluations and Rounds

It is the policy of the Department of Anesthesiology that each patient admitted to University Hospital and the Veterans' Administration Hospital for elective surgery be evaluated preoperatively by an attending anesthesiologist and/or a resident. This evaluation may be performed jointly or separately. For in-house patients, the resident must see the patient the evening before. For ambulatory or same-day admits, the patient’s chart must be reviewed by the resident the evening prior to surgery and discussed with the attending anesthesiologist the night prior to surgery. There is to be documentation of the pre-anesthetic evaluation by individual and separate notes from attending and resident anesthesiologist.

Postoperatively, an attending anesthesiologist and a resident again evaluate the patient. Also, individual notes from attending and/or resident anesthesiologist document the post-anesthetic visit. The resident providing anesthesia must do a postoperative note for in-patients within 24 hours of surgery.

In situations of emergency surgery, attempts will be made to have a timely preoperative visit by both resident and attending. In any case, separate preanesthetic notes are to be written by attending and resident anesthesiologist.
## Drug return procedure

**Drug Return Procedure**

1. All controlled drugs are to be returned to the Pharmacy (not to be wasted with a witness).
2. The controlled drugs will be signed out prior to each case by the anesthesiologist using the Controlled Drug Triplicate Sheet.
3. At the end of the case, all unused, drawn medications will be returned to the Pharmacist in a capped-off syringe (no needles) in the designated plastic bag with the pink narcotic control form.
4. The yellow narcotic control form is returned separately with the anesthesia recored (white) with the signed-out kit and any unused, unopened drugs.
5. All returns will be witnessed by a second LIP to confirm volume of the return.
Chemical dependency and substance abuse among anesthesiologists

Prevalance – 1-2% of resident and attending anesthesiologists

Disease Concept of Drug Addiction – Substance abuse is a complex disease, with genetic and environmental components. Our understanding of this disease is incomplete, and treatment is prolonged and difficult, with relapses a common feature. Early recognition and intervention are keys to keeping practitioners safe from this sometimes deadly disease. No practitioner should ever hesitate to "reach out for help" either for him/herself or for another practitioner.

Causes and special concerns for anesthesiologists
- High stress environment
- Ready availability
- High addiction potential
- Experimentation and the mistaken concept that “I can control this”

Abused drugs
- Fentanyl/sufentanil
- Meperidine
- Morphine
- Oral agents
- Inhaled agents
- Propofol is starting to join the ranks of abused drugs

Detection of Addiction (can be extremely difficult, as patients suffering from this may "hide" their habit)
- Early – Increasing isolation and withdrawal
- Domestic problems – fights, arguments, sexual dysfunction
- Unexplained illnesses, personality changes
- Late –
  - Sloppy, illegible record keeping
  - Signing out increasing amount of drugs
Charting inappropriate doses, patients c/o pain in spite of “plenty of narcs”
Prefer to work alone, refuse breaks, frequently break others
Volunteer for extra call and particularly night calls
In hospital when not on duty
Request frequent bathroom breaks (to take drugs)
Nap between cases (after using drugs)
Wants to personally administer drugs in AICU
Wears long sleeve gowns (hide needle tracks plus feeling cold)
Pinpoint pupils
Diaphoresis and tremors
Weight loss and pale skin
Found comatose
And, unfortunately, the most tragic “first sign”? Found dead.

Intervention
Carefully planned group meeting to confront addict with evidence of addiction.

Denial is common

Treatment
  2-4 months, sometimes more. Often starts out inpatient. Can be done outpatient with extremely close monitoring.

Aftercare
  Abstinence. A substance abuser is never “cured of fentanyl addiction”, for example. They are always addicted to fentanyl and will never be able to “try just a little”.
  Self-help meetings.
  Close monitoring, with follow up urine samples at random times
  Monitoring the physician.

Back to Work Contract
  No night/weekend call for 3 months
  No narcotics for 3 months
  Naltrexone for 6 months (this is controversial)
  Random testing of returned syringes

Prognosis
  Variable, no reliable data.
  High relapse rate for fentanyl

IN CASE OF DOUBT, CONTACT THE CHAIRMAN, CLINICAL DIRECTOR, RESIDENCY DIRECTOR, CHIEF RESIDENT, OR ANY ATTENDING. CONTACT SOMEONE.
1. It is the policy of the Department of Anesthesiology that the PROFESSIONAL MEDICAL CONDUCT of all staff members shall adhere to the provisions of the Public Health Law (Title II-A, Section 230), the Education Law (Title 8, Article 130, paragraph 6509), and the regulations of the Department of Health, all of the state of New York.

2. Members of the medical profession are under legal obligation to report any incidence, or even a suspicion, of drug or alcohol abuse. In fact, the law states that a physician who in good faith submits an erroneous report will be held harmless.

3. In practical terms, any staff member who harbors a suspicion of drug or alcohol abuse or mentally aberrant behavior must make a confidential report to a departmental chairman, who serves as the departmental Control Officer for this purpose, at the earliest possible moment.

4. The chairman will see to it that proper notification to the Governing Body of the institution is made, and that the institution carries out its responsibilities in terms of notification of the health Department of the State of New York. The chairman will also see to it that the rights and privileges of the individual remain protected and, furthermore, that the services of a qualified psychiatrist/psychologist and the New York State Society of Medicine Program for Impaired Physicians will be made available to the individual.

5. The Chemical Dependence Guidelines for the Department of Anesthesiology, published by the American Society of Anesthesiologists will be applied in so far as they are not already covered by the legal statutes of the State of New York.

6. As stipulated in the ASA guidelines, the departmental chairman shall act as the confidential resource person on chemical dependence.

7. This policy supersedes the departmental policy of April 1, 1991, and complements the policy recently issued by the Office of the President of the University.

8. All incoming residents, their spouses or significant others, are required to attend a dinner and discussion with a senior faculty...
member reviewing the video “Wearing Masks”. All new residents receive a copy of the “Wearing Masks” video.
Dress Code Policy

Anesthesiologists see themselves as highly trained specialists and professionals. It is important that our colleagues see us in the same light and absolutely essential that our patients perceive us as such. Their fears for life and limb must be relieved to the extent that they place their fullest confidence in their assigned anesthesiologist.

This requires, at a minimum, a highly professional approach and relationship. In appropriate dress can vitiate our best efforts. Hence the need for a dress code.

Therefore it is the policy of the Department of Anesthesiology that in the visits to and interactions with patients, the attending and resident staff be dressed properly. For males this means a business shirt, necktie, appropriate trousers and shoes, and the wearing of a jacket or white coat. For females, the wearing of a dress or a blouse and skirt with appropriate shoe wear is suggested.

Under given conditions it may be necessary to make a preanesthetic and postanesthetic visit when wearing green scrubs. This is certainly allowed, provided one wears a clean white coat or yellow gown on top. However, the wearing of surgical head covering and booties is never allowed outside the OR. Infection Control demands that we adhere to these standards.
Personal Religious Beliefs and Ethics Policy

It is the policy of the Department of Anesthesiology to respect religious beliefs and ethical considerations of all patients. This respect goes so far as to warmly welcome the challenges that may be presented to our staff by the considerations and beliefs held by our patients.

It is also the policy of the Department of Anesthesiology fully to respect and support the religious beliefs and ethical convictions of its staff and to accord equal value to the beliefs, ethics, and convictions of patients and physicians. The physician staff of the Department of Anesthesiology are not required entirely to sacrifice and subjugate their own clinical and moral standards to those maintained by and respected in our patients.
Miscellaneous requests

Requests for days off to attend board review classes, take exams, or go to job interviews should be made as far in advance as possible – preferably prior to completion of the monthly call schedule. These requests must be made in writing to Dr Gallagher, Dr Rosenfeld, and the chief Residents, and should be submitted to Ms Claeson, who will keep track of the days. Verbal approval by one of the above parties is not acceptable.

Please keep in mind that time off for these activities is part of your allotted vacation time. For the CA-3’s, this should be the “5th week” of vacation.

Special situations should be discussed in person with Dr Gallagher.
Sick Call

When a resident is sick, he/she must call the attending in charge of that particular rotation prior to 7 AM. Furthermore, the sick call must also be called to Ms Claeson so she may keep track of sick days.

Any sickness greater than 3 days requires a doctor’ note. The Anesthesia Department reserves the right to extend the time of residency if excessive sick call is deemed to have violated ABA guidelines for total days absent.
Call requests

Call Requests

All residents must submit their call requests to the Chiefs prior to the 15th of the preceding month, for example, prior to July 15 for August. Requests should be limited to one weekend request and one weekday request. Requests submitted after the 15th may not be honored.

Residents who have a 2 week or greater vacation block will be given call the Thursday preceding their vacation. Residents who have a 1 week vacation block will not be guaranteed Thursday night call prior to their vacation.
Anesthesia library

Anesthesia Library

Serious losses of books and journals require considerable monetary outlays to keep the anesthesia library adequately stocked. These losses have hampered the function of our library.

The library is a reference library, no material whatsoever may be borrowed from the library.
21. Anesthesia Machine Introduction

Learning how to check out the machine by reading about it and not actually doing the checkout is like reading about tennis and never picking up a racquet.

The only way to learn about the anesthesia machine is to walk up to it and check the thing out yourself. Here’s a little guidance. Do yourself a favor and keep this sheet with you the first time you do the checkout. The ASA website has this if you just want to print out the guidelines and have them with you.

Recommendations for Pre-Anesthesia Checkout Procedures (2008)

Sub-Committee of ASA Committee on Equipment and Facilities
Task Force Members*
Russell C. Brockwell, MD
Jerry Dorsch, MD
Susan Dorsch, MD
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Jeffrey Feldman, MD (Task Force Chair)
Julian Goldman, MD
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Tom C. Krejcie, MD
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Donald Martin, MD (Chair, ASA Committee on Eqpt. & Facilities)
Julie Mills (GE Healthcare)
Michael A. Olympio, MD
Gerardo Trejo (ASATT)

Contributors (Individuals who have contributed in some fashion in the process of developing the new checkout guidelines)
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Chad Driscoll, CRNA, MHS
Ann Graham (FDA)
Guidelines for Pre-Anesthesia Checkout Procedures

Background

Improperly checking anesthesia equipment prior to use can lead to patient injury and has also been associated with an increased risk of severe postoperative morbidity and mortality. In 1993 a pre-anesthesia checkout (PAC) was developed and widely accepted to be an important step in the process of preparing to deliver anesthesia care. Despite the accepted importance of the PAC, available evidence suggests that the current version is neither well understood nor reliably utilized by anesthesia providers. Furthermore, anesthesia delivery systems have evolved to the point that one checkout procedure is not applicable to all anesthesia delivery systems currently on the market. For these reasons, a new approach to the PAC has been developed. The goal was to provide guidelines applicable to all anesthesia delivery systems so that individual departments can develop a PAC that can be performed consistently and expeditiously.

General Considerations

The following document is intended to serve not as a PAC itself, but rather as a template for developing checkout procedures that are appropriate for each individual anesthesia machine design and practice setting. When using this template to develop a checkout procedure for systems that incorporate automated checkout features, items that are not evaluated by the automated checkout need to be identified, and supplemental manual checkout procedures included as needed. Simply because an automated checkout procedure exists does not mean it can completely replace a manual checkout procedure or that it can be performed safely without adequate training and a thorough understanding of what the automated checkout accomplishes. An automated checkout procedure can be incomplete and/or misleading. For example, the leak test performed by some current automated checkouts does not test for leaks at the vaporizers. As a result, a loose vaporizer filler cap, or a leak at the vaporizer mount, could easily be missed. Ideally automated checkout procedure should clearly reveal to the user the functions that are being checked, any deficient function that is found and recommendations to correct the problem. Documentation of the automated checkout process should preferably be in a manner that can be recorded on the anesthesia record. Operator’s manuals, which accompany anesthesia delivery systems, include extensive recommendations for equipment checkout. While these recommendations are quite extensive and typically not utilized by anesthesia providers, they are nevertheless important references for developing machine-specific and institution-specific checkout procedures.

Personnel performing the PAC

The previously accepted Anesthesia Apparatus Checkout Recommendation placed all of the responsibility for pre-use checkout on the anesthesia provider. This guideline identifies those aspects of the PAC that could be completed by a qualified anesthesia and/or biomedical technician. Utilizing technicians to perform some aspects of the PAC may improve compliance with the PAC. Steps completed by a technician may be part of the morning pre-use check or part of a procedure performed at the end of each...
Critical checkout steps (e.g., availability of backup ventilation equipment) will benefit from intentional redundancy (i.e., having more than one individual responsible for checking the equipment). Regardless of the level of training and support by technicians, the anesthesia care provider is ultimately responsible for proper function of all equipment used to provide anesthesia care.

Adaptation of the PAC to local needs, assignment of responsibility for the checkout procedures, and training are the responsibilities of the individual anesthesia department. Training procedures should be documented. Proper documentation should include records of completed coursework (e.g., a manufacturer course) or for in-house training, a listing of the competency items taught and records of successful completion by trainees.

Objectives for a new PAC

Outline the essential items that need to be available and functioning properly prior to delivering every anesthetic. Identify the frequency with which each of the items needs to be checked. Suggest which items may be checked by a qualified anesthesia technician, biomedical technician or a manufacturer-certified service technician.

Basic Principles

The anesthesia care provider is ultimately responsible for ensuring that the anesthesia equipment is safe and ready for use. This responsibility includes adequate familiarity with the equipment, following relevant local policies for performing and documenting the PAC and being knowledgeable about those procedures.

Depending upon the staffing resources in a particular institution, anesthesia technicians and/or biomedical technicians can participate in the PAC. Biomedical technicians are often trained and certified by manufacturers to perform on-site maintenance of anesthesia delivery systems and therefore can be a useful resource for completing regular checkout procedures. Anesthesia technicians are not commonly trained to perform checkout procedures. Involving the anesthesia technicians is intended to enhance compliance with the PAC. Each department should decide whether or not the available technicians can or should be trained to assist with checkout procedures. Formal certification of anesthesia technicians by the American Society of Anesthesia Technicians and Technologists (ASATT) is encouraged but does not necessarily guarantee familiarity with checkout procedures.

• Critical items will benefit from redundant checks to avoid errors and omissions.

• When more than one person is responsible for checking an item, all parties should perform the check if intentional redundancy is deemed important, or either party may be acceptable, depending upon the available resources.

• Whoever conducts the PAC should provide documentation of successful performance. The anesthesia provider should include this documentation on the patient chart.

• Whenever an anesthesia machine is moved to a new location, a complete beginning-of-the-day checkout should be performed.
• Automated checks should clearly distinguish the components of the delivery system that are checked automatically from those which require manual checkout.

• Ideally, the date, time, and outcome of the most recent check(s) should be recorded and the information made accessible to the user.

• Specific procedures for pre-use checkout cannot be prescribed in this document since they vary with the delivery systems. Clinicians must learn how to effectively perform the necessary pre-use check for each piece of equipment they use.

• Each department or healthcare facility should work with the manufacturer(s) of their equipment to develop pre-use checkout procedures that satisfy both the following guidelines and the needs of the local department.

• Default settings for ventilators, monitors and alarms should be checked to determine if they are appropriate

• These checkout recommendations are intended to replace the pre-existing FDA-approved Anesthesia Apparatus Checkout Recommendations. They are not intended to be a replacement for required preventive maintenance.

• The PAC is essential to safe care but should not delay initiating care if the patient needs are so urgent that time taken to complete the PAC could worsen the patient’s outcome.

### Item #1: Verify Auxiliary Oxygen Cylinder and Self-inflating Manual Ventilation Device are Available & Functioning

**Frequency:** Daily.

**Responsible Parties:** Provider and technician.

**Rationale:** Failure to be able to ventilate is a major cause of morbidity and mortality related to anesthesia care. Because equipment failure with resulting inability to ventilate the patient can occur at any time, a self-inflating manual ventilation device (eg. AMBU bag) should be present at every anesthetizing location for every case and should be checked for proper function. In addition, a source of oxygen separate from the anesthesia machine and pipeline supply, specifically an oxygen cylinder with regulator and a means to open the cylinder valve, should be immediately available and checked. After checking the cylinder pressure, it is recommended that the main cylinder valve be closed to avoid inadvertent emptying of the cylinder through a leaky or open regulator.

### Item #2: Verify patient suction is adequate to clear the airway

**Frequency:** Prior to each use.

**Responsible Parties:** Provider and technician.
**Rationale:** Safe anesthetic care requires the immediate availability of suction to clear the airway if needed.

**Item #3: Turn on anesthesia delivery system and confirm that AC power is available.**

**Frequency:** Daily

**Responsible Parties:** Provider or Technician

**Rationale:** Anesthesia delivery systems typically function with backup battery power if AC power fails. Unless the presence of AC power is confirmed, the first obvious sign of power failure can be a complete system shutdown when the batteries can no longer power the system. Many anesthesia delivery systems have visual indicators of the power source showing the presence of both AC and battery power. These indicators should be checked and connection of the power cord to a functional AC power source should be confirmed. Desflurane vaporizers require electrical power and recommendations for checking power to these vaporizers should also be followed.

**Item #4: Verify availability of required monitors and check alarms.**

**Frequency:** Prior to each use.

**Responsible Parties:** Provider or technician.

**Rationale:** Standards for patient monitoring during anesthesia are clearly defined. (7,8) The ability to conform to these standards should be confirmed for every anesthetic. The first step is to visually verify that the appropriate monitoring supplies (BP cuffs, oximetry probes, etc.) are available. All monitors should be turned on and proper completion of power-up self tests confirmed. Given the importance of pulse oximetry and capnography to patient safety, verifying proper function of these devices before anesthetizing the patient is essential. Capnometer function can be verified by exhaling through the breathing circuit or gas sensor to generate a capnogram, or verifying that the patient's breathing efforts generate a capnogram before the patient is anesthetized. Visual and audible alarm signals should be generated when this is discontinued. Pulse oximeter function, including an audible alarm, can be verified by placing the sensor on a finger and observing for a proper recording. The pulse oximeter alarm can be tested by introducing motion artifact or removing the sensor.

Audible alarms have also been reconfirmed as essential to patient safety by ASA, AANA, APSF and JCAHO. Proper monitor functioning includes visual and audible alarm signals that function as designed.

**Item #4: Verify availability of required monitors and check alarms.**

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**Rationale**: Standards for patient monitoring during anesthesia are clearly defined. (7,8) The ability to conform to these standards should be confirmed for every anesthetic. The first step is to visually verify that the appropriate monitoring supplies (BP cuffs, oximetry probes, etc.) are available. All monitors should be turned on and proper completion of power-up self tests confirmed. Given the importance of pulse oximetry and capnography to patient safety, verifying proper function of these devices before anesthetizing the patient is essential. Capnometer function can be verified by exhaling through the breathing circuit or gas sensor to generate a capnogram, or verifying that the patient’s breathing efforts generate a capnogram before the patient is anesthetized. Visual and audible alarm signals should be generated when this is discontinued. Pulse oximeter function, including an audible alarm, can be verified by placing the sensor on a finger and observing for a proper recording. The pulse oximeter alarm can be tested by introducing motion artifact or removing the sensor. Audible alarms have also been reconfirmed as essential to patient safety by ASA, AANA, APSF and JCAHO.i Proper monitor functioning includes visual and audible alarm signals that function as designed.

**Item #5: Verify that pressure is adequate on the spare oxygen cylinder mounted on the anesthesia machine.**

**Frequency**: Daily

**Responsible Parties**: Provider and technician

**Rationale**: Anesthesia delivery systems rely on a supply of oxygen for various machine functions. At a minimum, the oxygen supply is used to provide oxygen to the patient. Pneumatically-powered ventilators also rely on a gas supply. Oxygen cylinder(s) should be mounted on the anesthesia delivery system and determined to have an acceptable minimum pressure. The acceptable pressure depends on the intended use, the design of the anesthesia delivery system and the availability of piped oxygen. Typically, an oxygen cylinder will be used if the central oxygen supply fails.

If the cylinder is intended to be the primary source of oxygen (e.g. remote site anesthesia), then a cylinder supply sufficient to last for the entire anesthetic is required. If a pneumatically-powered ventilator that uses oxygen as its driving gas will be used, a full “E” oxygen cylinder may provide only 30 minutes of oxygen. In that case, the maximum duration of oxygen supply can be obtained from an oxygen cylinder if it is used only to provide fresh gas to the patient in conjunction with manual or spontaneous ventilation. Mechanical ventilators will consume the oxygen supply if pneumatically powered ventilators that require oxygen to power the ventilator are used Electrically-powered ventilators do not consume oxygen so that the duration of a cylinder supply will depend only on total fresh gas flow.

The oxygen cylinder valve should be closed after it has been verified that adequate pressure is present, unless the cylinder is to be the primary source of oxygen (i.e. piped oxygen is not available). If the valve remains open and the pipeline supply should fail, the oxygen cylinder can become depleted while the anesthesia provider is unaware of the oxygen supply problem.

Other gas supply cylinders (e.g. Heliox, CO2, Air, N2O) need to be checked only if that gas is required to provide anesthetic care.
Item #6: Verify that piped gas pressures are ≥ 50 psig.

**Frequency:** Daily

**Responsible Parties:** Provider and technician

**Rationale:** A minimum gas supply pressure is required for proper function of the anesthesia delivery system. Gas supplied from a central source can fail for a variety of reasons. Therefore the pressure in the piped gas supply should be checked at least once daily.

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Item #7: Verify that vaporizers are adequately filled and, if applicable, that the filler ports are tightly closed.

**Frequency:** Prior to each use.

**Responsible Parties:** Provider. Technician if redundancy desired.

**Rationale:** If anesthetic vapor delivery is planned, an adequate supply is essential to reduce the risk of light anesthesia or recall. This is especially true if an anesthetic agent monitor with a low agent alarm is not being used. Partially open filler ports are a common cause of leaks that may not be detected if the vaporizer control dial is not open when a leak test is performed. This leak source can be minimized by tightly closing filler ports. Newer vaporizer designs have filling systems that automatically close the filler port when filling is completed. High and low anesthetic agent alarms are useful to help prevent over- or under-dosage of anesthetic vapor. Use of these alarms is encouraged and they should be set to the appropriate limits and enabled.

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Item #8: Verify that there are no leaks in the gas supply lines between the flowmeters and the common gas outlet.

**Frequency:** Daily and whenever a vaporizer is changed.

**Responsible Parties:** Provider or technician.

**Rationale:** The gas supply in this part of the anesthesia delivery system passes through the anesthetic vaporizer(s) on most anesthesia delivery systems. In order to perform a thorough leak test, each vaporizer must be turned on individually to check for leaks at the vaporizer mount(s) or inside the vaporizer. Furthermore, some machines have a check valve between the flowmeters and the common gas outlet, requiring a negative pressure test to adequately check for leaks. Automated checkout procedures typically include a leak test but may not evaluate leaks at the vaporizer especially if the vaporizer is not turned on during the leak test. When relying upon automated testing to evaluate the system for leaks, the automated leak test would need to be repeated for each vaporizer in place. This test should also be completed whenever a vaporizer is changed. The risk of a leak at the vaporizer depends upon the vaporizer design. Vaporizer designs where the filler port closes automatically after filling can reduce the risk of leaks. Technicians can provide useful assistance with this aspect of the machine checkout since it can be time consuming.
Item #9: Test scavenging system function.

Frequency: Daily

Responsible Parties: Provider or Technician

Rationale: A properly functioning scavenging system prevents room contamination by anesthetic gases. Proper function depends upon correct connections between the scavenging system and the anesthesia delivery system. These connections should be checked daily by a provider or technician. Depending upon the scavenging system design, proper function may also require that the vacuum level is adequate which should also be confirmed daily. Some scavenging systems have mechanical positive and negative pressure relief valves. Positive and negative pressure relief is important to protect the patient circuit from pressure fluctuations related to the scavenging system. Proper checkout of the scavenging system should ensure that positive and negative pressure relief is functioning properly. Due to the complexity of checking for effective positive and negative pressure relief, and the variations in scavenging system design, a properly trained technician can facilitate this aspect of the checkout process.

Item #10: Calibrate, or verify calibration of, the oxygen monitor and check the low oxygen alarm.

Frequency: Daily

Responsible Parties: Provider or Technician.

Rationale: Continuous monitoring of the inspired oxygen concentration is the last line of defense against delivering hypoxic gas concentrations to the patient. The oxygen monitor is essential for detecting adulteration of the oxygen supply. Most oxygen monitors require calibration once daily, although some are self-calibrating. For self-calibrating oxygen monitors, they should be verified to read 21% when sampling room air. This is a step that is easily completed by a trained technician. When more than one oxygen monitor is present, the primary sensor which will be relied upon for oxygen monitoring should be checked. The low oxygen concentration alarm should also be checked at this time by setting the alarm above the measured oxygen concentration and confirming that an audible alarm signal is generated.

Item #11: Verify carbon dioxide absorbent is not exhausted.

Frequency: Prior to each use

Responsible Parties: Provider or technician

Rationale: Proper function of a circle anesthesia system relies on the absorbent to remove carbon dioxide from rebreathed gas. Exhausted absorbent as indicated by the characteristic color change should be replaced. It is possible for absorbent material to lose the ability to absorb CO2 yet the characteristic color change may be absent or difficult to see. Some newer absorbents do change color when desiccated. Capnography should be utilized for every anesthetic and, when using a circle anesthesia system,
Item #12: Breathing system pressure and leak testing.

**Frequency**: Prior to each use.

**Responsible Parties**: Provider and technician.

**Rationale**: The breathing system pressure and leak test should be performed with the circuit configuration to be used during anesthetic delivery. If any components of the circuit are changed after this test is completed, the test should be performed again. Although the anesthesia provider should perform this test before each use, anesthesia technicians who replace and assemble circuits can also perform this check and add redundancy to this important checkout procedure. Proper testing will demonstrate that pressure can be developed in the breathing system during both manual and mechanical ventilation and that pressure can be relieved during manual ventilation by opening the APL valve. Automated testing is often implemented in the newer anesthesia delivery systems to evaluate the system for leaks and also to determine the compliance of the breathing system. The compliance value determined during this testing will be used to automatically adjust the volume delivered by the ventilator to maintain a constant volume delivery to the patient. It is important that the circuit configuration that is to be used be in place during the test.

Item #13: Verify that gas flows properly through the breathing circuit during both inspiration and exhalation.

**Frequency**: Prior to each use.

**Responsible Parties**: Provider and technician.

**Rationale**: Pressure and leak testing does not identify all obstructions in the breathing circuit or confirm proper function of the inspiratory and expiratory unidirectional valves. A test lung or second reservoir bag can be used to confirm that flow through the circuit is unimpeded. Complete testing includes both manual and mechanical ventilation. The presence of the unidirectional valves can be assessed visually during the PAC. Proper function of these valves cannot be visually assessed since subtle valve incompetence may not be detected. Checkout procedures to identify valve incompetence which may not be visually obvious can be implemented but are typically too complex for daily testing. A trained technician can perform regular valve competence tests. (See Note 4 in Appendix) Capnography should be used during every anesthetic and the presence of carbon dioxide in the inspired gases can help to detect an incompetent valve.

Item #14: Document completion of checkout procedures.

**Frequency**: Prior to each use.
**Responsible Parties**: Provider and technician.

**Rationale**: Each individual responsible for checkout procedures should document completion of these procedures. Documentation gives credit for completing the job and can be helpful if an adverse event should occur. Some automated checkout systems maintain an audit trail of completed checkout procedures that are dated and timed.

**Item #15: Confirm ventilator settings and evaluate readiness to deliver anesthesia care. (ANESTHESIA TIME OUT)**

**Frequency**: Immediately prior to initiating the anesthetic.

**Responsible Parties**: Provider

**Rationale**: This step is intended to avoid errors due to production pressure or other sources of haste. The goal is to confirm that appropriate checks have been completed and that essential equipment is indeed available. The concept is analogous to the “time out” used to confirm patient identity and surgical site prior to incision. Improper ventilator settings can be harmful especially if a small patient is following a much larger patient or vice versa. Pressure limit settings (when available) should be used to prevent excessive volume delivery from improper ventilator settings.

**Items to check:**
- Monitors functional?
- Capnogram present?
- Oxygen saturation by pulse oximetry measured?
- Flowmeter and ventilator settings proper?
- Manual/ventilator switch set to manual?
- Vaporizer(s) adequately filled?

**SUMMARY OF CHECKOUT RECOMMENDATIONS BY FREQUENCY AND RESPONSIBLE PARTY TO BE COMPLETED DAILY**

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22. Difficult Intubation

Who are we kidding, the difficult airway is the main thing we need to be able to master. So early on, get cracking on learning this all-important skill.

Towards that end, the following is excerpted from the chapter on awake intubations in Anesthesia Unplugged. No need to tell the author that this was stolen, I wrote it!

The Crown Jewel of Intubations, Awake Fiberoptic.

“These things must be done delicately, delicately.”

The Wicked Witch of the West
The Wizard of Oz
1939

Introduction:

Yea verily I say these words unto you, all ye who would venture into that land of airway management. For it will come to pass that each and every one of you, great and small, rich and poor, wise and cretin-like, will come across the difficult airway.

And there will be great gnashing of teeth and rending of garments.
And unhappy will be the assembled host.
And spooky and boop-boop-boop-ic will be the pulse oximeter.

And so it will come to pass on this day most terrible, that you will raise your hands on high and cry out to a universe devoid of compassion, and you will say, “Whyssoever did I not follow the path of righteousness, and do this damnable intubation awake?”

You will note in this chapter that I go to a lot more length than usual to explain every aspect and thought about securing an airway
awake. Why? This is THE MOST IMPORTANT PROCEDURE WE DO. Who are we kidding? If you can get the tube in, you can fix almost any other problem that comes along.

But if you can’t get that tube in, well…

Indications:

- Securing a difficult airway.
- Securing an airway that might be difficult, that you don’t want to find out is difficult, and now it’s too late.
- Securing an airway where you need patient cooperation after the intubation is complete (for example, their C-spine is at risk and you need to make sure they can still move everything after you are done intubating)

Contraindications:

- Kids who can’t cooperate (try talking a two year-old into an awake intubation)
- Adults who can’t cooperate (mentally incapacitated from congenital or acquired central nervous system pathology)
- Adults who might be able to cooperate, but are now under the influence of drugs or alcohol and just won’t hold still.
- Upper airway so smunched up that a fiberoptic would get lost in a sea of blood and torn-up tissue (need to go with a trach in such a case)

Equipment:

- Anti-sialagogue given intra-muscularly (my preference) or intra-vascularly at least 20 minutes before planned intubation
- Local anesthetic to topicalize the airway
- Local anesthetic delivery system (this can vary depending on your taste, some like to aerosolize a la breathing treatment, others like to spray directly, still others like trans-tracheal and superior laryngeal nerve blocks)
- Endotracheal tube soaking in warm water to make it soft and non-destructive
- Fiberoptic system (some prefer to look directly, still others prefer a “tower” with a TV screen so everyone can see)
- Oxygen to blow through the fiberoptic and blow away secretions (female-female oxygen tubing works well)
- Oral airway (if you go the oral route). Either an Ovassapian or a Miller are acceptable.
- All the usual anesthesia monitors to keep an eye on blood pressure, oxygen saturation, to detect CO2.
- Suction.
- Working IV to sedate the patient and to induce once the endotracheal tube is in.
- Breathing circuit to hook up to once the deed is done.

Philosophy of Awake Intubations:

- To get slick at awake intubations, you have to embrace awake intubations, rather than flee from them. If you go forever and forever and forever without doing an awake intubation, then when that awful airway comes to the OR (or ICU or ER, wherever), your brain will tell you, “Oh no! This is a bad airway, I have to do this awake! Oh my God, this is the end of life
as I know it. This is an epic monstrosity! This is a fire-breathing dragon I must slay and all I've got is a butter knife!

- If you do awake intubations on a more regular basis, you will have the right attitude, “Oh, this patient needs an awake intubation, no biggie. Doing an awake intubation freaks me out no more than any other procedure we do.
- You want to get to the point where you think along these lines: patient needs an a-line, patient gets an a-line; patient needs a spinal, patient gets a spinal; patient needs an awake intubation, patient gets an awake intubation. There is nothing different here, an awake intubation is just plain something that some people need, so just DO IT.
- The best thing about an awake intubation is that you haven’t burned any bridges, you keep the patient breathing and controlling their airway reflexes as long as possible. If it takes you a while, OK, it takes you a while, but you’re not under the same time pressures you are under when you’ve already induced and the patient is not breathing!
- The next big impediment to doing awake intubations is getting all the stuff to topicalize the patient. If you don’t have a difficult airway kit (with local anesthetic, aerosolizing equipment, oral airways), you’re more likely to shrug your shoulders and say the fateful words, “Oh, getting all this crap is too much of a pain, besides, I think I can get it.” Don’t fall into that trap. That is lazy thinking and lazy airway management.
- Juries appear deaf to the argument, “I didn’t do the intubation awake because I didn’t want to bother getting the topicalization stuff, so instead I proceeded and killed the patient.”
- Wherever you work, identify (in the light of day, with people around), where all the stuff is that you might need to do an awake intubation:
  - topicalizing drugs and equipment
  - Ovassapian, Miller, or nasal airways, whichever you like
  - fiberoptics
  - light sources.
- If you don’t have the stuff you like, buy donuts for the anesthesia techs and pharmacy and get them on your side. Get them to order what you want, then put all the airway equipment you need in a place you can get at, reliably, day or night, holidays and weekends.
- Bad airways have a way of appearing when no one’s around and you are all alone. So get the airway situation taken care of before you are all alone and no one’s around.
- If it’s easy to get the airway stuff, you’re more likely to do the right thing.
- If it’s easy to get the stuff, you’re less likely to say, “Oh hell, I think I can get it.”

The Importance of Adequate Preparation:
- Dry the patient, dry the patient, dry the patient
- If your plan is to topicalize, then consider this before you actually lay any topical on the patient’s airway:
  1. Go to your garage.
  2. Close the door and plug up the gaps at the bottoms of all the doors.
  3. Turn on some water.
  4. Fill your garage up with 2 inches of water.
  5. Now, with your garage floor under 2 inches of water, get a bucket of paint.
6. Paint the floor of your garage. Ain’t gonna happen. How could you possibly get the paint to contact and bond with your garage floor? The paint will get diluted, and no matter how you thrash around and “froth up” your garage, you’re just not going to paint that floor. Same deal if you don’t dry up the patient. Topical anesthetic only works when it lands on and soaks into the mucous membranes you’re trying to topicalize. And to do that, you’ve got to get your ass in gear and dry the patient up, and the sooner the better!

What Happens When you don’t Adequately Prepare:
- Secretions everywhere.
- Patient is fighting, uncomfortable, miserable, blood pressure is 10,000 and heart rate is Too Numerous To Count.
- You have just arrived at the station marked Going Nowhere Fast. The surgeon’s ticked, the patient is going to hell in a hand basket, and your “Option Tank” is running on empty.
- Even if you start to dry the patient up now, it will take another good 20 minutes (if things go absolutely perfectly, which they won’t), and by then the surgeon will be poking pins into a Voodoo Doll that looks just like you.
- Lesson learned – give drying agents early.

What’s This About Giving Drying Agents IM?
- Your target organ is the salivary glands. They secrete over time. Give an IM injection, then your drying agent sticks around for a while and you keep the salivary glands off. Long term drying.
- If you give the glycopyrrolate IV and the levels jump up and go down again, then it’s like turning off Niagara Falls for a few minutes, then letting it turn back on again. It’s still wet downstream.
- Another advantage to IM – if you see a bad airway and the patient doesn’t have an IV, you can get that drying agent in NOW, PRONTO, and let it start working. That, no kidding, is the key to good topicalization (which translates into smooth intubating).
- Anticipate!
- Get that drying agent in in the holding area. Give it time to work! We’re so used to giving drugs, we forget that the toughest drug to give is time. Get the anti-sialagogue in, then go get your stuff, go recheck the room, look over the chart. You give the drying agent time to work, you won’t regret it.
- Rush the drying agent, you will regret it.
- Of note, there are other agents you can give to dry out, atropine, scopolamine, or diphenhydramine. Of these, I’d shy away from atropine for the tachycardia, and scopolamine for the central nervous system “weirding out”. Diphenhydramine is a good option because it gives you good drying and some sedation.

Focusing on Topicalization:
- Give the topical time to do its thing, and you'll be one happy camper.
- Rush the topical, and both you and your patient will be miserable.
- There are a ton of ways to topicalize, each with its champion and advocate. One common thread recurs – be diligent about making sure the patient actually gets numb!
- If you give lidocaine as you would an inhaled bronchodilator, don't just let the lidocaine cloud float around the patient's head, encourage the patient to breathe the lidocaine “into their airway”.
- If you poke a mucosal atomization device (my personal favorite!) into the patient's mouth, show the patient how to breathe the stuff in, and make sure they do it.
- If you think you are done aerosolizing and you place an oral airway and the patient goes bonkers, guess what? The patient is not adequately anesthetized and you have to give more local. So give more local, and give it more time!

**Sedation:**

- Lot of different options, just keep this in mind – if you are doing an awake intubation, then don't do an ASLEEP intubation. Don't pour so much sedative into the equation that you have lost your biggest ally, the patient themselves.
- Good explanation and good rapport go a long way to reducing anxiety and the need for sedatives.
- Midazolam with a touch, I mean a touch of fentanyl is one traditional technique. Just keep in mind the synergistic effect of drugs and the apnea potential of (every drug but especially) narcotics.
- Dexmedetomidine is a dandy, dandy drug for awake intubations. It takes about 20 minutes to work if you give the loading dose and start a drip. And that's about how long you need anyway to topicalize. Patients tend to cooperate, not mind the procedure, and keep good hemodynamics.
- Drips and drabs of propofol? Myself, I don't like that, it just seems too much a drift into general anesthesia land.

**Awake intubation History and Physical:**

- Ask about difficulties with intubation in the past.
- Examine old anesthetic records, looking for the intubation notes.
- Look for subtle clues, such as, “Seven attempts, four different practitioners, five different blades, finally got it with a prayer to all major deities and a blind stab.”
- Examine the airway for the “usual suspects” – short chin, thick neck or tongue, big teeth, trach scar (!), immobile neck.
- Look for “tight-packed fat” in the area under the chin. This is the area you will be attempting to lift with a laryngoscope. If the fat is tight and immobile rather than loose and jowly, you’ll have trouble lifting it.
- Any appliances on the head or neck (halo, jaw wired shut, Man in the Iron Mask)
- Obese – always think of “what will I do if I don't get the tube in the first time?” An obese person, being hard to mask ventilate and quick to desaturate, could paint you into a corner in no time flat.
- Beard? Same question, they could be hard to mask ventilate if you “miss the first time.”
- On a weird orthopedic bed and hard to get to? Again, if you can’t get at their airway and then you have problems, do you have a plan B ready?
Technique (caveat, this is my own personal technique, and there are many others. The single biggest change in recent years has been the advent and widespread use of the intubating LMA, which affords a whole new “option” in the case of a lost airway):

- Glycopyrrolate the nanosecond I suspect a patient may be difficult. (That way, even if I do an “asleep” intubation, if I have to back out and wake the patient up, at least their airway will already be dry.) Go away for 20 minutes at least.
- Explain to the patient what you’re going to do. No need to freak them out or to turn them into an “Airway Anatomy PhD”. I just say, “Before you go to sleep, I’m going to numb up your mouth and look in with a flashlight.” All right, you could criticize me for candy-coating it a little, but that is, in effect, what we do.
- Sedate to taste. (Myself, a little midazolam. Some people use dexmedetomidine and swear by it. Whatever you use, don’t convert an “awake” intubation into a “99% asleep oh-damn-he-stopped-breathing intubation.”)
- Grab my pre-packaged airway kit which has all the stuff I like.
- Place an endotracheal tube in a bottle of warm water to make the tube soft and less traumatogenic.
- Place 5% Lidocaine ointment on the top of a tongue depressor like an ice cream cone. Place this way way back in the mouth, all the way back to the posterior pharynx. (This is the place where the meanie pediatrician and family practice docs swab your throat for Strep.) This is the toughest part to anesthetize, because this is the part where patients will fight you. (How much do you like it when those bastards swab your throat?) So, I start topicalizing this part first, giving it the most time to get numb.
- All other things being equal, I’ll go through the mouth, because I don’t want a nose bleed. But if you have to go through the nose, then I give some neo-synephrine drops up each nostril. Make sure the patient breathes it way in. Then, like everything else in the airway, give the medicine time to do its thing.. Then I spray up the nose with 4% lidocaine using the Mucosal Atomization Device. To goopity goop up the nostril, I fill a 10 cc syringe with 2% lidocaine jelly (keep these percentages and jellies/ointments straight) and squooszie it into the nostril. (I like a lot getting injected in there so it can completely coat all the little twists and turns in those conchas.)
- I take the smallest possible nasal airway and pass it through that lidocaine-besquoozed nares. I pass this only to see if something can pass, this is not and no nasal airway should be viewed as a “dilator”! Pupils dilate, cervixes dilate – nasal airways don’t have a dilate function. All they do is ream. Passing a bunch of these nasal airways just causes bleeding.
- If the small nasal airway passes, then the next thing I place into the nose is a lidocaine jelly-besotted endotracheal tube. As you pass it, you’ll feel a “woomph” as you pop back into the posterior pharynx. At this point, you’re golden. (To help patients through the “woomph” push, I tell them, “This will be unpleasant for about 3 seconds, now breathe through your mouth”. That usually distracts them just enough to allow you to get the endotracheal tube into the posterior pharynx.
- If I go orally or nasally, I place a Mucosal Atomization Device with 4% lidocaine liquid in their mouth and tell them, “Pant and breathe deep” and I breathe along with them.
- Topicalization is not a spectator sport! The more you get into it and work with the patient, the better it goes. (When I do it, people think I’m nuts, but such is the price one pays.)
- If I go orally, I place the Williams airway (the pink one, I find the Ovassapian airway wiggles around too much). On top of the airway, I put a fine coat of 5% lidocaine ointment, so whatever the airway touches, their will be yet more local there.
- Whichever route you take, have an assistant lift the chin. This keeps everything straight and aligned. If you’re going
orally, it locks the Williams airway between the upper and lower teeth. This means when you look with the fiberoptic, you will just have to go ahead and you’ll see the cords. (If they don’t lift the chin, the airway will go a little off to the side and you won’t get a straight shot at the cords. You’ll slide into the cheek or some damn thing and you’ll just see the infamous “It’s all pink!” view.

- “load” the endotracheal tube as close to the cords as I can. Nasally, that means placing the endotracheal tube through the nose into the “supra-whoomphic” section of the posterior pharynx. If orally, that means I load the endotracheal tube into the Williams airway.
- My thinking is this – if I do get the fiberoptic through the cords, I want the shortest possible advancement between me and glory. If the endotracheal tube is a mile back up the fiberoptic, I have to slide the tube all the way down, through the mouth or nose (overcoming Mr. Whoomp in the nose) then go through the cords. And all this time, the patient may be coughing and struggling.
- Better to have the endotracheal tube right near the cords and just go ZIP from up close.
- When you place the fiberoptic, you can either look right through it with your eyeball, or you can look via camera at a TV screen (the same thing the surgeons do now for all their fiberoptic procedures).
- Adjusting to the camera takes a little, well, adjustment but it allows all in the room to look along, an obvious advantage in the teaching setting. For laughs, look around the room during one of these, and you’ll see everyone using body language to try to finesse the tube in.
- Respect and love your fiberoptic. Remember, those little light elements in there are spun glass, no less, so they can break. (Look at a surgeon’s headlight cable once, sometimes you’ll see little shafts of light shooting out where their fiberoptic glass threads have broken). Over time, if you crank the living bejeebers out of the fiberoptic, the view will get fuzzier and fuzzier, until you develop a kind of macular degeneration of the fiberoptic. Turn the shaft of the fiberoptic as a unit, don’t twist it.
- Hook oxygen up to the suction port of the fiberoptic, that way you will blow spit and blood out of the way (like Moses parting the Red Sea) to clear your vision.
- If you hook up suction to the fiberoptic, you will just suck a glob of saliva to the end of the fiberoptic (that suction port is tiny!) and blind yourself.
- By blowing oxygen through the suction port, you will also provide a little supplemental oxygenation, just in case you were a little heavy handed with the sedation and the patient has involuntarily become a facultative anaerobe.
- When the fiberoptic pops out of the end of the endotracheal tube, you ideally get the impression of a “cave” with a little space to look around in. Then, lo and behold, you see the epiglottis off in the distance.
- As you advance towards the epiglottis, use itty-bitty-teeny-weeny movements of the fiberoptic control to angle the end of the fiberoptic probe. Easy does it!
- Pink is the great enemy. If you “just see pink”, you’re stuck in mucosa. Pull back until you get that “cave” feel. If nothing helps and you are marooned in Pinksville, USA, then pull the endotracheal tube back. The cave is the thing. Seek the cave, Luke!
- No luck? Have your assistant lift the chin again. Sometimes your assistant can give a little cricoid or wiggle the neck around for you. The main thing is, like any other procedure, don’t reinforce failure, do something different.
- Try sitting the patient up, that will alter the terrain a little, turn their head one way or another – why not, if what you’re doing isn’t working, this can’t make things any worse!
- Topical through the fiberoptic? I like it. Squirt a little in the injection port, then blast your oxygen through it.
- If you’ve topicalized in a major groovy fashion, you can often slip the tube in without the patient even noticing. That is the coolest, as well as being of great utility. (For example, a patient has a fractured cervical spine and you want to do a neurologic exam after intubation.)
- Pull out the fiberoptic, hook up the circuit, check for CO2, take the Williams airway out (if the patient is cool and calm, they can cooperate). If you are scared you might spaz out and pull out the endotracheal tube as you are pulling out the oral airway, then slip the fiberoptic back in and keep it there as a “bridge to reintubation” should you pull the tube out by mistake.
- And there you have it!

Awake Fiberoptic Glitches:
- The main problem is complacency, the feeling that “I can intubate anybody”.
- If I had a dime for everyone who has said, “I didn’t think it would be so hard to intubate this guy”, I’d be a millionaire.
- The most frequent “surprise” comes from obese males, the soft tissue caves in on you, you can’t see anything, and they desaturate in an instant.
- Practice, practice, practice. Keep doing fiberoptics, don’t get out of practice.
- The biggest screw-ups in the procedure itself are failure to dry the patient and failure to take the necessary time to do a real thorough topicalization.
- If you don’t topicalize or sedate well, the hemodynamics can and do go through the roof. If that is happening, hey, chill out! Stop the procedure! Re-evaluate, re-topicalize, re-sedate, treat the hemodynamics (nitroglycerin, labetalol, cardene, whatever it takes). An awake intubation is an exercise in pharmacologic finesse, not a tractor pull!
OR Pharmacy

23. OR Pharmacy

The staff of the OR Pharmacy welcomes you to Stony Brook.

Kathleen Robertson, RPh
Ed Andolino, RPh
Denise Kelly, Certified Pharmacy Technician
Anthony Fasio, RPh (relief)

Hours of operation – Monday through Friday, 5 AM to 6 PM. After hours, you can get meds from the Pyxis. The OR Pharmacy supplies meds for the OR, AICU, and CTICU.

For anesthesia, we provide medications in the forms of trays, IV preparations and kits.

One of our important tasks is the monitoring of controlled substances. To that end, we have a strict policy for the dispensing and returning of controlled substances.

11. We have standardized kits for your use. There are 4 types
   Standard kits used in the OR
   Cardiac kits used in the OR
   Regional kits used in Labor and Delivery
   General kits used in Labor and Delivery

12. We adhere strictly to the one-kit-per-case rule with no exceptions.
13. Additional controlled substances can be added to the kit at our request.
14. When you sign out a kit, personally or electronically (that is, via the Pyxis), YOU are personally responsible for that kit unless you sign that kit over to the person relieving you.
15. You return your leftover meds to the pharmacy. They will be randomly tested for accuracy.
16. After hours supply of controlled substances can be obtained from Pyxis. It is very important that you use that kit for the patient for whom you took out the kit. If that case gets cancelled, you must return the kit.
17. In the event the Pyxis is down, contact the main pharmacy (4-5627). If Pyxis cannot be fixed promptly, there are kits in
the main pharmacy on the 1st floor.

18. **Always** check the narcotic kits before you sign for them.

19. **Completion of paperwork is mandatory.**

Lastly, the OR has a policy that all medication require orders. Currently, this does not apply to medications requested by anesthesia (with the exception of infusions and IV piggybacks). However, be aware, if you send a third party for any medication (nurse, OR tech, student) **you must** write an order for them to obtain the medication.

**Malignant Hyperthermia Kit**

The MH hotline is 1-800 644-9737 (MHH-YPER)

36 vials of dantrolene  
2 bags sterile water for injection, each 1 liter  
4 syringes and vial of sodium bicarb 8.4%, 50 ml  
10 vials of mannitol 25%, 50 ml  
1 vial furosemide 10 mg/ml, 10 ml  
2 vials dextrose 50%, 50 ml  
1 vial regular insulin  
2 vials calcium chloride 10%, 10 ml  
1 16 gauge needles

**Adult Intubation Box**

Atropine 1 mg/10 ml  
Cetacaine spray  
Ephedrine 50 mg/ml  
Etomidate 2 mg/ml, 20 cc bottle  
Lidocaine 2%, 5 ml syringe  
Lidocaine Jelly 2%, count 2  
Phenylephrine 10 mg/ml, 5 ml  
Phenylephrine nasal spray 0.025%  
Rocuronium 10 mg/ml, 10 cc count 2  
Succinylcholine, 20 mg/ml, 10 cc count 2  
Propofol 10 mg/cc, 20 ml  
Narcan 0.4 mg vial  
Epinephrine 1mg syringe
**Anesthesia Travel Box**

- 8 bottles of propofol, each 50 cc.
- Vented spikes for propofol
- 1 albuterol inhaler
- 2 rocuronium
- Prior to dispensing, the pharmacist will add:
  - 1 succinylcholine bottle
  - Ephedrine (5 mg/cc) and phenylephrine (100 mcg/cc) syringes

**Renal Transplant Box**

- **Top Drawer**
  - CaCl2 prefilled syringe
  - Diphenhydramine 50 mg/ml
  - Furosemide 100 mg, count 3 vials
  - Heparin 1000U/ml
  - Methylprednisolone 500 mg, count 2 bottles
  - Verapamil 5 mg/2ml

- **Middle drawer**
  - Mannitol 25% 50 ml count 8 bottles
  - Latex free extension set for same

- **Bottom drawer**
  - Albumin 25% 50 ml count 4 bottles
  - Dopamine 800 mg/500 ml  Nota bene: Renal dopamine doesn’t work!
  - NaHCO3 50 meq syringe count 4.

**Trauma Cart – in Room 6**

- **Top drawer**
  - 10 CaCl2 syringes
  - 10 Epi syringes
  - 7 Bicarb syringes
  - 3 Lidocaine syringes (Be aware, amiodarone has replaced lidocaine in all algorithms.)
  - 10 Epinephrine amps
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<tr>
<td>5 Norepinephrine vials</td>
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<tr>
<td>5 Vasopressin 20 unit vials (Useful in resuscitation, especially if unresponsive to norepi)</td>
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<tr>
<td>3 Sodium Bicarb syringes</td>
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<tr>
<td>2nd Drawer</td>
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<tr>
<td>5 Atropone 1 mg syringes</td>
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<tr>
<td>7 Lidocaine 2% syringes</td>
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<tr>
<td>5 Sodium bicarb 50 mEq syringes</td>
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Conclusion

25. Conclusion

That wraps up the resident guidebook. Let us know how we can improve this, since it’s always a work in progress. As questions come up not addressed in this book, just ask the residency director, Dr Gallagher, or Dr Gan, and we'll be happy to fill you in.
Your success is our success.
Good luck!