University of Minnesota

Graduate Medical Education

2014-2015

Program Policy & Procedure Manual

Department of Anesthesiology
Residency Program

Policies, Guidelines & Reference Listings
Introduction/Explanation of Manual
The Program Policy Manual for Residents in Anesthesiology consists of a compendium of institutional policies also available in the University of Minnesota Medical School Institutional Manual [http://www.med.umn.edu/gme/] and departmental policies. The Program Policy Manual will be continually updated as policies change, are added, or deleted. Policies included in the Program Policy Manual are listed in the Table of Contents.

The information contained in this Department Manual pertains to all residents in the department's programs except as otherwise identified in the Department Fellowship Manual or addendum (Program Policy Manual).

Application of the Department Manual
All residents and fellows in the Department of Anesthesiology including affiliated rotations are subject to these policies.

Institution Policy Manual

Department Mission Statement
With respect to the Anesthesiology Residency/Fellowship Programs, the missions of the Department are as follows:

1. To provide excellent care to our patient population in the areas of preoperative patient assessment and preparation, surgical anesthesia, perioperative and postoperative pain management, and critical care.
2. To promote patient safety at the departmental and institutional level
3. To provide a strong clinical base employing excellence in clinical education along with clinical experience to anesthesiology residents.
4. To supplement the clinical teaching with a strong didactic program of lectures, seminars, quality improvement projects, high-fidelity simulations, workshops, case conferences, and visiting professors.
5. To provide a strong research program available to the residents to complete their education.
6. To ensure that all graduates of the residency are consultant anesthesiologists capable of handling all types of clinical challenges and capable of becoming Board Certified in the specialty.

Program Mission Statement
The Program's mission is to provide strong training in Anesthesiology and its subspecialties, including critical care medicine, regional anesthesia and pain management, cardiovascular anesthesia, obstetrical anesthesia, neuroanesthesia, pediatric anesthesia, basic science and clinical research. The Program's philosophic mission is to develop a sturdy medical knowledge/skill base and professional attributes that allow all residents and fellows to independently and competently practice anesthesiology with a life-long commitment to continued learning, participation in departmental and institutional quality improvement, patient safety and overall excellence.
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SECTION 1 - SERVICES

University Pagers
Pagers are provided for each resident. Pagers for call and code pagers are also provided. Please obtain initial pager from the Anesthesiology Residency Coordinator and confirm it is working. Thereafter, and damaged or lost pagers can be reported at the front desk of the UMMC (directly in front of the Main Entrance on the 2nd floor). The fee for lost or damaged pagers (currently $65) will come out of any remaining educational funds, or withheld from bi-weekly stipend, if none are available.

ID Badges
You are required to wear both a University and University of Minnesota Medical Center badge at all times. Wearing of the University ID badge is a condition of employment, so DON’T BE CAUGHT WITHOUT IT due to possible consequences of noncompliance—termination.

E-mail Accounts
E-mail accounts and Internet access are available for each resident. Computers are available for the residents to use in the Anesthesiology Library, B508 Mayo and throughout the medical center facility.

To activate your e-mail account (you’ll need your x500 and password) go through the U of M website and visit the www.umn.edu/myaccount and go the Internet/Email account.

![Internet Login](image)

Click on the Student Internet Account Initiation and fill out the form. This must be done in order to activate your e-mail account. Each resident/fellow must initiate their own account as it is password protected and only they know their password (not the coordinators).

Residents are required to maintain a University of Minnesota e-mail account which must be checked on a 24-hour basis (except in rare instances – travel, etc.), as this is the Department’s preferred method of communication. Due to HIPAA laws ALL transfers of possible restricted patient information must take place on an umn.edu account. Residents should refrain from forwarding their umn.edu account to other unsecure mail services for this same reason.

Internet Access
Internet access for personal computers can be obtained by logging in with your x.500/password to the secure campus Wi-Fi or by plugging directly into a physical jack, logging in with your x.500 at the following link, clicking on the register new address button, and then entering your hardware MAC address: https://wired.netaccess.umn.edu/cgi-bin/register.pl?rm=view_edit

Department Web Sites
The Anesthesiology department web site is: www.anesthesiology.umn.edu and houses current lecture schedules, upcoming events and other useful information, as well as links to the Resident and department - Page 7 -
Wiki pages and the department Moodle page. Please check the site often for updates.

Social Networking Policy
While it is recognized that social networking websites and applications are an effective and timely means of communication, residents must be aware of the importance of maintaining the confidentiality of all patient information and identifiers as well as not compromising the image of their profession and the institutions connected with them. Please be aware of the GME policy on Social Networking and the fact that residents who violate University policies may be subject to adverse academic actions that could include a letter of reprimand, probation or dismissal from the program.

Campus Mail
Campus mail is available for residents and fellows in the resident lounge B508 Mayo.

Individual physical mailboxes are provided in the resident library. Mail is distributed on a daily basis, including first class, hospital and campus mail, O.R. and lecture schedules, special notices, meeting announcements, informational memos, etc. Please note that residents are responsible for checking their mailboxes weekly. Mailboxes should not be used as a storage area.

Department mail address:
Department of Anesthesiology
University of Minnesota
420 Delaware Street S.E.
MMC Box 294
Minneapolis, MN 55455

HIPAA and Data Security Training
On April 14, 2003, the federal Health Information (Health Information Portability and Accountability Act), went into effect. HIPAA establishes strict privacy standards—and legal consequences if "protected health information" is inappropriately disclosed.

"Protected health information" is that information that can be used to identify an individual; it is created when a person has seen a health-care professional, been treated by one, or paid for health services. It can be spoken, on paper, or electronic. It is protected wherever the information is created or received. Under HIPAA, only the minimum information necessary for a specific purpose should be used or disclosed.

To prepare you for compliance with the HIPAA privacy regulations, every University of Minnesota student, faculty member, researcher, and staff person who may have access to "protected health information" must complete the online courses about privacy and data security.

This is an important obligation imposed by federal law and the University takes this responsibility very seriously. Members of the University community who do not complete training on time place the University at risk and will be subject to appropriate University disciplinary procedures, which will be directed by this office and implemented through the appropriate channels. This process may include suspension of your internet ID, as well as conventional disciplinary action.

For details about HIPAA and Data Security, please contact Sally Sawyer, HIPAA and Data Privacy Coordinator for the ALRT Administrative Center at sallyann@umn.edu or call (612) 625-3518.

For more information on HIPAA and Data Security, go to the Privacy and Security Project Web site at http://privacysecurity.umn.edu, e-mail privacy@umn.edu, or call (612) 624-7447.
To start your HIPAA training go to the Academic Health Center portal, www.myu.umn.edu and click on “myU” located in the upper right hand corner of the web page. Sign in with your x500 to complete your courses. *Note: You will need to activate your x500 as directed above before being able to access your training modules.*

If you have any technical problems accessing the courses, please call the University of Minnesota Helpline at (612) 301-HELP for assistance or contact Mike Hahne, program coordinator at (612) 625-4116.

**Tuition and Fees**
Tuition and fees are being waived at this time. If you receive a letter from the admissions office requesting payment for either registration or fees for late registration, please contact your program coordinator immediately and refrain from paying them unless told to do so. Trainees who are enrolled in Graduate School however, will be required to pay tuition and fees for those classes.
SECTION 2 - BENEFITS

Stipends
Stipends paid to residents and fellows in Anesthesiology will be dependent on the range of remuneration negotiated between the Association of Teaching Hospitals and the University of Minnesota. For the 2014-2015 stipends, please see [www.med.umn.edu/gme/residents/stipendinfo/home.html](http://www.med.umn.edu/gme/residents/stipendinfo/home.html)

Professional Education Fund Policy
1. Residents will receive $1000 per year for educational and education-related travel expenses (including carryover of unused funds. Max=$3000 for residency)
2. Residents will sometimes be required to make purchases from their Education Funds for things such as a missing/lost pager. If funds are not available residents should understand that any such fees will be deducted from their stipend.
3. Residents have the option of purchasing books and anesthesiology equipment, paying registration and conference attendance fees or professional board certification and application fees from this fund at the discretion of the Department Chair. Please see the Reimbursement Policy below for instructions on how to use the fund. Please note that replacement iPads are not an eligible use for this fund.
4. Please note that this fund can be temporarily suspended or permanently lost for becoming non-compliant with department regulations and/or policies.

Resident Academic Achievement Incentives Policy
1. CA1: Rewarded an additional $750 education fund bonus toward basic anesthesia board reimbursement, if resident attains a scaled score equal to or above the 75th percentile on the basic component of the ABA in-training exam.
2. CA2: Rewarded an additional $500 education fund bonus, if resident attains a scaled score equal to or above the 75th percentile on the ABA in-training exam.
3. CA3: Rewarded an additional $750 education fund bonus toward the written anesthesia board reimbursement if resident attains a scaled score equal to or above the 75th percentile on their ABA in-training exam.
4. Additionally every CBY resident, who has completed all the USMLE requirements, and every CA-1 through CA-3 resident, who’s ABA in-training exam is in the 50th percentile or greater:
   a. Who is not actively presenting will be allowed an additional $500/year for travel expenses to attend major meetings;
   b. Who is actively presenting (poster, oral presentation, etc.) at a major meeting will be allowed an additional $1000/year for travel expenses.

iPad Requirement
As part of the anesthesiology resident curriculum, residents are required to have an iPad for assigned readings. If you do not have an iPad, one will be purchased by the department for personal use over the duration of residency. For more information, please see iPad policy.

Reimbursement Policy
Residents have two options to use their book funds. The first, and preferred, option is to have the residency coordinator purchase the item for you using the department purchase card. The payment will be transferred directly from your educational fund and no additional paperwork is required. The other option is to contact your coordinator for advance approval, then purchase the item with your private funds. Following that, download and complete an Employee Expense Form and submit a signed copy along with your original receipts to the residency coordinator. Please note that residents cannot be reimbursed for any taxes paid nor can reimbursements be guaranteed for any items that were not preapproved. Reimbursements are added to your stipend payments but are separate from automatic taxes and FICA deductions.
Absences
(Vacation, sick leave, meetings, leaves of absence)

1. The American Board of Anesthesiology Information Booklet states in section 2.03 that the “total of any and all absences may not exceed 60 working days (12 weeks) during the Clinical Anesthesia 1-3 years of training. Attendance at scientific meetings, not to exceed five working days per year, shall be considered a part of the training program” and that “absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.” This is broken down as follows:
   ♦ The department’s Vacation / Sick Leave and LOA Request Form must be used to self-report all leaves, conference attendance, vacations, sick days, or deviations from the schedule that result in absence from clinical time. Please be advised however, submitting a request does not guarantee its approval – particularly important when away time includes travel. Only after both Chief Resident and Program Director have signed off on a request is it considered approved.
   ♦ All residents are entitled to twenty days (excluding weekends and holidays) free of Departmental duties each academic year. Of these 20 days, 15 are normally used as vacation and five are available for sick/emergency leave. Sick leave exceeding beyond these five days must be made up either by use of vacation days or additional assignments beyond the normal completion of the program.
   ♦ Anticipated days away from clinical duties, such as doctor appointments, MUST be requested via the Vacation / Sick Leave and LOA Request Form at least four weeks ahead of the desired date. Only after both Chief Resident and Program Director have signed off on a request is it considered approved.
   ♦ All sick days must be reported by the RESIDENT and you ARE REQUIRED to find coverage among your resident peers. When reporting, you must notify all of the following at least 6 hours prior to shift start:
     o the appropriate Control Room for your rotation by phone (UMMC number is 273-2926)
     o the chief resident by page/text page
     o the department by entering the request on the Web Form (please call 625-4116 to leave recorded message in the event that you don’t have access to the web form).
   This is particularly important when assigned to ancillary sites such as HCMC, Regions, United, and the VA. Failure to report such absence/illness will be considered a serious breach of professionalism and reported during the next Clinical Competency Committee meeting for the ABA.
   ♦ Single sick days require no proof of illness. Sick leave of two days or more may require a physician’s statement of legitimate illness.
   ♦ All residents have up to five (5) working days per year for scientific meetings and conferences that will be counted as clinical time. Attendance beyond these five days must be made up either by use of vacation days or additional assignments beyond the normal completion of the program.

Operational caveats include the following:
- Vacation days must be scheduled for time off from residency education.
- Meeting days (or vacation days) must be scheduled for attendance at all approved anesthesia meetings. This includes events like the Washington legislative conference, ASA, IARS, MSA, WARC etc.
- Please note that the ABA 60 working days rule is INCLUSIVE of sick days. Therefore, any and all sick days must be reported BY THE RESIDENT to the program coordinator at (612) 625.4116 on the day of his/her illness.

2. Any time off from clinical duties (vacation, meeting, etc.) must be approved well in advance and in writing by the Chief Resident and Program Director. The following protocol must be followed: A leave request on the department’s Vacation / Sick Leave and LOA Request Form listing the time off; you will then be notified after that request has been signed off by the PD and Chief Resident.

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No one beyond the joint approval of the Chief Resident and Program Director can approve time away.

3. As a general rule, Residents will not be granted vacation between July 1 and September 15.

Scientific Meeting / Professional Peer Conference Attendance Policy
While active participation at regional and national scientific meetings is strongly encouraged, our patient care mission must continue without interruption. Thus, it is essential that some appropriate number of CA-1, CA-2, and CA-3 residents continue on clinical service throughout all time periods.

At any given time during the scientific meetings there should be at least:
   o 2-3 Senior residents, and
   o 2-3 CA-2 residents in the OR, plus
   o 3 (first half of year) / 2 (second half of year) Residents on night float pool.
      • *** 7 residents total in main OR each 24 hour block.

Algorithm for Attendance (priorities):
1. Residents presenting a new scientific abstract, Challenging Case Presentation, or similar work will have Top Priority.
2. Residents representing the department, medical school, or official society (e.g., MSA or ASA delegate) will have next highest level of priority.
3. Seniority order: CA-3 > CA-2 > CA-1 > CA-0.
4. A resident that attended the meeting the previous year is allocated to lowest layer of priority within their respective year of training.

Scientific Meeting / Professional Peer Conference Travel Policy
1. Residents presenting at department approved conferences will be eligible for up to $1000 per year to cover related travel expenses.
2. Residents are required to present at a peer conference at least one time during the 3 years of residency.

Travel
1. Approval of the meeting must be obtained at least six weeks prior to the meeting, based on the initial submission via the Vacation / Sick Leave and LOA Request Form.
2. At least two weeks prior to making travel arrangements (airfare) please check with the program coordinator for any changes in the University of Minnesota and departmental travel policies.
3. An Employee Expense Form must be completed and turned into the Anesthesia Office, along with all original receipts/invoices claimed, within two-weeks after returning from the conference. Lack of compliance will result in no reimbursement of meeting expenses.
4. Note: receipts are no longer required for travel meals. University policy allows travelers to claim the flat Federal per diem rate for their travel destination. You must claim no more than the official rate for any individual travel meal. Group meals and hospitality with a business purpose are treated differently; they must be fully documented and must comply with all relevant University and Libraries policies. Please check with ALRT Accounting for current policies.
5. Residents are encouraged to attend one meeting each year.
6. Residents must submit, and be prepared to present a 15-minute report, about the educational value gained, within six weeks of the meeting.
7. Meetings that will be approved:
   ♦ CA-1: Midwest Anesthesia Residents Conference
   ♦ CA-2: Midwest Anesthesia Residents Conference, ASA Annual Meeting, IARS Annual Meeting, ASA Regional Refresher Courses or Workshop
   ♦ CA-3: Any meeting listed above plus Society of Cardiovascular Anesthesiologists Annual Meeting,

♦ Fellows: Meeting must be approved by Program Director and Department Head

8. A resident presenting an abstract or poster at a meeting is eligible to receive funding specific to that meeting over and above his/her annual travel funds, as determined by the Program Director and the Department Head.

Leaves of Absence
The department’s Vacation / Sick Leave and LOA Request Form must be used to self-report all leaves listed below – failure to do so could result in the need for an extension of training. For information on the following leaves, please see http://www.med.umn.edu/gme/InstitutionPolicyManual2013/index.htm

Family Emergency Leave:
Family emergency leave maybe authorized upon request to the Program Director for serious illness in a spouse/significant other, parent, or child. The length of leave will be determined by the Program Director based upon individual circumstances and will not total more than 10 working days in an academic year. In exceptional circumstances, the Program Director may authorize a request for leave beyond 10 days provided it is in the best interest of the University, the Program, and the Resident.

Parental Leave:
Please contact the Program Coordinator, Program Director and Department Head when scheduling Parental Leave and complete the LOA form in Appendix B. Compliance with the GME policy is also required. For more information please see: http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_472720.pdf

Bereavement Leave:
http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_425257.pdf

Medical Leave:
Please contact the Program Director and Department Head regarding scheduling a medical leave (if possible) and complete the LOA form in Appendix B.
http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_425267.pdf

Family Medical Leave Act (FMLA)
http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_425264.pdf

Jury/Witness Duty:
See the Witness or Jury Duty Leave policy. Leave will be authorized consistent State and Federal Court requirements. The Program Director must be promptly notified when a Medical Resident requires jury duty or court leave in writing. Note: Please contact the Program Director and Department Head when notification of Jury/Witness Duty is received and complete the LOA form in Appendix B.

Military Leave:
Military leave may be authorized upon request and normally will not exceed 10 working days each academic year. See GME Military Leave policy. Military leave is granted in full accordance with State and Federal Regulations. Please contact the Program Director and Department Head when notification is received and complete the LOA form in Appendix B.

Personal Leave of Absence:
Please contact the Program Director and Department Head regarding scheduling a Personal Leave of Absence and complete the LOA form which follows.
Professional Leave:
Please contact the Program Director and Department Head when scheduling Professional Leave and complete the LOA form in Appendix B. Compliance with the GME policy is also required.

Vacation/Sick Leave:
Please contact the Program Coordinator, Program Director and Department Head when scheduling Professional Leave and complete the LOA form in Appendix B. Compliance with the GME policy is also required.

Holiday Note:
Holiday schedules vary, depending on the institution. When rotating to a particular site, the holiday schedule for that institution must be followed.

Policy on Effect of Leave for Satisfying Completion of Program
Please keep in mind that any leave of absence, paid or unpaid, could extend your residency program. Note the American Board of Anesthesiology policy:

“Absence from Training. The total of any and all absences may not exceed 60 working days (12 weeks) during the clinical Anesthesia 1-3 years of training. Attendance at scientific meetings, not to exceed five working days per year, shall be considered a part of the training program. Duration of absence during the Clinical Base year may conform to the policy of the institution and department in which that portion of the training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

A lengthy interruption in training may have a deleterious effect upon the resident’s knowledge of clinical competence. Therefore, when there is an absence for a period in excess of six months, the Credentials Committee of the ABA shall determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.”

Meal Cards
Each resident involved in clinical duties will receive a Fairview meal card at the start of the academic year. The dollar amount on each card will be determined by the number of on-call days the department designates to the resident and/or fellow. The following restrictions apply:

A. On-call meals (dinner & breakfast) will be provided for residents and fellows who work 24 consecutive hours on site or are pre-scheduled for 5 and no more than 6 12 hour night shifts (night float).
B. ID Badge Requirement - Residents and fellows are required to have a Fairview ID badge visible and present in order to obtain on-call meals.
C. Bulk Purchase Limitation – Bulk purchases are not allowed. A limit of 3 bottles and one half pound of candy or snacks may be purchased at one time.
D. Sharing Restriction – This privilege is for the resident and/or fellow use in the hospital and may not be shared with medical students, families, or other hospital staff.

Non-compliance with this policy may result in short-term suspension of meal card privileges or termination of privileges. The Vice President of Medical Affairs at UMMC-F reserves the right to suspend or terminate meal card privileges at any time, without notice.

Lab Coats / Laundry Policy
Two labs coat are provided for each resident. Lab coats used at Fairview must be laundered through the hospital laundry facility. Residents are not allowed to launder them themselves.
Parking
The Department currently provides contract parking for residents for CA-1, CA-2 and CA-3 residents. If a CA-1, CA-2 or CA-3 resident goes on an extended leave (i.e., maternity leave) the Department may request that you return the parking card to the office during your absence. The card would then be reinstated upon your return to work. Please note that this privilege can be temporarily suspended or permanently lost for becoming non-compliant with department regulations and/or policies.

Memberships
The Department covers the cost of your annual American Society of Anesthesiologists, Minnesota Society of Anesthesiologists and the Anesthesia International Research Society dues for the duration of your residency.

Health, Dental, and Additional Insurance Coverage
Please see the Office of Student Health Benefits website with descriptors of the following insurance coverage:

- Health & Dental
- Short and Long Term Disability Coverage
- Professional Liability Insurance
- Life Insurance
- Voluntary Life Insurance
- Insurance Coverage Changes

Worker’s Compensation Program Specific Policies and Procedures
Please see the GME website for a detailed description of Worker’s Compensation policy

Needle Sticks and Blood Borne Pathogen Exposure (BBPE) Management
Please use the following address which can be found on the GME page for needle stick procedures http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_428154.pdf. All needle sticks must be reported, using the office report linked in the above address, within the first 24 hours. Blood borne pathogens are serious business; please treat them as such for your own safety. Additionally, be sure to direct all coworkers who you witness having an event to these pages.
SECTION 3 - INSTITUTION RESPONSIBILITIES

SECTION 4 - DISCIPLINARY AND GRIEVANCE PROCEDURES

INSTITUTIONAL POLICIES

Disciplinary/Grievance Procedures: Discipline/Dismissal/Non-Renewal
Residents/Fellows can be disciplined for both academic and non-academic reasons. Forms of discipline include, but are not limited to: warning, required compliance, remedial work, probation, suspension, contract non-renewal and dismissal. There are separate grounds and procedures for each type of discipline as outlined below.

Discipline/Dismissal for Academic Reasons
A. Grounds
As students, residents/fellows are required to maintain satisfactory academic performance. Academic performance that is below satisfactory is grounds for discipline and/or dismissal. Below satisfactory academic performance is defined as a failed rotation; relevant exam scores below program requirements; and/or marginal or unsatisfactory performance, as evidenced by faculty evaluations, in the areas of clinical diagnosis and judgment, medical knowledge, technical abilities, interpretation of data, patient management, communication skills, interactions with patients and other healthcare professionals, professionalism, and/or motivation and initiative.

To maintain satisfactory academic performance, residents/fellows also must meet all eligibility requirements throughout the training program. Failure or inability to satisfy licensure, registration, fitness/availability for work, visa, immunization, or other program-specific eligibility requirements are grounds for dismissal or contract non-renewal.

B. Procedures
Before dismissing a resident/fellow or not renewing the contract of a trainee for academic reasons, the program must give the trainee:
- Notice of performance deficiencies;
- An opportunity to remedy the deficiencies; and
- Notice of the possibility of dismissal or non-renewal if the deficiencies are not corrected.

Trainees disciplined and/or dismissed for academic reasons may be able to grieve the action through the Conflict Resolution Process for Student Academic Complaints Policy. This grievance process is not intended as a substitute for the academic judgments of the faculty who have evaluated the performance of the trainee, but rather is based on a claimed violation of a rule, policy or established practice of the University or its programs.

Academic Probation
Trainees who demonstrate a pattern of unsatisfactory or marginal academic performance will undergo a probationary period. The purpose of probation is to give the trainees specific notice of performance deficiencies and an opportunity to correct those deficiencies. The length of the probationary period may vary but it must be specified at the outset and be of sufficient duration to give the trainee a meaningful opportunity to remedy the identified performance problems. Depending on the trainee’s performance during probation, the possible outcomes of the probationary period are: removal from probation with a return to good academic standing; continued probation with new or remaining deficiencies cited; non-promotion to the next training level with further probationary training required; contract non-renewal; or dismissal.

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Discipline/Dismissal for Non-Academic Reasons

A. Grounds

Grounds for discipline and/or dismissal of a trainee for non-academic reasons include, but are not limited to, the following:

- Failure to comply with the bylaws, policies, rules, or regulations of the University of Minnesota, affiliated hospital, medical staff, department, or with the terms and conditions of this document.
- Commission by the trainee of an offense under federal, state, or local laws or ordinances, which impacts upon the abilities of the trainee to appropriately perform his/her normal duties in the residency program.
- Conduct, which violates professional and/or ethical standards; disrupts the operations of the University, its departments, or affiliated hospitals; or disregards the rights or welfare of patients, visitors, or hospital/clinical staff.

B. Procedures

1. Prior to the imposition of any discipline for non-academic reasons, including, but not limited to, written warnings, probation, suspension, or termination from the program, a resident/fellow shall be afforded:

   a) Clear and actual notice by the appropriate University or hospital representative of charges that may result in discipline, including where appropriate, the identification of persons who have made allegations against the trainee and the specific nature of the allegations; and,

   b) An opportunity for the trainee to appear in person to respond to the allegations.

Following the appearance by the trainee, a determination should be made as to whether reasonable grounds exist to validate the proposed discipline. The determination as to whether discipline would be imposed will be made by the respective Medical School department head or his or her designee. A written statement of the discipline and the reasons for imposition, including specific charges, witnesses, and applicable evidence shall be presented to the trainee.

2. After the imposition of any discipline for non-academic reasons, a trainee may avail himself or herself of the following procedure:

   a) If within thirty (30) calendar days following the effective date of the discipline, the trainee requests in writing to the Dean of the Medical School a hearing to challenge the discipline, a prompt hearing shall be scheduled. If the trainee fails to request a hearing within the thirty (30) day time period, his/her rights pursuant to this procedure shall be deemed to be waived.

   b) The hearing panel shall be comprised of three persons not from the residency/fellowship program involved: a chief resident; a designee of the Dean of the University of Minnesota Medical School; and an individual recommended by the Chair of the Graduate Medical Education Committee. The panel will be named by the Dean of the Medical School or his or her designee and will elect its own chair. The hearing panel shall have the right to adopt, reject or modify the discipline that has been imposed.

   c) At the hearing, a resident/fellow shall have the following rights:

- Right to have an advisor appear at the hearing. The advisor may be a faculty member, resident/fellow, attorney, or any other person. The resident/fellow must identify his or her advisor at least five (5) days prior to the hearing;
- Right to hear all adverse evidence, present his/her defense, present written evidence, call and cross-examine witnesses; and,
• Right to examine the individual's residency/fellowship files prior to or at the hearing.

d) The proceedings of the hearing shall be recorded.

e) After the hearing, the panel members shall reach a decision by a simple majority vote based on the record at the hearing.

f) The residency/fellowship program must establish the appropriateness of the discipline by a preponderance of the evidence.

g) The panel shall notify the resident/fellow in writing of its decision and provide the trainee with a statement of the reasons for the decision.

h) Although the discipline will be implemented on the effective date, the stipend of the trainee shall be continued until his or her thirty (30) day period of appeal expires, the hearing panel issues its written decision, or the termination date of the agreement, whichever occurs first.

i) The decision of the panel in these matters is final, subject to the right of the trainee to appeal the determination to the President's Student Behavior Review Panel.

3) The University of Minnesota, an affiliated hospital, and the department of the resident/fellow each has a right to impose immediate summary suspension upon a trainee if his or her alleged conduct is reasonably likely to threaten the safety or welfare of patients, visitors or hospital/clinical staff. In those cases, the trainee may avail he or she of the hearing procedures described above.

4) The foregoing procedures shall constitute the sole and exclusive remedy by which a trainee may challenge the imposition of discipline based on non-academic reasons.

**Non-renewal of Agreement of Appointment**

In instances where a trainee’s agreement is not going to be renewed, the University of Minnesota Medical School ensures that its ACGME accredited programs provide the trainees with a written notice of intent not to renew a trainee’s agreement no later than four months prior to the end of the trainee’s current agreement. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the agreement, the University of Minnesota Medical School ensures that its ACGME-accredited programs provide the trainee with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement.

Trainee will be allowed to implement the institution’s grievance procedures if they have received a written notice of intent not to renew their agreements.
DEPARTMENTAL POLICIES
Grievance Procedure and Due Process
The department grievance policy and information on due process may be found in Section 8 of each resident’s yearly Residency Agreement.

Breach of Professionalism / ECAP Form

EVALUATION AND REMEDIATION OF A RESIDENT IN DIFFICULTY AND EDUCATIONAL CORRECTIVE ACTION PLAN FORM
Department of Anesthesiology, University of Minnesota

Fill out the form. Circle the appropriate names, methods, competencies, etc. in section 1-9 and make comments where appropriate.

Section 1. (circle the appropriate)
Resident evaluated on __________________ at the Clinical Competency Committee Meeting
consisting of the following faculty:
1. Dough Koehntop
2. Richard C. Prielipp
3. David Bebe
4. Kumar Belani
5. Martin Birch
6. Megan Nolan
7. Mojca Remskar Konia
8. Jason Johnson
9. 
10. 

Section 2. (circle the appropriate)
Evaluation of resident based on the following evaluation criteria/methods:
- resident evaluation forms
- verbal communication from faculty (single/two/multiple)
- 360 evaluation forms
- personal report from resident mentor
- written exam
- anesthesia record review
- structured case-based discussion/oral exam
- assigned conference presentations
- learning logs
- simulation performance

Section 3 (circle the appropriate)
Resident deficiency determined to be in the ACGME competency area:
- medical knowledge
- patient care
- interpersonal skills and communication
- professionalism
- practice-based learning and improvement
- system-based practice

Comments:

Section 4 (circle the appropriate)
Possible causes/categories of deficiency:
- cognitive (knowledge, judgment, clinical problem solving)
- non-cognitive (interpersonal, skills, attitudes, professional behavior)
- technical (psychomotor)
- secondary causes (distraction, imbalance work/life, new city, sleep deprivation, residency/self induced, depression, drug abuse, disease, learning disability, ADHD, personality disorder)

Comments:

Section 5
In case of secondary causes the department has asked for an independent evaluation from:

Section 6 (circle the appropriate)
Should the resident remain on regular duty? (If the answer to any of the questions below is no, the resident should be removed from usual duty and offered restricted responsibilities or a leave of absence)
1. Will patients be safe with the resident? Yes/No
2. Will students and junior colleagues learn from this resident? Yes/No
3. Is the resident capable of continuing to learn while on this rotation? Yes/No
4. Will the moral and standards of this program be maintained if this resident remains on duty? Yes/No

Comments:

Section 7
If a leave of absence is indicated, the financial support during the leave of absence will be:

Anesthesiology ECAP FORM
Date: 5/4/2011

Comments (continued):

Section 4 (circle the appropriate)
Possible causes/categories of deficiency:
- cognitive (knowledge, judgment, clinical problem solving)
- non-cognitive (interpersonal, skills, attitudes, professional behavior)
- technical (psychomotor)
- secondary causes (distraction, imbalance work/life, new city, sleep deprivation, residency/self induced, depression, drug abuse, disease, learning disability, ADHD, personality disorder)

Comments:

Section 5
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4. Will the moral and standards of this program be maintained if this resident remains on duty? Yes/No

Comments:

Section 7
If a leave of absence is indicated, the financial support during the leave of absence will be:

Anesthesiology ECAP FORM
Date: 5/4/2011

Comments (continued):

Section 4 (circle the appropriate)
Possible causes/categories of deficiency:
- cognitive (knowledge, judgment, clinical problem solving)
- non-cognitive (interpersonal, skills, attitudes, professional behavior)
- technical (psychomotor)
- secondary causes (distraction, imbalance work/life, new city, sleep deprivation, residency/self induced, depression, drug abuse, disease, learning disability, ADHD, personality disorder)

Comments:

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4. Will the moral and standards of this program be maintained if this resident remains on duty? Yes/No

Comments:

Section 7
If a leave of absence is indicated, the financial support during the leave of absence will be:

Anesthesiology ECAP FORM
Date: 5/4/2011

Comments (continued):

Section 4 (circle the appropriate)
Possible causes/categories of deficiency:
- cognitive (knowledge, judgment, clinical problem solving)
- non-cognitive (interpersonal, skills, attitudes, professional behavior)
- technical (psychomotor)
- secondary causes (distraction, imbalance work/life, new city, sleep deprivation, residency/self induced, depression, drug abuse, disease, learning disability, ADHD, personality disorder)

Comments:

Section 5
In case of secondary causes the department has asked for an independent evaluation from:

Section 6 (circle the appropriate)
Should the resident remain on regular duty? (If the answer to any of the questions below is no, the resident should be removed from usual duty and offered restricted responsibilities or a leave of absence)
1. Will patients be safe with the resident? Yes/No
2. Will students and junior colleagues learn from this resident? Yes/No
3. Is the resident capable of continuing to learn while on this rotation? Yes/No
4. Will the moral and standards of this program be maintained if this resident remains on duty? Yes/No

Comments:

Section 7
If a leave of absence is indicated, the financial support during the leave of absence will be:
Section 9 (circle the appropriate)
Educational Corrective Action Plan:
Type:
- Remediation (program of intensive tutoring to help student improve knowledge, clinical judgment, technical skills, suboptimal but not inappropriate behavior)
- Probation (primary intervention is to clearly warn a resident that behavior is wrong and must be stopped. Resident has not met professional responsibilities or has demonstrated inappropriate communication/behavior)

1. Time frame for expected improvement:

2. Mentored by faculty:

3. Specific deficiencies targeted:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Section 9
Resident notified of the deficiency and the consequences on:

Problem discussed with resident: Yes/No
Comments:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Resident given opportunity to correct deficiencies: Yes/No
Comments:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Section 10
Remediation/probation outcome evaluation
1. Mentor re-evaluation
2. Program Director re-evaluation
3. Clinical Competency Committee Meeting re-evaluation

Plan if no insufficiency improvement:
- extended remediation
- extended training
- dismissal/contract nonrenewal
Substance Abuse (Chemical Dependency) Policy
1. There shall be a regular lecture/seminar regarding substance abuse and the Departmental policy on substance abuse included in the introductory resident lectures or regular resident lecture series.
2. It is the responsibility of any Department member, resident or employee to report any suspicious activity concerned with substance abuse to the Department Head. Suspicious activity might consist of a sudden change in habits, a change in personality or suspicions about drug counts and handling.
3. The Department Head will, in consultation with appropriate experts, determine whether any Department member, resident, or employee is suffering from substance abuse.
4. Any Department member, resident or employee judged to be suffering from substance abuse shall be placed on an immediate leave of absence and be required, at their own expense, to enroll in an approved treatment and follow-up program.
5. Return must be approved by Department Head and follow the Department’s Guidelines for re-entry.
6. The Department resource person for substance abuse is: Barbara S. Gold, MD
   Office: (612) 624-9990 Pager: (612) 899-2335
7. Refer to Institutional Manual (formerly Part A)

Guidelines for Re-Entry after Substance Abuse
1. The Department of Anesthesiology is under no obligation to re-employ any member or employee on leave of absence because of substance abuse.
2. The Department Head will, in consultation with appropriate experts, determine whether any Department member, resident or employee will be allowed to re-enter or will be asked to resign.
3. Any individual allowed to re-enter must:
   ◆ Supply the name of the treating physician/program and agree to allow free access by the Department Head to his/her records.
   ◆ Agree to continue after care programs.
   ◆ Agree to random urine and/or blood drug screens.
   ◆ Pay all costs related to the treatment program after care program and drug screens.
   ◆ Sign a letter admitting to his/her drug abuse problem, agreeing to permanent abstinence from addicting/offending drugs, and accepting that any relapse may result in immediate and permanent dismissal from the Department.
SECTION 5 - GENERAL POLICIES AND PROCEDURES

UM Anesthesiology Department Policy Regarding Resident Academic Performance

The ABA defines an anesthesiology consultant as: A Board certified anesthesiologist is a physician who provides medical management and consultation during the perioperative period, in pain medicine and in critical care medicine. A diplomate of the Board must possess knowledge, judgment, adaptability, clinical skills, technical facility and personal characteristics sufficient to carry out the entire scope of anesthesiology practice. An ABA diplomate must logically organize and effectively present rational diagnoses and appropriate treatment protocols to peers, patients, their families and others involved in the medical community. A diplomate of the Board can serve as an expert in matters related to anesthesiology, deliberate with others, and provide advice and defend opinions in all aspects of the specialty of anesthesiology.

Given that a level of academic performance is mandatory to become board certified and to succeed as a consultant anesthesiologist, it is the departmental policy that residents consistently achieve benchmark scores ≥ 25%. This will be evaluated with current national standardized testing as follows:

A. Standardized tests will be any combination of the ABA/ASA In-Training or other tests or AKT (Anesthesia Knowledge Test, Metrics Associates, Inc.) examinations.

B. Any 3 sequential test scores which are below the 25% rank (normalized to national standards by comparison to the comparable Clinical Anesthesia year cohort group defined by American Medical School Graduates) will be considered unsatisfactory in the area of knowledge by the Clinical Competence Committee. This is a score that indicates inadequate knowledge to function as a consultant anesthesiologist or to pass the certification exam. Performance at this level will result in:

1. Mandatory academic probation and an ABA six-month evaluation of “unsatisfactory.”
2. Notification to the resident of their probationary status, and a remedial course of action outlined and recommended by the CCC.
3. Failure to remedy the probation status within six months, or at the next testing opportunity, could result in loss of training credit as per ABA requirements [see ABA Booklet of Information].

In addition, all Residents are expected to maintain a minimum conference/didactic attendance of 75% - inclusive of all sick days; formally excused rotations (including night float, call, and call-intensive rotations such as SICU) are not included in this formula.

Residency Program Overall Goals and Supporting Curriculum

The residency program goals incorporate the American Board of Anesthesiology’s (ABA) criteria defining a competent anesthesiologist and the essential elements of the six general competencies adopted by the Accreditation Council for Graduate Medical Education (ACGME). Abbreviated definitions of the ACGME’s six general competencies are as follows:

General Competencies

Patient Care: gather data, order diagnostic tests, interpret data, make decisions, perform procedures, manage patient therapies, work with others to provide patient-focused care.

Medical Knowledge: fund of knowledge, active use of knowledge to solve medical problems.

Practice-based Learning & Improvement: analyze practice performance and carry out needed improvements, locate and apply scientific evidence to the care of patients, critically appraise the scientific literature, use the computer to support learning and patient care.

Interpersonal & Communication Skills: develop a therapeutic relationship with patients and their families, use
verbal and non-verbal skills to communicate effectively with patients and their families, work effectively as a team member or leader.

**Professionalism:** demonstrate integrity and honesty, accept responsibility, act in the best interest of the patient, demonstrate sensitivity to patients; ethnicity, age, and disabilities.

**Systems-based Practice:** demonstrate awareness of interdependencies in the health care system that affect quality of care, provide cost-effective care, advocate for quality patient care, work with hospital management and interdisciplinary teams to improve patient care.

Except for the sixth category, System-based practice, which is being taught and assessed by our sponsoring institution’s core residency lectures, the first five competency categories can be readily assimilated with one of the five sections of criteria used by the ABA to define a competent, board certified anesthesiologist.

**ABA description of a competent anesthesiologist:**

I. Essential Attributes:
The physician must possess those abilities, traits, and skills that are essential to the safe practice of anesthesiology, critical care, and pain management.

- Demonstrates high standards of ethical/moral behavior.
- Demonstrates honesty/integrity; reliability/responsibility.
- Learns from experience; know limits.
- Reacts to stressful situations in an appropriate manner.
- Has no documented current abuse of alcohol or illegal use of drugs.
- Has no cognitive, physical, sensory or motor impairment that precludes acquiring and processing information in an independent and timely manner or independent responsibility for any aspect of anesthesia care.
- Demonstrates respect for the dignity of patients and colleagues.
- Has no restrictions, conditions, limitation or revocation of license to practice medicine.

II. Acquired Profession Skills:
The physician should demonstrate the following acquired professional skills that are important to the practice of anesthesiology.

- Communicates and works effectively with patients, their families, and members of the health care team in relevant health care delivery settings and systems.
- Demonstrates appropriate concern for patients.
- Has a commitment to lifelong learning.
- Is adaptable and flexible.
- Is careful and thorough.
- Is complete and accurate in record keeping.
- Possesses business skills important for effective practice management.
- Uses information technology to optimize patient care.
- Is an advocate for quality care.
- Is appropriately self-confident; recognizes gaps in knowledge and expertise.
- Demonstrates continuous practice improvement through performance evaluation.

III. Knowledge:
Possesses an appropriate fund of medical knowledge. Can critically evaluate and use current medical information. The ABA In-training Examination and Anesthesia Knowledge tests are used by the Department to measure the adequacy of knowledge. The scope of this knowledge is currently defined in the ABA Content Outline of the In-training Examination.
IV. Judgment:
The physician must possess the ability to elicit the essential information from patients and physicians and to integrate it with a fund of medical knowledge and clinical skills that permits diagnosis and understanding of conditions and prescriptions for appropriate and safe anesthetic management.

- Demonstrates use of a sound background in general medicine in the management of problems relevant to the specialty of anesthesiology.
- Recognizes the adequacy of preoperative preparation of patients for anesthesia and surgery and recommends appropriate steps when preparation is inadequate.
- Selects anesthetic and adjuvant drugs and techniques for rational and safe cost-effective anesthetic management.
- Recognizes and responds appropriately to significant changes in the anesthetic course.
- Prescribes and advises appropriate post anesthetic care.
- Provides appropriate consultative support for patients who are critically ill.
- Evaluates, diagnoses, and selects appropriate therapy for acute and chronic pain disorders.

V. Clinical Skills:
The physician must demonstrate the facility to organize and expedite safe anesthetic procedures. Medical interviewing, physical examination, diagnostic studies (selection, implementation, application), synthesis of clinical information, development of management plan, technical expertise, counsel of patient and family, respect for patient’s privacy. The following contains examples that aid the evaluation of psychomotor performance.

   - Adequacy and speed of preparation.
   - Indicated vascular cannulations including venous, arterial, central venous, and pulmonary arterial catheter insertions.
   - Appropriate application and use of current technology for efficient and safe anesthesia care and life support of patients. Examples include direct and indirect blood pressure measurements, ventilation and respiratory gas monitoring, assessment of neuromuscular function, electrocardiographic, electroencephalographic, and evoked-potential monitoring, and evaluation of laboratory results (chemistry, radiographys, etc.).
   - Instrument and anesthetic machine testing and calibration.
   - Operating room safety procedures for oxygen delivery, electrical safety, waste gas evacuation and principles of universal safety precaution.
   - Proper patient positioning during anesthesia.

2. General anesthesia.
   - Airway management: head position, ventilation by mask, appropriate use of oral and nasal airways.
   - Tracheal intubation: oral and nasal intubation by various techniques, appropriate and adequate tracheal and airway local anesthesia, fiber optic techniques.
   - Maintenance of respiration and gas exchange including management of various types of mechanical ventilation.
   - Support of the circulation during the perioperative period, including the management of all types of shock.
   - Support of renal function perioperatively.
   - Management of the patient with increased intracranial pressure.
   - Appropriate administration of fluids and maintenance of fluid, electrolyte, and acid-base balance.
   - Judicious use of blood products.

3. Regional anesthesia and pain (including postoperative) management.
   - Spinal and epidural anesthesia and analgesia.
   - IV regional anesthesia.
   - Nerve blocks for diagnostic, therapeutic, and surgical procedures.
4. Special procedures.
   • Management of cardiopulmonary resuscitation.
   • Anesthetic management of cardiopulmonary bypass.
   • One-lung ventilation.
   • Deliberate hypotension.
   • Pain management—perioperative, acute, and chronic.

The ABA criteria of a competent anesthesiologist will continue to be the specific goals of the program and thus remain the primary outline for the forms used to evaluate a resident’s performance and progress. However, due to the extensive compatibility between the five ABA sections defining a competent anesthesiologist and five of the categories describing the ACGME’s general competencies of a physician, each ACGME section except for System-based practice is merged with its ABA counterpart as follows:

I. ABA Essential Attributes plus ACGME Professionalism.
II. ABA Acquired Characteristics plus ACGME Interpersonal and Communication Skills.
III. ABA Knowledge plus ACGME Medical Knowledge.
IV. ABA Judgment plus ACGME Practice-based Learning.
V. ABA Clinical Skills plus ACGME Patient Care.

The above unification of the ABA competency sections with a corresponding ACGME competency results in a cohesive expansion of the program goals. This will ensure that all the necessary attributes of a physician are acquired at the same time that the trainee is taught to provide safe anesthetic management in a wide variety of situations.

Thus, the program’s goals, curriculum, and assessments are now better designed to provide an educational environment and process that will result in an anesthesiologist that has achieved the ABA’s broader definition of a board-certified anesthesiologist:

• Possesses knowledge, judgment, adaptability, clinical skills, technical facility, and personal characteristics to carry out the entire scope of the anesthesiology practice.
• Is able to communicate effectively with peers, patients, their families, and others in the medical community.
• Can serve as an expert in matters related to anesthesiology, deliberate with others, provide advice, and defend opinions in all aspects of the specialty of anesthesiology.
• Is able to function as the leader of the anesthesiology care team.
• Have sufficient levels of knowledge, skills, and clinical judgment to allow them to be competent in providing anesthesia care in an independent environment.
• Possess those personal characteristics essential to the ethical and safe practice of medicine.

Certification Requirements
At the time of certification by the American Board of Anesthesiology, the candidate shall be capable of performing independently the entire scope of anesthesiology practice and must:

• Hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States or province of Canada that is permanent, unconditional and unrestricted. Further, every United States and Canadian medical license the applicant holds must be free of restrictions.
• Candidates for initial certification and ABA diplomates have the affirmative obligation to advise the ABA of any and all restrictions placed on any of their medical licenses and to provide the ABA with complete information concerning such restrictions within 60 days after their imposition or notice, whichever first occurs. Such information shall include, but not be limited to, the identity of the State Medical Board imposing the restriction as well as the restriction’s duration, basis, and specific terms.
and conditions. Candidates and diplomates discovered not to have made disclosure may be subject to sanctions on their candidate or diplomate status.

- Have fulfilled all the requirements of the continuum of education in anesthesiology.
- Have on file with the ABA a Certificate of Clinical Competence with an overall satisfactory rating covering the final six-month period of clinical anesthesia training in each anesthesiology residency program.
- Have satisfied all examination requirements of the Board.
- Have a professional standing (see Section 5.06) satisfactory to the ABA.

Staged Examination
The staged examinations of the Primary Certification Examination System were designed to better support the movement toward competency-based training in graduate medical education. The staged examinations consist of three distinct parts: the BASIC Examination, the ADVANCED Examination and the APPLIED Examination. Each is designed to assess different qualities of Board certified anesthesiologist as defined in Section 1.02.D.

The staged examinations for ABA primary certification in anesthesiology apply to individuals who began a four-year CA training residency in July 2012 and are scheduled to complete residency training on or after June 30, 2016. Residents are automatically enrolled in the staged examination process when their anesthesiology residency program submits a resident enrollment form. Residents must then register for each examination when they meet the registration eligibility criteria for that examination.

A. The **BASIC Examination**, which will be administered at the beginning of a resident’s CA-2 year, focuses on the scientific basis of clinical anesthetic practice including content areas such as pharmacology, physiology, anatomy, anesthesia equipment and monitoring. The content outline available at [www.theABA.org](http://www.theABA.org) provides a detailed description of the covered topics. The first examination will be administered in July 2014. Starting in 2015, it will be offered in January and July/August of each year. Residents must pass the BASIC Examination to qualify for the ADVANCED Examination. Additionally, residents must pass the BASIC Exam to satisfactorily graduate from residency. Failure to pass the BASIC exam will possibly delay graduation and may require remediation or possible termination.

B. The **ADVANCED Examination**, which will be administered after graduation from residency training, focuses on clinical aspects of anesthetic practice including subspecialty-based practice and advanced clinical issues. The content outline provides a detailed description of the topics covered, which is inclusive of the topics covered in the BASIC Examination. The first examination will be administered in July 2016. Starting in 2017, it will be offered in January and July of each year. Candidates must pass the ADVANCED Examination to qualify for the APPLIED Examination.

C. The **APPLIED Examination** is designed to assess the candidate’s ability to demonstrate the attributes of an ABA diplomate when managing patients presented in clinical scenarios, with an emphasis on the rationale underlying clinical management decisions. These attributes include sound judgment in making decisions, proper management of surgical and anesthetic complications, appropriate application of scientific principles to clinical problems, adaptability to unexpected changes in clinical situations, and logical organization and effective presentation of information.

The APPLIED Examination includes two components: a Standardized Oral Examination (SOE) and an Objective Structured Clinical Examination (OSCE). The SOE is an oral assessment using realistic patient cases with two Board-certified anesthesiologist examiners questioning an examinee in a standardized manner. These examination assess clinical decision-making and the application or use of medical knowledge with realistic patient scenarios. The OSCE is a series of short simulated clinical situations in which a candidate is evaluated on skills such as history-taking, physical exam, procedural skills, clinical decision-making, counseling, professionalism, and interpersonal skills. Both components are administered by Directors of the Board and other ABA diplomats who assist as associate examiners.

Beginning in 2017 the APPLIED Examination will be administered as many as eight times a year. Candidates will receive a separate score for each component of the APPLIED Examination. If one component is failed, the candidate will retake only the failed component. Candidates must pass both components of the APPLIED Examination to become Board certified.

- Page 26 -
D. ABA examinations are administered to all residents and candidates under the same standardized testing conditions. The Board will consider a resident’s/candidate’s complaint about the testing conditions under which an ABA examination was administered only if the complaint is received within one week of the examination date.

Training/Graduation Requirements
Training and Graduation Requirements will, at all times, be those described in the Booklet of Information of the American Board of Anesthesiology published annually by the Board. These booklets can be obtained through the American Board of Anesthesiology’s web site www.theaba.org

ACGME Competencies
All University of Minnesota Medical School Residency/Fellowship training programs define the specific knowledge, skills, attitudes, and educational experiences required by the RRC to ensure its residents/fellows demonstrate the following:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
- Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
- Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals.
- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

Clinical Competency Committee
The Program Director appoints the Clinical Competency Committee. The Clinical Competency Committee must consist of at least 3 members of program faculty, and it may consist of faculty from other departments and non-physician members of the health-care team.

The Clinical Competency Committee will:
  a) meet quarterly (in September, December, March and June)
  b) review all resident evaluations quarterly;
  c) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME;
  d) advise the program director regarding resident progress, including promotion, remediation, and dismissal.
  e) prepare and assure the reporting of each resident’s progress, including promotion, remediation, and dismissal semi-annually to ABA;

Program Evaluation Committee
The Program Director and Chair appoint the Program Evaluation Committee.

The Program Evaluation Committee will:
  1. Must be composed of at least two program faculty members and should include at least one resident.
2. Will actively participate in: (a) planning, developing, implementing, and evaluating educational activities of the program; (b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (c) addressing areas of non-compliance with ACGME standards; and (d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

3. The residency program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation.

4. The residency program must monitor and track each of the following areas: a) resident performance; b) faculty development; c) graduate performance, including performance of program graduates on the certification examination; d) program quality; e) progress on the previous year’s action plan(s).

5. Residents and faculty will have the opportunity to evaluate the residency program confidentially and in writing at least annually, and

6. The residency program will use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.

7. The Program Evaluation Committee will prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section 4, as well as delineate how they will be measured and monitored.

8. The action plan will be reviewed and approved by the teaching faculty and documented in meeting minutes.

Rotation Goals and Objectives
Please see http://www.anesthesiology.umn.edu/anesthesiology-residency/residency-rotation-summary/goals-and-objectives/index.htm for specific rotation goals and objectives.

Residency Curriculum
I. The program must demonstrate a judicious balance between didactic presentations and clinical care obligations. Clinical responsibilities must not prevent the resident from participating in the requisite didactic activities and formal instruction. The ultimate goal is to produce a consultant anesthesiologist who relates confidently and appropriately to other specialists in addition to being a competent clinical anesthesiologist.

Program Design
The continuum of education in anesthesiology consists of 4 years of training: the Clinical Base Year (CBY) and 36 months of clinical anesthesia training (CA-1, CA-2, and CA-3 years).

♦ Clinical Base Year
One year of the total training must be the Clinical Base Year, which should provide the resident with 12 months of broad education in medical disciplines relevant to the practice of anesthesiology. The Clinical Base Year usually precedes training in clinical anesthesia. It is strongly recommended that the Clinical Base Year be completed before the resident starts the CA-2 year; however, it must be completed before the resident begins the CA-3 year.

The Clinical Base Year must include at least 10 months of clinical rotations of which at most 1 month may involve training in anesthesiology. Clinical Base Year rotations include training in internal medicine or emergency medicine, pediatrics, surgery or any of the surgical specialties, critical care medicine, obstetrics and gynecology, neurology, family practice, or any combination of these. At most, 2 months of the Clinical Base Year may be taken in
electives or in specialties other than those listed above. If an accredited anesthesiology program offers this year of training, the RRC will verify that the content is acceptable. When the parent institution provides the Clinical Base Year, the anesthesiology program director must approve the rotations for individual residents and must have general oversight for rotations on the services that are used for the Clinical Base Year.

Clinical Anesthesia Training: CA-1 through CA-3 Years
These three years, usually the second through the fourth years of graduate medical education, consist of training in basic and advanced anesthesia. They must encompass all aspects of perioperative care to include evaluation and management during the preoperative, intraoperative, and postoperative periods. The clinical training must progressively challenge the resident's intellect and technical skills and must provide experience in direct and progressively responsible patient management. As the resident advances through training, she or he should have the opportunity to learn to plan and to administer anesthesia care for patients with more severe and complicated diseases as well as patients who undergo more complex surgical procedures. The training must culminate in sufficiently independent responsibility for clinical decision making and patient care so that the program is assured that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a consultant in anesthesiology.

CA 1 and 2 years
Experience in basic anesthesia training must emphasize the fundamental aspects of anesthesia. At least 12 months of the CA-1 and CA-2 years should be spent in basic anesthesia training, with the majority of this time occurring during the CA-1 year. Residents should receive training in the complex technology and equipment associated with the practice of anesthesiology. There must be documented evidence of direct faculty involvement with tutorials, lectures, and clinical supervision of beginning residents.

Anesthesiology encompasses the theoretical background and clinical practice of a variety of subspecialty disciplines. Exposure to these should occupy a minimum of 7 months in the CA-1 and CA-2 years. There must be identifiable 1-month rotations in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. Experiences in perioperative care must include a 2-month rotation in critical care, a 1-month rotation in pain management, and 2 contiguous weeks in the post anesthesia care unit. All CA-1’s must provide documentation of a passing USMLE Step 3 score, PRIOR TO JANUARY 1st OF THEIR PGY2 YEAR (per ACGME policy).

ACGME Policy:
All residents must provide their program with documentation of a passing score on the United States Medical Licensing Examination (USMLE) Step 3 or an equivalent examination that qualifies for medical licensure (i.e. Comprehensive Osteopathic Medical Licensing Examination – COMLEX) by January 1 of their PGY2 year.

The program director may determine the sequencing of these rotations. The resident should be evaluated following each rotation, and the written evaluations should be maintained in each resident's file. There must be a written description of each rotation in the CA-1 and CA-2 years. The goals and objectives for the CA-1 and CA-2 experience must be separate and distinct from those designed for the CA-3 year training.

CA-3 year
The program must provide 12 months' experience in advanced and complex anesthesia assignments in the CA-3 year. In addition, the resident must complete an academic assignment. A curriculum for the CA-3 year, as well as the specific program for each resident, must be on file in the department.

Clinical assignments in the CA-3 year must include difficult or complex anesthesia procedures and the care of seriously ill patients. Subspecialty rotations are encouraged, but none may be longer than six months. A curriculum specific to each of the subspecialty programs offered must be on file in the department. This curriculum must be distinct from the CA-1 and CA-2 years subspecialty curricula and must reflect increased responsibility and learning opportunity. These assignments must not compromise the learning opportunities for the CA-1 and CA-2 residents.

Academic projects may include special training assignments, grand rounds presentations, preparation and publication of review articles, book chapters, manuals for teaching or clinical practice, or similar academic activities. A faculty supervisor must be in charge of each project. The academic project may, at the program director's discretion, occur prior to the CA-3 year.

♦ Research Track
The program must have the resources to provide a Research Track of up to 6 months devoted to laboratory or clinical investigation. For the residents who elect this track, it is expected that the results of the investigations will be suitable for presentation at a local, regional, or national scientific meeting. The Research Track generally occurs in the CA-3 year, but at the program director's discretion, it may be taken earlier. A curriculum describing the goals and objectives of this track must be on file in the department.

♦ Clinical Components
A wide spectrum of disease processes and surgical procedures must be available within the program to provide each resident with a broad exposure to different types of anesthetic management within the anesthesiology residency program. The following list represents the minimum clinical experience that should be obtained by each resident in the program.

1. 40 patients undergoing vaginal delivery. There must be evidence of direct resident involvement in cases involving high-risk obstetrics;
2. 20 patients undergoing cesarean sections;
3. 100 patients less than 12 years of age undergoing surgery or other procedures requiring anesthetics.
   a. Within this patient group, 20 children must be less than three years of age,
   b. including five less than three months of age;
4. 20 patients undergoing cardiac surgery. The majority of these cardiac procedures must involve the use of cardiopulmonary bypass;
5. 20 patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intraabdominal vascular surgery, or peripheral vascular surgery. Excluded from this category is surgery for vascular access or repair of vascular access;
6. 20 patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures;
7. 20 patients undergoing intracerebral procedures.
   a. These patients include those undergoing intracerebral endovascular procedures.
   b. However, the majority of these twenty procedures must involve an open cranium;
8. 40 patients undergoing surgical procedures, including cesarean sections, in whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for perioperative
analgesia. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;
9. 20 patients undergoing procedures for complex, life-threatening injuries. Examples of these injuries include trauma associated with car crashes, falls from high places, penetrating wounds, industrial and farm accidents, and assaults. Burns covering more than 20% of body surface area also are included in this category;
10. 40 patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics. Use of a combined spinal/epidural technique may be counted as both a spinal and an epidural procedure;
11. 40 patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or perioperative analgesic management;
12. 20 new patients who are evaluated for management of acute, chronic, or cancer related pain disorders. Residents should have familiarity with the breadth of pain management including clinical experience with interventional pain procedures;
13. Patients with acute postoperative pain. There must be documented involvement in the management of acute postoperative pain, including familiarity with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities;
14. Patients scheduled for evaluation prior to elective surgical procedures. There must be documented involvement for at least four weeks in preoperative medicine;
15. Patients who require specialized techniques for their perioperative care. There must be significant experience with a broad spectrum of airway management techniques (e.g., performance of fiberoptic intubation and lung isolation techniques such as double lumen endotracheal tube placement and endobronchial blockers). Residents also should have significant experience with central vein and pulmonary artery catheter placement and the use of transesophageal echocardiography and evoked potentials. The resident must either personally participate in cases in which EEG or processed EEG monitoring is actively used as part of the procedure or have adequate didactic instruction to ensure familiarity with EEG use and interpretation. Bispectral index use and other similar interpolated modalities are not sufficient to satisfy this requirement;
16. Patients immediately after anesthesia. There must be a postanesthesia care experience of 0.5 month involving direct care of patients in the postanesthesia-care unit and responsibilities for management of pain, hemodynamic changes, and emergencies related to the postanesthesia-care unit. The Review Committee expects resident clinical responsibilities in the postoperative care unit to be limited to the care of postoperative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. Designated faculty must be readily and consistently available for consultation and teaching.
17. Critically ill patients. There must be a minimum of four months of critical care medicine distributed throughout the curriculum in order to provide progressive responsibility to trainees in the later stages of the curriculum. No more than two months of critical care medicine will be credited for training that occurs before the CA-1 year. Each critical care medicine rotation should be at least one month in duration, with progressive patient care responsibility in advanced rotations. Overall, this training must take place in units providing care for both men and women in which the majority of patients have multisystem disease. The postanesthesia-care unit experience does not satisfy this requirement. Anesthesia residents must actively participate in all patient care activities and as a fully integrated member of the critical care team. During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically ill patients and the educational activities of the residents.

Credit Granted
1. The ABA grants credit toward the CA1-3 year requirements for Clinical Anesthesia Training that satisfies all four of the following conditions:
   a. The CA1-3 years of training are spent as a resident enrolled with the ABA by no more than two ACGME-accredited anesthesiology residency programs in the United States or its territories.
   b. The period of Clinical Anesthesia training as an enrolled resident of any single program is at
least six months of uninterrupted training.

c. The six-month period of Clinical Anesthesia training in any one program ends with receipt of a satisfactory Certificate of Clinical Competence.

d. No more than six months during the first two Clinical Anesthesia years, and a maximum of 12 months during the three years of Clinical Anesthesia training are spent training outside the parent programs in affiliated or non-affiliated institutions. The Credentials Committee of the ABA must prospectively approve Clinical Anesthesia training in nonaffiliated programs.

Exceptions *Prospective approval is required for exceptions* to policies regarding the training planned for residents. The Credentials Committee of the ABA considers requests for prospective approval on an individual basis. The ABA must *receive* the request at least *two months before* the resident begins the training in questions.

**Chief Resident Election Process**

Being awarded the position of a Chief Resident is an honor and acknowledgement of hard clinical work, hard academic work and active participation in the Residency Program during the previous years of residency.

Residents interested in the position of Chief Resident need to:

1. Apply for the position;
2. Be eligible based on the below criteria;
3. Write a short explanation of their vision for the Chief Resident year.

All faculty and residents vote. Voting process is anonymous. The applicant who wins the highest number of votes gets appointed as Chief Resident, after they have been approved for the position by the Chair, Vice Chair of Education and Program Director.

Eligibility criteria for applicants are:

1. Active involvement in the development of the Residency Program throughout residency
2. ITE exam scores above 30th percentile
3. Never on probation

**Policy for the Supervision of Residents:**

**INSTITUTIONAL POLICIES**

**Supervision Policy for the Residents:**

University of Minnesota Medical School (UMMS)
Graduate Medical Education (GME) Administration

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<tr>
<th>Policy: Supervision</th>
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<tr>
<td>Original Approval:</td>
<td>Effective Date: 1.14.11; 9.20.02</td>
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<tr>
<td>Approved by GMEC: 9.20.02</td>
<td>Revision Date:</td>
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<td>Distribution: R/F; PD; PC; Institution Policy Manual; GME website</td>
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**Purpose:**

To ensure that the UMMS GME programs provide appropriate supervision for all trainees that is consistent with proper patient care, the educational needs of trainees, and the applicable Review Committee (RC) and Common Program Requirements.

**Policy:**

There must be sufficient institutional oversight to assure that trainees are appropriately supervised. Appropriate supervision means that a trainee is supervised by the teaching attending in such a
way that the trainees assume progressively increasing responsibility according to their level of education, proven ability, and experience. On-call schedules for teaching attending must be structured to ensure that supervision is readily available to trainees on duty. The level of responsibility accorded to each trainee must be determined by the program director/teaching attending.

Responsibility:
It is the responsibility of individual program directors to establish detailed written policies describing trainee supervision at each level for their residency/fellowship programs. The policies must be maintained in the Program Manual. The requirements for on-site supervision will be established by the program director for each residency/fellowship in accordance with ACGME guidelines and should be monitored through periodic department reviews, with institutional oversight through the GMEC internal review process.

Levels of Supervision
- Direct – the supervising physician is physically present with the trainee and patient
- Indirect
  - With supervision immediately available the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision
  - With direct supervision available the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by phone and/or other electronic modalities and is available to provide direct supervision
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after the care is delivered

Clarification:
A trainee may request the physical presence of an attending at any time and is never to be refused.

Any significant change in a patient’s condition must be reported immediately to the attending physician. All patients scheduled for discharge must be discussed with the attending prior to the discharge.

**Department Policy**

**Patient Care/Academic Responsibility**
All resident will have a professional and moral responsibility to provide best practices patient care at their appropriate level of training in the perioperative area, intensive care unit, and out-patient care environments under the supervision of attending faculty. Furthermore, in the spirit of intellectual curiosity, all residents will be responsible for the full body of knowledge expected for their level whether or not the subjects have been explicitly covered in lecture or other instruction. Residents are expected to take full ownership of their education and begin to exhibit the level of professionalism that will be required of them after leaving Residency.

**Progressive Responsibility**
In accordance with ACGME competencies the goal of resident education is achievement of independence in all six competencies. The rotations will therefore be structured in a way which will allow residents to at least progress in cognitive domain from knowledge to analysis or sometime synthesis, in the effective domain from receiving to receiving to internalizing, and in the psychomotor domain from perception to complex overt response and/or adaptation. Rotational goals and objectives have been designed to outline clear demarcations of responsibility and outline progressive growth expected during the period. Program director and faculty will provide residents with direct experience in progressive responsibility for patient management.

**Supervision of Residents**
All patient care is supervised by qualified faculty. The program director will ensure, direct, and document adequate supervision of residents and fellows at all times for their appropriate level. Residents/Fellows will be provided with rapid, reliable systems for communication with supervising faculty. 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 - the supervising physician must be the ones to determine the level of responsibility given to each resident. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty.

Faculty and Residents/Fellows are educated to recognize the signs of fatigue and will adopt and apply policies to prevent and counteract the potential negative effects. The staff anesthesiologist must be present in the University of Minnesota Hospital and immediately available throughout all anesthetics. This policy applies to general anesthesia, regional anesthesia for surgical and diagnostic procedures, and monitored anesthesia care (local standby).
Resident Duty Hours and Work Environment

INSTITUTIONAL POLICIES

General Policies & Procedures: Duty Hour Policy
University of Minnesota Medical School (UMMS)
Graduate Medical Education (GME) Administration

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<th>Policy: Duty Hours Policy and Procedure</th>
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Purpose
To outline the revised ACGME duty hour requirements, which take effect July 1, 2011, and the responsibilities of the trainees, programs as well as the sponsoring institution.

Policy Statement
All programs are required to adhere to and monitor compliance of their trainees with the ACGME duty hour standards as outlined in the revised ACGME Common Program Requirements. Programs must also follow the program-specific guidelines as outlined by their individual Review Committees (RCs). The sponsoring institution monitors program's adherence to the duty hour requirements through regular review of duty hour violations in RMS, the Internal Review process as well as annual review of program manuals to ensure the proper policies are in place.

Principles:
1) The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
2) The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
3) Didactic and clinical education must have priority in the allotment of residents’ time and energy.
4) Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Responsibilities of Program

Supervision
Programs must ensure that appropriate levels of supervision are provided to each trainee based on their level of training. Programs must enhance their current supervision policies to include the new ACGME requirements.

Transition of Care

- Must design clinical assignments to minimize the number of transitions in patient care
- Programs must ensure that trainees are competent in communication with team members in handover process
- Attendings and trainees must inform patients and family members of their roles in their care

Alertness Management

- Must educate faculty and trainees to recognize the signs of fatigue and sleep deprivation
- Must education faculty and trainees in fatigue mitigation process
- Develop fatigue mitigation processes to manage potential issues with patient care and learning (i.e. strategic napping, back-up call schedules). Programs must have a process in place to ensure that there is back-up in case a trainee is unable to perform his/her patient care duties
Responsibilities of Sponsoring Institution

Supervision
Sponsoring Institution is responsible for ensuring that programs have the appropriate supervisory lines in place for each PGY level.

Transition of Care
- Along with the program the Institution must ensure and monitor effective, structured handover process to facilitate both continuity of care and patient safety
- Must assure the availability of schedules that inform patients and all members of the healthcare team of faculty and trainees currently responsible for patient care.

Alertness Management
Must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely drive home.

Duty Hours
Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Max Hours per Week
- Duty hours must not exceed 80 hours per week averaged over a four week period inclusive of call and moonlighting activities
- Trainees in their final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods within the context of the 80 hour max

Continuous Duty Hours
- PGY-1 trainees must not exceed 16 hours
- PGY-2 trainees and above: must not exceed 24 hours. Trainees may spend an additional 4 hours to hours to complete transitions in care. Residents may not attend continuity clinics after 24 hours of continuous in-house duty. Trainees must have at least 14 hours free after 24 hours of in-house duty.

Duty Hour Expectations
Duty hour exceptions of 88 hours per week averaged over a four week period for select programs with sound educational rationale are permissible. Program must obtain permission from the Designated Institution Official and Graduate Medical Education Committee prior to submission to their Review Committee.

Mandatory Time Free of Duty:
- Trainees must have a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned during this time.
- PGY-1 residents should have 10 hours and must have eight hours free between duty periods.
- Intermediate-level residents should have 10 hours and must have eight hours free between duty periods. There must be at least 14 hours free of duty after 24 hours of in-house duty.

Call
In-House Call
PGY-2 and up: every third night when averaged over a four week period.
At-Home Call
- Time spent in the hospital must count toward the 80 hour week limit. At home call is not subject to the every third night limitation however trainees must receive one-in-seven free of duty when averaged over a four week period.
- At home call should not be so frequent or taxing to preclude rest or reasonable personal time for each resident
- Trainees are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80 hour weekly maximum will not initiate a new off-duty period
- PGY-1 residents are limited to 16 hour shifts and are not allowed to take at home call

Night float:
Trainees must not be scheduled for more than six consecutive nights of night float. Check with your individual RCs for maximum number of months of night float per year that may be allowed.

Moonlighting:
- PGY-1 residents are not permitted to moonlight
- Moonlighting must not interfere with the ability of a trainees to achieve the goals and objectives of the educational program
- Time spent by trainees in Internal and External moonlighting must be counted towards the 80 hour maximum weekly duty hour limit

Recording and Reporting Duty Hours:
In accordance with the Residency Management Suite (RMS) updating and approving assignments and hours in the duty hours policy, trainees are required to accurately record their duty hours on a daily basis in RMS.

Reporting Duty Hour Violations
In accordance with the Institution Duty Hour Monitoring Policy trainees concerned about continuous duty hour violations by their program can contact the Designated Institution Official or send a confidential email to gmedhv@umn.edu.

General Policies & Procedures: Duty Hours Prioritization of Call Rooms
On-call room assignments are made in order of priority based on the individual’s status and responsibilities.

Assignment Order:
- Residents and fellows required to take on-call from the hospital
- Year 3 and 4 medical students required to take on-call from the hospital (first- and second-year medical students are not required to take in-house call)
- Faculty required to take on-call from the hospital
- All other trainees, staff physicians or medical students needing an on-call room
- Non-medical staff, excluding CRNAs.

A trainee who is on-call and must remain at University of Minnesota Medical Center-Fairview (either campus) is guaranteed a room in which to sleep. The trainee will have the first option for selection of on-call rooms on the fourth floor of the Mayo Building (University campus) until 9:00 p.m. (2100 hours). Thereafter, call rooms will be distributed on a first-come, first-served basis. If the on-call rooms on the fourth floor of the Mayo Building are full, the nursing supervisor will be contacted and she/he will locate a room for the trainee. Every effort will be made to secure call rooms for Year-3 and -4 medical students and/or attending staff physicians who are on-call and need to remain in the hospital overnight.

General Policies & Procedures: Duty Hours/On Call Schedules
Providing trainees with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and trainees well-being. Each program must ensure that the learning objectives of
the program are not compromised by excessive reliance on residents/fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of trainees’ time and energies. Duty hour assignments must recognize that faculty and trainees collectively have responsibility for the safety and welfare of patients.

**General Policies & Procedures: Chief Resident Candidate Application and Election Process**

Being awarded the position of a Chief Resident is an honor and acknowledgement of hard clinical work, hard academic work and active participation in the Residency Program during the previous years of residency.

**Candidate Application:**
Residents interested in the position of Chief Resident need to:

1. Apply for the position;
2. Meet eligibility criteria, see below;
3. Write a short explanation of their vision for the Chief Resident year.

**Eligibility Criteria for Chief Resident Applicants:**

1. Active involvement in the development of the Residency Program throughout residency
2. ABA In-training exam scores above the 30th percentile
3. Never on probation

**Election Process:**
After Chief Resident candidates are announced, all faculty and residents will be allowed one vote each during an open announced voting period. This voting process will be anonymous. The Chief Resident applicant who wins the highest number of votes after the completed voting period has ended will be appointed as Chief Resident after they have been approved by the Chair, Vice Chair of Education and Program Director. The Chair, Vice Chair of Education and Program Director have the authority to assign the Chief Resident without a vote.

**Institutional Policies**

Institution Responsibilities: Duty Hour Monitoring at the Institution Level Policy and Procedure
DEPARTMENTAL POLICIES

Daily Operating Room Schedule
Residents are expected to be ready for operating room work by no later than 0600 unless an earlier start time is required for a specific case or given specific instructions otherwise by the rotation or program director.

Case Pre-Op and Attending Notification East Campus
Next day staff assignments will be made available by 3pm, if at all possible. Please review case information and patient histories on EPIC prior to contacting faculty. Be prepared to discuss detailed case management for the first case, and any pertinent anesthetic issues for the subsequent cases. Given typical schedule shifts over the weekend, final assignments for Monday cases may not be available until Sunday afternoon—please check online for changes and plan to discuss cases with staff on Sunday afternoon or early evening.

All inpatients should be seen and examined in person and a full preoperative anesthesia note (including physical exam) written in EPIC. At this time, an EPIC “pend” note function in the perioperative arena is not available. Do not enter template notes. A “pend” function may be available in the near future and the policy on template notes will be amended at that time.

Consult staff communication preference sheet and either page or call or text message staff after leaving OR for the day, but no later than 8pm. If paging, leave your pager number and/or cell phone number as staff may not be able to return your call immediately.

Case Pre-Op and Attending Notification West Campus
The next day resident assignments will be made available by 3pm, when possible. On the day before, residents are welcome and encouraged to look at the next day’s scheduled cases with the faculty member they are working with, to determine their room preference, based on their case log needs. Faculty assigned to the resident room for the following day will be notified by e-mail by 5-6pm, when possible.

Residents are advised to review case information and patient histories on EPIC prior to contacting their assigned faculty. The residents need to be prepared to discuss detailed case management for the first case, and any pertinent anesthetic issues for the subsequent cases. Given typical schedule shifts over the weekend, final assignments for Monday cases may not be available until Sunday afternoon – please check online for changes and plan to discuss cases with staff on Sunday afternoon or early evening.

All inpatients should be seen and examined in person, followed by entry into EPIC and a full preoperative anesthesia note (including physical exam). At this time, an EPIC “pend” note function in the perioperative section is not yet available. Residents must not enter template notes. A “pend” function may be available in the near future and the policy on template notes will be amended at that time.

Residents may consult their staff via pager, phone call or text message staff after leaving OR for the day, but no later than 8pm. If paging, leave your pager number and/or cell phone number as staff may not be able to return your call immediately.

Duty Hours / Electronic Evaluations (RMS Resident Management Suite software)
The department, as a part of the larger MMCGME (Metropolitan Minnesota Council on Graduate Medical Education) organization requires the resident’s use of RMS to log their daily duty hours for reimbursement and to complete electronic evaluations. Residents must submit their approved duty hours for the month through RMS by the first working day of the following month. In the event that duty hours are not logged in accordance with the above, the resident will receive an email reminder as a first notification, followed by action if required as deemed appropriate by the Clinical Competency Committee.

Duty Hour violations will not be tolerated. Any violation of duty hours will be carefully analyzed by the Program Director and Coordinator to determine the source. In the event that there is a pattern of persistent violations corrective action will be taken by the Program Director and Chair. In rare instances in which the
resident feels the violation relates to patient safety, unusual patient condition, or specific resident interest the duty hour violation will be tolerated only to a strictly limited extent and must be documented accordingly.

**Resident On-Call Activities and Duty Hours**

Duty Hours are defined as all clinical and academic activities related to the training 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. Duty hours are tracked by the Residency Management Suite (RMS). This is required as the Duty Hours report is an ACGME requirement.

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.
- Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

**Unique Call Rules:**

- All residents in the Department of Anesthesiology shall be assigned evening, night, weekend, and holiday call consistent with their experience and level of training.
- Post-call Residents will not administer anesthesia without a minimum of 10 hours off duty.
- Every resident shall have a period of 24 continuous hours off duty every week at a minimum when averaged over a four-week period.
- In-house call must occur no more frequently than every third night, averaged over a four-week period.
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents/Fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care. No new patients may be accepted after 24 hours of continuous duty.

**Electronic Evaluations (RMS Resident Management Suite software)**

Using the RMS electronic evaluation form, residents are evaluated against the ACGME’s core competencies at the end of each rotation (every one - four months) and quarterly by all faculty. Evaluations are obtained after all rotations, including affiliated institution and elective resident-tailored specialty rotations. The residents are provided with continuous feedback (both written and verbal) on their performance during each rotation. In general midpoint written evaluations are only done on a rotation in which a trainee is performing sub-optimally. During the last days of each rotation, the coordinating teaching faculty member is expected to personally discuss their evaluation with the trainee. Trainees further acknowledge that their evaluations have been discussed with their advisors on Meeting with Advisor forms kept in their binder.

Trainees are evaluated on their performance and attainment of the rotation’s goals and objectives, demonstrated ability to provide informative consultation to the clinical service teams, their medical knowledge, their application of this knowledge to efficient/quality patient care, their technical and observational skills, the effectiveness of their teaching skills, and their attendance and participation in conferences. Trainees are also evaluated on their interpersonal skills, professional attitudes, reliability, and ethics with members of the teaching faculty, peers, laboratory staff, and clinicians. They are further evaluated on their appropriate use of initiative in fostering quality patient care and use of the medical literature. Their timely completion of assigned interpretive reports is another component of the evaluation. Trainees on probation receive a written mid-rotation evaluation.

These evaluations review a trainee's service performance and identify their strengths and weaknesses related
to the practice of Anesthesiology. Such regular faculty evaluation of the trainees provides guidance and direction for continued professional and personal development. Towards the goal of facilitating regular and timely faculty evaluations with written documentation:

1. Through RMS the Program Coordinator will send evaluation forms to the coordinating teaching faculty members on the last day of the month in which the trainee completes their current rotation. Quarterly general evaluation forms will be sent to the coordinating teaching faculty members during September, December, March, and June.
2. The coordinating teaching faculty members will complete the electronic evaluation form prior to meeting with the trainee.

Likewise, resident promise to submit their own evaluations of faculty and rotations within the time periods allowed.

Resident Portfolio (RMS Resident Management Suite software)
Residents will create a scholarly activities portfolio in RMS and upload QI improvement project presentations, IHI open school certifications, journal assignments and any other relevant projects or presentations throughout their anesthesiology residency.

Anesthesia QI Commitment and Case List
Improvements in quality and patient safety are outcomes promoted by the ACGME. Conversations about teamwork, systems, continuous process improvement and practice based on evidence and outcomes should be a part of our everyday practice. As part of our department’s quality and safety programs we have developed an Anesthesiology QI Case List within EPIC. Residents should use this case list to log all cases and procedures that have an outcome that is interesting or unexpected for discussion of any of the six ACGME competencies.

To access the Anesthesiology QI Case List within EPIC please follow the instructions below:
1) To add a patient to the list, right click on the patient name and go to List Memberships. Then select UMMC Anesthesia Case List
2) Once the patient has been added to the list, you may refresh this list and you will see the patient name on the list
3) To add any modifiable factors to the sticky notes to physicians tab, click on Hospital Chart on the right upper side of the screen
4) Click on Snap Shot (At the top of the left hand side of the screen below patient name)
5) Click on Index
6) Click on add/edit comment button in blue (it’s the very top field for MD sticky notes) and add whatever note you would like to be saved
7) At this point if you click refresh again on the patient list the MD sticky note will appear in the field box.

Residents will further be expected to participate in a QI lecture series, complete on-line materials provided to them during the lecture series and complete a QI project (individually or in teams). The QI project will consist of several stages: defining a problem and finding a faculty mentor (CA-1 year), completing the project and presenting the project at different stages to faculty and co-residents for feedback (CA-2-3).

ACLS/BLS/PALS Certification Requirements
All CA-3 residents must be certified as providers for advanced cardiac life support (ACLS).
Prior to junior residents being assigned duties which include responding to codes, emergency room intubations, they will become certified in ACLS and, additionally, before assignment on a pediatric rotation residents will become certified in PALS. PALS will serve to supplement their current ACLS certification to expand their expertise to children. The goal is to improve residents’ confidence in stressful situations dealing with sick or deteriorating children, and improve their assessment skills and knowledge in this unique patient subset.
Work Environment:

Call Rooms
The Call Rooms are maintained in space leased by Fairview at the following locations: CA-3 (C492) 273-7187 & CA-1 (C408) 624-3979. If there is an issue with the call room please call the Security Monitor (612) 626-6330 so that they can record the issue for the Fairview coordinator Mira Jurich. If the issue is during the day you can contact Mira directly at mjurich1@Fairview.org or (612) 273-7482 – please contact/Cc the program coordinator as well to allow for follow-up.

Security/Safety
Appropriate security and personal safely measures must be provided to residents at all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities (e.g. medical office building).

Prevention of Tuberculosis During Educational Rotations
In accordance with OSHA regulations for health care workers, AHC students will be required to complete mask fit testing. Students will carry documentation of testing and the mask requirements during rotations.

Support Services
Patient support services, such as intravenous services, phlebotomy services, and laboratory services, as well as messenger and transporter services, must be provided in a manner appropriate to and consistent with education objectives and patient care.

Laboratory/Pathology/Radiology services
There must be appropriate laboratory, pathology, and radiology services to support timely and quality patient care in the program. This must include effective laboratory, pathology, and radiologic information systems.

Medical Records
Residents use the ACGME Case Logs to log all procedures conducted during their training. Complete, accurate and up to date record keeping is not only an essential part of their professional duties, but also for comprehensive patient care. In recognition of this case logs are reviewed regularly by the coordinator and Program Director for the above as well as progress towards completion of the minimum clinical experience level required by the ACGME and the ABA for completion of the residency.

Comprehensive, timely and legible medical records are an element of their rotational and quarterly evaluations and are reviewed by the coordinator and Program Director and at regular Clinical Competency Meetings.

A medical records system that documents the course of each patient’s illness and care must be available at all times and must be adequate to support quality patient care, the education of residents, quality assurance activities, and provide a resource for scholarly activity.

Fatigue
Once a patient care jeopardizing level of fatigue has been identified, the affected resident and/or identifying peer/staff should contact the Officer of the Day immediately (or, if after hours, the available attending or the senior resident on call) to arrange for an immediate transfer of care to another provider. Cab vouchers for residents too fatigued to drive will be provided by University of Minnesota Medical Center –Fairview and distributed in the following way:

- Monday-Friday daytime hours
  Contact Officer of the Day on OR floor or call numbers below
  University Campus - contact the Anesthesia Control Room @ (612) 273-2926.
  Riverside Campus – (612) 273-4097.
• Evenings and weekends
  University Campus - Anesthesia Control Room @ (612) 273-2926 or CA-3 Resident @ (612) 899-8989
  Riverside Campus – (612) 273-4097.

Monitoring of Resident Well-Being
Program Director is responsible for monitoring resident stress, including mental or emotional conditions inhibiting performance or learning, and drug-related or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Situations that demand excessive service or that consistently produce undesirable stress on residents will be evaluated and modified.

Moonlighting
INSTITUTIONAL POLICY
University of Minnesota Medical School (UMMS)
Graduate Medical Education (GME) Administration

| Policy: Moonlighting Policy |  |
|----------------------------|  |
| Policy #                   |  |
| Original Approval:         | Effective Date: 6.25.04 |
| Approved by GMEC: 6.25.04  | Revision Date: 9.23.13; 10.7.13 |
| Distribution: R/F; PD; PC; Institution Policy Manual; GME website | Policy Owner: GME Administration |

Purpose
The purpose of this policy is to provide residents/fellows (trainees) and their programs with information on managing moonlighting in compliance with the ACGME requirements, CMS regulations, immigration law and the Minnesota Board of Medical Practice. If statements in this policy contradict those of the ACGME, CMS, immigration law or the Minnesota Board of Medical Practice, their policies take precedence.

Policy
Trainees must not be required to engage in moonlighting activities.

PGY-1 residents are not permitted to moonlight.

Programs are not required to permit moonlighting for their trainees and may choose to disallow these activities as a matter of program policy.

Moonlighting must not interfere with the trainee’s ability to achieve the goals and objectives of the training program.

Moonlighting activities are not considered to be part of the educational curriculum in University of Minnesota residency and fellowship programs.

Time spent moonlighting must be reported as a part of duty hours monitoring and must be included in assessments of compliance with ACGME duty-hour requirements.

Trainees must seek and receive written permission from their program director BEFORE engaging in moonlighting activities. This permission must acknowledge the trainees understanding that
  • their trainee professional liability coverage through the University of Minnesota does not cover moonlighting activities,
  • moonlighting activities must not interfere with their achieving program goals and objectives, including compliance with duty hour regulations, and
• the program director may review moonlighting activities at a later date and reserves the authority to withdraw permission to moonlight.

The program must retain a copy of this correspondence in the trainee’s file.

Trainees on J-1 visas are not permitted to be employed outside their training program and are not permitted to moonlight.

Trainees on H-1B visas must obtain separate H-1B visas for each facility where the trainee works outside the training program.

**Trainee Responsibility**

1. Trainees who wish to moonlight must obtain prior permission from their program directors. Failure to get prior approval is grounds for discipline under Section VI of the Residency/Fellowship Agreement.
2. Trainees must report moonlighting as a part of their duty hours in the Residency Management Suite (RMS).

**Program Responsibility**

1. The Program Director determines the moonlighting policy for all trainees within their program.
2. Program directors will acknowledge in writing their awareness that a trainee is moonlighting and will include this information in their training file.
3. Program directors may withdraw permission to moonlight for any given trainee or group of trainees at their discretion.

**Professional Liability**

University of Minnesota professional liability coverage for trainees does not cover moonlighting or any other activities outside the curricular components of the training program. Trainees must obtain separate liability coverage for moonlighting activities.

**Other Information**

Trainees engaged in moonlighting activities must be properly licensed and credentialed as determined by the organization hiring them to provide the service. **It is the hospital’s or clinic’s responsibility to determine whether billing is appropriate.**

• When moonlighting occurs in an inpatient facility that is an educational site for University of Minnesota residency and fellowship training, neither the hospital, a clinical group, nor a physician should bill for services provided by the trainee.

• When moonlighting occurs in an emergency department or outpatient clinic at a facility that is an education site for residency and fellowship training, the hospital may be able to bill for services provided by the trainee, if the trainee:
  1. Is licensed and credentialed to practice in that hospital; and
  2. Has a separate contract which identifies how the moonlighting duties are separate from regular resident duties and not part of the educational program.

• When moonlighting occurs at a facility that is not an educational site for University of Minnesota residency and fellowship training, the facility may be able to bill for services provided by the trainees.

**Procedure**

1. The trainees thoroughly reviews the institutional moonlighting policy, their program moonlighting policy and the moonlighting request form.
2. If the trainee’s program allows moonlighting, the trainee must complete the University of Minnesota Graduate Medical Education Standard Moonlighting Request Form located in the Department Notices section of their RMS homepage.
3. The trainee must complete tall sections of the form and present it to their program director for review.
4. The program director may deny or approve the request.
5. If the program director approves the request the trainee may proceed with moonlighting at the approved site.
6. If the program director denies the request, the trainee may not moonlight.
7. The fully executed moonlighting request form (all signatures obtained) will be uploaded to RMS. It will reside in the files and notes section of the trainee’s personnel record in RMS.
8. The program must use this naming standard as they scan and save the completed form: Moonlighting Request Form Year/Month_Last Name, First Name (e.g. Moonlighting Request form 2013.10_Smith, John)

Definitions
Moonlighting: Any activity that is not an explicit expectation of the curriculum of the training program and for which a trainee receives compensation.

Participating Site: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of sites include: a university, a medical school, a teaching hospital which includes its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency an organized health care delivery system, a health maintenance organization (HMO), a medical examiner’s office, a consortium or an educational foundation.

DEPARTMENT POLICY
Moonlighting
Moonlighting requires a prospective, written statement of permission from the program director that will be made part of the residents’ file; Residents are not required to engage in Moonlighting*; Moonlighting activities will not be allowed to conflict with the scheduled and unscheduled time demands of the educational program and its faculty; the Resident/Fellow’s performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission; and all Moonlighting (internal or external) must be counted toward the 80-hour weekly limit on duty hours.

Moonlighting definitions:
- Internal Moonlighting is worked preformed for the sponsoring institution or its affiliated residency sites.
- External Moonlighting is all additional work that is not considered Internal Moonlighting.

Moonlighting may be allowed only so long as it does not interfere with the resident’s duties in the affiliated teaching hospitals nor with the resident’s night and weekend call rotations at those hospitals. The Department Head on an individual basis will deal with any case where a resident is known to moonlight and is doing poorly in his/her program.

The guidelines set by the University of Minnesota Medical School Administration will be followed Please see www.med.umn.edu/gme/ for policy on moonlighting. Any resident that chooses to moonlight must notify the Program Director, in writing, that they are moonlighting. The Program Director, in turn, will acknowledge this notification, also in writing, and a copy of both will be placed in the resident’s file. Failure of the resident to follow the moonlighting guidelines will result in disciplinary action.

However, physicians holding a J-1 visa are not authorized to moonlight. They may only receive compensation for activities that are an integral part of the residency/fellowship program for which they are sponsored. Employment outside the approved training is a violation of program status and would subject the J-1 physicians to termination of his or her program.
Recruitment, appointment, eligibility, selection, and promotion of residents

INSTITUTIONAL POLICY — ELIGIBILITY AND SELECTION

General Policies & Procedures: Essential Capacities for Matriculation, Promotion & Graduation for U of M GME Programs

Essential Capacities for Matriculation, Promotion, and Graduation
University of Minnesota Medical School Graduate Medical Education Programs

I. General Issues
A. Overview
- Graduate Medical Education requires that the accumulation of scientific knowledge be accompanied by the simultaneous development of specific skills and competencies. Because our Medical School has a responsibility to society to graduate the best possible physicians, all resident physicians and fellows must meet both our academic standards and our technical standards to matriculate, to progress through the curriculum and to meet the requirements for graduation from University of Minnesota Medical School residency and fellowship programs.

Academic standards refer to acceptable demonstrations of mastery in various disciplines, before matriculation and after, as judged by faculty members, examinations, and other measurements of performance. Acceptable levels of mastery are required in six broad areas of competency once a student matriculates at the University of Minnesota Medical School. These six areas of competency are used by graduate medical education programs to evaluate their residents.

These six areas of competency are:
- Medical/scientific knowledge
- Clinical Skills/patient care
- Professionalism
- Communication/interpersonal skills
- Practice-based learning (engaging in self-assessment and utilizing appropriate resources to make improvements in one’s learning and performance)
- Systems-based practice (understanding complex medical systems in order to effectively carry out responsibilities to optimize patient care)

The University of Minnesota Medical School residency and fellowship programs are committed to preparing our residents and fellows within the continuum of medical education. Our academic and technical standards are based upon the goal of training capable, well-rounded future clinicians.

Academic standards are addressed in more detail in the curriculum. Any resident or fellow who has specific questions about performance requirements, should speak with the residency/fellowship program director.

Our technical standards are described in detail under item II. Technical standards refer to the essential aptitudes and abilities that allow individuals to perform the duties required of resident physicians and fellows. Additional technical standards may be added to meet the specific requirements of individual programs.

Without the capability to meet our technical standards, residents and fellows cannot fulfill the requirements of residency/fellowship programs at the University of Minnesota Medical School. Meeting the University of Minnesota Medical School technical standards (detailed below) is, therefore, required for 1) matriculation (inasmuch as the abilities can reasonably be determined before matriculation), 2) subsequent promotion from year to year, and 3) successful completion of a residency/fellowship program from the University of Minnesota Medical School.

B. Residents and Fellows with Disabilities
It is our experience that a number of individuals with disabilities (as defined by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act) are qualified to study and practice medicine with
the use of reasonable accommodations. To be qualified for the study of medicine at the University of Minnesota Medical School, those individuals must be able to meet both our academic and technical standards, with or without reasonable accommodation. Accommodation is viewed as a means of assisting individuals with disabilities to meet essential standards by providing them with an equal opportunity to participate in all aspects of the program. (Reasonable accommodation is not intended to guarantee that residents/fellows will be successful in meeting the requirements of the course or program.)*

*Reasonable Accommodations May Not:

- fundamentally alter the nature of the training program
- compromise the essential elements of the program
- cause an undue financial or administrative burden
- Endanger the safety of patients, self or others

C. The Use of Auxiliary Aids and Intermediaries

Qualified residents/fellows with documented disabilities are provided with reasonable accommodations at the University of Minnesota Medical School, which may include involvement of an intermediary or an auxiliary aid. No disability can be reasonably accommodated at the University of Minnesota Medical School with an intermediary that provides cognitive support or substitutes for essential clinical skills, or supplements clinical and ethical judgment. Thus, accommodations cannot eliminate essential program elements or fundamentally alter the residency/fellowship program curriculum.

II. The University of Minnesota Medical School Technical Standards

Residents and fellows at the University of Minnesota Medical School must meet the technical standards, with or without reasonable accommodations, which are grouped in five broad areas:

A. Perception/Observation

Residents and fellows must be able to perceive, by the use of senses and mental abilities, the presentation of information through:

- Small group discussions and presentations
- Large-group lectures
- One-on-one interactions
- Demonstrations
- Laboratory experiments
- Patient encounters (at a distance and close at hand)
- Diagnostic findings
- Procedures
- Written material
- Audiovisual materials

B. Communication

Residents and fellows must be able to skillfully (in English) communicate verbally and in written form with faculty members, other members of the healthcare team, patients, families, and other students, in order to:

- Elicit information
- Convey information
- Clarify information
- Create rapport
- Develop therapeutic relationships
- Demonstrate the Medical School and core competencies

C. Motor/tactile function

Residents and fellows must have sufficient motor function and tactile ability to meet the competencies required for graduation and to:

- Attend (and participate in) classes, groups, and activities which are part of the curriculum
• Communicate in a written format
• Examine patients (including observation, auscultation, palpation, percussion, and other diagnostic maneuvers)
• Do basic laboratory procedures and tests
• Perform diagnostic procedures
• Provide general and emergency patient care
• Function in outpatient, inpatient, and surgical venues
• Perform in a reasonably independent and competent way in sometimes chaotic clinical environments
• Demonstrate the Medical School and core competencies

D. Cognition
Residents and fellows must be able to demonstrate higher-level cognitive abilities, which include:
• Rational thought
• Measurement
• Calculation
• Visual-spatial comprehension
• Conceptualization
• Analysis
• Synthesis
• Organization
• Representation (oral, written, diagrammatic, three dimensional)
• Memory
• Application
• Clinical reasoning
• Ethical reasoning
• Sound judgment

E. Professionalism:
Residents and fellows must be able to:
• Consistently display integrity, honesty, empathy, caring, fairness, respect for self and others, diligence, and dedication
• Promptly complete all assignments and responsibilities attendant to the diagnosis and care of patients (beginning with study in the first year)
• Develop mature, sensitive, and effective relationships, not only with patients but with all members of the medical school community and healthcare teams
• Tolerate physically, emotionally, and mentally demanding workloads
• Function effectively under stress, and proactively make use of available resources to help maintain both physical and mental health
• Adapt to changing environments, display flexibility, and be able to learn in the face of uncertainty
• Take responsibility for themselves and their behaviors

Any residency or fellowship applicant or resident/fellow who has a question about whether he or she can meet these standards due to the functional limitations from a disability, should contact Disability Services for a confidential discussion.

Disability Services
University of Minnesota Twin Cities
McNamara Alumni Center
200 Oak St SE Suite 180
Minneapolis, MN 55455
Phone: (612) 626-1333 (V/TTY)
Fax: (612) 626-9654
www.ds.umn.edu

A disability specialist is available to talk with any medical school applicant or resident/fellow about their concerns related to a physical, sensory, medical, learning, or psychiatric condition that may be a disability.
General Policies & Procedures:
Standing and Promotion Policy

INSTITUTIONAL POLICY

USMLE Step 3 Policy
All residents must provide their program with documentation of a passing score on the United States Medical Licensing Examination (USMLE) Step 3 or an equivalent examination that qualifies for medical licensure (i.e. Comprehensive Osteopathic Medical Licensing Examination – COMLEX) by January 1 of their PGY-2 year.

Residents who do not notify their program of a passing score by January 1 of their PGY-2 year forfeit their continuing position in the training program and are subject to contract non-renewal. Upon application to the program, residents who transfer into a University program (PGY-3 and beyond) are required to provide documentation of a passing score on their examination.

SECTION 5A - INSTITUTION POLICIES AND PROCEDURES

SECTION 5B - ROTATION SPECIFIC GOALS AND OBJECTIVES
Please see www.anesthesiology.umn.edu/residency/rotations/home.html for specific rotation goals and objectives.

SECTION 5B.1 – FAIRVIEW SPECIFIC POLICIES AND PROCEDURES
Please see https://contentprod.fairview.org/fv/groups/public/documents/publishedweb/p_c_006729.hcsp for the most current Fairview institution policies and procedures. Appendix C at the end of this document contains many highlighted selections from the above website including important perioperative, patient, and MRI safety policies.
SECTION 6 - ADMINISTRATION

Payroll Information
Residents/fellows are paid bi-weekly (every other Wednesday. If you have direct deposit (encouraged) your statement will be accessible on-line only. To access go to www.umn.edu/ohr/hrss. You will need your x.500 number (the beginning of your email address) and your own password.

Department and Program Administration Contacts
Phone Number: (612) 624-9990, fax: (612) 626-2363 unless otherwise noted. (See http://www.anesthesiology.umn.edu/ for additional information)

Dr. Ioanna Apostolidou, Associate Professor, Anesthesiology
Dr. David Beebe, Professor of Anesthesiology
Dr. Kumar Belani, Professor of Anesthesiology
Dr. Martin Birch, Assistant Professor, Anesthesiology
Dr. Chandra Castro, Assistant Professor, Anesthesiology
Dr. Eliza Chen, Assistant Professor, Anesthesiology
Dr. Elif Cingi, Assistant Professor of Anesthesiology
Dr. Megan Clinton, Assistant Professor, Anesthesiology
Dr. Chad Cutshall, Assistant Professor, Anesthesiology
Dr. Erin Danahy, Assistant Professor, Anesthesiology
Dr. Mark Eggen, Assistant Professor, Anesthesiology
Dr. Barbara Gold, Associate Professor, Anesthesiology, UMP Senior VP for Clinical Quality
Dr. Christine Herr, Assistant Professor, Anesthesiology
Dr. Jacob Hutchins, Assistant Professor, Anesthesiology
Dr. Douglas Koehntop, Assistant Professor, Anesthesiology
Dr. Mojca R. Konia, Associate Professor, Anesthesiology; Vice Chair of Education; Residency Program Director
Dr. Thomas Kozhimannil, Assistant Professor, Anesthesiology
Dr. David Lane, Assistant Professor, Anesthesiology
Dr. Megan Lanigan, Assistant Professor, Anesthesiology
Dr. Susan Lava-Parme, Assistant Professor, Anesthesiology
Dr. Shau-Shau Lin, Associate Professor, Anesthesiology
Dr. Nina Morrisette, Assistant Professor of Anesthesiology
Dr. Megan Nolan, Assistant Professor of Anesthesiology
Dr. Shannon Peters, Assistant Professor, Anesthesiology
Dr. Richard Prielipp, JJ Buckley Professor, Anesthesiology
Dr. Martina Richtsfeld, Assistant Professor, Anesthesiology
Dr. Rehan Siddiqui, Assistant Professor, Anesthesiology
Dr. Aaron Summers, Assistant Professor, Anesthesiology
Dr. Michael Sweeney, Associate Professor of Anesthesiology and Pediatrics
Dr. Joyce Wahr, Professor, Anesthesiology
Dr. Mike Wall, JJ Buckley Professor and Program Chair, Anesthesiology

Ms. Theresa Diggs, Executive Student Support Services Assistant
Ms. Jeanne Miner, Executive Office and Administrative Specialist
Mr. Mike Hahne, Program Coordinator
Ms. Sally Sawyer, ALRT Graduate Medical Education Manager, (612) 625-3518 or sallyann@umn.edu
## APPENDIX A: UM ANESTHESIOLOGY RECOMMENDED READING LIST

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**BIO-MEDICAL LIBRARY:**
All required resident reading can be found under quick links on the University of Minnesota’s [Bio-Medical Library](http://example.com/bio-medical-library).
APPENDIX B: UNIVERSITY OF MINNESOTA MEDICAL CENTER – FAIRVIEW SELECTED POLICIES AND PROCEDURES

While the following procedures highlight many of the safety policies and procedures within UMMC-F, please see https://contentprod.fairview.org/fv/groups/public/documents/publishedweb/p_c_006729.hcsp for the most current Fairview institution versions.

General Safety:
Magnetic Resonance Imaging Safe Practice Guidelines
Magnetic Resonance Imaging Safety Policy
Patient Fire Safety
Surgical Attire
Time Out for Patient Safety

Anesthesia Preoperative Guidelines:
Anesthesia Preoperative Guidelines
Roles and Responsibilities of Medical Staff
Preoperative Area Admission Criteria
Assessment of Patients in Perioperative Services
Perioperative Anesthesia Orders Protocol
Care of Patient Receiving Local Anesthesia
Care of Patients in Perioperative Services
Documentation in Perioperative Services
Verbal Medication Delivery Process: Operating Room
Medication Administration and Security
Admission, Transfer, Discharge from PACU

MEDICAL EMERGENCY COVERAGE PROVIDED BY HOSPITAL TEAMS

University of Minnesota Medical Center, Fairview

Updated March 2010

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<td>Rapid Response</td>
<td>Team/House Doctor Stat</td>
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<td>Team/House Doctor Stat</td>
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<tr>
<td>Corporate</td>
<td>Code Blue</td>
<td>Rapid Response</td>
<td>Team/House Doctor Stat</td>
</tr>
</tbody>
</table>

The Rapid Response Team responds to all RRT and House Doctor Stat calls on Riverside campus no matter which way they are called. The preferred method is to request the Rapid Response Team.

University Campus

<table>
<thead>
<tr>
<th>Building</th>
<th>Type of Medical Emergency Call</th>
<th>First Response</th>
<th>Rapid Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit J</td>
<td>Code Blue</td>
<td>Code Blue</td>
<td>Rapid Response Team</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Blue</td>
<td>Intended for any patient, visitor or staff member who is:</td>
</tr>
<tr>
<td></td>
<td>• Bleeding excessively</td>
</tr>
<tr>
<td></td>
<td>• Unconscious or unresponsive</td>
</tr>
<tr>
<td></td>
<td>• Not breathing</td>
</tr>
<tr>
<td></td>
<td>• Without a pulse</td>
</tr>
<tr>
<td></td>
<td>• Showing any signs of cardiac or respiratory arrest</td>
</tr>
<tr>
<td></td>
<td>• Seizing</td>
</tr>
<tr>
<td>First Response</td>
<td>Intended for any patient, visitor or staff member in an outpatient or non-patient care area with a condition or symptoms that are not immediately life-threatening, but require an assessment or assistance that the clinic or area is unable to provide. Such issues may include:</td>
</tr>
<tr>
<td></td>
<td>• Falls with injury</td>
</tr>
<tr>
<td></td>
<td>• Dizziness or fainting</td>
</tr>
<tr>
<td></td>
<td>• Serious cuts</td>
</tr>
<tr>
<td></td>
<td>• Hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>• Shortness of Breath</td>
</tr>
<tr>
<td></td>
<td>• Chest pain</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>Intended to bring immediate critical care expertise to the bedside of any inpatient or ancillary care area patient appearing at risk for deterioration that has not responded adequately to initial treatment. The RRT will assess the patient, explore additional treatment options, and if appropriate, facilitate transfer to a higher level of care.</td>
</tr>
<tr>
<td></td>
<td>The Rapid Response Team should be called whenever:</td>
</tr>
<tr>
<td></td>
<td>• Someone caring for the patient believes, for whatever reason, that the patient is not properly responding to existing attempts to stabilize or prevent deterioration.</td>
</tr>
<tr>
<td></td>
<td>• Someone caring for the patient believes that the current plan to stabilize or prevent deterioration cannot be adequately executed or sustained at the current level of care.</td>
</tr>
</tbody>
</table>

911 should be called for medical emergencies in all other buildings (on either campus).

When there is any doubt about the severity of the problem or uncertainty about which team is appropriate, a **Code Blue** should be called.

Note that the PWB Response Team is temporarily unable to respond to calls due to short-term staffing issues.
Response team requests will be immediately upgraded to Code Blue until this problem is rectified (likely by May 2010).