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Welcome and Introduction

It is our pleasure to welcome you to the Department of Anesthesiology at Tulane University School of Medicine. We appreciate your selecting this program and have prepared this handbook to answer some of your questions about the program.

The residency program in anesthesiology is designed to assist each resident in the acquisition of excellence in each of the Accreditation Council for Graduate Medical Education’s core competencies: Medical Knowledge, Patient Care, Professionalism, Interpersonal and Communication Skills, Practice Based Learning and Improvement, and Systems Based Practice. Our goal is to prepare graduates for the demands of practice in a variety of settings, or for advancement into subspecialty fellowship training. As consultants in perioperative medicine our graduates will possess the knowledge and skills necessary to competently negotiate the complexities of patient care in the operating suite, intensive care unit, hospital floor, or out-patient clinic. Emphasis will be placed on understanding the role of anesthesiologist as facilitator in a complex medical care delivery system. Furthermore, the importance of professionalism and skill in communication will pervade the entire training experience of each resident.

The department and the residency program has a clearly defined mission, and goals and objectives, that are designed to nurture efficiency, motivation, intellectual honesty, critical appraisal, accountability, self-evaluation and a spirit of inquiry.

In pursuit of this educational mandate we have developed a clinical and didactic curriculum to include a variety a clinical experiences in graduated levels of intricacy as well as a comprehensive and well organized lecture series, complemented by journal clubs, mock oral exams, grand rounds presentations, and morbidity and mortality rounds. The opportunity to develop competency in various technical skills will be incorporated into our simulation experience. High fidelity human patient simulation will focus on critical event training including effective crisis resource management.

Upon successful completion of the residency training program, you will be well prepared for American Board of Anesthesiology primary certification. You will know and understand the role of an anesthesiologist as a perioperative consultant. You will possess the set of skills necessary to advocate for patient safety, and you will count yourself among those of us who have the distinct privilege to be entrusted with the care of another.

Jonathan Weed, M.D.
Residency Program Director
Key Personnel

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Website: tulaneanesthesiology.com/web

Up-to-date copies of this document can be found at:
http://www.tulaneanesthesiology.com/web/default.asp?id=departmentalpolicies
Mission Statement

**Mission:** The Department’s mission supports that of the Hospital, Medical School and University and, therefore, encompasses education and research as well as patient care and administration. The standard for the department is excellence, and is expected in:

1. **Clinical Care:** Excellent Patient Care – Deliver humane, state of the art management in all aspects of perioperative medicine. Patient safety will never be compromised.

2. **Education:** To promote high quality education of residents, medical students, faculty, healthcare providers and community members in an environment of innovation and scholarship.

3. **Research:** To foster an environment that supports relevant cutting-edge research leading to the advancement of our department, our specialty and society.

4. **Leadership:** To actively participate in the administration and the committees of the medical school, hospital, and practice plan and to actively promote leadership development within the department through education and mentorship.

5. **Quality of Life:** To have a high regard for what benefits one’s work/life balance.

To achieve excellence in all areas the department promotes a collegial cohesive work environment so that the institution will flourish and provide quality, affordable health care for Tulane’s patients. Additionally, as a collegial environment is essential to achieving the mission, members of the department seek excellence in interpersonal relationships to promote an environment that fosters creativity, inquiry, and study. To provide the best possible patient care in a collegial cohesive work environment that is committed to enhancing the quality of life of both our patients and members of our department.

Revised July, 2016
Anesthesiology Residency Goals and Objectives

Goal:
The Tulane University Department of Anesthesiology Residency Program aims to provide an environment of academic and clinical excellence in which trainees are given the opportunity to achieve. Graduates will attain the clinical competency, technical skill, and professional perspective necessary to become leaders in the field of anesthesiology.

Objectives:
Above all, the primary objective of the Anesthesiology Residency Program is to prepare graduates to meet the high standards necessary for primary certification by the American Board of Anesthesiology. This credential, more than any other, provides anesthesiologists with opportunities for career success. Additionally, successful graduates will demonstrate competency in Medical Knowledge, Patient Care, Professionalism, Interpersonal and Communication Skills, Practice Based Learning and Improvement, and Systems Based Practice in accord with the Accreditation Council for Graduate Medical Education standards.

Your progression throughout the residency will be measured utilizing the ACGME and ABA’s Milestones. These are provided in Appendix A. Familiarize yourself with these so that you will be able to understand the standards by which you will be measured. In addition, increasing levels of proficiency in each of the core competencies is expected as follows:

1. End of One Month

   Medical Knowledge
   2. Average 70% or better on weekly quizzes.
   3. Have working knowledge of inhaled and intravenous anesthetics, muscle relaxants, opioids, and emergency drugs present in the anesthesia cart.
   4. Be familiar with the content of the last one month of Anesthesiology and Anesthesia and Analgesia.
   5. AHA Basic CPR

   Patient Care
   1. Maintain an airway in an anesthetized, spontaneously ventilating healthy patient with no anatomical airway problems.
   2. Perform laryngoscopy and oral intubation in normal anesthetized patients without assistance most of the time.
   3. Set up all necessary anesthesia equipment for a simple procedure and check the anesthesia machine.
   4. Set up an EKG monitor.
   5. Set up and check an anesthesia machine, including checks for leaks, ventilator function, "fail-safe" operation, flow meters and alarm.
6. Anesthetize an ASA I patient for an uncomplicated surgical procedure without assistance, including induction, maintenance, awakening and transportation to the PACU.
7. Present to an attending anesthesiologist an ASA I or II patient in a concise manner and include all important preanesthetic factors and problems.
8. Formulate and describe in detail a plan for the anesthetic management of an ASA I patient having uncomplicated surgery.

Interpersonal and Communication Skills

1. After one month of training residents will be expected to display the interpersonal and communication skills necessary to successfully integrate into the department.
2. Residents will be expected to provide concise and well-organized presentations of their patients to faculty, and to demonstrate the ability to build rapport with patients and care team members.

Professionalism

1. Demonstrate the qualities of a medical professional expected of the clinical base year.
2. Report on time, well prepared, and ready to begin day’s assignments.
3. Demonstrate an attitude of ownership over the care of assigned patients.

Practice-Based Learning

1. Integrate feedback given by faculty into the care of subsequent patients.
2. Attend problem-based learning sessions in order to develop methodologies of approach to patient problems.
3. Prepare for upcoming cases by discussing plans with faculty and researching practice standards for particular cases.

Systems Based Practice

1. After one month, residents are expected to begin the process of understanding patient throughout in the perioperative process.
2. Understand the basics of the intraoperative care team and how to mobilize support if necessary.
3. Express understanding of the basics of anesthesia billing and compliance with Medicare/Joint Commission standards.

2. End of Three Months

Medical Knowledge

1. Barash, Cullen, Stoelting, Cahalan and Stock; Clinical Anesthesia 6th Edition, Chapters 1-8
2. Anesthesiology – past 3 months
3. Anesthesia and Analgesia –past 3 months
4. Average 70% or better on weekly quizzes,
5. Demonstrate basic understanding of anesthetic issues involved in the perioperative care of 
ASA Physical Status I and II patients undergoing low risk surgical procedures.

**Patient Care**

1. Maintain an airway during induction, maintenance, and awakening in most patients, 
breathing or apneic, without an endotracheal tube.
2. Perform laryngoscopy and oral intubation in most patients without assistance.
3. Perform technical aspects of spinal anesthesia in most patients.
4. Perform technical aspects of lumbar epidural anesthesia with assistance.
5. Perform arterial cannulation including setting up of transducers and lines and calibration 
of monitors with assistance.
6. Perform central venous cannulation (brachial, external jugular, or internal jugular) with 
assistance.
7. Witness or perform at least one regional anesthesia block (other than spinal and lumbar 
edpidural blocks).
8. Provide general and/or spinal anesthesia without requiring assistance for most ASA II 
patients having uncomplicated surgery.
9. Present to an attending anesthesiologist an ASA III patient in a concise manner and 
include all important preanesthetic factors and problems.
10. Formulate and describe in detail a plan for the anesthetic management of an ASA II or III 
patient having uncomplicated surgery. It should include a list of likely problems and at least 
one solution for each problem.
11. Explain the rationale for all drugs and procedures used.

**Interpersonal and Communication Skills**

1. Residents should demonstrate the ability to effectively establish rapport and communicate 
the details of an anesthesia care plan to patients and family.
2. Communicate effectively with the surgical team regarding the anesthetic needs of the 
patient.
3. Present perioperative complications in clear medically precise language at mortality and 
morbidity conferences.

**Professionalism**

1. Demonstrate a consistent attitude of ownership over the anesthetic care of the assigned 
patient.
2. Practice and interact in a manner that reflects the essential characteristics of an 
anesthesiology professional: honesty, vigilance, trustworthiness, altruism, and competence.
3. Attend all assigned activities and arrive well prepared for the assigned case.

**Practice-Based Learning**

1. Continue to integrate faculty feedback into anesthesia practice.
2. Integrate published practice guidelines into anesthetic plan, and modify as the needs of the 
patient dictate.
3. Participate in simulation and group discussion of intraoperative scenarios and approaches to 
problem solving.
Systems Based Practice

1. Residents should begin to understand the process necessary to insure efficiency in individual O.R. caseload.
2. Residents should become familiar with the integration of services necessary to provide surgical service.
3. Residents should be able to invoke emergency assistance should it be necessary.

3. End of Six Months

Medical Knowledge

2. Anesthesiology – past 6 months
3. Anesthesia and Analgesia – past 6 months
4. Average 70% or better on weekly quizzes
5. Demonstrate thorough understanding of anesthetic issues involved in the perioperative care of ASA Physical Status I and II patients undergoing low and moderate risk surgical procedures.
6. Demonstrate basic understanding of anesthetic issues involved in the perioperative care of ASA Physical Status III and IV patients undergoing low and moderate risk surgical procedures.

Patient Care

1. Perform airway maintenance and orotracheal intubation with only rare requirement for assistance.
2. Perform nasotracheal intubation under direct vision and with assistance.
3. Insert a pulmonary artery catheter with direction and assistance.
4. Perform two different regional anesthesia blocks (other than spinal and lumbar epidural blocks).
5. Provide general, spinal or epidural anesthesia with minimal assistance for most ASA III patients having uncomplicated surgery.
6. Provide general, spinal or epidural anesthesia with assistance for ASA IV and V patients.
7. Take care of patients in the Post Anesthetic Care Unit (P.A.C.U.) with assistance, including setting-up and adjusting ventilators to provide appropriate ventilation, pain management, blood pressure control, fluid management, monitoring and appropriate time of discharge.
8. Present to an attending anesthesiologist ASA IV or V patients in a concise manner and include all important preanesthetic factors and problems.
9. Formulate and describe in detail a plan for the anesthetic management of ASA IV patients including a list of likely problems and two possible solutions for each problem.

Interpersonal and Communication Skills

1. Demonstrate effective communication with patients and their families regarding issues pertaining to perioperative management.
2. Become an integrated team member of both the operating room community as well as the department of anesthesiology.
3. Consistently deliver organized and appropriate presentations of patients’ clinical history and anesthetic plan to assigned faculty.

Professionalism

1. Dependably arrive at the patient’s bedside in holding area on time and prepared for the day’s caseload.
2. Address colleagues and patients in a manner that displays respect, confidence, and competence. Ask questions when appropriate and follow instructions as given.
3. Adhere to all regulations governing the perioperative care of patients.
4. Display an attitude helpfulness and team spirit.

Practice-Based Learning

1. Consistently integrate faculty feedback into the care of subsequent patients.
2. Demonstrate understanding of the care standards for healthy patients undergoing straightforward surgical procedures.
3. Lead discussions of clinical scenarios at morning problem-based learning sessions.

Systems Based Practice

1. Residents should demonstrate an understanding of the process by which patients navigate between various health care providers necessary to successfully undergo a surgical procedure.
2. Residents should be able to demonstrate a basic understanding of the role of the department of anesthesiology in the hospital community.
3. Residents should consistently complete all necessary processes in order to insure compliance with billing and documentation standards.

4. End of One Year

Medical Knowledge

1. Familiarity and working knowledge of Chapters 1-30 of Barash, Cullen, Stoelting, Cahalan, and Stock’s; Clinical Anesthesia 6th Edition
2. Anesthesiology – past one year
3. Anesthesia and Analgesia – past one year
5. Average 70% or better on weekly quizzes.
6. Score over 30th percentile on American Board of Anesthesiology In-Service Exam.
7. Have working knowledge of all journal articles presented at journal club during CA-1 year.
8. Demonstrate basic knowledge of anesthetic issues involved in the perioperative care of any patient undergoing any surgical procedure regardless of surgical risk.
9. Pass American Board of Anesthesiology Basic Examination.
Patient Care

1. Perform all general anesthesia techniques without assistance.
2. Perform all monitoring techniques without assistance except for insertion of pulmonary artery lines (may need assistance).
3. Perform three different regional anesthesia blocks (other than spinal and lumbar epidural blocks).
4. Perform spinal and epidural blocks without assistance in most patients.
5. Provide general and/or regional anesthesia without assistance for ASA I and II patients having major complicated surgical procedures (general, orthopedic, urologic gynecologic, eye, ENT but not including major liver or trauma surgery).
6. Provide anesthesia for any adult patients with direction and assistance.
7. Demonstrate: ability to function appropriately in emergency situations.

Interpersonal and Communication Skills

1. Residents will demonstrate an understanding of the role of effective communication as it applies to the development of a therapeutic relationship with the patient; residents will learn the common barriers to effective communication, and will learn the importance of effective communication between members of the patient care team.
2. Residents will demonstrate effective communication with their patients, particularly during the pre-anesthetic assessment and the discussion of benefits and risks of both general and regional anesthesia.
3. Residents will develop effective listening skills, and must be able to communicate effectively with other members of the health care team.
4. Residents must demonstrate commitment to accurate and legible documentation of pre-operative information, intraoperative record keeping and post-operative orders.
5. Residents will appreciate the importance of effective communication with both patients and other health care providers; residents will develop behaviors that contribute to effective communication.

Professionalism

1. Residents should be able to define the basic domains of medical professional behavior including; altruism, honor and respect, caring and compassion, respect, responsibility and accountability, excellence and scholarship.
2. Residents will demonstrate a commitment to professionalism in their day-to-day interactions with both patients and co-workers by; showing respect for their patients’ wishes; interacting with nursing and other staff in a polite and respectful way; observing patient confidentiality practices at all times; dressing appropriately; arriving for work on time; answering pagers in a timely way; attending departmental conferences and education activities; complying with departmental policies and procedures.
3. Residents will develop an appreciation of the importance of professional behavior and how it impacts on patient care and the smooth functioning of the health care system. Residents will complete all preoperative, intraoperative and post operative documentation according to departmental requirements.
Practice-Based Learning

1. Residents will develop an understanding of the importance of life long learning and the various modalities available for practiced based learning including; didactic lectures; conferences and grand rounds; morbidity & mortality and quality improvement (QI) conferences; journal clubs; local, national and international meetings; journals and web-based educational material; use of “real time” simulation in anesthesia education; residents will learn statistical methods for evaluating research; the principles of evidence based medicine; the importance of learning from experience.

2. Residents will attend the educational conferences available to them in the anesthesia department.

3. Residents will demonstrate behaviors that show a commitment to practice based learning, they will be expected to take part in all the educational activities organized by the anesthesia department.

Systems Based Practice

1. Residents will gain understanding of the broader aspects of the health care system and how the care they offer patients influences, and is influenced by other parts of the health care system; residents will learn about quality improvement programs; control of health care costs; the importance of working as part of a team; practice management; patient flow through the operating room system including the pre-anesthesia clinic and post-anesthesia care unit.

2. Residents will be able to demonstrate anesthetic practices that include systems issues such as reducing costs; working as a member of an interdisciplinary team member (PACU, pre-anesthesia clinic); managing post-operative complications; facilitating case turn over.

3. Residents will show considerations for the broader aspects of the health care system when working in the operating room; residents will become advocates for improving the health care system and assisting their patients in negotiating the system.
5. End of Two Years

Medical Knowledge

1. Strong working knowledge of information contained in Barash, Cullen, Stoelting, Cahalan, and Stock; Clinical Anesthesia 6th Edition
2. Anesthesiology – past two years
3. Anesthesia and Analgesia – past two years
4. Average 80% or better on weekly quizzes.
5. Score over 30th percentile on American Board of Anesthesiology In-Service Exam.
6. Have working knowledge of all journal articles presented at journal club during CA-1 and CA-2 years.
7. Demonstrate thorough understanding of anesthetic issues involved in the perioperative care of any surgical patient.

Patient Care

1. Perform all general anesthesia and monitoring techniques without assistance.
2. Perform spinal, lumbar, epidural, caudal, intercostal, axillary, interscalene, femoral, sciatic, popliteal and ankle blocks with success most of the time.
3. Provide general and/or regional anesthesia without assistance from an attending anesthesiologist (but may have technical help) for all patients for all procedures except cardiac and neonatal surgery.
4. Provide anesthesia for cardiac and neonatal surgery with attending anesthesiologist's assistance.
5. Take care of all anesthesia related problems in patients in the PACU.
6. Take care of most Intensive Care Unit patients with some faculty guidance.

Interpersonal and Communication Skills

1. Residents should display their understanding of the role of effective communication as it applies to the development of a therapeutic relationship with the patient and particularly with more complicated patients; residents will gain knowledge of the means to ensure effective communication with pediatric patients and their parents.
2. Residents will be able to demonstrate effective communication with their patients; particularly pediatric patients and their parents and obstetric patients; residents will demonstrate appropriate methods of communicating with patients on the intensive care unit and with the families of these patients; residents will develop effective listening skills; residents will be able to communicate effectively with other members of the health care team as demonstrated by accurate and legible documentation of pre-operative information, intraoperative record keeping and post operative orders;
3. Residents will appreciate the importance of effective communication with both patients and their families and other health care providers; residents will develop behaviors that contribute to effective communication.

Professionalism
1. Residents will further develop their knowledge of professionalism and expand these principles into the subspecialties including pediatrics, obstetrics, intensive care and pain management.

2. Residents will be able to demonstrate a commitment to professionalism in their day-to-day interactions with both patients and co-workers by; showing respect for their patients’ wishes; interacting with nursing and other staff in a polite and respectful way; observing patient confidentiality practices at all times; dressing appropriately; arriving for work on time; answering pagers in a timely way; attending departmental conferences and education activities; complying with departmental policies and procedures.

3. Residents will develop an appreciation of the importance of professional behavior and how it impacts on patient care and the smooth functioning of the health care system. Residents will complete all preoperative, intraoperative and post-operative documentation according to departmental requirements.

**Practice-Based Learning**

1. Residents will develop an understanding of the importance of life-long learning and the various modalities available for practiced based learning including; didactic lectures; conferences and grand rounds; morbidity & mortality and quality improvement (QI) conferences; journal clubs; local, national and international meetings; journals and web-based educational material; use of “real time” and web-based simulation in anesthesia education; residents will learn statistical methods for evaluating research; the principles of evidence based medicine; the importance of learning from experience.

2. Residents will attend various educational conferences available to them in the anesthesia department; resident will undertake an active role in the preparation of presentations for local and national meetings.

3. Residents will demonstrate behaviors that show a commitment to practice based learning, they will be expected to take part in all the educational activities organized by the anesthesia department.

**Systems Based Practice**

1. Residents will gain understanding of the broader aspects of the health care system and how the care they offer patients influences, and is influenced by other parts of the health care system; residents will learn about quality improvement programs; control of health care costs; the importance of working as part of a team; practice management; patient flow through the operating room system including the pre-anesthesia clinic and post-anesthesia care unit.

2. Residents will be able to demonstrate anesthetic practices that include systems issues such as reducing costs; working as a member of an interdisciplinary team in the obstetric unit, on interdisciplinary pain rounds and taking part in post operative rounds; managing patients with post anesthesia complications; facilitating case turn over.

3. Residents will show considerations for the broader aspects of the health care system when working in the operating room; residents will become advocates for improving the health care system and assisting their patients in negotiating the system.
6. End of Three Years

Medical Knowledge

1. Demonstrates competency in all areas of medical knowledge required by the American Board of Anesthesiology.
2. Average 90% on weekly quizzes.

Patient Care

1. Clearly demonstrate the ability to function independently and competently in all clinical environments expected of an anesthesiologist.
2. Practice anesthesiology consistent with all standards and guidelines of the American Society of Anesthesiology.
3. Fulfill all of the following requirements of the American Board of Anesthesiology:

Case Requirements (Cumulative)

a. 40 vaginal deliveries
b. 20 C-sections
c. 100 pediatric cases (< 12 years of age)
   i. 20 must be < 3 years of age, including 5 less than 3 months of age)
d. 20 cardiac cases (majority must involve cardiopulmonary bypass)
e. 20 intrathoracic noncardiac cases
f. 20 intracerebral cases (open or endovascular with majority open)
g. 20 open or endovascular surgery on major vessels
h. 20 Major Trauma cases
i. 40 patients with spinal blocks for surgery
j. 40 patients with epidural blocks for surgery
k. 40 peripheral nerve blocks for surgical procedures
l. 20 patients evaluated for the management of acute, chronic, or cancer pain

Interpersonal and Communication Skills

1. Residents must demonstrate mastery of techniques for effective communication with patients concerning pre-operative assessment, explaining the process and discussing risks of general and regional anesthesia.
2. Residents must demonstrate effective listening skills and show effective communication with both patients and other members of the patient care team.
3. Residents must demonstrate behaviors that show commitment to effective communication with both patients and other members of the surgical team; residents should be able to communicate pertinent data about the patient to their attending in a medically precise and efficient manner.

Professionalism

1. Residents are expected to contribute to the smooth running of the operating rooms, and are expected to efficiently complete all pre, intraoperative and post-operative documentation in accordance with departmental requirements.
2. Residents must demonstrate commitment to professional practice in their interactions with patients, colleagues and other members of the health care team.

**Practice-Based Learning**

1. Residents will demonstrate the practice of reflection on their performance and how to learn from experience; they will understand the principles of life-long learning and evidence – based medicine.
2. Residents will demonstrate reflective practice and display skills to enhance learning from various sources including the use of web-based learning.
3. Residents will demonstrate commitment to continually trying to improve their performance and take an active role in furthering their knowledge.

**Systems Based Practice**

1. Residents must understand the team approach to how patients present, are investigated, assessed and optimized for surgical procedures and how their management impacts on this team approach; residents will understand the practice of fast tracking patients after surgery and how this impacts on cost effective practice.
2. Residents will take part in practices and initiatives such as quality improvement programs that interact with other areas of the health care system; residents will be expected to function as a team member and work with nurses, surgeons and staff to improve the care they offer their patients and their own understanding of the broader aspects of the health care system.
3. Residents will demonstrate behaviors that show an appreciation for the impact of their practices on the whole system caring for patients undergoing surgery.
Tulane University School of Medicine  
Department of Anesthesiology  

**Affiliated Hospitals**

Tulane University Hospital and Clinic (TUHC)  
1415 Tulane Ave.  
New Orleans, LA 70112  
504.988.5800

Tulane-Lakeside Hospital (TU-LK)  
4700 I-10 Service Rd.  
Metairie, LA 7001  
504.988.5800

Children’s Hospital-New Orleans (CH-NO)  
200 Henry Clay Ave.  
New Orleans, LA 70118  
504.899.9511

Ochsner Medical Center (OH)  
1514 Jefferson Hwy  
New Orleans, LA 70121  
504.842.3000; 504-842-4937 – GME office

Southeast La. Veterans Health Care System (VA)  
1601 Perdido Street  
New Orleans, LA 70112  
800.935.8387; 504.566-8408, GME office; 504-412-3700, x7565 surgery services

Baton Rouge General Medical Center (BRG)  
3600 Florida Blvd.  
Baton Rouge, LA 70806  
225.387.7000; 225-387-7736 – GME office

Medical Center of Louisiana-New Orleans  
Interim LSU Hospital Campus (UH)  
2021 Perdido Street  
New Orleans, LA 70112  
504.903.3000; 504-903-4441 – GME office

West Jefferson Medical Center (WJ)  
1101 Medical Center Blvd.  
Marrero, LA 70072  
504.347.5511; 504-349-1897-GME office
### Organization of the Anesthesiology Residency

The residency in anesthesiology at Tulane University School of Medicine is a four-year program starting at the PGY-1 year. The Clinical Base Year (CBY) level is designed to provide the anesthesiology resident the wide range of clinical experience that the resident needs prior to entering into his/her clinical anesthesia training. The CA-1 (PGY II) level is devoted to the basics of anesthesia. Early emphasis is placed on teaching the resident the basics of preoperative anesthesia care, general anesthesia, monitored anesthesia care, post-anesthesia care and anesthesia equipment. Later in the CA-1 level the emphasis shifts to the anesthetic care of children and pregnant women as well as critical care medicine. The CA-2 (PGY III) level is set aside for basic rotations in the subspecialties of anesthesiology. The CA-3 (PGY IV) level is dedicated to the mastery of anesthesia, including advanced subspecialty experiences as requested by the resident. In addition, a Research Option is available in the CA-3 year, and the Department has many research clinicians as well as basic scientists who will open their laboratories to support resident research. The CBY, CA-1 and CA-2 levels are relatively rigid in design; however, the CA-3 level is much more flexible and allows the resident to individualize his/her educational experience.

### CBY Level

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
<td>TUHC/UH</td>
</tr>
<tr>
<td>ICU</td>
<td>2 months</td>
<td>TUHC/UH</td>
</tr>
</tbody>
</table>

Remaining rotations will be determined by the program director of the Internal Medicine Residency Program. All requirements of both the Accreditation Council of Graduate Medical Education’s Residency Review Committee for Anesthesiology and the American Board of Anesthesiology for the Clinical Base Year will be fulfilled.

### CA-1 Level

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>General OR</td>
<td>5-6 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>General OR</td>
<td>2-3 months</td>
<td>TU-LK</td>
</tr>
<tr>
<td>SICU</td>
<td>1 month</td>
<td>OH</td>
</tr>
<tr>
<td>OB Anes</td>
<td>2 months</td>
<td>TU-LK</td>
</tr>
<tr>
<td>PACU</td>
<td>0.5 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>Pre-Op Clinic</td>
<td>0.5 months</td>
<td>TUHC</td>
</tr>
</tbody>
</table>

### CA-2 Level

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>General OR</td>
<td>1-2 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>Cardiothoracic Anes</td>
<td>2 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>Neuroanesthesia</td>
<td>2 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>Pain (Chronic)</td>
<td>2 months</td>
<td>VA</td>
</tr>
<tr>
<td>Acute Pain &amp; Regional</td>
<td>1-2 months</td>
<td>TU-LK</td>
</tr>
<tr>
<td>Pediatric Anes</td>
<td>2 months</td>
<td>CH-NO</td>
</tr>
<tr>
<td>SICU</td>
<td>1 month</td>
<td>OH</td>
</tr>
</tbody>
</table>

### CA-3 Level - Advanced Anesthesia Training

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Adv Clinical Anes</td>
<td>1-2 months</td>
<td>TUHC</td>
</tr>
<tr>
<td>Trauma Anesthesia</td>
<td>1 month</td>
<td>UH</td>
</tr>
<tr>
<td>Advanced Cardiac</td>
<td>1-2 months</td>
<td>BRG or TUHC</td>
</tr>
<tr>
<td>Advanced Pediatrics</td>
<td>1-2 months</td>
<td>TU-LK</td>
</tr>
<tr>
<td>Elective/Research</td>
<td>4-6 months</td>
<td>TBA</td>
</tr>
</tbody>
</table>
In the CA-3 year, emphasis will be placed on clinical competence, complex training experiences and independence. According to ABA regulations, “The program director, in collaboration with the resident, will design the resident’s CA-3 year of training….residents are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining months in advanced anesthesia training, in one to three selected subspecialty rotations, or in research. Residents may train in one anesthesia subspecialty for at most six months during the CA3 year and no more than twelve months during the CA 1-3 years”.

Advanced Anesthesia Training consists of 6 months of required rotations as stated above and six additional months in selected subspecialty rotations. The selected subspecialty rotations can be any of the subspecialty rotations for the CA-3 level as listed below. The following criteria are considered in selection of advanced subspecialty rotations for each resident: First, residents who are deficient in the number of cases required by the RRC and ABA will be assigned to rotations that will allow the resident to obtain the number of cases that they need. Second, residents whom the anesthesia faculty members feel need additional training in certain areas of anesthesia will be assigned to rotations that will allow them to gain that additional training. After these two criteria have been met, the resident can choose the rotation(s) that s/he wishes to take from the options below. No particular month(s) can be specified. The resident will list choices in order of importance (first choice is number one). All subspecialty months (up to 6) can be the same subspecialty. All requests for specific rotations must be submitted in writing to the Residency Coordinator by May 1 of the CA-2 year.

The subspecialty rotations for the CA-3 level include:

1. Adv Clinical Anes  
2. Adv Neuroanesthesia  
3. Adv Cardiothoracic Anes  
4. Adv Pediatric Anes  
5. Adv Obstetric Anes  
6. Adv Pain Medicine (Chronic)  
7. Adv Pain Medicine (Acute)  
8. Adv Critical Care Medicine  
9. Adv Trauma Anes

Options for Research

This option is for residents who are pursuing a career in academic medicine. It allows the resident to spend time in a clinical research project or a basic science research project. There are both clinical and basic-science research faculty who can be mentors. The option consists of 6 months of required rotations as stated above and up to six months in research assignments. All requests for Research Options must be submitted in writing to the residency coordinator by January 31 of the CA-2 year, and all arrangements for research rotations must be finalized by May 1 of the CA-2 year. Requests must specify a well-defined research project that will lead to publication in a peer-reviewed academic medical journal. Approval by the Chairman of the Clinical Competence Committee and the Chairman of the Department of Anesthesiology is necessary for a resident to be assigned a research month. Residents who have been on probation during their CA-2 year are not eligible.
Specific Clinical Rotation Information

Information about specific clinical rotations is contained in the individual rotation Goals and Objectives. **Residents are required to obtain and review this information at least two weeks prior to the beginning of the rotation.** The Goals and Objectives will contain expectations for each of the ACGME core competencies, the reading assignments and any required presentations for the specific clinical rotation. All rotation goals and objectives are available on the departmental website: www.tulaneanesthesiology.com.
Anesthesiology Residency Program Requirements

USMLE Step 3

All residents must pass the USMLE Step 3 before they enter the CA-1 year. Passing USMLE scores must be received by the residency program coordinator prior to July 1st of the CA-1 year. Failure to pass USMLE Step 3 prior to July 1st of the CA-1 year may result in termination from the program.

Licensure

All residents must possess a valid unrestricted license or training permit to practice medicine from the Louisiana State Board of Medical Examiners. Annual renewal of licensure is the responsibility of each resident, and any restriction, suspension, or revocation of licensure must be reported to the Residency Program Director immediately. A copy of each resident’s current valid medical license must be kept on file with the Residency Program Coordinator. Residents are prohibited from taking part in any clinical activities while any question whatsoever exists regarding the current status of medical licensure.

Louisiana State Board of Medical Examiners
Contact Info

Mailing Address:  P.O. Box 30250  New Orleans, LA 70190-0250
Physical Address:  630 Camp Street  New Orleans, LA 70130

Telephone:  504.568.6820  Fax:  504.568.8893
Email:  lsbme@lsbme.la.gov
Website:  www.lsbme.louisiana.gov
Governing Bodies

Tulane University School of Medicine
Office of Graduate Medical Education

The office of Graduate Medical Education is responsible for supervising the administration of resident education for the University. The Residency Program Director works closely with the Vice Dean for Graduate Medical Education to insure that all standards of the University and its accrediting agencies are met. An annual update of the policies and procedures governing resident Graduate Medical Education as well as the Tulane University School of Medicine Resident Handbook are available at the Graduate Medical Education website listed below.

GME Website Info:  www.tulane.edu/som/gme/index.cfm
mailing address:  1430 Tulane Ave.
                  Box 8025
                  New Orleans, LA 70112
GME Office Address:
                  131 S. Robertson Street, Suite 1520
                  New Orleans, LA 70112
                  Telephone:  504.988.5464

Accreditation Council for Graduate Medical Education (ACGME)

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the accreditation of postgraduate medical training programs within the United States. Their website is an excellent source of information regarding residency programs and their requirements.

https://apps.acgme.org/connect/login

Residency Review Committee (RRC)

The RRC for Anesthesiology has established requirements that must be met by anesthesia residency training programs to maintain accreditation for training purposes.

American Board of Anesthesiology (ABA)

The ABA certifies physicians who complete an accredited anesthesiology training program. Its mission is to maintain the highest standards of the practice of anesthesiology and to serve the public, medical profession and health care facilities and organizations. http://www.theaba.org/
ABA Requirements

Full details of the ABA requirements are published in the ABA booklet of information (BOI) http://www.theaba.org/Home/publications

You may also access the following link to find information regarding: http://www.theaba.org/Home/examinations_certifications

- Calendar of Activities
- Application for Certification
- Entrance Requirements
- Fees
- Written/Oral examination documentation

Certificate of Clinical Competence

The ABA requires each resident training program to file an Evaluation of Clinical Competence in January and July every year for each resident in the program. This will be done by the anesthesiology residency office, provided residents have received a satisfactory report from the Clinical Competency Committee.

If an unsatisfactory evaluation is submitted to the ABA for a given 6 month period, the resident may still receive credit toward the ABA requirement of 36 months of clinical anesthesia training, provided that the resident achieves a satisfactory rating for the next consecutive 6 month period. If a resident receives two or more consecutive 6-month periods of unsatisfactory performance prior to a 6-month period of satisfactory performance, then the ABA will grant no more than 6 months of the satisfactory period toward the ABA requirements. In such a case, the resident’s training would have to extend beyond 36 months.

Absence from training

The ABA specifies that any and all absences from training may not exceed 60 working days during the Clinical Anesthesia 1 – 3 years. Attendance at scientific meetings, not to exceed five working days per year is considered part of training.

ABA Examination Application Details

It is an expectation that all graduates of the Tulane Anesthesiology Residency Program successfully achieve ABA Board Certification. The ABA board certification testing process consists of 3 staged exams: the BASIC, ADVANCED, and APPLIED Exams. The BASIC exam is taken in June at the end of the CA-1 year (and is offered again in November). The ADVANCED exam is taken after completion of residency (usually offered twice a year in July and January). The APPLIED exam consists of 2 components: a Standard Oral Examination (SOE) and an Objective Structured Clinical Examination (OSCE--still in development). The APPLIED exam is offered several times per year and can be taken after a passing score is achieved on the ADVANCED exam.

Each resident must make his/her own application for admission to the ABA examination system using the ABA Electronic Application system, via the ABA website at www.theABA.org. Residents must apply for certification by creating a portal account at this website. Current fees,
dates, eligibility for the exams, and information about the exam content are posted on the ABA website at [www.theABA.org](http://www.theABA.org).

ABA candidates must satisfy all requirements for Board certification, including successful completion of the BASIC, ADVANCED and APPLIED Examinations, within 7 years of the last day of the year in which residency was completed.

Residents who have completed 18 months of satisfactory training including CB and CA will be eligible to register for the BASIC Examination held in the June at the end of their CA-1 year. If residents begin training “off cycle” and will complete the 18 months satisfactory training requirement before March 31, they may register for the following summer BASIC Examination. Residents who complete this requirement before September 30 may register for the following fall BASIC Examination.

Approximately 5 months prior to each administration of the BASIC Examination, eligible residents will be notified by the ABA office and provided with detailed information about how to pay the examination fee and schedule their examination appointment through Pearson VUE. Residents who take the BASIC Examination will receive an email notification from the ABA office informing them when their results have been posted to their ABA online portal account. It is mandatory that all CA-1 residents register and take the BASIC Examination at the first opportunity unless written approval for a delay is given in advance by the Program Director. A resident who fails the BASIC Examination on the first attempt will automatically receive an unsatisfactory for the Clinical Competence Committee (CCC) reporting period during which the examination was taken, and may be subjected to remediation and/or academic probation as determined by the CCC. The resident will then be required to take the BASIC exam again at the next available opportunity. Failure to pass the BASIC Examination on 2 consecutive attempts will result in a non-renewal or termination of your residency contract.

Residents who have passed the BASIC Examination and have completed 30 months of satisfactory CA training may register for the ADVANCED Examination, even though they have not yet satisfied the Continuum of Education in Anesthesiology requirement (36 months of satisfactory CA training). Approximately 5 months prior to each administration of the examination, eligible residents will be notified by the ABA and will be provided with detailed information about how to pay the examination fee and schedule their examination appointment through Pearson VUE. Registration will begin in February for the summer ADVANCED Examination and in August for the January BASIC Examination. Residents who take the ADVANCED Examination will receive an email notification from the ABA office informing them when their results have been posted to their ABA online portal account.

**Mailing Address:**
The American Board of Anesthesiology, Inc.
4208 Six Forks Road, Suite 1500
Raleigh, North Carolina 27609-5765
Phone (866) 999-7501; fax (866) 999-7503
Introduction

During the first few weeks of the program, all new residents have several seminars and in-service training sessions for the use of different pieces of equipment and monitoring devices that are likely to be utilized during anesthesia. During the first few months of anesthesia training, basic information is stressed in the areas of anatomy, physiology, pharmacology, basic sciences in Anesthesiology and technical procedures. Additionally, residents in the first month of training will be introduced to the six ACGME general competencies that will be used to guide both the residents’ training and evaluation. During the beginning of the CA-1 year, the anesthesia resident is assigned to the perioperative anesthetic management of surgical cases with easily managed problems undergoing relatively simple surgery. Assignment to more complex surgical cases occurs during the latter part of the first clinical anesthesia year. The goals and objectives for each resident rotation are included in the last section of the resident handbook and any updated versions are available from the Departmental Website. Prior to the start of any new rotation, residents must review the goals and objectives and direct any questions regarding responsibilities and expectations to the respective rotation’s director.

General Duties

All house staff are expected to be dressed in appropriate operating room apparel and present in the surgical, obstetrical, outpatient areas by 6:30 a.m. The resident on-call must be present in the outpatient surgery area by 6:00 a.m. in order to evaluate and consent any patients who have not completed a pre-operative evaluation prior to the day of surgery. All residents assigned to the Tulane Hospital operating room must have completed their room setup and be present at the patient’s bedside in the holding area by 7:00 a.m. Every resident is responsible for formulation of the anesthetic plan with their assigned faculty, setting up the room and checking of the anesthesia machine and all other equipment needed for induction of anesthesia prior to the beginning of each case. During the first two weeks of the program, the residents will be given a complete set of in-service training sessions designed to familiarize each resident with various monitoring, safety, and anesthesia related equipment issues. It is the responsibility of every resident to be familiar with all aspects of safety and the proper functioning of the equipment. During the first few months of the training, it is recommended that the residents come in earlier in order to set up their rooms properly prior to the start of the day.

Policy on Proper Handling of Medications

During orientation all CA-1 residents will receive training on proper medication labeling, handling, administration, and disposal. The hospital must adhere to strict regulations on proper medication management and is subjected to routine inspection by the Department of Health and the Joint Commission. Residents who fail to comply with policies on medication management may be subjected to discipline, including an Unsatisfactory ABA Report on Professionalism. Detailed medication policies can be found at www.jointcommission.org.
All medications that are drawn up into syringes must be immediately labeled with drug name, concentration, date, time, and initials. The syringe label and the vial/ampule label should be double-checked prior to setting the syringe down onto the work surface. For single-use vials, always draw up the entire contents of the vial into the syringe.

When administering medications to patients, residents should utilize the “Five R’s” (or “Five RIGHTs”) of safe medication administration. Prior to administering a drug, the provider should pause and verify that they are giving the

1. RIGHT MEDICATION to the
2. RIGHT PATIENT in the
3. RIGHT DOSE and the
4. RIGHT ROUTE at the
5. RIGHT TIME.

While this process in no way eliminates the possibility of error, it is a quick and simple checklist that is effective at catching the most commonly made medication errors and should be part of every point-of-care provider’s routine.

Residents are responsible for maintaining control over all medications in their possession at all times. “Possession” refers to the period of time from withdrawal of the medication from the Pyxis until disposal. Medications must never be left unattended and unsecured—always lock medications in a secure location before leaving the OR.

At the end of the case all unused portions of medications should be disposed of in a sink. Do not place partially-filled vials or ampules into the trash or sharps containers. For controlled substances, a witness must sign off on your waste of portions being disposed of. Prior to disposing of controlled substances make sure that the amount of medication administered to the patient and the amount to be wasted is carefully and legibly documented on the anesthesia record.

There is a PYXIS machine located in each Operating Room. Medications must be withdrawn under the proper patient. For non-controlled medications that are taken out of the open-access drawer, it is important to check those medications out under the proper patient, to ensure that the counts remain accurate.

When performing spinal anesthesia (ie, in the L&D ORs), unless a different local anesthetic or concentration is indicated, utilize the vial of 0.75% bupivicaine that is packaged in the spinal kit. When performing a combined spinal-epidural using an epidural kit, the spinal bupivicaine must be checked out of the PYXIS. In these cases, always employ a 2-person verification of the medication when drawing up the spinal dose.
Specific Daily Responsibilities

Daily duties include the following:

1. Providing anesthesia care to the assigned patients.
2. Pre-anesthetic evaluation and formulation of anesthetic plan.
3. Post-anesthetic rounds and assessment of the assigned patients.
4. Relieving residents and other anesthesia team members for necessary lunch breaks.
5. On Call duties on the assigned weekdays, weekends, and holidays.
6. Attendance and participation in all educational activities.
7. Any other assigned clinical, educational and administrative duties.

Each morning, the resident is expected to check the operating room schedule to determine any changes in the assignment or timing of surgical procedures and all other additions or deletions. Emergency cases from the night before may still be continuing, and a resident may be required to assume the anesthetic management of these cases or asked to prepare other anesthetic locations to accommodate changes in the schedule. The residents assigned to the duties outside the O.R. are expected to be present at their respective working locations prior to the start of the operating schedule. If a resident is unavoidably delayed, he or she must inform the resident or CRNA on call (Beep: 504.538.0594) at the earliest opportunity. All residents must check out with the Anesthesia Scheduling Director (Board Runner) prior to leaving the O.R. area at anytime and especially at the end of the day.

Preoperative Care

Outpatients

This describes all patients who are admitted to the surgical area through outpatient surgery on the day of surgery, regardless of whether or not they will be discharged the day of surgery. These patients will be evaluated in the pre-admit testing clinic prior to the day of surgery, or in outpatient surgery on the day of surgery. In either case, the responsibility for evaluating these patients falls to the resident assigned to the preoperative clinic rotation. Residents assigned to the preoperative clinic must meet with the rotation director on the first day of the rotation to review the expectations for the rotation and the logistics of the preoperative evaluation process. Each day the resident must meet with the faculty anesthesiologist in charge to coordinate a faculty review of each preoperative assessment. It is important to note that the responsibility for insuring the adequacy of the preoperative assessment and medical optimization for surgery is the responsibility of the department of anesthesiology. It is our responsibility to insure that ALL necessary preoperative testing and therapy is ordered and verified prior to the patient’s arrival in the operating area. Please, remember that the focus of our surgical colleagues is different from ours, and thus, we cannot assume that the surgical preoperative assessment will meet the anesthetic needs of our patients.
A review of the important aspects of the pre-anesthesia evaluation will be conducted at the beginning of each academic year. At a minimum, the pre-anesthesia evaluation must include:

1. Directed history and physical exam
2. Description of the planned procedure
3. Complete list of medications and allergies
4. Comprehensive airway exam
5. Written results of all pertinent pre-anesthesia testing (EKG, Labs, Echo, Stress testing, Heart catheterization, PFT’s, etc.)
6. **WRITTEN list of medications to be taken or avoided prior to the procedure provided to the patient (No exceptions!)**
7. Description of the anesthetic plan/s discussed with the patient
8. All necessary orders written for additional testing or pre-operative therapies (B-blockers, anti-emetics, breathing treatments, etc.)
9. Documentation of informed consent
10. Documentation of NPO instructions

**In-house patients**

The preoperative evaluation of in-house patients is the responsibility of the senior resident on-call. The preoperative visit should include a review of the patient's chart, laboratory data, an interview with the patient or the responsible guardian, and an appropriate physical examination. The same minimum standards for the pre-anesthesia evaluation (as listed above) also apply to in-patients with the understanding that the medical conditions of patients in the hospital tend to be more complicated and acute. Therefore, particularly close attention should be paid to insuring that the patient is properly prepared for anesthesia and surgery. If questions or concerns regarding the patient’s medical condition or anesthetic plan are raised during the evaluation, consultation with the faculty anesthesiologist on call should be made immediately to avoid any delays in care. If no immediate concerns arise, the pre-anesthetic evaluations for all in-house patients can be reviewed with the on-call faculty anesthesiologist by the end of the call shift (7:00 p.m.).

**Premedication**

Appropriate pre-operative medications should be ordered for all patients. In-patients should have their medication orders checked to insure that p.o. medications that should be taken on the morning of surgery are not held because of “NPO after midnight” orders written by the surgical team.

**Intraoperative Care**

Residents will prepare their own anesthetic drugs, check the machine, prepare appropriate lines [IV's (through blood warmers, if necessary), arterial lines, CVP's, PA catheters, end-tidal CO2 monitors, etc., as deemed necessary]. Residents should not begin a case before checking with the attending anesthesiologist. Relief during a case is a luxury, not a right, and therefore, whether temporary or permanent, is to be accepted only when the patient is stable, and the patient's health or anesthetic course will not be endangered in any manner. Anesthesia faculty should be informed immediately of any significant intra-operative events and at the time of emergence from anesthesia.
Extubation should not proceed until the attending anesthesiologist is present or has given explicit instructions to proceed.

**Postoperative Transitions of Care**

Patients must be transported from the operating room with supplemental oxygen to the post anesthesia care unit (PACU). A brief report should be given to the nurse assuming care of the patient. The report should include a description of the procedure performed, brief patient history, list of allergies, description of significant intra-operative events, estimated blood loss, fluids given, urine output, anticipated need for pain control and sedation, list of necessary post-op medications, labs, and procedures.

Patients being admitted to the Surgical Intensive Care Unit post-operatively should be transported with supplemental oxygen and monitoring of blood pressure, pulse oximetry, and EKG. The anesthesia attending must be informed of the transport. Upon arrival in the SICU, transitioning of the monitor should take place in a controlled manner in order to minimize the time between continuous monitoring periods. A report in the “I PASS THE BATON” format should be given to the nurse assuming care of the patient, and the surgical team should be informed of any post-operative concerns. A transfer progress note must be written in the patients chart and must include the following:

1. A description of the procedure and its indication
2. Brief history of co-morbidities
3. Intra-operative complications if any
4. List of fluids and blood products given
5. Urine output
6. Infusions running
7. Type and location of lines placed
8. List of invasive monitors if any
9. Anticipated post-operative needs (volume replacement, diuresis, labs, meds, blood products, etc.)

**NO RESIDENT WILL ABANDON A PATIENT WHO IS UNSTABLE ON ARRIVAL TO THE SICU!** The responsibility for the wellbeing of our post-operative patients cannot be transferred to the ICU team or surgical service until the patient has been stabilized or the attending physician of the team assuming primary responsibility for the patient is present at the bedside and has discussed care with the attending anesthesiologist and mutually agreed to transfer care. Even then, the anesthesia providers must remain and be available to assist in the care of any unstable patient until such assistance is unnecessary. We must never “dump” an unstable patient on another service regardless of the time-pressure of our next clinical responsibility.
Intra-operative handoffs (transitions of care)

Due to the added risk to patients, intraoperative transitions of care should be kept to a minimum. When these handoffs do occur a report in the “I PASS THE BATON” format must be given to the incoming provider. The attending faculty member must be informed of a change in anesthesia provider and given an opportunity to participate in the transition of care. Documentation of the transition of care must be made in the patient’s medical record. Information exchanged during the transition must include at a minimum the following:

1. Description of the procedure and its indication
2. Brief history of co-morbidities
3. Description of patient’s positioning
4. IV sites and lines placed
5. Infusions running
6. Urine Output
7. Goals for hemodynamics and plan for dealing with hypo/hypertension or arrhythmia
8. Volume status and plan for fluid/blood replacement
9. History of airway manipulation and extubation/emergence strategy
Policy on Resident Duty Hours and Working Environment:

This policy should be viewed as a supplement to the Tulane University School of Medicine, Graduate Medical Education policy on resident duty hours contained in the TULANE UNIVERSITY SCHOOL OF MEDICINE RESIDENT AND STAFF GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES attached below*.

Specifically, the following is added to the University’s resident duty hours policy to further clarify the resident duty hour requirements of the Department of Anesthesiology.

1. Any resident who appears fatigued or emotionally unfit to provide direct care for patients must be immediately relieved from duty.
2. If any resident works after 8 pm on any operating room shift, that resident MUST be relieved from all departmental responsibilities for start of the next work day. The resident may be asked to report to work after a 10 (ten) hour rest period if he/she has clinical or educational duties the following day.

Working Environment:

Faculty must ensure that:

1. The residents work environment is free of physical hazards.
2. The residents work environment is free of verbal, sexual, or emotional abuse or intimidation.
3. Compliance with “Universal Precautions” is maintained.
4. Necessary radiation shielding is always available and used appropriately.
5. Appropriate private call rooms are available to those residents on in-house call.

*TULANE UNIVERSITY SCHOOL OF MEDICINE
RESIDENT AND STAFF GRADUATE MEDICAL
EDUCATION POLICIES AND PROCEDURES 2013-14

VIII. POLICY ON RESIDENTS' DUTY HOURS

A. Each residency program must be committed to and responsible for promotion patient safety and resident wellbeing, and to providing a supportive educational environment. Regardless of where affiliated rotations are offered, duty hours and on-call time periods must not be excessive for the residents. Duty hours must be consistent with the ACGME Institutional and Specific Program Requirements. In specific:

1. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
2. Didactic and clinical education must have priority in the allotment of residents’ time and energy.
3. The learning objectives of the program must not be compromised by excessive reliance upon residents to fulfill service obligations.
B. Duty hours must comply with the following standards:

1. A resident must not work more than 80 hours per week.
2. The program director is responsible for including “moonlighting” hours toward the 80 hours limitations noted above. (See Chapter VI: Moonlighting).
3. PGY-1 residents must work no longer than 16 hours in a row.
4. An upper-level resident (PGY-2 or above) must work no longer than 24 hours of continuous on-site duty. Up to 4 additional hours are permitted for patient transfer and other activities as defined in RRC requirements; however no new patients may be admitted after the 24 hours of continuous duty.
5. A resident must have at least 8, and preferably 10, hours off for rest and personal activities between duty periods and after call.
6. A resident must have at least 14 hours off after each call duty.
7. Residents must have at least one day off per week. A day off is defined as 24 hours of continuous time without patient care obligations, including not holding a home-call pager. It is desirable that each resident have one 48-hour period free of all patient care obligations each month.
8. Each program is responsible for monitoring duty hours, inclusive of moonlighting hours. The method of monitoring must be presented to and approved by the DIO as part of the internal review process and the annual program report.
9. In-house call may not occur more frequently than every third night.

C. Home Call

1. For residents and fellows assigned home call, the actual time spent answering calls, or delivering in-house patient care is to be counted toward the 80 hour standard.
2. A resident on home-call who is called into the hospital for an extensive period of time should be released from duty the following day. The program director is responsible for establishing a jeopardy system involving other residents or faculty, which ensures that the resident may be released from duty the following day if the previous night’s requirements were excessive.
3. Residents on home-call must still have one day off in seven without holding the pager.

D. Program directors & faculty are responsible for adopting policies to prevent, monitor and counteract effects of fatigue.

1. Program directors are responsible for ensuring a yearly in-service to educate residents and faculty on the signs, risk, and methods of counteracting fatigue.
2. The program leadership is responsible for ensuring that residents have alternative means of transportation home should they feel too fatigued to safely return home following a shift. In such cases, residents should:
   a. First seek alternative transportation from colleagues, program faculty, or program administration.
   b. If this option is not feasible, the resident should take a taxi, and produce the receipt for the trip home to the program leadership. The resident will subsequently be reimbursed for the taxi expenses to their home.

E. Tulane University allows no exceptions to the duty hours as listed above.

Approved by the GMEC; August 17th, 2011
Policy on Resident Supervision

This policy should be viewed as a supplement to the Tulane University School of Medicine, Graduate Medical Education policy on resident supervision contained in the TULANE UNIVERSITY SCHOOL OF MEDICINE RESIDENT AND STAFF GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES Section 3, XIII.

Specifically, the following is added to the University’s supervision policy to further clarify the supervisory role of attending anesthesiologists who work with residents in the operating room.

1. Attending anesthesiologists MUST be immediately available to the operating room dressed in proper attire and ready to immediately assist in patient care at all times that patients are undergoing any surgical procedure.
2. Attending anesthesiologists must be present at the induction of and emergence from general anesthesia. Residents at all levels of training are required to notify their attending prior to induction of anesthesia and prior to emergence/extubation.
3. Residents must present a focused history and physical, and discuss the anesthetic plan with their attending faculty prior to proceeding with monitored anesthetic care.
4. Attending anesthesiologists must be consulted prior to any invasive procedure during surgical anesthesia care.
5. Attending anesthesiologists must be notified prior to any ICU transfer.
6. CA-1 residents on call must inform an attending anesthesiologist prior to any elective airway manipulation.
7. CA-1 residents should be accompanied by an attending anesthesiologist at all “code blue” resuscitations.
8. Upper level residents (CA-2 and 3) with elective airway manipulations or “code blue” resuscitations may proceed with these interventions without an attending present based on the urgency of the procedure. Faculty members should be consulted for challenging procedures (difficult airways, complex resuscitative efforts, etc.) as time and the urgency of the clinical situation permits.
9. Faculty members must be consulted prior to any end of life discussions by residents of all training levels.
10. Clinical anesthesia residents in the ICU may perform, without faculty present, only those procedures expressly stated in their ICU credentials. A list of these procedures is maintained for each resident in the program coordinator’s office and should be referenced prior to any ICU rotation.
11. Attending anesthesiologists must supervise no more than two anesthetizing locations.
12. On OB, an attending anesthesiologist must supervise no more than one anesthetizing location (c-section) in addition to supervising the care of laboring patients.

Case and Procedure Logs

The ACGME requires that all residents maintain a record of cases and procedures performed and enter this information into the Resident Case Log System on the ACGME website. These web based case logs should be updated at least weekly. Residents will review the case logs and evaluations for each monthly rotation with their respective faculty mentors. The American Board of Anesthesiology’s requirements for resident cases and procedures are available from the program coordinator or from the ABA website.
Didactic Curriculum

The goal of the didactic curriculum is to provide the resident with the fund of knowledge necessary to serve as a perioperative consultant anesthesiologist. Residents will apply the information presented in the didactic sessions to their clinical practice and develop an understanding of the science of anesthesiology.

This didactic program is structured to comprise two full academic years. A satisfactory attendance record is defined as attendance at 80% or more of the lectures and conferences.

The curriculum includes both basic sciences and clinical components. The lecture series of the didactic component will be held on Thursday afternoons from 1:00 p.m. - 5:00 p.m. in the Anesthesia Library. Attendance is mandatory for residents who are not on leave. The residents will be relieved of clinical duties to attend. The Thursday afternoon session consists of the following components.

Pretest: The faculty moderator will prepare an examination, which is administered as a pretest prior to the scheduled lecture. The pretest has been instituted to ensure that assigned chapter readings have been completed and to ascertain a measure of comprehension of the material. These examinations are graded and each resident’s performance on these tests will be monitored on a weekly basis. If there are three weeks of poor performance based on these scores, the resident’s faculty mentor and the program director are notified. Exploration of the circumstances leading to this poor performance occurs and a corrective action plan instituted as deemed necessary and beneficial.

Core lecture Series: A lecture of approximately one hour based upon a chapter of the core textbook, Clinical Anesthesia, 6th edition, Edited by Barash, Cullen, Stoelting, Cahalan, and Stock is presented. The entire text is reviewed every two years.

Faculty Advanced Lecture Series: A one hour series of lectures presented by faculty on topics of their particular interest of expertise. These lectures are meant to provide an in-depth treatment of key topics in anesthesiology.

Practice Management Lecture Series: Faculty and guest speakers review the issues surrounding the management of anesthesia practice. Topics include operating room management, staffing and human resources, financial planning, contract negotiations, billing, and compliance.

Core Competency workshops: These workshops are designed to augment the medical knowledge/patient care didactic series and focus primarily on the core competencies of professionalism, communication and interpersonal skill, and systems based knowledge. Practice based learning is addressed at our problem-based learning sessions and quality improvement conferences.

Preparation for the ABA written Boards: This resident driven conference covers ABA keyword topics and practice anesthesiology board questions with a clear emphasis on understanding concepts key to successful completion of the ABA written board examination.
These weekly comprehensive afternoon sessions are designed to facilitate successful attainment of certification by the American Board of Anesthesiology. The residents are encouraged to expand their studies to encompass material from other textbooks, journals and varying educational materials.

Weekly/Monthly conferences, meetings, seminars, and rounds are designated for a variety of topics throughout the year and include Grand Rounds, Visiting Professorships, Morbidity and Mortality presentations, Journal Club, Mock Oral Examinations, Case Conferences, and various conferences for presentation of selected topics.

Other Conferences

**Departmental Grand Rounds**
Grand rounds will be held monthly usually in the Anesthesia Library and will consist of formal presentations often by guest speakers. Subject matter for grand rounds varies, including basic sciences, research, clinical anesthesia, case presentations, education and other topics. Each CA-3 resident will give a grand rounds style presentation in their final year. This will normally occur on one special day in May or June. The goal of these and other oral presentations is to develop the communicative skills necessary as a consultant anesthesiologist and for successful completion of the ABA oral board process. Attendance is mandatory.

**Problem Based Learning Sessions**
Two to three problem based learning sessions will be presented each month on specified Friday mornings at 6:45 a.m. A team of facilitators consisting of a resident and a faculty member will host these sessions. The facilitating team will present an assigned clinical scenario and lead a discussion of the relevant perioperative issues regarding the care of a particular fictional patient.

**Morbidity and Mortality/Quality Improvement Conference**
Monthly morbidity and mortality intradepartmental conferences provide an additional opportunity for resident participation in critical evaluation of patient care. At these conferences, residents and/or staff will present patient care occurrences and discussion will take place regarding patient management. Staff anesthesiologists will serve as moderators of discussion during the morbidity and mortality conferences and will interject with comment.

**Journal Club**
In addition to the above curriculum, the Department will have a monthly Journal Club led by various faculty members, in which residents and staff will present interesting and relevant articles as selected by staff members and residents. This will not only encourage the residents to follow peer-reviewed journals, but it will help the resident to develop the skills necessary to read such material critically.
In-Training Examinations (ITE)

In February or March of each year including the clinical base year (PGY-1) residents take the ABA In-training examination. A score of at least the 20th percentile for level of training is required to remain in the program. A score of at least the 30th percentile or above is necessary to remain in good academic standing. Lastly, a score of at least the 35th percentile is necessary to be eligible for any added responsibilities (moonlighting, admission to the MBA program, etc.)

Resident Mock Oral Examinations

Mock oral exams will be held monthly and are designed to prepare the residents for successful completion of the American Board of Anesthesiology certification process.

High-Fidelity Human Simulation

Residents rotating on the general anesthesia rotation at Tulane Medical Center will participate in a variety of activities at the Tulane Center for Advanced Medical Simulation and Team Training. High fidelity simulation scenarios will stress emergency intra-operative events and the management of those events. The principles of crisis resource management and team training will be integrated into the learning experience. In addition, common anesthesia procedures and airway maneuvers will be taught and rehearsed as part of a comprehensive skills training curriculum.

National organizations

The American Society of Anesthesiologists (ASA)
The International Anesthesia Research Society (IARS)

Membership in each of these societies is provided for Tulane Anesthesiology residents by the Department. Each publishes a journal of current research and clinical reports. The Southern Medical Association also offers free resident memberships. IARS dues and ASA dues are only paid for one year at a time and renewal is not automatic. If you receive a dues notice, please submitted to the Residency Coordinator, otherwise they will not be paid. Forms are available from the Residency Coordinator at the beginning of your residency.
Educational Fund

The Department of Anesthesiology would like to encourage each resident to build a core library throughout his or her training. An educational (or book) fund has been established to assist with this goal. The amount available in the educational fund for each resident is initially $1500 for CA-1, then $1000 for CA-2, and $1500 for CA-3 years. This is available to reimburse residents for the cost of educational materials purchased during the residency. These funds can be used for any of the following:

- Books
- ABA BASIC AND ADVANCED EXAMS
- PERMIT FEES
- Medical Journal subscriptions
- Subspecialty Society dues
- Board Review courses and materials
- Travel expenses to approved educational conferences

Please, check with the residency coordinator prior to making any purchase in order to confirm account balance and eligibility of reimbursement. A copy of the original receipt and description of the purchased item must be submitted to the residency coordinator in order to process the reimbursement.
Call

Residents are required to provide in-house on-call coverage for the department from 6:00 a.m. to 7:00 p.m. weekdays and from 7:00 a.m. Saturdays to 7:00 a.m. Sundays (24 hours). A **written** report (sign-out) must be given to the resident or CRNA assuming on-call responsibilities at the end of each call shift. Call responsibilities include but are not limited to the following:

- Pre-operative evaluation of first case patients not previously seen by anesthesiology
- Pre-operative evaluation of in-house patients and add-ons
- Code Blue Team member*
- Post-operative assessments of in-house post-op patients
- Manage Anesthesiology consults (typically for airway management or intravenous/arterial access) see policy for resident supervision.

*Participation on the code blue team is **NOT** limited to airway management. Anesthesiology residents must assume the position of code team leader unless another provider more senior is present and willing to accept the position. Further, anesthesiology residents responding to a code blue are expected to assist the treating team and patient in whatever manner necessary (consistent with level of training and experience). This includes all diagnostic and therapeutic modalities consistent with the American Heart Association’s published guidelines for Advanced Cardiac Life Support.

Resident Pagers

Unless on vacation, residents MUST be available by pager or telephone at all times. While residents will not be asked to assume clinical duties unless on-call, the occasional need to discuss changes in schedule or clinical responsibilities necessitates the ability to communicate with individuals outside of the hospital. Each resident will be provided a pager during orientation and batteries are available at the O.R. front desk. Furthermore, a separate “code pager” is carried by the anesthesiology department member on-call and must be attended at all times. Please, check the batteries of the code pager at the beginning of each on-call shift.

Lunch

On-call residents are provided with money on their dining cards for breakfast, lunch, and dinner. During hours that the cafeteria is not open the on-call residents have access to the resident room, where there is an assortment of food and drink options.
Emergency Surgery Scheduling

When a surgeon schedules surgery, the surgical resident notifies the anesthesia resident. They jointly agree upon a realistic time for anesthesia induction and notify their respective attending. The surgical resident informs the nursing supervisor, who calls the O.R. team. Nursing personnel will have the patient in the O.R. at least 15 minutes ahead of the scheduled start time. Where management or timing of the procedure requires discussion, the attending surgeon and anesthesiologist shall confer by telephone. Either O.R. 10 or 14, should be set-up and ready for emergencies at all times. Residents are responsible for maintaining these OR's in a state of readiness (including restocking anesthesia supplies) when on-call.

Monitoring

The anesthesia resident shall be available to provide arterial, central line and pulmonary artery catheter placement. Please consent the patient for line placement including indications and risks. Peripheral arterial lines may be started without supervision. Attending staff MUST be contacted prior to starting central venous or femoral arterial lines. A note must be made in the patient's chart after any medical intervention.

Resident E-mail

Residents will be assigned a Tulane email address. This will be used to communicate vital information about the academic program, including changes to schedules and other information about general professional duties. Residents must check their Tulane email regularly to avoid missing important information.

Mail

In the anesthesiology offices, residents' mail is placed in individual files in the department mail cabinet. Please, check your mail regularly.

Coats

Two coats are provided for each resident. Laundering of these coats is also provided. Dirty coats must be brought to the Linen Room in the Medical School on Thursday and will be returned the following Thursday.
Scrub Suits

Hospital policy forbids wearing of scrub suits home from the hospital. After using the scrubs they are to be exchanged for clean scrubs via the scrubEx machines located in the locker rooms. Remove OR hats, shoe covers and masks and place in the trash hamper. Wear your coat over your scrubs if you leave the OR.

Parking

Free parking is provided for all residents training at Tulane when assigned to University Hospital, Veterans Hospital and the Tulane Medical Center Hospital. In July, parking cards are issued through Parking Services in the Medical School. These cards can be used by the residents when rotating through the hospitals noted above. When rotating to other hospitals, the card is "locked out" and cannot be reactivated until the resident returns from rotation. The Graduate Medical Education office has made arrangement for residents to have parking available in the Hospital Garage, Lasalle St., but each resident must apply for this second card. Please see the Residency Coordinator for parking forms or go to the TU Parking office in the Tidewater Bldg., room 803, 1440 Canal St., 988-5577

Medical School Library

The main Tulane University Medical Library is located on the second floor of the medical school. Library cards may be obtained at the main desk. The Anesthesia library of books and pertinent journals is located within the Anesthesia Library on the third floor of the hospital. These are for the entire department's use and should be returned promptly. All books and journals should be checked out with the anesthesia secretary responsible for the library. In addition, access to the online library is available through either a link from the Departmental Website of the Matas Library Website.

Faculty Mentor

All residents will be assigned a faculty mentor. Residents must schedule a monthly meeting with their mentors. The resident is responsible for updating his/her learning portfolio prior to each meeting. At the meeting all evaluations, test scores, procedure logs, and rotations remaining will be reviewed. A written report of the meeting and any actions needed will be given to the program coordinator at the conclusion of each meeting.
Vacation, Educational, and Sick Leave

According to the American Board of Anesthesiology a resident is allowed only twenty (20) working days off per year. Those 20 days are to be used for the following:

1. **Vacation** – 15 Days
2. **Sick leave or Emergency leave** - 5 Days

In addition, 5 days per year may be taken in order to attend an approved educational conference. Residents will be asked to submit a request for all vacation/leave days to be taken during the academic year by June of the preceding year. These requests must be prioritized in order to facilitate scheduling. All attempts will be made to accommodate resident requests. However, the needs of the department and fellow residents will also have to be taken into account when awarding vacation time. The following rules will be used to guide the process.

1. No more than 2 senior level (CA-2/3) residents and 3 total residents (CA-1, 2, or 3) will be allowed on vacation/leave at any one time.
2. Residents not submitting vacation requests on time will be assigned vacation days.
3. The 5 available sick days may be scheduled, however all residents are cautioned that missing more than 20 working days per year may lead to an extension of residency training as determined by the ABA.
4. Priority for scheduling vacation will be given to the more senior resident.
5. All vacation/leave requests must be approved by the program director.
6. Vacation/leave scheduling will be done by the program coordinator with assistance from the Chief Resident.
7. No vacation may be taken during the month of July for those residents rotating in the Tulane operating room.
8. No vacation may be taken by CA-1 residents during the months of July or August.

Educational Leave

Educational leave (maximum of 5 working days including travel time) is considered part of the education and as such is not considered part of the twenty days allowed by the ABA. Individual education funds (BOOK FUND) may be used for Program Director approved conference registration, travel, lodging and food. When requesting reimbursement for travel expenses, original receipts must be submitted: food receipts must be itemized; all receipts must show that they were paid. The airline ticket and proof of travel (boarding pass, etc.) must be submitted with all requests whether seeking reimbursement for the airfare or not. Email receipts may be forwarded in email to the Residency Coordinator. The department may pay the registration fee and possibly assist with more reimbursement when a scientific paper is presented.

Parental Leave

Please see the Tulane University School of Medicine Resident Policies on Graduate Medical Education website.
Policy on Moonlighting (Supplement to Tulane University Policy VI.)

The Department of Anesthesiology does allow residents to moonlight outside of the Tulane Medical Center on a case by case basis.

The ability to moonlight outside of the Tulane Medical Center is a privilege extended to those CA-2 and CA-3 residents who meet the department’s academic requirements listed below:

1. Approval of the Residency Program Director (based on evaluations of performance in each of the six core competencies).
2. Approval of the Program Director in writing and made a part of the residents permanent record.
3. In-training exam score at or above the 50th percentile for residents at similar level of training.

Residents must report any hours worked in moonlighting. All hours worked will count toward the maximum allowable work hours as listed in the Tulane University GME policies and procedures handbook (Policy VIII, page 14).

The program director reserves the right to limit, restrict, or revoke the moonlighting privilege “if he/she feels that the moonlighting is adversely affecting the resident’s patient care or education, or is putting the resident at risk for work hours violation or excessive sleepiness/fatigue” (TU GME Policy VIII.)
**Evaluation**

Goals of the Evaluation Process

1. To allow anesthesia residents to develop into competent, well-educated practitioners who display professional attitudes in all aspects of their work.
2. To determine that a resident, at the end of her or his training, is capable of performing independently the entire scope of anesthesiology practice.

Anesthesia residents work in relative isolation from their peers and cannot directly compare their performance with others, so it is particularly important that residents receive timely feedback on their performance from the faculty. The evaluation process is intended to assist residents in recognizing their strengths and weaknesses, and provide suggestions on how to improve performance. This process is applied to all residents even those whose performance is already satisfactory.

Evaluation of residents will be based on both objective criteria and subjective assessment from members of the Anesthesiology faculty. The Clinical Competence Committee (CCC) that is comprised of a subgroup of faculty, the chief resident, and the program director, meet quarterly to review resident evaluations that are causing concerns.

**Clinical Competency Committee**

The Program Director/Departmental Chair will designate a group of faculty to constitute the Clinical Competence Committee (CCC). This group will meet at least semiannually to review resident progress. The aims of the CCC are to:

1. Regularly review the clinical and academic performance, and professional development of all residents based on the ACGME general competencies, ABA essential attributes and the program requirements.
2. Identify residents who are experiencing problems with their clinical, academic and professional development and assist these residents in rectifying their problems.
3. Determine what constitutes satisfactory and unsatisfactory levels of performance at each stage of the residents’ clinical, academic, and professional development.
4. Make recommendations to residents and their advisors about the actions that should be taken to improve performance.
5. Determine if a resident should be placed on academic probation and make the appropriate recommendations to the Program Director and the Chairman of the Department of Anesthesiology.
6. Identify what actions a resident, with the assistance of his/her advisor, needs to undertake to be removed from academic probation.

The information used in the evaluation process will include materials contained in each resident’s file, rotation evaluations, letters and e-mails from various individuals, patient safety net reports, standardized test results, clinical skills tests conducted as part of the resident education process, records of attendance at lectures, conferences and special educational programs and adherence to departmental and hospital compliance requirements. On occasions an individual attending may be
asked to make direct comments concerning a resident’s progress, in order to verify reports made by
other attendings.

It should be emphasized that the main goal of the CCC is to help all residents graduate from the
residency program as successful, competent practitioners. However, the residency program, as well
as the CCC has a responsibility to protect the general public by ensuring that anesthesiology
residents who complete their training have achieved appropriate levels of competence in the manner
defined by the ACGME, ABA and outlined in this manual.

**Program Evaluation Committee**

The Program Director/Departmental Chair will designate a group of faculty and residents to
consistute the Program Evaluation Committee (PEC). This group will meet at least semiannually to
review resident educational program, areas for improvement, and performance of the residency
program. The PEC actively participates in:

1. Planning, developing, implementing and evaluation of educational activities of the
   residency program
2. Reviewing and making recommendations for revision of competency-based curriculum
   goals and objectives
3. Addressing needs of non-compliance with ACGME standards
4. Reviewing the program annually using evaluations of faculty, residents and others
5. Actively ensuring a continual quality improvement process regarding program
   outcomes.

The program monitors and tracks each of the following areas:
1. Resident performance
2. Faculty development
3. Graduate performance
4. Program quality
5. Progress on the previous year’s action plan.

The program, through the PEC, documents formal, systematic evaluation of the curriculum
and renders a written Annual Program Evaluation (APE). The PEC prepares a written plan of
action, based on in-depth review of the APE components, to formulate and document initiatives to
improve performance in one or more of the areas listed above.

**End of Rotational Evaluations**

Residents will receive a summary evaluation at the end of each clinical rotation, if the
rotation is longer than 1 month, the resident will also receive an interim evaluation. In most cases
the end of rotation evaluation will be a summary of the assessments of attending faculty responsible
for teaching on the rotation.

At the end of each rotation the faculty will assign a satisfactory, marginal or unsatisfactory
grade to the resident. This grade is based on the resident’s performance of the six ACGME
competencies. Where the majority of scores are 2 or less the resident’s performance will be deemed
marginal or unsatisfactory.
Certain “core” subspecialty rotations must be completed in a satisfactory manner to allow the resident to graduate from the program or in some cases be promoted to the next level. These include Cardiothoracic anesthesiology (2 months); Obstetric anesthesiology (2 months), Critical Care (2 months), Pain (Chronic and Acute) (3 months), Neuroanesthesiology (2 months), Pediatric anesthesiology (2 months).

Residents will be notified of remedial action required to rectify a marginal or unsatisfactory end of rotational evaluation.

**Faculty Evaluation**

It is the policy of the Department to provide monthly written confidential faculty evaluations by the residents. These evaluations are used by the faculty, residency program director, and the Chairman to improve teaching skills and ensure educational quality. These evaluations are also useful in identifying perceived weaknesses and initiating corrective action where indicated.

**Didactic Lectures Evaluations**

At the end of each didactic lecture, every resident is requested to evaluate the lecture using the forms that will be provided. This evaluation form also serves to confirm attendance at the lecture. The residents evaluate the faculty for their clinical teaching skills. These lecture evaluations are anonymous.

**Program Evaluation**

The residents and faculty will be asked to evaluate the residency program as a whole at the end of each academic year. The results of this survey will be reviewed annually by the Education Committee with the aim of improving the standards of resident education.
Department of Anesthesiology Substance Abuse Policy:
(Also see Tulane University SOM Resident Policies on GME website “Policy on Substance Abuse” (sec 3, XVI) and “Residents Assistance Program” (sec3, XV)

All incoming residents are informed that national statistics prove that drug abuse is a significant danger for the anesthesiologist because of the unique access these practitioners have to drugs of potential abuse. It is therefore mandatory that the incoming residents attend departmental substance abuse educational programs as designated by the department. They are furthermore required to sign the departmental alcohol and drug abuse consent form. Because an impaired resident physician may prove a risk to patient care and safety, the resident is required to adhere to the impaired resident physician policy of the School of Medicine.

The Department of Anesthesiology alcohol and drug abuse consent form follows:

I understand that national statistics prove that drug use (including alcoholism) is a significant danger for anesthesiologists and nurse anesthetists partly because of the unique access members in this career field have to drugs. A nurse anesthetist or anesthesiologist working while under the influence of either drugs or alcohol presents a grave danger to the patient.

To provide protection to the patients, I hereby acknowledge by accepting a position at Tulane Medical Center, I have given my implied consent to undergo blood testing or urinalysis for alcohol or drugs under the following circumstances:

1. If at any time I present myself for duty in a condition in which the chairman or acting chairman has a belief that I am under the influence of drugs or alcohol he may order me to undergo said testing. If I refuse, I acknowledge that I am subject to immediate disciplinary action up to and including dismissal from the department and institution.

2. I understand that if the results of any testing indicate that I am under the influence of drugs, alcohol, or drugs without proper prescription and medical justification then the results of said testing can be used to justify disciplinary action and up to and including dismissal.

3. I understand the severity of the discipline will depend upon my entire personnel history and the seriousness of the present incident. I also understand that upon confirmation of drug or alcohol use, my chairman or acting chairman may require that as a condition precedent to return to work, I undergo appropriate counseling and/or treatment.

Signature_________________________             Date______________

Chairman of Anesthesiology_____________________   Date______________

If there is suspicion that a resident is using substances of potential abuse, including but not limited to, drugs and alcohol, the chairman and the residency director will conduct a private meeting with the resident to discuss this matter. The resident will be accompanied to the Tulane Drug Analysis Lab for testing. (Dr. Luis Remus III, Operational Manager). The resident will be suspended from duties during the investigative process. All residents testing positive will be mandated to participate in the Resident Assistance Program (RAP). This program is supervised by Andrew Morson, M.D. (PHONE: 504-322-3837, email: dr.morson@ibhnola.com). Residents who test negatively will likewise be offered entry to the RAP.

Counseling by the Chairman and/or the Residency Director will be performed under Dr. Morson’s guidance.
Control of Medications

As an anesthesiology provider we are given an incredible responsibility in the care of our patients. We are also given great responsibility in the medications that we take into our possession for the administration to our patients. These medications can be used for great good. However, there are some individuals who would like to use these medications for their own needs or addictions. We must be protective of our medications in order to prevent the abuse or misuse of these medications while they are under our watch. We must maintain great vigilance during the control of these medications. To this measure you must consent to the following agreement and understand that there may be harsh punishments for those that do not take this responsibility with the proper respect that is required.

Control of Medications

I acknowledge that I have received training during orientation on the proper handling of medications in the perioperative setting.

I understand that I must maintain control of my medications at all times.

Medications that I check out for patient care are always locked or in my immediate control.

I understand that disciplinary action will follow when I deviate from this standard.

Disciplinary actions can include verbal warning, written warning, suspension or termination.

_________________________________________  ______________________
Signature                        Date
Appendix A: Anesthesiology Milestones

AnesthesiologyMilestones.pdf