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RESIDENT SELECTION PROCESS

Policy: Resident selection process will follow defined steps and will be based on an applicant's submitted application, letters of reference, transcript, USMLE or COMLEX scores, Dean's letter, personal statement, and interview.

Purpose: To ensure that there is a defined, consistent and fair process of selection within the Department that will treat all potential applicants for residency training equally and without bias or prejudice.

1.1 All applicants will complete and submit, through ERAS, an application form, 3 letters of recommendation, Dean's letter, medical school transcripts, and USMLE or COMLEX scores. Initial screening of applications will be performed by the Program Director or his/her designee and, based upon the initial screening, the applicants will be invited for interview.

1.2 The initial screening criteria will include USMLE, Part I/II (scores greater than 210) and/or COMLEX, Part I/II (scores greater than 525), positive letters of references, no failing grades during medical school, no unexplained absence from training, no history of legal or criminal activities and a strong recommendation noted in the Dean's letter.

1.3 Once the interview date is determined, the applicant will be notified. The applicant must arrange for transportation and housing.

1.4 The interview will include an interview with the Program Director, anesthesiology staff and resident. The applicant will also be given a tour of the facility. A resident or residents will then take the applicant to lunch.

1.5 During the interview, the resident will be advised about salary, vacation, professional leave, sick leave, professional liability insurance, hospital and health insurance benefits, call rooms, meals on call or on duty, parking, laundry, and other policy and procedures applicable to the application process. A formal written packet of information outlining the program and benefits package will be given to the applicant.

1.6 At the end of the interview period, the Resident Selection Committee will objectively evaluate each candidate and prepare a list of applicants in rank order of departmental preference. The rank order will be based on
undergraduate and medical school grade point averages, medical school class rank, USMLE (board) scores, personal references, professional references, Dean’s letter, work ethic, appearance, motivation, attitude, communication skills, reasons for choosing anesthesia and overall interview. (See attached scoring form).

1.7 The rank order list will be forwarded to the NRMP prior to the published deadline.

APPROVED BY: ___________________________ DATE: July, 2010
E. E. Fibuch, M.D.
Program Director
LICENSURE

Policy: All residents must be licensed in the State of Missouri before they can assume patient care responsibilities.

PURPOSE: To ensure that there is a process in place to facilitate licensure for residents.

2.1 As a condition of participation in the residency program, it is the policy of the Department of Anesthesiology and UMKC School of Medicine that the resident will, prior to the starting date and throughout the term of his/her contract with UMKC, be licensed by the State of Missouri as a physician. UMKC will reimburse the resident for temporary license application and renewal fees. A permanent medical license is not required for training. If the resident chooses to obtain a permanent medical license, all associated expenses (including Federation Report), permanent DEA number and permanent Missouri BNDD will be the sole responsibility of the individual resident and will not be reimbursed.

2.2 In addition to maintaining a State license to practice medicine, the resident must acquire and maintain his/her BNDD number and DEA number. Residents will be reimbursed, by UMKC, for their application fee, the initial temporary application, and renewal.

2.3 Failure to maintain state licensure, BNDD and DEA numbers will result in the resident being placed on mandatory administrative leave of absence without pay until the appropriate license(s) is/are obtained. Lost training time, resulting from absence due to administrative leave, will be made up by lengthening the residency training period by the number of days the resident was on administrative leave of absence.

E. E. Fibuch, M.D.
Program Director

DATE: July 2010
EDUCATIONAL TRAVEL TIME

**Policy:** To establish an educational travel policy that will be used by residents to request time away from the training program in order to attend an educational meeting.

**Purpose:** To ensure that there is a uniform, consistent and fair process of securing educational travel time for each resident, on an annual basis, during their CA-1, CA-2, and CA-3 years.

3.1 Residents in their CA-1, CA-2, and CA-3 years will be allowed to take up to five working days per year for educational travel and meeting attendance. The resident will not be given an extra day for travel time.

3.2 The maximum reimbursement to the resident for travel is $1,000.00 paid by UMKC per academic year. This funding will allow the resident to attend at least one major meeting per year (see Policies A-46, A-47 and A-48).

3.3 Although the choice of meetings will be left to the discretion of the resident, the Program Director must approve the meeting. The following criteria will be used to determine which meetings a resident will be allowed to attend:

   **Criteria:**
   - Approval by the Program Director
   - National or regional location
   - Non-subspecialty meeting
   - Review courses or a major comprehensive meeting is preferred (ie ASA Annual Meeting or New York Postgraduate Meeting)
   - NO ski or beach meetings will be allowed

3.4 Residents who are invited to present papers, lectures or abstracts at Regional or National meetings may apply for additional travel assistance through the Medical Education Office (see Policy A-48).

3.5 If a resident chooses not to attend a meeting, UMKC will reimburse the resident up to $1,000.00 in educational books and journals or a PDA. PDAs must be purchased in the first quarter of the contract year. Any resident choosing not to attend a meeting is not eligible to take a week of meeting time off (see Policy A-47).
3.6 All requests for reimbursement must include original receipts clearly documenting titles of Books, journals, travel expenses etc.

3.7 See attached policy and guidelines statement for additional details (see policies A-46, A-47 and A-48).

3.8 Anesthesiology program will follow UMKC GME Travel Reimbursement Guidelines. See attached guidelines (see policies A-46, A-47 and A-48).

APPROVED BY: 

E. E. Fibuch, M.D.  
Program Director  

DATE: July 2010
SICK LEAVE POLICY

Policy: To establish guidelines/policy that will be used by residents in requesting sick leave during their training program.

Purpose: To ensure that there is a uniform, consistent and fair process of securing sick leave time for each resident in training when needed.

4.1 Residents shall earn sick leave at the rate of one (1) day per month for each consecutive month of employment. Sick leave can accumulate to a maximum of forty-eight (48) days.

4.2 Any resident unable to attend work due to illness should inform his/her attending anesthesiologist and the Medical Education Office (see attached “Call-In” procedure).

4.3 If extended time off is required (more than five days), the Program Director and the Medical Education Office should be notified in writing. It must be emphasized that the resident is responsible for completing 36 months of clinical anesthesia training, during the CA-I, CA-II, and CA-III years, and 12 months of the Clinical Base year. It will be left to the Program Director, in consultation with the Clinical Competency and Education Committees of the Department, to decide whether, in individual cases, a resident needs to extend his/her residency training program in order to make up time lost during illness. Each case will be handled on an individual basis.

4.4 See attachment from UMKC concerning leave of absence for additional details (see policy A-49).
ANESTHESIOLOGY
POLICY AND PROCEDURE
FOR
Calling in Sick

SAINT LUKE’S – MAIN OPERATING ROOM – 932-2031
When on rotation in the main operating room call the main scheduling desk at 932-2031. If no one answers, call the anesthesia staff on call.

SAINT LUKE’S – e-ICU ROTATION – 251-9809
When on rotation at e-ICU call 251-9809. If you get a recording, leave a message.

SAINT LUKE’S – PAIN MANAGEMENT CLINIC – 932-2932
When on rotation at PMC call 932-2932. Someone will be in at 7:30am. You can also call 932-2572 and leave a message before 7:30 am.

SAINT LUKE’S – HEART INSTITUTE – 932-3679
When on rotation at the Heart Institution you are to call 932-3679 before 7:00 am. If no one answers, leave a message.

SAINT LUKE’S – NSICU ROTATION
When on rotation in the ICU call the person you are working with that month. If you can not get in touch with that person, then call the Chief Surgery Resident who is on-call.

TRUMAN MEDICAL CENTER – 556-3216
When on rotation at TMC call the CRNA pager at 816-864-3210 and ask the CRNA on call to inform the anesthesiology staff.

CHILDREN’S MERCURY HOSPITAL – 234-3285
When on rotation at CMH call the OR control desk at 234-3285 and ask them to tell the anesthesiologist on call.

APPROVED BY: E. E. Fibuch, M.D.
Date: July 2010
Program Director
MATERNITY LEAVE POLICY

Policy: To establish a policy that will be used by female residents in requesting maternity leave during their training program.

Purpose: To ensure that there is a uniform, consistent and fair process of securing maternity leave time for each female resident during their training program, if pregnancy should occur.

5.1 Residents are eligible for paid maternity leave by using either Family Medical Leave Act (FMLA) or Personal Leave of Absence. To qualify for FMLA, you must have 12 months of employment with UMKC. You are allowed to take FMLA (for any medical reason) up to 12 weeks during any 12 month period.

5.2 When you take a Leave of Absence (personal or FMLA) you must use any accrued sick and vacation time.

5.3 The Program Director and the Medical Education Office must be notified. In addition, please notify UMKC and the Insurance Company so that your new child can be added to your policy. This must be done within 31 days of delivery. After 31 days the new baby can still be added, however treatment and care will fall under “Pre-existing conditions” and some charges may not be covered expenses.

5.4 Because of special requirements for training, it may be necessary for the resident to make up the time missed during the maternity leave to complete her training program.

5.5 See attached UMKC policy covering leave of absence for additional details.
Paternity Leave Policy

Policy: To establish a paternity leave policy that will be used by residents in requesting leave during their training program.

Purpose: To ensure that there is a uniform, consistent and fair process of securing paternity leave time for each resident during their training program, if the need arises.

6.1 Male Residents have the option of taking up to one-week paternity leave per year during which time full salary and benefits would be continued. This is subject to approval by the Program Director.

6.2 Because of special requirements for training, it may be necessary for the resident to make up the time missed during the paternity leave to complete the training program. Individual arrangements should be made with the Program Director.

6.3 See attached UMKC policy covering leave of absence for additional details.

E. E. Fibuch, M.D.
Program Director
VACATION POLICY

**Policy:** To establish a vacation guideline/policy that will be used by residents in requesting vacation time during their training program.

**Purpose:** To ensure that there is a uniform, consistent and fair process of securing vacation time for each resident in training.

7.1 Fifteen working days per year of vacation are granted for residents in the CB, CA-1, CA-2 and CA-3 years.

7.2 The scheduling of vacations and educational leaves will be ultimately determined by the Program Director. Vacation requests are granted on a first-come/first-serve basis.

7.3 Unless vacations are of an emergency nature, they must be scheduled and coordinated with the staff vacation schedule at least one month prior to publication of the coming month's call schedule. Since a staff anesthesiologist is responsible for the daily operative schedule, the resident must notify his/her staff in advance of the vacation.

7.4 For those residents not completing an entire academic year, vacation will be prorated according to the number of months of residency spent during that year.

7.5 Dr. Jaax or his designee (for SLH) must approve and sign vacation requests, and the vacation request form must be then signed by the resident and delivered to Medical Education before vacation will be granted.

7.6 If vacation is desired while on rotation at either TMC or CMH then the request form must be signed by Dr. Kara Settles (or her designee) at TMC or Dr. Pieters at CMH (or his designee).

7.7 At CMH, requests for vacation or meeting time should be made well in advance of the pediatric anesthesia rotation and must be taken a week at a time. Time off is granted on a first-come/first-serve basis. Requests for attendance at the ASA annual meeting should be made by April 15th of the same year.
7.8 All vacation/meeting requests must be completed in writing, and filed with the Department of Medical Education at Saint Luke's Hospital.

7.9 CA-1 and CA-2 residents must take 2 of the 3 weeks of vacation in one week increments. The remaining 5 vacation days may be taken on a day only basis.

7.10 CA-3 residents will be allowed to take vacation in any day combinations that will not be disruptive to the overall clinical coverage and call schedule. The CA-3 vacation requests will be monitored by the Chief Resident to ensure that the process will not be abused.

7.11 Once a vacation request has been approved, the resident agrees to take the requested vacation days and can not change these requested days unless approval is given by the responsible faculty and Chief Resident.

7.12 The Chief Resident and his/her designee, will assist the Residency coordinator in keeping track of each resident’s number of vacation days for the year.

7.13 Each resident will discuss his/her intentions to request vacation with each of the other resident on his/her rotation prior to submitting the vacation request.

APPROVED BY:  
E. E. Fibuch, M.D.  
Program Director  

DATE: July  2009
**RESPONSIBILITY OF CHIEF RESIDENT**

**Policy:** To define the responsibilities and duties of the Chief Resident.

**Purpose:** To ensure that the responsibilities and accountabilities are consistent with the framework of the role of the Chief Resident and to establish the authority of the Chief Resident as the leader and spokesperson for all the residents.

8.1 The Chief resident will be selected, via ballot, by the Anesthesiology staff and residents, and serve for a 12-month period, beginning on July 1 and extending through June 30th of each academic year.

8.2 The Chief resident will act as liaison between the residents and the Program Director.

8.3 The Chief resident will be responsible for making out the resident call schedule both monthly and yearly (holidays).

8.4 The Chief resident will serve as the representative of the residents on the Education, Competency and Resident Selection Committees.

8.5 The Chief resident will assign a resident to serve on the Quality Assurance Committee of the Department of Anesthesiology at SLH.

8.6 The Chief resident will actively participate in resident recruiting interviews.

8.7 The Chief resident will help the Program Director plan for and initiate resident enrichment conferences.

8.8 The Chief resident will meet with the Program Director on a regular basis to report on resident issues/concerns and to make recommendations on how to improve the training program.

8.9 The Chief resident will call a monthly meeting of all the residents, establish an agenda for the meeting, and keep minutes of all resident meetings.

8.10 The Chief resident will serve as a role model for all residents.

**APPROVED BY:**

E. E. Fibuch, M.D.
Program Director

**DATE:** July 2009
MEMBERSHIP TO ANESTHESIOLOGY AND ANESTHESIA AND ANALGESIA

Policy: The Department of Anesthesiology will provide the necessary funding to pay for journal subscriptions for Anesthesiology and Anesthesia and Analgesia for each resident.

Purpose: To help facilitate resident education, provide an additional personal reference source for each resident and encourage residents to begin reading the two major journals in anesthesiology.

9.1 The Anesthesiology Department will pay for the resident’s dues for membership in the American Society of Anesthesiology and also Anesthesia Research Society. Membership in both of these organizations automatically entitles the resident to receive Anesthesiology and Anesthesia and Analgesia.

9.2 The Department of Medical Education will administer the funds to pay the dues through the Saint Luke’s Foundation.
EDUCATIONAL GRANT

Policy: At the start of the resident’s CA-1 year, the Department of Anesthesiology will provide each resident with an educational grant to be used to purchase textbooks.

Purpose: To help ensure that each new resident has a basic anesthesia reference library for his/her personal use.

10.1 At the beginning of the CA-I year, residents will be given a $1,000.00 educational grant for the specific purpose of purchasing anesthesia-related textbooks or anesthesia related software. An approved list of textbooks from which the resident may choose will be supplied. This is in addition to any reimbursement for textbook material from UMKC in place of meeting reimbursement.

10.2 The Department of Medical Education will administer the funds to pay for the books through the Saint Luke’s Foundation.

APPROVED BY: 

E. E. Fibuch, M.D.
Program Director

DATE: July 2009
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES

UMKC SCHOOL OF MEDICINE
SAINT LUKE’S HOSPITAL
TRUMAN MEDICAL CENTER
CHILDREN’S MERCY HOSPITAL

Program: Anesthesiology
Subject: Ear piece
Policy #: A-11

EARPIECE

Policy: All residents will have their own personal earpiece to be used during the administration of anesthesia.

Purpose: To provide each resident with an additional monitoring tool for the care of patients undergoing an anesthetic.

11.1 All residents will be expected to have appropriately fitting earpiece.

11.2 The Department of Anesthesiology will pay the expense of purchasing the initial earpiece for new residents when purchased through Audiology at Saint Luke’s Hospital.

11.3 Any resident wishing to purchase a second earpiece may do so through Saint Luke’s Audiology Department however, the cost of the second earpiece will be the resident's responsibility and the procedures for ordering a second earpiece will be slightly different. The resident will, however, receive the same discounted price.

APPROVED BY:                         DATE: July 2009

E. E. Fibuch, M.D.
Program Director
REIMBURSEMENT POLICY

Policy: Resident expenses will be reimbursed according to guidelines established by the University of Missouri and administered through University of Missouri – Kansas City School of Medicine.

Purpose: To ensure a consistent and fair process of reimbursement of resident expenses.

12.1 See attachment for details/guidelines. (see A-46, A-47 and A-48)
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES

UMKC SCHOOL OF MEDICINE                          Program: Anesthesiology
SAINT LUKE’S HOSPITAL                               Subject:   Hygiene and
TRUMAN MEDICAL CENTER                              Dress Code Policy
CHILDREN’S MERCY HOSPITAL                          Policy #:   A – 13

HYGIENE AND DRESS CODE POLICY

Policy: All residents are expected to present themselves in a professional manner at all times while they are physically present at each of the teaching hospital campuses (SLH, TMC, CMH, and KCUMB) and the University of Missouri-Kansas City. This policy provides guidelines for residents to follow regarding appropriate dress and hygiene.

Purpose: Professional demeanor is an important aspect of ACGME core competency. In addition, patient and staff expectation also denotes the importance of being professional at all times. Appropriate dress and appearance is a reflection of personal professionalism.

13.1 All residents will be expected to dress appropriately and in a professional manner while on duty in the hospital. The appropriate dress will be in compliance with the attached Dress Code/Professional Appearance Policy of Saint Luke’s Hospital, Truman Medical Center, Children’s Mercy Hospital, and Kansas City University of Medicine and Bioscience. (See attached dress code approved 11-14-2008) In addition to the hospital’s dress code policies, the Department of Anesthesiology requires that residents will not wear scrub clothes when leaving or coming to the hospitals.

13.2 It is important to recognize that, as resident physicians, close personal contact occurs with patients. Proper hygiene and appearance are expected by the patient and the faculty.

13.3 Residents who do not maintain appropriate dress and hygiene will be counseled by the Program Director.

13.4 Residents who continually violate reasonable standards of appearance and hygiene may be required to participate in a remediation process consisting of counseling or, in circumstances of continued violation, the resident may lose clinical privileges until the situation is rectified to the satisfaction of the Program Director.
13.5 Loss of privileges will result in lost training days and possibly necessitating extending a resident’s training time.

APPROVED BY: E. E. Fibuch, M.D.  
Program Director  

DATE: July 2009
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES

UMKC SCHOOL OF MEDICINE  Program: Anesthesiology
SAINT LUKE’S HOSPITAL  Subject: Moonlighting Policy
TRUMAN MEDICAL CENTER  Policy #: A – 14
CHILDREN’S MERCY HOSPITAL

MOONLIGHTING POLICY

Policy: Residents will not be allowed to moonlight under any circumstances while they are in their training. This applies to the CB, CA-1, CA-2 and CA-3 years.

Purpose: Residency training is considered by the Department of Anesthesiology to be a full-time occupation. The faculty recognizes that fatigue is an issue during training and is supportive of the ACGME guidelines on resident work hours. Moonlighting by a resident will only worsen fatigue (potential harm to patients) and will impact the intent of the ACGME work hour rules.

14.1 Due to the intensity, complexity and demands of anesthesiology training, it is the department’s policy that moonlighting will not be allowed for residents in their CB, CA-1, CA-2 or CA-3 year of training. Moonlighting is felt to be a distraction to training and to the educational experience.

APPROVED BY: _________________  DATE: July 2009

E. E. Fibuch, M.D.
Program Director
CONFERENCE ATTENDANCE POLICY

POLICY: To monitor resident attendance at academic conferences (SLH, TMC and CMH) and to initiate corrective action for those residents who do not maintain an acceptable attendance rate at conferences.

PURPOSE: To ensure that residents attend a departmentally specified minimum number of academic conferences during the CA-1, CA-2, and CA-3 years.

15.1 Residents are required to attend all academic conferences given at Saint Luke’s, Truman Medical Center and Children’s Mercy Hospital while on rotation at these institutions.

15.2 Residents must sign the conference attendance report for each conference in order to get credit.

15.3 All Conference sign-in sheets will be maintained in the Department of Medical Education at Saint Luke’s Hospital and will be collated monthly for each resident.

15.4 Residents must sign the attendance sheet within 10 minutes of the start of a conference. Credit will not be given for late arrival.

15.5 Residents who leave ten (10) minutes before the end of conference will not be given credit.

15.6 A resident must attend a minimum of 90% of scheduled conferences per month.

15.7 If a resident does not attend 90% of scheduled conferences for a given month, then the resident will be required to attend 100% of the conferences the following month. Failure to do so will result in loss of academic credit for the first month. If the resident continues to attend less than 90% of the conferences in the subsequent months, he/she will lose additional credit toward graduation from the program.

15.8 Any months of lost academic credit will have to be made up at the end of the training program in order to graduate successfully from the training program.
15.9 The resident is not required to attend anesthesiology sponsored conferences under the following circumstances:
A. While in the laboratory (3 months) but must attend laboratory conferences
B. Excused written absence from an attending anesthesiologist indicating that patient care duties conflicted with conference attendance
C. For health reasons (sickness, doctor’s appointment, etc.)
D. Vacation time
E. Meeting time

15.10 Academic conferences at St. Luke’s Hospital are held 4 days a week from 0640 to 0710 on Monday, Tuesday, Wednesday, and Friday and on Thursday from 0640 to 0740. Residents are required to be in attendance 5 minutes before the scheduled conference starting time in order to participate in the Question of the Day.

15.11 Academic conferences at Truman Medical Center are held 4 days a week from 0640 to 0710 (Monday, Tuesday, Wednesday and Friday) and on Thursday from 0700 to 0800. Conference attendance is mandatory.

15.12 At Children’s Mercy Hospital, lectures are provided 4 days a week: Monday, Tuesday, Wednesday and Friday. Conferences begin at 0630 and last 30-45 minutes. Topics will be pertinent to pediatric anesthesia. Topics follow recommended core pediatric anesthesia curriculum by the SPA, sequence over 3 months. A monthly schedule of lectures/lecturers will be posted in the Anesthesia Office. If you are scheduled to do the first case of the day at 0730, you will have to plan accordingly and arrive earlier than the lecture to prepare your room. On Thursdays a M & M conference is held once a month, and other presentations are given on the remaining Thursdays. One Friday a month a departmental meeting on quality improvement is held. Both are at 0630. Residents are expected to attend.

15.13 Conference preparation is essential for a good educational experience. Therefore, when a resident is assigned a conference, he or she will prepare a written handout (outline or narrative). Audiovisual aids are considered important tools for teaching and residents are encouraged to use them.

15.14 It is the responsibility of the resident to make appropriate changes with another resident if he/she cannot be in attendance to present an assigned conference.

15.15 Conference assignments are made in June prior to the beginning of the academic year for St. Luke’s Hospital and Truman Medical Center

15.16 Tracking resident attendance at conference is a tool used by the faculty to help fulfill a number of requirements defined by the ACGME for competency testing. This includes such requirements as preparation, professionalism, ability to verbalize, knowledge, demonstrates analytical thinking, application of basic issues to the care of patients, ability to utilize information technology, is careful and thoughtful, etc. Therefore, residents will be required to sign on attendance sheet for each conference.
15.17 All conference attendance will be aggregated for a six-month period. A resident must attend, in aggregate, at least 90% of the conferences.

15.18 Biannually, the aggregated average resident conference attendance will be entered into the resident’s portfolio and will become one of the metrics used in a resident’s biannual evaluation.

APPROVED BY: ___________________       DATE: July 2009

E. E. Fibuch, M.D.
Program Director
# DEPARTMENT OF ANESTHESIOLOGY
## ADMINISTRATIVE POLICIES

<table>
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<th>UMKC SCHOOL OF MEDICINE</th>
<th>Program: Anesthesiology</th>
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<tbody>
<tr>
<td>SAINT LUKE’S HOSPITAL</td>
<td>Subject: In-Training Exam</td>
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<tr>
<td>TRUMAN MEDICAL CENTER</td>
<td>Policy #: A – 16</td>
</tr>
<tr>
<td>CHILDREN’S MERCY HOSPITAL</td>
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</tr>
</tbody>
</table>

## IN-TRAINING EXAM:
ASA-ABA (summer) and Internal (spring)

**Policy:** All residents will be required, during their CB, CA-1, CA-2 and CA-3 years, to take the ASA/ABA In-Training examination, which is usually given on the second Saturday in July. In addition, all CA-1, CA-2 and CA-3 residents will be required to take the Departmental internal examination in the spring of the academic year (usually March or April). CB residents will be required to take the internal medicine in-training examination in the fall of their CB year. In addition, CA-1 residents will be given a written examination, one month into their CA-1 year.

**Purpose:** To provide the faculty with some additional objective evaluative information regarding residents knowledge in addition to giving the residents adequate exposure to taking a written examination and using the examination results as an additional tool for each residents’ ongoing evaluation (biannual score card).

| 16.1 | All residents will be expected (during the CB, CA-1, CA-2 and CA-3 years) to participate in the ASA/ABA In-training examination. UMKC will pay the fee for this examination. |
| 16.2 | All residents will be expected to take (CA-1, CA-2, and CA-3) years) the departmental, spring internal examination. |
| 16.3 | The results of these two yearly examinations will be used as part of the biannual resident scorecard. |
| 1.   | The ASA/ABA examination will be used for the July – December biannual evaluation period and will be worth 10% of a resident’s grade. A resident must score above the 25\(^{th}\) percentile in his/her National cohort. |
| 2.   | The departmental internal examination, given in the spring of each year (March or April), will be used in the January – June evaluation period. The results of the examination will be worth 10% of the resident’s grade on the scorecard. The resident must answer 50% (or greater) of the questions correctly in order to be given credit for the examination. |

16.4 Following the completion of a successful CA-3 year, the resident is eligible to take the written examination of the American Board of Anesthesiology.
16.5 The responsibility for applying for the ABA written and oral examination is that of the resident.

APPROVED BY: ________________  DATE: July 2009

E. E. Fibuch, M.D.
Program Director
EVALUATION POLICY

Policy: To define an evaluation and advancement policy for anesthesiology residents that will allow an appropriate transition from the CB year through to the CA-3 year.

Purpose: To ensure that there is a uniform, consistent and fair Departmental process that allows the faculty to evaluate residents’ performance and competency using prospectively developed tools and to define a process of advancement from year to year of training that meets the intent and framework of the requirements of training by the RRC and ABA.

17.1 Residents are evaluated during their CB, CA-1, CA-2 and CA-3 years.

17.2 During the CB year residents are evaluated by their attending medicine faculty using a defined evaluation form approved by the Internal Medicine Department (see attached form). Data from the monthly evaluations are reviewed by the Anesthesiology Program Director and aggregated for the final biannual clinical competency report to the ABA.

17.3 During the CA-1, CA-2 and CA-3 years, residents are evaluated using the framework of the six core competencies: 1) patient care; 2) medical knowledge; 3) practice based learning and improvement; 4) interpersonal and communication Skills; 5) professionalism, and 6) system-based practice as defined by the ACGME and the RRC.

17.4 The following tools are used by the faculty to evaluate the residents’ attainment of the six core competencies:
   1. Monthly evaluations (see attached evaluation form)
   2. Biannual aggregate faculty evaluations
   3. Conference attendance
   4. Annual ASA/ABA In-Training examination
   5. Annual departmental examination
   6. Performance at mock oral examinations
   7. Performance at conference presentation

17.5 All residents will be evaluated during the CB, CA-1, CA-2, and CA-3 years on a monthly basis by their assigned faculty. The evaluations, from the assigned faculty, will be turned into the Program Director. If during any given month a resident receives an unsatisfactory evaluation, he/she will be notified of that
evaluation by the Program Director and the evaluation will be discussed in person with the resident (see Remediation Policy).

17.6 In the event that a resident consistently receives doubtful or unsatisfactory evaluations, the Clinical Competence Committee will review the resident's aggregate performance and will determine if corrective steps need to be taken (see Remediation Policy).

17.7 The Clinical Competence Committee will review the evaluations and scorecard for each resident biannually, and recommendations for advancement in the training program will be made. The summary biannual evaluations and recommendations of the Clinical Competence Committee will be reviewed with the resident by the Program Director on a biannual basis.

17.8 Semi-annual summary Clinical Competency Reports will be sent to the American Board of Anesthesiology for each resident. The resident will be shown his/her summary evaluation and asked to sign it prior to the clinical competency report being sent to the ABA.

17.9 On a biannual basis, the data provided by the evaluation tools used by the faculty will be aggregated into a biannual score card for each resident. A resident must attain a score of 7 or greater in order to advance in the program and achieve a satisfactory clinical competency report that will be forwarded to the ABA. This must be achieved in addition to receiving a score of greater than 2.5 on the biannual evaluations.
RESIDENT ADVANCEMENT/PROMOTIONS POLICY

Policy: To define the annual reappointment process for resident advancement.

Purpose: To ensure that there is a consistent and fair reappointment process that meets all of the educational and contract guidelines established by the University of Missouri – Kansas City (the employer), the University of Missouri – Kansas City School of Medicine and the Department of Anesthesiology.

18.1 Resident promotion (advancement to the next training level) will follow the contractual guidelines established by UMKC as the employer, applicable educational guidelines of the School of Medicine and the promotion and evaluation policy of the Department of Anesthesiology.

18.2 Residents will be advanced to the next level of training based on satisfactory completion of all training requirements (see table 18.12) and satisfactory clinical competency based on the residents achieving satisfactory clinical competency evaluations (biannual ABA clinical competency report and the Departmental biannual scorecard) (see Evaluation Policy).

18.3 Resident reappointment will be for a 12-month period.

18.4 Residents will be notified of non-reappointment at the earliest possible time.

18.5 Residents who are not reappointed as a result of not achieving a satisfactory ABA Clinical Competency Report and Departmental scorecard may utilize the grievance process (see Due Process Policy).

18.6 To be eligible for consideration of promotion to the CA-2 year, a resident must have successfully completed the examination requirements necessary for permanent medical licensure (Steps I, II and III of USMLE or COMLEX).

18.7 A resident will be required to show documentation of examination status at the time of signature of employment contract for CA-2 and CA-3 years.

18.8 If all examination requirements have not been met by the beginning of the CA-2 year, the Program Director will be notified by the UMKC –SOM GME office and will be asked to refer the resident to the Program Education Committee for development of a remediation plan.

18.9 A decision by the program faculty to not promote a resident to the next level of training will necessarily be accompanied by one of two recommendations: a) retain the resident at the current level of training for a specified period of time prior to re-evaluation, or b) dismiss the resident from the training program.
18.10 In situations where a resident is not making adequate progress towards advancement to the next level of training, the faculty may decide against renewal of the resident’s contract. If this occurs, the resident will receive at least 4 months advance written notice. If the reason for non-renewal of contract occurs within the 4 months prior to the end of the current contract, the program will provide the resident with as much written notice of its intent not to renew as the circumstances will reasonably allow.

18.11 With any adverse action that maybe taken by the program faculty, the resident has the right to appeal the action through the Departmental Dismissal Policy # A-30.

18.12 See attached Table
<table>
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<tr>
<th></th>
<th>CBY to CA-1</th>
<th>CA-1 to CA-2</th>
<th>CA-2 to CA-3</th>
<th>CA-3 to Graduation</th>
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<td>Completion</td>
<td>NA</td>
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<td>Completion of Research</td>
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<td>Completion</td>
</tr>
<tr>
<td>Maintenance of Case logs</td>
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</tr>
</tbody>
</table>

APPROVED BY: ___________________________ DATE: Oct. 2011
E. E. Fibuch, M.D.
Program Director
PEDIATRIC ROTATION POLICY

Policy: All residents will be required to fulfill their pediatric case requirement by spending 3 months at Children’s Mercy Hospital.

Purpose: To ensure that the residents have a defined teaching experience in pediatric anesthesia that will allow them to safely conduct a pediatric anesthetic and fulfill their pediatric case requirements.

19.1 All residents will be expected to take a three-month rotation at Children’s Mercy Hospital sometime during their CA-2.

19.2 Residents are expected to abide by the rules and regulations of the Department of Anesthesiology at Children’s Mercy Hospital and the Medical Staff of Children’s Mercy Hospital.

19.3 Conference attendance at Children’s Mercy Hospital is mandatory for all residents.

19.4 Residents will take call at Children’s Mercy Hospital when assigned by the pediatric faculty.

19.5 The integrated program will maintain all benefits and compensations for the residents while he/she is on rotation at Children’s Mercy Hospital.

19.6 Residents will be evaluated using the same evaluation tool as is used in the integrated program. All Children’s Mercy Hospital evaluations will be forwarded to the program director.

19.7 Any daily or operational concerns that the resident might have while on rotation at Children’s Mercy Hospital should first be directed to the Associate Program Director at Children’s Mercy Hospital (currently Barbara Furgason, MD).

APPROVED BY: E. E. Fibuch, M.D.
Program Director

DATE: July 2009
IN-HOSPITAL CALL RESPONSIBILITY POLICY

Policy: To define the requirements for in-hospital call for CA-1, CA-2 and CA-3 residents. Call is an important aspect of the educational experience and, therefore, all residents are expected to participate equally in call responsibilities.

Purpose: To ensure that there is a uniform, consistent and fair call process that meets the intent and framework of the ACGME guidelines for resident duty hours.

20.1 The resident is responsible for taking a maximum of six call nights per month at Saint Luke’s Hospital, unless otherwise directed by the Program Director. These calls will be appropriately divided during the week and on weekends. When a resident is on rotation at Truman Medical Center, he/she will participate in the call rotation at Saint Luke’s Hospital. When a resident is on rotation at Children’s Mercy Hospital, he/she will be scheduled to take 1 weekend call in the hospital (Children’s Mercy) per month. When a resident is on his/her laboratory rotation, he/she will participate in the Saint Luke’s Hospital call rotation (weekends only) at the discretion of the Chief Resident. Call will begin promptly at 5:00pm.

20.2 It is the responsibility of the Chief Resident to make out the resident call schedule. This call schedule must be turned into the Anesthesia Secretary at least one week prior to the beginning of the month.

20.3 CA-1 residents will begin taking call at the end of their first month in the operating room or as deemed reasonable by the Program Director.

20.4 Call will begin promptly at 5:00 pm and ends at 6:00am the following day. In accordance with the ACGME policy the resident may be required to end his/her post call time till after the end of the daily educational conference to provide for continuity of patient care, provide for transfer of patient information and participate in the daily conference.
20.5 The day after call, if it occurs during the week, is considered a non-clinical day for the resident without patient care responsibilities. Residents will be relieved of their usual assignment in the operating room the day after call.
RECORD MAINTENANCE POLICY

Policy: To define the expectations of the faculty, medical staff and Institutions regarding the responsibility that a resident has toward timely and accurate record keeping.

Purpose: It is the expectation that all residents will maintain and complete their patient, academic, and administrative records accurately and in a timely fashion.

21.1 All residents, including the CB residents will be expected to keep an ongoing record of their clinical experience in and out of the operating room. This must be turned in once per year to the American Board of Anesthesiology. (see example of data form)

This data should include the following:

- type of operation
- type of anesthetic
- age of patient
- case number
- type of procedures (OR, ICU, Pain)
- number of consultations
- reason for consultation
- number of follow-up visits (ICU/pain)
- number of post-op visits

21.2 The ACGME has made the software program accessible from any computer with Internet access in order to track cases. Residents are required to keep their individual case record up to date and accurate.
21.3 Residents are expected to complete all of their patient medical records accurately and in a timely manner in accordance with the Medical Staff and Institutional Rules and Regulations at Saint Luke’s Hospital, Truman Medical Center and Children’s Mercy Hospital. Failure to comply with this policy might result in suspension of the residents’ clinical privileges and could jeopardize the resident completing his/her training on time.

APPROVED BY: ___________________________ DATE: July, 2009
E. E. Fibuch, M.D.
Program Director
SUPERVISORY OVERVIEW

Policy: The following lists of policies refer to elements of supervisory accountability for residency training within the policy manual.

Purpose:
The purpose of this policy is to be an overview policy regarding resident supervisory/accountability for all aspects of anesthesiology training.

22.1 Policy A-3 Travel
Policy A-4 Sick Leave
Policy A-5 Maternity Leave
Policy A-6 Paternity Leave
Policy A-7 Vacations
Policy A-17 Evaluations
Policy A-20 Call Responsibility
Policy A-23 Supervision of Anesthesiology Residents during the intra-operative and post-operative care of patients
Policy A-25 Case Preparation and Presentation to the Staff
Policy A-26 Resident Induction/Emergence
Policy A-27 Resident Counseling
Policy A-28 Resident Remediation
Policy A-29 Due Process
Policy A-30 Resident Dismissal

APPROVED BY: ___________________________ DATE: July 2011
E. E. Fibuch, M.D.
Program Director
SUPERVISION OF ANESTHESIOLOGY RESIDENTS POLICY

Policy: Residents, during clinical care of patients, will be supervised by faculty at all times, at all three training hospitals (SLH, TMC and CMH) and while they are in their laboratory rotation at UMKC or KCUMB. The level of supervision will depend on the resident’s year in training, the procedure or activity and at the discretion of the faculty. The Department and faculty has adopted the definition of supervision provided in the Common Requirements, dated July 2, 2011 from the ACGME.

Purpose: At all three of the UMKC School of Medicine teaching hospitals (SLH, TMC and CMH) residents are never left unattended by the faculty in the operating room during the elective surgical schedule. During the non-elective (emergency cases) schedule at SLH and TMC, there is faculty presence in the hospital 24 hours per day, 7 days a week, and, therefore residents have 100% access and coverage by the faculty. When residents rotate to CMH the faculty are present 100% of the time for resident supervision in the patient care areas during elective and emergency cases. During the after hours period, CMH faculty are on beeper call at home. If an emergency case arises, the faculty will return to the hospital and will be present for the induction, emergence and postoperative care of patients. Residents are never left in an unsupervised situation. Faculty at all three teaching institutions (SLH, TMC, and CMH) have personal pagers (many carry cell phones) and their home phone numbers are published for the residents to access if needed. From time to time (very rare), when a severe life threatening emergency (ie code blue in the emergency department) occurs, the residents are instructed to page their staff and proceed with patient care. See attached Supervision Policies: SLH (October 2002) and TMC (February 2008).

23.1 Inpatient and outpatient care rendered by resident physicians shall be provided under faculty supervision.

23.2 Patient care is ultimately the responsibility of the attending anesthesiologist and involved consultants.

23.3 Attending anesthesiologist and consultants directly responsible for the supervision of patient care services provided by resident physicians must be available to participate in that care as if residents were not involved and the attending anesthesiologist must be available to participate in a patient’s care when requested by a resident physician.
23.4 Program faculty directly responsible for the supervision of patient care services provided by resident physicians should be available to participate in that care as if residents were not involved and program faculty must be available to participate in a patient’s care when requested by a resident physician.

23.5 When a resident is involved in the care of a patient, it is the resident’s responsibility to communicate effectively with their attending anesthesiologist regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions and anesthetic plan on a continuous basis.

23.6 When allowing care of their patients by residents, attending physicians do not relinquish their rights or responsibilities to: examine and interview, admit or discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement or correcting the statement and initialing the change.

23.7 The attending anesthesiologist (or consultant) shall review entries made by the residents in the medical record and make any necessary corrections in the medical record, initialing all changes.

23.8 Residents shall notify the appropriate attending anesthesiologist or consultant, upon patient admission, if there is any change in a patient’s condition or prior to initiating significant changes in a patient’s treatment, including patient discharge.

23.9 Residents may perform history and physical examinations and consultations without the attending anesthesiologist or consulting physician being physically present. It is the responsibility of the resident to discuss their findings with the attending anesthesiologist or consulting physician upon completion of their examination. Admitting history and physical examinations shall be countersigned by the attending anesthesiologist or consulting physician.

23.10 Residents may evaluate patients and write daily progress notes without the attending anesthesiologist being physically present. It is the responsibility of both the resident and attending anesthesiologist or consulting physician to discuss their findings and treatment plans documented in the progress note on a daily basis, or more often as described above, when a patient’s condition changes, or prior to initiating changes in a patient’s treatment.

23.11 Residents may write daily orders on patients for whom they are participating in their care. These orders will be implemented without the co-signature of an attending anesthesiologist or attending physician. It is the responsibility of the resident to discuss their treatment plans with the attending anesthesiologist or consulting physician. Attending and consulting physicians may write orders in patients’ charts on all teaching cases.
23.12 Residents will be supervised by the physical presence of the attending physician (or a senior resident in the CB year) during all procedures for which the resident has not achieved independent proficiency as verified by the residency program director. If, at any time, a resident is called upon to perform one of the specified procedures, which he is not verified to perform independently, the patient’s attending physician must be notified before informed consent is obtained from the patient or the appropriate individual representing the patient.

23.13 During the elective OR schedule, there will never be any circumstance in which a resident is left unattended in the operating room without faculty presence.

23.14 There will be faculty coverage in the operating room 24 hours a day, seven days a week. There will never be a circumstance in which a faculty is on call but not in the institution, except at CMH, as noted previously.

23.15 Faculty will be available at all times within the confines of the operating suite or obstetrical suite, unless on rare occasion, there is an emergency somewhere else in the institution requiring specific faculty presence.

23.16 A new resident beginning in the CA-1 year will have more intense faculty coverage in the operating room. This usually lasts anywhere from four to six weeks until the resident advances in his/her training and the faculty feels reasonably comfortable that intense supervision is not necessary. The resident will then be covered by faculty who will circulate through the operating suite, usually covering another room staffed by a senior CRNA.

23.17 As a general rule, faculty supervision is limited to one staff anesthesiologist per two operating rooms. The Department’s policy always requires direct faculty supervision of a resident.

23.18 There is direct faculty coverage in the operating room for all open-heart procedures and those cases in which the patient is critically ill.

23.19 Residents are expected to make pre and post operative rounds on their patients. Although the resident performs this activity independently, the resident is expected to contact their respective faculty and discuss any issues requiring faculty input/recommendations.

23.20 Residents will spend a minimum of two weeks at the Pre-Assessment Center (PAC) at SLH learning how to perform preoperative patient assessments. This is an independent activity. The resident is required to followup with an assigned PAC faculty member for all non-routine patient care issues.

23.21 The resident will spend a minimum of two weeks in the recovery room (SLH). Routine care by the resident is usually performed independently however the resident is required to contact the appropriate faculty for all non-routine patient care issues. At all three teaching hospitals, faculty oversee and are responsible for patient care activity in all of the PACUs.
23.22 The program director will develop a list of procedures that resident may be allowed to perform without supervision. Once competency has been documented in any of these specific procedures by the program, the resident may perform these procedures without direct supervision but with the permission of the attending physician. Such list will be developed with input from members of the appropriate department or service, and will be submitted to the Office of Graduate Medical Education. The program director will review such list on an annual basis. (See attached Medical Education Policy regarding Resident/Fellow supervision).

23.23 Program specific written descriptions of resident roles, responsibilities, and patient care activities will be distributed by the program director, to faculty supervising residents. Competency of each resident for the defined procedures will be reviewed on a regular basis (every 3-months) by the Clinical Competency Committee of the Department of Anesthesiology and the recommendations of the Clinical Competency Committee will be forwarded to the Education Committee for final approval.

23.24 Definition of Supervision Effective 09/01/2011

- **Direct supervision**: the supervising physician is physically present with the resident and the patient

- **Indirect supervision-direct supervision immediately available**: the supervising physician is physically present within the hospital or other site of patient care and is immediately available to provide direct supervision

- **Direct supervision available such that the supervising physician is not physically present within the hospital or other site of patient care**: the supervising physician is immediately available by means of telephone or other electronic means

- **Oversight**: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

23.25 Rotational and year of training supervision guidelines will be followed. See Goals/Objectives

23.26 See attached Supervision Grids

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<thead>
<tr>
<th>APPROVED BY:</th>
<th>DATE:</th>
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<tbody>
<tr>
<td>E. E. Fibuch, M.D.</td>
<td></td>
</tr>
<tr>
<td>Program Director</td>
<td>September 2011</td>
</tr>
</tbody>
</table>
PRE- AND POST-OPERATIVE ROUNDS

Policy: To define the requirements for pre and post operative rounds by anesthesiology residents. Pre and post operative rounds are considered important aspects of patient care and form an integral part of the educational experience of residents.

Purpose: To ensure that there is a uniform and consistent Departmental policy regarding the pre and post operative rounds by residents and to ensure that patients are seen in a timely manner.

24.1 All residents will be responsible for preoperative and post-operative rounds on their patients, including writing the appropriate notes and orders in the patient's chart.

24.2 All residents will be responsible for the timely and appropriate completion of their medical records.

24.3 All residents are expected to date, time and legibly sign all orders and progress notes.

24.4 All residents will communicate to their attending faculty any patient issues that require faculty intervention.

APPROVED BY: E. E. Fibuch, M.D.  
Program Director  
DATE: July 2009
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES

UMKC SCHOOL OF MEDICINE                                Program:  Anesthesiology
SAINT LUKE’S HOSPITAL                                    Subject:  Case
TRUMAN MEDICAL CENTER                                   Presentation
CHILDREN’S MERCY HOSPITAL                                Policy #:  A – 25

RESIDENT RESPONSIBILITIES FOR CASE PREPARATION

Policy: To define the expectation of the faculty that all residents are responsible for seeing their patients preoperatively, evaluating the patients prior to induction of anesthesia, write pre-operative orders and contact and discuss their cases with their assigned faculty.

Purpose: To ensure that all patients are seen preoperatively by the resident assigned to perform that patient’s case. To facilitate the residents’ learning through interaction with both the faculty and the patient. To ensure appropriate patient care through the transfer of patient related information.

25.1 Residents are expected to see their patients preoperatively, evaluate the patients, write preoperative orders when needed, write a preoperative note, and develop an anesthetic plan.

25.2 During the CA-1, CA-2 and CA-3 years, residents who are assigned to the operating room will be expected to contact their assigned staff for the next day and discuss the management of the patients.

APPROVED BY: ________________                              DATE:  July 2009
                           E. E. Fibuch, M.D.
                           Program Director
RESIDENT INDUCTION/EMERGENCE POLICY

Policy: Residents are required to have faculty in attendance for all inductions of anesthesia and emergence from anesthesia, unless otherwise directed by the faculty.

Purpose:
Induction into and emergence from general anesthesia is considered to be hazardous. The faculty has developed the following policy for all residents to follow when residents are about to induce general anesthesia, initiate a regional block or facilitate a patient’s emergence from general anesthesia. This policy is intended to improve patient safety, provide faculty coverage for the resident and establish a time for instruction and learning.

26.1 All residents will page (call) their responsible faculty prior to induction of general anesthesia and wait for the faculty to respond before proceeding. Residents may proceed with induction without staff presence in the following circumstances:
1. When the life of the patient is at serious risk, or
2. When the faculty responsible for the case instructs the resident to proceed with induction of general anesthesia

26.2 All residents will page (call) their responsible faculty prior to the initiation of a regional block and wait for the faculty to respond before proceeding. Residents may proceed with the initiation of the regional block without staff presence in the following circumstance:
1. When the faculty responsible for the patient instructs the resident to proceed with the block.

26.3 All residents will page (call) their responsible faculty prior to the emergence of a patient from general anesthesia and must wait for the faculty to respond before proceeding with emergence. Residents may proceed with emergence in the absence of the faculty in the OR in the following circumstance:
1. When the faculty responsible for the case instructs the resident to proceed with emergence.
26.4 Failure to follow the policy will result in the potential unsatisfactory evaluation of the residents' performance by the faculty or referral of the incident to the Competency Committee of the Department for review and recommendation of disciplinary actions to the Program Director.

APPROVED BY: ___________________________ DATE: July 2009
E. E. Fibuch, M.D.
Program Director
RESIDENT COUNSELING POLICY

Policy: To ensure that a defined process is in place to provide the residents with the benefit of securing professional counseling, if needed, during their residency training.

Purpose: The purpose of this policy is to provide the resident with the benefit of receiving professional counseling, if needed, during the course of residency training. It is recognized that residency training in anesthesiology can, from time to time, be stressful or that other factors such as marital discord, depression, interpersonal communications deficit, ADD or other learning problems, or drug/alcohol abuse may interfere with a resident’s performance or result in aberrant behavior.

27.1 If a resident demonstrates, through his/her performance or through aberrant behavior that psychological counseling is needed, the Program Director, in concert with the Competency Committee of the Department of Anesthesiology, will offer the resident the opportunity to seek counseling through the EAP at Saint Luke’s Hospital or through the counseling program at UMKC.

27.2 If the resident’s performance or behavior is considered to be seriously affected by one or more of the above factors, then the Program Director reserves the right to mandate attendance at counseling as a precondition for the resident to remain fully in-stated in the program.

27.3 The length of counseling will be determined by the Program Director based on the advice of the residents’ counselor and the demonstrable improvement shown by the resident.

27.4 If the resident has been shown to have an alcohol/drug abuse problem he/she may be required to participate in the State of Missouri Physician’s Health Program (MPHP)
27.5 Participation in any counseling program does not guarantee that the resident will be allowed to remain in the training program. Continued participation in the training program is contingent upon not only completing the counseling, but is also dependent on the resident demonstrating improvement in his/her clinical and academic performance.
RESIDENT REMEDIATION POLICY

Policy: To establish a process of remediation for residents who, determined by the Clinical Competency Committee, Education Committee and/or the Program Director, may need remedial training based on the residents prior unsatisfactory or doubtful performance either clinically or academically.

Purpose: The purpose of this policy is to define the process by which a resident is required to undergo remediation. During the training (CB, CA-1, CA-2 and CA-3 years) of anesthesiology residents, a problem (both academic or nonacademic) may be identified which will require remedial action to be taken by the Competency Committee of the Department of Anesthesiology and the Program Director. This policy outlines the plan to be followed should such a problem arise.

Residents are evaluated on a monthly basis by the faculty, utilizing either the ABA competency form (CA-1, CA-2 and CA-3) or the Internal Medicine Departments’ evaluation form (CB year). Residents are evaluated in six: Core competencies of ACGME, which consist of: 1) patient care; 2) medical knowledge; 3) practice-based learning and improvement; 4) interpersonal and communication skills; 5) professionalism 6) systems-based practice.

28.1 Identification

a) Any staff physician/faculty member, hospital staff or peer physician may identify a problem with the performance or behavior of an anesthesiology resident.

b) The nature and severity of the problem (i.e. personal, emotional, clinical or academic), the specifics of the problem (i.e. timeline, individuals involved, causes, resulting action) need to be defined and recorded.

c) If, following the aggregation of a resident’s six month evaluation for compiling the ABA competency report, the average total score falls below 2.5(see: Evaluation Policy), then the resident may be required to participate in remedial training.

28.2 Documentation

a) The problem or issue needs to be documented in detail and presented to the Program Director.
28.3 Discussion
a) The Program Director or his/her designee will discuss the issue/problem with the resident and provide the resident with the details and available documentation.
b) The Program Director or his/her designee will outline any next steps the resident will take in order to correct the problem or issue.
c) The Program Director will make sure that all documentation including a summary of the discussions with the resident will be placed in his/her file. The Program Director may elect (based on the circumstances) to involve the Competency Committee at this point particularly if the resident denies the problem and resists working toward a resolution to the problem.

28.4 Resolution
An outline of possible next step actions that could be recommended by the Program Director/Competency Committee are as follows:

1.) Remedial work – time, place and type to be determined by the Program Director and/or the Competency Committee
2.) Additional intense supervision by the faculty.
3.) Mandatory counseling (i.e. EAP)
4.) Leave of absence from the program.
5.) Repeat previous rotations based on the evaluation and advice of the Clinical Competency Committee.
6.) Academic probation
7.) Referral to the Education Committee for potential termination.
8.) Non-renewal of the resident’s contract.

APPROVED BY:

E. E. Fibuch, M.D.
Program Director

DATE: July 2010
RESIDENT DISCIPLINARY ACTION POLICY AND PROCEDURE
(Due Process)*

Policy: To provide a process by which a resident can, in a formal way, challenge disciplinary action that has occurred, including action taken by the Competency Committee, Education Committee and/or the Program Director that might result in termination.

Purpose: To ensure that the residents have a consistent and fair process by which they can seek redress regarding any disciplinary action that the Competency Committee, Education Committee and/or the Program Director might take against them during their training.

29.1 The “Due Process” procedure will be initiated in any instance in which the Resident and the Program Director are unable to reach an agreement regarding a resident disciplinary issue.

29.2 Disciplinary action may be initiated with the Program in the event of determination by the Competency Committee that such action is warranted, based on the results of resident evaluations, poor academic performance, or documentation of inappropriate or unprofessional behavior. It is required that the program director evaluate residents at least biannually and that formal clinical competency evaluation be forwarded to the American Board of Anesthesiology.

29.3 In the event that patient welfare is jeopardized or the effective functioning of any affiliated institution is threatened, the Program Director, or an Associate Program Director in the absence of the Program Director, is empowered to suspend a resident from clinical duty, pending a formal hearing. The Hospital Associate Deans and Office of Graduate Medical Education will be notified immediately of a suspension of clinical duty.
29.4 The Competency Committee of the Department of Anesthesiology shall make recommendations regarding disciplinary actions to be taken. The Competency Committee shall consist of faculty members of the Department and a resident representative. The Competency Committee shall meet at its earliest opportunity to determine any disciplinary action to be taken but no later than 14 days after the date of any suspension. The Competency Committee by majority vote may elect to take no action, issue a warning or reprimand, place a resident on probation, place a resident on suspension from patient care management, determine that unsatisfactory rotations must be satisfactorily repeated, recommend suspension, nonrenewal of contract, or termination of a resident, or other actions as agreed upon by the same committee.

29.5 Upon determination of a disciplinary action by the Competency Committee, a letter will be sent to the resident clearly identifying the problem, delineating the requirements to correct the deficiency (Remediation Plan), assigning a faculty mentor, delineating the duration of remediation, establish resident performance goals with appropriate methods of assessment and consequence of not meeting the goals, stating the effects of remediation, on length of training, proposing the method of any additional clinical supervision, and delineating the actions required by the resident to bring about a conclusion of the remediation program. The Competency Committee will forward the Remediation plan to the Education Committee, which will have as members, the Chief Resident, to review and approve the plan/action.

29.6 Upon implementation of any disciplinary action by the Education Committee, the resident will be notified within 5 days of any such decision. In the event the resident disagrees with the decision of the committee, the resident has the option to formally appeal the decision in writing within 5 days, and appear in person before the Education Committee. This hearing before the Committee shall take place within 4 weeks of the notification of the resident. Written notice of the time and location of the hearing, with copies of the Committee’s recommendations and supporting documentation for the disciplinary action, will be sent to the resident at least 5 days prior to the hearing. The resident is required to attend the hearing and present his/her views on the subject matter. The resident will be allowed to present evidence regarding the matter to the Committee. The resident may bring witnesses to the hearing and may bring on supportive person (legal counsel or other representative) of their choice to the hearing. The resident must, however, inform the Committee in writing of the names and total number of any witnesses and representative/counsel/support personnel whom (s)he wishes to bring to the hearing, at least 2 days prior to the hearing date.
29.7 If the Education Committee determines that no disciplinary action is warranted following the hearing, the resident will be notified of such decision. If disciplinary action is felt warranted by the Committee, a letter confirming the final recommendation of the Committee will be forwarded to the resident within 7 days following the conclusion of the hearing. This final letter (remediation plan) will clearly identify the problem, delineate the requirements to correct the deficiency, assign an advisor, delineate the duration of remediation, state the effects of remediation on length of training, propose the method of any additional clinical supervision, and detail the actions required by the resident to bring about a conclusion of the remediation plan.

29.8 In the event that the Competency Committee recommends continued suspension of a resident from clinical duties, dismissal of a resident, or an action that adversely affects the resident intended career development or prolongs the length of his/her program, the Education Committee will forward a copy of all documentation to the Council of Graduate Medical Education of the University of Missouri – Kansas City School of Medicine. The Council will review the documentation provided and confirm that due process was followed. The resident will be informed by the Council of his/her rights as a non-regular academic employee. This will include their right to access the Academic Grievance Procedure as stated in Section 370.010 of the Collected Rules and Regulations of the University of Missouri. In the event that resident nonrenewal of contract or dismissal is recommended, all relevant University Procedures will be followed, including UMKC-School of Medicine GME policy 06 (see attached policy).

* Approved March 2008
  Council on Graduate Medical Education
  University of Missouri – Kansas City
  School of Medicine
Resident Dismissal Policy

Policy: To establish guidelines for resident dismissal consistent with established due process policy and the provisions for dismissal noted in the residents contract with the University of Missouri - Kansas City.

Purpose: To ensure that there is a consistent, defined, and fair process that outlines prospectively the steps required in case a circumstance arises requiring a resident dismissal from the Anesthesiology training program.

30.1 Resident dismissal will follow the guidelines listed in the resident contract from the University of Missouri – Kansas City.

30.2 The decision to dismiss the resident will be based on resident performance evaluations, academic performance, and compliance with institutional rules, regulations and policies.

30.3 In the event of poor performance, the resident will be given an opportunity for remediation.
   1. The resident may be placed on probation for a 6-month period.
   2. The resident may be required to have regular meetings with his/her mentor, may be required to have one-on-one training by staff or senior resident, may be assigned additional reading assignments, or may have their rotation schedule revised in order to help improve their performance. In addition, the Program Director may suggest weekly visits to the Employee Assistance Program.

30.4 A resident who fails to obtain or maintain required licensure or comply with rules and regulations, or who exhibits significantly severe unprofessional behavior may be subject to dismissal without remediation (see Remediation Policy).

30.5 In the event of the decision to terminate a resident for academic reasons, for failure to maintain licensure, for failure to comply with rules/regulations, or for unprofessional behavior, an opportunity to utilize the grievance procedure provided, as an addendum to the resident contract will be offered.

30.6 In the event a resident is suspended for more than thirty days or dismissed; the Council on Graduate Medical Education of the UMKC School of Medicine must be notified.
30.7 The Council on Graduate Medical Education of the UMKC School of Medicine will review all information obtained during the grievance procedure, and will make recommendations to the respective institution/employer regarding adjudication of the matter, specifically determining if the grievance procedure was fair, appropriate, and that the grievance procedure was followed correctly.

30.8 If a resident is terminated, a final termination evaluation will be completed by the Program Director, including the dates of training and a summary of the resident's performance.

30.9 At the time of termination, the Program Director will notify the American Board of Anesthesiology in writing, of the termination of the resident from the program.

APPROVED BY:  
E. E. Fibuch, M.D.  
Program Director  

DATE:  July 2009
ALCOHOL, SUBSTANCE ABUSE AND IMPAIRED RESIDENT POLICY

Policy: The policy of the Department of Anesthesiology regarding alcohol and substance abuse among the residents is “zero tolerance” and to establish a drug and alcohol free educational and patient care environment.

Purpose: The purposes of this policy are as follows:
- To help further the safety of patients who entrust their care to anesthesiology residents.
- To establish and maintain a safe, healthy working environment for all residents.
- To reduce the incidents of accidental injury to persons or property.
- To reduce absenteeism, tardiness and indifferent job performance.
- To provide assistance toward rehabilitation for residents who seek the Department’s help in overcoming any addition to dependence upon, or problem with alcohol or drug use and to prevent the use of drugs and alcohol in the workplace.

This policy applies to all the residents (CB, CA-1, CA-2 and CA-3) in the Department of Anesthesiology. The Department recognizes that its success is dependent on part upon the physical and psychological well being of its residents. It is the intent of the Department to maintain a safe, healthful, secure and efficient working environment and to protect patients. To this end, it is the policy of the Department to establish an alcohol and drug free educational and patient care environment.

Definitions:
- **Alcohol or alcoholic beverages** means any beverage that may be legally sold and consumed and that has an alcoholic content, including medication containing alcohol.
- **Illegal Drug Use** as defined in this policy means the illegal use of any drug, controlled substance, prescription drug, inhalant or perception altering substance.
- **Lawful Prescription Drug Use** means any substance, including a controlled substance prescribed by a licensed medical practitioner for the individual lawfully consuming it, and used in compliance with the prescription.
• **Under the influence** means that the person is affected by alcohol or drugs in a detectable manner. The symptoms of influence are not confined to those consistent with misbehavior or to the obvious impairment of physical or mental ability such as slurred speech or difficulty in maintaining balance. The determination of being under the influence can be established by a professional opinion, a scientifically valid test, or supervisory judgment.

• **Controlled substance** as used in this policy means any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana, or any other controlled substance, as defined in Schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. & 12) and as further defined by regulation at 21 C.F.R. 13.08.11 through 13.08.15.

• **Impaired Physician:** An impaired resident is a physician whose behavior has been affected by alcohol, chemicals, drugs, mental illness, stress, or any other illness, with the result that the physician's individual health, or ability to function competently, has been compromised. An impaired resident's behavior may be characterized by compulsion, loss of control, continued use of chemicals despite adverse consequences, financial irresponsibility, sexual inappropriateness with patients, sexual addiction, sexual harassment, excessive absenteeism and/or tardiness, errors in judgment, poor decision making ability and problems in inter-personal relationships.

• **Chemical Substances:** Chemical substances include alcohol, drugs or any other chemical or chemicals that alter the body's natural biochemistry. Such chemicals and/or drugs include, but are not limited to, any over-the-counter medications, any prescribed medications, any illegal or unprescribed drugs or chemical substances, any alcoholic beverage, or any substance that causes adverse psychological behavior.

• **Drug-related Misconduct:** Drug-related misconduct includes, but is not limited to, possession and/or illegal distribution of drugs on the premises of any hospital or other facility affiliated with the University of Missouri Kansas City. Use of drugs on or off said premises in a manner that adversely affects the resident's performance, his/her own safety, or the safety of others, or adversely impacts the reputation or regard of the University of Missouri Kansas City School of Medicine or any of its affiliates in the community.

• **Intervention:** An intervention is an organized approach by trained individuals with a potentially impaired resident for the purpose of encouraging and motivating the resident to acknowledge he/she is impaired and to accept evaluation and treatment for an illness or severe stress resulting in behavioral problems. The person(s) conducting the intervention will consist of an appropriate individual designated by the Clinical Competence Committee.
• **Evaluation:** An evaluation is an assessment of the impaired resident by a professional and/or treatment center (i.e. Employee Assistance Program – EAP, or the MPHP – Missouri Physician health Program) approved of, and designated by the Program Director and/or the Education Committee.

• **Treatment:** Treatment is the process whereby the resident is assisted to recognize and change behavior patterns that contribute to the impairment.

• **Monitoring:** Monitoring of an impaired resident will be done by the MPHP program or others as authorized by the Program Director or the Clinical Competency Committee. Regular reports with regard to the resident’s compliance and progress in recovery will be communicated, in confidence, to the Clinical Competency Committee.

31.1 **Lawful Drug Possession and/or Use:** Lawful use of controlled substances, prescription drugs or legally obtained drugs, including over-the-counter drugs, while performing Departmental business or while in a Hospital facility is permitted only when in accordance with direction or prescription, and then only to the extent that such use will not negatively affect the safety of others, job performance, or the secure and safe operation of Hospital/Departmental property and facilities.

31.2 **Unlawful Behavior:** The unlawful manufacture, distribution, use, possession, or sale of any drug, including controlled substances, or Hospital(s) property is prohibited. The unlawful presence of any detectable amount of any drug, including any controlled substance, in resident, while on Hospital(s) premises or on Hospital(s) business, is strictly prohibited.

Residents are required to advise the Program Director of any criminal drug statute conviction or plea of “no contest” within five (5) days of being convicted or pleading. The action may be reviewed, upon request of the program Director, by the Clinical Competency Committee of the Department of Anesthesiology.

The theft or unauthorized possession of prescription drugs or controlled substances of any kind by any resident is cause for potential termination and referral to law enforcement authorities and reporting to the appropriate licensure office.

31.3 **Alcoholic Beverages:** No alcoholic beverages may be brought on to or consumed on Hospital(s) premises unless express authorization has been granted by the Hospital(s) Administration.

A resident having in his/her possession, or being under the influence of intoxicating beverages, or having intoxicating beverages on his/her breath while he/she are on hospital premises or on hospital business is prohibited. This rule prohibits returning to the hospital premises during off duty hours “under the influence” of alcoholic beverages or while having alcoholic beverages on your breath.
31.4 A resident having a history of illegal drug addiction, who is no longer engaging in the illegal use of drugs, including controlled substances, will be required to provide evidence of rehabilitation satisfactory to the Program Director. Such evidence of rehabilitation may include ongoing, periodic, unannounced drug testing while the resident is employed by the University of Missouri – Kansas City.

31.5 A resident who, because of present alcohol abuse or history of alcohol abuse, may pose a direct threat (i.e. a significant note of substantial harm) to the safety or health to themselves, co-employees, patients, family members or members of the public, which direct threat, cannot be eliminated or reduced below the level of direct threat by reasonable accommodation, will not be maintained as a resident in the Department of Anesthesiology.

31.6 Drug or alcohol use, including off-duty drug or alcohol use, which results in excessive absenteeism or tardiness, or is the cause of poor performance or unsafe work practices, will result in discipline up to and including termination in accordance with Departmental “Due Process Procedures”.

31.7 The Department of Anesthesiology will provide reasonable accommodation to qualified residents having a history of alcoholism or illegal drug addiction as necessary and appropriate.

31.8 To further the safety of Hospital(s) personnel, patients, and the public, the following conditions of continued employment may be required upon request of the Program Director:

- Submission of blood, urine, saliva, breath, hair or other tests for the determination of alcohol and/or illegal drug use in the following circumstances as determined by the MPHP and recommendations from the resident’s treating psychiatrist.
- Reasonable suspicion by the Program Direct/Competency Committee/ Education Committee, the resident may be violating any portion of this alcohol and drug abuse policy.
- Involvement in an accident or safety related incident in which there is reasonable suspicion of members of the Department or others, that alcohol or controlled substance use was a contributing factor in the accident or incident.
- Post-treatment or rehabilitation testing.

31.9 Samples will be tested only by a testing laboratory approved by the MPHP and, in the event of a positive test, a portion of the sample will be preserved by the testing laboratory for a reasonable period of time.

31.10 Resident who provides adulterated drug tests will be considered to have a positive test result, which will result in termination of employment.

31.11 Residents who provide an abnormally dilute sample will be required to repeat the drug test the next day. If this second sample is also abnormally dilute, it will be considered equivalent to a positive test and reviewed by the Program Director, resulting in termination.
31.12 Residents who provide a specimen that is out of acceptable temperature range will have their specimens sent to the laboratory for processing, but no opportunity to retest will be provided as this is considered a positive test resulting in termination of employment.

31.13 Residents who are unable to provide a sufficient specimen for testing within a 4 hour time frame are considered “refusing to test”, no opportunity to retest will be provided, and the resident will be terminated.

31.14 Direct Observation of obtaining a sample of urine by a professional of the same sex as the resident will be done upon the recommendation of the program Director.

31.15 All presumptively positive test results for drugs will be reviewed by the Program Director. Any drug test results determined by the Program Director to be positive following review will be reported to the Competency Committee of the Department of Anesthesiology. A positive test result for alcohol means having a blood test of 0.02% or above. Having “alcohol on the breath” while at the Hospital(s) or performing Hospital duties, however, even in the absence of a positive alcohol test, may result in discipline up to and including termination, as set for above.

31.16 Violation of any portion of this policy, including the refusal to submit to testing or an Employee Assistance Program mandated evaluation can result in disciplinary action, up to and including termination of employment, even for the first offense.

31.17 If a resident is suspended while awaiting the results of the test for drug and/or illegal drug use, the resident will be paid during the period of suspension if the test results are negative and if no independent basis for suspension exists.

31.18 The results of all physical examinations and blood and/or urine tests will be treated as confidential, and distribution will be limited to those having a “need to know.”

31.19 All correspondence/communication between the treatment program (EAP) or those involved in intervention and the Program Director will be strictly confidential.
31.20 Anesthesiology Residency Program, as part of the UMKC School of Medicine’s Graduate Medical Education, will, as appropriate, defer to the previously established (GME Impaired Resident/Fellow Policy, approved 4-01-04) for procedural reporting of resident impaired and subsequent institutional action. See attached GME Policy.

APPROVED BY: _______________________________ DATE: July 2010

E. E. Fibuch, M.D.
Program Director
OVERVIEW POLICY
HOUSTAFF ORIENTATION MANUAL

Policy: It is the intent of the Department of Anesthesiology to abide by and enforce the general policies and procedures outlined in the Housestaff Orientation Manual.

Purpose: To ensure consistent, timely and fair processes for all of the anesthesiology residents and to participate equally with all specialties.

32.1 Refer to Housestaff Orientation Manual – Saint Luke’s Hospital

APPROVED BY: E. E. Fibuch, M.D.
Program Director

DATE: July 2009
Policy: The Department of Anesthesiology will abide by the recommendations and required established guidelines established by the ACGME regarding resident duty hours and the GME Committee of the UMKC School of Medicine.

Purpose: To ensure the residents have an adequate amount of time away from clinical duties in order to minimize fatigue, burnout, and provide for safe patient care.

33.1 Refer to the attached Resident Duty Hour Policy approved 8/18/11, by the UMKC School of Medicine GME Committee (see attached).

33.2 Duty hours will be monitored by the Program Director and the Education Committee of the Department of Anesthesiology using both qualitative and quantitative methods.

33.3 The quantitative methods will consist of requiring the residents to log their work hours into New Innovations.

33.4 The Program director will monitor duty hours from New Innovations monthly and provide the Education Committee periodic reports.

33.5 In addition, qualitative methods will be used consisting of: 1) verbal reports from the Chief resident or individual residents, 2) review of the ACGME generated annual work hour survey, and, 3) review of the internally generated GME work hour survey,
LEAVE OF ABSENCE POLICY

Policy: To establish a leave of absence policy residents desiring to leave the training program for a short period of time for personal reasons other than sickness, pregnancy or paternity.

Purpose: To ensure that there is a uniform, consistent and fair process for residents to secure a leave of absence from the training program for personal reasons other than sickness, pregnancy or paternity.

34.1 Resident desiring to secure a leave of absence from the training program must meet with the Program Director and outline the reasons for requesting the leave of absence, and must define the dates of absence.

34.2 The resident must acknowledge in writing that all compensation including benefits received by the resident from the training program will be terminated during the leave of absence.

34.3 The resident must acknowledge in writing that, if the leave of absence is of a prolonged nature, the program is not obligated to guarantee a training position to the resident upon the termination of the leave of absence.

34.4 The Program Director will notify the American Board of Anesthesiology of the leave of absence and any other appropriate regulating agencies including the Dean of the School of Medicine.

34.5 All compensation including benefits will be terminated at the beginning of the leave of absence and resume if the resident returns to the program.

34.6 The resident will be required to make up lost training time following resumption of training. (see attached Leave of Absence Policy)

34.7 Granting of the leave of absence will be at the sole discretion of the Program Director in consultation with the Education Committee of the Department of Anesthesiology.

APPROVED BY: E. E. Fibuch, M.D. PROGRAM DIRECTOR DATE: July 2009
PROFESSIONALISM POLICY

Policy: To define the elements (framework) of professionalism within the Anesthesiology Residency training program, which all residents will adhere to as they relate to patients, families, faculty, referring physicians, nurses, administrators and all other personnel.

Purpose: The purpose of this policy is to define the elements of professionalism, outline the failures of professionalism, suggest the methods the Department/Faculty will use to measure professionalism, and to establish the course of action the Education/Competency Committees will take if a resident violates this policy.

Fundamentals of Professionalism/Standards of Professional Conduct
All physicians in training will naturally focus on acquisition of clinical skills and specialty knowledge. Residents must be expected to acquire the essentials of professionalism, including:

A. Excellence and Quality of care
   - masters techniques and technologies of learning
   - is self-critical and able to identify own areas for learning/practice improvement
   - has internal focus and direction, setting own goals
   - takes initiative in organizing, participating, and collaborating in peer study groups
   - participates in continuous health care quality improvement and seeks to optimize health care outcomes
   - seeks to improve patient safety and reduce medical errors.
   - promotes opportunity of care

B. Altruism/Humility
   - values human interest and ideals
   - advocates for, and empowers patients to make informed decisions
   - places others needs above his/her own
   - takes time and gives effort to help others
   - commits to improving access to care and works to eliminate barriers to care
   - responds to societal needs (i.e., advocates for fair distribution of healthcare resources and actively works to eliminate discrimination of healthcare)
   - contributes to the medical profession; active in local and national organizations such as the AAMC
C. **Honesty/Ethics/Confidentiality**
   - demonstrates integrity (no lying, cheating or stealing)
   - forthcoming with information; does not withhold and/or use information for power
   - admits errors
   - adheres to professional and/or ethical standards (i.e., faculty, residents, fellows, and students conduct their affairs related to MATCH in an ethical and professional responsible manner and Program Directors and institutional officials honor conditions of their agreement with NRMP)
   - behaves with high morality
   - maintains and protects patient privacy and confidentiality (i.e., by knocking on the door before entering a patient room, appropriately draping a patient during an examination, not discussing patient information in public area including elevators and cafeteria, by keeping noised levels low, especially when patients are sleeping, and by the appropriate sharing of medical information with a patient and colleagues involved in the care of a patient)
   - commitment to honesty with patients
   - provide informed consent to patients
   - deals with confidential information discreetly and appropriately
   - does not misuse resources (e.g., institutional computers and supplies)

D. **Orderliness/Cooperation/Critique**
   - observant of order, authority or rule
   - admits mistakes
   - is non-argumentative
   - willing to act jointly with others
   - accepts and responds to constructive criticism by appropriate modification of behavior
   - looks at self objectively
   - takes steps to correct shortcomings

E. **Dependability/Reliability/Responsibility/Punctuality**
   - demonstrates awareness of own limitations, and identifies developmental needs and approaches for improvements
   - cares for self appropriately and presents self in a professional manner (i.e., demeanor, dress, hygiene)
   - recognizes and reports errors/poor behavior in peers
   - informs others when not available to fulfill responsibilities and secures replacement
   - takes responsibility for appropriate share of teamwork
   - arrives to classes, clinics, meetings and appointments on time
   - accountable for deadlines; completes assignments and responsibilities on time
   - answers letters, pages, e-mail, and phone calls in a timely manner

F. **Attire/Personal Hygiene**
   - adheres to established dress codes (medical school and affiliated institutions)
- wears attire generally accepted as professional by the patient populations served
- maintains a neat and clean appearance acceptable to practice setting

G. Empathy, Sensitivity, Compassion, and Respect for Other People
- good listener
- considerate and appreciative of others’ positions
- attempts to identify with others’ perspectives
- considerate to patients
- sensitive to patients pain, emotional state or condition (i.e., disabilities, gender, ethnicity issues)
- treats the patient as an individual, taking into account lifestyle, beliefs, personal idiosyncrasies, support system
- communicates bad news with sincerity and compassion
- deals with sickness, death, and dying in a professional manner with patient and family members
- supports a balance in personal and professional activities for peers and subordinates
- treats other people including patients and their families respectfully and without bias

H. Communicates Skills/Collegiality/Language Use/Discretion
- respects institutional staff and representatives
- respects faculty during teaching session
- communicates with discretion appropriate to circumstances
- treats colleagues and co-workers and leaders in a respectful manner without bias (i.e., age, race, gender, ethnicity, sexual orientation, disability, religion, national origin or role in education)
- mutual respect between teachers and learners (i.e., insightful rather than aggressive questioning; no belittlement; constructive feedback with opportunities for remediation)
- shows team spirit
- communicates with appropriate terminology and vocabulary
- communicates with appropriate gestures and mannerisms
- asks permission how to address patient, (i.e. sir, ma’am, miss, etc)
- shakes hands with and introduces oneself to patients and patients’ families
- wears name tags that clearly identify their name and roles
- commitment to maintaining appropriate relationships with patients, peers and subordinates (relationships between physicians and patients must be avoided)
- keeping legible, appropriate, (e.g., disputes or criticisms are not communicated via the chart) and up-to-date medical records
- responds promptly to phone messages and page

I. Initiative/Leadership
- self-directed in undertaking tasks
- self-motivated and independent
- demonstrates ability to guide peers
leads by example
- teaches others
- helps build and maintain a culture that facilitates professionalism
- does not provide disruptive leadership (e.g., organizing pranks, inappropriately confronting authority figures)

J. Stress Management/Well-being
- remains calm, levelheaded and composed in difficult or critical situations
- demonstrates ability to relax and recoup after stressful situations
- does not use alcohol or drugs in ways that impair his/her ability to perform necessary work

K. Professional Competence
- maintains medical knowledge and clinical and team skills
- strives to see that all members within the profession are competent
- seeks consultation and supervision whenever ability to play their role in the care of a patient is inadequate because of lack of knowledge or experience

L. Maintaining Trust by Managing Conflicts in Interest
- recognizes and discloses conflicts of interest (i.e., relationships with industry, opinion, leaders, etc.)
- only accepts pharmaceutical equipment/goods consistent with the Code of Ethics of the American Medical Association pertaining to Gifts to Physicians from Industry

M. Scientific Knowledge
- promotes research
- upholds scientific standards, integrity

Unacceptable/Inappropriate Behaviors
Certain behaviors are inherently destructive to any educational or professional relationship and will not be tolerated at the SOM. These include but are not limited to:
- sexual harassment
- discrimination
- psychological punishment

Any member of the medical school community experiencing mistreatment or witnessing unprofessional behavior is strongly encouraged to report the facts immediately to an appropriate individual as outlined in this policy. All such reports will be treated confidentially and reprisal or retaliation of any kind will not be tolerated.

Conduct for which students, residents, fellows, faculty, and staff members may be subject to sanctions includes but is not limited to:
A. Threats and intimidation

B. Unwanted physical contact (i.e., touching, hitting, slapping, kicking, pushing) or threat of same
C. Sexual harassment (defer to UMKC’s policy on Sexual Harassment 330.060) and Departmental Policy A-45.

D. Discrimination based on age, race, gender, sexual orientation, disability, religion, or native origin, disability, or Vietnam era veterans status (defer to UMKC’s policy on Sexual Discrimination and Guidelines on Discrimination on the Basis of Religion or National Origin). The University also has an AIDS policy statement consistent with state laws that prohibits discrimination against persons with Aids or who are HIV positive.

E. Requiring learners to perform personal chores (i.e., running errands, babysitting)

F. Verbal harassment in public or privately

G. Use of grading and other forms of assessment in a punitive or self-serving manner

H. A Program Director at a teaching hospital participating in the NRMP main MATCH offering a written or verbal contract before main MATCH day to a U.S. senior from an allopathic medical school (a Program Director or an applicant can express a high degree of interest in each other but must not make statements implying a commitment)

I. Derogatory or slanderous comments or acts (i.e., it is unethical to imply without relative evidence – by word, gesture, or deed that a patient has been poorly managed or mistreated by a colleague)

J. Destructive criticisms

K. Grading or assigning tasks used to punish rather than evaluate objective performance

L. Lying, cheating or stealing

M. Discussing confidential patient information in public areas (e.g., elevators)

N. Romantic, sexual, or non-professional patient relationship while involved with a patient’s care

O. Accepting inappropriate gifts from industry (refer to the American Medical Association’s Code of Ethics, E-8.061 Gifts to Physicians from Industry)

P. Scientific misconduct (i.e., fabricating or misrepresenting data, failure to obtain appropriate informed consent, refer to UMKC policy)

Q. Falsification, forgery, alteration or misuse of patient’s medical record or medical information
R. Use of fraud, deception, lies, or bribery in securing any certificate or registration or authority, diploma, permit, or licensure issued, or in obtaining permission to take any examinations

S. Impersonation of any person holding a certificate of registration or authority, permit, license, or allowing any person to use his/her certificate of registration or authority, permit, licensure, or diploma from any school

**Measurement of Professionalism**
The Competency Committee will depend on the monthly faculty evaluations, monthly nursing evaluations, formal complaints from patients and others, and peer to peer observation to measure the above elements of professionalism

**Failures in Professionalism**
Failure in resident performance regarding the element of professionalism can occur in almost infinite possible ways. Some common-denominators for failure include, but are not limited to, the following:

1. abuse of authority with subordinates
2. bias
3. sexual harassment
4. poor handling of confidential information
5. arrogance
6. greed
7. dishonesty
8. impairment
9. laziness
10. conflict of interest
11. inappropriate use of resources
12. scientific – investigation fund

**Professionalism in Anesthesiology**
Much of the literature about physician professionalism originates within Internal Medicine. The American Board of Internal Medicine has a long history of interest in the teaching and measurement of professionalism and is at least five years into a major education effort, entitled: “Project Professionalism” and most recently released a physician charter of professionalism.

Anesthesiology has also recognized the vital importance of professionalism. The American Board of Anesthesiology recognizes the role of behavior in evaluating residents. Gradually, the role of the “acquired characteristics” has increased in importance, and in the present, any resident rated unsatisfactory for acquired characteristics, must be rated unsatisfactory overall.

Even though we clearly place a high value on professionalism in Anesthesiology, it is not often objectively defined. As always, the extremes are easily identified – the model resident is a “poster child” and the difficult resident is often most defined by unprofessional behavior. To objectify professionalism in anesthesiology, it is useful to
define professionalism in the primary settings where anesthesiologists interact. These include the interface with:
- patients
- surgeons
- colleagues
- members of the support team

**Professionalism in the Interaction with Patients**

In distinction to the internist who has a long-term relationship with patients, the Anesthesiologist has a very brief opportunity to interact with the patient. Because the Anesthesiologist is a consultant (to the surgeon), the patient assumes that details of the present illness, the surgery and medical history are already known to the Anesthesiologist. This is only correct if the information is reviewed prior to preoperative interviews. A rapid assessment of the communication skills of the patient, anxiety level, and ability to understand health care is a required element of the interview, one goal of which is to provide reassurance to the patient. Informed consent must be obtained and the patient’s cooperation with the anesthesia plan confirmed, without terrifying the patient or trivializing their serious concern with their health. Although a detailed assessment of health and co-morbidity may be the underlying agenda, the minimum performance requirement must also leave the patient informed, calm and willing to cooperate.

Professionalism must also extend into the perioperative period. Because the OR is so focused on procedures and efficiency and filled with complex technology, it is easy to neglect the human needs of the awake patient. Although each case is unique, every patient is entitled to autonomy, modesty and respect. It is important that the resident not completely identify the patient as the object for the next procedure. Absolute respect for the dignity of the patient should never be sacrificed to the need for efficiency. The same level of professional behavior must also extend to the procedure oriented post-anesthesia care unit (PACU). This is especially true when PACU is busy since many patients will be able to observe either good or poor professional behavior simultaneously.

Confidentiality is also an element of professionalism that is a right of every patient. Proper anesthesia care requires that all health information; professionalism requires that this information be treated with respect. State and federal laws require the protection of the identity of patients. This requires that residents keep records, charts and case logs from exposure in public places.

A final element of professionalism and patient interaction is dealing with the unhappy customer. Patients have increasing levels of demands for service and when not-satisfied, can be very demanding. The role of the anesthesiologist is to understand, which at times can require tolerance of unfocused and sometimes poorly educated criticism. The essence of professionalism is to deal with aggressive criticism without negative emotion and with a reasonable level of empathy. This kind of interaction can be the most challenging test of the lofty goals of professionalism – an angry, unrealistic customer who is very likely to be never encountered again. The natural human response from the anesthesiologist would be hostile – the professional response is neutral with a modest element of empathy – a lofty goal.
Professionalism in the Interaction with Surgeons

The natural tendency in anesthesia providers is to regard surgeons as “the enemy”. This is particularly true for anesthesia residents – they often deal directly with surgical house staff who may only partially understand the clinical situation – or they may be forced to deal directly with staff surgeons who may treat them as less-than full members of the team. Both elements of the surgical team – staff and support-group may be used to problem-solving by confrontation. The surgical residents may be primed toward confrontation by virtue of the expectations of their staff. Conflict is inevitable. From the purely professional perspective – the surgeon is the primary physician and the anesthesiologist is a consultant. In an absolute sense, the conflict is over the management of “their” patient.

Objectively, it is a fact of perioperative medicine that the anesthesia team assumes a role that focuses on patient safety. In this role, professionalism requires that the anesthesiologist consider the well being of the patient first and the personal well-being of the anesthesia team member second. In an absolute sense, when the surgical team interacts with the anesthesia team in an inappropriate manner, the anesthesia provider must consider the patient’s needs first. In a real sense, this means toleration of ridiculous (or other inappropriate) communication from people who are using sharp instruments on the patient. The most professional response of the anesthesiologist must act in a way that fosters the best interest of the patient. In the dynamic world of the OR, this may require the anesthesia team member to quietly accept aggressive criticism with minimal response. Unless the response will improve patient care, the professional response is silence.

Surgeons as the primary care providers in the OR are entitled to some elements of professional courtesy. When the anesthesiologist is asked to participate in the perioperative care of a hospitalized patient, the request is for a consultative service. This can result in conflict. The surgeon expects a response that prepares the patient for surgery. Most often this response from the anesthesiology team will define specific goals. This can be the source of conflict. One of the elements of professionalism for the Anesthesiologist is risk management. How much risk is associated with the proposed surgical procedure is an example of where professionalism can be complicated. There will be patients for elective procedures who will have serious co-morbidity and state that they would prefer to accept the perioperative morbidity in contrast to living with the uncorrected surgical diagnosis. This means that patients with serious co-morbidities may be scheduled for elective surgery and the surgeon may be asking the consulting anesthesia service if the proposed surgery can be performed without an exorbitant degree of risk, this is where professionalism can be at its best or worst.

On the one hand, serious co-morbidity can be identified and recognized as a factor that limits the extent of the surgery. Although the surgeon ultimately chooses the surgical procedure, a consultant will be helpful. Although the subsequent care of the patient may be challenging, this should not be translated into advice to the patient that moves the choice away from surgery or toward another institution. Consultative services are an essential element of professionalism. As the perioperative medicine expect, the anesthesiologist is uniquely prepared to facilitate patient care for the surgical patient.
Risk assessment, optimization and post-surgical patient care are excellent examples. Many institutions recognize the unique skills of the anesthesiologist to manage the running of the operating rooms. As such, many anesthesiology departments run the operating room, manage the OR schedule and have staff designated as the OR Director. Other hospital-wide activities and committees are well suited to the skill-set of the anesthesiologist, including risk management, transfusion review, pharmacy and therapeutics, etc. Most anesthesiology departments will recognize their commitment to professionalism and provide qualified staff for these roles.

**Professionalism in the Interaction with Colleagues**

Professionalism is measured clearly in the interactions between residents, between residents and staff and with the department. Anesthesiology departments are a team and professionalism requires team work. An assumed element of professionalism in anesthesiology is the unstated requirement that everyone does their job everyday. Punctuality is an absolute requirement. Dependability means knowing what to do, preparing and executing tasks. Being able to trust the work of a colleague is essential to the daily running of a department. Honesty and objectivity are universal expectations. Sharing work, helping a colleague, minimizing complaints and problems solving are essential attributes of professionalism.

Professionalism is also demonstrated in the use of valuable resources. Respect for equipment, reasonable use of the time of support people and a commitment to avoid waste are essential elements of professionalism. It is an ethical requirement that in the case of treatment equivalency, the best economic choice is required, although teaching learning modifies this absolute. An element of professionalism requires each anesthesiologist to become a student of pharmacoeconomics – the discipline that looks at economic outcomes. A single expensive intervention can result in considerable cost reduction; a less expensive treatment option can significantly increase the total cost of care. Pharmacoeconomics is the never-ending struggle to balance short and long-sightedness in the battle to deal with cost.

Professionalism in the anesthesiologist requires a commitment to education. While in training, the motivation can be obvious – in-training exams, board certification. But true professionalism requires the commitment to learning – a natural extension is life-long learning. Although motivated on a simple level by time-limited board certification, the sustained commitment to learning is an element of professionalism readily apparent to colleagues.

The evolution of scientific information is based on investigation and honest reporting of outcomes. For any anesthesiologist involved in research in any way – professionalism requires not only absolute honesty, but a commitment to understand the rules. If not presently required, eventually all anesthesiology residents will be required to complete research ethics courses. Conflict-of-interest (COI) policies are examples of documents that should be evaluated. Avoidance of any activity with COI issues or even the suggestion of possible COI is an essence of professionalism. But this requirement goes farther, the anesthesiologist must learn to read the literature and identify flawed scientific method, commercialism and CO*I in scientific literature and avoid changing clinical behavior based on these elements. Examples of plagiarism and ghost-writing in...
scientific papers reported in anesthesiology within the last five years are obvious examples.

Professionalism in anesthesiology requires a clear understanding of the risk of substance abuse and the impaired physician that are unique to anesthesiology. Education about substance abuse risks in anesthesiology is essential to prevention. Recognition of the impaired physician and the appropriate response is an unfortunate element of anesthesiology. Professionalism in anesthesiology requires some familiarity with these unpleasant subjects.

Because of the shared environment and the impact of many kinds of legislation on the practice of anesthesiology, each provider must understand the law. Fraud and denial of reimbursement are the two extremes. Each provider has a role in the overall success with compliance.

**Professionalism in the Interaction with Members of the Support Team**
The physician as the “captain of the ship” or “healthcare monarch” is a model that has become passé. Partnership with all members of the team for a common objective is the new way – driven by economics, regulation and the common sense that has been demonstrated by these driving forces. The ability to work in partnership with all levels of the healthcare team is an essential element of professionalism for the anesthesiologist. As the leader of the perioperative team, the anesthesiologist sets the tone – either confrontation or cooperation. Despite the political conflict between anesthesiologists and CRNAs, the tone of professionalism should be set by the anesthesiologist. Resident behavior should be learned from observation of optimum behavior by staff.

35.1 All residents will adhere to the elements in this policy.

35.2 Failure to adhere to this policy will result in loss of credit for the six-month period of training in which the lack of professionalism occurred.

35.3 Determination of a resident’s failure to adhere to this policy will be made by the Department’s Resident Competence Committee after a thorough review of the available data defined under “Measurement of Professionalism” noted in the policy.

35.4 A determination of a resident’s failure to adhere to this policy will be made by the Competence Committee to the Education Committee.

35.5 If the Education Committee, after reviewing all the information concerning the resident, agrees with the Competence Committee then the Remediation Policy will go into effect (A-28).

35.6 An annotated Bibliography is attached to this policy for review.

35.7 Guidelines for the ethical practice of anesthesiology (House of Delegates – October 3, A67 and last amended on October 17, 2001) is attached for review.
APPROVED BY: ___________________________  DATE: July 2010

E. E. Fibuch, M.D.
Program Director
 Dangerous/Unapproved Abbreviations and Symbols POLICY


PURPOSE: To ensure and maintain patient safety at all times

36.1 Residents should not use vague instructions such as “Take as directed” or “Take/Use as needed” as the sole direction for use. Specific directions to the patient are useful to help reinforce proper medication use, particularly if therapy is to be interrupted for a time.

36.2 Residents are not to use the following dangerous abbreviations or dose designations:

APPROVED BY: E. E. Fibuch, M.D.
Program Director
DATE: July 2009
Impaired Resident Policy

POLICY: The policy of the Department of Anesthesiology regarding impaired residents is one of “zero tolerance”, and to establish an environment in the Department and practice as one in which there are no impaired anesthesiology residents. Patient safety is a foremost concern.

PURPOSE: The purposes of this policy are as follows:
- To help further the safety of patients who entrust their care to anesthesiology residents.
- To establish and maintain a safe, healthy working environment for all residents.
- To reduce the incidents of accidental injury to persons or property.
- To reduce absenteeism, tardiness and indifferent job performance.
- To provide assistance toward rehabilitation for residents who seek the Department's help in overcoming any addition to dependence upon, or problem with alcohol or drug use and to prevent the use of drugs and alcohol in the workplace.

This policy applies to all the residents (CB, CA-1, CA-2 and CA-3) in the Department of Anesthesiology. The Department recognizes that its success is dependent on part upon the physical and psychological well being of its residents. It is the intent of the Department to maintain a safe, healthful, secure and efficient working environment and to protect patients.

37.1 Please refer to Policy #A-31 for policy definitions and procedures.
Hand-Off Policy

POLICY:  It is the policy of the Department of Anesthesiology that all residents will use effective and clear hand-off methods in communicating all patient care and administrative information during the transfer of patients from one provider to another and in communicating all types of information. This is a professional requirement of residents to communicate effectively, accurately, and in a timely manner to their colleagues in all matters that relate to Departmental activities, to the practice of medicine, and to the care of patients. Fulfilling this expectation consistently will reduce communication errors, improve patient safety, and collegial relationships.

PURPOSE:
- To decrease patient safety errors.
- To improve collegial communication of critical information.
- To foster efficiency and accuracy in departmental and patient care activities.

38.1 The following Departmental policies are applicable:
- A-4
- A-7
- A-23
- A-24
- A-25
- A-26
- A-35

38.2 It is expected that residents will, at the time of assuming the care of patients, and handing off care of patients to another care-giver, will effectively and completely communicate the future direction of care to include, but not be limited to:
- Appropriate history and physical findings.
- Medication profile and allergy history.
- Appropriate laboratory and testing results.
- Appropriate past and present plan of care.
- Complications and co-morbidities.
- Other caregivers involved in the care of patients.

38.3 It is recommended that residents use the “hand-off” tool of SBAR (S = Situation; B = Background; A = Assessment and R = Recommendation) in handing of patients to another provider.
38.4 It is expected that residents will communicate in a timely and complete manner, those issues, concerns or events to faculty or hospital management that could impact hospital or departmental operations, safety or efficiency.

38.5 Failure to communicate effectively could result in disciplinary action being considered by the Program Director or the Competency Committee of the Department of Anesthesiology.

38.6 See attached educational materials.
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES

UMKC SCHOOL OF MEDICINE
SAINT LUKE'S HOSPITAL
TRUMAN MEDICAL CENTER
CHILDREN'S MERCY HOSPITAL

Program: Anesthesiology
Subject: Mentoring Policy
Policy #: A – 39

Mentoring Policy

POLICY: It is the policy of the Department of Anesthesiology for the faculty to serve as role models and mentors for all of its residents. Role modeling professional behavior and serving as mentors is an important activity for the future growth and development of residents.

PURPOSE:
• To role model professional behavior.
• To assist residents in the achievement of learning objectives and career development.
• Provide one on one faculty to resident advice on any topic/issue a resident desires help with.
• To create an environment conducive to learning, growth and inquiry.

39.1 Program Director, with the oversight of the Education Committee of the Department of Anesthesiology will create a list of Faculty Mentors, annually, and assign those mentors to the residents.

39.2 Residents will be notified annually of their assigned mentors and encouraged to seek out and establish a relationship with their assigned mentor, if they desire. If the resident does not desire to establish a working relationship with their assigned mentor, they may choose a different faculty member.

39.3 The guidelines that are to govern the mentoring process are attached to this policy. These guidelines are intended to serve as a framework to help assist residents and faculty in developing a strong mentoring relationship that benefits both the faculty member and the resident.

APPROVED BY: E. E. Fibuch, M.D.
DATE: July 2009
Program Director
Scholarly Activity Policy

POLICY: It is the policy of the Department of Anesthesiology that all CA-1/CA-2 residents will author one written paper (case report, small review article or clinical research project) under the mentorship of a faculty member during the first 21 months of their CA-1/CA-2 years. The written paper will be completed by March 30 of the CA-2 year, in a form suitable for publication.

PURPOSE: The purpose of this policy is to:
• Refine the writing and communication skills of the residents.
• Provide the residents with an opportunity to do a clinical scholarly activity, if desired
• Create an environment of scholarly investigation.

40.1 All anesthesiology residents are required to complete this written scholarly work in order to advance to their CA-2 and/or Ca-3 year and fulfill a graduation requirement.

40.2 This written scholarly activity can be fulfilled by the resident authoring either a:
   1. case report
   2. small review article
   3. clinical research project

40.3 The written scholarly work needs to be in a form suitable for publication and composed in standard journal format with references (see attached guidelines).

40.4 All residents are responsible to pick a topic (see 40.2) and choose a faculty mentor.

40.5 All residents must meet defined deadlines (see 40.8).

40.6 The written scholarly activity will be graded by the Research Committee. A letter grade of A-F will be employed. A resident must obtain a “C:” or greater to receive credit and graduate from the training program. A resident who presents his/her work in either a verbal or poster format at an external meeting will be given a monetary award if all time table requirements have been met (see 40.8). An additional monetary award may be given if the scholarly work is accepted for publication during the residents’ CA-3 year.
40.7.1 Failure to satisfactorily complete this written scholarly activity requirement by the end of the third quarter of the CA-2 year (March 30) will delay promotion to the CA-3 year, and possible loss of a satisfactory CCC to the ABA. In addition, progress to completion (or lack thereof) will be documented on each resident’s individual portfolio, which will become part of the resident’s permanent educational performance record.

40.8 The following dates will be enforced:
- Selection of topic and mentor (December 22\textsuperscript{nd} of CA -1 year)
- 1\textsuperscript{st} Draft of paper/project (May 30\textsuperscript{th} of CA -1 year)
- 2\textsuperscript{nd} Draft with figures/tables (September 28\textsuperscript{th} of CA-2 year)
- Submission of completed scholarly work (March 30\textsuperscript{th} of CA-2 year)
- Revision of paper (if required) (September 30\textsuperscript{th} of CA – 3 year)

40.9 All drafts and required completion results will be submitted to Lisa Young in a timely manner.

40.10 Failure to meet the above deadlines will result in an adverse letter of concern being placed in the resident’s permanent education file.

APPROVED BY: __________________________ DATE: September 2010
E. E. Fibuch, M.D.
Program Director
Program Support During a Disaster
Policy and Procedure

Policy: The Anesthesiology Residency Program will adhere to the UMKC – GME policy concerning the potential occurrence of a disaster. This policy defines the procedures that the training program will follow if a disaster does occur.

Purpose: To ensure continued high quality educational experiences for the Department’s residents during a time of disaster affecting UMKC SOM or one of its affiliated hospitals or training sites.

41.1 See attached UMKC Policy – dated March 20, 2008.

APPROVED BY: __________________________ DATE: ____________
E. E. Fibuch, M.D.
Program Director

July 20110
Equal Clinical Training Access
For Residents

Policy: To define the methods that will be used by the Program Director and Education Committee of the Department of Anesthesiology to ensure that all residents will be given equal access to clinical experiences.

Purpose: To ensure that all residents in the program will have equal access and experience to clinical, academic and research learning opportunities and that all residents will be able to achieve minimum case numbers.

42.1 Annual resident rotational schedules for all four training years will be developed/updated for all residents in the program.

42.2 These rotational schedules will be constructed based on block/service schedules (monthly) and equally distributed among all residents.

42.3 The equal distribution of these monthly rotations will ensure that:
A. Clinical Base residents will each be assigned to the following rotations:
   - Cardiology 2 months
   - Nephrology 2 months
   - Emergency Medicine 1 month
   - Pulmonary/ CC 1 month
   - e-ICU 1 month
   - General Anesthesia 1 month
   - CVICU 1 month
   - Neurology 1 month
   - General Medicine 2 months

B. CA-1 residents will each be assigned to the following rotations:
   - General Anesthesia 2.5 months
   - CVICU 1 month
   - Closed Urology (cysto) 1 month
   - ENT-Plastics 1 month
   - Obstetrical Anesthesia 2 months
   - Orthopedic Anesthesia 1 month
   - Pain Medicine 2 months
   - Pre-op Assessment 1 month
   - Recovery Room 0.5 month
C. CA-2 residents will each be assigned to the following rotations:
   - CVICU 2 months
   - Neuro Anesthesia 2 months
   - Pediatric Anesthesia 2 months
   - CVICU 2 months
   - Outpatient Anesthesia 1 month
   - Regional Anesthesia 1 month
   - Vascular Thoracic Anesthesia 1 month

D. Ca-3 residents will each be assigned to the following rotations:
   - CVICU 2 months
   - Pediatric Anesthesia 2 months
   - Research Laboratory 3 months
   - OR Management 1 month
   - Cardiovascular Anesthesia 1 month
   - Elective rotations 2 months

42.4 Residents, during their clinical rotations, will be given priority in room assignments.

42.5 Biannually, the Program director will review resident case logs to ensure appropriate and equal distribution of cases.

42.6 Faculty are required, on a monthly bases, to validate that residents assigned to their area of responsibility have fulfilled the goals and objectives of the rotation.

42.7 Monthly, residents are required to sign an attestation form indicating that they have fulfilled the goals and objectives of the rotation they have just completed.

APPROVED BY: E. E. Fibuch, M.D.
DATE: July 2011
Program Director
AWARDS AND RECOGNITION POLICY

Policy: To prospectively define the process by which the faculty of the Department of Anesthesiology will select residents for specific awards and recognitions and the specific awards and recognitions that will be given to residents on an annual basis.

Purpose: The purpose of having an Awards and Recognition process in the Department of Anesthesiology for Anesthesiology Residents is to formerly recognize superior achievement and to encourage other residents to strive for higher levels of academic and professional performance.

43.1 In order to encourage superior benchmark performance and achievement by CA-3 residents, in preparation for taking the ABA Written Board Certification Examination at the completion of their CA-3 year, the faculty has determined that an in-training examination test result of 32 or greater is predictive of superior benchmark performance by a CA-3 resident, the following year, in the written portion of the ABA certification examination.

43.2 Any CA-3 resident who achieves a standard score of 32 or greater will be awarded $2,000.00 from Departmental UMKC Discretionary funds.

43.3 The Education Committee has determined the scholarly activity (i.e. case reports, review articles and peer reviewed papers) authored by residents is important, and should be recognized.

43.4 Residents (CA-2) who fulfill the requirements established by the Education Committee and delineated in Department Policy A-40 will be awarded $500.00 from Departmental UMKC Discretionary funds, for authoring their scholarly work. The scholarly activity must be turned in by March 31st of their CA-2, reviewed and approved by the Chair of the Clinical Research Committee of the Department of Anesthesiology and approved by the Education Committee of the Department of Anesthesiology based on merit and quality.
43.5 Residents (CA-3) who present their scholarly work (completed in their CA-2 year) at the Midwest Anesthesiology Residents’ Conference or a National Anesthesiology Conference, will receive a $500.00 award for superior achievement from Departmental UMKC Discretionary funds.

43.6 As part of achieving completion of a 48-month educational continuum in the specialty of Anesthesiology, CA-3 residents will receive a framed copy of the Oath of Hippocrates in recognition of superior achievement and to foster and encourage residents to fulfill their professional obligations and responsibilities upon leaving the training program.

43.7 In recognition of outstanding and meritorious performance as the resident leader, the Chief Resident, annually, will be recognized by the Chairman of the Department with an embossed leather portfolio signifying achievement in leadership. This award is in lieu of a recognition plaque and will be funded from the Departmental UMKC discretionary funds.

43.8 The Outstanding Anesthesiology Award will be given annually to a resident selected by the faculty who has demonstrated outstanding achievement in leadership and clinical performance. The selected resident will receive a monetary grant to further his/her education in the amount of $1,000.00. Funding will come from the Helen Kingsbury Outstanding Anesthesiology Resident Fund held by the Saint Luke’s Foundation.

APPROVED BY: ___________________________  DATE: July, 2010

E. E. Fibuch, M.D.
Program Director
REPORTING PROCEDURES FOR EXPOSURE TO AIR/BLOODBORNE PATHOGENS POLICY

Policy: The Reporting procedures for exposure to air/bloodborne pathogens is to provide guidelines and appropriate actions in the event that a resident is exposed to an air/bloodborne pathogen.

Purpose: To ensure a safe environment for learning and patient care

44.1 See attached UMKC School of Medicine's GME policy dated 03/23/07
SEXUAL HARASSMENT POLICY

Policy: Sexual harassment policy will follow the defined steps and content as outlined in the UMKC School of Medicine’s GME policy dates 03/23/2007.

Purpose: To ensure that there is a defined, consistent and appropriate sexual harassment policy for prevention and reporting.

45.1 Refer to attached sexual harassment prevention and reporting policy of UMKC School of medicine approved by GME Committee on 03/23/2007.
TRAVEL REIMBURSEMENT POLICY

Policy: Travel reimbursement policy of the Department of Anesthesiology for resident Physicians will follow the guidelines and requirements established in the UMKC School of Medicine Travel Reimbursement policy approved by the School of Medicine’s GME Committee 03/07/2007.

Purpose: To ensure that there is a defined and systematic approach for travel expense reimbursement.

46.1 Refer to attached UMKC School of Medicine Travel Reimbursement policy approved by the School of Medicine’s GME Committee on 03/07/2007.

APPROVED BY: _________________________________

E. E. Fibuch, M.D.
Program Director

DATE: July, 2009
REIMBURSABLE RESIDENT EDUCATIONAL EXPENSE POLICY

Policy: Reimbursable resident educational expense policy of the Department of Anesthesiology for resident physicians will follow the guidelines and policy requirements established in the UMKC School of Medicine’s Reimbursable Resident Education Policy approved by the School of Medicine’s GME Committee on 4/18/07.

Purpose: To ensure that there is a defined and systematic approach for educational expense reimbursement to residents

47.1 Refer to attached UMKC School of Medicine Resident Educational Expense Policy dated 04/18/07.
RESIDENT/RESEARCH PRESENTATION FUND POLICY

Policy: Reimbursable resident research presentations expenses of the Department of Anesthesiology for resident physicians will follow the guidelines and policy requirements established in the UMKC School of Medicine’s Resident Research Presentation Fund Policy approved by the School of medicine’s GME Committee on March, 2008.

Purpose: To ensure that there is a defined and systematic approach for the reimbursement of expenses incurred in the process of presenting a research poster.

48.1 Refer to attached UMKC School of Medicine’s Resident Research Presentation Fund Policy dated March, 2008.

APPROVED BY: ___________________________  DATE: July, 2009

E. E. Fibuch, M.D.
Program Director
PROCEDURE FOR REPORTING WORK-RELATED INJURIES POLICY

Policy: The procedure for reporting work-related injuries of the Department of Anesthesiology for resident physicians will follow the guidelines of policy requirements, established in the UMKC School of Medicine’s Procedure for Reporting Work-Related Injuries Policy approved by the School of Medicine’s GME Committee on 4/18/07.

Purpose: To ensure that there is a defined and systematic approach for the reimbursement of expenses incurred in the process of presenting a research poster.

49.1 Refer to attached UMKC School of medicine’s Procedure for reporting work-related Injuries dated 04/18/07

APPROVED BY: E. E. Fibuch, M.D. 
Program Director 

DATE: July, 2009
**FATIGUE/MITIGATION POLICY**

**Policy:** This policy is intended to ensure that the Department of Anesthesiology, its faculty and residents will meet the standards of the ACGME common program requirements (version 2011), item VI.C page 13 concerning alertness management/fatigue mitigations. UMKC Anesthesiology Faculty and Residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply the following programs and procedures to prevent and counteract potential associated negative effects on patient care and learning. These programs and procedures are designed to:

a) Raise faculty and residents’ awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care
b) Provide faculty and Residents with tools for recognizing when they are at risk
c) Identify strategies for faculty and residents to use that will minimize the effects of fatigue (in addition to getting more sleep)
d) Help identify and manage impaired residents

**50.1 Definition of Fatigue:**
Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician’s judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety

There are many signs and symptoms that would provide insight to one’s impairment based on sleepiness. Clinical signs include:

a) Moodiness
b) Depression
c) Irritability
d) Apathy
e) Impoverished speech
f) Flattened affect
g) Impaired memory
h) Confusion
i) Difficulty focusing on tasks
j) Sedentary nodding off during conference or while driving
k) Repeatedly checking work and medical errors
50.2 **Definition of Duty Hours:**
Duty hours are defined as all clinical and academic activities required for the residency program; i.e., patient care (direct patient care: both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities such as required conferences. Duty hours *do not* include reading and preparation time spent away from the duty site. Duty hours restrictions are based upon the ACGME Duty Hour rules as found in the Common Program Requirements on the ACGME website: 
[http://www.acgme.org/acWebsite/home/home.asp](http://www.acgme.org/acWebsite/home/home.asp)

50.3 **Individual Responsibility:**
Resident’s Responsibilities in identifying and Counteracting Fatigue

a) The resident will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives (motor vehicle accidents)

b) The resident is expected to adopt habits that will provide him/her with adequate sleep in order to perform the daily activities required by the program

c) Duty hours should be strictly adhered to. In the event that the resident is too sleepy to drive home at the end of the work period, he or she should be encouraged to use another form of transportation (taxicab), or take a nap prior to leaving the training site.

Faculty Responsibilities in identifying and counteracting fatigue:

a) Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients

b) Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the resident that will correct this problem.

c) The faculty will learn to accept the limitations on the role of the resident under the duty hour mandates and will not penalize the resident as being lazy or disinterested when the resident leaves a work assignment “on time’

50.4 Each member of the department will receive written educational materials regarding fatigue and fatigue mitigation on an annual basis

50.5 Resident will be shown the ASA video on fatigue at least twice per academic year

50.6 The faculty will be responsible to ensure continuity of care in the event a resident must be relieved of patient care duty secondary to fatigue and/or signs of sleep deprivation

50.7 In the event a resident becomes too fatigued to drive him/her self home following a period of patient care duties, the resident will be given the option to sleep in the resident call facility or will be given money to order a cab to transport him/her home. It is the resident’s responsibility to notify the faculty of the need to secure
transportation home following an extensive period of patient care due to fatigue and the inability to drive safely home

50.8 The following fatigue/mitigation educational material from the Department of Graduate Medical Education, Duke University Hospital will be provided to all residents/faculty (see addendum to this policy)

50.9 **Counseling:**
In the event that a resident is reported as one who appears to be persistently sleepy or fatigued during service, the Program Director and faculty mentor to the resident will counsel the resident individually to determine if there are some medical, physical, or psychosocial factors affecting the resident’s performance. An appropriate referral will be made based on the finding during the interview.

50.10 **Evaluation:**
The effectiveness of this policy will be measured by:

a) The number of residents who report that they have received the training (ACGME Resident Survey)

b) The number of residents who comply with the Duty Hour requirements

c) The assessment by faculty and others of the number of incidents by which a resident can be identified as fatigued during work hours and the number of medical errors attributed to Resident’s fatigue

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**APPROVED BY:** ______________________

**DATE:** __Nov. 2011_

E. E. Fibuch, M.D.
Program Director
REQUIRED PI PROJECTS

Policy: The performance improvement process within the Department of Anesthesiology at Saint Luke’s Hospital will include a required team-based PI activity for all CA-1, CA-2 and CA-3 residents. The CA-1, CA-2 and CA-3 residents will be required to work as a team under the mentorship of a faculty member to complete a PI project on an annual basis.

Purpose: The purpose of this policy is to engage residents in the practical application of a performance improvement activity through the use of a team-based approach, incorporating the PDSA cycle.

51.1 Annually, the Clinical Chairman of the Department at SLH will assign an individual faculty-mentor to the CA-1, CA-2 and CA-3 resident groups.

51.2 The Chairman of the Department’s PI committee will provide a list of suggested projects to the CA-1, CA-2 and CA-3 residents as possible projects for them to initiate. These suggested projects would not limit the residents from selecting their own project.

51.3 This is a required academic activity and will be graded by the faculty-mentor and the grade will be included on each resident’s performance portfolio.

51.4 Residents will follow the PDSA methodology.

51.5 During the month of July, each group of residents (CA-1, CA-2, and CA-3) will meet with their respective faculty-mentor to review possible projects.

51.6 During the month of August each group of residents (CA-1, CA-2 and CA-3) will be instructed in the use of the PDSA cycle and related PI tools.

51.7 During the month of September, each group of residents (CA-1, CA-2 and CA-3) will initiate the Plan phase of the PDSA cycle.

51.8 During the month of October, each group of residents (CA-1, CA-2 and CA-3) will initiate the Design Phase of the PDSA cycle.
51.9 During the months of November and December, each group of residents (CA-1, CA-2 and CA-3) will initiate the Study Phase of the PDSA (collect data and recommend a course of action).

51.10 During the month of January, each group of residents (CA-1, CA-2 and CA-3) will implement their recommendation.

51.11 During the months of February, March and April, each group of residents (CA-1, CA-2 and CA-3) will maintain data collection and implement their recommendations.

51.12 During the month of May, each group of residents (CA-1, CA-2, and CA-3) will initiate the Assess Phase of the PDSA cycle, formulate conclusions and present their results to the Department.

51.13 The faculty-mentor for each group of residents will provide a letter grade based on the quality of the project, the completeness of approach used by the residents and the ability of the residents to be participative team members. This letter grade will be given to the Program Director for inclusion in the resident’s individual portfolios.

APPROVED BY: E. E. Fibuch, M.D.  DATE: December, 2011
Program Director
CODE OF CONDUCT

Policy: Residents, while on duty, will adhere to the attached Code of Conduct.

Purpose: The purpose of this policy is to provide guidance in carrying out daily activities by residents in the care of patients, being an active member of the Department and anesthesia care teams and in serving the community.

52.1 A comprehensive code of conduct presently exists, which the faculty is required to follow (see attached).

52.2 Residents will follow this policy

52.3 Failure to follow this policy could result in the initiation of “Due Process” by the Competency Committee of the Department of Anesthesiology.

APPROVED BY: ____________________________
E. E. Fibuch, M.D.
Program Director

DATE: June, 2012
CONFLICT OF INTEREST

Policy: Residents will adhere to the attached Conflict of Interest Policy.

Purpose: The purpose of this policy is to ensure that residents do not have or engage in conflicts of interest during their training.

53.1 A comprehensive policy regarding conflict of interest exists for all personnel at the primary teaching hospital (SLH) (see attached)

53.2 All residents will adhere to this policy

53.3 Failure to adhere to the attached Conflict of Interest policy could result in dismissal from the training program.
POLICY: To provide direction for anesthesiology residents in acute patient care situations when immediate (or semi-immediate) clinical interventions (or administrative) are required.

PURPOSE: The purpose of this policy is to ensure consistent communication process in order to effectively manage difficult or time dependent clinical or administrative process issues and to provide for timely and effective patient care.

54.1 During normal working hours (6 am to 6 pm Monday through Friday) resident will communicate directly with their assigned faculty regarding all clinical and administrative issues. Administrative issues might include when or how to place a patient of DNR, transferring a patient (i.e. to an ICU) or issues of compliance.

54.2 During the evening hours (6 pm to 6 am) and on all weekends, junior residents (CBY, CA-1 or CA-2) may elect to communicate to either the Chief resident or senior resident (CA-3) before communicating to the on-call faculty. If the Chief resident or senior resident cannot resolve the issue, then the faculty must be notified.

54.3 For all educational academic or non-healthcare related issues, the resident should first communicate the situation/problem with the chief resident. If the Chief Resident is not able to solve the problem/issue then the resident should communicate to either the Associate Program Directors or the Program Director.

54.4 All resident related administrative issues should be communicated first to the Chief Resident.

54.5 Any issue/problem (both clinical and administrative) that cannot be resolved with the departmental or education governance should be taken to the respective hospital (SLH, TMC, CMH) Associate Deans.

54.6 The following Department Policy is applicable (A-38).

54.7 The attached SLH protocol will be applicable.
Back Up Policy

**Policy:** Residents will always have “back up” providers available to them in case of emergencies or when the resident requires additional assistance in the care of patients.

**Purpose:** To ensure that residents are never left in any circumstance in which they are not capable of handling and to ensure that patients are safely and effectively cared for.

55.1 Residents will be supervised by faculty at all three clinical training sites (SLH, TMC, CMH) either in a 1:1 or 1:2 ratio 24 hours per day, 7 days per week.

55.2 Faculty will maintain back up or second call, schedules in case additional faculty are required to help in the care of patients.

55.3 All three training sites (SLH, TMC and CMH) will provide CRNA backup.

55.4 This policy links to the following policies relative to supervision of residents and times of communication:

- Policy #: A-22
- A-23
- A-53

**APPROVED BY:** E. E. Fibuch, M.D.

**DATE:** June, 2012

Program Director
DEPARTMENT OF ANESTHESIOLOGY
ADMINISTRATIVE POLICIES
UMKC SCHOOL OF MEDICINE                                Program: Anesthesiology
SAINT LUKE’S HOSPITAL                                        Subject: DNR in Operating
TRUMAN MEDICAL CENTER                                      Room or Special
CHILDREN’S MERCY HOSPITAL                                   Procedure Areas
Policy #: A – 56

DO NOT RESUSCITATE
ETHICAL GUIDELINES

Policy: The anesthesiology residency training program’s ethical guidelines concerning “Do Not Resuscitate” in the operating room or other special procedures areas will follow the ASA House of Delegates Committee on Ethics ethical guideline statement concerning DNR originally published on October 17, 2001 and reaffirmed on October 22, 2008.

Purpose: The purpose of this policy is to confirm the residency training program’s acceptance of the ASA ethical guidelines for the anesthesia care of patients with DO-NOT-RESUSCITATE orders or other directives that limit treatment.

56.1 The attached ethical guidelines from the Ethics Committee of the ASA will form the basis of decision making regarding patients with DNR or other orders that limit treatment.

APPROVED BY: ___________________________            DATE: June, 2012
E. E. Fibuch, M.D.
Program Director
Timely Completion of Resident Evaluations

**Policy:** Each faculty is required to complete a resident evaluation on every resident that rotates on the faculty’s service on a monthly basis using the electronic application, New Innovations, in a timely basis (i.e. less than 30 days follow the resident’s rotation)

**Purpose:** The purpose of this policy is to ensure that all residents receive their evaluation on a timely basis in order to facilitate the evaluation process and ensure accurate grading.

57.1 Each faculty member who supervises a resident will complete an electronic version of the rotation evaluation form following e-mail notification to do so.

57.2 The faculty will use the approved software program “New Innovations”

57.3 Each faculty must complete an individual resident evaluation within 30 days following the resident’s completion of a given rotation.

57.4 Failure to complete the evaluation in New Innovations will result in an e-mail notification of failure to complete the evaluation

57.5 The program coordinator will notify the faculty and request completion of the evaluation

57.6 If the faculty does not complete the evaluation within two weeks of being notified by the program coordinator than the Program Director will personally inform the faculty to complete the evaluation within 24 hours

57.7 Failure to complete the required evaluation will result in a formal complaint being sent to the Education and Research Committee for adjudication.
Reporting of Duty Hour Violations

**Policy:** It is the Policy of the Department that all work hour violations will be reported in a timely manner to the program director/program coordinator and that residents will document the circumstances of the work hour violation in New Innovations.

**Purpose:** The purpose of this policy is to ensure that work hour violations do not occur and that, if there is an occurrence of a work hour violation the Program Director can take expedient action to make the circumstances that resulted in the violation to not occur again.

58.1 All work hour violations are required to be reported by residents as soon as they occur to the Program Director or Program Coordinator.

58.2 All work hour violations must be recorded in New Innovations and appropriate circumstances surrounding the violation be noted.

58.3 If the Program director concludes, after reviewing the written documentation, that action needs to occur, he/she will interview the resident and faculty regarding the issue and request any needed changes in clinical process in an order to ensure that the particular violation does not occur again.

58.4 Any further violation by the same faculty/rotation will result in the issue being taken to the Education and Research Committee for adjudication.

**APPROVED BY:**

E. E. Fibuch, M.D.
Program Director

**DATE:** September, 2012