Department of Anesthesiology, Perioperative & Pain Medicine

Residency Training Program Manual

2024-2025

UNIVERSITY OF CALGARY

Table of Contents

Select list item to view associated page

Table of Contents

Select list item to view associated page

Table of Contents

Select list item to view associated page

Table of Contents

INTRODUCTION

The University of Calgary (U of C) offers a five-year specialist-training program in anesthesiology that is recognized and fully accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC). Training locations include all acute care sites in Calgary. All sites take responsibility for training our residents, and all training sites have a voice on the Residency Program Committee (RPC). We constantly strive to accomplish the right balance of general versus subspecialty training and tertiary care versus community care experiences. The training is rigorous and resident wellness is always a priority. Our goal is to graduate excellent, well- rounded physicians who, as Medical Experts, possess the specialized knowledge and skills required in modern anesthetic practice. Teaching and evaluation also encompass the intrinsic CanMEDS competencies: Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional.

Teaching takes place primarily in the operating room where residents work one-on-one with faculty anesthesiologists. Additional learning opportunities include off-service rotations, simulation, academic half-day sessions, Journal Club, events sponsored by the Post-Graduate Medical Education (PGME) Office, various courses (e.g. ATLS, ACLS, PALS, and NRP, POCUS skills, FATE/FAST and emergency lung ultrasound, basic echocardiography), scholarly project days, formal rounds, conferences, and oral and written examinations. Residents are encouraged to develop life-long learning habits during the five-year program. Study time is provided for preparation for the Royal College examinations in anesthesiology in the year preceding the examination.

Clinical Opportunities

Hospital teaching sites associated with our program include the Alberta Children's Hospital (ACH), the Foothills Medical Centre (FMC), the Peter Lougheed Centre (PLC), the Rockyview General Hospital (RGH), and the South Hospital Campus (SHC). Residents also benefit from the unique experiences provided in a variety of non-hospital facilities, such as the Chronic Pain Clinic and Accredited Non Hospital Surgical Facilities. Training done outside of these centers must satisfy the regulations of the RPC, PGME Office, and the RCPSC.

The hospitals in Calgary serve a population of at least 1.7 million living in the Calgary area, southern Alberta, and parts of British Columbia and Saskatchewan. FMC is a designated level 1 adult trauma and tertiary care centre, and ACH is a pediatric referral site. All major surgical sub-specialty services are provided in Calgary. Anesthesia services are also provided for non-surgical treatments such as electroconvulsive therapy, electrical cardioversion, and non-invasive and invasive radiological procedures. Residents participate on the Code Team and Trauma Team at FMC, and have the opportunity to work with STARS Air Ambulance and Pediatric Transport teams during elective time. In addition, multidisciplinary Pre- Admission Clinics (PAC) and Acute Pain Services (APS) operate out of the affiliated teaching hospitals.

Table of Contents

ROTATIONS AND SCHEDULES

The Master Schedule is produced by the Program Director (PD) each winter. Requests from residents are solicited yearly. Great effort is made to grant requests; however, there are many constraints on the schedule that make it difficult to satisfy all. Residents may request to have rotations moved to a different year to facilitate their career progression and planning, but this is done at the PD's discretion.

Sub-specialty rotations may have a senior and junior resident scheduled at the same time. In the event that there are a limited number of sub-specialty cases, the senior resident will get precedence in assignment to the sub-specialty case.

Rotation Schedule for Competence by Design (CBD) Program
Our program has functioned as a fully CBD training program for several years. We have successfully adapted historic 28-day block rotations to our CBD curriculum and find that this facilitates scheduling within the logistical structure of our university.

Transition to Discipline Stage (block 1 and 2)
This stage of training is completed at FMC and RGH. The Transition to Discipline (TTD) stage of training serves to provide a foundation in essential anesthesia knowledge. In addition to intraoperative learning experiences, educational opportunities include simulation, didactic lectures, and small group learning sessions. These first two blocks also focus on developing the camaraderie and social connectedness of our new residents. New residents are welcomed at the annual Awards & Graduation Dinner at the end of June, followed by other activities hosted by the residents. The Anesthesia Knowledge Test (AKT)-1 is written at the end of Block 1. Residents complete the required three TTD entrustable professional activities (EPA's) during this initial stage.

Stage	Education Experiences (in their typical sequence)	Typical Length	Learning Site(s)
Transition to Discipline	1. Adult anesthesia 2. Adult anesthesia	2 blocks	FMC, RGH

Foundations of Discipline Stage (PGY-1 block 3 to PGY-2 (i.e. 17 blocks and 1 elective)
The 'Foundations' rotations that will be scheduled in **PGY-1/PGY-2** include:

Stage	Education Experiences (in their typical sequence)	Typical Length	Learning Site(s)
Foundations	1. Emergency Medicine 2. Pediatric Surgery or Pediatric Emergency 3. General Surgery 4. Trauma Surgery 5. Obstetrics 6. Obstetric anesthesia 7. Internal medicine 8. Adult anesthesia 9. Adult anesthesia 10. Adult anesthesia & preoperative assessment clinic 11. Adult anesthesia 12 Adult anesthesia 13. Airway 14. Adult anesthesia 15.Pediatric anesthesia 16. ICU 17. ICU 18. Elective	18 blocks (Rotation order will vary for each resident. OB & OB anesthesia occur together when possible)	FMC, ACH, PLC, RGH, SHC

Table of Contents

On anesthesia rotations, **call requirements for PGY-1 residents** are as follows:

- if the resident **has not** yet completed a rotation in obstetric anesthesia, they will work during the day and stay until the main operating room (OR) closes; if the main OR closes after 2200h, the resident will not work the next day;
- if the resident has **completed obstetric anesthesia**, their call shifts are identical to other residents (i.e. pre- and post-call day off); the first one to two call shifts at FMC are done with a senior resident (i.e. buddy call).

Core of Discipline Stage (PGY-2 to PGY-5 (37 blocks)) The 'Core' rotations that will be scheduled in **PGY-2/PGY-3/PGY4/PGY-5** include:

Stage	Education Experiences (in their typical sequence)	Typical Length	Learning Site(s)
Core	1. Junior neuroanesthesia 2. Pulmonary 3. Junior Regional anesthesia 4. Adult anesthesia/ OB anesthesia 5. CICU 6. Adult anesthesia 7. Community anesthesia 8. Junior thoracic anesthesia/head & neck) 9. Junior vascular anesthesia 10. POCUS 11. Adult anesthesia 12. Acute pain service 13.PICU 14. ICU 15. Senior neuroanesthesia 16. Pediatric anesthesia 17. Adult anesthesia 18. Adult anesthesia/pre-op clinic 19. Elective 20. Adult anesthesia 21. Cardiac anesthesia. 22. CVICU 23. Cardiac anesthesia 24. Senior regional anesthesia 25. Perioperative medicine 26. Senior thoracic anesthesia 27. Obstetric anesthesia 28. Chronic pain 29. Senior vascular anesthesia 30. Out of Operating Room anesthesia 31. Pediatric anesthesia 32. Elective 33. Adult anesthesia/Medical education 34. Adult anesthesia/Medical education 35. Elective 36. Elective	36 blocks	FMC, ACH, PLC, RGH, SHC, community location (Lethbridge/Red Deer or other), chronic pain centre

The Chronic Pain rotation consists of: 1 week Pediatric Chronic Pain, Transitional Pain exposure, and 2-3 weeks in the Chronic Pain Clinic. If a resident asks for vacation, it will be 1 week of Chronic Pain Clinic. Residents should work with the Chronic Pain Rotation Coordinator to determine the specific dates for their Pediatric Chronic Pain experience at least 3-6 months prior to their rotation; residents may also have to coordinate this with Dr. Nivez Rasic (can be reached via her AHS e-mail address) at the Pediatric Chronic Pain clinic.

The CanNASC Simulation Assessment will take place in the spring of PGY-4.

The RCPSC Written Examinations will be scheduled in the fall, and the oral exam in the spring of the PGY-5 year.

Transition to Practice Stage (PGY-5 blocks 5-13 (i.e. 9 blocks))

Stage	**Education Experiences (in their typical sequence)**	**Typical Length**	**Learning Site(s)**
Transition to Practice	1. Acute Pain Service 2. Adult anesthesia (Manager focus) 3. Adult anesthesia (Pre-op assessment focus) 4. Pediatric Anesthesia 5. Anesthesia elective 6. Anesthesia elective 7. Anesthesia elective 8. Anesthesia elective 9. Anesthesia elective	9 blocks	FMC, ACH, PLC, RGH, SHC

From the date of the written exam until December and from the oral exam to the end of residency, R5's attend Core Program on Thursday afternoons in a faculty role.

Following the Fellowship examination, graduating residents are expected to 'debrief' the PGY4 residents and assist them in planning for the coming year.

EPAs (ENTRUSTABLE PROFESSIONAL ACTVITIES) & COMPETENCE REPORTS

The most recent list of EPAs for Anesthesiology can be found on the Royal College website.

'Difficult to Plan' or 'On-Call' EPA Assessments

Residents should always be on the lookout for opportunities to achieve the following EPAs in the **Core** stage:

- **Core 6**: Demonstrating required skills in POCUS (point of care ultrasound) to answer a clinical question
- **Core 7**: Providing peripartum anesthetic management for high-risk parturients
- **Core 8**: Initiating resuscitation and providing anesthetic management for unstable parturients
- **Core 23**: Managing goals of care discussions with patients and families, including perioperative care plans

Unique EPA Assessments

Foundation of Discipline

Foundation 7 – Assessing the indications for transfusion of blood products and managing side effects and complications

Residents can satisfy this EPA by completing Academic Half Day National Transfusion Bootcamps and the following two online modules:

1. The **Massive Hemorrhage and Transfusion in the Operating Room** module available through the Canadian Anesthesiologists Society (CAS)webpage (Massive hemorrhage and transfusion in the operating room | Canadian Anesthesiologists' Society (cas.ca)). A certificate of completion will be provided upon completion.

Residents should **include the certificate of completion** with their **Competence Report** for **promotion from Foundations to Core**. Note that the RPC/Competence Committee will change the requirements for this EPA as resources evolve.

Core of Discipline

Core 8 – Initiating resuscitation and providing anesthetic management for unstable parturients.
Residents will have an opportunity to achieve one observation for this EPA during their mandatory OB Team Simulation in PGY-4.

Core 18 – Providing perioperative anesthetic management for patients undergoing thoracic surgery.
One observation will consist of a case discussion about anterior mediastinal mass. Please make arrangements with the Thoracic Anesthesia Rotation Coordinator to do the case discussion during the junior or senior thoracic rotation.

Core 25 – Recognizing and managing ethical dilemmas that arise in the course of patient care.
Residents can submit the reflective critique to their Academic Coach, and their Academic Coach will be responsible for signing off this EPA as complete. Additionally, several other faculty members are able to debrief this exercise. Please discuss with PD. Residents should have this **completed before the end of PGY-4**, and they should include the **letter** of completion authored with their **Competence Report** for **promotion from Core to Transition to Practice**.

EPAs to Work on Throughout Residency Training

Residents will need to work on the following EPAs throughout their training in order to successfully graduate from their training program.

1. **Transition to Practice 5 – Developing an academic portfolio**
    - **a.** Teaching Dossier
    - **b.** Scholarly Project

Competence Reports

The Competence Report Checklist form and template can be found on the CBD Resident Basecamp. Competence Reports should include the following:

1. **A letter outlining your proposed outcome of the review.** Please ensure this is specific to the purpose of the review, acknowledges any deficiencies, and presents a plan for improvement. In crafting this letter please incorporate the information contained in the documents below. Fundamentally what we are looking for is an honest appraisal of your progression and a plan moving forward.
    a. **As a part of your letter please include a succinct narrative summary of your EPA progression**.
        i. Please highlight those areas where you feel you are behind and those areas where you feel you may be ahead.
            1. In determining the correct pace for EPA acquisitions refer to the EPA-rotation mapping document.
        ii. Please comment on any factors that you believe to be impacting your ability to progress.
            1. These can be personal or programmatic.
    b. The competence committee will have access via one45 to review your EPAs so you do not need to provide us with copies.
2. **A copy of all rotation ITER's since the last time you submitted a competence report.**
3. **A copy of your excel EPA logbook.**
4. **Standardized test results**
5. **A brief description of the progress on your scholarly project**
6. **Dates, short descriptions, and evaluations of rounds and half-day presentations**
7. **Copies of any other non-clinical activity assessments completed on one45;** Examples of non-clinical activities include: OSCE, simulation
8. **Certificates** from mandatory and voluntary courses
9. **Documents requested specifically by the competence committee** in lead up to your review or as the result of a previous review.
10. Any **additional documents** that you feel will bolster your application, add context to your performance, or improve our understanding of your proposal.

Table of Contents

CORE PROGRAM (ACADEMIC HALF-DAY)

Core Program takes placing during academic half-day (Thursday afternoons from 1300-1630h) throughout the year. The entire curriculum is completed over a 2-year cycle, with the exception of Crisis Resource Management (CRM). Residents have previously found these sessions quite valuable, so we offer them regularly throughout the year.

There are twelve primary units:

1. Medicine;
2. Physics and Equipment;
3. Pharmacology;
4. Pediatric Anesthesia;
5. Thoracic Anesthesia;
6. Neuroanesthesia;
7. Regional Anesthesia;
8. Cardiovascular Anesthesia;
    a. Consists of Cardiac Anesthesia sessions and Vascular Anesthesia sessions
9. Obstetric Anesthesia;
10. Statistics & Research Methodology
11. Crisis Resource Management
    a. Case-based Lectures & Simulation sessions (see below)
12. CanMEDS;
    a. Includes half-days dedicated to Wellness & Resiliency, Feedback, Substance Use, Ethics, Unconscious Bias in Medicine, Indigenous Health, Equity/Diversity/Inclusion and Global Health, exam preparation, quality and safety

Each unit has a faculty unit manager who decides the direction and objectives for the unit and organizes the weekly sessions. Weekly sessions begin with senior resident moderated “challenging case of the week” discussion from 1300-1330. Staff are invited to join at 1330 for the weekly session. A resident and a preceptor collaborate to lead each of these weekly sessions. Facilitators are encouraged to utilize a diverse array of educational techniques, including but not limited to: lectures, problem-based learning sessions, seminars, case-based discussions, labs, simulations, mock oral exams and journal article reviews. Strategies that encourage active learning and participation are especially valuable. Guest speakers are invited on occasion to supplement discussions and/or lead sessions. For example, the Indigenous Health and Unconscious Bias in Medicine half-days will be run with assistance and support from PGME.

Many units also administer a mandatory written examination or assignment to facilitate resident learning. If Residents are absent on the day that these are administered or assigned, they must make arrangements with the Unit Manager to ensure that they are completed. Although the goal of these exams is for growth of resident knowledge, incomplete or poor performance on these exams/assignments will be discussed at RPC.

Attendance at Core Program is **mandatory** for all anesthesia residents; when residents are post-call attendance is optional. **On anesthesia rotations, call is structured such that residents will only be post-call a maximum of one Thursday per block** (when call is not scheduled by a Lead Resident, residents must not schedule themselves on call more than one Wednesday night per block). Our program also asks off-service rotations not to schedule our residents on call on Wednesday nights if possible. **Residents should be excused from all rotations at 1200h for academic half-day activities. Residents should not**

leave Core Program sessions early when on call that evening; rather, all clinical duties can wait until Core Program is completely finished (Core Program sessions are scheduled from 1300-1630h). Visiting residents and clinical clerks are also invited to academic half-day.

Each daily session is evaluated by the residents via weekly program survey; feedback is subsequently collated, reviewed by program leadership, and provided to the presenters in an anonymous manner. Each unit is evaluated by the residents for content and quality as part of our ongoing residency program review. A formal overall review of Academic Half-day activities occurs on an annual basis.

Intrinsic (i.e. non-Medical Expert) CanMEDS Competencies Education

Education on intrinsic CanMEDS competencies is spread throughout the academic year and residency, although education may occur during a concentrated CanMEDS unit.

All PGY-1 residents begin the longitudinal Safety and Quality course during the 'Transition to Discipline' blocks. This course includes the 'Disclosure of Untoward Medical Outcomes Course'. Residents completing these sessions are then eligible to pursue the completion of the requirements for certification in 'Investigating and Managing Patient Safety Events' (through the Cumming School of Medicine) later on in residency.

Our program encourages medical education courses that provide a general introduction to medical education, including: lesson planning, small group teaching, teaching in the clinical environment, large group teaching, simulation education, and assessment. Several of our senior residents have successfully applied to and completed the prestigious Teaching Excellence Program (TEP) offered through the Office of Faculty Development in the Cumming School of Medicine.

The Office of PGME also provides mandatory workshops for our residents, including:

- Ethics (PGY-1);
- Medical-Legal Workshop (PGY-1);
- Residents as Teachers Workshop (some time during residency);
- Providing and Learning from Feedback;
- Conflict Management; and
- Financial Management.

The PGY-3 residents are required to complete the online module 'Leadership Begins with Self-Awareness' (offered through the CMA) during the first six months of the PGY-3 year (PLI programs for individuals | CMA), or (Login/Register | CMA Connect). Residents are also able to apply for 'Resident Leadership Travel Grants' through PGME to pursue further leadership training (https://cumming.ucalgary.ca/pgme/faculty-and-staff/awards-and-grants/grants/resident-leadership-travel-grants).

Other sessions are periodically offered to residents as needed including PGME delivered time management and study strategies specific for anesthesia residents.

Residents are taught intraoperative non-technical skills through the Anesthesia Crisis Resource Management (ACRM) course (see section 'Simulation' below for more information).

Table of Contents

SIMULATION

Simulation-based medical education is incorporated into our residency training program in a variety of ways.

PGY-1 Bootcamp
PGY-1 residents review common intraoperative crises during the first 'Transition to Discipline' block, and practice managing these scenarios with a high-fidelity mannequin scenario. All residents are provided with a personal physical copy of the Stanford Emergency Manual (http://emergencymanual.stanford.edu/).

Anesthesia Crisis Resource Management (ACRM) Course
All PGY-1 to PGY-4 residents participate in the mandatory Anesthesia Crisis Resource Management course. Residents attend these sessions two-three times per year, with the primary focus of developing non-technical skills required during the management of perioperative crises. The specific medical emergencies are linked to Royal College objectives and competencies. In the last session, additional formative assessment is given in a checklist format to provide an appreciation for how simulation performance can be used to assess both Medical Expert and non-technical skills, in anticipation of the CanNASC milestones.

Inter-professional *in situ* Simulation
Our residents can participate in inter-professional simulation sessions with our OR, PACU (Post-Anesthesia Care Unit), and OB (Obstetrics) nursing colleagues, as well as RT's (Respiratory Therapists). Our residents also engage in inter-professional simulation sessions with residents from other specialties, such as obstetrics and gynecology.

Advanced Skills for Simulation Educators and Teachers (ASSET)
(formerly known as the Workshop in Simulation Education (WISE) Course)
Residents interested in medical education and simulation can complete the ASSET courses offered.

Pediatric Anesthesia Simulation
While on Pediatric Anesthesia rotations, residents can participate in *in situ* inter-professional simulation sessions at offered. All residents rotating through Pediatric Anesthesia Core Program engage in simulation-based medical education events.

Managing Emergencies in Pediatric Anesthesia (MEPA) Course:
During the PGY3 year, residents will have the opportunity to participate in the MEPA course. This course is an internationally designed pediatric simulation course that will help anesthesiology trainees develop a management strategy when faced with emergency situations in pediatric anesthesia. The course will introduce crisis resource management in pediatric anesthesia and translate the knowledge into practice through simulation scenarios. The course discusses the current practice in pediatric anesthesia and, through participation in the simulated scenarios, trainees will be able to review their technical and clinical management. Each scenario will be followed by a debriefing session that will be individualized to the team's performance. In anticipation for the CanNASC requirements for certification, residents will receive both formative and summative feedback.

CanNASC (Canadian National Anesthesia Curriculum)
PGY-4 residents will participate in the national CanNASC simulation program, as part of the national requirements for certification and residency program completion. The clinical situations in which competence must be demonstrated through simulation-based assessment using CanNASC methodology are:

- Management of the difficult airway

- Management of a severe adverse drug reaction
- Management of undifferentiated shock
- Management of a malignant hyperthermia crisis
- Management of equipment malfunction

Part-task Trainers: Echocardiography, ultrasound, bronchoscopy, and epidural simulators
The Department of Anesthesiology, Perioperative and Pain Medicine owns the echocardiography (transesophageal, transthoracic) simulator and conducts simulation sessions for our residents during their Perioperative Ultrasound and Vascular Anesthesia rotations. Residents interested in echocardiography also have opportunities to complete an echocardiography elective to further their knowledge. All anesthesia residents can complete the echocardiography course for ICU Fellows in PGY- 3, as well as a department-run POCUS course taught by faculty members in the Department of Anesthesiology, Perioperative and Pain Medicine prior to their R3 POCUS rotation. Our residents also have access to the Vimedix ultrasound simulator at the Advanced Technical Skills Simulation Laboratory (ATSSL) at the U of C. The ATSSL also has cadavers on which residents can hone their ultrasonography skills for regional anesthesia.

The PGY-1 residents also develop their bronchoscopy and epidural insertion skills with the part-task trainers and can utilize the intravenous and airway management part-task trainers during the 'Transition to Discipline' block.

Table of Contents

SCHOLARLY PROJECT

The scholarly project is designed to help prepare residents for lifelong learning and critical thinking. It has been designed to help trainees fulfill the CanMEDS role of Scholar. Through the scholarly project, residents develop advanced inquiry and problem-solving skills to support clinical practice and future research endeavors throughout their careers. Specific project goals and objectives are developed in consultation with scholarly project supervisor and the Scholarly Project Coordinator, Dr. Andrew Walker.

Potential projects include:
1. **Letter to the Editor for publication**
2. **Retrospective Clinical Study**
3. **Prospective Cohort Study or Randomized Controlled Trial**
4. **Systematic Review/Meta-Analysis**
5. **Quality Assurance/Quality Improvement**
6. **Educational Project**

*Additional project ideas are welcome to be developed by the resident and in consultation with their scholarly project Supervisor with final approval given by the Scholarly Project Coordinator and Program Director

Regardless of the category of the project selected, it must fulfill the stated requirements below.

Definition of Scholarship
Scholarship or the scholarly method is a rigorous and systematic approach to acquiring knowledge. Boyer describes 4 types of scholarly activity: the scholarship of discovery, of integration, of application, and of teaching. Glassick describes 6 standards that must be fulfilled in all four forms:

1. **Clear Goals** – Does the scholar state the basic purpose of their work clearly? Does the scholar define objectives that are realistic and achievable? Does the scholar identify important questions in the field?
2. **Adequate preparation** – Does the scholar show an understanding of existing scholarship in the field? Does the scholar bring the necessary skills to their work? Does the scholar bring together the resources necessary to move the project forward?
3. **Appropriate methods** – Does the scholar use methods appropriate to the goals? Does the scholar apply effectively the methods selected? Does the scholar modify procedures in response to changing circumstances?
4. **Significant results** – Does the scholar achieve the goals? Does the scholar's work add consequentially to the field? Does the scholar's work open additional areas for further exploration?
5. **Effective presentation** – Does the scholar use a suitable style and effective organization to present their work? Does the scholar use appropriate forums for communicating the work to its intended audiences? Does the scholar present their messages with clarity and integrity?
6. **Reflective critique** – Does the scholar critically evaluate their work? Does the scholar bring an appropriate breadth of evidence to their critique? Does the scholar use evaluation to improve the quality of future work?

Requirements of the Scholarly Project

1.0 Types of Scholarly Projects

Trainees, in consultation with the Scholarly Project Coordinator (Dr. Andrew Walker), will select an appropriate project from a list of proposed projects or present a project to the Scholarly Project Coordinator and Program Director that they wish to pursue for approval. In consultation with the Project Supervisor, specific goals and objectives will be established for the resident to ensure scholarly project requirements are met.

1. **Letter to the Editor for publication** (in collaboration with Supervisor): Requires critical review of a published manuscript, literature review followed by a concise and focused written response meeting specified journal requirements for publication. Such a letter would meet senior presenter requirements at Journal Club.
2. **Retrospective Clinical Study** (in collaboration with Supervisor): In conjunction with their Supervisor, resident will be responsible for project conceptualization/literature review, ethics development and submission, electronic data extraction (in consultation with our department data analyst), data analysis, project write-up.
3. **Prospective Cohort Study or Randomized Controlled Trial (RCT)**: In consultation with their Supervisor, the resident will be responsible for the completion of at least one of three project segments. Specific goals and objectives for each segment will be developed with your supervisor.
   Segment 1: Project conceptualization, literature review, ethics development and submission, AHS operational approval, and clinicaltrials.gov registration
   Segment 2: Participant recruitment, data collection/extraction, initialization of data analysis
   Segment 3: Completion of data analysis (in consultation with Andrew Walker, where appropriate), drafting of manuscript discussion, conclusion, and manuscript submission
   Scholarly project presentations would follow the completion of each project segment. Residents involved in earlier segments (e.g., 1 or 2) are welcome to remain involved in the project through completion even if scholarly project requirements have been met.
4. **Systematic Review/Meta Analysis**: In consultation with their Supervisor, the resident will be responsible for the completion of at least one of three project segments. Specific goals and objectives for each segment will be developed with your supervisor.
   Segment 1: Project conceptualization, proposal development, literature review, project registration with Prospero, consultation with librarian to develop appropriate search strategy, completion of literature search, and selection of literature that meets inclusion criteria
   Segment 2: Data extraction from literature that meets inclusion criteria, bias assessment of included literature, assessment of effect modifiers via meta-regression, completion of meta-analysis
   Segment 3: Final assessment in confidence of results, manuscript synthesis (completion of results, discussion, and overall manuscript development) for publication
   Scholarly project presentations would follow the completion of each project segment. Residents involved in earlier segments (e.g., 1 or 2) are welcome to remain involved in the project through completion even if scholarly project requirements have been met.
5. **Quality Assurance/Quality Improvement**: Project conceptualization/literature review, ARECCI score completion, obtaining waiver of ethics or ethics submission in consultation with the Conjoint Health Research Ethics Board (CHREB), data collection, analysis, and project/manuscript write-up.

6. **Educational Project**: Project conceptualization, literature review/needs assessment, proposal development, ethics submission (where applicable), project roll-out/data collection, data analysis, and project write-up

2.0 Project Initiation

In consultation with their Project Supervisor, the resident must submit their proposed project (or specific contribution to a prospective, randomized controlled trial or systematic review and network meta-analysis study) to the Scholarly Project Coordinator and Program Director for approval no later than **February of their PGY-2 year**. This timeline ensures the resident will meet the lightning talk presentation deadline of **March of their PGY-2 year**. The resident must provide to the Scholarly Project Coordinator and Program Director, the specific project goals, objectives, and deliverables as established with their Supervisor.

Consider discussing the following with your Supervisor for your specific project of interest:
1. **Significance** – Based on the literature review, what are identified as the aims of the project? If the aims are achieved, how will scientific knowledge or clinical practice be improved?
2. **Environment** – What resources, space, supplies are needed to implement the plan and answer the questions?
3. **Innovation** – How is this different than what is in the literature already?
4. **Approach** – What methodology and research design is proposed to accomplish the project – qualitative, quantitative, or experimental?
5. **Timeline for project**
6. **References**

3.0 Authorship

The resident(s) on a scholarly project must meet the International Committee of Medical Journal Editors definition of "Who is an Author?"

- Substantial contribution to project conceptualization/study design, data acquisition, analysis, or interpretation AND
- Drafting of the final project write-up or critically reviewing AND
- Providing final approval of the version to be submitted for publication AND
- Agreeing to be accountable for all aspects of the project and ensuring that questions related to project accuracy/integrity are investigated and resolved

4.0 Assessment of Scholarly Project

The Scholarly Project will culminate with a final presentation at our annual Scholarly Project Evening. In addition, you are welcome to submit your project for presentation at local, national, or international conference and/or for peer-review publication. To fairly evaluate a wide and diverse range of academic projects and to determine whether a project fulfills program requirements, the following domains will be assessed:
1. The project is pertinent to the theory or practice of anesthesia, or other relevant areas of medicine
2. The presentation and content are clear and concise
3. There is a clear statement of the project objectives
4. The literature review (where applicable) is comprehensive, contemporary, and critical
5. All references cited in the text are listed at the end of the report
6. The project uses methodology (and analysis) suitable to its format, and there is a plan for project implementation
7. Relevant results are presented appropriately

8. The discussion provides a concise summary of the main findings
9. Conclusion relates to the research question and is supported by the study results

5.0 Scholarly Project Timeline

1. In consultation with their Supervisor, the resident will define the goals and objectives of a proposed project and plan for project implementation (**PGY 1 to no later than February of PGY-2 year**).
2. The proposed project with goals and objectives will be submitted to the Scholarly Project Coordinator and Program Director for approval (**no later than February of PGY-2 year**).
3. Presentation of a 2-minute Lightning Talk providing a brief overview of project goals and objectives at our annual Scholarly Project Evening (**March of PGY-2 year**).
4. Prior to the end of each academic year, residents must submit a progress report to the Scholarly Project Coordinator. This should be a half page report outlining the status of the project and next steps. The Scholarly Project Coordinator will communicate with residents as to the specific date for submission.
4. Final 8-minute scholarly project presentation at our annual Scholarly Project Evening (**PGY-3, no later than PGY-4**).

Scholarly Project Protected Time and Elective

Protected Time for Scholarly Project

Residents may use up to 10-half days or 5-full days (or any combination for a maximum of 10 half days) for scholarly project work. **Research days may be requested Monday through Thursday and are available PGY2 through 1st half of PGY4**. Requests for this time away from clinical duties must be approved by the Project Supervisor, Rotation Coordinator, Scholarly Project Coordinator, and Program Director through the usual mechanisms needed for residents to be excused from clinical work. Lead residents must also be informed of your request for scholarly project protected time. One45 evaluations must be submitted to the Scholarly Project Coordinator for evaluation after each designated research protected half or full day. Requests must be made a minimum of 8-weeks in advance.

Research/Scholarly Project Elective

Residents may choose to undertake one or more research/scholarly project elective blocks during residency. Approval for a research elective will be contingent on current progress/stage of the scholarly project, appropriate goals, and objectives (clearly outlined, practical and achievable within research block), and Research Supervisor, Program Director, and Scholarly Project Coordinator approval. Goals and objectives for each research block will be assessed on a case-by-case basis depending on the specifics of the scholarly project. Residents are encouraged to use this elective particularly for scholarly project work that can be completed in a specific time window (e.g., completing a meta-analysis, complex data analysis/statistical methods, computational modelling, laboratory bench work achievable within a specific time, manuscript preparation/revisions). Questions regarding a research elective should be discussed with the Research Supervisor and Scholarly Project Coordinator. One45 evaluations must be submitted weekly during the elective to the Research Supervisor with a final block evaluation submitted upon elective completion.

Scientific Meetings and Medical Education Research

Scientific Meetings

Residents are encouraged to present at scientific meetings. Partial funding is available from the PGME Office to presenting residents: (PGME | Resident Research Travel Grants | POSTGRADUATE MEDICAL EDUCATION | Cumming School of Medicine | University of Calgary (ucalgary.ca)). Please also refer to the Conference Leave Policy in the program manual.

Residents are encouraged to attend scientific meetings for professional development and career exploration, and, will be granted time according to the PARA contract. All requests to attend conferences must be submitted to the Program Director in accordance with Conference Leave policies.

Residents should be familiar with the Cumming School of Medicine policy on integrity in scholarly activity (FACULTY OF MEDICINE RESEARCH POLICY GUIDELINES (ucalgary.ca)).

Medical Education Research

Residents interested in scholarship in medical education may apply to the Resident Education Scholars Program (RESP), a joint initiative between PGME and the Office of Health Professions and Medical Education Scholarship (OHMES) through the Cumming School of Medicine. Foundational instruction in health professions education research is provided through a series of podcasts. Following completion of these instructional podcasts, the resident will work with a supervisor from the Department of Anesthesiology and an MSc/PhD member of OHMES to create a research proposal. Mentorship and funding of projects is provided through OHMES. A certificate of completion is provided by the Cumming School of Medicine.

Details can be found here: Resident Education Scholars Program | Office of Health and Medical Education Scholarship | Cumming School of Medicine | University of Calgary (ucalgary.ca)

Clinician Investigator Program

The Clinician Investigator Program (CIP) at the University of Calgary is a Royal College of Physicians and Surgeons of Canada residency training program accredited by the Royal College of Physicians and Surgeons of Canada, designed to foster the career development of clinician investigators across Canada. Successful applicants to CIP must commit to a minimum of two years, focusing on thesis-based postgraduate training (MSc, PhD, or post-doctoral).

CIP enhances postgraduate training by integrating rigorous research training and experiences with clinical practice. Trainees establish specific goals with their thesis committee and regularly meet with the CIP Program Director to assess progress based on CanMEDs competencies, discuss career advancement, and strategies for achieving long-term goals. The program includes a mandatory seminar series hosted by trainees, covering a variety of topics such as obtaining a faculty position, knowledge translation, publishing research, data management, securing funding, managing a laboratory, fostering research collaborations, and improving presentation skills. Trainees also have opportunities to attend the Clinician Investigator Trainee Association of Canada's annual meetings and utilize PGME resources to participate in research society meetings.

While enrolled, trainees dedicate 80% of their time to research activities while clinical activities are limited to a maximum of 20%. There is no call schedule. This level of protected research time facilitates full engagement in scholarly activities while allowing trainees to maintain their clinical skills. Funding is guaranteed for 2 years and provided at a level equivalent to the trainee's residency salary. For trainees who stay in the program beyond the minimum two years (e.g. to pursue a PhD), additional funding options, such as the CSM CIP Award, are available.

A review by the RCPSC of CIP's first decade highlighted significant achievements:

> *Most CIP alumni had completed Masters (58%) or Doctoral (39%) programs during their CIP training and published on their CIP research (97%). Among alumni who completed CIP and residency, many obtained an academic appointment with protected time for research, with 39% receiving an external career award. Sixty percent of alumni reported no drawbacks to CIP and recognized the added values included Royal College recognition (CIP designation), structured training, pursuit of graduate studies, integration of clinical/research training and enhanced mentorship (Hayward et al, 2011).*

The CIP is recognized by both trainees and faculty as an effective pathway for developing highly qualified clinician investigators, crucial for faculty renewal.
For more information or to discuss how CIP can help achieve your specific career goals, please email the Program Administrator at cip@ucalgary.ca to set up a meeting, or explore additional information on our website http://cumming.ucalgary.ca/cip/

Table of Contents

QUALITY AND SAFETY

The outline for all Safety & Quality Education is based on an integration of the Royal College of Physicians & Surgeons (RCPSC) CBD requirements, and the Health Quality Council of Alberta's (HQCA) Quality & Safety Education Framework. The HQCA's various frameworks (https://hqca.ca/resources-for-improvement/frameworks/) are intended to answer the question: "How can health care be made safer?". The frameworks' learning topics have been compared to the CanMEDS 2015 roles and exceed CanMEDS Quality & Safety requirements.

Stage	*Activity*
Transition to Discipline (PGY 1)	• Introduction to Safety & Quality (1.5 days) • Disclosure Done Well workshop (0.5 days)
Foundations (PGY 2-4) through Core	• Attendance at Academic Half Day Annual September Quality Assurance Workshop • IHI Open School Modules #1-#6 • EPA Foundations #6B – 'Reflection on Patient Safety' ○ PGY3 participation in a Quality Assurance Review (QAR), presentation at Morbidity & Mortality (M&M) rounds or at a Quality Assurance Committee (QAC) meeting, or an equivalent activity • EPA Core #24 – 'Providing care for patients who have experienced a patient safety incident' ○ Organic participation in the clinical setting

Activities

Introduction to Quality & Safety

During the Transition to Discipline block, residents will attend this 2-day seminar. Residents will start to acquire knowledge and skills in Safety and Quality. Where applicable, anesthetic concepts and examples are provided, such as in the Human Factors section of the course.

Disclosure Training

In the Transition to Discipline block, half a day is spent in an introduction to disclosure. Residents have previously taken a course developed by the Institute for Healthcare Communication (http://healthcarecomm.org/) and named the 'Disclosure of Untoward Medical Outcome (DUMO)' course. Incoming residents now attend 'Disclosure Done Well', developed by Alberta Health Services and the Canadian Medical Protective Association. Video resources may be found at https://www.albertahealthservices.ca/assets/info/hp/ps/if-hp-ps-qhi-qpse-disclosure-done-well-video-fac-guide.pdf.

IHI Open School Modules

The Institute of Healthcare Improvement offers a number of free online modules (http://www.ihi.org/education/IHIOpenSchool/Courses/Pages/OpenSchoolCertificates.aspx) about quality improvement, patient safety, and change leadership. If your cohort requires completion of this activity, you will need to register for an account on the website and complete these courses in your own time.

Six of the modules have been selected as particularly helpful as foundation work prior to participating in patient quality assurance reviews and day to day quality improvement initiatives. They are part of the 'Basic Certificate in Quality & Safety' set:

1. QI 101: Introduction to Health Care Improvement;
2. QI 102: How to Improve with the Model for Improvement;

3. QI 103: Testing and Measuring Change with PDSA Cycles;
4. QI 104: Interpreting Data: Run Charts, Control Charts, and Other Measurement Tools;
5. QI 105: Leading Quality Improvement; and
6. L 101: Introduction to Health Care Leadership.

The deadline for completion of these 6 courses is the end of the Foundations of Discipline block. Evidence of completion must be included in your portfolio in order to move on to the Core stage. If a resident has previously completed the full Basic Certificate in Quality & Safety, they may also email a copy of their certificate of completion to fulfill this residency requirement. Please email the Associate PD (QI/PS Coordinator) Dr. Edward Choi and the Competence Committee Chair (Dr. Lorraine Chow) with your completion screenshots or certificate once this requirement is complete.

Participation in a Quality Assurance Review (QAR)

Previous residents have taken the Introductory Investigating and Managing Patient Safety Events course (https://hqca.ca/education/introductory-investigating/) that was offered jointly by the Cumming School of Medicine, the HCQA, and W21C. This course provided residents with preparation to systematically review their own cases and those of colleagues in a system-focused, non-punitive manner. Introductory training in Systematic Systems Analysis, the SAFER Matrix, and the process of quality assurance reviews is now provided during the Introduction to Safety & Quality lectures during Transition to Discipline, and refresher content is included as part of academic half day sessions each September and may also be included in department/site grand rounds.

Participation in a QAR allows residents to achieve most of the milestones in EPA #6B and some of the ones in #24. However, it is dependent on the availability of a QAR being performed by the Calgary Anesthesia Quality Assurance Committee (QAC). If there are not adequate numbers of QARs during a resident's training to permit individual participation, residents may need to share current or past QARs.

Following participation in a QAR, the resident must prepare their incident Timeline & SAFER Matrix for discussion with a QAC member. When this is completed the QI/Patient Safety Resident Coordinator (APD) will sign off on EPA #6B. The resident does not necessarily have to be the one presenting the QAR at a QAC meeting.

The QI/Patient Safety Resident Coordinator (APD) will keep an ongoing list of residents who require EPA #6B to be signed off, and will work with the QAC to assign residents to QARs as appropriate cases appear, typically during the resident's late R3 period early R4 period. EPA #24 may be completed organically as opportunities arise in the clinical setting and does not need to be supervised by a QAC member.

Residents are ultimately responsible for their own EPA completion and learning. Residents should reach out to the QI/PS coordinator to make alternative arrangements if they have not had EPA #6B or #24 signed off by the time they are completing their Core stage.

M&M Rounds or QAC Meeting Presentation

As PGY-5s transition to practice, they should be able to identify a patient safety incident & complete a patient case review, as they would once they become independent, practicing anesthesiologists. Some residents will have an opportunity to participate in a formal QAR during their training, while others will not. As an alternative to QAR participation, residents may select and review a patient case of their own (with guidance from a preceptor who has undergone QAR training) and present their findings at any hospital site's rounds (in consultation with the rounds coordinator for scheduling). It is also reasonable for residents to present their findings at a QAC meeting instead.

This R5 task does not need to be completed in order to sign off EPA #6B or #24 during the R1-R4 years. However, should the resident not be able to participate in a QAR or were otherwise unable to complete the EPA in their junior years, this provides another opportunity. The EPA completion would then be based

on discussion with a QAC member of a completed SAFER Matrix for the incident that they have chosen. The senior resident is responsible for initiating this activity if needed for completion of an EPA.

TEACHING OPPORTUNITIES

All anesthesiology residents are expected to participate in teaching their colleagues – this is recognized as an important aspect of our program. Examples of such opportunities include teaching at Core Program, Journal Club, morning teaching sessions, and grand rounds.

Residents are also expected to teach the tutorial sessions for clinical clerks on anesthesia rotations. Clerks evaluate resident teaching and the collated results are used to award the **Resident UME Award**, which is presented each June along with the faculty teaching awards.

Residents interested in medical education often volunteer to teach at the medical school; these opportunities are always forwarded to residents, and residents in good standing are fully supported in all their educational endeavors. Residents often help teach Procedural Skills sessions in airway management, lumbar puncture, and intravenous access. **However, written permission from the Program Director must be obtained prior to engaging in any teaching session.** Several of our residents have received teaching awards from the Cumming School of Medicine for their undergraduate medical education (UME) initiatives. Residents are also actively involved in the medical school's Anesthesia Interest Group.

The University of Calgary Teaching Excellence Program https://cumming.ucalgary.ca/office/ofdp/TEPis a competitive and prestigious educational program that many of our senior residents have completed in past years. Our program has supported and granted residents the time off necessary to complete this course. Many graduates of this program go on to pursue careers in medical education and scholarship.

All residents are required to compile a Teaching Dossier as part of the requirements of the Transition to Practice EPA #5, and the Medical Education rotation in PGY-4/5 allows residents to develop a foundation for their future roles as clinical teachers.

ACADEMIC COACHES, LONGITUDINAL PRECEPTORS, MENTORSHIP, RESIDENT WELLNESS AND SAFETY

Academic Coaches

Every resident is assigned their own academic coach. The Academic Coach guides the resident to be the best anesthesiologist they can be, in the broadest terms possible. This includes the intrinsic CanMEDS roles, resiliency, work-life balance, professional identity formation, emotional intelligence, leadership, mentorship, and other academic skills. When required, Academic Coaches may be asked to accurately present their resident to the Competence Committee for assessment, particularly for promotion from one stage to the next or during periods of academic struggle.

Academic Coaches and residents are strongly encouraged to work together clinically (preferably in the operating room) four times per year. **Residents may spend one day on any adult anesthesia rotation, even at another site, or during their second or later obstetrical anesthesia rotation. When travelling to another site for their Coach Day, residents should submit a Leave Form stating "Academic Coach Day". When their Coach is at the same site, a request should be submitted to the Rotation Coordinator and/or scheduling resident, ideally ahead of the daily OR assignments being completed.**

The responsibilities of the Academic Coaches are:

- Coaches require an understanding of all formative and summative evaluations and promotion processes.
- The Coach will be sent copies of all Competence Committee assessments, as well as any unsatisfactory rotation evaluations.
    - It is ultimately the responsibility of the Competence Committee to mandate the use of Learning Plans, Remediation, or Probation, although the Coach may recommend these as well.
- Coaches will occasionally receive informal feedback about a Resident's performance, often from the Rotation Coordinator; the Coach will use this information to achieve their objectives for resident success only, as it is not their role to engage in formal evaluations.
- Mandatory contact (in-person/electronically/telephone) once per block, ideally in 3rd week to review previous, current, and upcoming blocks. In-person meetings should occur about once every 3 months.
- Coaches are asked to help identify and address issues early. Assistance will be provided by the Coach Program Lead and by PGME regarding the use of Learning Plans, or during any periods of Remediation or Probation processes.
- The Coach-Resident relationship is one in which both members drive the relationship; Coaches are expected to participate actively, negotiate communication and acknowledge the needs of both parties, trust where appropriate, and recognize when they need help.

The responsibilities of the residents are:

- The Resident is responsible for communicating all observation/assessment data to their Coach.
- The Resident will work with their Coach to generate their Competence Reports.
- It is suggested that they promptly discuss any significant negative feedback or remarkable commendations with the Coach to optimize the Coach's ability to coach and assist effectively.
- Both parties drive the Coach-Resident relationship; residents are expected to participate actively, negotiate communication and acknowledge the needs of both parties, trust where appropriate, and recognize when they need help.

Coaches and Residents should re-evaluate the relationship each year. Residents must always have a coach. If either the Coach or Resident would like a change in the relationship, they should contact the

Academic Coach Program Lead, Dr. Talia Ryan, to establish and facilitate a solution.

Mentorship

Our formal mentorship program is a Mentorship Teams model comprised of residents at each stage of training, a staff anesthesiologist, and a recently graduated junior staff member who was previously in that mentorship team.

In addition to this program, we endeavor at all times to cultivate a mentorship culture in our program, interweaving formal and informal mentorship into OR and out-of-OR activities. During the Transition-To-Discipline stage, incoming residents experience peer cohort mentorship as they socialize, learn, and work in the OR together, staff mentorship by a dedicated group of staff, and daily mentoring conversations with a current PGY-5 resident. Residents participate in mentorship team activities at social events and some academic events, they occasionally work together in the OR, and certainly study together and gather socially.

Resident Wellness and Safety

Our program has a dedicated Wellness Director, Dr. Meredith Hutton. Dr. Hutton sits on the RPC but operates at arm's length to that committee. The wellness director role offers the residents both formal and informal resources for wellness.

Our program hosts multiple programs each year to facilitate resident wellness. These include the PGY1 Welcome BBQ, annual Calgary Anesthesia Resident Retreat (CARR), Winter Wellness dinner and the annual mandatory team building day in March (formerly known as ski day).

Residents are encouraged to involve their partners and families in their resident life, particularly at the annual CARR. The partners of all residents are invited to the annual Awards, Graduation, and Retirement Dinner.

POLICIES

The Department of Anesthesiology, Perioperative and Pain Medicine abides by the Professional Association of Residents of Alberta (PARA) Collective Agreement (https://www.para-ab.ca/agreement/).

Clinical Work Policies
Regulatory Requirements
College of Physicians and Surgeons of Alberta (CPSA)
Each resident must obtain and maintain their standing on the Educational Register. (https://cpsa.ca/physicians/registration/apply-for-postgraduate-training-in-alberta/)
Licentiate of the Medical Council of Canada (LMCC) (http://mcc.ca/)
Each resident must complete the LMCC examinations. Proof of successful completion of this examination must be submitted to the Program Director.
Canadian Medical Protective Association (CMPA) (https://www.cmpa-acpm.ca/)
Each resident is required to have current CMPA membership.
Royal College of Physicians & Surgeons of Canada (RCPSC) (http://www.royalcollege.ca/
Residents are encouraged to utilize the resources available to them through the RCPSC. Residents are strongly encouraged to utilize the Maintenance of Certification Program tools to track their professional development activities (MAINPORT) (https://mainport.royalcollege.ca). Each resident is responsible for their application to the RCPSC for Assessment of Training and the Fellowship Examination.

Resident Room and Task Assignments
Each site assigns residents to operating rooms in a different manner. Residents are responsible for ensuring that they adhere to the proper protocols at each site. Residents are encouraged to optimize their room assignments for their education and professional development.
In the event that an Attending Anesthesiologist would like a resident to leave their current room or task assignment to participate in another endeavor that Attending Anesthesiologist must speak directly with the resident's current supervising Attending Anesthesiologist to discuss and confirm the optimal location or task for the resident's education and professional development.

Clinical Responsibilities

1. Obtain and wear AHS identification when working and/or learning in the hospitals/facilities in the Calgary zone.
2. Residents will not wear scrubs to and from the hospital and will not remove scrubs from the hospital premises.
3. Establish goals and learning objectives before each rotation, and work to meet them. Seek out learning opportunities.
4. Show up at a time each day that facilitates the on-schedule functioning of the clinical environment.
5. Be prepared for the scheduled cases of the day. See inpatients the day before surgery.
6. Outline a full anesthetic plan (pre-, intra- and post-operative) and discuss it with staff whenever time and circumstances allow.
7. Do not induce anesthesia (general anesthesia or major regional anesthesia) unless the Attending Anesthesiologist is present, or you have been given explicit orders to do so (this should occur within the limits of graded responsibility, as outlined elsewhere in this document).
8. Follow-up patients postoperatively, when possible and appropriate.
9. Be involved in emergency cases in the OR.
10. Actively seek interesting cases in other operating rooms, recovery room, etc., in order to maximize the educational experience. For any particularly unusual cases, senior residents may

move to another site for the day to participate in the case, provided all involved parties are made aware.
11. Perform consults on wards and discuss them with staff members
12. Leave each day only after responsibilities to patients and preceptors are fulfilled.
13. Adhere to call limitations (PGME & PARA on call guidelines), which also take into account Physician Extender activities.
14. Residents are required to inform their Attending about their EPA progress for any procedural/technical skill prior to performing the procedure. Faculty members may use their discretion in deciding whether or not the resident can perform the procedural skill independently.

Absence from Clinical Work

Residents with illness or family emergencies requiring an urgent absence from work must notify the following individuals:

- the Program Director – via e-mail;
- the Site/Rotation Coordinator – via e-mail;
- the Attending Anesthesiologist for the day – call the OR or the preceptor directly and email preceptor;
- the Lead Residents – via e-mail; and
- the Program Administrator – via email. A voicemail can also be left at 403-944-1991 but this voicemail is not monitored on a daily basis.

A doctor's note must be provided to the PD regarding absence due to illness greater than 5 consecutive days.

Call Requirements

Night and weekend call are important learning environments in anesthesia because of the challenges that non-elective procedures present. Comfort and an appropriate pace in this setting come only with experience. We also recognize the importance of encouraging a balance of elective, scheduled, routine, uncomplicated cases along with the complex, high-intensity emergency work.

Swapping of call shifts is acceptable as long as your call continues to adhere to PARA rules and that the exchange does not result in additional pre-call/post-call time away from a subspecialty anesthesia rotation. Swaps must be coordinated by the residents involved, and then submitted to the PD and site Lead Resident.

The Lead Residents will endeavor to release finalized call schedules **6 weeks** prior to the beginning of each block.

Accommodation for Mandatory Educational Events

1. Residents may attend Core Program and other mandatory educational activities after a night on call at their discretion. However, to optimize learning experiences and resident wellness, it is strongly advised to organize your schedule such that occurrence of these mandatory educational events on post call days is minimized. To facilitate reasonable learning and on call scheduling, schedules for mandatory events such as ACRM are published months in advance.
2. Residents on call during Journal Club presentations are to be excused from duties for a reasonable period to attend these educational activities.
3. Residents must attend all mandatory educational activities pre-call.
4. Residents are not to leave mandatory educational activities early to fulfill call duties (e.g. although call shifts at many sites begin at 1600h, Core Program is scheduled to end at 1630h and thus residents are expected to start call after the conclusion of Core Program).
5. Residents are to be on call on no more than one Wednesday night per block; this will optimize resident participation in Core Program
6. Residents who are members of the RPC are excused from their call duties in order to attend RPC meetings.
7. Vacation may be taken during some mandatory events, however, with the exception of AHD;

prior approval is required from the Program Director. The mandatory schedule is published months to a year in advance in order to allow advance planning.

Call Cross-Coverage

1. All call requirements while on rotations at SHC are to be done at FMC.
2. One to two weekends of call at FMC may need to be done while on the Chronic Pain rotation.
3. One to two call shifts at FMC may need to be done while on research electives.
4. One to two call shifts at FMC may need to be done while on the perioperative medicine rotation. Attempts will be made to avoid weekday call.

Call and Pregnancy

1. Please refer to the current PARA agreement: "*Unless a pregnant Resident Physician otherwise chooses, they will not be required to perform on-call duties in excess of twelve (12) hours or between 2400 and 0600 hours, nor be scheduled for standard or shift based duty hours in excess of twelve (12) hours or between 2400 and 0600 once they have* ***completed twenty-four (24) weeks of gestation****, or earlier if a valid medical reason is provided. AHS may require a medical certificate confirming any medical restrictions related to the provision of services by the Resident Physician during pregnancy*"

Visiting Anesthesia Residents

PGY-2 or higher visiting anesthesia residents will be expected to take call shifts after spending one week at a site. These call shifts will be assigned in a manner similar to U of C anesthesia residents, and expectations and policies for call are the same as for U of C anesthesiology residents.

PGY-1 Anesthesia Rotations

Prior to the completion of the OB Anesthesia rotation, PGY-1 residents at RGH or PLC will fulfill their anesthesia rotation call requirements (full call at 1:4) by working an elective day, followed by working in the main OR. If the emergency cases are completed after 2200h, then the resident will be granted a post-call day off; if not, they are expected to work the next morning. At FMC they will do buddy call with the usual scheduling of a pre- and post- call day.
After a PGY-1 resident has completed the OB Anesthesia rotation, they will assume call duties like every other anesthesia resident (i.e. pre-call day off, work in main OR and L&D at night, post-call day off).

Pre-Exam Call for Residents in RCPSC Anesthesiology Examination Year

Residents will be excused from weekend call for the four weeks prior to both the written and oral RCPSC anesthesiology exams. For the two-week period prior to both the written and oral RCPSC exams, they will be excused from call completely. There will be no call on the weekend immediately following the RC oral examination. Similar allowances may not be made by off-service or non-UofC rotations.

Regional On-Call Application (ROCA)

The Program Administrator will ensure that all resident call shifts are published on ROCA for anesthesia (and sub-specialty) rotations at all sites in the city.

Labour Epidural Policy

1. Residents require direct supervision of labour epidural insertion until the resident has achieved **30 successful** labour epidural EPA assessments.

All residents must send their Attending a text page notifying the Attending that they are about to insert a labour epidural; the resident and Attending may agree that the resident need not wait for a response from the Attending prior to performing the procedure.Electives

Residents must be in good standing and must apply to the PD for approval of electives; this should be done at least **three months** in advance. A broad variety of elective opportunities are available, and residents are encouraged to broaden their knowledge, pursue special interests, consolidate career plans, and improve on weaknesses through electives. The PD may change an elective block to Adult Anesthesia if an elective has not been arranged according to policy. In addition, the PD may designate

remedial work during elective blocks as needed

For ***Scholarly Project electives***, residents can expect to do 1-2 call shifts at FMC during the block. The timing of these shifts can be negotiated if the shifts conflict with scholarly project needs.

For ***non-anesthesia electives***, *or* ***electives conducted at sites not affiliated with the U of C***, the resident must submit a written proposal to the PD outlining the dates, site, objectives, structure of the elective, and the preceptor responsible for overseeing the residents and completing the ITER. This also applies to Scholarly Project electives. Residents are responsible for ensuring evaluations are completed and sent to the PD.

For ***non-U of C electives***, the resident must also obtain licensure, insurance, housing, and visas as necessary.

For ***out-of-province electives***, a description of call commitment during the elective must be secured before undertaking the elective, and the planned call should be consistent with the PARA agreement. This will increase the chances of the resident receiving call stipend payments for call shifts done during the elective.

For ***out-of-province and out-of-country electives***, residents must notify our program administrator about the elective as soon as possible so that AHS can apply for WCB coverage for the resident. Please ensure that you include the city and hospital name of where the elective will be completed. For *out-of-country electives*, please also indicate whether you are doing courses, observership, actual clinical work, or a combination of these. Residents are also responsible for confirming with CMPA whether they are still covered by CMPA.

Alberta Health and the University of Calgary are no longer involved in the support of residents for short-term electives in the United States. If a resident wishes to do an elective in the United States, they should contact the institution hosting the elective to determine if a J1 visa is required, and then contact US immigration with the resulting information. CMPA no longer provides coverage for residents undertaking US electives, so third-party insurance must be secured. The U of C also requires residents working out of country to do the following:

1. Register your travel
    a. Register with the University of Calgary Travel Registration system at https://iac01.ucalgary.ca/RiskMgmt/. This allows us to contact you if we become aware of an emergency in the country/area to which you are travelling. It also allows us to assist you if you phone the University in an emergency situation.
    b. Register with the Government of Canada at https://travel.gc.ca/travelling/registration. This allows the consulate to contact you in an emergency situation.
2. Download the Emergency App on your Smartphone and make note of the emergency phone numbers
    a. Download the SOS International Emergency App for mobile phones. Visit http://app.internationalsos.com/ on your smartphone. Download the application. Enter the university's membership number **27AYCA093142.** This will give you 24 hour access to telephone advice from a physician and referrals to more than 79,000 global, vetted providers for medical and security situations. It also gives you travel information and alerts for each country.
    b. International SOS - **Phone:** 1-215-354-5000 (call collect)

   c. **University of Calgary – Emergency Security Dispatch – 24 hrs/365days**
      i. **Phone:** 1-403-220-5333 (call collect)
      ii. **Email:** assist@ucalgary.ca
3. Obtain UCalgary Emergency Assistance Card
   a. Print off the UofC Emergency Assistance Card at https://www.ucalgary.ca/risk/risk-management-insurance/travel/before-you-go which has a collection of important websites, phone numbers and instructions in the event of an emergency abroad. This card can be easily printed and carried in your wallet. You can also email us at riskmgmt@ucalgary.ca to obtain cards.
4. Note information for Government of Canada Assistance
   a. Canadian Consular Emergency Assistance (Ottawa) - +1 613 996 8885 (call collect where available)
   b. The list of Canadian Government Offices Abroad can be accessed at http://travel.gc.ca/assistance/embassies-consulates
5. Other Items and Resources:
   a. Review your travel emergency health and repatriation coverage.
   b. Check out international travel information, University International Travel policies and other resources at https://www.ucalgary.ca/risk/risk-management-insurance/travel
   c. Please also review the PGME policies on international electives at: https://cumming.ucalgary.ca/pgme/current-trainees/residents/during-residency-training/international-travel

Clinical Work Policies for Off-Service Rotations

The following guidelines have been developed for residents working in all patient care delivery areas. Anesthesia residents should take particular note of the following responsibilities when on ward or clinic-based off-service rotations.

It is the responsibility of every Resident to:

- inform every patient (and/or family) that he/she is being cared for on a teaching unit and that patient care is managed by a team approach under the supervision of the Attending Physician;
- notify (i.e. verbally inform and document in the chart) the Attending or Consulting Physician when:
  - an emergency patient is admitted to hospital;
  - a patient's condition is deteriorating;
  - the diagnosis or management is in doubt;
  - a procedure is planned;
  - there is a question as to the responsible service or physician;
  - an out-patient has been examined or treated; and
  - a discharge is required for a patient from the Emergency Department, hospital inpatient service, or ambulatory care setting (unless previously approved by the responsible physician).

It is the responsibility of the Attending Physician to:

- inform the patient that residents may be involved with the patient's care;
- review the chart with the resident within 24 hours of a patient's admission and routinely thereafter, including:
  - a discussion of findings and their significance to patient management;
  - decisions relating to management and disposition;
  - procedures, including direct supervision when required for patient safety or when requested by the trainee;
  - educational aspects of the case;
- be available by pager or telephone at all times.

The Attending Physician has a dual professional responsibility: to provide appropriate patient care, and to provide education for trainees. There must be careful assessment of the responsibility delegated to

the trainee. **Anesthesia residents should not embark upon anesthetic procedures supervised by preceptors who would not normally supervise an anesthetic.** For example, a cardiologist may not act as the supervisor to an anesthesia resident administering anesthetic drugs during a cardioversion.
The PGME policies on resident supervision can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Supervision of Residents'.

Electronic Logbook
Residents are strongly encouraged to document their clinical activity in an electronic logbook in accordance with instructions they receive from the residency program. The program currently uses an excel spreadsheet for each resident. This spreadsheet can be found in the Docs & Files section of the Residents basecamp.

Patient Information Security
Residents must make every effort to protect patient information at all times and on any electronic device that they utilize.
If a resident must send patient information via e-mail, they must adhere to the following:

1. do not send information to a non-AHS e-mail address; and
2. put "Private!" in the subject line (the message will then be encrypted).

Guidelines for Faculty Members
Faculty members should be familiar with resident assessment policies listed below.
Faculty members are encouraged to notify residents in advance of any particularly interesting or rare cases; this can be done by sending an e-mail to the Lead Residents, who will forward the request on to all the residents. Preference will be given to the most senior resident available for the case.
The Guidelines to the Practice of Anesthesia, Revised Edition 2024, state:
"Residents in anesthesiology are registered medical practitioners who participate in the provision of anesthesia services both inside and outside the OR as part of their training. The Royal College of Physicians and Surgeons of Canada and provincial and local regulatory authorities require that a responsible attending staff anesthesiologist must supervise all resident activities. The degree of this supervision must consider the condition of each patient, the nature of the anesthetic service, and the experience and capabilities of the resident (increasing professional responsibility). At the discretion of the supervising staff anesthesiologist, residents may provide a range of anesthetic care with minimal supervision. In all cases, the supervising attending anesthesiologist must remain readily available to give advice or assist the resident with urgent or routine patient care. Whether supervision is direct or indirect, close communication between the resident and the responsible supervising staff anesthesiologist is essential for safe patient care. The anesthetic care provided by a resident must also be within the scope of practice of the supervising anesthesiologist. Each anesthesia department teaching anesthesia residents should have policies regarding the activities and supervision of residents." (Can J Anesth 2024;71: https://doi.org/10.1007/s12630-023-02675-0).

The PGME supervision of residents policy can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines

Expectations of Preceptors

1. Expectations for graded responsibility and resident supervision are governed by the supervising staff anesthesiologist's fiduciary responsibility for patient care, the provincial health care insurance plan, Surgical Patient Care Committee policy, and educational goals.
2. Finding the appropriate level of supervision is a dynamic process, often negotiated to different end-points for each preceptor and resident assignment. Determinants are the resident's level of training and performance to date, resident and staff comfort levels, and the complexity of the clinical material. In all cases, the supervising staff anesthesiologist must remain readily available to assist the resident.

3. Although many of the service-oriented activities of residency do enhance learning, preceptors should minimize the delegation of service tasks that are devoid of educational merit.
4. The practice of double-booked rooms (one anesthesiologist supervising two OR's with one resident in each room) is not endorsed at the U of C teaching sites, nor by the CAS. The requirement to do so may arise rarely in dire emergencies, but only as a temporizing measure and the situation must be acceptable to both anesthesia residents affected. The one exception to this relates to PGY-5 residents who have successfully completed their written FRCPC exam, and are in the final Transition to Practice phase of training, where longitudinal independent clinical assignments with appropriate staff availability is considered an important learning opportunity.
5. Legal considerations about delegation of care to residents require that the following questions can be answered in the affirmative:
   a. Is this an act that I am capable of delegating?
   b. Is this an act that I should be delegating?
   c. Is it appropriate to delegate this act to this resident?

Expectations of Residents

The resident who is **PREPARED** to accept responsibility will:

- be acquainted with the medical, anesthetic and surgical considerations of scheduled cases;
- describe an anesthetic plan that addresses these considerations;
- order necessary preoperative testing and interventions;
- discuss the above with the preceptor along with plans for intraoperative complications;
- demonstrate active engagement and responsibility for the patient's anesthetic care; and
- arrive in sufficient time to prepare the anesthetic machine and equipment for the case.

The resident who is **UNPREPARED** to accept responsibility will:

- arrive without any preparatory reading or knowledge of scheduled cases;
- be unable to identify key preoperative investigations or measures;
- proceed without minimizing patient risk;
- have an anesthetic plan which is 'cookbook' oriented, incomplete, inappropriate, or inadequate for the case;
- be unable to identify key intraoperative risks or goals;
- rely on passive learning and demonstrate no ownership for patient care;
- show enthusiasm that is limited to new anesthetic procedures without justification of risk/benefit to the patient; and
- not allow sufficient time for anesthetic equipment preparation.

The following table may be used as a guide for graduated supervisions of residents in our program.

Stage of Training	ASA I	ASA II	ASA III	ASA IV	ASA V/VI	Technique not mastered
Transition to Discipline	**C**	**C**	**C**	**C**	**C**	**C**
Foundations	**C-I**	**C-I**	**C**	**C**	**C**	**C**
Core- 1st half	**E**	**E**	**I**	**C-I**	**C**	**C**
Core- 2nd half	**E**	**E**	**E**	**C-I**	**C**	**C**
Transition to Practice	**E**	**E**	**E**	**E**	**C-I**	**C**

C – continuous supervision
I – supervision may be for induction, emergence, and significant events only
E - supervision may be for evaluation only

Labour Epidural Supervision Policy:
1. Residents require direct supervision of labour epidural insertion until the resident has achieved 30 successful labour epidural EPA assessments.
2. All residents must send their Attending a text page notifying the Attending that they are about to insert a labour epidural; the resident and Attending may agree that the resident need not wait for a response from the Attending prior to performing the procedure.

Off-service Resident Site Assignments
Off-service residents and fellows will be assigned to sites in Calgary as follows:

- ACH – Pediatric, Pediatric Emergency Medicine, Emergency Medicine
- FMC –General Internal Medicine, Plastics Surgery, Cardiac Surgery
- FMC: - Cardiac Anesthesia – Critical Care Medicine, Cardiac Surgery
- PLC – Critical Care Medicine, ENT Surgery, General Surgery
- RGH – Emergency Medicine (both FRCPC and CCFP)
- SHC – Family Medicine

Assessment Policies

PGME policies regarding assessment can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Assessment'.

Daily Observation Forms
Residents are required to submit a daily observation form at the beginning of each work period (e.g. elective day, call shift) **to their preceptor via one45**. **Residents are required to ask their preceptor to complete and review the daily observation form with them at the end of each work period** (e.g. end of elective day, call shift, etc.). The Attending may defer the request; if this occurs, the resident has fulfilled their responsibility to ask for feedback. However, our department strongly encourages its faculty members to discuss feedback with residents. The **goal is 100% One45 submission** for every anesthesia clinical rotation; a one45 evaluation submission for each clinical shift. In order to successfully pass a given anesthesia rotation **75% of clinical shifts must have an associated One45** evaluation submitted. As per PGME rules, 75% attendance is required to pass any rotation.
The daily evaluation system has been invaluable in the early identification and remediation of problems. Identified weaknesses should be promptly addressed by residents so that improvement may be documented over the course of the rotation. This activity, in conjunction with the ability to use 'difficult' days as learning experiences, is essential for progress. Site Coordinators must notify the PD before the end of a block if a resident is not meeting expectations.
In addition to the daily observation form, residents are also required to ask their attending to complete an EPA (Entrustable Professional Activity) assessment for each work period. Residents should make arrangements with their Attending about this before the work period begins. Again, the Attending may defer the request; if this occurs, the resident has fulfilled their responsibility to ask for feedback.

EPA Assessment
Residents must notify Attending Anesthesiologists ahead of time, as much as possible, if they would like to have an EPA assessed. If a TTD, Foundations, or Core stage resident would like a non-Attending physician to assess an EPA, the minimum rank for that resident must be PGY-4 or above. A maximum of 10% of anesthesia EPA observations may be completed by senior residents/fellows that are in good standing for an anesthesia rotation. The only exception to this would be on Internal Medicine and Pediatric Wards, where a PGY-3 resident may do an EPA assessment. A maximum of 40% of off-service EPA observations may be completed by senior residents/fellows that are in good-standing.

Rotation ITERs
Site Coordinators and Rotation Coordinators collate the daily observations to complete the ITER. Rotations over one month's duration require a mid-term evaluation. Coordinators have until 2 weeks after the end of a rotation to review ITER's with residents.

Evaluations for Off-Service Rotations
If the department of an off-service rotation has its own evaluation policy and procedure in place, then evaluations for anesthesia residents will be conducted in accordance with that department's policies and procedures. For off-service rotations with departments that do not have a formal evaluation policy and procedure in place, residents are required to ensure that evaluations are completed by all the faculty members that they work with. For example, a resident working with four different preceptors over the course of a 4- week rotation is required to submit an evaluation to each preceptor that they work with.

Appeals
Evaluation results may be appealed according to Appeal Procedures. All residents should be aware of the PGME policies on resident appeals. This can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Appeals'.

Remediation and Probation
After a borderline or unsatisfactory rotation ITER, the resident will be placed on remediation. If a resident receives a borderline or unsatisfactory rotation on two rotations within a twelve-month period, they may be placed on probation according to PGME policies. See the PGME website for more information on Remediation and Probation https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Remediation, Probation & Dismissal'.

Formative Feedback
All residents are given formal practice oral examinations annually. Verbal feedback is provided. Formative evaluations are also available for residents from their simulation experiences and OSCE preparation. These will be stored on one45.

Promotion
Promotion from stage to stage in CBD is granted by the Competence Committee.

Graduation from Residency Program
Graduation from the residency program requires fulfillment of all the program requirements as outlined in this program manual.

Non-Clinical Work and Academic Policies
Non-Clinical Learning Responsibilities and Code of Conduct

1. Adhere to a learning plan that enables you to cover the necessary knowledge as outlined in the National Anesthesia Curriculum.
2. Attend all educational sessions, including informal morning rounds.
3. Present at least two Core Program sessions each year.
4. Present at grand rounds in accordance with program policies.
5. Present at Journal Club when requested.
6. Attend simulator training when the opportunities arise.
7. Participate in program evaluation by completing questionnaires in a timely and professional manner, and by taking issues to the resident representatives on the RPC.
1. Pay all University of Calgary tuition fees on time

(https://www.ucalgary.ca/registrar/finances/tuition-and-fees) in order to be promoted at the end of each academic year.

8. Use Basecamp and your AHS e-mail address, check it regularly, and respond promptly when requested.
9. All residents should be aware of the PGME policies on code of conduct expected of residents. This can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Code of Conduct'. In particular, residents should review the "CPSA Advice to the profession" on social media.

Absence from Mandatory Educational Event

Mandatory events are listed on the Annual Mandatory Events schedule. If a resident is unable to attend a mandatory educational event, the resident is required to notify the following individuals via e-mail:

- the Program Director;
- the faculty member planning or coordinating the educational event;
- the Lead Residents; and
- the Program Administrator(s).

Unexplained absences from mandatory events will be reviewed by the Competency Committee. Professionalism concerns may arise in the event of three or more unexplained absences in an academic year. Attendance at Journal Club is mandatory for residents, and every effort should be made to be excused from call when on off-service rotations. Residents on call for anesthesia rotations are excused for the academic portion of the evening but must return to the hospital for the remainder of the call period.

Absence from University of Calgary Postgraduate Medical Education (PGME) Education Event

U of C residents have the opportunity to attend PGME-sponsored education events; some of these are mandatory, while others are not. All of these require an RSVP with PGME. If a resident signs up to attend a PGME Education Event, the program's aforementioned 'Absence from Mandatory Educational Event' policy should be adhered to. If a resident is absent from the PGME Education Event and did not follow the 'Absence from Mandatory Educational Event' policy, they will be charged a vacation day and may be cited for a lack of professionalism.

Grand Rounds Presentation Requirements

Residents are required to present a grand rounds presentation at least once per academic year; they are encouraged to present more if they so desire. The schedule of presentations is as follows:

- PGY-1 – present at SHC (during Adult Anesthesia rotation);
- PGY-2 – present at RGH
- PGY-3 – present at PLC (during either Perioperative Ultrasound or Vascular Anesthesia rotation);
- PGY-4 – present at ACH;
- PGY-5 – present at FMC

Non-Clinical Activity During Working Hours

All non-clinical activity conducted during working hours (e.g. teaching, courses, conferences) requires the approval of the Program Director and Site/Rotation Coordinators.

Exams and Written Assignments

Residents must also write the AKT-0, AKT-1, AKT-6, and AKT-24 exams at the assigned times; if they cannot write the exam on the assigned date, they must make alternative arrangements with the Program Director. The timing for these examinations are as follows:

- AKT-0 – orientation week;
- AKT-1 – week 4 of Transition to Discipline;
- AKT-6 – July of PGY-2; and
- AKT-24 – July of PGY-4.

All residents must complete exams and written assignments that are part of Core Program. If a resident is absent on the day the exam/assignment is administered, they must make arrangements with the Unit Manager to have these completed.

Study Days for Examination Preparation

RCPSC study days are not governed by any resident contract but are granted by the RPC. Residents may not exclude study days from vacation requests (i.e. may not designate the week off as "four days of holiday plus one study day"). Residents are provided time to attend formal mock oral exams provided by the program (formerly CAREs/Making a Mark) exam preparation weekend(s). The RCPSC Examination Committee regularly reminds residents and educators of the importance of OR exposure in the weeks leading up to the examinations. Protected study time is necessary, but it should not be taken in excess of that noted below, and any further time out of the OR is discouraged.

Protected study time for Royal College exams (updated July 2024)

- *Written RC exam Fall:*
  - *January 1st to April 1st of PGY4: Friday afternoon ½ independent study day with mandatory in-person attendance at Friday morning rounds*
  - *April 1st to September exam date PGY4/5 year: Friday full independent study days with mandatory virtual attendance at Friday morning rounds. Program granted study days can be taken pre-call one occurrence per block.*
  - *Note, if the resident PGY4/5 study cohort deems that Thursday AHD is also a critical educational event, they may request to attend both Thursday AHD and Friday independent study day and this is at the discretion of PD/APD/rotation lead.*
  - *PARA contracted 5 nonconsecutive full study days that can be taken within 8 weeks of September RC written exam; full days (not to be divided into ½ days); as per PARA, consecutive days may be requested and are at discretion of PD/APD/rotation lead. PARA granted study days are to be taken on days that are not pre- or post call.*
  - *Study days are mandatory educational days and as such, do not count towards days away from the rotation*
- *Oral RC Exam Spring:*
  - *After written September exam through December of PGY5 year, mandatory attendance at Thursday AHD in leadership educator role (lead senior resident 1300-1330 case based challenging cases discussions and be available to provide case based relevance to each didactic lecture) and mandatory in person attendance at Friday morning rounds.*
  - *January 1st until week of April/May PGY5 spring exam: Friday afternoon ½ independent study day with mandatory in-person attendance at Friday morning rounds. Program granted study days can be taken pre-call one occurrence per block.*
    - *Note, if the resident PGY5 study cohort deems that Thursday AHD is also a critical educational event, they may request to attend both Thursday AHD and Friday independent study day and this is at the discretion of PD/APD/rotation lead.*
  - *PARA contracted 5 nonconsecutive full study days within 8 weeks of spring oral exam full days off (not to be divided into ½ days); as per PARA, consecutive days may be requested and are at discretion of PD/APD/rotation lead; do not count towards days away from rotation. PARA granted study days are to be taken on days that are not pre- or post call.*
  - *RC oral exams return to in person as of Spring 2025; as per PARA contract, PGY5 residents will have 5 full days off Monday through Friday for the week of their oral exam in Toronto; this 5 days allows for travel and exams. Residents will not be scheduled for call duties on the weekend following their oral examinations.*
    - *Study days and exam days (5 days including travel) are mandatory educational days and as such, do not count towards days away from the rotation*
    - *After oral exam through June 30 PGY5 year: Mandatory attendance at Thursday AHD in leadership educator role (lead senior resident 1300-1330 case based challenging cases discussions and be available to provide case based relevance to each didactic lecture) and mandatory in person attendance at Friday morning rounds.*

Resident Committee Membership
Residents who are members of department committees (e.g. RPC, Anesthesia Academic Council, etc.) are required to attend all meetings scheduled by the respective committees; every effort should be made to be excused from call in order to attend these meetings. Residents who are unable to attend a meeting must notify the Committee Chairperson and the Program Director at a reasonable time via e-mail.

Calgary Anesthesiology Residents' Retreat (CARR) Costs for Cancellations
Residents may be asked to cover costs associated with last-minute cancellations in the event that their significant others/family members are unable to attend at the last minute.

ACLS, ATLS. PALS, and NRP Course Requirements and Reimbursement
These courses are reimbursed by AHS for anesthesiology residents. Residents are responsible for maintaining certification in these courses and must submit a copy of the provider card and the original proof of payment to the Program Administrator for reimbursement. The following certifications must be current for various off-service rotations:

- ACLS – Coronary Intensive Care Unit (CICU), ICU, and CVICU
- PALS – PICU

It is strongly recommended, that residents be certified in ATLS prior to their Trauma Rotation in PGY-1. Residents should complete NRP in PGY-4.
Courses are offered either through AHS or other organizations. Please ensure that you make arrangements for these courses well in advance of the proposed rotations they fill quickly.

Conference and Course Funding Policy
Residents presenting at a major conference are eligible to receive funding from the PGME office. This funding must be applied for in advance; information on this can be found at: https://cumming.ucalgary.ca/pgme/faculty-and-staff/awards-and-grants/grants/resident-research-travel-grants.
All residents are encouraged to participate in the annual CAS meeting by submitting abstracts and applying to the Residents' Research Competition. When the CAS is hosted in Calgary, residents are strongly encouraged to attend.
Residents interested in attending courses or conferences for leadership development may apply for a PGME Resident Leadership Travel Grant https://cumming.ucalgary.ca/pgme/faculty-and-staff/awards-and-grants/grants/resident-research-travel-grants.

The RPC occasionally has funds available to support resident conference or course attendance that cannot be funded by other means (e.g. PGME travel grants). In these situations, requests for funding will only be considered once the resident has either received permission by the RPC to attend a conference, or the resident is using their vacation/flex time to attend the conference or course. The goal of funding these types of requests is to provide an opportunity for education that is unique and not available locally and is appropriate for the level of training of the applicant.
When a resident applies for funding from the RPC, their application must list what funding the resident has already received from the RPC during their training, as well as any other funding they have already received for that conference/course. The Program Administrator will maintain records of funding for individual trainees.
There are no guarantees that the RPC will have available money, but funding for conference or course attendance will be stratified as follows:

1. Group 1 – Very High priority for funding:
    a. Courses or meetings that the RPC mandates that a resident should attend.
    b. Major meetings which the resident is presenting a paper or poster where alternative university funding is not available.
2. Group 2 – High priority for funding:
    a. Annual meetings of major anesthesiology associations (e.g. CAS, ASA, World Congress of

Anesthesiology, other meetings as approved by the RTC, ASRA, SOAP, etc).
   b. Anesthesiology review courses targeted at trainees in anesthesiology.
3. Group 3 – Moderate priority for funding:
   a. Annual meetings of smaller anesthesiology organizations, such as provincial or state organizations.
      i. Physician Leadership Institute (CMA) meetings.
4. Group 4 – Low priority for funding:
   a. Review courses targeted at practicing anesthesiologists (i.e. those no longer in training) (e.g. California Society of Anesthesiologists review course in Hawaii, etc).
   b. Courses that can be done remotely or by correspondence (e.g. Physician Leadership Institute courses available electronically or offered locally).
   c. Requests for travel funding on courses that are offered locally.

Guidelines for Interactions with the Pharmaceutical Industry
Residents should not enter into arrangements with industry representatives without the knowledge of the PD.
The Department of Anesthesiology, Perioperative and Pain Medicine has a supportive and mutually respectful relationship with pharmaceutical industry representatives. The U of C and AHS have policies and guidelines around interactions with industry representatives. The U of C endorses the CMA guidelines (https://policybase.cma.ca/link/policy14454). Direction may also be found in the AHS policy on Conflict of Interest (Conflict of Interest Bylaw (albertahealthservices.ca)).
The Code of Marketing published by Canada's Research-Based Pharmaceutical Companies is another useful reference (Code of Marketing Conduct (canadiangenerics.ca)).

Transfer Policies
Anesthesia residents wishing to transfer to (or from) another program should review the policies at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Transfer'.

Vacation and Leave

Vacation
The PGME vacation policy can be found at: https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under the tab 'Vacation'.

General Vacation Information
The residency program adheres to the vacation allotments as outlined in the PARA contract. Residents are only guaranteed time off for either the weekend immediately prior to, or following, 5 consecutive weekdays of vacation. No more than one week of vacation in each four-week rotation should be taken except in unusual circumstances; residents may submit special requests to the appropriate Rotation Coordinator for consideration. The Rotation Coordinators, Lead Residents, and PD have the final authority for granting vacation.

Resident Physicians will receive six (6) consecutive days off duty with pay between December 20 and January 5 in lieu of Christmas Day, Boxing Day, and New Year's Day... Where possible, Resident Physicians shall not be scheduled for on-call service the day preceding the six (6) consecutive days off. Time off in excess of six (6) consecutive days may be granted at the discretion of the Program Director.

Vacation Requests
In keeping with the PARA policy, vacation requests should be submitted at least 8 weeks in advance when possible; exceptions may be requested by residents to the Rotation Coordinator and PD. Approval/disapproval notification will be provided as soon as possible via One45. Vacation requests

during anesthesia rotations will be reviewed within 5 business days; if a Rotation Coordinator has not approved a vacation with that time, the request will automatically be approved.
In accordance with PGME policies, **residents may only request up to 7 days off (5 weekdays and 1 weekend) during a 28-day block, and 8 days off for those blocks longer than 28 days**.
Vacation requests longer than 7-8 days (e.g. during a 2-month rotation) need to be approved by the PD (not a designate).

All requests should be submitted through One45. Requests that do not contain sufficient information (e.g. "conference" without specifying which conference) will be denied.
Off-service requests will be forwarded to, and undergo the approval process of, the rotations coordinators from those services.
For anesthesia rotations, the approval process consists of review by the PD, the Rotation Coordinator, and the site Lead Resident.

Carrying Forward Vacation
Vacation is important to maintain physical, mental, and emotional well-being; it should be used in the year during which it is earned. Under exceptional circumstances, residents may request a portion of vacation to be carried over into the next academic year; such requests must be approved in writing by the PD and Associate Dean PGME during the year in which the vacation is earned. Vacation can only be carried forward for one year. In the final year of residency, all vacation (earned and carried over, if any) should be taken. The PARA contract allows residents to be paid in lieu of unused vacation time at the end of their residency training. However, this should occur in exceptional circumstances only and will require consultation between the PD and the Associate Dean, as well as approval by the PGME Committee and AHS.

Day in Lieu
Days-in-lieu should be taken during the same rotation in which the holiday occurred. These should be arranged by notifying the PD, Rotation Coordinator, the site Lead Resident, and the Program Administrator prior to release of the final call schedule. The date selected should not interfere with call duties and efforts should be made to avoid scheduling them on academic half-day.

Exam Leave
The residency program adheres to the PARA contract agreement with regard to exam leave policies.
Residents may take exam leave for the LMCC II Examination, RCPSC Anesthesiology Written Examination, and RCPSC Anesthesiology Oral Examination.
All requests for exam leave must be submitted to the PD through one45 at least 28 days in advance of the event.
Residents may be granted unpaid leave up to 10 days total over the course of residency training to take all components of the USMLE (in accordance with PARA contract).
Applications for exam leave must be made in writing to the PD a minimum of 28 days in advance of the exam date. Applications shall indicate the date of departure on leave and the date of return.
Confirmation of the leave shall be made by the PD within 14 days of the initial request.

Scholarly Project Days
In addition to elective blocks for Scholarly Project work, residents may take up to 10 half-days or 5-full days (or any combination for a maximum of 10 half days) while on anesthesia (preferably not sub-specialty) rotations during their residency to complete scholarly project work. **Research days may be requested Monday through Thursday and are available PGY2 through 1st half of PGY4**. Requests for this time away from clinical duties must be approved by the Project Supervisor, Rotation Coordinator, Scholarly Project Coordinator, and Program Director through the usual mechanisms needed for residents to be excused from clinical work. Lead residents must also be informed of your request for scholarly project protected time.

Conference Leave

The residency program adheres to the PARA contract regarding leave with pay to attend educational events such as medical conferences.

To be granted leave from clinical duties to attend or present at a conference, the resident will:

1. be in satisfactory academic and clinical standing;
    a. unless a resident is on a remediation or probation program or they have been informed by the competency committee that they are not in good standing, they are considered to be residents in good standing;
    b. for residents not in good standing, decisions for conference leave will be made on a case-by-case basis;
2. follow the procedures listed below to apply for conference time;
3. take a maximum of 5 conference days per year (these are business days plus a maximum of one weekend);
    a. this will be prorated if the resident is away for clinical duties for a period of time;
    b. **if a resident is presenting at a conference, this time will not be deducted from their allowed annual allotment of conference days;**
    c. Lead Residents will be granted additional conference days to attend ICRE;
    d. unused conference days cannot be carried forward to the next academic year;
    e. educational leave days (e.g. for courses such as ATLS) will not be deducted from conference leave time.

The procedure for applying for conference time is as follows:

1. The resident will e-mail the PD with the dates, title and location of the conference they wish to attend (along with objectives and rationale for attending the conference if it is not on the list of pre-approved conferences) at least 28 days prior to the event.
    a. If the above criteria is met and conference is "pre-approved" (see list below), the PD can approve the application.
    b. If the above criteria is not met or the conference is not "pre-approved", the RPC will discuss the application and a decision will be made.
2. Once the PD gives approval, the resident will apply for clinical time off viaone45 (thus notifying the Rotation Coordinator).
3. After steps #1 and #2 are completed, the resident should then register for the conference and make necessary travel arrangements.

The following conferences are "pre-approved" conferences (that is, the PD or RPC can approve attendance at these conferences without a formal RPC vote on the matter):

- CAS Annual Meeting;
- Alberta Anesthesia Section Meeting;
- ICRE (International Conference on Resident Education);
- Canadian Pediatric Anesthesia Society;
- ASA Annual Meeting;
- Any ASA-affiliated sub-specialty meeting (e.g. ASRA, SPA, SCA, SEA, SNACC, STA, SAMBA, SOAP, etc); and
- World Congress of Anesthesiology.

If a resident wishes to attend a conference not listed above, the PD will discuss the application with the RPC and a decision will be made as soon as possible. Residents may be asked to provide objectives and a rationale for attending the conference.

Leaves of Absence (LOA)

The PGME LOA policy can be found at: https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under the tab 'Leaves of Absence'.
Leave will be granted by the PD in accordance with the PARA contract, and PGME/AHS/RCPSC policies.
The PGME Associate Dean shall be notified by the PD of any resident taking a LOA.
Confirmation of approval or denial of leave of absence requests will be made by the PD within 14 days

of receipt of the initial request.
Applications for leave should include the planned date of departure on leave and the date of return. Residents may not work for gain as a Resident Physician during an approved paid LOA except with the advance express consent of AHS.

Special Leave
Residents will be granted up to a maximum of 5 days in each appointment year for special leave. Special leave includes reasonable circumstances where the resident is unable to report to service due to an unanticipated circumstance which requires the Resident's personal attention and which may include illness in the Resident's immediate family. Residents may be required to submit satisfactory proof demonstrating the need for Special Leave. Residents must communicate their need for Special Leave to their clinical supervisor and PD as soon as possible.

General Compassionate Leave
Upon request, a resident may be granted leave of absence for compassionate reasons. For the first 5 days of such a leave, the resident shall suffer no loss in pay or health benefits. In extenuating circumstances, paid compassionate leave may be extended by up to a maximum of 5 additional days subject to prior approval of the Associate Dean. If further time off is required, such additional leave needs to be approved by the Associate Dean PGME and is unpaid.

Bereavement Leave
Upon request, a resident will be granted bereavement leave in the event of a death of a relative. For the first 5 days of such a leave, the resident shall suffer no loss in pay or health benefits. In extenuating circumstances, paid bereavement leave may be extended by up to a maximum of 5 additional days subject to prior approval of the Associate Dean. If further time off is required, such additional leave needs to be approved by the Associate Dean PGME and is unpaid.

Compassionate/Terminal Care Leave
Unpaid leave up to 27 weeks for a qualified relative with a serious medical condition with a significant risk of death within twenty-six (26) weeks from the commencement of the leave.

Sick Leave
Residents will be provided pay and health benefits for illness or non-occupational injury for a total up to 90 days for each Appointment Year. In the event educational requirements are not met, the resident may be required to make up the period of appointment missed due to the illness or non- occupational injury. Residents may be required to submit a medical certificate in support of any illness or non-occupational injury.

Critical Illness of a Child Leave
A parent of a critically ill or injured child is entitled to up to 36 weeks of unpaid leave to care for their critically ill child.

Disappearance of a Child Leave
A parent of a child who has disappeared where it is probable that the child disappeared as a result of a crime is entitled to an unpaid leave of absence for a period up to 52 weeks.

Death of a Child Leave
A parent of a child who has died where it is probably that the child died as a result of a crime is entitled to an unpaid leave of absence for a period up to 104 weeks.

Domestic Violence Leave
A resident who has been subjected to domestic violence may require time off from work to

address the situation and is entitled to an unpaid leave of absence for a period up to 10 days in a calendar year.

Citizenship Ceremony Leave
Residents are entitled to a half-day to attend a citizenship ceremony to receive a certificate of citizenship.

Unpaid General Leave
A LOA without pay may be granted to a resident upon request to the PD and approval by the Associate Dean PGME, in consultation with AHS.

Maternity Leave
Please refer to the PARA contract for details. Note that a pregnant resident whose pregnancy ends other than as a result of a live birth within sixteen (16) weeks of the estimated due date is entitled to maternity leave.

Parental Leave
Please refer to the PARA contract for details. In addition to the two weeks of paid parental leave, residents can apply for unpaid parental leave up to a period of 61 weeks for birth mothers, and 62 weeks for non-birth parents and adoptive parents.

Return to Work Policy

Purpose

The purpose of this policy is to outline the general principles for supporting the return to work (RTW) of Residents in the Anesthesiology Residency Training Program in the Cumming School of Medicine at the University of Calgary. A successful return to training is ultimately a customized journey, led by the Resident and supported by the residency program, with patient safety the key factor to be addressed by both parties. Given those factors, this document is intended to provide an understanding of the considerations and processes for navigating a return to work from an extended leave of absence (LOA) from residency training. To that end, this document provides a broad overview and references to the key principles in facilitating the development of a positive return of clinical currency and confidence for Anesthesia Residents.

Scope

This policy applies to all Anesthesiology Residents in the Anesthesiology Residency Training Program in the Cumming School of Medicine at the University of Calgary. Please refer to relevant Residency Program, PGME, and other policies relevant for disability leaves, remediation or probation periods.

Definitions

An LOA is an approved interruption of training, which may be granted for a variety of reasons. For the purposes of this policy, an LOA greater than 6 blocks is considered an extended LOA.

Policy Statement - Preamble

Examples of extended leaves include, but are not limited to: parental, long-term educational, special leave, compassionate, bereavement, extended sick leave and general unpaid leave.
Before returning from an extended LOA, the Program Director (PD), in discussion with the returning Resident and her/his Coach (Academic or Longitudinal), should determine:

- the appropriate residency level to which the Resident might return following the leave: and
  Note 1: Depending upon the length of leave, the appropriate level would normally be the same level as at the time of leave.
  Note 2: Any leave of more than 1 year's duration may require that the Resident be reassessed for training level at re-entry at the discretion of the PD and RPC. Any extended leave of greater than 2 years must be reviewed jointly by the PD, the RPC, the Associate Dean, and the Alberta Health Services Medical Education Office (MEO) to assess ongoing availability of training and/or

termination of the residency position. (AHS Resident Leave of Absence Process)
- any modifications and/or extensions to the Training Program to ensure that residency requirements are met.

Policy Statement

For LOA periods of 6-12 months, Residents may choose to participate in 1 block of a non- assessed Adult Anesthesia "Return to Work (RTW)" rotation (at the site of her/his Academic/Longitudinal Coach).
During this time, the Resident is paid, but is free to schedule work as s/he and her/his Academic/Longitudinal Coach deem suitable; s/he is not required to do call. The exact details of this block would be organized by the Resident and her/his Academic Coach. While the Academic/Longitudinal Coach would be the primary preceptor for this block, they would be able to delegate supervision of the Resident to colleagues as they see fit.
For LOA periods of greater than 12 months, Residents must participate in at least 1 block of a non-assessed Adult Anesthesia "Return to Work (RTW)" rotation (the details of which are described above). The Resident would also be able to submit a request to the RPC for a second RTW block if s/he felt that s/he would benefit from it. The RPC may, in collaboration with the Resident and her/his Academic/Longitudinal Coach, also prescribe a second RTW block if the RPC feels it is in the Resident's best interests.
The Resident and Coach, in consultation with the PD, will develop the RTW plan and should specifically address areas of professionalism, physician well-being, and clinical competence. A concurrent Learning Support Plan is encouraged (https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines).

The rotation structure will be flexible to adequately support the Resident's individual return to work needs, while recognizing risks to patient care that may arise from large changes to typical schedules or routines, such as from increased patient handover or barriers to focused vigilance. The RTW Plan must be submitted to the RPC and must consider whether it is most appropriate for the Resident to return to training at the proposed time, what her/his potential barriers to residency training success will be, and the types and intensity of support needed.

It may be determined during the RTW rotation that adjustment of the appropriate training level and modifications to program structure are needed; such changes would then be brought to the RPC for implementation. Possible outcomes of an RTW rotation include unconditional resumption of the program, extension of the RTW rotation, or resumption of training with a modified structure/training level. Other outcomes are also possible, such as, an ongoing Learning Support Plan, remediation, probation, another period of leave, switching specialties, leaving specialty training, etc.
Responsibilities
Residency Training Program:
- To support Residents in their RTW

Academic or Longitudinal Coach:
- To work closely with her/his Resident to identify RTW needs (educational and non- educational) and support a structured plan for meeting such needs and addressing patient safety concerns, so as to enable a successful RTW for both the Resident and the Residency Program;
- This RTW Plan must specifically consider how to maintain and develop Resident engagement in the areas of professionalism, physician well-being, and clinical competence;
- To consider all resources available from the Residency Program, PGME, AHS, or elsewhere that may promote success;
- To consider possible consequences of the RTW Plan from a perspective of patient safety
- To identify local faculty who may serve as preceptors of the Resident during the RTW rotation, with expectations clearly outlined;
- To review with the Resident her/his self-reflection of learning from cases during the RTW rotation, along with her/his weekly self-reflection submissions considering all aspects of the

RTW rotation

Resident:

- To communicate the proposed RTW date to the Coach and Program Director;
- To modify this date as necessary after thorough discussion of her/his needs and potential barriers to success;
- To meet with the Coach to plan the RTW rotation;
- To identify the RTW educational and non-educational needs to be met during the RTW rotation and develop a plan for meeting such needs at least four weeks before, to allow for implementation planning;
- This RTW Plan must specifically consider reintegration in the areas of professionalism, physician well-being, and clinical competence;
- To consider possible consequences of the RTW Plan from a perspective of patient safety;
- To seek assistance early when adjustments are needed during the RTW rotation;
- To use the self-reflection form to review cases done during the RTW rotation. At a minimum, one comprehensive self-reflection submission that addresses all identified needs and potential barriers is required each week;
- To request a second RTW Rotation as necessary to optimize her/his successful return to work.

An RTW rotation is deemed successful if:

1. The Coach confirms that at least weekly contact has been maintained during the RTW rotation;
2. The Coach confirms that at least weekly self-reflection submissions were reviewed;
3. The Resident submits an end-of-RTW-rotation statement demonstrating why they feel the rotation was successful. Additional requests and learning supports may continue to occur in conjunction

with a successful rotation;

4. The Coach has not submitted any concerns about the Resident's insight into her/his return to work;
5. The RPC is satisfied with the above documentation and has no further concerns about the Resident's readiness to return to work.

An RTW rotation may be deemed unsuccessful if:

1. The Coach does not feel the Resident is ready, based on inadequate demonstration of reintegration in the areas of professionalism, physician well-being, and/or clinical competence;
2. The RPC does not feel the Resident is ready, based on inadequate demonstration of reintegration in the areas of professionalism, physician well-being, and/or clinical competence;
3. The Resident does not feel ready after two RTW blocks.

Such cases will be reviewed on a case-by-case basis by the PD, RPC and/or the Associate Dean. An ongoing Learning Support Plan may be recommended by the RPC even with a successful RTW rotation.

References

University of Calgary PGME Leave of Absence Policy, https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines

Alberta Health Services Resident Leave of Absence Process, https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines

PARA-AHS-UofA/UofC Agreement, https://www.para-ab.ca/uploads/source/PARA-Final-Agreement-2018-2020.pdf (Article 9.04: Maintenance of Residency Position During Extended Absences)

University of Calgary PGME Guidance Notes for Learning Support, Remediation, and Probation, https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines

Council of Ontario Faculties of Medicine (COFM), Leaves from Ontario Postgraduate Residency Programs, May 2015, https://cou.ca/reports/leaves-from-ontario-postgraduate-residency-programs/

University of Saskatchewan Policy Leave of Absence from Residency Training, https://medicine.usask.ca/policies/leave-of-absence-from-residency-training.php#relatedForms https://medicine.usask.ca/documents/pgme/policy/10.b-Graduated-return-to-residency-plan.docx

University of Saskatchewan PGME Graduated Return to Residency Plan, November 2018, https://medicine.usask.ca/policies/leave-of-absence-from-residency-training.php

Royal College of Physicians and Surgeons of Canada, July 2019, www.royalcollege.ca/rcsite/documents/credential-exams/policy-procedure-certification-fellowship-e.pdf

Return to practice guidance, Northern School of Anaesthesia and Intensive Care Medicine, 2019, https://www.nsaicm.com/research-in-the-region

Royal College of Anaesthetists, Returning to work after a period of absence, 2021, https://www.rcoa.ac.uk/media/20786

Anesthesiology Residency Return to Work Process/Procedure

To establish the procedure for requesting, approving and returning from an extended (>6 months) leave of absence from the Anesthesiology Residency Training Program, as well as notifying the relevant parties.

Prior to Absence

Acknowledgment/approval of an LOA is provided to the Resident by her/his PD as early as possible, with copies sent to the PGME and MEO.

A Resident should meet with her/his Academic or Longitudinal Coach and/or PD before starting her/his LOA, whenever possible, to discuss:

- Duration of the LOA
- Adequate completion of necessary paperwork/notifications of the LOA
- Current stage of training, current progress and competencies achieved
- Anticipated specific educational needs upon return
- Plans for keeping up-to-date during the absence
- Understanding of available resources for return to work (mentors/peer support, seminars, simulation, etc.)

During Absence

A Resident shall:

- Maintain regular contact with her/his Coach and/or PD
- Meet with her/his Coach 4-6 weeks (if possible) prior to the RTW to discuss educational needs, the RTW rotation details, the plan for meeting mid-way through the RTW rotation, use of the self-reflection tool during the RTW rotation. (This is not for assessment but to ensure that the RTW rotation is achieving a supported return to clinical currency and confidence.)
- Contact the Program within 30 days of the approved return date to confirm the date and ensure that all RTW paperwork has been initiated (PARA Article 9.04.a.ii)

It is suggested that the Resident keep up to date as able and maintain informal contact with Resident peers. (There is no expectation of attendance at any Training Program events during the leave.)

If an absence needs to be extended or there is a change to the nature of or circumstances requiring the absence, the Resident shall submit notice to the Residency Training Program immediately and changes are subject to the leave of absence approval process.

Returning from an Absence

If the leave was due to illness, then a medical note providing Declaration of Readiness to Return to Work must be submitted to the Residency Program. This note will be forwarded to the PGME and the MEO.

A formal return date should be determined in advance (preferably >30 days) by the Resident, her/his treating physician (in the case of sick leave), and the Residency Training Program. This is required in order to organize schedules, assessment, and any modifications, including part-time training.

Once the return date has been confirmed, then the Residency Training Program will notify the PGME and the MEO.

A Resident cannot resume training until his/her CPSA licensure, AHS credentialing/privileges and access, and CMPA are reinstated.

Residents should not return from a leave of absence until they are ready. For extended medical leave, a written Medical Certificate or Declaration of Readiness to Return is required as a condition of returning to work. Resident privacy is to be respected and information on the certificate will not disclose the reason for the medical leave.

Residents returning after a prolonged leave of absence may require a modified educational program and may be assigned to a less advanced training level than that prior to the interruption of training.

In exceptional circumstances, the Residency Program Committee may determine that it is not appropriate for the Resident on a leave of absence to return to the program. This decision must be submitted to and must be approved by the Associate Dean, PGME. The Resident will be notified by the Associate Dean, PGME of a program's decision against re-entry to the training program.
Appeals of this decision follow the Postgraduate Medical Education policies/procedures for appeals.
For the RTW rotation, the Resident, in conjunction with her/his Coach, will:

- Identify a limited number of supervising preceptors with responsibilities clearly defined;
- Agree to the specific case types to be done, timelines for her/his self-reflection, and submission and review with appropriate individuals;
- Determine timing of meeting(s);
- Decide when call is to be resumed, if appropriate
- Undertake a signing off process/report to the RPC of the progress/success of the RTW rotation Updates to consider upon RTW:
- Significant leadership/departmental changes
- Checklist of non-clinical and clinical items for re-orientation
- Participation in RTW specific educational activities (workshop, simulation) If needed, sources for additional support should be contacted.

Anesthesiology Residency Return to Work Rotation Plan

The Anesthesia Return to Work (RTW) rotation is intended to provide a supportive environment for Residents to ease them back into the Residency Training Program after a prolonged leave of absence (LOA) while maintaining patient safety. An RTW rotation is suggested for a Resident returning after an LOA of 6- 12 months duration and is required for an LOA of >12 months.
Section 1: Resident Information

Name	
Date leave commenced	
Date of return	
Duration of absence	
Training Year and Stage of Training	
Academic or Longitudinal Coach	

Section 2: General Information about the RTW rotation

Proposed Start Date of RTW rotation	Click here to enter a date.
Site of RTW rotation	
Any specific learning needs	
Any particular concerns over returning to work	
Anticipated progression of work duties and/or hours	

Section 3: Return to work review: Support Provided
Support provided to the Resident can include review of program objectives and expectations, additional supervision and mentorship, modified duties and work schedule, working in a team instead of by oneself, extra teaching and practice of skills (clinical or procedural), and directing the Resident to appropriate resources, etc.
No assessments will be completed during this period. Rather the Resident will discuss her/his self-reflection of completed cases with her/his Academic Coach to ensure that educational needs are met. (See the Anesthesia RTW Self-Reflection Form).

Provide details on the support to be provided to the Resident (e.g. frequency of the meetings with the Coach, duties of the Coach/other preceptors, other resources available to the Resident, etc.).

Supports provided	
Additional comments	
Date of review meeting (1- 2 weeks after RTW)	

Section 4: Outcomes
After the Anesthesia RTW rotation period has passed, the following may occur:
Unconditional resumption of the training program;

1. Extension of the Anesthesia RTW rotation by one block;
2. Resumption of training with a modified structure/training level, as determined by the RPC;
3. Other (see Policy & Procedure documents for details).

Section 5: Signatures and Approvals

Resident			
Signature		Date	

Academic Coach			
Signature		Date	

Program Director			
Signature		Date	

Waiver of Training

The University of Calgary Anesthesiology Residency aims to train excellent anesthesiologists and takes the view that 5-years of blocks are required to achieve this. Residents entering the program should do so with the expectation that residency will be 65 blocks. As a general principle, the RPC does not support waivers of training and will be phasing out waiver of training requests for residents graduating after 2024. In rare circumstances, the RPC will, on a case-by-case basis, consider requests for waiver of training for up to a **maximum of one block.** A waiver of training will only be considered for residents who have required a Leave of Absence during training.

All residents who have taken a LOA are eligible to apply **except** in the following circumstances:

a) Any period of remediation or probation
b) A pattern of documented professionalism concerns
c) Unsuccessful completion of off-service or Anesthesia rotations
d) Failure to complete other mandatory components of training in a timely fashion including, but not limited to, mandatory certifications & courses (PGME/non-PGME), scholarly project activities, EPAs.

Process for application: A written application for a waiver of training must be made to the Program Director in the final year of training prior to completion of oral certifying exam, and 6 months prior to the expected program end-date. The request will be considered first by the PD and Competence Committee and subsequently reviewed by the RPC prior to approval.

Training Credit towards Fellowship

Following successful completion of written and oral FRCPC examinations and completion of all other residency program requirements for graduation, the RPC may consider, on a case by case basis, a resident completing subspecialty fellowship rotations in their final two blocks of training.

Process for application: A written application for a subspecialty fellowship elective in Blocks 12 and 13 of the R5 year must be made to the Program Director prior to the final year of training. The request will be considered first by the Competence Committee and subsequently reviewed by the RPC prior to approval. Approval will be conditional on successful completion of all graduation requirements prior to start of the elective and acceptance for subspecialty training.

Resident Wellbeing and Safety

Resident well-being is given a high priority in our program. For health, personal, and career concerns, residents are encouraged to seek assistance early. In addition to the resources available within the department, excellent support is available through the University Health Services at the U of C, the Office of Resident Affairs and Physician Wellness https://cumming.ucalgary.ca/pgme/wellness/residents, and the Physician and Family Support Program (PFSP) of the Alberta Medical Association (AMA) (https://www.albertadoctors.org/services/physicians/pfsp).

Personal and Professional Responsibilities

1. Be aware of escalating health problems, sleep deprivation, stress, worries and doubts, and promptly discuss these issues with the Wellness Director, Chief Residents, academic coach, faculty members, Assistant PD or the Program Director.
2. Be aware of signs of drug misuse in your colleagues and seek advice if you have concerns.

Harassment and Bullying, Ombudsman

Any resident who feels that they are being harassed or bullied should notify either: Wellness Director, Lead Residents, academic coach, faculty members, Assistant PD or the Program Director. All allegations of harassment and bulling are taken seriously by the RPC and will be investigated and addressed as needed.

If the resident is not comfortable addressing the matter with any member of the Department of

Anesthesiology, Perioperative and Pain Medicine, they should contact the program's ombudsman, Dr. John Graham (john.graham@ahs.ca) (General Surgeon at Rockyview General Hospital) to have the matter addressed.

Resident Safety Policy

All residents should be aware of the PGME policy on resident safety. This can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Resident Safety'. The RPC wishes to act promptly to address identified safety concerns and incidents, and to be proactive in providing a safe learning environment.

Physician Extender Activity

1. Eligibility
    a. Anesthesia residents are currently allowed to apply for physician extender privileges after January 1 of the PGY-2 year. The PGME policy on physician extenders can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Physician Extender'.
    b. Historically, anesthesia residents have served as physician extenders in the ICU, CVICU, PICU, CICU, and Pediatric Transport teams. Anesthesia residents may work as physician extenders only at those sites approved by the RPC.
2. Requirements
    a. The resident must be in good standing.
    b. Any resident who intends to pursue Physician Extender contracts must notify the PD in writing at least two months prior to beginning the work.
    c. The resident will need to apply for licensure as a Physician Extender through the CPSA (https://cpsa.ca/physicians/registration/apply-for-physician-extender-registration/physician-extender-application-form/). This application will require a letter of support from the PD.
    d. Residents who are employed as Physician Extenders must also change their CMPA coverage accordingly (https://www.cmpa-acpm.ca/en/joining-cmpa/residents-and-clinical-fellows).
3. Maximum number of shifts per block
    a. According to CPSA policies (http://www.cpsa.ca/eligibility/physician-extender/), combined call shifts and physician extender shifts cannot violate call rules as defined in the PARA contract (cannot exceed a ratio of 1:4 and more than 2 weekends in a 4 week block).
    b. The PD and RPC receive monthly reports from each of the units on which our residents work as physician extenders, and these are reviewed to monitor for compliance with this policy.
    c. There must be at least eight hours of unscheduled time between a Physician Extender shift and the resident's next clinical duty.

Residents may not use their residency status to work as a GP Anesthetist.
Residents who violate any of the aforementioned Physician Extender policies will have their extender privileges revoked.

Additional Program Extender Information

ANESTHESIA RESIDENCY PROGRAM EXTENDER GUIDELINES & EXTENDER PRIVILEGE APPLICATION (approved RPC October 2023)

1. *Review and know the PGME, CPSA and PARA guidelines as they relate to resident extender privileges*

2. *ICU extender privilege application process*
    a. *Step 1: Meet the following criteria*
        i. *successful completion of a minimum 18 months of residency training*
        ii. *successful completion of at least one ICU rotation*
        iii. *in good standing for all metrics of program advancement*
        iv. *know and follow PGME/CPSA/PARA extender policies*
        v. *awareness of potential challenge of balancing extender shifts with program requirements and personal wellness*

vi. *understand that individual extender privileges will be withdrawn if points 3-5 are not met*

b. *Step 2: letter to PD and RPC requesting ICU extender privilege*

c. *Step 3: Once PD/RPC provides written support of application, follow ICU and CPSA process.*

3. *CSS extender privilege application process*

a. *Step 1: Meet the following criteria*

i. *successful completion of a minimum 3 years of residency training, current level R4 or R5*

ii. *in good standing for all metrics of program advancement*

iii. *know and follow PGME/CPSA/PARA extender policies*

iv. *awareness of potential challenge of balancing extender shifts with program requirements and personal wellness*

v. *ensure CSS provides quarterly reporting of all extender shifts covered by resident direct to PD*

vi. *understand that extender privileges at CSS will be withdrawn for ALL residents if points 3&5 are not met by individual residents*

b. *Step 2: Letter to PD and RPC requesting CSS extender privilege*

c. *Step 3: Once PD/RPC provides written support of application, contact Dr. Wendy Hall for her support.*

d. *Step 4: Once Dr. Hall/CSS support obtained, follow extender CPSA process and ICU process with documentation going to CSS.*

i. *CSS requirements*

1. *Current CPR certification*
2. *Current ACLS certification*
3. *Current CPSA Physician Extender Practice Permit*
4. *Security clearance within 3 months of first shift*

ii. *CSS Day shifts are from 0700 – 1700*

iii. *CSS Night shifts are from 1700 – 0700*

iv. *It is understood that extenders may have to arrive late or leave early based on academic responsibilities. Communication re. same is important.*

Extender Policy and guidelines from PGME Cumming School of Medicine

College of Physicians & Surgeons of Alberta Policy to Permit Educational Register Members to work as Physician Extenders.

- *CPSA Physician Extender Policy*

For further information, please visit the CPSA website: cpsa.ca/eligibility/physician-extender

Postgraduate Medical Education (Last updated July 2022)

- *Operating Standard on Extender Shifts*

REFERENCES:

1. CMPA FAQ https://www.cmpa-acpm.ca/en/site-resources/faq/residents-and-residency#moonlighting

2. Apply for Physician Extender Registration https://cpsa.ca/physicians/registration/apply-for-physician-extender-registration/

3. Resident Physician Agreement

Agreement | Professional Association of Resident Physicians of Alberta (para-ab.ca)

Important points to emphasize from PGME, CPSA and PARA Policies

PGME

Residents engaging in moonlighting activities must:

I. Ensure that these activities do not negatively impact performance in the residency program

II. Ensure that moonlighting responsibilities do not interfere with duties within the residency program.

6.2 Commitments for Extender shifts shall not interfere with the Resident's training and regular duties.

i. Extender shifts are prohibited during regular duty hours during the week, including when a Resident is post-call. This does not apply to vacation, i.e. if a resident is on vacation during a weekday, this would not be a regular duty hour, therefore extending shifts would be allowed.

ii. Residents must not participate in Extender shifts while simultaneously scheduled for duty within their Program, this includes academic half day, or any other mandatory event scheduled by the Program (including Journal Club). (This means that you cannot simultaneously cover an extender shift AND cover call, for example APS, within the program – no double coverage.)

iii. Extender shifts which involve overnight call are prohibited during on-call duty shifts on days that precede regular duty hours. I.e. a resident cannot extend Sunday night if they have regular clinical duties Monday morning.

iv. Residents have a collective responsibility provide acute care coverage and work together to ensure continuity of care. An Extender shift must never justify a Resident's failure to contribute equitably towards adequate coverage of the clinical services.

v. Residents must maintain a satisfactory academic standard to participate in the Extender schedule. Any change in the Resident's status (e.g. learning support plan, remediation, probation, part-time training, or accommodation) may affect the Resident's eligibility to work Extender shifts.

vi. Extender shifts shall only occur at a site and service other than those where the Resident is currently being assessed to ensure disambiguation of the two roles, expectations, and supervision.

vii. Formal assessments (EPAs, ITERs, Field notes etc.) shall not be requested during an Extender shift as this is not a Program educational experience and falls outside of the residency schedule. Such assessments are to be completed on scheduled rotations.

viii. Decisions to engage in Extender shifts must consider resident wellness, Fatigue Risk Management and patient safety

6.3 Pursuant to the Resident Physician Agreement, the number of days on service each month defines a maximum number of in-house or home calls that a Resident may provide. Residents must adhere to these guidelines, even when Extender shifts are combined with their resident duty hours.
6.4 Residents may not be scheduled for in-house call on two consecutive days, or home call for three consecutive days, even if one of those days is an Extender shift.
6.5 In any given month, Residents may not be scheduled for in-house or home call on any portion of more than two weekends out of four (or three out of five when applicable), even when one of those call days is an Extender shift.
6.6 Residents may not be scheduled for in-house or home call on more than two consecutive weekends, even if one of those days is an Extender shift.
6.7 The Resident must track and submit a summary of Extender shifts worked at least semi-annually to their Program Director (or designate) to tabulate their extender and rotation call shifts and confirm that the specific limits have not been exceeded. (Note, anesthesia program is asking for this quarterly)

ARTICLE 23: DUTY HOURS SCHEDULING pg 17 "The minimum rest period between in-house duty hour shifts is eight (8) hours. This includes standard duty hours, shift-based duty hours, and call shifts where an individual has been required to work 'in-house' providing service and is not being provided a post-call day off." Also includes extender shifts. I.e. a resident cannot extend Monday night if they have a regular clinical day Tuesday morning. A resident may extend Friday night after a regular day if they are not scheduled for any clinical duties Saturday morning.

6.8 No Extender shifts are carried out two weeks prior to certification or licensing examinations.
6.9 Residents must maintain a balance between their personal and professional life to sustain their own physical and mental health and wellbeing.
i. Promote and model professional conduct at all times.
ii. Recognize limitations in their knowledge base and technical skills and call for appropriate help in a timely fashion.

CPSA Rules for Participating:

The CPSA[2] has 8 rules for Residents registered with Physician Extender Practice Permits. If at any time there is an indication the Resident is struggling with their academic program, it is expected that the Program Director will intervene and potentially withdraw their support for the license.

1. There is a clear link between the service the Extender shifts, and the Resident's Program. Program Directors must be aware of the intended extender experiences and confirm that these are in alignment with the goals and objectives of the residency training program

2. The Resident, Program, and Extender program need to agree on reasonable shift length and have it in writing.

3. The Resident needs to maintain satisfactory academic performance.

4. The Resident's Extender shifts can't interfere with the normal clinical and training responsibilities to their Program.

5. The Resident's additional clinical activities cannot place a burden on their fellow trainees.

6. After-hours coverage and shifts can't be in breach of the Resident Physician Agreement.

7. The Resident's performance must be thoughtfully reviewed at least semi-annually by the Extender service and their Program Director.

8. The extender must secure adequate professional liability protection before their Extender work starts.

9. Contracts for sponsored trainees prohibit participation in Extender shifts or Moonlighting. Resident Physicians governed by these contracts must not engage in these clinical activities.

CPSA Minimum Requirements for Physician Extender Practice Permits

- *i. Completed at least 18 months of related postgraduate training.*
- *ii. Licentiate of the Medical Council of Canada (LMCC); and*
- *iii. The support of the Resident's current Program Director.*

Residency Training Program Manual 2023-2024, page 49.
"Physician Extender Activity
1. Eligibility
a. Anesthesia residents are currently allowed to apply for physician extender privileges after January 1 of the PGY-2 year. The PGME policy on physician extenders can be found at https://cumming.ucalgary.ca/pgme/current-trainees/residents/starting-residency-training/policies-guidelines under 'Physician Extender'.
b. Historically, anesthesia residents have served as physician extenders in the ICU, CVICU, PICU, CICU, and Pediatric Transport teams. Anesthesia residents may work as physician extenders only at those sites approved by the RPC.
2. Requirements
a. The resident must be in good standing.
b. Any resident who intends to pursue Physician Extender contracts must notify the PD in writing at least two months prior to beginning the work.
c. The resident will need to apply for licensure as a Physician Extender through the CPSA (https://cpsa.ca/physicians/registration/apply-for-physician-extender-registration/physician-extender-application-form/). This application will require a letter of support from the PD.
d. Residents who are employed as Physician Extenders must also change their CMPA coverage accordingly (https://www.cmpa-acpm.ca/en/joining-cmpa/residents-and-clinical-fellows).
3. Maximum number of shifts per block
a. According to CPSA policies (http://www.cpsa.ca/eligibility/physician-extender/), Physician Extender shifts may not be done at a frequency such that the combined number of call shifts and physician extender shifts exceeds a ratio of 1:4 (i.e. more shifts than the maximum number of call shifts allowed) in the block.
b. The PD and RPC receive monthly reports from each of the units on which our residents work as physician extenders, and these are reviewed to monitor for compliance with this policy.

c. There must be at least eight hours of unscheduled time between a Physician Extender shift and the resident's next clinical duty.
Residents may not use their residency status to work as a GP Anesthetist. Residents who violate any of the aforementioned Physician Extender policies will have their privileges revoked"

THE RESIDENCY PROGRAM COMMITTEE (RPC)

The RPC is responsible for all aspects of the postgraduate training program in Anesthesiology. Responsibility is delegated from the U of C Cumming School of Medicine through the Office of the Associate Dean, Postgraduate Medical Education. Specific responsibilities include selection, evaluation, and promotion of residents, as well as provision of an educational program that meets the standards of the RCPSC.

The RPC meets monthly (excluding summer months of July and August); *resident members of the RPC are excused from call duties to attend the meeting, and it is expected that they will attend as much as possible*. An agenda is pre-circulated and minutes are recorded. All members are required to respect the confidentiality of the RPC's deliberations.

Membership of the RPC
While many members of the RPC are appointed as representatives of various groups within the program, all members must act in a manner that places the overall good of the educational program ahead of any sub-specialty or geographical interest.

The Program Directorship is a University appointment made by the Dean, subsequent to recommendations by the Associate Dean for PGME and the Department Head. Typically, the Residency Program Director is appointed for a five-year term.

The Program Director, after consultation with the Department Head, appoints non-site-related individual committee members (Education Coordinators, Simulation Coordinators, Scholarly Project Coordinators, Quality & Safety Coordinators). These members are typically chosen because of their interest in resident education. Site Coordinators and Associate Site Coordinators are appointed by the Program Director after consultation with the Section Heads for their respective sites.

The RPC consists of:

1. the Program Director;
2. the Associate Program Director;
3. Lead Residents;
4. one Senior Resident Representative (PGY-3 resident elected by peers);
5. one Junior Resident Representative (PGY-2 resident elected by peers);
6. CAS Resident Representative (non-voting member);
7. Co-Site Coordinators from ACH, FMC, PLC, RGH, and SHC;
8. Education Coordinators;
9. Simulation Coordinators;
10. Scholarly Project Coordinators;
11. Quality & Safety Coordinators;
12. Journal Club Coordinator;
13. the Director of Undergraduate Medical Education
14. Director of Resident Wellness and Safety; and
15. Head of the University of Calgary Department of Anesthesiology, Perioperative and Pain Medicine (ex-officio);

16. the Program Director of the Family Practice Anesthesia Program.

Membership, Residency Program Committee, 2023-2024

Program Director (Chair)	Dr. Debbie McAllister
Associate Program Director	Dr. Edward Choi
Head, University Department (ex-officio)	Dr. Gary Dobson
ACH Co-Site Coordinator(s)	Drs. Lindsay McMillan, Karthik Sabapathi
FMC Co-Site Coordinators	Drs. Chris Young & Pierre Laurencelle
PLC Co-Site Coordinators	Drs. Afra Moazeni, Kristi Santosham
RGH Co-Site Coordinators	Drs. Erin Bruce, Zahid Sunderani
SHC Co-Site Coordinators	Drs. Ravi Pullela, Alan Chu
Academic Coach Lead	Dr. Talia Ryan
Curriculum Co-Coordinators	Drs. Hai Chan (Carlos) Yu, Bethany Oeming
Scholarly Project Co-Coordinator	Dr. Andrew Walker
Simulation Coordinator	Dr. Christopher Dyte
ACRM, Bootcamp & TTD Coordinator	Dr. Chris Young
Quality & Safety Coordinator	Dr. Edward Choi
Journal Club Coordinator	Dr. Paul Zakus
UME Clerkship Leads	Drs. Karl Darcus, Nina Hardcastle
Program Director (Family Practice Anesthesia)	Dr. Julia Haber
Director of Resident Wellness	Dr. Meredith Hutton
Rotation Coordinators (not in a role above)	Drs. J. Bennitz, A. Bopardikar, J. Haber, D. Finegan, A. Todd, C. Phillips, J. Ng, C. Allen, L. MacKenzie, N Webb, J. Ahn, K Biefer, A Fard, C Allen, N. Brown
Lead Residents	Drs. Kelsey Wagner, Ben Abelseth
Senior Resident Representative	Dr. Brynn Walker
Junior Resident Representative	Dr. Lilly Nichols
CAS Resident Representative (non-voting)	Dr. Saud Sunba

RPC Responsibilities

- Develop and oversee operation of the program, providing all required components training
- Selection of candidates for admission to the program
- Evaluation and promotion of residents
- Maintenance of an appeal mechanism
- Establishment of mechanisms to provide career planning and counseling for residents, and to deal with problems such as those related to psychological stress and performance problems.
- Ongoing program review, including resource allocation, components, meeting of objectives, balance of service demands, teaching, and teachers
- Maintenance of current and appropriate goals and objectives that are reflected in program planning and operation, as well as in resident evaluation

Program Director

The Program Director (PD) is responsible for the overall conduct of the residency program and is accountable to the Head of the Department of Anesthesiology, Perioperative and Pain Medicine, the Associate Dean for PGME, and the RCPSC.

Specific duties of the PD, assisted by the RPC, include:

- the development and operation of the program to meet general and specific standards of accreditation;
- selection of candidates for admission to the program, including the organization of the CaRMS selection process;
- evaluation and promotion of residents in accordance with appropriate policies;
- maintenance of an appeal mechanism;

- facilitation of career planning;
- counseling residents as required and dealing with problems such as stress; and
- ongoing program review to include:
  - the educational experience (including the curriculum as it relates to goals and objectives);
  - optimal use of available resources and facilities;
  - opinions of the residents;
  - teaching and teachers.

The PD will ensure that the formal teaching in the program is organized, relevant, and continually updated. Assistance and resources will be provided to faculty involved in educational programs. The PD acts as a liaison between the residents and faculty, frequently in the role of resident advocate. Residents' specific needs and requests are to be dealt with compassionately and rationally. With the assistance of faculty and the RPC, the PD is required to have an ongoing awareness of resident performance. Concerns must be taken to the resident and the RPC in a timely manner.

The PD is an active member of the PGME Committee and as such must attend and participate in monthly meetings, the annual PGME retreat, and other PGME functions as requested. The PD must also participate in internal and external program reviews.

The PD is also a member of the ACUDA Postgraduate Education Committee and is expected to attend meetings biannually, participate in national anesthesia residency matters, and collaborate with other Canadian anesthesia program directors. The PD is also a member of the RCPSC Anesthesiology Specialty Committee and is required to attend those meetings as requested.

The PD is also a member of the Zone Anesthesia Executive Committee and is required to attend those monthly meetings. It is expected that information relevant to the RPC and residents will be conveyed, and that RPC concerns are brought to the attention of anesthesia executive members as necessary.

The PD will ensure that program documents are current and widely available.

Associate Program Director
The Associate Program Director (APD) assists the PD as needs arise and assumes PD responsibilities when the PD is absent.

Site Co-Coordinators
Site Coordinators (SC's) are expected to liaise with the PD on all matters of residency education at their site, and they are responsible for the overall conduct of residency education at their respective sites. They are essential members of the RPC and are expected to participate in decision-making, committee projects, the CaRMS selection process, and resolution of resident problems. SC's are responsible for educational rounds, scheduling of all learners (unless delegated to residents), and resident evaluation at their site. Site Coordinators are strongly encouraged to participate in all residency functions.

Site Coordinators are required to meet, in person, with any resident demonstrating weaknesses at the mid-point of a rotation and within 7 days of the conclusion of a rotation. They are also required to meet with residents at the end of each block to discuss resident ITER's, or delegate this task to another RTC faculty member at their site.

Curriculum Coordinators
The Curriculum Coordinators (CC's) are responsible for scheduling, updating, and planning sessions for the academic half-day. The CC's are responsible for recruiting Unit Managers for Core Program, and may assist the Unit Managers in recruiting faculty to teach Core Program sessions. The CC's are also responsible for working with residents to administer and maintain the learning management system utilized to organize Core Program material online.

The CC's are responsible for evaluating the quality and format of Core Program annually, formally reporting to the RPC every three years, in advance of Internal and External reviews, and making recommendations as appropriate.

Room and equipment bookings are coordinated by the Program Administrator. For units with examinations, these marks should be forwarded to the PD. Attendance at Core Program is monitored by the CC's, and attendance problems are reported to the RPC.

Scholarly Project Coordinator
The Scholarly Project Coordinator is the primary liaison between residents and faculty for scholarly activity and works to ensure that the scholarly project requirements of the RCPSC are met. Specific duties may include: maintenance of a faculty research catalogue (ongoing and prospective research interests), assisting residents in finding a faculty preceptor for projects and funding, developing the presentation and writing skills of the residents, and the planning of the annual Resident Scholarly Project Dinner.

Simulation Coordinators
The Simulation Coordinators are responsible for conducting all resident simulation activities.

Quality & Safety Coordinator
The Quality & Safety Coordinator assists with coordinating scholarly activity related to quality improvement or assurance and patient safety and provides expertise in residency education matters related to quality and safety.

Journal Club Coordinator
The Journal Club Coordinator is responsible for planning and conducting journal club sessions (September, February, May) with the residents.

Director of Resident Wellness and Safety
The Director of Resident Wellness and Safety is a faculty member to whom residents may reach out to regarding issues of wellness and safety. This faculty member is also responsible for updating the Resident Safety Policy, and leading initiatives for the residents related to wellness and safety.

Sub-Specialty Rotation Coordinators
The coordinators for anesthesia sub-specialty training are faculty members and are responsible for rotation design, supervision, education, and completion of rotation ITER's. Like SC's, sub-specialty rotation coordinators must meet with residents are having difficulty at the mid-point of a rotation, and also with residents at the end of a rotation to review the ITER (this may be delegated to an RPC faculty member at their site if they are unavailable to do so). Residents should communicate specific requests and directions directly to the appropriate rotation coordinator.

Sub-Specialty Rotation Coordinators, 2023-2024

Acute Pain Service	FMC	Dr. D. Finegan
Airway Anesthesia	FMC	Dr. J. Haber
Cardiac Anesthesia	FMC	Dr. N. Webb
Chronic Pain	Chronic Pain Centre	Dr. A. Bopardikar
Out of Operating Room Anesthesia	FMC	Dr. A. Todd
Medical Education	FMC / RGH	Drs. C. Young, Z. Sunderani
Neuroanesthesia	FMC	Dr. J. Bennitz
Pediatric Anesthesia	ACH	Dr. L. McMillan
Perioperative Ultrasound	PLC	Dr. K Beifer

Obstetrical Anesthesia	FMC / PLC / RGH	Dr. P. Zakus, Dr. L. MacKenzie, Dr. Z. Sunderani
Perioperative Medicine	FMC	Dr. C. Phillips
Regional Anesthesia	SHC	Dr. N. Brown
Senior Regional Anesthesia	PLC	Dr. A. Fard
Thoracic Anesthesia	FMC	Dr. P. Laurencelle
Vascular Anesthesia	PLC	Dr. C. Allen

Competence Committee (CC) and Competence Reports

The Competence Committee's purpose is to review and make recommendations to the RPC related to the progress of residents.

The current members of CC are:

- Dr. Lorraine Chow – Chair
- Dr. Graeme Bishop – past chair
- Dr. Edward Choi
- Dr. Meggie Livingstone
- Dr. Debbie McAllister
- Dr. Kristi Santosham
- Dr. Evan Woo

Lead Residents

Lead Residents are appointed each year; their terms of duty begin on January 1 of their PGY-3 year and end on December 31 of their PGY-4 year. Residents interested in the position apply to PD, and the appointment is made by the PD in consultation with the RPC.

Applications to be Lead Resident are due on **November 1**, and the selection process occurs at the December RPC meeting to allow for transfer of responsibilities during the month of December.

The Lead Residents:

- are members of the RPC, attend and participate in all meetings, and present a monthly Lead Residents' Report;
- act as a liaison among residents, the Program Administrator, faculty, the PD, and the RPC;
- contact the PD promptly about urgent resident issues;
- designate one or more senior residents at each site to assign clinical clerks, residents, and any other allied health care professionals to appropriate clinical locations (i.e. daily OR assignments);
- prepare the monthly resident on-call schedules at adult Calgary sites and distribute them to all designated parties (Site Coordinators, Program Director, PARA, Program Administrator, Site Administrator);
- arbitrate resident disputes over the resident call schedule at any site;
- meet with residents as a group regularly to discuss program-related issues;
- forward all pertinent information to residents;
- ensure completion of the resident attendance sheet at all mandatory events; this may be delegated to another senior resident;
- assign Journal Club presentations to residents;
- ensure residents have presented the minimum number of required Core Program sessions each year;
- collate, edit if necessary, and forward teaching feedback from Core Program to resident and faculty presenters;
- observe polices and guidelines for relationships with industry; confirm appropriateness with PD when in doubt;
- assist with guest speakers at Core Program to ensure their arrival, comfort, and departure;
- assist in the resident selection process and participates in CaRMS interviews;

- coordinate resident vacation requests, ensuring that program policies and PARA rules are followed;
- arrange voting for faculty teaching awards;
- coordinate the PGY-1 buddy program;
- orient the incoming Lead Residents at the end of their term;
- help to orient all new residents;
- liaise with medical students interested in anesthesiology and our program to help promote both;
- toast the graduating residents at the Graduation and Awards dinner;
- will have time out of the OR, as necessary, to carry out these functions.

Senior Resident Representative

This resident's term of duty begins on Jan 1 of their PGY-2 year and ends on Dec 31 of their PGY- 3 year; they are elected to this position by their peers (i.e. the PGY-2 cohort). Duties and responsibilities include:

- assisting the Lead Residents as necessary with administrative matters;
- serving as CARR Planning Committee Chair; if this resident becomes the Lead Resident, they will appoint another PGY-3 resident to assume Chair duties once they assume Lead Resident duties;
- planning the annual site tours for PGY1s (along with the Junior RPC Resident representative);
- maintain residency program website (in collaboration with IT support provided by the U of C and the Department);
- ensure Department of Anesthesiology, Perioperative and Pain Medicine is up to date with all residency-related matters on a monthly basis; and
- others as assigned by the Program Director or Lead Residents.

Junior Resident Representative

This resident's term of duty begins on Jan 1 of their PGY-1 year, and ends on Dec 31 of their PGY- 2 year; they are elected to this position by their peers (i.e. the PGY-1 cohort). Duties and responsibilities include:

- assisting the Lead Residents as necessary with administrative matters;
- planning the annual site tours for candidates (along with the Senior RPC Resident representative);
- sending completed Core Program sign-in sheet to Program Administrator after each session;
- manage the residency program social media.
- ensure Department of Anesthesiology, Perioperative and Pain Medicine is up to date with all residency-related matters on a monthly basis; and
- others as assigned by the Program Director or Lead Residents.

CANADIAN ANESTHESIOLOGISTS' SOCIETY (CAS) MEMBERSHIP AND CAS RESIDENT REPRESENTATIVE

Membership to the CAS is complimentary for all residents (https://www.cas.ca/).

A CAS Resident Representative is appointed by the Program Director, in consultation with the RPC, after a careful review of applications from residents interested in the position. Residents may only serve in this role in their PGY-2 to PGY-4 years. The roles and responsibilities for this individual include:

- serving as an active member of the CAS Resident Section; this individual is encouraged to hold an executive position in the CAS Resident Section in the second and/or third year of their term;
- attend RPC meetings and serve as a non-voting member of the RPC;
- keep the other residents up to date with CAS activities (at the very least a written report to the residents and RPC within one week of returning to Calgary from the annual CAS meeting, and one

report in the December of each academic year), enable the University of Calgary anesthesiology residents to become more actively involved in the CAS; and

- other duties as assigned by the Program Director and Lead Residents.
- This individual may receive up to $1000-$2000 per year to attend the CAS Annual Meeting depending on the annual RPC budget.

RESIDENT SELECTION PROCESS

Applications for residency positions are made through the Canadian Resident Matching Service (CaRMS) (http://www.carms.ca/).

Selection procedures are determined by the CaRMS Selection Committee, which is a sub-committee of the RPC. These are reviewed annually for fairness and effectiveness. Members of this committee consist of both RPC and non-RPC faculty and residents.

Candidate files are reviewed, and selected candidates are invited for an interview. The date for the Calgary interview is determined in discussion with other Anesthesiology Program Directors in Canada. Interviews are not offered on alternate dates. Our program keeps a waitlist for interviews, and potential candidates will be contacted by our office if an interview spot becomes available.

During the selection process, consideration is given to academic record, clinical performance record, letters of reference, personal letter, evidence of extracurricular involvement and interests, and the interview. The ranking decisions are final.

Our department endeavors to accommodate as many requests for electives from clinical clerks as possible. We appreciate that electives in anesthesia at Calgary sites are very challenging for students to obtain. Interested medical students are welcome to arrange for a meeting with the Program Director, Dr. Debbie McAllister (Debbie.McAllister@ahs.ca) during PD “Office Hours” and the Lead Residents in order to learn more about the program. Telephone or videoconference meetings are always an option. Each fall, the PD and the residents offer virtual program information nights to interested CaRMs applicants.

Table of Contents

HOSPITAL TEACHING SITES

The Site Coordinator at each site is the residents' primary source of site-specific information.

Alberta Children's Hospital

Welcome to the ACH. The hospital opened in 2006. ACH has approximately 133 inpatient beds and provides comprehensive tertiary health services to children from birth to age 18 from southern Alberta, southeastern British Columbia and southwestern Saskatchewan. It is an accredited pediatric level 1 trauma center.

The surgical suite has eight general use ORs, an endoscopy room and an interventional radiology room. The PACU has 22 bed spaces. Approximately 10 000 anesthetics are administered annually by the 26 members of the Section of Pediatric Anesthesia. On weekdays, clinical care is supported by 4- 5 RT's. All surgical specialties and sub-specialties are represented at ACH except cardiac surgery.
Although the bulk of the caseload is routine medical and surgical patients, we provide elective and emergent perioperative care for complex pediatric cases including neonatal surgery, scoliosis surgery, thoracoscopic/laparoscopic surgery, airway surgery and neurosurgery. ACH is a tertiary pediatric trauma center and the provincial center for pediatric bone marrow transplant.

A significant part of the workload comprises anesthesia services for diagnostic and interventional radiology, including MRI, both at ACH and other sites. Residents are encouraged to participate in the care of children undergoing dental procedures at non-hospital surgical facilities.

The ACH Pediatric Pain Management team provides a 24/7 service for the management of children with acute pain. The acute pain service provides inpatient care with the assistance of a nurse practitioner and a respiratory therapist. This service also provides anesthetic care for diagnostic and therapeutic oncology procedures such as bone marrow aspiration and radiation therapy. Pediatric complex pain management is provided primarily through an outpatient setting, with the capability for daily therapy through an Intensive Pain Rehabilitation Program. There is also a new service to bridge the gap between the Acute and Complex Pain Services, called the Bridging Pain Service providing care to prevent the transition from acute to chronic pain for at risk children. Residents are encouraged to participate in these services.

The anesthesia staff at ACH hold clinical academic appointments with the Cumming School of Medicine at the U of C. We provide didactic and clinical training for anesthesia residents as well as other students and health care staff. Off-service physicians, students, RT's, and nurses also come to the OR to gain experience in pediatric anesthesia.

Service Commitment of the Anesthesia Resident at ACH

At the beginning of the block, each new resident will receive a brief orientation to the equipment and the computerized anesthesia record keeping system. Following that, they will attend the hospital every weekday to provide clinical care under the supervision of a staff anesthesiologist. Graded responsibility is introduced during the resident's rotation. Initially, the resident will be closely supervised at all times, but there is opportunity for independent practice later on, if the resident is deemed capable. A staff anesthesiologist is always immediately available.

List Allocation at ACH

Residents and Fellows may self-select lists based on their educational needs. This is coordinated by the most senior resident at ACH during the block. There is no hierarchy for picks (e.g. the PGY-5 does not get to pick before the PGY-2). All trainees should come together, including the Fellow, and discuss their needs to manage the weekly list allocation. In general, each level of trainee should have differing educational requirements so there should not be too much overlap between lists. Unless otherwise indicated, the Fellow is not to have a trainee attached to them during their solo lists.

This process should be complete by the end of workday Thursday, and should be communicated to the Co-Site Coordinator(s) (Dr. Lindsay McMillan and Dr. Karthik Sabapathi) so it can be checked in good time to be

circulated out to the section on Friday. There may be issues unknown to the residents that affect allocation.

Call Requirements

Call is 'home call'. The resident will be on call one day a week and one weekend per block; the weekend call consists of Friday and Sunday of home call. If the resident works on call past 2200h, then the next day will be a post-call day off. E-mail your staff anesthesiologist for that day and mark it on the slate at the front desk. Residents are expected to work on post-call days when call does not extend beyond 2200h. Sunday call has a guaranteed post-call day on Monday.

Emergency cases are booked directly with the staff anesthesiologist, who will contact the resident on call. If you are contacted for a patient prior the staff anesthesiologist, please redirect them immediately to the staff. It is your responsibility to communicate directly with the on-call staff person, letting them know how you can be reached. Please communicate with the OR Charge Nurse and leave your name and pager number on the emergency list whiteboard. The resident may be expected to do 'late call' one night each week; this entails staying until the second (late) room is finished.

Preoperative Consults

Pediatric inpatients are often complex. Therefore, inpatients scheduled for surgery (whether or not the resident is scheduled in that patient's subsequent OR) should be seen preoperatively by the residents so that the residents can formulate an anesthetic plan. The resident should discuss the patient with the staff anesthesiologist assigned to the case. If that staff anesthesiologist cannot be reached, then the resident should discuss the patient with the anesthesiologist on call.

In the unlikely event that there are a large number of pre-admission consults, residents should only pick the 1 or 2 most interesting patients or cases to see. Off-service residents will also gain from this experience, and thus they should also be allocated preoperative consults.

Residents are not required to come back to the hospital just to do pre-admission consults (e.g. after Core Program).

Most in-patients are admitted to the Short Stay Unit on the same day as their procedure ("ADOP"). Staff in that unit can help you locate your patient. Please consult the Fasting Guidelines. Blood tests and urinalysis are performed only for appropriate indications.

Preoperative medication is not routinely ordered but is prescribed when indicated e.g. for anxiolysis. Concerns identified by the resident at the preoperative visit should be discussed with the appropriate staff anesthesiologist.

There are two important areas to consider in pediatric preoperative visits:

1. Presence of the parents/caregivers during induction. A generic description of induction choices may be given to the patient or their parents/caregivers, but avoid making final decisions on behalf of the staff anesthesiologist until you know his or her preference. During COVID, parents/caregivers were no longer brought into the OR for induction. Parental presence during induction is currently being discussed. Please consult with the staff anesthesiologist to determine whether this is appropriate for each case.
2. Informed consent for combined regional and general anesthesia. Remember to include the patient in this discussion if age-appropriate.

Absences from the OR

Residents are released from the OR to attend Core Program lectures and other designated educational sessions or conferences. If residents are released from the OR to attend an education session, they must do so. Residents in their final year of training will be excused from clinical duties for scheduled exam preparation time. The ACH Site Coordinator, PD, and Program Administrator should be notified a week in advance if the absence is anticipated in the coming week for research projects, etc. Please inform the Site Coordinator, your scheduled preceptor and the anesthesia residency program admin in case of illness of another unexpected commitment. For sick days, please email the site coordinator, residency program and your staff for the day.

Pain Service

Residents are encouraged to spend one week on APS during their PGY-3 time at ACH. This will be arranged in conjunction with the weekly roster. When appropriate, the resident may carry a pager and take first call for the Pain Service during their 'Pain Week' – weekdays, weekend days and during nights they are already on call. Residents are expected to take part in daily pain rounds and participate in pain call activities, including diagnostic procedures at the Tom Baker Cancer Centre (at FMC) and the ACH Oncology Unit. Pain patients are seen at least once daily, including weekends.

Section of Pediatric Anesthesia Rounds

All residents should attend weekly anesthesia rounds each Friday morning from 0730-0830h (in Conference Room 3 (Anesthesia Library) unless otherwise noted. Residents are also encouraged to attend the weekly "Fellow Rounds". Please check with the pediatric anesthesia fellow(s) each week as the date and time varies.

Other Educational Activities

There is Monday morning teaching at 0700 in the anesthesia library. You should receive a confirmation email the week prior.

The OR starts an hour later on Fridays to accommodate rounds (except in the summer). There are a variety of rounds other than anesthesia rounds that residents can attend. You may check with the section administrative assistant for the rounds schedule.

Books and journals are also in the anesthesia office area and can be borrowed by the residents. All materials must be signed out through the anesthesia site secretary.

Assessment

Daily observation forms and collaborative input by all members of the section is sought. It is the responsibility of the resident to send an evaluation to the Attending staff person via one45 prior to the end of the day. CBD residents are responsible for initiating EPA assessments. Staff may complete an evaluation even if a resident does not choose to send the evaluation to the staff person.

Vacation

Vacation may be taken for periods of up to one week per one-month rotation. Vacation should be booked well in advance. In general, only one resident is allowed vacation at any one time. Vacation is booked in the usual manner (as outlined in the Program Manual).

Parking

Access to the outdoor parking lot on the southwest side of the building (Lot 5, access from Children's Circle NW) is included in the monthly parking fee used at the other sites. An additional monthly premium may be added to get access to the indoor parking garage on the east side of the grounds (Lot 1 and 2, accessed from 24th Ave NW).

Lockers

Please contact the section administrative assistant or Site Coordinator for information regarding lockers available for anesthesia residents.

Feedback

Residents are encouraged to provide rotation feedback. This feedback may be written or verbal, and it may be given during the rotation or at the end. Without feedback, we cannot make improvements. If we receive no feedback, we will assume everything is perfect!

Please direct questions and comments to the Site Coordinator or Associate Site Coordinator. All residents must complete a written assessment form upon completion of the rotation, and residents may have an exit interview with the Site Coordinator (or designate) if they wish.

Table of Contents

Foothills Medical Centre

Foothills Medical Centre is the largest tertiary care institution in southern Alberta.

FMC is the primary site for a large number of surgical services in southern Alberta including: cardiac surgery, neurosurgery, thoracic surgery, complex spine surgery, transplant surgery, major oncological surgery, and major plastic reconstructive surgery. FMC is also the designated Level 1 Trauma Centre for southern Alberta, operates the high-risk obstetrical unit for the area and has one of the largest Acute Pain Services in the city. FMC has the only magnetic resonance equipped surgical theatre in western Canada, which supports many of the innovative neurosurgical procedures performed in Calgary. There is also a very dynamic invasive neuroradiology service, which is actively supported by the Section. From a perioperative perspective, in addition to participating in the preoperative anesthesia clinic (PAC), we have an out of OR anesthesiologist who helps manage complex post-anesthesia care unit (PACU) issues, provide regional anesthesia services and POCUS. Some members of the FMC section are also heavily involved in conducting clinical research. Finally, the section of anesthesia at FMC is affiliated with the University of Calgary, and staff members regularly participate in resident and medical student training.

The size of the hospital and complexity of cases at FMC may seem intimidating at first, but it is an awesome place to work and learn! There are plenty of excellent staff invested in your education and great opportunities to seek out! If you ever have any doubts or would like clarification around expectations that are not covered in this document, please feel free to reach out to your chief residents or FMC coordinators. We are here to support you!

Daily Work

A resident's degree of independence correlates with their stage of training.

Residents are expected to be working in the OR administering anesthetics and learning clinical anesthesia daily. Theatre times begin at 7:35am (except Fridays from September to June which start at 8:35am). The resident should arrive with enough time to allow for thorough preoperative preparation of the anesthetic machine, anesthetic cart and any ancillary equipment, interview the patient and discuss the case with their staff prior to the patient being brought to the OR at 7:35am (including on days with morning teaching).

OR responsibilities end when the elective slate is finished (i.e. end of the scheduled elective cases) or at the discretion of the attending preceptor if emergency cases are added.

As much as possible, the resident should maintain continuity of a patient's care in the OR. In the event of an emergency call from other staff members, fellow residents, or nurses, the resident is expected to respond appropriately.

All residents who have in-patients on the next day's slate are expected to see these patients the day before surgery. Residents are expected to perform an anesthetic assessment, formulate an anesthetic plan, and discuss their assessment and plans with the patient and the attending anesthesiologist. This also applies to Monday lists and during the week when a resident is post-call.

Residents will be assigned a specific preceptor each day. Daily evaluations are recorded on One45 evaluation forms. The resident should send an evaluation form electronically to their preceptor for every day they work (including days on call). EPAs can also be sent to the preceptor in addition to a One45 for completion.

Table of Contents

Teaching and Grand Rounds at FMC

Teaching occurs at FMC from 7:00 – 7:30 am on Thursday mornings in the FMC Doc's Lounge (main floor of the main building). One or more staff anesthesiologists run teaching each week to provide a variety of opinions on the case(s) presented.

Grand Rounds occur from 7:00 – 8:30am on Friday mornings and are usually held in the ICU classroom. (basement floor of McCaig Tower).

There are NO ROUNDS on the first Friday of each month in lieu of a Business Meeting, which residents do not attend. All residents rotating at FMC are expected to attend rounds **in person** (there is free food and coffee!!) On occasion, there may only be the option to attend rounds virtually, in which case residents are expected to attend rounds virtually.

Residents rotating at FMC are expected to attend morning teaching and grand rounds unless they are pre-call, on vacation or doing a case at an alternate site that day (i.e. interesting case, coach day, etc.). Residents on-call should attempt to attend teaching and grand rounds, however sometimes obstetrics can be busy at this time and you may be called away for clinical duties. Residents who have full academic days or research days are still expected to attend morning teaching and grand rounds. If you do not make morning teaching or grand rounds, it is the responsibility of the learner to e-mail the FMC coordinators so they can keep track of absences. Residents on Cardiac Anesthesia Rotations may not be able to attend the entirety of morning teaching or Rounds due to Cardiac OR start times being slightly earlier.

Code & Trauma Pager

One resident should carry the code/trauma pager (102) whenever residents are present in the hospital.

There should always be a resident covering the pager (except during mandatory program events, e.g. journal club, CARR, etc.) During academic half-day, there may be PGY-4 or PGY-5 residents available to take the pager, unless they also elect to take their protected study day on Thursdays. If there is no resident on call, the coordinating or on-call anesthesiologist(s) should be informed and the pager should be left in the McCaig Anesthesia Lounge on the whiteboard..

The resident holding the pager is expected to respond to code blue and trauma pages, and they should be allowed by their preceptor to go to the code/trauma bay immediately. On days when there are two residents assigned to main OR call, the more junior resident will carry the 102 code/ trauma pager. Both residents are expected to attend all codes and traumas. The more senior resident is responsible for delegating consults, IV starts, and any other tasks that need to be performed during the call shift.

Residents of all levels are expected to attend the trauma call out and identify themselves as a member of the Anesthesia Department, including their PGY level. The trauma team leader will utilize resident skills according to need and resident skill level (this often means airway management).

Anesthesia residents will stay with the level 1 trauma patients (including to diagnostic imaging or other locations outside the trauma bay as necessary) until the Trauma Team Leader (TTL) states that the patient will not need to go to the OR. Depending on time-of-day and staffing, anesthesiologists may put ORs on hold to accommodate an incoming trauma. It is important that the resident attending the trauma communicate with the Task-Force Anesthesiologist (Pager 8269) as soon as they have determined (at direction of TTL) whether the patient will be coming to the Operating Room or not. Once this determination is made, the resident should either proceed to the OR to either help prepare for the trauma or return to their assigned room.

The supervision and evaluation of residents at level 1 traumas, in the absence of an Attending Anesthesiologist, is as follows:

- Airway management - anesthesia residents will be supervised and evaluated by ED physicians
- All other resuscitation and management of the trauma patient - anesthesia residents will be supervised and evaluated by the Trauma Team Leader.

Call Requirements

Minimum call requirements at FMC are tied to the current rotation and your stage of training.

Goals of call at FMC:

- Provide **consistent** and **adequate** call exposure for residents so that call expectations are **fixed** and **predictable** for residents dependent on their current rotation
- Optimize daytime learning on subspecialty rotations
- Call requirements for each resident will be based on the rotation the resident is on, so that everyone does the same (or similar) number of call over the 5-year program while on rotation at FMC (excluding electives).

What does call look like?

- Overall, there can be up to 2 residents on per call shift (Jr and Sr) to ensure adequate call exposure. However, the expectation is not to have full coverage of two residents per night
- We will aim for 100% coverage of at least a single resident on every night aside from mandatory event days excused by the RPC and PGME

The call requirements outlined below are a minimum number of calls you will be assigned for each rotation. At times, there may not be enough learners to cover the entire call schedule and you may be assigned an additional call to help cover the schedule. You will never be asked to exceed the maximum number of call outlined in the PARA agreement.

Weekday call starts at 17:00 and finishes at 8:00 the following morning
Weekend and holiday call is divided into two shifts:

- Day: 8:00 – 18:00
- Evening: 18:00 – 8:00

What do I need to do on call?

- If there is only **one** resident on for the evening:
    - You will cover the Code Blue/Trauma Pager
    - You may be asked to do consults and/or IV starts as directed by the 1st call anesthetist
    - You will cover APS after receiving handover from the APS Physician
    - Work in the main OR until it is shut down, then proceed to Labour & Delivery to assist there when paged
        - Please add your name and pager number to the whiteboard on L&D once the main OR is finished. If you get called back to the main OR, please let L&D know so they can remove your name from the board
        - You will have to re-add your name to the L&D whiteboard once you are available again
- If you are on a weekend day shift, all of the above applies except covering APS
- If there are two residents on:
    - Both residents stay in the main OR if there are 2 rooms running – no OB coverage
    - When down to 1 room in main OR – junior resident should stay with senior in main OR but also put name on OB to help out (and go up for epidurals/C/S, etc.)
    - When no rooms in main OR – residents will both be on OB together and can share the workload as they see fit dictated by the senior resident
    - In all cases, **both** residents should continue going to codes and traumas

Non-subspecialty Learners, OOOR, Medical Education, Transition-to-Discipline and Transition-to-Practice:

- Total call numbers for each block are reflected below

Subspecialty Rotation Call:

- **Thoracics JR/SR, Neuro JR/SR, Airway:**
  - 24h coverage with **NO Obstetrics** requirements
  - When on Thoracics, Neuro and Airway rotations, residents will complete a day list, then do main OR call (without going to L&D) and will get a post-call day
    - A separate resident will be dedicated to OB on these nights
  - The emphasis on these rotations is subspecialty exposure, so unless there is an excellent learning opportunity on-call (to be discussed amongst resident, subspecialty case staff and call staff), the resident is expected to finish their subspecialty list and then start call cases
    - They will still need to attend Traumas, Codes and get APS handover by 17:00
  - Residents on thoracics will ideally do 1 Thursday/Saturday and 1 Friday/Sunday call combo

- **Obstetric Anesthesia:**
  - Weekday and weekend call shifts are 1700-0800.
  - For all call shifts, the resident's primary responsibility will be to the L&D unit and only be in the main OR if necessary/requested.
  - Every effort is made to avoid daytime weekend call coverage. However, if scheduled for day shift weekend call 0800-1800 the primary responsibility of the resident will still be L+D.
  - Residents will only carry the 00102 pager and cover APS, code blues, and traumas only if there is no resident in the main OR.
  - Abnormally Invasive Placenta (AIP) cases:
    - These cases are good learning opportunities and should be prioritized. In order to assist with this, if an AIP case is scheduled either on the OB resident's pre-call or post-call day, the following is suggested and should be discussed in conjunction with the OB Anesthesia Resident Coordinator, FMC Rotation Coordinator and anesthetist on OB call
    - If an AIP case is scheduled on an assigned pre-call day, residents will be given the option to attend the AIP case, and begin call 3 hours later (i.e. 2000 start)
    - If an AIP case is scheduled on an assigned post-call day, it is suggested the resident re-assign their call on another day so they can attend the AIP case instead

- **Cardiac Anesthesia:**

Open-heart cases are done primarily during the daytime. To minimize the number of missed cases, Cardiac Anesthesia rotations are assigned a maximum of four calls over the two-block rotation and preferably on Saturdays.

- **Acute Pain Service (APS):**
  - Residents complete 5 weekday home calls and 2 weekend (24h) home calls on Saturday or Sunday
  - Call days are self-scheduled but attempts should be made to cover days where there is no APS resident coverage (off-service residents or no main OR resident coverage)
  - When on weekday APS home call the APS resident does not forward the pager to the main OR resident.
  - On weekend home call, the resident will round with the attending APS anesthesiologist in the morning, then cover the pager for all APS calls until 0800 the following morning
    - Do not hand the APS pager over to the main OR resident.
  - The resident on APS may assist with the OR and traumas depending on APS case load and educational opportunities, upon discussion with the supervising APS staff anesthesiologist.

- **Perioperative Medicine:**
  - Currently residents are doing up to two weekend "type 1" call shifts during the rotation.

- **SHC Regional/FMC Cross Coverage:**
    - Currently residents are doing up to two weekend "type 1" call shifts during the rotation.

- **Research Elective/ FMC Cross Coverage:**
    - One to two call shifts at FMC may need to be done while on Scholarly Project electives.

- **Chronic Pain/ FMC Cross Coverage:**
    - One to two weekends of call at FMC may need to be done while on the Chronic Pain rotation.

Goal Call Assignments per PG Year and Rotation:

PGY1:
Total call for PGY1 @ FMC: 9 (Average 4.5 per block)
- TTD FMC – 1 evening shift until 10pm, 1 weekend day buddy call
- Adult A/PAC – 7 call (5 weekday/2 weekend)

PGY 2:
Total call for PGY2 @ FMC: 16 (Average 5.3 per block)
- Adult A – 6 call (4/2)
- Neuro JR – 4 call (2/2)
- Airway – 5 call (3/2)

PGY 3:
Total call for PGY3 @ FMC: 21 (Average 4.7 per block + 7 home call)
- Neuro SR – 4 call (2/2)
- Thoracic JR – 4 call (2/2)
    - Ideally one Thursday + Saturday night and one Friday + Sunday day combo
- APS – 7 home call (5/2, one F/Su, one Sa)
- Adult A/PAC – 6 call (4/2)

PGY 4:
Total call for PGY4 @ FMC: 27 (Average 3.9 per block)
- Med Ed – 4 call (2/2)
- Cardiac A – 2 call (0/2)
- Cardiac A – 2 call (0/2)
- OB A – 7 OB call (5/2)
- Periop/PAC – 2 call (0/2)
- Adult A – 6 call (4/2)
- Thoracic SR – 4 call (2/2)
    - Ideally one Thursday + Saturday night and one Friday + Sunday day combo

PGY 5:
Total call for PGY1 @ FMC: 25 (Average 4.5 per block + 7 home call)
- Adult PAC – 5 call (3/2)
- OOOR/Manager – 5 call (3/2)
- TTP MED ED – 4 (2/2)
- TTP ADULT A – 4 call (2/2)
- TTP APS – 7 home call (5/2, one F/Su, one Sa)

Table of Contents

Longitudinal Med Ed Opportunities

There will be longitudinal medical education opportunities after residents have completed their first Med Ed rotation in R4. Ideally senior residents will be paired with junior learners no more than twice per block and only on general adult or Transition to Practice rotations. There will be a number of factors that influence the decision to add a "Med Ed" day to rotations including: other learning opportunities available to the senior resident, junior learner availability and both learners must be in good standing.
Scheduling of medical education days should be discussed with the FMC Med Ed Rotation Coordinator.

Time Off

In the case of unscheduled absences including on-call (i.e. sick time, rotation changes, a case at another site, etc.), residents are expected to contact the Program Director, Program Administrator, Rotation Coordinator, FMC Site Lead and their daily assigned preceptor as soon as they know they will be absent.

All vacation times, study days, examination times, and other requests for days off must be arranged in the usual fashion and approved by the FMC Lead Resident & FMC Rotation Coordinator. Service requirements may limit the number of residents that can be away on vacation at any one time. Priority is given to residents preparing for or taking examinations, and those with pressing needs.

Current FMC Rotation Contacts:

Program Director: Dr. Debbie McAllister
Program Administrator: Anca Petri or Camille Adams
Rotation Coordinators: Dr. Christopher Young and Dr. Pierre Laurencelle
FMC Site Lead: Dr. Kelsey Wagner (until January 2025)

Subspecialty Rotations:

Transition-to-Discipline:
Rotation Coordination: Dr. Christopher Young

All residents will rotate through a transition-to-discipline rotation at FMC during July or August of their first year. The goal is for incoming residents to re-familiarize themselves with the OR environment, begin to develop their anesthetic management skills and to meet the staff anesthesiologists who work at FMC (where the majority of subspecialty training will occur). Residents also have the opportunity to work with senior residents on their Medical Education rotations to begin forming connections with senior residents in the program.

Medical Education:
Rotation Coordination: Dr. Christopher Young

Residents will rotate through a Medical Education rotation once at FMC during their residency, either on a junior rotation (R4) or senior rotation (R5). During each rotation, residents will be paired with a junior learner 2-3 days per week to gain experience simultaneously teaching and managing an OR list. The focus during the junior rotation is working with R1s and medical students, while during the senior rotation there will be an effort to schedule Med Ed residents with R2s, FP-A residents and off-service residents.

Thoracic Anesthesia:
Rotation Coordination: Dr. Pierre Laurencelle

Residents rotate through thoracic anesthesia twice during their residency, once as a junior (R3) and once as a senior (R4) resident. The thoracic surgeons at FMC perform a variety of procedures including VATS and

thoracotomies, pneumonectomies, excision of mediastinal masses, hiatal hernia repairs and esophagectomies. This rotation offers the opportunity to develop expertise in lung separation strategies, as well as in the considerations unique to thoracic surgery. One day of thoracic pre-admission clinic is required during the block, which allows integration of concepts such as calculation of predicted post-operative pulmonary function test values. There is a dedicated group of subspecialty anesthesiologists interested in thoracic anesthesia who manage the bulk of the thoracic surgery lists. There is also a thoracic anesthesia fellow who provides dedicated teaching on lung isolation techniques using part-task trainers and will also form an important part of the education team while rotating through thoracic anesthesia.

Neuroanesthesia:
Rotation Coordination: Dr. Josh Bennitz

Residents will rotate through neuroanesthesia twice during their residency, once as a junior (R2) and once as a senior (R3) resident. FMC has both a busy spine surgery and intracranial neurosurgery service. In addition, FMC is host to the only MRI-equipped surgical suite in western Canada, and also has a busy interventional neuroradiology service, providing ample opportunities to be involved in neurosurgical procedures. FMC has both a dedicated group of anesthetists who form the Complex Spine Anesthesia Group and as well as a Neuroanesthesia Group. Members of these groups are assigned to manage the most complex spine and subspecialty neurosurgery cases, respectively.

Cardiac Anesthesia:
Rotation Coordination: Dr. Nicole Webb

Residents will rotate through Cardiac Anesthesia for two blocks, during which there will be a graded increase in responsibility. Residents will increase their proficiency in technical skills with advanced invasive monitoring, including an introduction to transesophageal echocardiography. They will be exposed to a variety of surgical cases via both sternotomy and minimally invasive approaches, as well as cases performed in collaboration with Interventional Cardiology. Residents will learn the various forms of cardiopulmonary bypass and extracorporeal oxygenation, and develop approaches to fluid management and blood transfusion. Learning in this rotation is further consolidated with a block in the CVICU.

Acute Pain Service:
Rotation Coordination: Dr. Donal Finegan

The Acute Pain Service rotation is a comprehensive, four-week program that provides exposure to a skilled interdisciplinary team specializing in advanced pain management modalities. During this rotation, residents gain experience with lidocaine/ketamine infusions, epidural anesthesia, tunneled epidurals, regional catheters and interventional approaches for palliative and cancer pain management. This immersive experience is designed to enhance clinical skills and knowledge in managing acute pain. For senior residents, the rotation offers a valuable leadership opportunity, allowing them to guide and coordinate the team's efforts, further refining their expertise in acute pain management within a collaborative healthcare setting.

Obstetric Anesthesia
Rotation Coordination: Dr. Paul Zakus

Residents rotate through obstetric anesthesia at FMC at least once during their residency. FMC in home to the tertiary obstetric centre for Calgary and the surrounding region meaning we see the most medically complex obstetric patients in Calgary. The Obstetric Anesthesia Subspecialty group hosts a dedicated obstetric preadmission clinic twice per month in order to help optimize medically complex parturients for delivery. FMC also hosts an Abnormally Invasive Placenta (AIP) program also managed by the Obstetric Anesthesia Subspecialty group. Residents are urged to participate in both of these opportunities while rotating through obstetric anesthesia at FMC.

Airway
Rotation Coordination: Dr. Julia Haber

Residents rotate through the Airway rotation as part of their PGY2 rotations. This rotation provides residents the opportunity to practice airway management techniques beyond the typically-used direct and video laryngoscopy. In particular, during this rotation, residents gain experience driving the bronchoscope and performing awake fiberoptic intubations.

Perioperative/PAC Anesthesia:
Rotation Coordination: Dr. Courtney Phillips

Residents rotate through the perioperative anesthesia rotation as part of their PGY4 rotations. Residents will spend 4 days in the preadmission clinic during this rotation to bolster their perioperative optimization experience. Residents also work with the Out-Of-Operating Room (OOOR) anesthetist on this rotation giving them an introduction to overall OR management. The OOOR anesthetist starts E0 and E1 emergencies booked during the day (including traumas), assists with sedations on the wards and for CT/MRI, manages ward consults and supports FMC's growing regional anesthesia program by performing blocks when requested by anesthetists in the OR for example for knee replacements, AV fistula creations or breast surgeries. Finally, residents attend subspecialty clinics such as Pulmonary Hypertension or Patient Blood Management, while on this rotation to better understand how to optimize patients for their upcoming surgery.

Table of Contents

Peter Lougheed Centre

Welcome to the PLC! We are one of the five primary adult tertiary care hospitals that share in the referral area spanning southern Alberta, southeastern British Columbia, and parts of Saskatchewan. Approximately 13000 surgical cases are performed in Sixteen OR's. Anesthetic care is provided by the 37 members of the PLC Section of Anesthesia.

We are the primary site for major vascular surgery and currently have the busiest labour and delivery department with two dedicated OR's on the unit. Other surgical services include: gynecology, general surgery, orthopedics, plastics surgery, and otolaryngology. Additional services regionally centered at the PLC include bariatrics, upper gastrointestinal, laryngology, and maxillofacial.

Specialized Clinical Services
Special interests of department members include: acute pain, regional anesthesia, POCUS, vascular anesthesia, obstetrical anesthesia, QA/QI and medical education. Additionally, ten members of our department provide transesophageal echocardiography (TEE) support in the OR and in a teaching capacity. The PLC is home to our residency program's echocardiography simulator. Clinical support for anesthetic services is provided by RT's and APS support is provided by a team of specialized pain nurses.

Academic Relationships
The Section of Anesthesia at the PLC is affiliated with the U of C and serves as a site for teaching fellows, anesthesia residents and medical students.

General Responsibilities

1. OR's start at 0740h on Monday to Thursday, and at 0840h on Friday, from September 1 to June 30; the start time is 0740h on Fridays during July and August. Ideally, the patient is in the OR ready for induction at 0750h/0850h. Please ensure that you arrive early enough to have prepared the OR and to see the first patient.
2. The most senior resident, or their designate, will assign residents to an OR the prior day, before the circulation of the "pick list" to the staff. This should be done before 0730h. Please be sure that the resident names appear on the master slate at the front desk.
3. Residents assigned to a room with an inpatient are expected to see that patient the day before surgery. Anesthetic plans are expected to have been prepared for all cases the night before.
4. Other than PRADM patients, all preoperative patients can be found across the hall on Unit 22. Patients from the emergency list will need to be sent for to the holding area that is by the OR front desk.
5. The resident call schedule will be made by the Lead Residents prior to the beginning of the rotation.
6. If a resident is absent for any reason, please notify both the OR front desk (403-943-5721-@7:00am) and the Staff Anesthesiologist (see preferred email staff contact list on the last page of this document), as well as following the usual absence reporting system for the residency program (i.e. notifying the program administrator and site coordinator)
7. Please ask at the OR front desk for the location and locker combination of the anesthesia resident lockers.

Call Responsibilities

Call Room # 2011
→Located on the 2nd floor hallway near the PACU. Access via swipe card.

PGY-1 Anesthesia Residents

If the resident has not yet completed their OB Anesthesia rotation, they will be assigned 4 weekday call

shifts in the main OR during the block. They will still be expected to go to the OR during the day for a normal assignment and will stay in the main OR until the conclusion of the emergency cases; these PGY-1 residents are not required to join the L&D anesthesiologist after the conclusion of the main OR. Residents are then given a day off post-call.

If a resident has completed their OB Anesthesia rotation, they will take call in the same fashion as the PGY 2-5 residents (see below).

PGY-2-5 Anesthesia Residents

General Adult Anesthesia Rotation
Coordinator: Dr. Afra Moazeni
Residents on Adult Anesthesia will do seven calls per four-week rotation (maximum 1:4 including vacation time): three weekend call shifts and four weeknight call shifts.

1. Weekday (M-F) call is 16 hours (1600-0800h)
    - When there are no longer cases in the main OR, residents are to report to the OB anesthesiologist on call and spend the rest of their shift on L&D; the resident may be called back to the main OR at the discretion of the OR anesthesiologist and this should be communicated to the OB anesthesiologist.
2. Saturday, Sunday, and Statutory Holiday callis split into two shifts, AM and PM. Am Shifts will be from 0800-1600, PM shifts from 1600-0800; the goal is that the patient is in the OR by 0750h; please contact the OR front desk (403-943-5721) the night before to determine the nature of the first call.
    - Weekend AM shifts are on call for the OR only and do not go up to OB if the OR closes during their shift.
    - Weekend PM shifts are on call for the OR until it closes, then will go up to OB. They may return to the OR if it re-opens, in discussion with the OR and OB anesthesiologist.

Sub-specialty Anesthesia Rotations

Obstetric Anesthesia Rotation
Coordinator: Dr. Lindsay MacKenzie
Residents on OB Anesthesia rotations will do one Friday/Sunday call, and one Saturday call of OB Anesthesia during their block. Friday call starts at 1600h, Saturday and Sunday are 24 hour call and start at 0800h. The responsibility of the resident is primarily to the L&D unit, though residents may be asked to assist in the main OR as needed.

An email with more rotation specific details will be sent the week before your rotation starts. If you have any questions or do not receive this informative email, please contact lmackenzie@plcgas.net.

Adult/OB Rotation
Coordinator: Dr. Lindsay MacKenzie
Residents are scheduled for Adult Anesthesia call, which includes some OB coverage as above. Residents should otherwise coordinate with Dr. MacKenzie during the Block to determine how many days they should spend on L&D.

Perioperative Ultrasound Rotation (POCUS)
Ultrasound Coordinators: Dr. Kristin Biefer
The same rules apply as the Adult Anesthesia Rotation.
Please review the Perioperative Ultrasound rotations goals and objectives prior to the first day of this block. Residents are also encouraged to refine and develop their skills in perioperative transthoracic and transesophageal echocardiography, emergency lung ultrasound, and FAST; they may request simulationsessions using the echocardiography simulator as necessary.

Vascular Anesthesia Rotation
Coordinator: Dr. Claire Allen
Junior call – Weekday call will be 24 hours – starting in the Vasc OR for the day cases, and then continuing with 1st call once day cases have finished. You will not go up to OB once the main OR closes. You get a post-call day. If your OR is running late it is your responsibility to let the first call staff know and communicate when you will join them. Weekend call is the same as the adult A rotation.

Vasc Sr call: Residents on Vascular Anesthesia will do self-scheduled vascular call only (i.e. home call, returning for vascular cases only). This call consists of one Friday/Saturday/Sunday, and one weekday per week – for a total of seven call shifts. Ideally, vascular residents do not place themselves on call the night prior to scheduled open aortic cases, endovascular thoracic cases, or other unique or demanding cases. If the resident is required to be in hospital after 2200h, they are not required to work the following day.

Please review the Vascular Anesthesia Goals and Objectives prior to the first day of the block.

In the event that multiple vascular OR's are running on a single day, the resident has the option of selecting the OR that meets their learning needs best. Ideally, this should be done prior to the circulation of the "pick list". If the slate changes later in the day, feel free to re-schedule yourself after discussing with the two involved staff.

In the event that no appropriate vascular OR's are running, residents can contact the APS/PAC physician and become involved in the preoperative consultation of patients booked for vascular surgery.

Sr. Regional Anesthesia Rotation
Coordinator: Dr. Arash Fard
Residents on the Regional Anesthesia rotation will do two Saturday call shifts in the main OR during the block with the APS/2nd call physician – shifts are 0800-1600hr. .

Please review the regional anesthesia rotations goals and objectives prior to the first day of this block. The non-technical responsibilities surrounding the provision of regional anesthesia often differ between hospitals. Please discuss the following issues with the staff anesthesiologist who is managing the OR in which the patient is booked: consent, timing and location of blocks, charting, patient follow-up and coordination with the APS team.

ICU off service Anesthesia rotations
Coordinator: Dr. Afra Moazeni
ICU off service residents on anesthesia rotations at the PLC will do two weekday OR only buddy call shifts (preferably with a senior anesthesia resident). They will work an elective slate during the day on weekdays (no pre-call) and will get a post call day.

Rounds

All rounds are mandatory for residents, except for those who are PRE-call. Rounds take place from September 5th to June 26th.

Thursday AM rounds at 0700h-0730h Location: Cafeteria
These rounds are usually case-based and presented to the residents in the format of an oral exam question. All residents are expected to attend, and to be on time for these sessions. The most senior resident on site is to coordinate the residents and advise the scheduled presenting staff at least one day prior if all residents will be absent.

Friday AM Anesthesia Grand Rounds at 0730h Location: refer to schedule

Table of Contents

A schedule for topic and location is produced regularly and can be found in the Anesthesia office. Once a month, there is a business meeting from which residents are exempt. Schedules and locations can be found on the door of the anesthesia office.

Evaluations

A satisfactory evaluation at the end of the rotation will be based both on resident performance, and meeting the expectations outlined above. Residents must send a daily evaluation via one45 to each day's preceptor. There are 2 daily forms in one45 1) Anesthesia PLC Daily evaluation Anesthesia Resident (PGY 3-5) and 2) Anesthesia PLC Daily evaluation Anesthesia Resident R1/R2. Subspecialty rotations will have their own tailored evaluations.

PLC Department of Anesthesia Contact List

Name	AHS Emails	PREFFERED: PLC Gas Email
Armstrong, J.N.	J.Armstrong@ahs.ca	**jnarmstrong@plcgas.net**
Azmayesh-Fard, Arash	Arash.Azmayesh-Fard@ahs.ca	**afard@plcgas.net**
Ahn, Joseph	Joseph.ahn@ahs.ca	**josephahn@plcgas.net**
Allen, Claire	Claire.allen@ahs.ca	**csallen@plcgas.net**
Biefer, Kristen	Kristen.Biefer@ahs.ca	**kbiefer@plcgas.net**
Bishop, Graeme	Graeme.Bishop@ahs.ca	**jagraemebishop@plcgas.net**
Brown, Alex	Alexander.Brown2@ahs.ca	**binniebrown@plcgas.net**
Cherry, Tadd	Tadd.Cherry@ahs.ca	**tadd_cherry@plcgas.net**
Cuk, Aleksander Sasha	Sasha.Cuk@ahs.ca	**acuk@plcgas.net**
Darcus, Karl	Karl.Darcus@ahs.ca	**kdarcus@plcgas.net**
Dobson, Gary M.	Gary.Dobson@ahs.ca	**gary.dobson@ahs.ca**
Donais, Phillip	Phillip.donais@ahs.ca	**pdonais@plcgas.net**
Halpenny, David G.	David.Halpenny@ahs.ca	**dhalpenny@plcgas.net**
Hokanson, Michelle	Michelle.Hokanson@ahs.ca	**MHokanson@plcgas.net**
Hung, Linda	Linda.Hung@ahs.ca	**Linda.hung@plcgas.net**
Hutton, Meredith	meredith.hutton@ahs.ca	**mhutton@plcgas.net**
Jadavji, Nadeem	Nadeem.Jadavji@ahs.ca	**nadeemj@plcgas.net**
Jordan, Dean – **section head**	Dean.Jordan@ahs.ca	**dean.jordan@plcgas.net**
Kruger, Marelise	Marelise.Kruger@ahs.ca	**mkruger@plcgas.net**
Lim, Beatriz	Beatriz.Lim@ahs.ca	**blim@plcgas.net**
MacKenzie, Lindsay	Lindsay.D.MacKenzie@ahs.ca	**lmackenzie@plcgas.net**
Maher, Neal	Neal.Maher@ahs.ca	**nmaher@plcgas.net**
Marois, Judy	Judith.Marois@ahs.ca	**judith.marois@ahs.ca**
Milne, David	David.Milne2@ahs.ca	**davidmilne@plcgas.net**
Moazeni, Afra	Afra.moazeni@ahs.ca	**amoazeni@plcgas.net** Cell to text: 403-826-8945
Parkinson, Bronwyn –	Bronwyn.Parkinson@ahs.ca	**bronwynp11@plcgas.net**
Patterson, Steven J.	Steve.Patterson@ahs.ca	**spatterson@plcgas.net**
Pearce, Craig	Craig.Pearce@ahs.ca	**cmpearce@plcgas.net**
Pitter, Curt A.	Curt.Pitter@ahs.ca	**capitter@plcgas.net**
Priddy, Richard E.	Richard.Priddy@ahs.ca	**rpriddy@plcgas.net**
Rabuka, Shannon	Shannon.Rabuka@ahs.ca	**srabuka@plcgas.net**
Sandhu, Sabrina	Sabrina.Sandhu@ahs.ca	**ssandhu@plcgas.net**
Santosham, Kristi	Kristi.Santosham@ahs.ca	**ksantosham@plcgas.net**
Stilling, Lee S.	Lee.Stilling@ahs.ca	**lstilling@plcgas.net**
Tiessen, Alan C.	Alan.Tiessen@ahs.ca	**atiessen@plcgas.net**
Wheeler, Steve	Steven.Wheeler@ahs.ca	**swheeler@plcgas.net**

Wong, Vanessa P.	Vanessa.Wong@ahs.ca	**vwong@plcgas.net**
Wood, Dan	Daniel.Wood@ahs.ca	**dwood@plcgas.net**
Yang, Theresa L.	Theresa.Yang@ahs.ca	**tyang@plcgas.net**

Rockyview General Hospital

Anesthesia residents training at the RGH will have the opportunity to provide anesthetic care for general surgery, gynecology/obstetrics, ophthalmology, urology, orthopedic surgery, plastic surgery, and ENT surgery patients. The hospital is the regional centre for urology and ophthalmology.

Anesthesia for all of these services is supplied by the 37 members of the section who staff 17 OR's each working day, and provide emergency services 24 hours a day, seven days a week. About 19 000 anesthetics are administered each year.

In addition, obstetrical anesthesia is provided for upwards of 4500 women who deliver babies. The section also provides anesthetic services at AHS-contracted non-hospital surgical facilities; the section also includes members who work at private facilities doing Worker's Compensation, dentistry, oral maxillofacial, and plastics surgery work.

An APS provides specialized care for patients, and all members regularly provide consultation services in the PAC.

The Section takes an active part in the education of anesthesia residents, medical students, and other allied health care professionals. In all this, we receive invaluable assistance from our RT's.

Several members volunteer their services to provide anesthesia and teaching the developing world with organizations such as Mercy Ships, Operation Outreach, and Health4Humanity.

Anesthesia Resident Duties and Responsibilities

1. The most senior resident (or designate) will assign junior residents (R1-2) and clinical clerks to elective lists (which is done two days prior to the scheduled OR shift). Every day, this resident must ask the Unit Clerk to send the "pick list" to their OR prior to the "pick list" being circulated to the staff. If no residents will be present to schedule learners, the staff will assign the residents and clinical clerks. Senior anesthesia residents (R3-5) will have the opportunity to choose their OR rooms (two days prior) by assigning their names to the pick list at the end of the day, after the staff have chosen. The OR slate for the next day is posted outside the OR front desk at1430h.

2. The call schedule will be prepared by the Lead Residents. It is the responsibility of the most senior resident to ensure the call schedule is posted on the board in the anesthesia office (in the OR) and the board just outside the front desk (next to the entrance to the men's change room).
The most senior resident must also ensure that a copy of the call schedule is placed with the "pick list" each month.

3. Residents must attend Friday morning rounds, except for the monthly business meetings; these rounds start at 0730h.
Residents will present at RGH either during their Airway rotation, or electively in R2/3 if they do their Airway rotation at FMC. Residents should contact the Site Coordinator and Site Administrator (Jennifer Kolb) to arrange.

4. Residents must attend Thursday morning teaching rounds at 0700h in the cafeteria. Oral exam

questions will be presented. If no residents are able to attend, please inform both Drs. Erin Bruce and Zahid Sunderani.

5. Vacation requests must be made at least 4 weeks prior to the start of a rotation.

6. If a resident will be late or absent, please follow the usual policy for reporting absence from clinical work.

7. All concerns are to be sent to Drs. Erin Bruce and Zahid Sunderani.

Call Responsibilities

- Two to three call shifts will be "OR only", where you begin an elective list at 0740, then continue in the main OR after your list is done until the OR closes. You do not report to L&D after the main OR closes in an "OR Only" call.
- The calls are 16 hours in duration: 1600-0800h where you start working in the main OR until it closes, and then report to the L&D Anesthesiologist on unit 62. Call rooms are located in the Highwood Building near the 'Red Thread' gift shop.

Call requirements for a PGY-5 Adult Anesthesia Rotation / Medical Education Rotation:

- 1 weekday call shift: 0800-0800h
- The R5 will function as the OR1 on-call anesthesiologist. After the OR shuts down, the R5 does not go up to L&D. The R5 would be part of any conference calls that re-open the OR, and would be responsible for those cases. Post-call day off.
- 1 weekend Saturday call shift and 1 weekend Friday/Sunday call shift: 0800-0800h - The R5 will function as the OR1 on-call anesthesiologist, meaning that they are in charge of the OR. After the OR shuts down, the R5 does not go up to L&D.

PGY-1 Residents

Obstetric Anesthesia Rotation (Rotation Coordinator: Dr. Zahid Sunderani)

- Residents are required to do 3, 24 hour (in-house) call shifts; these shifts should include two weekends – preferably 1 Saturday shift, and 1 Friday/Sunday call, the Friday shift starts at 0800h*

These residents are primarily responsible to L&D. However, they will work in the main OR when they are not required on the L&D unit.

PGY-2 to PGY-4 Residents

Adult Anesthesia Rotation (Rotation Coordinator: Drs. Erin Bruce + Zahid Sunderani)

- Residents will be on call for 7 type 1 (in-house) shifts, inclusive of two weekend calls with at least one weekend consisting of a Friday/Sunday rotation. For 2 out of every 5 weekday call shifts, residents will work a regular day in the OR (starting at 0740h) and continue with call in the main OR until the main OR closes; on these days, residents are not required to work on L&D.

For the remaining (i.e. 3 out of 5) weekday call shifts, the resident starts their shift at 1600h with call in the main OR and then works on L&D after the main OR closes.

Airway Anesthesia Rotation (Rotation Coordinator: Drs. Erin Bruce + Zahid Sunderani)

- Residents are required to do 2 Saturday call shifts (type 1).

Lockers

Please see the Docs & Files section of the 'Residents' basecamp

Medical Education Rotation

Table of Contents

Goals:
1. To facilitate the development of senior residents' knowledge and skills in teaching junior learners as part of their transition to practice as a staff anesthesiologist.
2. To train residents to be able to provide effective and high quality bedside clinical teaching without compromising concomitant patient care and safety.
3. To introduce residents to essential elements of devising, planning and delivering a learning activity.
4. To develop residents' skills in giving constructive and effective feedback to their junior learners.
5. To reinforce residents' knowledge of major principles of effectively searching, and critically evaluating medical literature.

Objectives:
1. Residents will be assigned to the ORs with junior learners where they will be expected to supervise and teach junior learners in order to emulate the responsibilities of clinical teaching routine to independent anesthesia practice. While performing these teaching roles the residents should:

• Identify the learning needs of a learner
• Choose teaching methods and topics appropriate for the learner's level of training and learning style
• Use strategies for deliberate, positive role-modeling
• Promote a safe learning environment
• Supervise learners to ensure they work within limitations, seeking guidance and supervision when needed
• Balance clinical supervision and graduated responsibility, ensuring the safety of patients and learners
• Provide feedback to enhance learning and performance

2. Residents will be expected to plan, prepare and deliver a learning activity for a small group of learners composed of medical students and junior residents (small group teaching rounds on Thursday morning 7am).

• Define specific learning objectives for a teaching activity
• Apply knowledge of the clinical and biomedical sciences relevant to Anesthesiology
• Adapt and plan learning activity appropriate to the level of the learner

3. Residents should choose a narrow topic of interest relevant to clinical practice at RGH and search medical literature for the most up-to-date studies about the aforementioned topic. They should then critically evaluate and synthesize the findings of 3-4 of those publications and present/discuss this with one or more staff members during their workday. Through this activity residents should:

• Determine the validity and risk of bias in a source of evidence
• Critically evaluate the integrity, reliability, and applicability of health-related research and literature
• Describe how various sources of information, including studies, expert opinion, and practice audits, contribute to the evidence base of medical practice
• Summarize the scientific knowledge on a topic or a clinical question and integrate evidence into decision-making in clinical practice

Reading/Resources:
Pardo M, Randall MS. Teaching Anesthesia. Miller's Anesthesia 8th Edition, Chapter 9: pp 210-231.

Articles supplied on Basecamp

Table of Contents

South Health Campus

Welcome to the SHC!
We opened in 2013; we are a relatively small group of anesthesiologists from across the country who are passionate about education while maintaining a friendly and pragmatic community feel. Surgical services include orthopedics, general surgery, bariatric surgery, ENT, plastics, obstetrics and gynecology. Our 9 elective OR suites and 2 cesarean section ORs are located on the third floor. Obstetrics is housed in the Family Maternity Place on unit 76 and is served by a dedicated emergency elevator.

In addition to surgical services, we have a regional anesthesia block room, we run Calgary's original Transitional Pain Clinic, and overall maintain a very engaged and collaborative focus on pain management. Our staff also cover obstetrics, APS, PAC, ECT, endoscopy, diagnostic imaging (MRI and interventional procedures such as kyphoplasty), outpatient gynecology clinic, and AHS-contracted non-hospital surgical facilities.

Our section provides teaching opportunities to residents, medical students, other physicians, and allied health care students and staff. Our section members have fellowships in regional anesthesia, ultrasound and echocardiography, chronic pain, obstetrical anesthesia, along with training in global health, medical education, leadership, and patient safety and quality improvement. A majority of our patients are day surgery or short-stay cases and there is a strong emphasis on ambulatory anesthesia principles with several TIVA advocates among staff.

The SHC site uses cell phones as an approved form of communication, and many staff prefer this technology over traditional pagers; signal boosters are present throughout the hospital. Contact numbers are available from the main OR desk:

- OR Main Desk – 403-956-1800
- PACU/Block Area – 403-956-1888
- Pre-Admission Clinic – 403-956-3200
- Obstetrics Charge Nurse Desk – 71722
- Administrative Assistant Ms. Leslie Vester – 403-956-3690

Please be proactive and take advantage of all learning opportunities at our site – our staff anesthesiologists are flexible and interested in helping you advance in your learning. Review the OR slate in advance, read around cases before and after, and discuss cases/plans with your preceptor. Reflect on what you need to take your anesthetic practice to the next level.

Junior and Senior Adult Anesthesia Rotations
Rotation Coordinator: Dr. Ravi Pullela (ravi.pullela@ahs.ca, p: 418-516-9642)

For the junior rotation, we use a longitudinal preceptor approach to this rotation to optimize learning and mentorship opportunities, so you will be assigned staff preceptor(s) for the rotation. Residents on their senior anesthesia rotation will self-assign to meet education goals while working toward independent practice. This rotation provides opportunities to consolidate your fundamental anesthetic case management skills, with a focus on ambulatory anesthesia principles and pain management. Your block will include PAC and APS time, and a precepted anesthesia rounds presentation. All residents are encouraged to seek opportunities to provide care outside the OR (e.g. ECT, kyphoplasty, gyne procedure room). Due to the ubiquity and volume of regional anesthesia at our site, you will gain experience in regional techniques, though residents on their regional anesthesia rotation and fellows maintain priority over nerve block opportunities. We will endeavor to provide you with useful feedback on all your activities over the rotation.

All residents are asked to introduce themselves to Dr. Ravi Pullela, SHC Site Coordinator, early in your rotation, and to contact him if any issues arise.

Junior Regional Anesthesia and TTP Regional Anesthesia Rotations
Rotation Coordinator÷Dr Nathan Brown (Nathan.brown@ ahs.ca)

What is unique about the SHC in Calgary, is that this is a place where regional anesthesia is considered on equal footing with general anesthesia. Our Regional Anesthesia rotations are generally busy and will demand considerable energy, communication skills, preparation, ongoing reading, and dedication to skills improvement. It is an extremely rewarding rotation for residents who are able to put in the appropriate amount of preparation and effort. Well ahead of your rotation, please review the rotation document in detail.

Regional residents are expected to prepare ahead by reviewing the OR slate for the following day, identifying which patients may be candidates for a block or nerve catheter, and reading up on the appropriate nerve block techniques (at least ultrasound-guided, but preferably nerve stimulator and landmark approaches as well) and anatomy. They need to obtain approval from the Attending Anesthesiologist and Surgeon for each patient to be consulted, to ensure that a regional technique is acceptable. In addition to the technical aspects of doing blocks, the resident must obtain an appreciation of how regional anesthesia fits into the overall care plan of the patient. These include:

1) nuances of informed consent, and the "time out" prior to the OR; 2) intra-op management of regional technique vs. GA, and backup plans if regional anesthesia in inadequate; 3) peri-operative workflow of regional vs. GA, eg. maintaining efficiency, giving blocks adequate efficacy time, patient disposition; 4) pain management plan, transition to oral analgesics post-block, mandatory patient follow-up.

Call Requirements
Two call shifts per block that will avoid interference with daytime regional anesthesia exposure.

Community Anesthesia Rotation (Lethbridge & Red Deer)

Lethbridge and Red Deer are our locations for our community anesthesia rotation. Application for an alternative location will be considered on a case by case basis. The specific learning/professional objectives of an alternative location should be stated.

Chinook Regional Hospital (Lethbridge)

Chinook Regional Hospital services Southern Alberta including Lethbridge and surrounding rural areas-with a catchment population of about 150 000 or more. Currently there are 250 acute care beds with 45 geriatric beds and 15 bassinets in our NICU.

Our facility has an ICU, and Emergency Room – and is an accredited Level 3 Trauma Centre and provides coverage in pediatrics, geriatrics, general surgery, obstetrics and gynecology, ENT, urology, orthopedics and plastics. We also have Cancer services.

Our Operating Room runs 7 theatres daily, with up to 3 private dental suites. We also have a designated "Out of OR" anesthesiologist each day from 7:15-15:15h who provides services to Acute Pain on the wards, consult services in Pre-Admission Clinic, consults on the wards and covers labour and delivery as well as ECTs from psychiatry. Our OOR Anesthesiologist may also be involved with level 1 traumas or other acute care patient needs during the day. We have 2 additional ORs with our new labour and delivery unit for C-sections.

When you arrive

When you first arrive in Lethbridge, you will receive instructions from Leah Oviatt (leah.oviatt@ahs.ca) from administration regarding hospital access passes, ID badges, pagers and parking availability. If you do not receive such instructions, you can also contact SZ.MedicalAffairs@ahs.ca. If you have questions at any time, please contact your primary preceptor, Dr. Brent Francis at cell 403-635-3654 or brent.francis2@gmail.com. If he is not available, he will assign a designate in his place.

Entry into the Operating Room is on the 3rd floor on the East side of the building. There are 3 doors, one via the change room, one via the staff lounge and another via the main desk (double doors). Your pass should get you through each of these entries once you have had it activated via instructions from Leah. On the South East side of the OR, there is also entry via the Doctor's Lounge. This door has the same card access as the other OR doors.

Scrubs are available in the OR change room and should not be removed from the hospital. There is a designated locker for anesthesia residents in both the male and female change rooms. If not, use a day use locker.

Work Expectations

You are expected to work in the OR each regular work day unless vacation has been preapproved or you are post call. Exception to this is your afternoon academic time which will be protected while you are here. Please remind the person you are working with that day that it is protected time. Our days begin at 7:10 and ends around 15:15 – however this can be variable.

When you arrive, please inform Dr. Francis which days of call you are taking. You are expected to be on call one weekday a week that you are here and one weekend day. A Friday/Sunday call will count as a weekday and weekend. Expectations for call should be similar to PARA guidelines. Individual exceptions to this can be discussed between your program director and Dr. Francis.

You may discuss with your staff regarding post call days. In general, if you have worked past 2200h, you can take the following day off to rest. If you are in the "grey zone"; right at 2200h, you may discuss this with your staff that evening. If possible, please inform your staff person in advance you will be working on call with them – **the call schedule can be viewed with the help of the front admin staff or one of the staff Anesthesiologists.**

Call cases begin generally once the earliest room is done and the on call anesthesiologist begins around 1515h. Cases are prioritized based on E status and no cases with an urgency of E24 or less are started after 2300h. After 2300h, we are often busy doing epidurals and covering labour and delivery. We also are part of the trauma team and respond to level 1 traumas.

Call is home call, but you are welcome to stay in house if you prefer. Most evenings we have on call cases that go to 2200 or after. We will stay in house if there is an epidural running or an obstetrical patient on standby. There is a second call room in the new Labor and Delivery that can be used to stay in house if desired. It is room number 3L 343 and the code is 135#. Let labor and delivery know prior if you intend to use this room.

During the workdays, you will have exposure to a multitude of interesting cases. The slates for the following day will be made available after noon the day prior. Often, the OR Respiratory therapists will provide you a copy of the slate. On the right of the slate will indicate if there are any particular needs for a case (but not always) such as a difficult intubation, myasthenia gravis or pseudocholinesterase deficiency patient, for example. Interesting days include ENT (often includes pediatrics), and Urology cases (prostatectomies, nephrectomies, etc) and AV fistulas under brachial plexus blocks etc. Once you

have selected your room that you will do the following day, please try to inform the staff you will be working with. If they are not in hospital, you may obtain their contact information from the front desk or Dr. Francis.

You are also welcome to join the "Out of OR" Anesthesiologist. They will have days of rounds, ECTs and consults as well as epidurals; however, there are some days that are less busy. If you are interested in this type of day, contact the staff scheduled for it the day before. This position and our 1st Call Anesthesiologist carry a Wi-Fi phone with extension 6012. Most beneficial OOR days will be those with at least once c-section and ECTs booked.

Rounds

While here, you are expected to present a rounds topic to the department. This is usually set up at a nice restaurant followed by a paid meal. Please discuss with Dr. Humphrey Cheung a topic and possible dates to present when you arrive. Typically, we do this on the last week that you are here but this is flexible. The topic can be something you have presented before; the goal is not for you to have to prepare something new but for you and our department to benefit from work you've already done. We have access to our own departmental projector and computer if you require them. Please contact Dr. Cheung, Dr. Francis or Dr. Derdall regarding access to these items.

Education

If you would like to join your fellow residents for academic half day, you may do so but please remind your staff on the day. We have capability for wireless internet access and camera/ teleconferencing. Otherwise, Thursday will be your academic time to use to study. Please respect this opportunity to use it for your own academic benefit as you best see fit.

There are also textbooks in our anesthesia office that you are welcome to read.

Objectives

Please reflect on your personal objectives that you would like to accomplish while doing an anesthesia rotation here. For most people, this is an opportunity to consolidate your CanMEDS skills and try to discover your independent practice style. Senior anesthesia residents are often caught in a "specialty" mode that it often takes a while as a practicing staff to reclaim that approach of handling anything that comes through the door. We encourage you to try to be independent and make your own decisions, while presenting your plans to your attending staff. You should be in the habit of always justifying your decisions. This will help you prepare for your exams.

Being away from Calgary, please also realize that most of us do not know you. The first time we work with you, please understand we will often be present in the room, regardless of your level of training. Once we have achieved a comfort level with you, and have had an opportunity to assess your abilities, you will be eased into your expected level of independence.

Overall, we are excited to have you here. We often learn from each other so it is a great opportunity for all. Relax, have fun and do not forget to check out our beautiful city and surrounding areas while here. Our goal is to make this rotation as beneficial to you as possible, our focus is on education and not service. At the end of the rotation, we would like feedback from you to know how we can continue to improve the rotation.

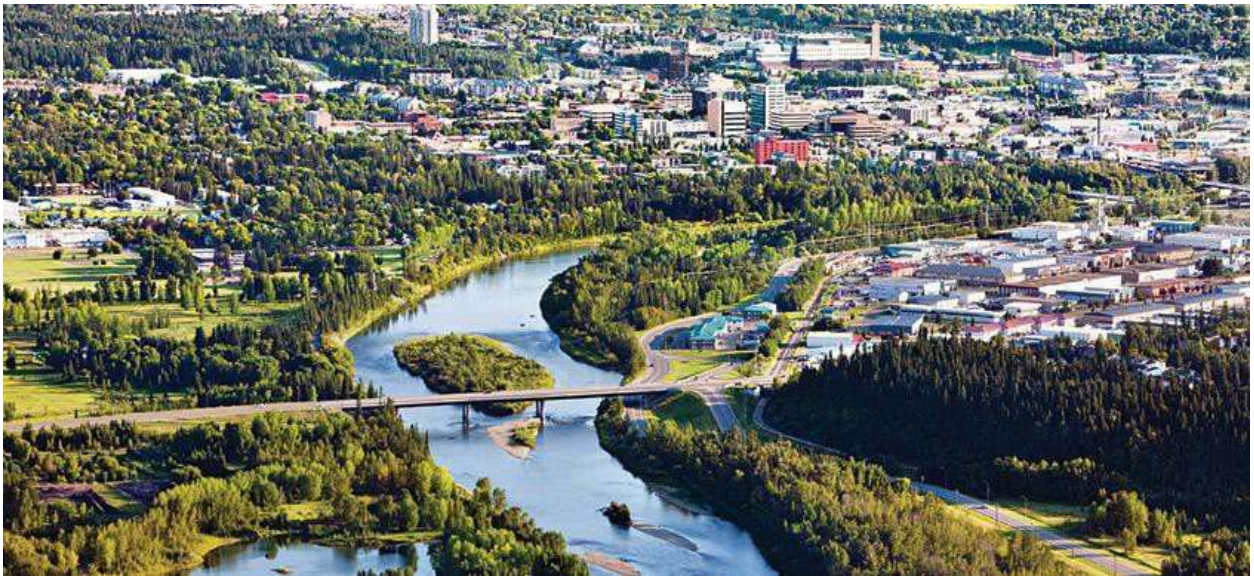
Do not hesitate to text/email/call me if you have questions.

Sincerely, Dr. Brent Francis BSc MD FRCPC

Table of Contents

Red Deer Regional Hospital

Are you an Anesthesiology resident seeking a unique and enriching experience? Look no further than Red Deer, Alberta! Nestled in the heart of stunning Central Alberta, Red Deer offers an unparalleled opportunity for residents to immerse themselves in a thriving medical community while surrounded by the beauty of nature.



Why Choose Red Deer for Your Community Rotation/Elective?
1. Exceptional Learning Environment: Red Deer is home to a dynamic medical community that includes the Red Deer Regional Hospital, known for its commitment to excellence in patient care and medical education. Our Anesthesiology Department is dedicated to providing residents with mentorship, and a safe learning environment.

2. Diverse Case Load: During your rotation in Red Deer, you'll have the chance to work on a wide variety of cases. With the third busiest Emergency Department in Alberta, and a level III trauma centre there is a large mix of trauma, urgent, and elective cases. A catchment area of over 500,000 people results in a very busy General Surgery, Orthopedics, Urology, Ophthalmology, Gynecology, ENT, and Plastics Surgery services. There is also a large Obstetrics practice at the hospital, dealing with both low and high-risk deliveries. There is a busy pre-admission clinic that you can choose to participate in. Approximately 150 surgical cases are completed per week at the hospital.

There is a 20-bed ICU, and during your rotation you can participate in ICU care as desired.
While there is no formal Acute Pain Service as of yet, as a resident you will have the opportunity to follow your patients post-operatively who have had varying pain interventions during their peri-operative course.

There is opportunity to perform a wide variety of regional anesthesia techniques, with three dedicated RTs in the Operating room to assist.

There is opportunity to support electroconvulsive therapy once a week at the Red Deer Hospital.
The above outlined diversity will enhance your clinical skills and prepare you for a transition to a busy high-turnover, high-acuity practice.

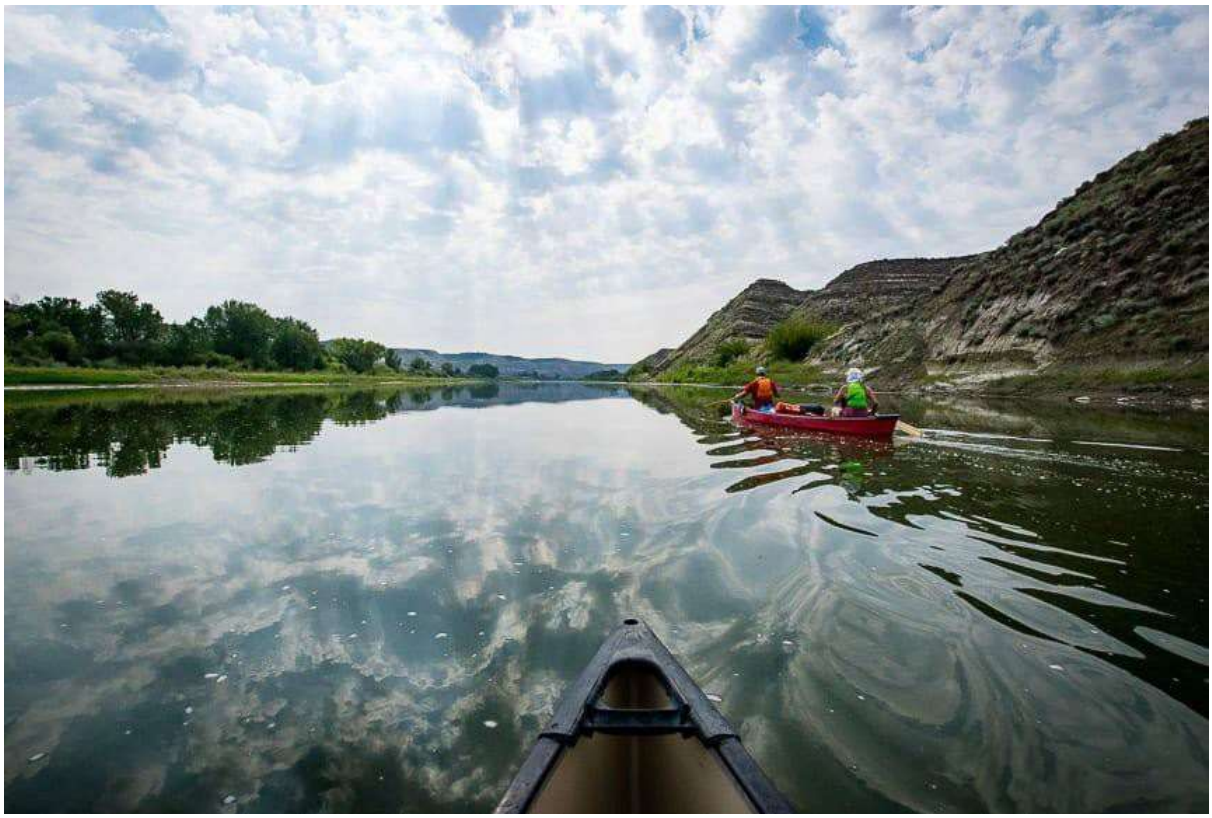
3. Mentorship and Collaboration: Our experienced faculty and staff are passionate about education and are eager to help you excel in your residency. You'll have the opportunity to work closely with mentors who are committed to your growth and success.

4. Community-Centered Care: Red Deer is known for its strong sense of community, and you'll experience this firsthand in our medical facilities. Our residents often find this environment deeply rewarding as they contribute to the well-being of the local community.

5. Natural Beauty and Recreation: When you're not in the hospital, Red Deer's natural surroundings offer endless opportunities for relaxation and outdoor adventures. Explore the nearby national parks, go hiking, skiing, or simply unwind in the serene beauty of the nearby Rockies.

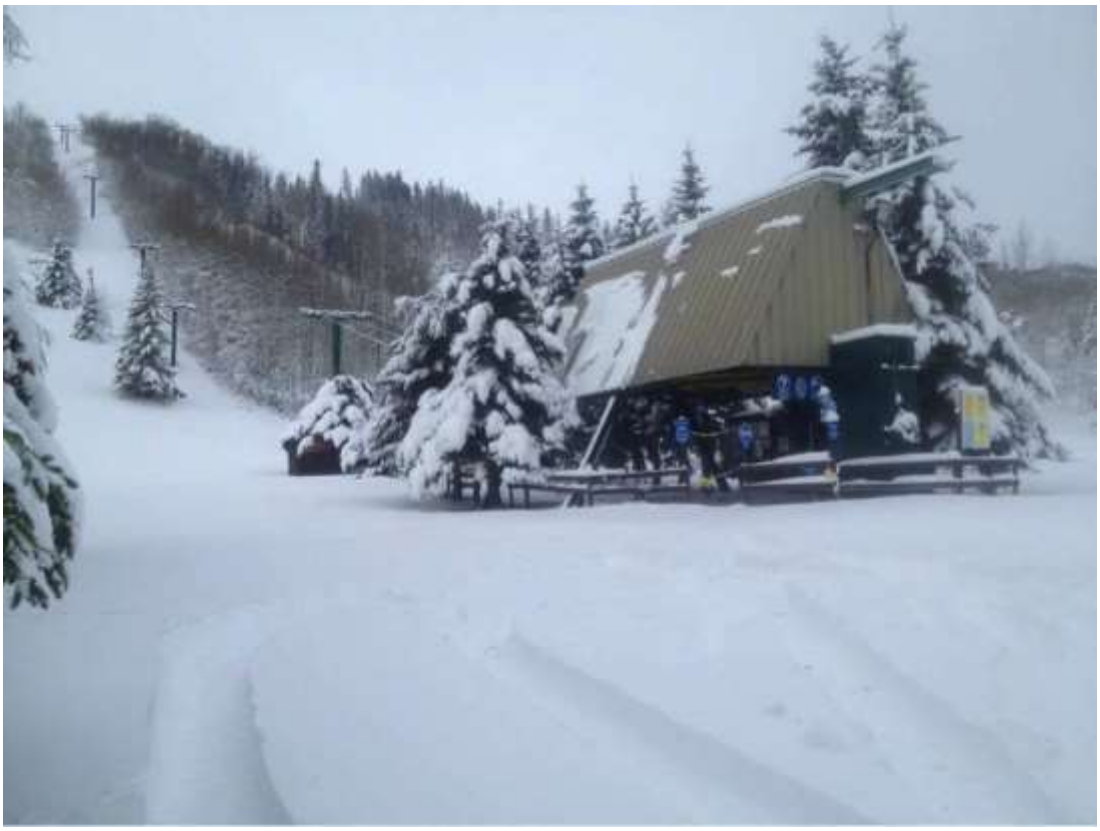
6. Cultural Enrichment: Red Deer boasts a vibrant arts and cultural scene. You'll have access to museums, theaters, and local festivals that celebrate the region's rich history and diverse heritage.

7. Quality of Life: Red Deer is a welcoming and family-friendly city with a lower cost of living compared to major metropolitan areas. This makes it an ideal place to explore, as you transition into independent practice.



Call requirements:
Residents will be expected to sign-up for one in-house call shift per week of their rotation. This can be on a weekdays or weekends, at the discretion of the resident. Call duties generally will start at 1600h and will end at 0800h. Residents will be expected to take a post-call day as per PARA agreements. We encourage residents to schedule their call shifts to best balance their personal obligations.

Rounds:
Educational rounds are held once a month on the third Thursday from 0730h-0830h. If a resident is in Red Deer during this time, they have the option to present an educational topic of their choosing. These are Royal College Accredited educational sessions and can be utilized for CPD credits.



Join Us in Red Deer for an Unforgettable Anesthesia Rotation Experience!
Red Deer, Alberta, offers a unique blend of professional growth and personal fulfillment. Here, you'll find an anesthesia community that's dedicated to your success, a diverse and enriching case load, and a lifestyle that balances work with leisure in one of Canada's most breathtaking regions.

Take the next step in your anesthesia residency journey by choosing Red Deer, Alberta, for your community rotation or elective. We look forward to welcoming you to our close-knit medical community and helping you achieve your career aspirations.

Contact Dr. Karim Mohamed at karim.mohamed@albertahealthservices.ca to schedule your community rotation or elective.

Table of Contents

CONTINUOUS PROGRAM EVALUATION

Our program is evaluated externally every eight years by the RCPSC; our next external review will take place in 2030. For interim assurance of the quality of our program, internal reviews are conducted by the PGME office in between external reviews, and annual program evaluation is carried out by the RPC. These activities are all mandated for accreditation of our program. Our program is currently fully accredited by the RCPSC.

Formal annual program evaluation is carried out by:

- annual reviews of rotations – the RPC regularly discusses different rotations to determine whether any improvements can be made; over the course of the year, every rotation is discussed at least once;
- the PGY-1 review – carried out by the PGY-1 residents at the end of their year;
- rotation evaluation forms – completed by each resident after each rotation;
- Core Program evaluation – completed by each resident at the end of each session;
- Faculty teaching evaluations – carried out by all residents via one45 and are presented to the staff yearly in a summarized form.

Other means of program assessment include:

- resident opinion taken to the RPC through the resident representatives; and
- annual individual meeting with the PD (these sessions are also used to discuss career plans, problems, requests, etc.).
- annual PGY cohort meeting with the PD (these sessions are used to discuss cohort concerns about rotations, educational events, leadership changes, brainstorm new approaches and innovations to rotations and educational activities)

RESIDENT AND FACULTY AWARDS

Resident Awards

Top Junior and Senior Resident Awards

Purpose: This award recognizes the outstanding clinical performance and academic achievement of resident physicians in the Department of Anesthesiology, Perioperative and Pain Medicine.
Eligibility: All residents in good standing will be considered for this award. Postgraduate Year (PGY)- 1 and PGY-2 residents are considered for the junior resident award, while PGY-3 and PGY-4 residents are considered for the senior resident award.
Criteria: The following domains will be considered, in decreasing order of importance:

1. all clinical rotation In-Training Evaluation Reports(ITER's);
2. performance on standardized exams;
3. scholarly activity; and
4. professionalism.

Selection Process: The Program Directors will review all PGY-1 to PGY-4 resident files in accordance with the aforementioned criteria. They will generate a list of residents for the RPC to consider, and the RPC will select the recipient(s) for this award.

Extra Mile Award

Purpose: This award recognizes extraordinary selflessness and peer support of the resident physicians in the Department of Anesthesiology, Perioperative and Pain Medicine.
Eligibility: All postgraduate year (PGY)-1 to PGY-5 residents in good standing may be considered for this award.
Criteria: The individual has demonstrated exemplary support and dedication to the wellbeing of their fellow resident physicians.

Nominations: Any resident is invited to submit a nomination. Nominations should include a brief letter to the Program Director stating why the individual has met the above criteria demonstrating commitment to resident wellbeing.
Selection Process: Nominations will be reviewed by the Program Director, Associate Program Director, and Lead Residents. Resident physicians deserving of this award will subsequently be presented to the RPC for final approval.

Undergraduate Medical Education Award

This award is presented to the resident who's teaching of the mandatory anesthesia clerkship session has been rated the highest by clinical clerks. The selection process is conducted by the department's Undergraduate Medical Education Committee.

Faculty Awards

Excellence in Postgraduate Medical Education Award

Purpose: This award recognizes the extraordinary contributions made by an individual to resident education in the Department of Anesthesiology, Perioperative and Pain Medicine through teaching, administration, or program development which benefit residency education and physician development.
Eligibility: All current faculty members of the Department of Anesthesiology, Perioperative and Pain Medicine.

Criteria: The individual has demonstrated outstanding teaching of residents and has made significant contributions to any of the following: program development; program administration; innovative approaches to teaching and learning; research contributions to teaching and assessment or other aspects of residency education.
Selection Process: All residents in good standing may participate in the selection process. The residents will nominate and select the recipients of this award from each Calgary hospital. This process will be led by the Lead Residents. The residents may recognize up to 20% of the faculty members at each Calgary hospital with this award. One award may be given to a Fellow each year.

Outstanding Educator Award

Purpose: This award recognizes the exemplary and exceptional contributions made by an individual to resident education in the Department of Anesthesiology, Perioperative and Pain Medicine.
Eligibility: Recipients of the 'Excellence in Postgraduate Medical Education Award'
Criteria: The individual has made unique and outstanding contributions to multiple domains of residency education.
Selection Process: All residents in good standing may participate in the selection process. The residents will nominate and select the recipients of this award from each Calgary hospital. This process will be led by the Lead Residents. The residents may recognize only one faculty members at each Calgary hospital with this award.

Leo Strunin Award

Purpose: This award recognizes a unique faculty member of the Department of Anesthesiology, Perioperative and Pain Medicine who has contributed to resident education in a manner that deserves exceptional recognition.
Eligibility: Recipients of the 'Outstanding Educator Award'
Criteria: The individual has personified the highest standards and expectations of the ideal medical educator.
Selection Process: All residents in good standing may participate in the selection process. This process will be led by the Lead Residents. The residents may recognize only one faculty member in the Department of Anesthesiology, Perioperative and Pain Medicine with this award.

Faculty Extra Mile Award
Purpose: This award recognizes extraordinary selflessness and personal support of the resident physicians in the Department of Anesthesiology, Perioperative and Pain Medicine. **Eligibility**: All faculty members may be considered for this award.
Criteria: The individual has demonstrated exemplary support and dedication to the wellbeing of resident physicians.
Nominations: Any resident is invited to submit a nomination in support of a faculty member deserving this award. Nominations should include a brief letter stating why the individual has met the above criteria demonstrating commitment to resident wellbeing.
Selection Process: The Lead Residents will lead the selection process with the residents. Once selected, the Lead Residents will inform the RPC of who the award recipients are.

RESOURCES FOR RESIDENTS

Agencies
PARA representatives may be contacted through the PARA website at http://para-ab.ca/
The AMA offers a variety of services (https://www.albertadoctors.org/), including emergency support. The AMA Physician and Family Support Program (https://www.albertadoctors.org/services/physicians/pfsp) manages a hotline at 1-877-SOS-4MDS (767-4637) (https://www.albertadoctors.org/services/physicians/pfsp/i-need-help-now). Up to six one-hour counseling sessions per family member per year are available free of charge.

AHS also has an Employee and Family Assistance Program that can be reached at 1-877-273- 3134 or https://homeweb.ca/

The main campus of the U of C offers a variety of services, including a bookstore, recreational facilities, The Chaplains' Association, Student Rights Advisor, and Academic Counseling.
All residents are urged to have a Family Physician throughout their training. Self-medication, prescription writing without formal consultation, and removal of pharmaceuticals from the OR are not supported. While it is reasonable to keep a limited number of labeled syringes/vials to be taken to patient care areas while on call, **keeping narcotic boxes in the on-call room is absolutely prohibited**.

If you think you might be, or are faced with, a serious complaint or a threat of a lawsuit, then you should notify the CMPA by telephone 1-800-267-6522 at once. Send complete, concise information. **Do not contact the CMPA by e-mail**. Wait for a reply from the CMPA before taking any further steps or making any statements. Be sure your clinical records are secure. Do not consult a lawyer without instructions from the CMPA. The CMPA does not accept responsibility for the payment of legal expenses incurred without its prior approval. Do not answer any letters of complaint from patients, lawyers or others without first receiving the CMPA's advice.

PGME Office of Resident Affairs and Physicians Wellness (Brochure at end of Program Manual)

An appointment can be booked by calling 403-210-6525 or by email at residentwellness@ucalgary.ca.

University of Calgary Sexual Violence Support Advocate
Carla Bertsh is the university's sexual violence support advocate (SVSA). The SVSA provides information and confidential support to anyone affected by sexual violence.
Support looks different for everyone and can include:
- talking through reporting options
- offering information on therapeutic or self-care options
- advocating for academic or self-care options
- attending appointments (Calgary Police Service, Campus Security, instructors, etc.)

- helping managing everyday challenges
- having someone to listen
- Contact:
- https://www.ucalgary.ca/sexual-violence-support/sexual-violence-support
- svsa@ucalgary.ca|403-220-2208

Experts from Outside the Specialty
Experts in the areas of law, practice management, accounting, lifestyle, time management, addiction, learning problems, exam-writing anxiety, multiple choice answering strategies, sleep disorders, and a variety of other areas of potential interest to residents are frequently invited to present at academic half-day and CARR. The PD and Program Administrator will also facilitate arrangements for individual residents to get help in these areas as needed.

Facilities
Residents are encouraged to obtain a Unicard (http://www.ucalgary.ca/unicard/) and to make use of the Main Campus recreational and arts facilities.

Funds
Funds for resident education are provided through various PGME grants; this funding is available only for a restricted list of events (e.g. research presentation).
Contributions from industry are also managed through the RPC.
The Department of Anesthesiology, Perioperative and Pain Medicine's Anesthesia Academic Council will consider requests for funds required to carry out research.

Ombudsman
The role of the ombudsman is to assist residents who perceive that they have been offended or treated unfairly and feel that they are not being adequately supported within their own program. The ombudsman for the anesthesia residency training program is **Dr. John Graham** from the division of General Surgery at the Rockyview General Hospital.

Libraries
The Department of Anesthesia's Library is located on the second floor of the FMC with security access (see Lead Residents for combination). Computer workstations with Internet access are dedicated for resident use. A full service medical library can be found at the medical school, adjacent to FMC. In addition, the program has purchased a selection of key textbooks that are available from the program administrator's office. A complete list of textbooks, along with a sign-out sheet, is available on the Docs & Files section of the 'Residents' Basecamp.

Textbook Recommendations
Source textbooks and medical journals for the RCPSC examinations in anesthesia can be found at http://www.royalcollege.ca/rcsite/documents/ibd/anesthesiology_examformat_e
Most of the aforementioned books and journals can be found electronically via the U of C Health Sciences Library. Although most resources are found in 'Clinical Key', a search of the library catalogue will lead you to all the books available through the library.

Table of Contents

Standard Textbooks (RCPSC Examination References):

- A Practice of Anesthesia for Infants and Children by Cote, Lerman, and Anderson
- Anesthesia and Uncommon Diseases by Fleisher
- Clinical Anesthesia by Barash et al.
- Miller's Anesthesia by Miller et al.
- Obstetrical Anesthesia: Principles & Practice by Chestnut et al.
- Stoelting's Anesthesia & Coexisting Disease by Hines and Marschall
- Stoelting's Pharmacology & Physiology in Anesthetic Practice by Flood, Rathmell, and Shafer

General Textbooks

- Anesthesiologist's Manual of Surgical Procedures by Jaffe

- Anesthesiology by Longnecker et al.
- Clinical Anesthesia by Barash et al.
- Crisis Management in Anesthesiology by Gaba et al.
- Evidence-Based Practice of Anesthesiology by Fleisher
- Miller's Anesthesia by Miller et al.
- Morgan and Mikhail's Clinical Anesthesiology by Butterworth, Mackey, and Wasnick
- Stoelting's Anesthesia & Coexisting Disease by Hines and Marschall
- Stoelting's Pharmacology & Physiology in Anesthetic Practice by Flood, Rathmell, and Shafer
- Yao and Artusio's Anesthesiology: Problem-oriented Patient Management by Yao
  http://pie.med.utoronto.ca/CA/index.htm

Airway

- Management of the Difficult and Failed Airway by Hung and Murphy

Cardiac Anesthesia

- Kaplan's Cardiac Anesthesia by Kaplan, Reich, and Sayino
- A Practical Approach to Cardiac Anesthesia by Hensley et al.
- A Practical Approach to Transesophageal Echocardiography by Perrino and Reeves

ICU

- www.teachingmedicine.com
- Critical Care Medicine: The Essentials by Mrini and Wheeler

Internal Medicine

- Harrison's Principles of Internal Medicine by Harrison et al.
- Dynamed Plus (available through U of C library)

Medical Education

- Crucial Conversations: Tools for Talking When the Stakes are High by Patterson
- Educational Design: A CanMEDS Guide for the Health Professions
- Understanding Medical Education: Evidence, Theory and Practice by Swanswick

Monitoring and Equipment

- A Practical Approach to Anesthesia Equipment by Dorsch and Dorsch
- Anesthesia Equipment: Principles & Applications by Ehrenwerth, Eisenkraft, and Berry
- The MGH Textbook of Anesthetic Equipment by Sandberg, Urman, and Ehrenfeld
- http://pie.med.utoronto.ca/Edwards/index.htm
- http://www.capnography.com/

Neuroanesthesia

- Cottrell and Young's Neuroanesthesia

Obstetric Anesthesia

- Obstetrical Anesthesia: Principles & Practice by Chestnut et al.
- http://pie.med.utoronto.ca/OBAnesthesia/OBAnesthesia_content/OBA_spinalUltrasound.html

Pediatric Anesthesia

- A Practice of Anesthesia for Infants and Children by Cote, Lerman, and Anderson

Physiology

- Nunn's Applied Respiratory Physiology by Nunn
- Review of Medical Physiology by Ganong
- Respiratory Physiology: The Essentials by West

- Stoelting's Pharmacology & Physiology in Anesthetic Practice by Flood, Rathmell, and Shafer
- http://library.med.utah.edu/kw/pharm/1Atrial_Systole.html
- http://bk.psu.edu/clt/bisc4/ipweb/systems/systems/respiratory/index.html
- http://virtuallabs.stanford.edu/demo/
- http://www.teachingmedicine.com/

Question Banks

- Anesthesia: A Comprehensive Review: Hall MD, Brian A., Chantigian MD, Robert C.: 9780323567190: Anaesthesia: Amazon Canada
- Anesthesiology: A Comprehensive Review for the Written Boards and Recertification: Matthes, Kai, Urman, Richard, Ehrenfeld, Jesse: 9780199733859: Anesthesiology: Amazon Canada

Regional Anesthesia

- Atlas of Regional Anesthesia by Brown
- Neural Blockade by Cousins and Bridenbaugh
- http://usra.ca/
- http://nyrsora.com
- http://www.osuultrasound.com/

Research

- How to Read a Paper: the Basics of Evidence Based Medicine by Greenhalgh
- JAMA User's Guides to the Medical Literature by Guyatt et al.
- The Research Guide: A Primer for Residents, Other Health Care Trainees, and Practitioners

Thoracic Anesthesia

- Principles and Practice of Anesthesia for Thoracic Surgery by Slinger

Transfusion Medicine

- Bloody Easy 3
- Perioperative Blood Management: A Physician's Handbook by AABB and SABM

Other Useful Journals and Resources

- Continuing Education in Anaesthesia, Critical Care, and Pain (CCEACP)
- World Federation of Societies of Anesthesiologists: Tutorial of the Week (http://www.wfsahq.org/resources/anaesthesia-tutorial-of- the-week)

Wellbeing

- The Time Management Guide
- CanMEDS Physician Health Guide

Table of Contents

DOCUMENT CONTROL

Document Name: Program Manual 2024-2025
Revised: August 2024
Review Date: August 2024

Table of Contents

Index of Acronyms

ABA – American Board of Anesthesiology
ACH – Alberta Children's Hospital
ACRM – Anesthesia Crisis Resource Management
AHS – Alberta Health Services
AKT – Anesthesia Knowledge Test
AMA – Alberta Medical Association
APD – Associate Program Director
APS – Acute Pain Service

CanNASC – Canadian National Anesthesia Simulation Committee
CaRMS – Canadian Resident Matching Service
CARR – Calgary Anesthesia Residents' Retreat
CAS – Canadian Anesthesiologists' Society
CBD – Competency By Design
CCM – Critical Care Medicine
CICU – Coronary Intensive Care Unit
CMA – Canadian Medical Association
CMPA – Canadian Medical Protective Association
CPSA – College of Physicians and Surgeons of Alberta
CTC – Critical Thinking Course
CVICU – Cardiovascular ICU

EC – Education Coordinator
ECT – Electroconvulsive Therapy
ENT – Ears, Nose, Throat

FITER – Final In-Training Evaluation Report
FMC – Foothills Medical Centre

ICU – Intensive Care Unit
ITER – In-Training Evaluation Report

L&D – Labour and Delivery
LMCC – Licentiate of the Medical Council of Canada LOA – Leave of Absence
NICU – Neonatal ICU
OB – Obstetrics
OR – Operating Room

PAC – Pre-Admission Clinics
PACU – Post-Anesthesia Care Unit
PARA – Professional Association of Residents of Alberta
PD – Program Director
PFSP – Physician and Family Support Program

PGY – Postgraduate Year
PICU – Pediatric Intensive Care Unit
PLC – Peter Lougheed Centre
PGME – Post-Graduate Medical Education

QA/QI – Quality Assurance/Quality Improvement

RC – Research Coordinator
RCPSC – Royal College of Physicians and Surgeons of Canada
RGH – Rockyview General Hospital
ROCA – Regional On-Call Application
RT – Respiratory Therapist
RTC – Residency Training Committee

SC – Site Coordinator
SHC – South Hospital Campus
SimC – Simulation Coordinator
TEE – Transesophageal echocardiography
U of C – University of Calgary
UME – Undergraduate Medical Education

UNIVERSITY OF
CALGARY