ACKNOWLEDGMENT

I have in my possession and have read the Ohio State University Medical Center Dental Anesthesiology Residency Program Policies and Procedures, including the controlled substances distribution policy, due process policies, complaint information and blood borne pathogens policy.

I understand and accept my obligations as outlined.

___________________________  _______________________
Signature                          Date
DENTAL ANESTHESIOLOGY
RESIDENCY PROGRAM
POLICIES AND PROCEDURES
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Program Description

The Ohio State University Medical Center offers a 27-month Anesthesiology Residency for dentists, which fulfills all the requirements for accreditation by The American Dental Board of Anesthesiology (ADBA).

This program prepares the dentist to manage pain and anxiety in the most comprehensive manner in the adult and pediatric dental patient by utilizing pharmacologic as well as non-pharmacologic methods. At the conclusion of the program, the dentist will be proficient in providing intubated and non-intubated general anesthesia, deep sedation and conscious sedation for diverse dental, oral and maxillofacial surgical procedures performed on healthy and medically compromised patients.

The program begins with a 3-month Dental Anesthesiology rotation consisting of general anesthesia, pharmacology, physiology and medicine training at Nationwide Children’s Hospital (NCH) and the OSU College of Dentistry. The following 15 months are spent providing anesthesia and critical care medicine services at University Hospital and Nationwide Children’s Hospital and one month in Internal Medicine training at Grant Medical Center. While on the anesthesia services, the dental resident functions as other medical residents in regard to types of surgical procedures, medical compromise status of patients and call responsibilities in this Level I trauma center. During the Internal Medicine rotation, the anesthesiology resident again functions as his/her physician counterparts: admitting patients and actively managing his/her own case load, participating in rounds and call responsibilities. This includes overnight management of the Coronary Care Unit and Surgical Intensive Care Unit. A rotation in the Surgical Intensive Care Unit at University Hospital can also be arranged.

The resident then returns for 9 months of Dental Anesthesia rotation at both NCH and the College of Dentistry. Generally, time is usually split equally between both institutions. At the College of Dentistry, two days per week of anesthesia services is devoted to oral & maxillofacial procedures including LeFort osteotomies, mandibular osteotomies, bone grafting procedures, various plastic procedures, and dento-alveolar surgery. One day per week is spent in the GPR clinic providing general anesthesia for medically, emotionally, and intellectually compromised patients. One day per week is devoted to the delivery of intubated and non-intubated pediatric dental anesthesia for complex restorative procedures. The resident also provides various anesthesia services, such as conscious sedation, general anesthesia, aesthetic and emergency equipment maintenance, BLS & ACLS certification and recertification, and pre-operative physical examinations for other departments within the College of Dentistry.

The resident participates in multiple didactic experiences and case management conferences and completes course work in Statistics and Experimental Design though the Graduate School. A research project is expected in the area of anesthesiology.
Graduates of the program are eligible for membership in the American Society of Dentist Anesthesiologists and examination by the American Dental Board of Anesthesiology for Diplomate status.

This is a funded position paying standard OSUMC PGY I, II & III salaries with applicable benefits. Malpractice insurance and tuition for Graduate School courses are waived. Parking passes and health insurance may be purchased through the University.
Overview of Curriculum Management Plan

This document is provided to serve as an overview of the curriculum plan of the OSUMC Dental Anesthesiology Residency Program. This is a 27-month Certificate program. Didactic experiences continue throughout the residency in all years as does ongoing clinical activity. A monthly overview of the major site of activity follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>1st Year</th>
<th>2nd Year</th>
<th>3rd Year</th>
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<tr>
<td>July</td>
<td>Dental Anes</td>
<td>UH Anesthesia</td>
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<tr>
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<td>Dental Anes</td>
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<td>UH Anesthesia</td>
<td>UH Anesthesia</td>
<td>Dental Anes</td>
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<td>UH Anesthesia</td>
<td>UH Anesthesia</td>
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<td>UH Anesthesia</td>
<td>Dental Anes</td>
<td>SICU</td>
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<td>December</td>
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<td>UH Anesthesia</td>
<td>Pain/PACU</td>
<td>Dental Anes</td>
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<td>Dental Anes</td>
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<td>February</td>
<td>UH Anesthesia</td>
<td>Internal Med</td>
<td>Dental Anes</td>
<td>Dental Anes</td>
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<tr>
<td>March</td>
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<td>UH Anesthesia</td>
<td>UH Anesthesia</td>
<td>Dental Anes</td>
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<tr>
<td>April</td>
<td>Children’s Anes</td>
<td>UH Anesthesia</td>
<td>Dental Anes</td>
<td>UH Anesthesia</td>
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<tr>
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<td>Children’s Anes</td>
<td>Dental Anes</td>
<td>Dental Anes</td>
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<tr>
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<td>Children’s Anes</td>
<td>Dental Anes</td>
<td>Dental Anes</td>
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</table>

UH Anesthesia: The resident will function full time at a CA I/II level with usual call responsibilities, including overnight call, as appropriate for other medical anesthesiology residents. Pain/PACU rotations two weeks each. SICU rotation will be at PGY I level.

Children’s Anesthesia: Full time at Nationwide Children’s Hospital Operating Rooms as CA I/II medical anesthesia residents.

Dental Anesthesia: Full time commitment with responsibilities split between the College of Dentistry and the Children’s Dental Surgery Center at approximately 50%/50%, excluding conference time. The allocation for each year is as follows:

1st Year - 3 months of Dental Anesthesia at COD & Children’s DSC
2nd Year – 6 months of Dental Anesthesia/Children’s DSC/Research
3rd Year – 3 months of Dental Anesthesia/Research/Ambulatory Anesthesia Associates/Children’s DSC
The incoming resident spends the last week of June in a formal history and physical examination course. At the end of the week, University Hospitals (UH) holds a day long orientation for all new residents.

The first three months of the program are spent at the Nationwide Children’s Hospital (NCH) and the College of Dentistry (COD). The PGY III resident serves as a mentor for the PGY I. They generally work together for most of these three months under faculty supervision. The PGY III will have time for completion of a research project.

The resident then attends full-time clinical hospital-based rotations for 15 months of the next 18 months as listed above. The resident then returns to Nationwide Children’s Hospital and the College for an additional 9 months of clinical anesthesia. Office-based and ambulatory surgery center practice is emphasized at this time as well as additional didactic course work and completion of a research project.

In this format, the resident has three months in which to prepare for his major hospital anesthesia experience by becoming competent in endotracheal intubation, intravenous access and knowledge of anesthetic and general pharmacology and clinical medicine. Once on the OSUMC Anesthesia Service, the resident is offered similar cases to other CA I/II residents. Anesthesia is provided for ASA I - IV patients for all forms of surgery, e.g., general, orthopedic, gynecologic, vascular, neurologic, plastic, ENT/maxillofacial, transplant, etc. Regional anesthesia is also offered. The resident works independently, under supervision similar to his/her medical colleagues, and performs pre-anesthetic evaluation, anesthetic induction, maintenance and emergence. The resident is placed on the regular call schedule.

The internal medicine rotation at Grant Medical Center is taken after 6 months of OR anesthesia when the resident has significant technical and patient evaluation skills. The resident functions as a PGY II medicine resident, and admits and manages his/her own patient family. On call, they are responsible for the general medicine floor as well as the CCU. In general, the resident attends multiple codes.

Two months of pediatric anesthesia is then provided at Nationwide Children’s Hospital as all pediatric care in central Ohio is referred to this facility. The resident functions as a CA I/II anesthesia resident and takes regular call.

For the Dental Anesthesia experience, the resident splits their time between NCH and the COD. The resident’s clinical anesthesia schedule is provided in the attached calendar, Overall Dental Anesthesia Calendar. This schedule allows for a good mix of intubated and non-intubated general anesthesia as well as sedation. Significant outpatient anesthesia experience in special needs, pediatrics and oral/maxillofacial surgery is provided.

The didactic program while the resident is on Dental Anesthesia consists of the CA I lectures for PGY I residents and the CA II/III for PGY II & III residents. Thursday Anesthesia Department conference for all residents as shown in the UH Calendar as well as all Section conferences listed in the College of Dentistry Didactic Calendar. While on-service in OSUMC anesthesia, pediatric
anesthesia and internal medicine, only regular conferences for those departments are attended. An additional calendar is provided which lists the “Keyword of the Day” while on the UH Anesthesia Rotation. This is the discussion topic of the day.

The resident also takes courses offered through the OSU Graduate School in Statistics and Experimental Design. A specific course in Orofacial Pain Management provided at the College of Dentistry is also attended.
DENTAL ANESTHESIOLOGY HOSPITAL RESIDENCY

DIDACTIC PROGRAM

Statistics 800
2 credit hours
Summer quarter PGY-1
Course Director: Dr. Robert Rashid

This is an introductory graduate level course designed to provide graduate students with the principles of statistical analysis. Statistics 800 consists of a lecture and a laboratory portion with development of the skills necessary to perform computer-aided statistical analysis. This course aids residents in the assessment of current literature, as well as in the appropriate statistical methodology which will be employed in their thesis projects. This course occurs for one quarter of the PGY1 year. Please refer to syllabus for detailed course description and objectives.

Experimental Design 802
2 credit hours
Winter quarter PGY-1 or 2
Course Director: Dr. William Johnston

This course is in basic research design, and complements the statistics course in that there is a lecture and a laboratory computer portion to the didactic program. This course helps residents organize a philosophy about a critical review of the literature, including an assessment regarding the statistical analysis and methodology. Residents are better able to design their research project as a result of the information taught in this course. This course takes place during the PGY1 or PGY2 year for one quarter. Please see syllabus.

Head and Neck Pain; Dent 805
3 credit hours
Course Director: Dr. Steven Ganzberg

A broad overview of pain neurophysiology is complemented by the clinical sciences relevant to musculoskeletal, neurovascular and neuropathic head and neck pain. A broad section on pharmacotherapy is also presented along with guest lectures by pain psychologists. See syllabus.
**Advanced Head & Neck Anatomy**
3 hour sessions twice monthly
August-April PGY 1, 2, 3 during Dental Anesthesia Experience
Course Director: Dr. James Maxwell

The goals of this course are to review basic head and neck anatomy and to focus on applied surgical anatomy, including airway anatomy and tracheostomy. This course consists of a lecture portion and a laboratory portion which includes a full dissection of fresh cadaver heads. See syllabus.

**Dent 700.01: Anesthesia Seminar**
2 hours once a month
Year round PGY 1-3
Course Director: Dr. Steven Ganzberg

This course is taught once a month and it is designed to familiarize residents with an understanding of a variety of anesthesia-related issues. This course examines anesthetic emergencies in an interactive type format, and the information learned in this course is applied to weekly sessions of the clinical practice of general anesthesia. Please see topic schedule.

**Physical Diagnosis**
6-8 hours/day for one week (last week in June)
PGY-1
Course Director: Drs. Erik Evans and Steven Ganzberg

This course is designed for PGY1 residents and is designed to introduce them to the standard components of the medical history and clinical examination of patients. This course is composed of a lecture series, as well as clinical patient assessment sessions.

**Introduction to Clinical Medicine**
Multiple 2 hour on-line modules
PGY 1-2
Course Director: OSU Medical Center

This course consists of a series of on-line lectures designed to compliment the physical diagnosis course and further discuss the clinical applications of the principles of physical diagnosis and history taking.
Introduction to Anesthesiology (and Medical Center Orientation)
6 – 10 hours/day for 2 weeks
PGY 1
Course Director: Dr. Ron Harter, Program Director, Anesthesiology
   Introduction to the medical center, anesthesiology, simulation in preparation for main OR rotation.

Anesthesiology CA I Lectures
1-hour/week
PGY 1
Course Director: Dr. Ron Harter, Program Director, Anesthesiology
   This course is designed to give the PGY 1 resident a broad overview of all topics in anesthesiology as a foundation for hospital and out-patient anesthesia provision. The course is taught primarily by the physician anesthesiologists at University Hospital and is also attended by PGY 1 medical anesthesia residents

Anesthesiology CA II & III Lectures
PGY 2 & 3 1-hour/week
Course Director: Dr. Ron Harter, Program Director, Anesthesiology
   This course is designed to give the PGY 2 & 3 resident more in-depth review of all topics in anesthesiology as case management becomes more complex. The course is taught primarily by the physician anesthesiologists at University Hospital and is also attended by PGY 2 & 3 medical anesthesia residents

Anesthesiology Morbidity and Mortality Conference
PGY 1, 2 & 3  45min/wk
Course Director: Dr. Ron Harter, Program Director, Anesthesiology
   This conference occurs weekly and residents are asked to present complications with patient care, and are questioned regarding the appropriateness of care, as well as management of complications. Also attended by all medical anesthesia residents

Anesthesia Conference
PGY 1, 2 & 3  45min/wk
Course Director: Dr. Ron Harter, Program Director, Anesthesiology
This Grand Rounds style conference presents a variety of anesthesia topics by faculty and invited lecturers. Also attended by all medical anesthesia residents.

**OMFS/Anesthesiology Morbidity and Mortality Conference**
1.5 hours per month
PGY 1, 2 & 3
Course Director: Dr. Peter Larsen

This conference occurs in the COD once monthly, and residents are asked to present complications with patient care, and are questioned regarding the appropriateness of care, as well as management of complications.

**Journal Club**
1 hour once a month
Year round PGY 1, 2 & 3
Course Director: Dr. Erik Evans

The journal clubs take place on a biweekly basis. The purposes of journal club are several: firstly, residents are asked to apply the principles which were taught in the statistics and experimental design courses in order to critically evaluate the current literature (medical, dental, surgical, anesthesiology, etc.). Also, journal clubs are designed to serve as topical sessions where specific topics are the focus, and key articles are presented and discussed in relation to our current understanding. Finally, an assessment of the current literature is performed in order to expose dental anesthesiology residents to the most applicable journals in our field of practice.

**OMFS/Anesthesiology Case Conference**
1.5 hours weekly (except when M&M conference is held)
Year round PGY 1, 2 & 3
Course Director: Dr. Peter Larsen

On a weekly basis, the anesthesia residents present a summary of all cases completed that week. Once per month, a case they completed in the recent past is presented to the full-time anesthesia and OMFS faculty, who serve as critical questioners in order to have the resident defend the diagnostic and treatment approaches which were employed for their patient. This forum is a simulation of the ASDA format of oral examination, and serves to acquaint residents with the process, and familiarize them with the stressful task of case defense. OMFS residents also present both surgical and anesthetic cases at this conference and frequently questioning of patient’s medical condition and anesthetic/surgical implications are stressed.
THE OHIO STATE UNIVERSITY
DENTAL ANESTHESIOLOGY RESIDENCY TRAINING PROGRAM
OFF-SERVICE ASSIGNMENTS

Medicine Rotation

Object of Assignment:

The objectives of the medical rotation are to learn to take a complete and comprehensive medical history, to do physical examinations, order and interpret laboratory studies, and manage patients with general medical problems.

Duties of resident including on-call responsibilities:

Residents are assigned inpatients that are admitted to the internal medicine service and manage their care under the supervision of the attendings and senior medical residents. The dental anesthesiology resident participates in the diagnosis and management of the patients. The dental anesthesiology resident has the same responsibilities as the medical students and residents of the medicine team. The rotation is two months long and it is completed during the second half of the first year of training. This rotation is done at Grant Medical Center, which is an affiliated teaching hospital of The Ohio State University.

Training received on assignment:

Dental anesthesiology residents devote full time to the medical service and their responsibility for patients is increased by the supervising senior residents and attendings as their level of confidence and skill increases. The residents on assignment attend all meetings and teaching sessions offered to the medical students and residents during the rotation.

Dental Anesthesiology Department commitments while on assignment:

The residents have no dental anesthesiology commitments while on assignment.

Faculty member responsible for the rotation:

Dr. Robert Skully, Chief Department of Internal and Family Medicine at Grant Medical Center is responsible for the medicine rotation.

Assessment of training and supervision:

The dental anesthesiology residents are evaluated by the residents and attendings of the medicine service. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them with the resident. The reports are then included in the resident’s permanent file.
THE OHIO STATE UNIVERSITY
DENTAL ANESTHESIOLOGY RESIDENCY TRAINING PROGRAM
OFF-SERVICE ASSIGNMENTS

University Medical Center Surgical Intensive Care Rotation

Object of Assignment:

The purpose of the anesthesia rotation is to

1. Gain practical experience in adult
   a. Assessment of the SICU patient
   b. Interpretation of complex laboratory studies
   c. Interpretation of chest radiographs
   d. Management of ventilator dependent patients
   e. Placement of various invasive monitoring devices
   f. Management of patients on the SICU service
   g. Management of urgencies and emergencies, including code response

2. Gain in-depth knowledge of human physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident including on-call responsibilities:

Dental anesthesiology residents will have daily assignments similar to other PGY I medical residents rotating on this service. They participate equally in the anesthesia on-call roster.

Training received on assignment:

Dental anesthesiology residents devote full time to the anesthesia SICU service and receive identical training as the medical anesthesia residents. The residents on assignment attend all meetings and teaching sessions offered to the anesthesia residents during the rotation.

University Hospital is accredited by The Joint Commission.

The resident has no commitments to the Department of Anesthesiology or Dental Anesthesiology while on assignment.

Faculty member responsible for the rotation:

Dr. Ron Harter, Interim Chair, Department of Anesthesiology at The Ohio State University College of Medicine is responsible for the portion of the anesthesia rotation at The Ohio State University Medical Center.

Assessment of training and supervision:

The dental anesthesiology residents are evaluated by the attendings of the anesthesia service. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them with the resident. The reports are then included in the resident’s permanent file.
THE OHIO STATE UNIVERSITY
DENTAL ANESTHESIOLOGY RESIDENCY TRAINING PROGRAM
OFF-SERVICE ASSIGNMENTS

Nationwide Children’s Hospital Anesthesia Rotation

Object of Assignment:

The objectives of the anesthesia rotation are to

1. Gain practical experience in pediatric
   a. Pre-operative patient assessment for general and regional anesthesia
   b. Techniques of premedication
   c. Use of intravenous, inhalational and regional anesthetic techniques
   d. Anesthetic management of medically complex patients, including management of the difficult airway
   e. Management of anesthetic urgencies and emergencies

2. Gain in-depth knowledge of pediatric physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident including on-call responsibilities:

Dental anesthesiology residents have daily assignments to the operating room that are identical to those of the CA 1 – 2 medical anesthesia residents rotating on the Children’s Hospital Anesthesia Service, including all types of surgery and patient ASA Physical Status 1 - 5. They participate equally in the anesthesia on-call roster. The two-month rotation is completed late in the first year after three months on the Dental Anesthesiology service and approximately 6 months on the University Hospital Anesthesia Service. Residents are responsible for performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit or Intensive Care Unit. They are also responsible for postoperative follow-ups on the patients admitted to the hospital after surgery as required. Pre-operative evaluation of in-hospital patients is also performed while on call.

Training received on assignment:

Dental anesthesiology residents devote full time to the pediatric anesthesia service and receive identical training as the medical anesthesia residents. The residents on assignment attend all meetings and teaching sessions offered to the anesthesia residents during the rotation.

Nationwide Children’s Hospital is accredited by The Joint Commission.

The resident has no commitments to the OSUMC Anesthesiology Department or the Dental Anesthesia Service while on assignment.

Faculty member responsible for the rotation:

Dr. Sharie A. Benoit, Associate Professor of Anesthesiology at The Ohio State University College of Medicine is responsible for the residents’ anesthesia rotation at Children’s Hospital of Columbus.

Assessment of training and supervision:

The dental anesthesiology residents are evaluated by the attendings of the anesthesia service. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them with the resident. The reports are then included in the resident's permanent file.
Object of Assignment:

The purpose of the anesthesia rotation is to

1. Gain practical experience in adult, special needs & pediatric dental anesthesia and sedation
   f. Pre-operative patient assessment for general and regional anesthesia
   g. Techniques of premedication
   h. Use of intravenous, inhalational and regional anesthetic techniques
   i. Anesthetic management of medically complex patients, including management of the difficult airway in an office setting
   j. Management of anesthetic urgencies and emergencies

2. Gain in-depth knowledge of human physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident responsibilities:

Dental anesthesiology residents will have assignments to the operating suites within the College of Dentistry, including the Oral & Maxillofacial Clinic, General Practice Residency, Dental Faculty Practice and various resident clinics throughout the College. ASA I – IV patients will be managed in this outpatient setting. There will be no call responsibility. The dental anesthesia resident, once completing the main hospital rotation, will be expected to manage in an increasingly independent way the anesthetic care of dental, oral and maxillofacial surgery patients, including for major surgeries such as LeFort osteotomies and iliac crest bone grafts. Residents are responsible of performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit or recover patients themselves in the operating suite. They are also responsible for postoperative follow-ups on the patients as required.

Training received on assignment:

Dental anesthesiology residents will devote full time to the dental anesthesia service when scheduled and also attend all meetings and teaching sessions offered to the anesthesia residents during the rotation. Time will be set aside to pursue a research project.

The College of Dentistry is accredited by the Commission on Dental Accreditation.

Faculty member responsible for the rotation:

Dr. Steven Ganzberg, Professor of Anesthesiology at The Ohio State University College of Medicine and Professor of Clinical Anesthesiology at the College of Dentistry is responsible for this portion of the dental anesthesia rotation.

Assessment of training and supervision:
The dental anesthesiology residents are evaluated by the attendings of the dental anesthesia and OMFS services. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them with the resident. The reports are then included in the resident’s permanent file.
THE OHIO STATE UNIVERSITY
DENTAL ANESTHESIOLOGY RESIDENCY TRAINING PROGRAM
OFF-SERVICE ASSIGNMENTS

Nationwide Children’s Hospital Dental Surgery Center Rotation

Object of Assignment:

The purpose of the anesthesia rotation is to
1. Gain practical experience in pediatric and special needs dental anesthesia and sedation
   a. Pre-operative patient assessment for general and regional anesthesia
   b. Techniques of premedication
   c. Use of intravenous, inhalational and regional anesthetic techniques
   d. Anesthetic management of medically complex patients, including management of the difficult airway in an office setting
   e. Management of anesthetic urgencies and emergencies
2. Gain in-depth knowledge of human physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident responsibilities:

Dental anesthesiology residents will have assignments to the operating rooms of the NCH Dental Surgery Center. ASA I – III patients will be managed in this out-patient setting. There will be no call responsibility. The dental anesthesia resident, once completing the main hospital rotation, will be expected to manage in an increasingly independent way the anesthetic care of dental and oral surgery patients. Residents are responsible for performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit. They are also responsible for postoperative follow-ups on the patients as required.

Training received on assignment:

Dental anesthesiology residents will devote full time to the NCH dental anesthesia service when scheduled and also attend all meetings and teaching sessions offered to the dental anesthesia residents during the rotation.

Nationwide Children’s Hospital and the Dental Surgery Center is Joint Commission accredited.

Faculty member responsible for the rotation:

Dr. Megann Smiley, Clinical Assistant Professor of Pediatric Dentistry at the OSU College of Dentistry is responsible for this portion of the dental anesthesia rotation.

Assessment of training and supervision:

The dental anesthesiology residents are evaluated by the attendings of the dental anesthesia and OMFS services. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them with the resident. The reports are then included in the resident’s permanent file.
Research

Mentor Selection - Research Project

An integral component of graduate education in dental anesthesiology is the performance of a research project. This project may be done in conjunction with an ongoing faculty in an area of established research or if the student has a specific area of interest, investigators outside of the department may be enlisted to serve as the advisor and mentor for the resident.

Immediately upon commencement of the resident’s training, a dentist anesthesiologist from the department is assigned to the resident. The assigned faculty serves as a mentor within the department and as a facilitator for the resident’s research project. The research project may be performed with this faculty as the primary advisor or with other faculty from within the OSUMC Department of Anesthesiology or the Section of Oral and Maxillofacial Surgery, Pathology and Anesthesiology in the College of Dentistry or from outside departments. This process allows the resident to have an immediately identifiable faculty member within the department to serve as an advisor but does not limit the breadth of research to only areas where dental anesthesiology faculty may have expertise. Many of the residents will perform research with the primary advisor from dental anesthesiology; however, many will also select other Masters advisors depending upon their project.

Research Protocol - Timing Line

Immediately after starting their residency, dental anesthesiology residents begin to consider possible areas of research interest. Residents are actively involved in clinical treatment of patients as well as participating in conferences and scheduled courses. These courses stimulate interest in a variety of topics allowing residents to focus their possible areas of interest for research. Residents also have a formal core course in statistical analysis which is given early on. This allows them to develop a communication with graduate students from other departments and begin discussing possible choices of project with the faculty associated with these courses as well.

During the first 15 months, while the resident is orienting to anesthesia and on their one year off-service rotations in anesthesiology and internal medicine, the resident is encouraged to define a research project and, if a human study is contemplated, to try to submit the proposal for IRB approval as soon as possible, even while off-service. If during the development of this project it appears that an outside advisor will be appropriate, the research facilitator from dental anesthesiology assists the graduate student in developing the necessary liaison with the outside faculty member.

When the student returns to the college, the protocol is reviewed and approved by the program director. There are several half-days when anesthesia is not provided at the college which enables the student to have dedicated time for research. Additionally, the dental anesthesiology faculty are very supportive of research efforts and will adjust the resident’s schedule as needed, within reason, to allow for data collection. If the resident has completed his/her project and desires an elective rotation, this must be discussed with the program director at least three months before an anticipated elective rotation. A firm outline of objectives must be
provided with the request for an elective rotation. Final approval will be at the discretion of the program director following discussion with the resident and possibly the proposed rotation mentor as well.

**Resident Evaluations**

Resident evaluations are performed twice yearly by the Program Director in consultation with other supervising faculty (Physician anesthesiologist, dentist anesthesiologists and OMFS). In addition, residents are evaluated after completion of off-service rotations by faculty from these rotations. Proficiency examinations are also provided to the residents and review is acknowledged by their signature. The evaluations are provided to the residents at a formal meeting and residents acknowledge the evaluation with their signature on the Evaluation Form.

Should deficiencies be revealed, they are communicated to the student/resident and a plan of corrective action is undertaken. As there are only two residents per year, close supervision of deficiencies and correction is generally immediate and continuous. If persistent deficiencies are noted, these are documented at the biannual review or earlier if needed.
Vacations & Sick/Maternity Leave

All residents, 2 weeks per year vacation

GUIDELINES

1. Vacations are approved ONLY by the program director

2. Vacations can not be taken during the Pediatric Anesthesiology & Internal Medicine rotations or during the first three months of residency. In PGY I, one or two weeks of vacation should be taken during the first six months of the UH anesthesia rotation and should be arranged as soon as possible in the PGY I year with the anesthesiology chief resident. The second week of vacation, which will count for the PGY I year, can be taken during July - September of PGY II if the resident prefers. Two additional weeks of vacation are then taken from October PGY II through September PGY III.

3. The PGY I, II & III residents will also have time off for the American Society of Dentist Anesthesiologists (ASDA) Annual Review Course, In-service Written Examination and, in PGY III, the ASDA Mock Oral Board Examination in early September. The PGY II resident will also have time off to attend the American ASDA Annual Scientific Session in the spring.

4. You cannot take two consecutive weeks.

5. Vacation requests should be turned in to the Program Director and, for PGY I residents, the anesthesiology chief resident by the end of July.

6. It is inappropriate to use a week’s vacation by taking one day at a time to make long weekends or in conjunction with planned department holidays.

7. Chief residents will be given 5 additional days for job interviews, if needed, and is available for prorated two weeks vacation in PGY III.

8. The appropriate Leave Forms must be completed BY THE RESIDENT for leave and reimbursement of expenses, if applicable.

9. Sick leave is limited to 5 days per year. Any sick time over this period will be paid but the days missed may need to be made up with extra unpaid days after September 30th of the third year, at the discretion of the program director. Malpractice coverage will be paid during these additional days and all College polices for graduate students followed, including the requirement for medical insurance coverage. This same policy applies to maternity leave, i.e., if more than 5 “sick” days are taken in maternity leave, then the additional days will have to be made after September 30th of the third year with unpaid days as the resident will be paid during the maternity period. Vacation days can be used for maternity leave. If the resident is the mother, she may take no more than 6 weeks of maternity leave, which includes any sick or vacation days used. Three (3) weeks is allowed for maternity leave for the father who is the resident, with the same rules applying as above.
This form is used to request, approve and record leave requests for staff and faculty.

Application for Leave

Employee Name ___________________________ Employee ID # ___________________________

Department ___________________________ College/Unit ___________________________

<table>
<thead>
<tr>
<th>LEAVE DESIGNATION:</th>
<th>☐ Family and Medical Leave*</th>
<th>☐ Work Related Injury/Illness*</th>
<th>☐ Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all boxes that apply</td>
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</table>

<table>
<thead>
<tr>
<th>PAID LEAVE:</th>
<th>Dates</th>
<th># Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Vacation</td>
<td></td>
<td></td>
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<tr>
<td>☐ Vacation in place of sick leave</td>
<td></td>
<td></td>
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<tr>
<td>☐ Parental Leave</td>
<td></td>
<td></td>
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<tr>
<td>☐ Organ Donation Leave</td>
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<td></td>
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<tr>
<td>☐ Compensatory Time</td>
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<td></td>
</tr>
<tr>
<td>☐ Jury Duty/ Court Appearance*</td>
<td></td>
<td></td>
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<tr>
<td>☐ Military Leave*</td>
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<tr>
<td>☐ University Business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Sick Leave*</td>
<td></td>
<td></td>
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</tbody>
</table>

Please Specify: Self Family*

<table>
<thead>
<tr>
<th>Dates</th>
<th># Hours</th>
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<table>
<thead>
<tr>
<th>☐ Illness/injury</th>
<th>☐ Medical appointment</th>
<th>☐ Death in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Family*</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
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</table>

<table>
<thead>
<tr>
<th>☐ Exposure to Contagious Disease</th>
</tr>
</thead>
</table>

TOTAL HOURS PAID LEAVE ___________

UNPAID LEAVE: ☐ MEDICAL* ☐ PERSONAL* ☐ Unpaid Time Off* (10 or fewer consecutive working days)

Beginning and Ending Dates ___________ # Hours ___________

☐ Unpaid Leave of Absence* (more than 10 consecutive working days)

Beginning and Ending Dates ___________ # Hours ___________

Last date worked ___________ Last date in active pay status ___________ Return date ___________

☐ Extension of previously approved leave of absence*

TOTAL HOURS UNPAID LEAVE ___________

ADDITIONAL INFORMATION: (Reason for absence, etc.)

*Any item followed by an (*) requires appropriate documentation. See reverse for explanation of documentation requirements.

I understand that approval of this request is contingent upon the availability of adequate leave balances. Falsification of this Application for Leave or of the supporting documentation is grounds for disciplinary action, up to and including dismissal.

Employee Signature: ___________________________ Date ___________

Department/Administrative Signature: ___________________________ Date ___________

College/Unit Signature: ___________________________ Date ___________

Staff absences require only the above two signatures. Faculty unpaid leaves and faculty paid leaves DUE TO UNIVERSITY BUSINESS that exceed ten consecutive work days during an academic quarter require approval by the department, college, and Provost (below).

Provost Signature: ___________________________ Date ___________

☐ Approved ☐ Disapproved Comments: ___________________________

Person responsible in my absence ___________________________ Phone #: ___________________________

In an emergency, I may be reached through ___________________________ Phone #: ___________________________ E-mail: ___________________________
Travel Requests
All travel requests for payment and/or reimbursement must be submitted prior to departure. These are processed in the Administration Office (Robbi Hall). “After the Fact” requests will not be honored. Complete this travel request form and return to the Administration Office (Robbi Hall) at least four weeks in advance.

NAME OF TRAVELER: ________________________________
EMPLOYEE I.D.: ____________________
PURPOSE OF TRAVEL (A PROGRAM FOR THE MEET MUST BE ATTACHED)
_____________________________________________________________________________________

DATES OF MEETING: ____________________________________________
PLACE OF MEETING: ____________________________________________

ESTIMATED TIME: _______ (am/pm) AND DATE: __________ OF DEPARTURE FROM COLUMBUS
ESTIMATED TIME: _______ (am/pm) AND DATE: __________ OF RETURN TO COLUMBUS

ANY SUPPORT OR HONORARY OTHER THAN THIS REQUEST? YES ___ NO ___

TYPE OF TRANSPORTATION
Estimated cost of airline: $___________
   Is airline ticket to be pre-paid by University? YES___ NO ___
   Travel Agency: ____________________________________________
Personal Auto: _________ miles round trip

REGISTRATION FEE $___________
   Is registration fee to be pre-paid by the University? YES___ NO ___
   If to be prepaid, registration fee to be sent to:
   __________________________________________________________

TO BE COMPLETED BY DEPARTMENT CHAIR
Is Traveler presenting a paper? YES___ NO ___
If yes, a copy of the invitation or program must be attached.
Charge to: ________________ School’s Account  ________________ Department Account
If to be charged to your department, indicate:  Department No._______________________
   Account No._______________________
Department Approval: __________________________________________
   (Get form from Robbi Hall)
Professional Meetings & Guidelines

The faculty supports the philosophical concept that resident education must be as broad as possible. To this end, resident attendance at professional meetings outside of the University will be encouraged, consistent with budgetary limitations and clinical obligations. Obviously, not all residents will attend all meetings. The following guidelines will describe the overall policy which should provide equality of opportunity:

1. The PGY II resident will attend the ASDA Annual Scientific Session in the spring. Prerequisite is submission (not necessarily acceptance) of an abstract.
2. The PGY I, II & III residents will attend the ASDA Annual Review Course, In-service Written Examination and, in PGY III, the ASDA Mock Oral Board Examination in early September.
3. Second and third year residents may be able to attend selected regional meetings, i.e. Ohio Dental Society of Anesthesiology. This will usually be limited to a total of four or five days during the year.
4. All residents may attend local meetings. Adequate anesthesia coverage in the College must be arranged.
5. Attendance at other meetings (regional or national) may be possible if, after consultation with the resident’s faculty advisor, program director and chairman, an abstract is submitted and accepted for presentation.
6. Requests for attendance at meetings will be made as far in advance as possible by the residents with details for coverage made available to the program director.

Off-Service Rotations

1. It is each resident’s responsibility to communicate with the off-service attending or chief resident as to when and where to meet on the first day. Try to do this at least 2 weeks in advance of the start of your rotation, especially if you need to take any days off.

*2. At the completion of your off-service rotation, give Dr. Ganzberg the name and address of one attending and one resident with whom you had worked closely, and he will send them evaluation forms.
Guidelines For Intravenous Sedation

I. GENERAL GUIDELINES
   A. All patients must have a current past-medical history immediately available for review prior to the start of the sedation procedure.
   B. Pre-sedation pulse rate, respiration rate, and blood pressure must be taken and recorded.
   C. No patient shall receive intravenous sedation unless a responsible adult escort is present, and the patient has been NPO for greater than 6 hours.
   D. Prior to the sedation, patients and escorts must both understand that the patient is not to drive, operate dangerous machinery or make important decisions until at least the next day.
   E. Dosages of all drugs and route of administration must be recorded. Pre operative, intra-operative, and post-operative vital signs must be recorded. The “street” fitness of the patient (i.e. ability to walk, level of alertness, etc.) as well as the name of the escort also must be documented.

II. INTRAVENOUS SEDATION (Categories)
   A. Conscious Sedation is a minimally depressed level of consciousness that retains the patient’s ability to maintain a patent airway independently and continuously and respond appropriately to physical stimulation and/or verbal command. The loss of consciousness should be unlikely and the drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. A typical example might include a single drug technique such as 10mg Diazepam for an ASA Class I patient.
   B. Deep Sedation is a controlled state of consciousness or unconsciousness from which the patient is not easily aroused, which may be accompanied by a partial or complete loss of protective reflexes, including the ability to maintain a patent airway independently and respond purposely to physical stimulation or verbal command. The intent of this sedation is to produce a marginal state of consciousness which borders on ultra light general anesthesia which is when the patient is most often in a state of unconsciousness.

III. SPECIFIC TECHNIQUE GUIDELINES (These may need to be more restrictive depending on the physical status of the patient)
   A. Conscious Sedation
      1. The minimum number of personnel needed to perform conscious sedation is two, a resident and another person acting as an assistant
      2. A continuous intravenous infusion or access is required
      3. Patient should be NPO for at least 8 hours for solids and 2 hours for clear liquids
      4. Blood pressure, heart rate, and respiratory rate to be recorded every 15 minutes
      5. The resident must not leave the patient until he/she is discharged to the escort’s care
B. Deep Sedation
1. All procedures utilizing ultra short acting barbiturates and similar drugs with narrow margins of use for conscious techniques are considered to fall into the class of deep sedation; other techniques with large doses or multiple drugs may be used for deep sedation.
2. Deep sedation is limited to those residents who have completed the hospital anesthesia rotation.
3. The minimum number of personnel needed to perform deep sedation is three, a resident with hospital anesthesia experience, another resident, and a person acting as an assistant; the resident who continuously monitors the patient must record the vital signs every 5 minutes.
4. A continuous intravenous infusion is required.
5. The patient must be NPO for 8 hours for solids and 2 hours for clear liquids.
6. Supplemental oxygen is required for deep sedation.
7. A pre-cordial stethoscope is the minimal requirement to continuously monitor the patient’s heart rate and rhythm as well as respirations; vital signs must be recorded every 5 minutes.
8. Appropriate emergency drugs and equipment must be immediately available in the cubicle as would be required for general anesthesia.
9. Permission for deep sedation and general supervision by a faculty who possesses an Ohio General Anesthesia permit is required.
10. The resident who has completed his hospital anesthesia rotation must be readily available in the clinical area until the patient is discharged to leave for home.

Guidelines For Out-Patient General Anesthesia

1. All patients must have a current past-medical history immediately available for review prior to the start of the general anesthetic.
2. Only oral surgery residents, teaching fellows, or faculty shall pre-op GA patients, and faculty approval must be obtained with a signature prior to the appointment being scheduled.
3. Only healthy patients are candidates for outpatient GA (ASA 1 & II)
4. All patients for GA must be NPO for a minimum of 8 hours for solids and 2 hours for clear liquids.
5. From the start of induction until the patient responds verbally to command, a faculty member with a State Anesthesia Permit must provide continuous, direct personal supervision in the operatory. At least one oral surgery resident must have had the hospital anesthesia rotation.
6. Pre-anesthetic pulse rate, respiration rate, and blood pressure must be taken and recorded.
7. No patient shall receive general anesthesia unless a responsible adult escort is present.
8. Prior to the anesthetic, patients and escorts must both understand that the patient is not to drive, operate dangerous machinery or make important decisions until at least the next day.
9. Dosages of all drugs and route of administration must be recorded. Pre-operative, intra-operative, and post-operative vital signs must be recorded. The “street fitness” of the patient (i.e. ability to walk, level of alertness, etc.) as well as the name of the escort must also be documented.

10. Only conscious patients are acceptable to enter the recovery room and they must never be left alone until discharged (see Recovery Room Protocol).

11. Ultra light GA’s as well as deep intravenous sedations (especially anytime propofol is used) must be administered in an operatory fully equipped for GA with appropriate supervision of faculty.

12. All residents must know where the emergency cart for advanced life support is located, and they must be familiar with its contents. Portable emergency oxygen/suction must be available as well as an EKG/defibrillator.

13. The anesthesia resident must assume the responsibility that all drugs, supplies and equipment are available and in working order.

Recovery Room Protocol

1. Patient to be brought to recovery room when fully responsive and with good airway.

2. Vital signs (BP, heart rate) will be taken and recorded upon arrival in the recovery room. The resident will not leave until this has been done.

3. When patient is stable, the resident will leave the patient in the care of the recovery room nurse (or any person capable of handling this duty).

4. Vital signs are to be taken periodically and recorded.

5. The recovery room staff person will take care of all the patient’s physical needs (this would include problems such as nausea and vomiting) unless it is felt that the patient has a serious problem at which time the resident will be alerted and will evaluate the problem.

6. When patient is fully AWAKE, recovered and ready for discharge, the escort will be allowed to enter the recovery room.

7. Although the patient’s escort is permitted in the recovery area, the escort will not be responsible for patient’s supervision until the patient is discharged.

8. Either the surgeon or nurse can discharge the patient and give post-operative instructions (or this may be delegated to the nurse).

**UNRECOVERED PATIENT CANNOT BE LEFT ALONE AT ANY TIME**
PACU DISCHARGE CRITERIA

Phase I PACU

Initial Assessment:

Postanesthetic management of the patient includes periodic assessment and monitoring of respiratory and cardiovascular function, neuromuscular function, mental status, temperature, pain, nausea and vomiting, drainage and bleeding, and urine output.

Guidelines for discharge from Phase I PACU:

Clinical judgment must always supercede these guidelines if the patient’s condition is not satisfactory in a given area. Whenever doubt exists about diagnosis or patient safety, discharge should be delayed.

If discharge criteria are not met or if there are any questions regarding a patient’s condition, the anesthesiologist and/or surgeon should be contacted prior to discharging the patient from Phase I PACU.

Patients transferred to a critical care unit may be discharged with a Post-Anesthesia Recovery (PAR) score ≥ 8 or at the discretion of the anesthesiologist or surgeon.

Patients transferred to Phase II PACU or to a hospital room may be discharged with a PAR score ≥ 8 or at the discretion of the anesthesiologist or surgeon and must meet the requirements listed below.

Patients should achieve preoperative level of consciousness and mental status. Patients whose mental status was initially abnormal should have returned to their baseline.

Vital signs should be stable and within acceptable limits.

Appropriate __ as evidenced by:

• Maintenance of pain intensity at < 4/10, or documented as “tolerable”
• Vital signs within preoperative range
• A calm, comfortable appearance
• Control of any nausea and vomiting
  Patency of tubes, catheters, drains, intravenous lines
  Adequate hydration status
• Stable vital signs
• Adequate urine output, if measured
• Appropriate skin color, condition and integrity in relation to the surgical procedure and to preoperative baseline status.

Appropriate surgical site conditions:
• Appropriate condition of surgical site and/or dressing.
• Appropriate output from surgical drainage systems.

Patients recovering from regional anesthesia
• Should expect the same standard of postoperative care as those who have undergone general anesthesia (GA).
• Should have progressively increasing sensory and motor control over involved extremities.
• Should exhibit hemodynamic stability.

Patients will not be discharged home directly from Phase I PACU. Patients anticipating discharge within twenty-four hours will be transferred to their assigned room for discharge home after the recovery phase.

Fast-Track Postoperative Care:
Selected patients who meet the PACU discharge criteria at the end of the operation can bypass the PACU and be transferred from the operating room directly to a discharge area (Phase II recovery or hospital room).

Guidelines for discharge from Phase II PACU:
If discharge criteria are not met or if there are any questions regarding a patient’s condition, the anesthesiologist and/or surgeon should be contacted prior to discharging the patient from Phase II PACU.

Initial assessment and documentation for discharge from Phase II PACU should be in addition to Phase I Criteria and include the following:
  - Re-documentation of vital signs and PAR score.
  - Adequate control of pain intensity at < 3/10 or documented as “tolerable”.
  - Ability to ambulate consistent with developmental age level.

Patients recovering from regional anesthesia
• Patients who have had a peripheral nerve block need not be detained until full return of sensation if discharge criteria have been achieved. It is acceptable to send a patient home with an anesthetized limb properly protected, with careful written and verbal instructions, and with a 24-hr contact telephone number.

Patients must achieve a PAR score of \( \geq 8 \) or at the discretion of the anesthesiologist or surgeon to be discharged home.

Patients must be discharged to a responsible adult who will accompany them home and be able to report any post-procedure complications.
  - Provided with written instructions regarding post-procedure diet, medications, activities, and a phone number to be called in case of emergency.
- Written discharge instructions given to patient/accompanying responsible adult.
- Documentation that patient and home care provider understand discharge instructions.
- Verify the correct phone number for follow-up phone call. The peri-anesthesia nurse will complete a post-op follow-up phone call to assess and evaluate patient status the next business day or per department protocol.

The patient is discharged in a wheelchair, or, if able, ambulates with assistance to the discharge area.

**Clarification of some discharge issues (2)**

**Requiring that patients urinate before discharge**
The requirement for urination before discharge should not be part of a routine discharge protocol and may only be necessary for selected patients.

**Requiring that patients drink clear fluids without vomiting before discharge**
The demonstrated ability to drink and retain clear fluids should not be part of a routine discharge protocol but may be appropriate for selected patients.

**Requiring that patients have a responsible individual accompany them home**
As part of a discharge protocol, patients should routinely be required to have a responsible individual accompany them home.

**Requiring a minimum mandatory stay in recovery**
A mandatory minimum stay should not be required. Patients should be observed until they are no longer at increased risk for cardiorespiratory depression.
## Post-Anesthesia Recovery (PAR) Scoring Criteria

**Modified Aldrete Scoring System (1)**

<table>
<thead>
<tr>
<th>PAR Score</th>
<th>Admission</th>
<th>15 min</th>
<th>30 min</th>
<th>60 min</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to move voluntary</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 extremities</td>
<td>2</td>
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</tr>
<tr>
<td>2 extremities</td>
<td>1</td>
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<td>0 extremities</td>
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<td>RESPIRATION</td>
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<td>Breaths deeply, coughs freely</td>
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<tr>
<td>Dyspnea, shallow or limited</td>
<td>1</td>
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<tr>
<td>Apneic</td>
<td>0</td>
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<tr>
<td>CIRCULATION</td>
<td></td>
<td></td>
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<tr>
<td>BP ± 20% of pre-op</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>BP ± 20-49% of pre-op</td>
<td>1</td>
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<td>BP ± 50% of pre-op</td>
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<tr>
<td>CONSCIOUSNESS</td>
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<tr>
<td>Fully awake</td>
<td>2</td>
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<tr>
<td>Arousal with minimal stimulation</td>
<td>1</td>
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<tr>
<td>Not responding</td>
<td>0</td>
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<tr>
<td>O₂ SATURATION</td>
<td></td>
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<td></td>
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<tr>
<td>&gt;92% on room air</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>Needs O₂ to maintain &gt; 90%</td>
<td>1</td>
<td></td>
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<tr>
<td>&gt;90% even with O₂</td>
<td>0</td>
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<tr>
<td>TOTAL</td>
<td>0-10</td>
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<tr>
<td></td>
<td>AGREE</td>
<td>DISAGREE</td>
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<tr>
<td>1. I have worked with this faculty enough during this last evaluation period to meaningfully evaluate (1=yes; 5 = no) If “yes”, proceed to question #2. If “no” turn in form.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>2. Available to take advantage of teaching situations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>3. Is tactful and diplomatic when criticizing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Encourages teacher-resident interaction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Gives residents adequate amount of responsibility</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>6. Provides guidance to pertinent literature references</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>7. Maintains a positive attitude</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>8. Relates clinical activity to basic biomedical science</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>9. Willing to spend adequate amounts of time teaching</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Is willing to explore new and divergent ideas</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Gives well organized and beneficial lectures</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Gives demonstrations to illustrate new techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. Avoids destructive embarrassing criticism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. Serves as a good role model</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. Is willing to discuss differences of opinion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. Provides useful contributions at seminars</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. Conducts meaningful and useful ward rounds</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. Gives residents opportunity to use own judgment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. Provides adequate feedback</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Provides support and guidance for research activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
# Dental Anesthesiology Resident Evaluation

| Name: Dr. | PGY Level: II | Rotation: Anesthesia | Period of Evaluation: Jan 09 – March 09 | Evaluator: |

## Part I

### General Knowledge

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to discuss disease or pathologic process adequately</td>
<td>Knowledge of disease is fair but has gaps in fundamental facts</td>
<td>Consistently demonstrates satisfactory knowledge base</td>
<td>Extensive knowledge base, conversant in disease complexities</td>
</tr>
</tbody>
</table>

### Professional Judgment

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fails to implement diagnostic and therapeutic management plans</td>
<td>Requires close supervision to implement management plans</td>
<td>Consistently implements appropriate patient management plans</td>
<td>Exemplary judgment and implementation of patient management plans</td>
</tr>
</tbody>
</table>

### Patient Evaluation

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to synthesize data for adequate patient evaluation</td>
<td>Occasional gaps in history, physical and laboratory evaluation</td>
<td>Synthesizes appropriate diagnoses for risk assessment/anesthetic plan</td>
<td>Excellent diagnostician; Assesses risk/anesthetic plan efficiently</td>
</tr>
</tbody>
</table>

### Technical Skills (IV access, endotracheal intubation, etc)

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to perform basic necessary technical procedures reliably</td>
<td>Requires additional work to acquire necessary skills</td>
<td>Reliably performs skills commensurate with level of training</td>
<td>Consistently performs skills at a higher level than peers</td>
</tr>
</tbody>
</table>

### Attendance/Punctuality

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently absent or late</td>
<td>Occasionally absent</td>
<td>Infrequently absent or late</td>
<td>Punctual and rarely absent</td>
</tr>
</tbody>
</table>

### Anesthetic Records

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrequent and inaccurate notes on patients</td>
<td>Occasional gaps/errors in medical records</td>
<td>Accurate medical records at appropriate intervals</td>
<td>Infrequent/no lapses in medical records</td>
</tr>
</tbody>
</table>

### Management of Urgencies/Emergencies

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to recognize and/or manage urgencies &amp; emergencies reliably</td>
<td>Recognizes urgencies/emergencies but requires frequent direction</td>
<td>Reliably manages urgencies &amp; emergencies commensurate with level of training</td>
<td>Consistently manages urgencies and emergencies effectively</td>
</tr>
</tbody>
</table>

### Teaching

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective teacher of students and residents</td>
<td>Limited capacity as teacher of students and residents</td>
<td>Effective teacher of students and residents</td>
<td>Outstanding teacher of students and residents</td>
</tr>
</tbody>
</table>

### Relationship with Peers / Other Professionals/Staff

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to work harmoniously / effectively with others</td>
<td>Occasional problems with maintaining harmonious relations</td>
<td>Able to maintain harmonious / effective relations with others</td>
<td>Role model in maintaining harmonious / effective relations with others</td>
</tr>
</tbody>
</table>

### Relationship with Patients / Families

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoids personal contact, frequently tactless</td>
<td>Has difficulty maintaining good relations with patients / families</td>
<td>Skillfully manages interpersonal relations with patients / families</td>
<td>Positive influence on patients and their families</td>
</tr>
</tbody>
</table>

### Attitude and Appearance

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>MEETS EXPECTATIONS</th>
<th>EXCEEDS EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate comments, unconcerned with appearance</td>
<td>Occasional inappropriate comments and attire</td>
<td>Behavior / appearance are consistently appropriate</td>
<td>Behavior / integrity / appearance are exemplary</td>
</tr>
</tbody>
</table>

## Part II

### UNSATISFACTORY* MARGINAL* BELOW AVERAGE SATISFACTORY GOOD VERY GOOD OUTSTANDING*

| Performs at an unacceptable level. Rehabilitation doubtful | Should not continue program without substantial improvements | May continue program, but performance is below standards | Satisfactorily achieves rotation objectives | Continued high performance in most aspects | Performs exceedingly well in nearly all aspects | Excellence in all aspects of performance, model and leadership |

*Requires comments

Comments: (Continue on back of page)

Evaluator’s signature: Date: Resident’s signature: Date:
To: All Residents and Teaching Interns
From: Gregory Ness DDS, Clinic Director
       Peter Larsen DDS, Program Director
Date: 03/03/00
Re: New Policy for Controlled Substance Distribution

Beginning Monday, February 21, 2000, we will return to using individual lock boxes to distribute our most commonly used controlled substances.

1. Each resident or teaching intern will receive a key to the new padlock securing their lock box. Every key is unique and will not open any other box. You will be responsible for keeping your key secure at all times. Do not loan your key to anyone else, and do not lose your key. If your key is lost, you will be responsible for replacement cost of the key and lock cylinder, which is approximately $30.

2. Each lock box is initially supplied with a 30 ml vial of Demerol (50 mg/ml) and six 10cc vials of Valium (5 mg/ml). As before, each vial of Demerol and each set of three vials of Valium has a corresponding record sheet. Do not share drugs with each other or “loan” each other drugs.

3. Each time you draw up any drug for a patient, the date, patient’s name, and the quantity dispensed must be indicated on the sheet. The record sheets are designed to easily reflect the usual quantities we dispense per patient, but any deviation in quantity must be clearly marked. It is NOT necessary to record wasted drug on these sheets.

4. The actual amount of drug given to the patient must be recorded on the Anesthesia Record in the spaces provided. An Anesthesia Record must be completed for every i.v. sedation or general anesthetic performed. The doctor who physically gives the drugs, whether resident or attending, is responsible for completing the form. Each form has three copies: the original for the patient chart, the second for the anesthetist’s personal records, and the third for the anesthesia case logbook. A basket at the front desk will be used to turn in the third copy of every Anesthesia Record. These copies will be kept in a binder in chronological order. It is the responsibility of the resident or intern to see that a copy is placed in the basket at the completion of each case. These records are necessary for credentialing and for drug record audits.

5. If you draw up a drug and then use NONE of it, you may return the unused drug to your lockbox for use on another patient. The drug should be dated and used within several days, or else wasted. Its disposition must be clearly marked on the same record sheet line where it was originally signed out (e.g. returned then wasted” or is returned used for Bob Jones 2/22/00” etc.)

6. Any drug remaining in a syringe or ampoule after PARTIAL use on a patient is to be wasted, not used on another patient. The amount wasted and the total amount used must be recorded on the Anesthesia Record form in the blanks provided. Again, it is NOT necessary to record wasted drug on the record sheets in your lock box.

7. When you empty a vial of Demerol or a set of three vials of Valium, you should have completed the corresponding record sheet. This can be turned in to any of the persons listed below and new drug vials and record sheets will be issued to you. Never leave these
forms on a desk or mailbox - exchange them for a new drug supply in person. New drugs can not be issued unless a complete, accurate record form is presented. It is your personal responsibility to maintain current accurate records at all times.

8. Our present manufacturer of Demerol seems to place EXACTLY 30 cc of solution in the vial. If you draw up 1 cc plus the volume of the needle and hub (about 0.15 cc) you will be several ccs short at the end of the vial. To prevent this, draw up ONLY 1 cc, and do not expel the air bubble and reaspirate from the vial. On the other hand, the Valium vials contain a small extra amount of solution. Any small surplus remaining at the end of three vials should be wasted before beginning to use the next set of three.

9. Record sheets are to be kept in the lock box at all times. These boxes are subject to random, unannounced inventory. If the record sheets are not present, all drugs not present in the lock box will be presumed missing and unaccounted for. Disciplinary action as described below may result.

10. Other controlled substances will continue to be available for use by attending approval only. These drugs will be dispensed on a case-by-case basis by any one of the persons listed below. Used, wasted, or returned drug will be recorded the same way as described above.

11. The following persons will have access to the drug cabinet outer door key: Drs. Ganzberg, Weaver, Ness and Larsen, and Ms. Mitchell. All of these persons except Dr. Larsen will also have access to the safe and can dispense new Valium or Demerol for your supply, or with attending approval provide other controlled substances on a case-by-case basis.

12. DISCIPLINARY ACTION: This drug dispensing protocol has been developed with input from faculty, residents, and the OSU Campus Police Narcotics Division. Full compliance with all of the above procedures is expected. Inventory audits will include spot checks of Anesthesia Record completion and correlation with the lock box record sheets. The controlled substances issued to you are your sole responsibility, and at any given time the quantity on hand, record sheets in your lockbox, and notations on the Anesthesia Records filed in the logbook must account for every cc. Audit discrepancies will be reported to the Residency Program or Clinic Director as appropriate. These reports will be retained in your permanent record, and will become part of your regular evaluations. They may also be used as a part of the confidential evaluation you will need to obtain hospital privileges, society memberships, etc. Repeated violations may be punishable by suspension without pay (second offense) or loss of controlled substance use privileges, which may lead to dismissal from the program (third offense).

13. If you discover any irregularity in your drug inventory or records, report it to one of the above persons immediately.

I have received a copy of this memo, and I have read and understand the above rules.

_____________________________________________________
Resident or Intern Signature
Miscellaneous Policies

1. **Moonlighting:**
   Moonlighting by dental anesthesiology residents is not allowed unless arranged with UH Anesthesiology. Violation will lead to dismissal from the program.

2. **Copying:**
   Copying is provided free of charge to residents with the following guidelines.
   a. Make single copies on department copier when at all possible.
   b. Utilize the dental school document service for all multiple copies.
   c. Utilize copy card in library for items that cannot be removed from library. If multiple copies are needed, make one master copy and have duplicates made at dental school.

3. **Photography:**
   A clinic camera is available for:
   a. Documentation of clinical findings as they pertain to the patient’s permanent record. Three photographs of each view will be taken. The faculty will provide one copy for the senior resident involved in the case, which may be duplicated at resident’s expense for other residents.
   b. Photography of interesting clinical and surgical items as deemed appropriate by the attending faculty with all photos going to said faculty with resident option to make copies at his/her expense.
   c. Exception to the above would be any photograph done by a resident for the expressed purpose of a specific presentation, under approval of faculty.
   d. The department will also provide film and developing for the slide maker for resident presentations.

4. **Faculty Practice Charts**
   a. Faculty practice charts that are going to be anywhere other than in the resident’s box or in a single readily identifiable rack within the resident’s room are to be signed out individually by the resident. Charts that are found on residents’ desks, in residents’ briefcases, on the floor under the residents’ desks, in the operating room with residents on days when surgery is not being done on that patient, etc, etc, etc, must be signed out to that resident.
   b. All charts from a given faculty post-operative clinic day should be returned with completed notes by 7:00 AM on the day immediately following post-operative clinic. It is understandable that it is sometimes difficult to complete all the chart work during the post-operative clinic, but there is no excuse to continue to have these charts in your possession for days after the patient has been seen. If there is further work that needs to be done on these patients, a note should be attached to the outside of the chart indicating to the faculty that you would like to have this chart returned to you after they have an opportunity to review it. Failure to return charts to Faculty Practice boxes in a timely manner after new patients have
been seen results in failure to write appropriate referral letters and insurance prior authorization letters, which we all know can lead to cancellation of surgery.

c. Do not place oral and maxillofacial surgery private patient charts inside of charts from other areas of the building such as the implant study, dental faculty practice, or within student charts. These are frequently filed away and are never retrieved, which results in a major problem with adequate post-operative patient follow-up.
Performance Guidelines

CORRECTIVE ACTION AND DUE PROCESS FOR HOUSE STAFF
Dental Anesthesiology Residency Program
Ohio State University Hospitals

1. GENERAL PROVISIONS

A. Expected Performance

Members of the Dental Anesthesiology House Staff are expected to conform to the Bylaws of the Medical Staff of the Ohio State University Hospitals and the Rules and Regulations adopted by that organization, the Rules and Regulations governing employment at the Ohio State University and state and federal laws.

Members of the Dental Anesthesiology house staff are also expected to make regular progress toward meeting the expectations of the Dental Anesthesiology House-staff Evaluation Committee and the criteria for satisfactory clinical competence as stipulated by the Commission on Dental Accreditation.

B. The Evaluation Process

Written evaluations completed by the attending staff members to whose services the resident is assigned will be kept in a permanent file. Other evaluation exercises will be administered by the faculty as necessary to meet its obligation to document the clinical competence of house-staff members. The overall evaluation process may include formal exercises as well as the informal observations of the faculty.

2. RIGHTS OF A RESIDENT IN THE EVALUATION PROCESS

A. The permanent file of written evaluations of performance will be accessible to the resident.

B. The resident has the right to challenge the accuracy of the written report of his/her performance. The resident may discuss the report with the Director of the Training Program, or if the problem is not satisfactorily resolved, may choose to meet with the House-staff Evaluation Committee to present rebuttal evidence.

C. The Due Process procedure (see below) will not be used in the course of challenging a written performance report unless that report contains accusations of such magnitude that they would, if proven accurate, lead to dismissal from the training program or would preclude certification of clinical competence.

D. Each resident has the right to expect advancement to the next level of training in Dental Anesthesiology unless his/her performance is sufficiently below the standards set by the Commission on Dental Accreditation.

E. A decision by the House staff Evaluation Committee to deny advancement of a resident to the next level of training must be given with adequate notice along with reasons for the decision.

F. The House-staff Evaluation Committee must meet its obligation to document the clinical competence of residents recommended to the American Dental Board of Anesthesiology. With this understanding, the Dental Anesthesiology house staff has the right to expect a hearing for their suggestions or advice regarding the evaluation process.
G. The house staff has the right to elect a committee of its members to meet with the Director of the Training Program, the Chairman of the Department or the House-staff Evaluation Committee for the purpose of discussing problems related to the evaluation process, the content of the training program or other problems of mutual concern.

3. **THE RIGHT OF DUE PROCESS**

   A. A Dental Anesthesiology resident is entitled to the right of due process when a charge is brought forward which would lead to dismissal from the residency training program or failure to achieve certification of clinical competence by the House-staff Evaluation Committee.

   B. A charge calling for corrective action may be initiated by a member of the regular attending staff of the Department of Anesthesiology, Dental Anesthesiology or Oral and Maxillofacial Surgery, the Director of the Training Program or the Chairman of the Department.

   C. Charges which would result in corrective action against a Dental Anesthesiology resident shall include:

      1. Failure to adhere to the code of ethical professional conduct as stipulated in the Bylaws of the Medical Staff of the Ohio State University Hospitals.
      2. Behavior in a manner detrimental to the best interests and safety of patients in The Ohio State University Hospitals or to the aims and goals of the Department of Dental Anesthesiology and its educational programs.
      3. Violation of State or Federal laws.
      4. Failure to demonstrate knowledge, expertise, competence or clinical judgment commensurate with his/her level of training such that the resident is judged incapable of accepting ordinary and expected clinical and educational responsibilities.
      5. Consistent performance at a level which provides cumulative evidence that he/she is unlikely to satisfactorily complete the training program and be certified by the American Dental Board of Anesthesiology.
      6. Grave misconduct other than specified above.

   D. **DUE PROCESS PROVISIONS**

      1. For an adverse decision regarding advancement in the training program. The decision to offer advancement to the next level of training in Dental Anesthesiology at The Ohio State University Hospitals is the joint responsibility of the Director of Training Program, the Dental Anesthesiology Steering Committee and the Chairman of the Department. An adverse decision will ordinarily be based on items 4 and 5, Section III, Paragraph C of this document and will take into account the best interests of the overall educational goals of the Department of Dental Anesthesiology, the care of patients in the University Hospitals, and the career aspirations of the resident. If a resident is not offered a position at the next level of training, and wishes to challenge the decision, he/she may meet with the House-staff Evaluation Committee to review the evaluations which led to that decision. If the outcome of that meeting does not resolve the problem, the resident may choose to have a
second meeting with the House-staff Evaluation Committee. The second meeting will also include the Chairman of the Department, the Director of the Training Program, and one Dental Anesthesiology resident elected for that purpose by the Dental Anesthesiology house staff. The meeting will be chaired by the Chairman of the House-staff Evaluation Committee. At this meeting the resident may submit rebuttal evidence and may be accompanied and represented by a member of the attending staff. If the question of advancement is not mutually resolved during the discussion, the matter will be decided by majority vote of those present in the absence of the resident and his representative. This decision will be final.

2. Charges calling for immediate dismissal of a resident from the training program or other correct action. A Dental Anesthesiology resident charged with a serious breach of medical ethics, major violation of state or federal law, or other grave misconduct will be immediately removed from the program. The resident is entitled to due process as follows. The faculty member(s) or other persons, including the Chairman, who initiates the charge against the resident may not serve as the investigator of the charge(s); chair or conduct any hearing or be a participant in an appellant procedure. The faculty member may, however, submit evidence, documentation, be present, provide testimony, serve as a witness, but may not otherwise participate in deliberations and shall not vote in any of these proceedings.

Any such charge must be promptly reported in writing with supporting documentation to the Chairman of the Department or his designee. The resident will then be promptly and confidentially apprised of the charge and details of the reasons leading to it.

The Chairman, or his appointee, will investigate the charge and evidence pro and con to determine if the charge is substantiated or not and make a recommendation whether corrective action should or should not proceed. His findings, evidence, documentation and recommendation will be reviewed with the accused resident and reported in writing to the Chairman or Director of the Training Program within two weeks.

The Chairman, or his designee, will review the findings, evidence, and recommendation provided by the investigator and decide whether the charge is sufficiently substantiated to proceed with corrective action. If the Chairman or his designee agrees that grounds for further action are substantiated, he will recommend appropriate disciplinary action or dismissal and so notify the resident in writing. He will then appoint a grievance committee of three faculty members, with no conflict of interest, and three oral surgery residents, elected for that purpose by the oral surgery house staff, to conduct a hearing with the charged resident present. The committee so appointed will elect one among them to chair the hearing. The documentation of action or actions leading to the charge will be presented to the resident. The resident shall have the right to refute the charge orally, in writing, by any other documentation, or witness(es) and may cross examine any participant and may likewise be cross examined. The resident may not have an attorney present before this hearing. The grievance committee will forward its findings and recommendations to the Chairman or Director of the Training Program. The Chairman or Director of the Training Program, after receiving the report and recommendation of the grievance committee, will evaluate these and decide:
a) if corrective measures should continue, b) the specific disciplinary measure, including dismissal, or c) that the charge is not sufficiently substantiated to continue further action. The Chairman or Director of the Training Program will promptly notify in writing the committee and the resident as to his decision.

If further corrective action is justified, the Chairman will convene the Senior faculty members (acting as the Executive Committee for the Department and as a hearing body) for a hearing to ascertain the validity of previous actions, evidence, and documentation and recommend what, if any, disciplinary action is appropriate. The accused resident will be notified both verbally and by certified return receipt mail at least ten days in advance as to the time and place of the hearing. The notice shall also contain a concise statement of the acts, omissions or behavior prompting the charge as well as a list of evidence documents, reports, names of potential witnesses to be called, or any other relevant material that may be considered during the hearing.

Unless the accused resident waives his rights to such a hearing in writing to the Chairman, he must personally attend at the specified time and place. If the resident waives his right to the hearing or fails to appear, unless for a good cause, the decision of the grievance committee and the Chairman or his designee shall become final and the disciplinary action will be implemented. If the resident appears before the hearing he or she shall have the right to: a) submit evidence, documentation, memoranda or procedural issues either prior to or during the hearing, b) be represented by an attorney of law, c) challenge or cross examine any witness or rebut any evidence. If the resident does not testify in his or her own behalf, she or he may be cross examined.

At the conclusion of the hearing, and in the absence of the resident, or any witnesses, the members holding the hearing may proceed forthwith to deliberate and make a decision by majority vote as to whether the charge and recommended disciplinary measure(s) shall be sustained or not, the hearing body, at its own discretion, may recess either for its own convenience or to pursue further evidence or investigations. In the latter event, the body will reconvene promptly at its own convenience to make a final decision. Within seven days after the decision is made, a written report of its findings and decision along with all evidence and supporting documents will be forwarded to the Chairman or his designee. The decision and recommendation resulting from the hearing will be submitted to the resident by certified return receipt mail.

APPELLATE PROCESS
In the event of an adverse finding resulting in a recommendation of disciplinary measure(s) or dismissal of the resident, he or she shall have access to due process in the form of an appeal. If the resident chooses this course, a request for such action in writing within ten days of receipt of notice from the hearing body must be forwarded to the Chairman or his designee.

Within fourteen days after receipt of such a request, the Chairman or his designee shall convene an appellate hearing committee composed of the Medical Director of University
Hospitals, who will chair the hearing, the Executive Director of University Hospitals, and the Chairman of the Department of Dental Anesthesiology or his designee.

The same rules, format, procedures and rights of the resident shall apply to such hearing as those described concerning the hearing before the hearing body.

After such an appellate hearing and deliberation by this body, the disciplinary measure(s) or dismissal of the resident may be sustained, altered or reversed. The decision of the appellate body will be considered final and its recommendation will be implemented.
Commission on Dental Accreditation Policy on Third Party Comments

The Commission currently publishes in its accredited lists of programs the year of the next site visit for each program it accredits. In addition, the Commission publishes in the spring and fall those programs being site visited January through June or July through December. Developing programs submitting accreditation eligible applications may be scheduled for site visits at other times; thus, the specific dates of these site visits will not be available at all times. Parties interested in these specific dates (should they be established) are welcomed/encouraged to contact the Commission office. The United States Department of Education (USDE) procedures now also require accrediting agencies to provide an opportunity for third-party comment, either in writing or at a public hearing (at the accrediting agencies’ discretion) with respect to institutions or programs scheduled for review. All comments must relate to accreditation standards for the discipline and required accreditation policies. In order to comply with the department’s requirement on the use of third-party comment regarding program’s qualifications for accreditation or pre-accreditation, the following procedures have been developed.

WHO CAN SUBMIT COMMENTS: Third-party comments relative to the Commission’s accredited programs may include comments submitted by interested parties such as faculty, students, program administrators, Commission consultants, specialty and dental-related organizations, patients, and/or consumers.

HOW COMMENTS CAN BE SOLICITED: The Commission will request written comments from interested parties in the spring and fall issues of Communications Update. In fairness to the accredited programs, all comments relative to programs being visited will be due in the Commission office no later than 60 days prior to each program’s site visit to allow time for the program to respond. Therefore, programs being site-visited in January through June will be listed in the fall issue of CU of the previous year and programs scheduled for a site visit from July through December will be listed in the spring issue of the current year. Any unresolved issues related to the program’s compliance with the accreditation standards will be reviewed by the site visit team while on-site.

Those programs scheduled for review are responsible for soliciting third-party comments from students and patients by publishing an announcement at least 90 days prior to their site visit. The notice should indicate the deadline of 60 days for receipt of third-party comments in the Commission office and should stipulate that comments must pertain only to the standards for the particular program or policies and procedures used in the Commission’s accreditation process. The announcement may include language to indicate that a copy of the appropriate accreditation standards and/or the Commission’s Evaluation Policies and Procedures (EPP) may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611, or by calling 1/800-621-8099, extension 4653.

TYPES OF COMMENTS CONSIDERED: All comments submitted must pertain only to the standards relative to the particular program being reviewed or policies and procedures used in the accreditation process. Comments will be screened by Commission staff for relevancy. For comments not relevant to these issues, the individual will be notified that the comment is not related to accreditation and, where appropriate, referred to the appropriate agency. For those individuals who are interested in submitting comments, requests can be made to the Commission office for receiving standards and/or the Commission’s Evaluation Policies and Procedures (EPP).
MANAGEMENT OF COMMENTS: All relevant comments will be referred to the program at least 50 days prior to the site visit for review and response. A written response from the program should be provided to the Commission office and the site visit team 15 days prior to the site visit. Adjustments may be necessary in the site visit schedule to allow discussion of comments with proper personnel.

Adopted: (07/95) Revised: (01/97) EPP (2000) Page 15

COMPLAINTS TO THE COMMISSION ON DENTAL ACCREDITATION

A complaint is defined by the Commission on Dental Accreditation as one alleging that a Commission-accredited educational program, or a program which has an application for initial accreditation pending, may not be in substantial compliance with Commission standards or required accreditation procedures.

REQUIRED NOTICE OF OPPORTUNITY AND PROCEDURE TO FILE COMPLAINTS WITH THE COMMISSION

Each program accredited by the Commission on Dental Accreditation must develop and implement a procedure to inform students of the mailing address and telephone number of the Commission on Dental Accreditation. The notice, to be distributed at regular intervals, but at least annually, must include but is not necessarily limited to the following language:

The Commission on Dental Accreditation will review complaints that relate to a program’s compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission’s policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.

The accredited program must retain in its files information to document compliance with this policy so that it is available for review during the Commission’s on-site reviews of the program.

(01/94)

REQUIRED RECORD OF COMPLAINTS: The program must maintain a record of student complaints related to the Commission’s accreditation standards and/or policy received since the Commission’s last comprehensive review of the program.

(07/96)

DUE PROCESS RELATED TO INVESTIGATION OF COMPLAINTS

The following procedures have been developed to handle the investigation of complaints about an accredited program, or a program which has a current application for initial accreditation pending, which may not be in substantial compliance with Commission standards or established accreditation policies.
Policy on Complaints Directed at CDA-Accredited Educational Programs

Students, faculty, constituent dental societies, state boards of dentistry, and other interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation (CDA) regarding any CDA accredited dental, allied dental or advanced dental education program, or a program which has an application for initial accreditation pending. The Commission is interested in the continued improvement and sustained quality of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

In accord with its responsibilities to determine compliance with accreditation standards and required policies, the Commission does not intervene in complaints as a mediator but maintains, at all times, an investigative role. This investigative approach to complaints does not require that the complainant be identified to the program.

The Commission, upon request, will take every reasonable precaution to prevent the identity of the complainant from being revealed to the program; however, the Commission cannot guarantee the confidentiality of the complainant.

Only written, signed complaints will be considered by the Commission; oral and unsigned complaints will not be considered. The Commission strongly encourages attempts at informal or formal resolution through the program’s or sponsoring institution’s internal processes prior to initiating a formal complaint with the Commission. The following procedures have been established to manage complaints:

Inquires:

When an inquiry about filing a complaint is received by the Commission office, the inquirer is provided a copy of the Commission’s Evaluation Policies and Procedures (EPP) manual (includes the Complaint Policy) and the appropriate Accreditation Standards document.

The initial screening is usually completed within thirty (30) days and is intended to ascertain that the potential complaint relates to a required accreditation procedure (i.e., one contained in Evaluation Policies and Procedures [EPP]) or to one or more accreditation standard(s) or portion of a standard which have been or can be specifically identified by the complainant.

Written correspondence clearly outlines the options available to the individual. It is noted that the burden rests on the complainant to keep his/her identity confidential. If the complainant does not wish to reveal his/her identity to the accredited program, he/she must develop the complaint in such a manner as to prevent the identity from being evident. The complaint must be based on the accreditation standards or required accreditation procedures. Submission of documentation which supports the non-compliance is strongly encouraged.

Written Complaints:

When a complainant submits a written, signed statement describing the program’s non-compliance with specifically identified procedure(s) or standard(s), along with the appropriate documentation, the following procedure is followed:

1. The materials submitted are logged in and reviewed by staff.
2. Legal counsel, the chair of the appropriate review committee, and the applicable review committee members may be consulted to assist in determining whether there is sufficient information to proceed.
a. If the complaint provides sufficient evidence of probable cause of non-compliance with the standards or required accreditation procedures, the complainant is so advised and the complaint is investigated using the procedures in the following section “formal complaints.”

b. If the complaint does not provide sufficient evidence of probable cause of non-compliance with the standards or required accreditation procedures, the complainant is so advised. The complainant may elect
   1) to revise and submit sufficient information to pursue a formal complaint
   2) not to pursue the complaint. In that event, the decision will be so noted and no further action will be taken.

c. Initial investigation of a complaint may reveal that the Commission is already aware of the program’s non-compliance and is monitoring the program’s progress to demonstrate compliance. In this case, the complainant is notified that the Commission is currently addressing the non-compliance issues noted in the complaint. The complainant is informed of the program’s accreditation states and how long the program has been given to demonstrate compliance with the Accreditation Standards.

Formal Complaints:

Formal complaints (as defined above) are investigated as follows:

3. The complainant is informed in writing of the anticipated review schedule.

4. The Commission informs the chief administrative officer (CAO) of the institution sponsoring the accredited program that the Commission has received information indicating that the program’s compliance with specific required accreditation procedure(s) or designated standard(s) has been questioned.

5. Program officials are asked to report on the program’s compliance with the required procedure(s) or standard(s) in question by a specific date, usually within thirty (30) days.
   a. For standard(s)-related complaints, the Commission uses the questions contained in the appropriate sections of the self-study to provide guidance on the compliance issues to be addressed in the report and on any documentation required to demonstrate compliance.
   b. For procedure(s)-related complaints, the Commission provides the program with the appropriate policy or procedural statement from EPP. Additional guidance on how to best demonstrate compliance will be provided to the program. The chair of the appropriate review committee and/or legal counsel may assist in developing this guidance.

6. Receipt of the program’s written compliance report, including documentation, is acknowledged.

7. The appropriate committee(s) and the Commission will investigate the issue(s) raised in the complaint and review the program’s written compliance report at the next regularly scheduled meeting. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the compliance report in a
telephone conference call(s). The action recommended by the committee(s) will be forwarded to the Commission for mail ballot approval in this later case.

8. The Commission may act on the compliance question(s) raised by the complaint by:
   a. determining that the program continues to comply with the procedure(s) or standard(s) in question and that no further action is required.
   b. determining that the program does not or may not continue to comply with the procedure(s) or standard(s) in question and going on to determine whether the corrective action the program would take to come into full compliance could be (i) documented and reported to the Commission in writing or (ii) would require an on-site review.
      i. If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
      ii. If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted.
         (1) If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission’s usual procedures for such site visits.

9. Within two weeks of its action on the results of its investigation, the Commission will also:
   a. notify the program of the results of the investigation.
   b. notify the complainant of the results of the investigation.
   c. record the action.

10. The compliance of programs applying for initial accreditation is assessed through a combination of written reports and on-site reviews.
    a. When the Commission receives a complaint regarding a program which has an application for initial accreditation pending, the Commission will satisfy itself about all issues of compliance addressed in the complaint as part of its process of granting initial accreditation to the applicant program.
    b. Complainants in will be informed that the Commission does provide developing programs with a reasonable amount of time to come into full compliance with standards that are based on a certain amount of operational experience.

(04/83;12/89) (new policy 0/11/95) (item & revised 07/1/96) (revised 07)
Policy and Procedures on Complaints Directed at the
Commission on Dental Accreditation

Policy: Interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding CDA policies or the implementation thereof. The CDA will determine whether the information submitted constitutes an appropriate complaint and will follow-up according to the established procedures:

1. Within two (2) weeks of receipt, the CDA will acknowledge the received information and provide the complainant with the policy and procedures.

2. The CDA will collect additional information internally, if necessary, and then conduct an initial screening to determine whether the complaint is appropriate. The initial screening is completed within thirty (30) days.

3. The CDA will inform the complainant of the results of the initial screening.

4. If the complaint is determined to be appropriate, the CDA (and appropriate committees) will consider the complaint at its next regularly scheduled meeting. The complaint will be considered in closed session if the discussion will involve specific programs or institutions; otherwise, consideration of the complaint will occur in open session. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the complaint in a telephone conference call(s). The action recommended by the committees will be forwarded to the Commission for mail ballot approval in this later case.

5. The CDA will consider changes in its policies and procedures if indicated.

6. The CDA will inform the complainant of the results of consideration of the complaint within two (2) weeks following the meeting or mail balloting of the Commission.

Sexual Harassment

Organization and Human Resource Development Office of Human Resources
The Ohio State University
150 Pressey Hall
1070 Carmack Road
Columbus, Ohio 43210-1002
614-292-4500
1999-2000
EXAMPLES OF SEXUALLY HARASSING BEHAVIORS
(Not an exhaustive list)

The behaviors listed below are examples of some of the behaviors that can constitute sexual harassment. At Ohio State, sexual harassment occurs if the behavior is sexual and unwanted, if an individual’s academic or work position is dependent on submitting to or accepting the behavior, or if it contributes to an offensive, hostile, or uncomfortable working or studying environment.

These behaviors are unacceptable and should not be present in the classroom, work environment, or advising sessions, in syllabi, tests, or other course material (unless it has a legitimate relationship to the subject matter of the course), or in any other academic or workplace arena.

• Sexual jokes, innuendoes, and gestures
• Unsolicited and unwelcome flirtations, advances or propositions, however subtle
• Graphic or degrading comments about an individual’s appearance, dress, or body
• Staring at an individual or focusing upon a particular area of the body
• Elevator eyes - looking someone up and down
• Whistling, cat calls, leering
• Terms of address such as “honey,” “baby,” “chick,” “hunk,” or “dear”
• Regularly offering personal gifts such as flowers, candy, etc.
• Display of sexually suggestive objects or pictures
• Sexual or intrusive questions about an individual’s personal life
• Explicit descriptions of sexual activities or experience
• Neck or shoulder massages
• Pressure for sexual activity, however subtle
• Explicit offers of sex for grades, money, or other rewards
• Any unnecessary, unwanted physical contact such as touching, rubbing, hugging, pinching, patting, or kissing
• Physical or sexual assault, including rape
RESPONSIBILITIES OF UNIVERSITY LEADERSHIP

Preventing Sexual Harassment

1. **Raise the subject of sexual harassment proactively.** Make sure that all faculty, staff and students understand what sexual harassment is, that it is not acceptable at Ohio State, and that prohibited behaviors are clearly understood. Distribute the Sexual Harassment Policy and Procedures on a regular basis. Offer training programs regularly for faculty, staff, and students at all levels.

   Sexual harassment training should be mandatory for managers. Managers and supervisors should be trained in sexual harassment prevention, to understand and enforce the policy, to recognize improper conduct among peers and employees, and to take appropriate action to prevent, stop, and remedy the misconduct. In the academic setting, faculty can be considered as classroom “managers” and thus may incur some of the liability associated with management responsibilities.

   Managers and supervisors and teachers in the classroom can be held liable if they knew or should have known that sexual harassment was occurring and they failed to take immediate corrective action.

2. **Expect and encourage faculty, staff, and students to behave professionally.** Set an example. Avoid flirting behaviors on the job. Keep in mind that jokes with any sexual content can imply or be interpreted by others that individuals are proposing or receptive to sexual behavior. Sexual jokes, like racial jokes, are not acceptable in the workplace. Set standards of dress and decorum in your department. Regardless of how anyone dresses, dress must not be interpreted as an “invitation” or serve as a justification for sexual harassment. No one asks to be harassed.

3. **Be frank about what is offensive.** Talk with harassers openly and tell them that their behavior is offensive. Encourage individuals to talk openly as well.

4. **Don’t tolerate any harassment, however inconsequential it seems to you or others.** The more tolerant the environment is, the more harassers will feel free to harass. Express disapproval of and take action to stop sexually harassing language and conduct. Indicate to harassers that the harassing behaviors must stop and that reoccurrences will not be tolerated.
Taking Disciplinary Action

1. *Determine what action, if any, should be taken to resolve the complaint.*
   Corrective/disciplinary action should be taken in consultation with the Offices of Academic Affairs and/or Human Resources. Follow relevant university policies (see Sexual Harassment Procedures, VII-B-8). Corrective action should generally reflect the severity of the conduct. Consider the harasser’s past record.

2. *Make follow-up inquiries* to ensure the harassment has not resumed and no retaliation has occurred.

3. *If the findings of the investigation are inconclusive,* remind the individual who was accused, as well as their supervisor, of Ohio State’s sexual harassment policy, and check back with the complaining party regularly to ensure that the alleged harassment has stopped.

A Few Other Points

1. *Document the harassment.* Keep a diary so you can provide specific information should you decide to report the harassment. Write down the date and time of the incident and the surrounding circumstances. This will also help you to determine if the behavior was one isolated incident or an ongoing pattern.

2. *Get a witness.* Let someone in your area know what is occurring and get him or her to watch when the harasser is around you.

3. *Provide support.* If you know someone who has been harassed, be there to support the individual. Remind them that they are not to blame. Suggest that the person take action, formal or informal, to regain control over their life.

4. *Get a copy of Ohio State’s Sexual Harassment Policy and Procedures.* Know what your rights are and what options are available to you.

5. *If you feel you must leave, state the real reason for leaving the job.* You may be able to collect unemployment because sexual harassment constitutes an unfavorable working condition.

6. *If you are terminated, speak with an attorney.* You may be able to receive back pay and, in the future, get a good employment recommendation.
CAMPUS RESOURCES

* Can receive a formal written complaint at Ohio State

FOR STUDENTS:

* Human Resources Consulting Services, 403 Archer House, 292-2800

* Student Judicial Affairs, 2050 Drake Union, 292-0748

* Dean, Chair, Supervisor, Professor, Advisor, Residence Hall Director

Counseling and Consultation Service, 4th floor Ohio Union, 292-5766

2nd floor Wilce Student Health Center, 292-5726

Women Student Services, 464 Ohio Union, 292-8473

Rape Crisis Center, 221-4447

Ohio Civil Rights Commission, 466-5928

Equal Employment Opportunity Commission, 466-8380

FOR STAFF:

* Human Resources Consulting Services, 403 Archer House, 292-2800

* Supervisor/Unit Head

Faculty and Staff Assistance Program, 140 Battelle, 1375 Perry Street, 293-2442

Rape Crisis Center, 221-4447

Ohio Civil Rights Commission, 466-5928

Equal Employment Opportunity Commission, 466-8380

FOR FACULTY:

* Human Resources Consulting Services, 403 Archer House, 292-2800

* Department Chair/Dean

Academic Affairs, 203 Bricker Hall, 292-5881

Faculty and Staff Assistance Program, 140 Battelle, 1375 Perry Street, 293-2442

Committee on Academic Freedom and Responsibility, 126 University Hall, 292-2423

Rape Crisis Center, 221-4447

Ohio Civil Rights Commission, 466-5928

Equal Employment Opportunity Commission, 466-8380
Office of Human Resources  
The Ohio State University  

Sexual Harassment  
Policy 1.15

The Ohio State University - Policies and Procedures http://hr.osu.edu/policy/policyhome.htm

Applies to: Faculty, staff, students, student employees, and volunteers

POLICY

Issued: 10/01/1980  
Revised: 03/05/2004  
Edited:

The University administration, faculty, staff, student employees, and volunteers are responsible for assuring that the University maintains an environment for work and study free from sexual harassment. Sexual harassment is unlawful and impedes the realization of the University's mission of distinction in education, scholarship, and service. Sexual harassment violates the dignity of individuals and will not be tolerated. The University community seeks to eliminate sexual harassment through education and by encouraging faculty, staff, student employees, and volunteers to report concerns or complaints. Prompt corrective measures will be taken to stop sexual harassment whenever it occurs.

POLICY GUIDELINES

I. Definition

Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other physical or verbal conduct of a sexual nature when it meets any of the following:

A. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic status.
B. Submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual.
C. Such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive environment for working, learning, or living on campus. Sexual harassment can occur between any individuals associated with the University, e.g., an employee and a supervisor; coworkers; faculty members; a faculty, staff member, or student and a customer, vendor, or contractor; students; or a student and a faculty member.

II. Examples of Sexual Harassment

Examples of sexual harassment include, but are not limited to:
A. Some incidents of physical assault.
B. Direct or implied threats that submission to sexual advances will be a condition of employment, work status, promotion, grades, or letters of recommendation.
C. Direct propositions of a sexual nature and/or subtle pressure for sexual activity that is unwanted and unreasonably interferes with a person's work or academic environment.
D. A pattern of conduct that unreasonably interferes with the work or academic environment (not legitimately related to the subject matter of a course) including:
   1. Sexual comments or inappropriate references to gender.
   2. Sexually explicit statements, questions, jokes, or anecdotes regardless of the means of communication (oral, written, electronic, etc.).
   3. Unwanted touching, patting, hugging, brushing against a person's body, or staring.
   4. Inquiries and commentaries about sexual activity, experience, or orientation.
   5. The display of inappropriate sexually oriented materials in a location where others can view them.

III. Regulations

A. Consensual relationships

No person involved in a consensual relationship will have direct responsibility for evaluating the employment or academic performance or for making decisions regarding the promotion, tenure, or compensation of the other party to the relationship. Consensual romantic and sexual relationships between supervisor and employee or between faculty and student are strongly discouraged.

These relationships may be subject to concerns about the validity of consent, conflicts of interest, and unfair treatment of other students or employees. Further, such relationships can undermine the atmosphere of trust essential to the educational process and the employment relationship.

In the event of an allegation of sexual harassment, the University will strictly scrutinize a defense based upon consent when the facts establish that an institutional power differential existed within the relationship.

B. Confidentiality and non-retaliation

The University will make every reasonable effort to conduct all proceedings in a manner that will protect the confidentiality of all parties. Parties to the complaint should treat the matter under investigation with discretion and respect for the reputation of all parties involved.

University policy and state and federal law prohibit retaliation against an individual for reporting sexual harassment, or for participating in an investigation. Retaliation is a serious violation that can subject the offender to sanctions independent of the merits of the sexual harassment allegation.

The University has a compelling obligation to address allegations and suspected instances of sexual harassment when it obtains information that would lead a reasonable person to
believe that this policy has been violated. The University is not precluded from taking any action it deems appropriate, including informing the alleged harasser of the complaint and pursuing an investigation even in cases when the complainant is reluctant to proceed. The complainant will be notified in advance when such action is necessary.

C. Corrective measures
When it has been determined that sexual harassment has occurred, steps will be taken to ensure the harassment is stopped immediately. Corrective measures consistent with the severity of the offense will be imposed consistent with applicable University procedures and may include sanctions.

Sanctions imposed on the harasser may include, but are not limited to, a reprimand, suspension, or dismissal from the University. In the event that a record of such sanctions will become a part of the harasser's personnel records, prior notice will be given to the harasser. Sanctions also may be imposed on any individual with a duty to act (under this policy and associated procedures) who fails to respond to a complaint of sexual harassment in a manner consistent with the provisions of this policy and the associated procedures. The complainant will be informed of the corrective measures taken.

D. False allegations

It is a violation of this policy for anyone to knowingly or with reckless disregard for the truth make false accusations of sexual harassment. Failure to prove a claim of sexual harassment is not equivalent to a false allegation. Sanctions may be imposed on individuals who knowingly or with reckless disregard for the truth make false accusations of sexual harassment.

E. Use of sexual harassment allegations in employment actions

When making decisions affecting an individual’s employment or academic status, allegations of sexual harassment may be considered only if they have been addressed through this policy or procedure, a court of law, or other administrative proceeding.

Whenever such an allegation is discussed as part of a determinant in the terms and conditions of an employment or academic status, the affected party should be given notice.

IV. Policy and Procedure Administration

The Office of Human Resources is responsible for the administration of this policy and the associated procedures. The president and each vice president, dean, department chair, director, administrator, faculty member, and supervisor is responsible for assuring compliance with this policy. Any such individual who obtains information that would lead a reasonable person to believe that this policy has been violated must refer the matter to the appropriate individual for investigation or, if so authorized, initiate a prompt and thorough investigation.
I. Educational Program Goals and Objectives

The University is committed to eliminating and preventing sexual harassment of faculty, staff, students, student employees, and volunteers and to fostering an environment of respect for all individuals. The University promotes educational programs coordinated by the Office of Human Resources to meet the following goals:

A. Informing all individuals about their rights through training and dissemination of the sexual harassment policy.
B. Including the sexual harassment policy in orientation materials for new faculty, staff, students, and volunteers.
C. Notifying persons of prohibited conduct.
D. Informing all individuals of the appropriate procedures and reporting mechanisms for addressing concerns of sexual harassment.
E. Informing the community about the problems caused by sexual harassment.
F. Addressing issues of sexual harassment from a multicultural perspective.

II. Who Can Make Allegations

Sexual harassment concerns can often be resolved by the person being harassed addressing the matter directly with the alleged harasser. When such resolution is not feasible, any faculty, staff, student, or volunteer may bring an allegation against any member of the University community or any customer, vendor, or contractor of the University.

III. Confidentiality

To the extent possible, all information received in connection with the filing, investigation, and resolution of allegations will be treated as confidential except to the extent it is necessary to disclose particulars in the course of the investigation or when compelled to do so by law. All individuals involved in the process should observe the same standard of discretion and respect for the reputation of everyone involved in the process.

IV. Retaliation

University policy and state and federal law prohibit retaliation against an individual for reporting sexual harassment, or for participating in an investigation. The University will not tolerate retaliation in any form against any faculty, staff, student, or volunteer who files an allegation, serves as a witness, assists an alleger, or participates in an
investigation of sexual harassment. Retaliation is a serious violation that can subject the offender to sanctions independent of the merits of the sexual harassment allegation. Allegations of retaliation should be directed to the Office of Human Resources, Consulting Services.

V. Counseling and Support

A person seeking counseling or support may contact any of the following units:

A. University Faculty and Staff Assistance Program

B. Student Gender and Sexuality Services, Rape Education and Prevention Program

C. Office of Residence Life

D. Counseling and Consultation Service

E. Office of Student Affairs

The role of the above offices is not to investigate allegations but to provide counseling and support.

VI. Receipt and Referral of Allegations

A. An alleged violation of the University's sexual harassment policy may be taken to any of the following designated individuals:

1. The human resources professional within a department or unit.


3. Any supervisor, faculty member, or faculty or staff administrator.

B. If the alleged harasser is the alleger’s supervisor, the alleger should directly contact either a higher level administrator in the college/unit or the Office of Human Resources, Consulting Services.

C. Cases involving student on student sexual harassment not in the employment setting will be handled in accordance with the Code of Student Conduct and are not covered under this procedure. The Office of Student Affairs will be responsible for the investigation and resolution of such allegations.

D. When the above individuals receive an allegation of sexual harassment, they will promptly refer the matter to the appropriate individual for investigation or, if so authorized, initiate a prompt and thorough investigation.

E. The Office of Human Resources, Consulting Services, is available to provide consultation to any person who has a potential sexual harassment concern. Likewise, consultants are available to assist any administrator in handling an allegation.
F. All individuals who are designated to receive allegations are expected to participate in training provided by the Office of Human Resources, Organization and Human Resource Development, related to handling sexual harassment allegations.

VII. Complaints

Procedures for filing and the investigation of allegations of sexual harassment are addressed in Guidelines for Investigating Complaints of Discrimination and Harassment.

RESOURCES

For consultation:
- Office of Human Resources, Consulting Services 614-292-2800
- Office of Academic Affairs 614-292-5881

For more information:
- Ohio State Discrimination/Harassment Investigation Guidelines
- OSU Record Retention Policy http://www.lib.ohio-state.edu/OSU_profile/arvweb/retention/gensched.htm
- Discrimination/Harassment Complaint Form http://hr.osu.edu/hrpubs/forms.htm
- Rules for Classified Civil Service http://hr.osu.edu/ccsrules/ccsrule1.htm
- Code of Student Conduct http://studentaffairs.osu.edu/resource_csc.asp
- Human Resources Policy 8.15, Corrective Action
- Human Resources Policy 10.10, Student Employment

For counseling and support:
- University Faculty and Staff Assistance Program (UFSAP) 614-293-2442
- Student Gender and Sexuality Services 614-688-4898
- Office of Residence Life 614-292-8266
- Counseling and Consultation Service 614-292-5766
- Office of Student Affairs 614-292-9334

For issues of academic freedom:
- Council on Academic Freedom and Responsibility (CAFR) http://senate.ohio-state.edu/CAFR.html
Blood or Body Fluid Exposure at the College of Dentistry

The procedure below refers to exposed persons as students. However, the same process applies to faculty and staff except that they are to report to Employee Health (if it is before 4:00 p.m.) instead of Student Health or their own physician. After hours all exposed persons must go to the OSU ED if they require urgent treatment per results, as described below. If there are any questions about this process after hours contact the OMFS Clinic Director.

A. The Student is to fill out Accident and Injury Report Form and the College of Dentistry Incident Report Form, found in the bottom drawer of the cabinet by the exam chairs in the front of the clinic. Make a copy of both and leave them in Oral Surgery for the clinic nurse.

B. Explain to patient that an exposure occurred and that protocol is to ask if we can draw blood to be tested for HIV, Hepatitis B and Hepatitis C. Also explain that the patient should not receive a bill and that if they do, to please let the College of Dentistry know so it can be taken care of.

C. If patient refuses the blood draw, thank the patient and send them on their way, and send the student to Student Health immediately. If it is late in the afternoon call the office of Dr. Roger Miller (Student Health) at 2-5019. They will tell you if the student can still be seen there or if they should go to the OSU ED. If they have private insurance they can go to their doctor, but they should do this immediately because the assumption is that no test means HIV positive. If it is after 4:00 pm the student should go to OSU ED. They need to tell the triage nurse that they are there for a Blood and Body Fluid exposure. They should expect to be treated as high priority and be counseled and prescribed meds very quickly.

D. If patient OK’s blood draw, then we have patient sign the HIV Consent Form. At the top of the HIV Consent Form fill out the patient’s name, address, date of birth, social security number and phone number. Attach it to the other papers the student completed. The blood draw kits are in the bottom drawer of the file cabinet by exam chairs up front. A single red/grey vacutainer of blood is drawn and labeled with the patient’s name, social security number, date, and blood drawer’s initials. On the lab requisition:

   • put the patient’s name and SS# in the upper right corner,
   • put the name and phone/pager of the person who will receive results in the blank provided,
   • check the box next to the name of the test (the only test on the form, but you have to check it anyway or they will call you about it).
• The blood is then placed in the sealed part of a specimen bag, and the requisition in the open pocket.

E. The student may return to work on the patient, or whatever other things they need to do. However, they must provide a phone number where they can be reached in the next 1-2 hours. Give them a copy of the Accident and Injury report form to take with them to Student Health.

F. Take the specimen packet to the OSU Labs Central Processing - Stat specimen’s area on the 3rd floor of Rhodes/Doan (almost exactly under OR 17).

G. The lab will call/page the rapid HIV results to the person who drew the blood in about 60 – 90 minutes. If it is non-reactive, inform the student. They must follow up at student health in the next day or two for evaluation of Hepatitis B and C. If the result is reactive (i.e. positive) they need to report to Student Health (if it is before 4:00) or the OSU ED immediately. Call Dr. Miller at 292-3301 if they will be going to Student Health.

H. When describing the results to the student their response will probably be somewhere between mildly alarmed and hysterical. It is important that they take the result seriously and seek prophylaxis, but it is also fair to remind them that the rapid HIV screen is oversensitive and tends toward false positives by design. Instruct them to immediately go to Student Health or to the OSU ED if it is after 4:00. If they will be going to the OSU ED, you will need to call the triage nurse and tell them that the student is coming. You must also tell them that the rapid HIV result will not be in the computer! The ED will need to call the hematology lab and ask for it by name and social security number (of the source patient), so give them this information. The way these samples are logged in they will never appear on the usual system, and results must be retrieved over the phone.
Blood and Body Fluid Exposure Protocol

An exposure includes cuts or punctures with blood contaminated needles or sharps, and/or blood and body fluid splashes to eyes, nose, mouth, and/or broken skin. The incident must be addressed IMMEDIATELY (Stop treatment at once.) according to the following protocol:

1. Perform wound care: Wash area thoroughly with soap and running water. If splash to the face, thoroughly flush eyes and/or mouth with water.

2. Weekdays: Inform supervising faculty and report to Oral & Maxillofacial Surgery reception desk on 2nd floor (take patient and chart with you.). Evenings or after hours: report to Clinic Director/Faculty and page Oral Surgery Resident on call. If your own bleeding is fully stopped, you may continue to treat the patient until the resident arrives. See back for additional information.


5. Written consent to test patient for HIV (obtained by Oral Surgery)

6. Yes
   - Exposed individual MUST remain in area or be accessible by phone over the next 2 to 3 hours so that results can be relayed and further instructions provided as needed.
   - Report to treatment area* for evaluation

7. No, OR source patient is unknown
   - The following steps are taken by the Oral Surgery Dept.

8. Person drawing blood receives results from lab and reports results to exposed individual

9. Negative HIV
   - Instruct individual to follow up promptly at treatment area* for evaluation of Hepatitis B and C

10. Positive HIV
    - Call results to treatment area*. Exposed individual should report to treatment area immediately. If seen in Emergency Dept., must still follow-up with Employee/Student Health for evaluation of Hepatitis B and C.

*Treatment Areas:

Employees: Employee Health Services, 2A University Hosp. Clinic, 456 W. 20th Ave. (293-8146)**

Students: Student Health Services, 1875 Millikin Rd, 292-3301)**

**If closed: Report to OSU Hospitals Emergency Dept. (292-9333) only if rapid HIV test is positive, or patient is unavailable or refused testing.
• To contact the Oral Surgery resident, call 293-8000 and ask for the name and pager number of the individual on call.

• Results of rapid HIV antibody tests are usually available within 2 hours of the time the specimen arrives in the lab. If HIV prophylaxis needs to be initiated, it is most effective if begun within 2 hours of the exposure.

  If results are not received in an appropriate length of time, call the OSU Hospitals Critical Care Lab @293-8375

• Injured individual should

  Inform patient that an exposure occurred.

  Notify a faculty member. If injured person is faculty, remaining faculty will attend to injured person’s student load as needed.

  Make a notation in patient’s record indicating the time, site and nature of the injury. If injured person is unable to make note, a faculty member should do so.

  Make sure the patient’s phone number is available (verify folder information).

• The patient does not need to remain in building after blood has been drawn and dental work is completed.

• Results of patient testing are confidential and may be shared only with the exposed individual and the physician in the treatment area. Patient’s name is not to be disclosed.

w-up.