

General Surgery Resident Supervision Policy

I. Purpose of Policy

This policy establishes supervision guidance in accordance with ACGME for Surgery Residents at Vanderbilt University Medical Center (VUMC).

II. Scope

This policy applies to the Residents, Program Director, Associate Program Directors, and Faculty of the VUMC Surgery Residency Program. All are expected to adhere to the following standards to optimize patient care and the educational experience. Supervision takes place in all facets of training and during all rotations

III. Definitions

Resident: A physician in an ACGME-accredited graduate medical education program, to include residents and fellows.

Progressive Authority and Responsibility: The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

Levels of Supervision

1. Direct Supervision: the supervising physician is physically present with the resident and patient.
2. Indirect Supervision
 - a. *with Direct Supervision Immediately Available:* the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
 - b. *with Direct Supervision Available:* the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
3. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. Policy Statement

Supervisory Lines of Responsibility

The care of the individual patient in the Vanderbilt University Surgical Residency Program is a group effort. The ultimate responsibility for care, decisions, procedures, etc., resides with the attending surgeon. The attending surgeon delegates aspects of the provision of care to the surgical residents on his/her service in proportion to the individual resident's level of training and expertise. Attending faculty members will encourage and be open and receptive to calls from residents regarding patient care issues. The service chiefs will state this explicitly at the beginning of each resident rotation and this

practice will be supported by the actions of all faculty members. The hierarchical system as a rule pertains (attending, chief resident, senior resident, junior resident, intern) with graded levels of responsibility, supervision, guidance, communication, and accountability. When attendings or residents are away, off, or unavailable, specific attending and resident coverage arrangements will be communicated by the call duty roster and verbally. While the attending may interact with any particular resident, communication and interaction among all members of the team are expected and normative. Documentation of supervision in the medical record is expected and encouraged.

Supervision of Residents in the Clinical Environment

Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed American Board of Medical Specialties (ABMS) board-certified surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS board-certified critical care physicians (e.g. anesthesia critical care physicians, critical care medicine physicians, surgical critical care physicians, etc.). Residents and faculty members should inform patients of their respective roles in each patient's care. The supervising physician may be the attending, fellow, or upper level resident, depending on the clinical scenario and the PGY of the resident.

During daytime working hours (0700-1700 Monday-Friday) each service has faculty and chief residents in the hospital and in each outpatient facility immediately available to provide direct supervision as needed. At night and on the weekends, there is a faculty member and a senior or chief resident available by phone at all times, and would be available to return to the hospital for direct supervision if needed. The gynecology services have faculty and fellows on call that can provide indirect supervision by telephone and are available to come in to directly supervise when necessary. In urgent situations, the in-house trauma surgical attending or fellow are available for direct supervision until the specific service's attending arrives. At all times, at least 1 junior (PGY-2) and/or 2 senior residents (PGY-3 and PGY-4) are also available for direct supervision on the in-house EGS and trauma services

Direct Supervision for PGY-1 Residents

Interns (PGY-1 residents) are supervised either directly or indirectly with direct supervision immediately available. There is no situation where an intern will be participating in clinical care where there is not this level of supervision available. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or manage a particular clinical scenario and include more senior residents (PGY-2 residents and above who have met competency for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents.

Defined Tasks for PGY-1 Residents

Indirect supervision is allowed for the following (in consultation as needed with supervising residents and attendings):

1. Patient Management Competencies

- a) evaluation and management of a patient admitted to hospital, including taking an initial history and conducting a physical examination, formulation of a plan of therapy, and determining necessary orders for therapy and tests
- b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
- c) evaluation and management of post-operative patients, including the conduct of monitoring and ordering medications, testing, and other treatments
- d) transfer of patients between hospital units or hospitals
- e) discharge of patients from the hospital
- f) interpretation of laboratory results

2. Procedural Competencies

- a) performance of basic venous access procedures, including establishing intravenous access (after competency has been established)
- b) placement and removal of nasogastric tubes and Foley catheters (after competency has been established)
- c) arterial puncture for blood gases (after competency has been established)

PGY-1 surgical residents are given a procedural checklist at the beginning of the year for central venous insertion, arterial cannulation, tube thoracostomy, tracheostomy change, and bronchoscopy. PGY-1 residents must have a supervising resident (PGY-3 or above with appropriate competency themselves) observe them performing the procedures, while providing minimum direction, and attest to their competency to perform the procedure with indirect supervision.

Senior Resident Responsibilities

It is the responsibility of the senior resident to assist and supervise the junior residents. Senior residents are expected to directly supervise junior residents for the aforementioned procedural competencies until the junior resident has demonstrated that they are able to successfully and safely execute the procedural task. Senior residents will also perform each of the patient management competencies and procedural competencies above when their role on the team requires it, and in cases where a junior resident is not available. They will assume graduated levels of responsibility, as deemed appropriate by the attending surgeon.

Chief Resident Responsibilities

Chief residents are expected to provide leadership throughout the residency. If questions or problems arise with a particular assignment, resident, or schedule, then this matter should be addressed with one of the Administrative Chief Residents. If a satisfactory resolution cannot be achieved, then the issue can be referred to the Residency Program Director. The GME administrative office of University Hospital may serve to resolve administrative disputes, grievances, or problems that cannot be managed by the Department of Surgery Education Office. Chief residents are responsible for delegating tasks and responsibilities equitably among team members, with appropriate attention to the level of skill of the resident. Ultimately, they are responsible for ensuring timely and appropriate patient care by all members of the team, including following up on daily inpatient labs/imaging, and ensuring that the plan of care determined on rounds is carried out. Chief residents will ensure that junior residents adhere to work hour rules, are in clinic ½ day per week, and attend all required teaching conferences. They will communicate directly with attending surgeons regarding patients in their care, and will respond to outpatient calls as determined by their clinical service assignment. They are to be role models of professionalism and exemplary patient care.

For all residents:

It is every resident's responsibility to know the limits of the scope of authority and the circumstances under which the resident is permitted to act with conditional independence.

The chain of command applies to both clinical and administrative issues. Decisions regarding patient care should be reviewed with upper level residents. In general, residents should consult the team member directly above them. Final decisions regarding management should be discussed with the senior team member, who will discuss the plan with the fellow and/or attending. Urgent patient care issues should be discussed immediately with the fellow and/or attending (see above). Consultation should be used freely within the chain of command, as this is optimal for learning, teaching, and patient care.

Direct supervision is **required** until competency is demonstrated (and then can transition to level appropriate supervision as noted above) for:

1. Patient Management Competencies

- a) initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (Advanced Trauma Life Support (ATLS) required)
- b) evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
- c) evaluation and management of critically-ill patients, either immediately postoperatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments

d) management of patients in cardiac or respiratory arrest (Advanced Cardiac Life Support (ACLS) required)

2. Procedural Competencies

- a) carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
- b) repair of skin and soft tissue lacerations and surgical incisions
- c) excision of lesions of the skin and subcutaneous tissues
- d) tube thoracostomy
- e) tracheostomy change
- f) bronchoscopy

3. Bedside Procedures and Level of Training:

a) PGY 1 Resident—direct supervision by upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated. Surgical trainees performing a bedside procedure should discuss the clinical appropriateness with the senior resident, fellow or attending prior to starting.

b) PGY 2 and Higher Resident—direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated. Surgical trainees performing a bedside procedure should discuss the clinical appropriateness with the senior resident, fellow or attending prior to starting.

The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again. The procedure should be aborted and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

Circumstances and events in which all residents must communicate with appropriate supervising faculty members/attending physicians:

Emergency admission

Consultation for urgent condition

Transfer of patient to a higher level of care

Code Blue Team activation

Change in DNR status

Patient or family dissatisfaction

Patient requesting discharge AMA

Patient death

Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If the attending does not respond promptly, the resident should ask the chief resident to assist in contacting the attending. The Rapid Response Team (RRT) should be utilized freely in urgent situations.

Faculty Responsibilities

The designation of faculty dictates these physicians are responsible for teaching, evaluating and supervising the residents; therefore, they have the privilege of having resident physicians assist them with patient care. The Program Director (or his/her designee) will structure faculty supervision assignments of enough duration so that individual faculty members can assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility for patient care interactions and procedures, both in and out of the operating room.

The faculty member will routinely review the Resident's documentation in the medical record, attesting clinical documentation with the faculty's own assessment. Further, they will ensure compliance with institutional requirements such as updating problems lists, performing medication reconciliation, and maintenance of accurate and timely medical record-keeping. Faculty members will serve as role models of professionalism, providing exemplary patient care and demonstrating excellent communication skills.

The faculty supervisor(s) assigned for each rotation or clinical experience (inpatient or outpatient) shall provide to the Program Director a written evaluation of each trainee's performance during the period that the resident or clinical fellow was under his or her supervision. Supervisors will also provide Residents with constructive feedback in real-time as appropriate.

References:

1. https://www.uab.edu/medicine/obgynresidency/images/PDFs/Policies/Supervision_of_Residents.pdf

2. ACGME Institutional Requirements. Retrieved from the ACGME.org: www.acgme.org/Designated-Institutional-Officials/Institutional-Review-Committee/Institutional-Application-and-Requirements
3. Common Program Requirements. Retrieved from ACGME.org: www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements
4. https://gme.dartmouth-hitchcock.org/policies/supervision_policy.html