

CONEMAUGH MEMORIAL MEDICAL CENTER
GENERAL SURGERY
SURGICAL RESIDENT SUPERVISION POLICY

I. PURPOSE

The MMC Surgical Residency Program follows the principle that resident supervision is required at all levels in order to insure optimal educational benefit as well as patient safety. As Surgical educators, we recognize the need for graduated responsibility and opportunity to make decisions in order to develop surgical judgment by residents at every level. The principle of graduated responsibility under supervision begins in the PGY-1 year with resident credentialing in basic patient evaluation and care skills and progresses from specific to general supervision. As residents gain knowledge, proficiency in manual and problem solving skills and begin to demonstrate good judgment, the intensity of supervision decreases to foster independent decision-making. Patient safety remains our primary concern followed by the facilitation of education and learning.

This document outlines policy and procedural requirements pertaining to the supervision of postgraduate residents. Attending surgeon refers to either full- or part-time faculty of the MMC Department of Surgery or faculty at participating institutions, who is providing supervision to residents in the postgraduate training program in General Surgery. All attending physicians should be Board Certified (or eligible to be examined) in General Surgery or a surgical specialty and have a specific interest in teaching residents in the General Surgery Residency Program. Only members of the Medical Staff who have been granted appropriate clinical privileges and who have been selected by the General Surgery Residency Program Director, as well as approved by the Surgical Core Faculty, shall be given the privilege of supervising surgical residents.

II. POLICY

The MMC Surgical Residency Program recognizes the ACGME's three classifications or 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 confines of the 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 confines of the site of the patient care, but is immediately available via phone and/or electronic modalities and is available to provide Direct Supervision.

3. Oversight:

The supervising physician is available to provide review of procedure/encounters with feedback provided aftercare is delivered.

III. DEFINITIONS

1. **Attending Physician:** A licensed independent practitioner who holds admitting and/or attending physician privileges consistent with the requirements delineated in the Bylaws, Rules and Regulations of the Medical Staff of Memorial Medical Center or with the requirements delineated in the governing regulations of the assigned and approved off-site healthcare entity.

2. **Trainee:** A physician who participates in an approved Graduate Medical Education (GME) program. The term includes interns, residents and fellows in GME programs approved by the MMC Committee on Graduate Medical Education. (A medical student is never considered a graduate medical trainee.)
3. **Supervision:** For the purposes of this document, supervision refers to the authority and responsibility that an attending surgeon exercises over the care delivered to a patient by a resident. Such control is exercised by observation, consultation, direction and demonstration and includes the imparting of knowledge, skills and attitudes by the attending surgeon to the resident. Supervision may be provided in a variety of ways, including person-to-person contact with the resident in the presence of the patient, person-to-person contact in the absence of the patient, and through consultation via the telephone, video linkages, or other electronic means unless otherwise prohibited by hospital laws.
4. **Teaching Assistant:** teaching assistant refers to a resident, acting under the appropriate supervision of an attending surgeon, who is providing guidance and/or assistance to a less experienced resident(s) in any clinical activities including the performance of invasive procedures and surgical operations.

IV. GENERAL PRINCIPLES

Within the scope of the training program, all residents, without exception, will function under the supervision of attending surgeons. A responsible attending must be immediately available to the resident in person or by telephone and must be physically present within a reasonable period of time, if needed. Each surgical service will publish and make available "call schedules" indicating the responsible attending physician.

The surgery residency program is structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge and judgment throughout the course of their training. Each participating facility must adhere to current accreditation requirements for all matters pertaining to the training program including the level of supervision provided. The requirements of the American Board of Surgery, American Board of Medical Specialties, Residency Review committee for Surgery and the ACGME have been incorporated into this training program to ensure that each successful program graduate will be eligible to sit for an American Board of Surgery examination.

V. GRADUATED LEVELS OF RESPONSIBILITY

1. Residents, as part of their training program, may be given progressive responsibility for the care of the patient. A resident may act as a teaching assistant to less-experienced residents. Assignment of the level of responsibility must be commensurate with their acquisition of knowledge and development of judgment and skill, and consistent with the requirements of the accrediting body.
2. Based on the attending surgeon's assessment of a resident's knowledge, skill, experience and judgment, residents may be assigned graduated levels of responsibility to:
 - a) Perform procedures or conduct activities without a supervisor present; and/or
 - b) Act as a teaching assistant to less experienced residents.
3. The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor present and/or act as a teaching assistant will be based on evidence of the resident's clinical experience, judgment, knowledge and technical skill. Such evidence may be obtained from the affiliated university, evaluations by attending surgeons or the Program Director, direct observation and/or other clinical practice information.

4. Documentation of a resident's assigned level of responsibility will be filed in the resident's record or folder maintained in the office of the Director.
5. When a senior resident is acting as a teaching assistant, the attending surgeon remains available for the quality of care of the patient, providing supervision and meeting medical record documentation requirements as previously defined.

The provisions of this document are applicable to all patient care services, including both inpatient and outpatient care settings, and the performance and interpretation of all diagnostic and therapeutic procedures. The attending and resident surgeons are responsible to assure continuity of care provided to patients.

PGY-1

The first year of residency emphasizes surgical diagnosis, pathophysiology and pre- and post-operative care. The PGY 1 resident, along with the more senior resident, is intimately involved in the routine daily care of the patient as well as work/teaching rounds with the attending surgeon where treatment plans are finalized. The PGY 1 resident follows the patient to surgery, where he/she acts as either the primary surgeon or the surgical assistant based on their level of experience. It is through these interactions, as well as completion of skills lab modules, surgical boot camp and specific modules of the ACS "Fundamentals of Surgery" curriculum, that the resident will progressively move from "Direct" or "Indirect" supervision. Senior level resident and attending surgeon help will ALWAYS be immediately available if needed. A resident should, at no time, place themselves or be placed into a position which could potentially result in patient harm due to lack of experience or ability. We all progress at different speeds and we must know and acknowledge our limitations. Calling for assistance is NOT a sign of weakness in this or any other program - it simply reflects good judgment by the resident.

PGY 1 residents require Direct Supervision until competency is demonstrated and documented for:

1. Patient Management Competencies:
 - a) Initial evaluation and management
 - b) Evaluation and management of post-operative complications
 - (1) Hypotension or hypertension
 - (2) Oliguria, Anuria
 - (3) Cardiac arrhythmias
 - (4) Starting of or discontinuation of antibiotics if not previously discussed with team
 - (5) Hypoxemia or any significant change in respiratory rate
 - (6) Change in neurologic status
 - (7) Compartment syndromes
2. Evaluation and management of critically ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring and orders for medications, testing and other treatments.

The PGY 1 must communicate with a senior level resident and/or attending physician for any and all calls regarding intensive care patients (patients in 6A, 6R and 7R) as well as any patients in the step-down/intermediate care unit 8A.

3. Management of patients in cardiac or respiratory arrest (ACLS required)
4. Procedural Competencies
 - a) Central venous access placement
 - b) Arterial catheterization
 - c) Temporary dialysis access

- d) Tube thoracostomy
- e) I & D of simple abscess at bedside
- f) Placement and removal of nasogastric tubes
- g) Placement and removal of Foley catheters

PGY 1 residents require Indirect Supervision for:

Patient Management Competencies:

- a) Evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy and 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 test.
- c) Evaluation and management of post-operative patients including the conduct of monitoring and orders for medications, testing and other treatments.
- d) Transfer of patients between hospital units.
- e) Discharge of patients from the hospital.
- f) Interpretation of laboratory results.

PGY 2-3 residents who demonstrate competency may be given responsibility for independent judgment and surgical decision-making with continued attending supervision. By the third year, residents may be given more responsibility for the evaluation of surgical patients in the emergency room to include the initiation of preoperative treatment and arranging for further surgical care. In addition, PGY 3 residents are more involved with the technical aspects of surgical care in the operating room.

PGY 4 residents are considered the senior/chief of the service and will supervise junior residents and medical students on their respective services. Senior residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while attending surgeons monitor their progress and continue to supervise the service. Senior residents are allowed and encouraged to exercise independent surgical judgment to the degree that is consistent with excellent and safe patient care. They will monitor junior residents for signs of fatigue and stress and report all expected instances to the administrative Chief Resident.

PGY 5 residents are considered the Chief of their respective services and supervise junior residents and medical students on their service as well as being available for services with PGY 3 or lower service chiefs. Chief residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while attending surgeons monitor their progress and continue to supervise the service. Chief residents are allowed and encouraged to exercise independent surgical judgment to the degree that is consistent with optimal and safe patient care. They will monitor junior residents for signs of fatigue and stress and report all expected instances to the Program Director.

Situations which mandate communication with an involvement of the responsible Attending Physician and/or senior resident are:

1. Any patient admitted to the service.
2. Transfer of a patient to another service or to another level of care (e.g. ICU, intermediate, etc.) or death of a patient.
3. The supervising physician must approve any recommendation to discharge a patient from the Emergency Room.
4. The supervising physician must be notified of any patient leaving the facility against medical

advice (AMA).

5. The resident may order consultations and testing on behalf of the attending physician following discussion with the attending physician. This must be documented by the resident or by the attending in the order or in the physician's notes.
6. Consultations requested by another service may be seen initially by the resident. The resident shall immediately discuss the consultation with the supervising physician for critically ill patients. The consulting physician shall personally evaluate the patient within 24 hours of the request for consultation for routine consults and within two hours for urgent consults.
7. Any situation in which the resident feels that the level of care for the patient exceeds their capability or circumstances in which the caseload exceeds the resident's capability, or any situation in which resident fatigue/stress would potentially result in less than optimal patient care. These can be communicated through the chief resident but the attending physician must be made aware of all such incidents and the program director must be informed of any and all resident stress/fatigue related instances.

Supervision of Residents Performing Invasive Procedures or Surgical Operations:

1. Diagnostic or therapeutic invasive procedures or surgical operations, with significant risk to patients, require a high level of expertise in their performance and interpretation. Such procedures may be performed only by residents who possess the required knowledge, skill, judgment and under an appropriate level of supervision by the attending physician.

Attending surgeons will be responsible for authorizing the performance of such invasive procedures or surgical operations. The name of the attending surgeon performing and/or directing the performance of a procedure should appear on the informed consent form.

2. During the performance of such procedures or operations, an attending surgeon will provide an appropriate level of supervision. Determination of this level of supervision is at the discretion of the attending surgeon. Their decision is based on the experience and competence of the resident, and the complexity of the specific case.
3. Attending surgeons will provide appropriate supervision for the evaluation of patients, the scheduling of cases, the assignment of priority, pre-procedural preparations and the procedural and post-procedural care of patients.
4. The supervising physician shall be physically present during the critical portion of each surgical procedure. This responsibility may be shared with a senior or chief resident who has been designated as being competent of performing a limited number of procedures without the direct presence of the supervising physician (i.e. chest tube placement, CVL, I&D of an abscess).
5. Residents in General Surgery will not operate independently. All cases taken to the operating room will be discussed with the attending physician and all operations will be performed under the direct supervision of the attending physician. The only exceptions will be when a Surgical Chief Resident is required to emergently take a patient to the operating room for a life saving intervention, but only when directed by the attending physician to do so and the attending physician will be en route to the hospital.

Emergency Situations:

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of or prevent serious impairment of the health of the patient. In such situations, any resident, assisted by

hospital personnel, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. As circumstances allow, the attending physician for that patient will be notified of the event and the most senior surgical resident available or a member of the Surgical Core Faculty will be notified for assistance.

Residents must be aware of the supervisory lines of responsibility. Any concern should be brought to the attention of the service chief or attending faculty physician who will either address the concern at their level or elevate it to the Program Director. If there is a serious concern related to supervision or any other aspect of the training which the resident does not feel has been addressed or for any reason the resident does not feel comfortable communicating with their direct supervisor, the resident can bypass the supervisory lines and communicate directly with the Program Director, Associate Program Director, or the Chairman of the Department of Surgery or the Chief Medical Officer (CMO) of the organization.

VI. SUPERVISION OF MEDICAL STUDENTS

The surgical residents will assist with the formal and informal instruction of medical students assigned to the surgical / trauma / ICU rotations. They will oversee medical student participation in patient care to include review and co-signature of chart notes, instruction and supervision of procedures (when appropriate) and mentoring of student-patient encounters. Under the direction of an attending physician, a resident may provide hands-on instruction to the medical students in the delivery of minor procedures.

Residents may be called upon to assist in the instruction of medical students in the skills lab on a monthly basis. Residents are also solicited to provide written feedback to the student coordinator regarding a medical student's performance during the surgical rotations. Any and all identified student problems will be brought to the attention of the attending physician and/or the Student Program Coordinator for the Department of Surgery.

Faculty Responsibilities for Supervision: Roles and Responsibilities:

1. Program Director and Chairman of the Department of Surgery:

The Department Chair and Program Director are responsible for implementation of and compliance with these requirements. The attending surgeon is responsible for, and must be familiar with all institutional / residency policies to include the policies on supervision, supervisory responsibilities as well as stress and fatigue recognition as well as mitigating strategies.

The GME office has instituted a system, New Innovations, which allows healthcare workers to track resident procedures that have been designated by the program director as competent to perform without direct attending supervision (i.e. chest tube placement, CFL, I&D of an abscess).

The Program Director and the Residency Coordinator will insure that this list of approved procedures and levels of required supervision is maintained and kept up to date. These are available through New Innovations.

The resident's profile is updated as progression through the program and acquisition of skills and competency is acquired. In addition, the residency program will monitor interns in the acquisition of skills for invasive procedures. Once a predetermined number of specific procedures have been completed satisfactorily and the appropriate skills lab VOP (Verification of Proficiency) has been completed, the Program Director has indicated that the resident is competent in performing such procedure, the resident may then, and only then, perform such procedures with attending approval but without direct supervision.

2. Attending Physician:

The position of attending physician entails the dual roles of providing quality patient care and effective clinical teaching. Although some of this teaching is conducted in the classroom setting, the majority of it is through direct contact, mentoring, and role modeling with trainees. All patients seen by the trainee will have an assigned attending physician. The attending physician is expected to:

- Exercise control over the care rendered to each patient under the care of a resident, either through direct personal care of the patient or through supervision of medical trainees and/or medical personnel.
- Effectively role model safe, effective, efficient and compassionate patient care and provide timely documentation to program directors required for trainee assessment and evaluation as mandated by the program's Residency Review Committee (RRC), where applicable.
- Participate in the educational activities of the training programs, and as appropriate, participate in institutional orientation programs, educational programs and performance improvement teams, institutional and departmental educational committees.
- Review and co-sign the history and physical within 24 hours.
- Review progress notes and sign procedural and operative notes and discharge summaries.
- Assure that discharge, or transfer, of the patient from an integrated or affiliated hospital or clinic is appropriate based on the specific circumstances of the patient's diagnoses and treatment.

The patient will be provided appropriate information regarding prescribed therapeutic regimens, including specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by attending countersignature of the hospital discharge summary or clinic discharge note.

- Assure residents are given the opportunity to contribute in discussions or participate on committees where decisions are being made, which will affect their activities. The Organization and Medical Staff are expected, to the extent practicable, to include resident representation on committees such as Medical Records, Quality Assurance, Utilization Review, Infection Control, Surgical Case Review and Pharmacy and Therapeutics.
- Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are:
 - a) medically indicated;
 - b) explained to the patient;
 - c) appropriately executed and interpreted; and
 - d) evaluated for appropriateness, effectiveness and required follow-up

Evidence of this assurance should be documented in the patient's record via a progress note(s) or countersignature thereof, or reflected within the resident's progress note(s).

The level of supervision required is not the same under all circumstances; it varies by specialty, level of training, the experience and competency of the individual trainee, and the acuity of the specific clinical situation. An attending may provide less direct personal care of a patient seen for routine care when supervising a senior level trainee, and may provide more direct personal care of a patient receiving complex care when supervising a junior level trainee. An attending physician may authorize the supervision of a junior trainee by a more senior level trainee based

on the attending physician's assessment of the senior level trainee's experience and competence, unless limited by existing or future hospital policies.

3. Faculty Supervisor:

The supervisory faculty of MMC has accepted the guidelines concerning supervisory expectations of faculty members as a condition of faculty appointment. The guidelines state that the faculty supervisor will:

- a) Accept the responsibility for the surgical residents and students assigned to his/her service.
- b) Allow the residents to actively participate under his/her supervision and control in the care of their patients, including the performance of procedures, commensurate with the resident's level of training.
- c) Recognize that the residents and students are involved in a program designed to help them master the art and science of surgery in a progressive fashion. Realize that residents have not yet reached that point in their careers when they can function without supervision by the surgical faculty attending staff.
- d) Recognize the responsibility of each surgical faculty member to assess the level of capability of each resident in each delegated task and to provide an appropriate level of supervision while delegating progressively increasing responsibility commensurate with increasing skill, medical knowledge and judgment.
- e) Recognize that all responsibilities which a surgical resident assumes are delegated responsibilities and that ultimately the attending surgeon is the physician responsible for the safety and welfare of the patients under their care and for the resident's participation in the management of those patients.
- f) Recognize that on occasion the number of service patients assigned to any one surgical resident may detract from their overall educational value. The number of patients assigned to any one resident or team of residents will be a result of a cooperative decision between the service chief and the attending faculty physician with the goal being to optimize the service to education ratio. The Program Director has the ultimate authority to modify patient care responsibilities as required to ensure an optimal learning environment.
- g) Recognize the importance of transitions of care policies and procedures and insure that emphasis is placed on and appropriate time is allowed for these processes as a daily quality initiative.
- h) Recognize the signs and symptoms of fatigue and stress in themselves as well as the residents and be aware of possible mitigating strategies so these episodes are minimized. They should be aware of the current institutional policies and report each episode to the Program Director immediately. Patient and Resident safety remain our primary goals as well as preserving the overall educational value of the clinical rotation by maintaining an optimal educational environment.