CONEMAUGH MEMORIAL MEDICAL CENTER
GRADUATE MEDICAL EDUCATION POLICY

PEER REVIEW PROCESS

Purpose

The Conemaugh Memorial Medical Center Residency/Fellowship Programs follow the principle that resident/fellow supervision is required at all levels in order to ensure optimal educational benefit as well as patient safety. The ultimate responsibility for patient care belongs to the attending physician responsible for supervising the resident/fellow. All accountability should roll up through the physician/department peer review process.

Applies To

All Conemaugh Memorial Hospital Graduate Medical Education training programs.

Policy

Residency/Fellowship training programs will follow the GME Supervision Policy as well as the Supervision Policy designed for their individual program. They will adhere to the peer review process set forth by the attending physician's department.

Procedure

Each program assists in some peer review at the department level including:

- **A.** M&M conferences are held in the Emergency Medicine, Internal Medicine, and Surgery residency programs where individual cases are discussed and reviewed
- **B.** Case Reviews including readmissions and operative logs when applicable
- **C.** Serious Events and Incidents - reported through the Safety Event Manager (SEM)
- **D.** Supervision issues on an as needed basis

It will be recommended that residents sit on their respective Department Peer Review Committees.

Resident/Fellow should refer to the GME Supervision Policy as well as the Supervision Policy for their department

GMEC Approved: 01/17/2019

CONEMAUGH MEMORIAL MEDICAL CENTER
GRADUATE MEDICAL EDUCATION POLICY

SUPERVISION POLICY

Purpose

The Conemaugh Memorial Medical Center (CMMC) Residency/Fellowship Programs follow the principle that resident/fellow supervision is required at all levels in order to insure optimal educational benefit as well as patient safety. As medical educators, we recognize the need for graduated responsibility and opportunity to make decisions in order to develop judgment by residents/fellows at every level. The principle of graduated responsibility under supervision begins in the PGY-1 year with resident/fellow credentialing in basic patient evaluation and care skills and progresses from specific to general supervision. As residents/fellows 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.

Principles

A. Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.

B. Clinical responsibilities must be conducted in a carefully supervised and graduated manner, allowing housestaff to assume progressively increasing responsibility in accordance with their level of education, ability, and experience.
   1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident or fellow must be assigned by the program director and faculty members after assessment of relevant competencies.
   2. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific criteria or milestones.
   3. Senior residents or fellows should be given the responsibility for supervising junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

C. Supervision of residents and fellows should foster humanistic values by demonstrating a concern for each housestaff member's well-being and professional development.
   1. Supervision must include timely and appropriate feedback and residents and fellows must be provided with rapid, reliable systems for communicating with supervising faculty.
   2. Supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.

D. Faculty members functioning as supervising physicians should delegate portions of care to residents and fellows, based on the needs of the patient and the skills of the resident or fellow. Residents, fellows and faculty members should inform patients of their respective roles in each patient's care.

E. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care,

the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

Policy

The CMMC Residency/Fellowship Programs recognize the ACGME's three classifications or levels of supervision:

A. **Direct Supervision** - the supervising physician is physically present with the resident/fellow and patient

B. **Indirect Supervision**:
   1. **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.
   2. **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.

C. **Oversight (Informal Supervision) -** the supervising physician is available to provide review of procedure/encounters with feedback provided aftercare is delivered.

Procedure

A. Each Program sponsored by CMMC shall develop and maintain appropriate supervision policies, compliant with ACGME/AOA Program Requirements, including an explicit description of the supervision for each activity or rotation and for each level.

B. The following site-specific faculty supervision requirements are applicable.
   1. Inpatient Services: A patient care team that may include medical students, interns, residents and fellows, under the supervision of a faculty physician, shall care for patients admitted to the service. Decisions regarding diagnostic tests and therapeutics, although initiated by housestaff, shall be reviewed with the responsible faculty member during patient care rounds.

      Patients shall be seen by the responsible attending and their care shall be reviewed at appropriate intervals. The attending shall document his/her involvement in the care of the patient in the medical record. Housestaff members are required to promptly notify the patient's faculty physician in the event of any controversy regarding patient care or any serious change in the patient's condition.

      Faculty members or their designees (covering physicians) are expected to be available, by telephone or pager, for housestaff consultation 24 hours per day for their term on service, on-call day or for their specific patients.

2. Emergency Departments: In the Emergency Departments, a faculty member must be on-site 24 hours per day.
3. Clinics and Consultation Services: In clinics and consultation services, a faculty member must review overall patient care rendered by housestaff.
4. Intensive Care Units: In intensive care units, housestaff decisions regarding patient care, including admission, discharge, treatment decisions, performance of invasive procedures and end-of-life decisions are to be discussed and reviewed by faculty.
5. Supervision of Housestaff in Operating Suites: In the operating suites, a surgical faculty member is responsible for the supervision of all operative cases. A surgical faculty member shall be present in the operating room with housestaff during critical parts of the procedure. For less critical parts of the procedure, a surgical faculty member must be immediately available for direct participation.

Monitoring Compliance

A. The quality of housestaff supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the housestaff's evaluations of their faculty and rotations, review of ACGME surveys and the GMEC's internal reviews of programs. When necessary, during the Special Reviews of programs, the GMEC shall request that each program provide a description of the procedures to ensure supervision in the program's clinical settings (including nights and weekends), an explanation as to how the program monitors compliance with its supervision policies, a description as to how the program becomes aware of and responds to exceptions or critical instances of breakdown of supervision and the mechanisms the program has in place to ensure accessibility and availability of faculty.

B. For any significant concerns regarding housestaff supervision, the respective program director shall submit a plan for its remediation to the GMEC for approval and the program director may be required to submit progress reports to the GMEC until the issue is resolved.

References

CR-VI.A (Supervision and Accountability)
IR-IV.I (Supervision)

GMEC Revised: 1/2016, 3/2018
GMEC Reviewed: 5/2013, 4/2018
Approved: 7/2013, 4/2018

CONEMAUGH MEMORIAL MEDCIAL CENTER

EMERGENCY MEDICINE RESIDENCY PROGRAM

DEM Resident Supervision Policy

Purpose: To optimize and organize EM Resident supervision in efforts to provide best patient care and safety. This also serves to maintain a safe learning culture and environment while working in our DEM.

Emergency Medicine Residents shall be under the supervision of qualified Medical Staff attending physicians whenever they are providing care as part of their residency responsibilities. Supervision must at all times be in compliance with the medical staff bylaws of the institution at which the resident is providing care. Supervision must meet the standards delineated in this policy.

A. Patients assigned to attending physician

All patients are the direct responsibility of an attending member of the Medical Staff. Each patient is assigned a primary attending physician (as outlined below), although other attending physicians may, at times be delegated responsibility for the care of a patient and provide supervision instead of or in addition to the assigned practitioner.

6a Resident → 6a Attending

9a Resident → 9a Attending

12p Resident → 12p Attending

3p Resident → 3p Attending

6p Resident → 6p Attending

9p Resident → 6p/10p Attending

10 Resident → 10p Attending

*Off service FP/IM Resident (9a or 2p) will always remain with same shift Attending.

*If an Attending is involved in Critical care, trauma, extensive procedural patient or is occupied for any extended period, Resident may communicate this and present to another Attending on shift.

*PGY 2 & PGY 3 Residents will respond to Trauma Alerts and manage airway under Attending physician. Communication is important here.

*Epic Charts must be complete and signed by end of shift.

*Signout & patient hand off corresponds to Resident/Attending of nearest shift. (ie. 6a team signs out to 2p team, etc.)

*Procedure logs correspond to supervising physician.

*New interns should refrain from presenting to new "outside" hires.

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.

B. Progressive resident responsibility

Attending physicians supervise patient care responsibilities of residents. Attending together with the Faculty/Clinical Competence Committee & Program Director are responsible for ensuring that the degree of professional responsibility and independence accorded to each resident are progressively increased through the course of training, commensurate with his/her skill, training and experience. The Faculty/Clinical Competence Committee/PD makes decisions about the individual resident's graded responsibility, progressive involvement and independence in specific patient care activities. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising attending (ie Critical care, procedures, etc.)

The system of supervision is monitored by structured evaluation processes for each resident through comprehensive CCC report, direct feedback from both residents/faculty, Nursing director/supervisors input, which may include combinations of daily attending evaluations of individual performance, regular written evaluations of each resident following specific rotations, results of internal or external examinations, and evaluation meetings with the Faculty/CCC/Program Director.

PGY-I

- Directly supervised by EM Faculty.
- See a broad spectrum of undifferentiated patients on all shifts, in order of presentation or assignment by attending physician.
- Emphasis will be on quality of patient evaluation and care.
- In-depth discussion of all cases with the attending physician prior to initiation of all but the most basic diagnostic studies or therapeutic interventions. The PGY 1 residents are expected to perform an appropriate history and physical and subsequently develop a differential diagnosis and treatment plan with the guidance of the attending physician. Orders should be placed only after this presentation to the attending is complete. The PGY 1 resident is expected to demonstrate appropriate ordering when utilizing laboratory, radiological, and adjunctive testing. The importance of excellent documentation is stressed at this level, as it is for all residents. Must discuss all cases with the attending physician prior to disposition decisions, or involving consultants.
- Are not to provide supervision of other residents. Medical students may work along side but not supervised by PGY-1.
- Common ED procedures must be done under approval and supervision of attending physicians. Selected procedures may be supervised by more senior residents with attending oversight as well.
- Management of multiple patients simultaneously is not stressed until the later part of the academic year.

PGY-II

- Directly supervised by EM Faculty.
- Continue to see full spectrum of patients in order of presentation or assignment by attending physicians. May exercise some selectivity in patient cases while serving as intermediate level resident, i.e. critical care, trauma airway, procedural sedation, fracture reduction.
- Emphasis on gaining experience with full spectrum of emergency medical procedures and honing proficiency.
- Emphasis on balancing quality of patient evaluation and care with improved overall efficiency.
- In-depth discussion of all cases with the attending physician. May initiate usual diagnostic studies and therapeutic. Must discuss all cases with the attending physician prior to disposition decisions, or involving consultants.
- Specialized diagnostic studies, uncommon therapeutic interventions, and use of consultants must be discussed with the attending physician prior to initiation.
- Primarily manage trauma airway under direction of EM Attending physician and Trauma team, in collaboration with Anesthesiologist/CRNA. Anesthesia rotation must be complete and airway procedures logged are approved and target met.
- Procedures must be done with attending supervision and approval.
- Assist the attending physician with the supervision of procedures by more junior housestaff and students.

- By the end of the academic year, the PGY 2 should have a solid knowledge base and exhibit a strong clinical performance in managing multiple patients in the ED.

- Responsible for handling necessary medical command of EMS calls with attending backup.

PGY-III

- Directly supervised by EM Faculty.
- Continue to see broad spectrum of ED patients, but with emphasis on those with highest acuity or greatest critical illness.
- Emphasis on time, resource, and efficiency management. Goal is to gain competence in managing administrative tasks, patient flow and team coordination activities, as well as continuing direct primary care of multiple patients concurrently.
- Optimize proficiency with full range of emergency medical procedures. Particular emphasis will be placed on airway management skills, including highly complex and difficult airways.
- Primarily manage trauma airway under direction of EM Attending physician and Trauma team, in collaboration with Anesthesiologist/CRNA.
- Must discuss all cases with the attending physician prior to disposition decisions, or involving consultants. May initiate most diagnostic studies and common therapeutic interventions prior to attending physician discussion.
- May discuss cases with more junior housestaff and medical students and assist in their patient care management with attending physician approval.
- May attempt or initiate the full range of ED procedures with attending physician approval and supervision.
- Responsible for handling necessary medical command of EMS calls with attending backup.
- PGY 3 residents have a lead role in helping other residents and medical students in developing their histories and physicals. They should be considered a primary teaching source in the ED, and are expected to develop skills as an effective clinical instructor.
- Although the PGY 3 is expected to practice with autonomy, all patients are seen by, reviewed and signed by the attending physician prior to disposition.
- The resident is required to inform an attending physician of all potentially critical patients, as well as when they are preparing to perform any procedure.

C. Level of supervision and availability of attending physicians

Supervisors will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment and level of training of the resident being supervised. Supervising physicians have the responsibility to enhance the knowledge of the resident and to ensure the quality of care delivered by any resident. This responsibility is exercised by observation, consultation and direction.

It includes the imparting of the practitioner's knowledge, skills and attitudes to the resident and assuring that the care is delivered in an appropriate, timely and effective manner. Fulfillment of such responsibility requires personal involvement with each patient and each resident who is providing care. Supervising Attending physicians should act professionally and as a role model for trainees. To ensure oversight of resident supervision and graded authority and responsibility, the following classifications of supervision are used:

Direct Supervision: In the DEM, the supervising physician is physically present with the resident and patient with EVERY case.

**IMPORTANT: Every case must be finalized & dispositioned with clear communication between resident and attending. Please discuss workup all results of any tests ordered (that would result that visit), assessment/plan, diagnosis, and disposition and assure that disposition is agreed upon.

Example 1 admitted patients:

Resident: Mr. Jones in room #10 has an intracranial hemorrhage from the mechanical fall. Patient also has a UTI & acute renal failure.

Attending: Let's sit at a computer & review Epic together.

Resident: I'm going to call Trauma team for ICH & fall. Patient is on HTN meds only, no anti-platelets & no anti-coagulants and is AAOx3. Can be admitted to trauma monitored bed. I'll call the Trauma team. Patient treated with 1L NSS for ARF and Rochephin 1g IV for UTI.

Attending: Sounds good but please call Neurosurgery as well. Also double check patients allergies to meds. Please let me know if there are any questions in your discussions with Trauma & Neurosurgery. I'll see if family has any remaining questions.

Example 2 discharged patients:

Resident: I saw a 6 yo male in room # 3 with right ear pain and fever. (continue full presentation). Discussed treatment options with parents including Motrin and studies regarding antibiotic treatment. Parents wish to hold off on antibiotics and will follow up with pediatrician tomorrow for recheck.

Attending: ok I will go see the patient now. Please do not click the discharge button until I relay to you that I saw the patient. Thanks. (**Please make sure patients are not discharged prior to attending physician seeing and assessing the patient. This takes clear communication between resident, attending, and nursing staff.)

Indirect Supervision: In the DEM, the supervising physician is always available for 24-7/365.

Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

All procedures must be directly supervised by an attending physician such as:

Intubation, thoracotomies, thoracostomies, pericardiocentesis, vaginal deliveries, cardiopulmonary resuscitations, cardioversion, dislocation/reduction, major trauma resuscitations, I&D, suturing.

Attending physician must be notified immediately for vital sign instability, any airway compromise or respiratory distress, patient or family question or concern.

Graded Supervision: Residents must be supervised according to level of training (following the specific recommendations of their RRC for Emergency Medicine), and based upon the needs of the patient and skills of the resident.

Off service rotations:

Direct Supervision: The supervising physician is available during rounds and available via phone/pager/oncall system 24 hours a day.

Indirect Supervision: DEM off service resident will always have access to the senior resident on individual service.

Oversight: The supervising physician is available to provide review of patient care with feedback provided after care is delivered. Attending physician should be notified immediately if there is vital sign instability, any airway compromise or respiratory distress, patient or family question or concern, patient needs transferred to higher level of care, i.e., ICU/transfer outside facility, patient death.

D. EMS Supervision/Medical Command

From time to time residents may be called upon to provide online medical command to EMS providers in the field. To qualify for medical command, residents must complete an online medical command course by the end of their first year of residency with the expectation they provide online medical command starting their second year. Residents will be responsible for reviewing and understanding the Pennsylvania State ALS, BLS, and CCT protocols to be able to provide effective command. Residents may be called upon to trigger trauma alert and stroke alerts based on medical command discussions and need to be understand the specific activation criteria. If trauma/stroke/critical action case (ie STEMI) is called, resident must immediately notify attending of such. At any time a resident wishes for advice or is uncomfortable with a medical command call, it is the responsibility of the resident to seek advice and guidance from an attending physician to receive this guidance.

There may also be times where a resident physician has the opportunity to provide medical command in the field. During these times the resident must not have active patient responsibility in the department and be released by their respective attending physician to perform field duties. At no time is a resident allowed to perform field procedures without first discussing the procedure with their attending, unless it is a life, limb, or critical saving procedure (ie intubation, use of tourniquet, chest needle decompression). If a procedure is attempted/completed, resident must notify attending physician immediately, as time allows.

E. Communication:

Supervising attending physicians should provide advice and support and should encourage trainees to freely seek their input. Residents are expected to make liberal use of the supervisory resources available to them and are encouraged to seek advice and input from their supervisors. The clinical environment should maximize effective communication including the opportunity to work as a member of interprofessional teams that are appropriate for the delivery of care in the DEM. Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

The Emergency Medicine Residency Program provides the following guidelines for circumstances and events in which residents must communicate with appropriate supervising physicians:

1. Residents must present all Emergency Department patients to the supervising attending physician prior to disposition of the patient.

2. Residents must present all critically ill or injured Emergency Department patients to the supervising attending physician during or immediately following their initial evaluation and stabilization.

F. Monitoring of compliance

The quality of resident supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the resident's evaluation of their supervisors and rotations, and by the Graduate Medical Education Committee (GMEC) internal reviews of programs. For any significant concerns regarding resident supervision, the EM Residency PD shall submit a remediation plan to the GMEC, DEM Chair/Vice Chair, Faculty, Nursing Director for final approval.

Resident can refer to the GME policy

Approved: 1/18/18
Reviewed:
Revised: 6/2018

DLP-CONEMAUGH
FAMILY MEDICINE
RESIDENT SUPERVISION POLICY

I. Purpose

To establish guidelines and requirements in the Family Medicine residency training program

II. Applies To

The Family Medicine residency program at DLP-Conemaugh

III. Policy

The Family Medicine residency training program will utilize standards and criteria for supervision of residents as put forth by the Residency Review Committee of the Accreditation Council for Graduate Medical Education and American Osteopathic Association.

IV. Definitions

Not applicable.

V. Procedure

- **A.** Ultimate responsibility for the care of a patient rests with the attending physician in both inpatient and outpatient resident experiences.
- **B.** Supervision of residents must be accomplished through an explicit written description of supervisory lines of responsibility for the care of patients and communicated to all members of program staff.
- **C.** The Family Medicine Program Director, faculty or an appropriate designee should delegate patient care responsibilities.
- **D.** Attending physicians should delegate responsibilities to residents in a way that will allow them to assume progressive responsibility according to their level of training, experience, and demonstrated clinical competence.
- **E.** Inpatient and ambulatory assignments must be developed to commensurate with residents' abilities and with appropriate supervision.
- **F.** Family Medicine residents must be provided with prompt and reliable systems for communication and interaction with supervisory physicians.
- **G.** All non-emergent invasive procedures should have the prior approval of the attending physician.
- **H.** Patient care rendered by a resident physician may not be contrary to the management approved by the attending physician unless it is directed by the appropriate department chairman in accordance with the Medical Staff by-laws.
- **I.** Senior residents with documented competencies may supervise assigned junior residents and resident physicians with documented competencies may supervise assigned students.
- **J.** Attending physician supervision must be available at all times for resident trainees.
- **K.** The GMEC may request written descriptions of program resident supervision policy at the Committee members' discretion.

VI. Attachments

Not applicable

Written JPS 10/28/03 Review 6/2/08 JPS; 5/5/10; 5/13/11; 6/6/12; 6/20/13 JLM; 5/14 JLM**;** 4/15JLM; 4/16JLM; 7/17JLM
4/18 JLM

CONEMAUGH MEMORIAL MEDICAL CENTER
INTERNAL MEDICINE RESIDENCY POLICY 03

SUPERVISION

POLICY:
To utilize standards and criteria for supervision of residents as put forth by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA).

SPECIFICS:
Ultimate responsibility for the care of a patient rests with the attending physician and must involve both inpatient and outpatient experiences.

Supervision of residents must be accomplished through an explicit written description of supervisory lines of responsibility for the care of patients and communicated to all members of program staff.

The program director, faculty, or an appropriate designee should delegate patient care responsibilities.

Attending physicians should delegate responsibilities to residents in a way that will allow them to assume progressive responsibility according to their level of training, experience, and demonstrated clinical competence.

Inpatient and ambulatory assignments must be developed commensurate with residents' abilities and with appropriate supervision.

Residents must be provided with prompt and reliable systems for communication and interaction with supervisory physicians.

All clinical procedures should have the prior approval of the attending physician.

Patient care rendered by a resident may not be contrary to the management approved by the attending physician unless it is directed by the Department of Medicine Chairman in accordance with medical staff by-laws.

Residents must write all orders for patients under their care with appropriate attending physician supervision, except as outlined in the IM Residency Order Writing Policy.

Senior residents, with documented competencies, supervise assigned junior residents; and junior residents, with documented competencies, supervise assigned students.

Attending physician supervision must be available at all times for residents.

Nursing personnel will contact the senior resident or attending physician on call with any questions about the level of supervision required for a resident to perform a specific procedure.

Senior residents are responsible to conduct official patient care rounds with interns and medical students. They must review the assessment and plan on all patients daily, either before or after

attending rounds. As part of the senior resident's responsibility, supervision of medical students includes examining the patient, discussing the patient with the medical student, reviewing the medical student's dictation, and writing a brief supervisory note with any additions or corrections. The senior resident's personal dictation must reflect that he/she has seen the patient.

If the service is busy on the weekends, the Friday night and Saturday night shift resident should see some patients before morning rounds and write progress notes before leaving for the day.

The night shift resident will transfer the care of these patients to the day team before leaving for the day.

gae
06/12

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 I 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.