

DEPARTMENT OF SURGERY SUPERVISION POLICY

Updated: June 2011

To ensure that physicians-in-training are appropriately supervised, in accordance with requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the ACGME.

The Department of Surgery is very careful about exposing residents only to levels of decision-making appropriate for their level of experience, and all of the residents function under the supervision of the faculty. We adhere to the GME Policies & Procedures regarding housestaff supervision.

The training of graduate medical trainees physicians is an important mission of Cedars-Sinai Medical Center. Graduate medical trainees must be supervised by teaching staff in such a way that trainees assume progressively increasing responsibility according to their level of education, ability, and experience.

General Guidelines

1. The supervision and communication between the attending surgeon and any resident should exceed that required to ensure that the clinical care delivered meets the established community standard of care.
2. The resident can identify and contact a responsible attending surgeon for a given patient **at all times**.
3. In the event that an attending surgeon is not be available to provide supervision, he or she must designate an alternate or covering attending and identify that person to the resident.
4. For ambulatory or non-urgent care, an attending surgeon is required to be available on-site at the facility during daytime hours of operation.
5. For inpatient admissions, an attending surgeon or supervising resident will be notified of the admission and such notification will be documented in the admitting resident's admission note. An attending surgeon will personally see and evaluate each assigned inpatient admission within twenty-four (24) hours of admission, and co-sign the resident's admitting note or create their own written or printed documentation.
6. For inpatients, residents should maintain ongoing communication **at least one (1) time per day** with the designated attending surgeon. The attending surgeon should document such communication by co-signing the resident's progress note, or the resident will include in his progress note that the case has been discussed with the attending surgeon.
7. It is assumed that there is a **mutual responsibility** on the part of both the resident and attending surgeon to recognize the need for increased frequency and quality of communication, and attending surgeon participation in the following circumstances
 - a. limited experience of the resident
 - b. increased acuity of the patient's condition (e.g. transfer to intensive care unit, need for higher level of clinical care, etc.
 - c. higher risk of complication or mortality associated with the clinical intervention being considered

Lines of Supervision and Communication

Consistent with the philosophy of graded levels of responsibility, it is expected that the resident will directly communicate with, and be, in turn, supervised by the most senior supervising resident on their assigned surgical team. In turn, it is expected that the most senior supervising resident will directly communicate with the designated attending surgeon. **In urgent, or emergent situations, immediate communication with the attending surgeon by any resident on the team is expected.**

The Program Director shall provide explicit written descriptions of lines of responsibility for the care of patients, which shall be made clear to all members of the teaching teams. In outlining those lines of responsibility, the Program Director will define supervision using the following classification of supervision:

1. **Direct Supervision:** the supervising physician is physically present with the resident and patient;
2. **Indirect Supervision 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;
3. **Indirect Supervision 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;
4. **Oversight:** the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Faculty Responsibility for Supervision. The attending surgeon is responsible for the overall management of the individual patient and for supervision of all residents involved in the care of that patient. The attending surgeon will state the specific expectations at the beginning of the rotation, and he/she will establish the chain of command for the care of patients based on knowledge of each resident's ability. Delegation of responsibility is made entirely at the discretion of the attending. Although the attending is expected to support the general principle of graded authority and increasing responsibility, the decision to delegate patient care to a specific resident will be the responsibility of the attending. Likewise, the decision to delegate supervision of a junior resident to a senior resident is the responsibility of the attending.

Supervision of PGY-1 Residents

Indirect supervision is allowed for:

a. Patient Management Competencies:

- evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests.
- pre-operative evaluation and management, including history and physical examination, informed consent, formulation of a plan of therapy, and specification of necessary tests
- evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
- transfer of patients between hospital units or hospitals
- discharge of patients from the hospital
- interpretation of laboratory results

b. Procedural Competencies

- performance of basic venous access procedures, including establishing peripheral intravenous access
- placement and removal of nasogastric tubes and Foley catheters
- arterial puncture for blood gases

Direct supervision is required until competency is demonstrated for:

Patient Management Competencies

- initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
- 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
- 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
- management of patients in cardiac or respiratory arrest (ACLS required)

b. Procedural Competencies

- carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis

access, and arterial cannulation

- repair of surgical incisions of the skin and soft tissues
- repair of skin and soft tissue lacerations
- excision of lesions of the skin and subcutaneous tissues
- tube thoracostomy
- paracentesis
- endotracheal intubation
- bedside wound debridement

Lines of Supervision by Service

ACS	MIS/BAR	Colorectal	SICU	THOR
Attending	Attending	Attending	Attending	Attending
R4	MIS Fellow	Colorectal Fellow	SICU Fellow	Thoracic Fellow
R2	R4	R4	R2	R4
R1		R1	R1	R1
AGS A	AGS B	SO/B (A)	SO/B (B)	PEDS
Attending	Attending	Attending	Attending	Attending
R5	R5	R5	Fellow	R3
R3	R3		R2	R1
R1				
VASCULAR	T/HB	OUTPATIENT	UROLOGY	Neuro
Attending	Attending	Attending	Attending	Attending
R5	Fellow	R1	Urology Fellow	R1
R3	R4		R1	
	R1			
NIGHT FLOAT				
Attending				
R4 or R5				
R2 or R3				
R1				

Invasive Procedures and Operations

1. An attending surgeon or supervising resident will be physically present with the patient for all invasive procedures.
2. An attending surgeon or supervising resident will be physically present with the patient for all operations. In the event that an attending surgeon is not physically present for an operation, the supervising resident will ensure that appropriate preoperative documentation of the attending surgeon's notification and approval of the operation was obtained prior to proceeding with the operation.
3. An attending surgeon or supervising resident will see and evaluate each patient prior to the operation and ensure that appropriate documentation of a preoperative note has been performed.
4. An attending surgeon or supervising resident will ensure that an appropriate and adequate informed consent has been obtained and documented in the medical record.
5. An attending surgeon or supervising resident will ensure that appropriate documentation of the procedure has been included in the medical record at the time of the conclusion of the procedure or operation.

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 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.

Backup Support System

Back-up support systems will be provided when patient care responsibilities are usually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. Back-up coverage is scheduled so support is readily available in the event that an assigned resident is unable to fulfill the assignment or when additional coverage is needed.

1. Residents are encouraged to call for back-up support when they need help in managing a clinical problem, or the amount of work is impossible to complete in an appropriate period of time.
2. To obtain back-up support, residents follow the departmental chain of command structure (included in handbook) and also notify the administrative chief resident.

Chain of Command

In addition to back-up support mechanisms (see separate program policy on consults/ back-up support), all physicians-in-training shall be informed of the program's "chain of command" for addressing patient care and administrative issues

It is the responsibility of the program director to ensure that a written chain of command (spanning from medical students and junior residents to upper Medical Center administration) is submitted to the appropriate channel (e.g., the GME Office) to provide for accessibility by all Medical Center administrators and patient care staff.