

APPENDIX I

GENERAL SURGERY RESIDENT SUPERVISION POLICY

(Reviewed 14 May 2014)

1. General Supervision Policy

a. The supervision policies set forth in this handbook are in accordance with the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) Trainee Supervision Policy, which can be located at:

<http://www.bamc.amedd.army.mil/saushec/general/policies/docs/SAUSHEC-Resid-Super-Policy.pdf>

b. All resident activities on the General Surgery Service are supervised by a teaching staff surgeon who accepts full responsibility for resident actions as long as the resident actions are in compliance with the policies of the general surgery teaching program set forth in this document and the resident manual. Teaching staff are surgeons appointed by the program director and are usually certified by the American Board of Surgery. Teaching staff does not necessarily include all credentialed hospital staff.

c. The requirement for resident supervision is intended to provide for high quality patient care and safety and allow residents to perform with increasing responsibility as they progress through the program and the program staff determines they are qualified to perform under less direct supervision. Therefore more senior residents are allowed greater latitude than more junior residents. Because residents may progress at different rates, their supervision requirements are determined individually by the teaching staff when resident promotions are considered or when performance of procedures is directly evaluated. This involves review of written evaluations of resident performance and discussion with staff supervisors who have directly observed resident performance. Because each resident will progress at a different rate, minimum numbers are rarely specified and observed competence is the criterion for progression.

d. An important aspect of a resident's learning experience is the opportunity of a senior resident to supervise more junior residents. As a general rule, senior residents, when acting in the role of a teaching assistant to less experienced residents, may supervise the performance of surgical/invasive procedures of lesser or more routine complexity. This, however, does not release the staff practitioner's responsibility for the oversight of the patient's care. When a resident is acting as a teaching assistant, the staff practitioner remains responsible for the quality of care of the patient, providing supervision and meeting medical recorded documentation requirements as defined within this policy.

2. Supervision Requirements

a. Supervision requirements are posted on the hospital intra-net and provided in writing to affiliate program directors at affiliated institutions. For each resident, procedures are individually designated by the following:

(1) Level A – Activity may be performed only in the presence of qualified supervisor.

(2) Level B – Activity may be performed only after notification of qualified supervisor (supervisor does not have to be present, but must be aware of planned procedure prior to resident action).

(3) Level C – Activity may be performed without prior notification of qualified supervisor. (Resident may choose to do the procedure without notification of staff and staff will accept responsibility provided resident is acting within the over-all guidelines of the program). The faculty will be informed of actions taken at first available opportunity and/or within 24 hours.

(4) Level D – Resident may act as qualified supervisor for activity. The resident must still obtain staff concurrence before doing the procedure unless the resident is also designated Level C.

b. In emergency situations, patients may benefit from immediate action, which precludes supervisor presence or notification. An “e” suffix denotes the procedure may be performed in an emergency setting as determined by the resident. For example, for a PGY-4 resident, “surgical airway” is a procedure that would be designated as A under non-emergent conditions (supervisor must be present) but C_e for emergent situations (may be performed in emergency before notification of staff). For all emergent procedures, the supervisor must be notified as soon as possible and the usual level of supervision established.

c. If a resident is qualified at level D for a given procedure, he or she may act as supervisor for that procedure. Some procedures require a credentialed staff surgeon as the qualified supervisor. If that is the case, there will be no resident designated D for that procedure. These procedures are marked with an asterisk.

d. The designated supervisor level is a minimum requirement. Teaching staff may at their discretion for individual residents or specific situations, require a higher level of supervisor.

e. Supervision requirements do not determine whether a resident may take credit for a procedure in his or her operative log. For example, a PGY-2 resident may act as first assistant in a procedure with a chief resident. The supervision requirements for the chief resident apply. However, the PGY-2 resident may claim the case as “surgeon” for his operative log.

3. Documentation of Resident Supervision

Residents will record the supervision provided in the procedure or clinic note (e.g., "Discussed with Dr. Dickerson" or "Dr. Dickerson in attendance"). Outpatient clinic notes will be co-signed by staff supervisors on chart reviews at the end of each clinic day.

4. Specific Supervision Policies

a. General non-procedure physician functions such as obtaining a history and performing a physician examination, writing orders, and admitting or discharging a patient are tasks for which residents are trained in medical school. These activities are ordinarily designated levels B or C for all residents at the start of the PGY-1 year. No notes or orders written by interns or residents in the general surgery program *require* co-signature for documentation of supervision (although some may require co-signature IAW medical staff by-laws).

b. Performance of procedures requires level A supervision (presence of supervisor required) until direct observation, evaluation and determination of competence by a qualified supervisor takes place or until the resident is promoted to a level where his or her experience and time in the program justify greater responsibility. Evaluation may occur in simulated or actual patient care.. PGY-1 residents will keep a record of ALL procedures performed in their resident case log Once competence is demonstrated to a qualified supervisor (Level D), the resident will provide that information to the program director who may grant increased levels of responsibility.

c. Requirements for various procedures are listed in the attached table. Venipuncture, nasogastric tube insertion, bladder catheterization, intravenous line placement, and arterial puncture are listed as *common ward procedures*. PGY-1 residents require observation and evaluation by a supervisor to advance to B, C, or D level. PGY-2 residents will be designated level D because of the training and experience gained in the program. Note that PA catheter placement is listed under *advanced ward procedures*. A PGY-2 resident requires the presence of a supervisor unless he or she has demonstrated competence and performed a minimum of 3 procedures.

5. Supervision of PGY-1 Residents

a. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. Therefore, PGY-1 residents will always have a more senior resident or attending in the hospital immediately available for supervision. During off-service rotations, PGY-1 residents will similarly be supervised by either senior residents or attending surgeons.

b. As with all residents, a graduated level of responsibility for PGY 1 residents is commensurate with their acquisition of knowledge and development of compassion, judgment and skill, in a manner consistent with safe and effective patient care. It is expected that the entering PGY 1 knowledge and skill will allow for indirect supervision with direct supervision immediately available from a more senior level resident or attending physician for the following:

1. 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
2. Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
3. Evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
4. Transfer of patients between hospital units or hospitals discharge of patients from the hospital
5. Interpretation of laboratory results

c. As closer supervision is required for more advanced patient management and procedural competencies, PGY 1 residents must have direct supervision (until competency is demonstrated) by a more senior level resident or an attending faculty for the following:

Patient Management skills

1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
2. 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
3. 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
4. Management of patients in cardiac or respiratory arrest (ACLS required)

Procedural skills

1. Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
2. Repair of surgical incisions of the skin and soft tissues
3. Repair of skin and soft tissue lacerations
4. Excision of lesions of the skin and subcutaneous tissues
5. Tube thoracostomy
6. Paracentesis
7. Endotracheal intubation
8. Bedside debridement

d. Once competency has been demonstrated, the PGY 1 resident can perform these skills under indirect supervision with direct supervision from a more senior resident or attending faculty member immediately available. A PGY 1 resident shall be considered competent in the patient management skills after completing ATLS, ACLS, and the Fundamentals of Surgery Curriculum. A PGY 1 resident shall be considered competent in the procedural skills after successfully completing all supervision requirements as noted in Section 4b.

6. Major Operations

Staff will be present and scrubbed for critical parts of all major operations. In circumstances considered appropriate by the teaching staff, PGY-4 or 5 residents may perform an operation with staff present for the operation but not scrubbed. In cases more complex than an appendectomy or hernia, staff will scrub. Participation of staff will be documented in the operative note. More stringent requirements for *billing purposes* may be instituted by the hospital, but the teaching staff considers the above policy sufficient for *supervision purposes* to insure safe, quality patient care.

7. Medical Students Supervision

Medical students will be under the supervision of staff for all patient encounters as outlined for residents above. For common physician functions such as order writing, note writing, and history and physician examinations, all medical student notes will be co-signed by a resident or staff and that resident or staff will take responsibility for the orders of information recorded. For common

ward procedures (venapuncture, nasogastric tube insertion, bladder catheterization, intravenous line placement, and arterial puncture), medical students will perform these procedures with a supervisor physically present unless the student has been instructed in the procedure and determined to be competent by his or her supervisor/instructor. Lacerations may be sutured after instruction and observed competence in suturing. Prior to closure, the wound to be sutured must be directly evaluated by a resident qualified at level D. A record of student instruction and observed competence will be kept in the student's evaluation file. For all other procedures, the presence of a supervisor qualified at the D level or staff presence is required.

USUAL SCOPE OF PRACTICE BY YEAR LEVEL

Clinic Procedures

| PROCEDURE | PGY-1 Level | PGY-2 Level | PGY-3 Level | PGY-4 Level | PGY-5 Level |
|---|--|---|---|---|---|
| Breast Examination | A (verified) | B | D | D | D |
| FNA Mass | A Advance with observed competence - no minimum | B | D | D | D |
| Soft tissue mass excise/incisional biopsy | A | B | D | D | D |
| US exam/Soft Tissue | A (verified) | A (verified) | A (verified) | B | B |
| Incise/drain abscess | A | B | D | D | D |
| Anoscopy | A | B | D | D | D |
| Rubber band hemorrhoids | A | B | D | D | D |
| Flex Sig/Proctoscopy | A | A Advance by Observed competence - 3 minimum | A Advance by Observed competence - 3 minimum | D | D |
| EGD | A | A | A | A | D |
| Colonoscopy | A | A Advance by observed competence - 3 minimum |

Note: All clinic procedures must be discussed with staff

Advanced Ward Procedures

| PROCEDURE | PGY-1 Level | PGY-2 Level | PGY-3 Level | PGY-4 Level | PGY-5 Level |
|-------------------------------|--|--------------------|--------------------|--------------------|--------------------|
| Paracentesis | A | B | D | D | D |
| Thoracentesis | A | B | D | D | D |
| Lumbar Puncture | A | B | D | D | D |
| Arterial Line Placement | A, Ce Advance with observed competence | D | D | D | D |
| Central Line Placement: adult | A, Ce | D | D | D | D |
| PA Catheterization | A | B | D | D | D |

Emergency/Trauma Procedures

| PROCEDURE | PGY-1 Level | PGY-2 Level | PGY-3 Level | PGY-4 Level | PGY-5 Level |
|------------------------------|--|---|--------------------|--------------------|--------------------|
| Peritoneal Lavage | A | A | A | D | D |
| Venous Cutdown | A, Be | D | D | D | D |
| Suture Laceration | A Advance with observed competence | D | D | D | D |
| Surgical Airway | A, Ce Advance with observed competence | C | D | D | D |
| Tube Thoracostomy | A, Ce | D Advance with observed competence | D | D | D |
| Resuscitative Thoracotomy | A* | A* | C | C | C |

Common Ward Procedures

| PROCEDURE | PGY-1 Level | PGY-2 Level | PGY-3 Level | PGY-4 Level | PGY-5 Level |
|------------------------|---|------------------------|------------------------|------------------------|------------------------|
| Venipuncture | A Advanced with observed competence | D | D | D | D |
| Place IV Line | A Advanced with observed competence | D | D | D | D |
| Place NG Tube | A Advance with observed competence | D | D | D | D |
| Place Bladder Catheter | A Advance with observed competence | D | D | D | D |
| Arterial Puncture | A Advanced with observed competence | D | D | D | D |