UTHSC GME Approved Supervision Policy Template

Effective: July 1, 2023

Training Program Supervision and Accountability Policy

Last updated: August 1, 2023

Please reference the complete UTHSC COM GME Supervision Policy (Microsoft Word - GME Policy #410 - Supervision of Residents_Fellows (uthsc.edu)**) for additional definitions and background information.**

General Surgery Residency Program

Training Sites: Baptist Memorial Hospital, Methodist Hospitals, LeBonheur Children's Hospital, Regional One Health, St. Francis-Memphis Hospital, Veterans Affairs Medical Center

Supervision Policy

I. PURPOSE

The General Surgery Residency Program Supervision Policy serves to ensure that residents in the division of Surgery are provided with adequate and proper levels of faculty supervision during their training and, at the same time, are able to deliver high-quality patient care with increasing levels of autonomy. The effective supervision of the residents requires progressive delegation of responsibility and conditional independence in the provision of all clinical settings with concurrent oversight by the faculty members with the goal of developing skills, knowledge, and attitudes in each resident to allow successful entry into the unsupervised practice of medicine at the completion of residency training.

II. BACKGROUND

All residents will provide patient care under the supervision of an appropriately credentialed Bariatric Surgeon, Colorectal Surgeon, Surgical Oncologist, Trauma Critical Care Surgeon, Vascular Surgeon, Thoracic Surgeon, Transplant Surgeon, Pediatric Surgeon, Cardiothoracic Surgeon, and General Surgeon, who is ultimately responsible and accountable for that patient's care. All faculty members supervising the General Surgery residents must have a University of Tennessee Health Science Center (UTHSC) faculty appointment. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. The

resident should give the patient the attending's name whenever requested, including the name of the covering attending if necessary.

III. LEVELS OF SUPERVISION

We use the following ACGME suggested classification of supervision to promote oversight of supervision while providing for graded authority and responsibility. Levels of supervision may be enhanced based on patient safety, complexity, urgency, and risk of serious adverse events.

1. **DIRECT SUPERVISION:** The supervising physician is physically present with the resident and patient during key portions of the patient interaction.
2. **INDIRECT SUPERVISION:** The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and direct supervision if needed.
3. **OVERSIGHT:** The supervising physician is available to provide a review of procedures/encounters with feedback provided after care is delivered.

	Direct Supervision	Indirect supervision with immediately available direct supervision	Oversight
Designated Levels	1	2	3

Level of Supervision required for different clinical settings.

Supervision Settings	**Supervision Level**
Inpatient wards, PGY 1 – 5	1, 2, 3
Operating Room, PGY 1 – 5	1, 2
Outpatient Clinic, PGY 1 – 5	1, 2

Level of Supervision required for different procedures and years of training.

Core Procedures	**PGY 1**	**PGY 2**	**PGY 3**	**PGY 4**	**PGY 5**	**PGY 6**	**PGY 7**
Advanced Cardiac Life Support	1, 2	1, 2, 3	1,2,3	1, 2, 3	1, 2, 3		
Advanced Trauma Life Support	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3		
Central Line Placement	1 ,2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3		
History and Physical Examination	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3		

Interpretation of Laboratory studies	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	[redacted]
Basic Cardiopulmonary Resuscitation	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Closure of Lacerations	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Debridement/closure of wounds under local anesthesia (Non-OR)	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Debridement of pressure ulcers (Non-OR)	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Drainage of superficial abscess (Non-OR)	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Venipuncture	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Excision of skin lesion (Non-OR)	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Arterial Puncture	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Nasotracheal or Orotracheal intubation	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Interpretation of Basic Radiologic exams	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Emergency Drug therapy	1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Write admission, preoperative or postoperative orders	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Bronchoscopy	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Pulmonary Artery Catheterization	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Peritoneal Lavage	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Thoracentesis	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Tube Thoracostomy	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Central Venous Pressure Line	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	
Venous Cutdown	1	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	

All supervision levels depend on resident meeting the required number for each procedure list under the Procedure Competency Requirement section. Once the fellow meets these minimum requirements, they may advance to indirect supervision depending on procedure and training year.

The American Board of Surgery announced the move to competency-based assessment of surgical trainees with the introduction of the ABS Entrustable Professional Activities (EPA) Project. Entrustable Professional Activities (EPAs) were developed to provide the opportunity for frequent, time-efficient, feedback-oriented and workplace-based assessment in the course of daily clinical workflow. EPAs are an

important clinical assessment component of competency-based resident education (CBRE). They offer the opportunity to operationalize competency evaluation and related entrustment decisions in the course of regular patient care, and address some of the challenges educators and trainees have faced in bridging core competency theory into clinical practice and performance assessment.

Entrustable Professional Activities	**Competency-Based Resident Education**
Evaluation & Management of a Patient with an Abdominal Wall Hernia Evaluation & Management of a Patient with an Acute Abdomen Evaluation & Management of a Patient with Benign Anorectal Disease Evaluation & Management of a Patient with RLQ Pain and Appendicitis Evaluation & Management of a Patient with Benign or Malignant Breast Disease Provide Surgical Consultation to Other Health Care Providers Evaluation & Management of a Patient with Benign or Malignant Colon Disease Perioperative Care of the Critically Ill Surgery Patient Flexible GI Endoscopy Evaluation & Management of a Patient with Gallbladder Disease Evaluation and Management of a Patient with an Inguinal Hernia Evaluation & Management of a Patient with Cutaneous and Subcutaneous Neoplasms Evaluation & Management of a Patient with Severe Acute or Necrotizing Pancreatitis Evaluation & Management of a Patient Needing Renal Replacement Therapy Evaluation & Management of a Patient with Small Bowel Obstruction Evaluation & Management of a Patient with Soft Tissue Infection Evaluation & Management of a Patient with Thyroid and Parathyroid Disease Evaluation & Management of a Patient Presenting with Blunt or Penetrating Trauma	To be determined

IV. SUPERVISION POLICIES

Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. The attending physician is responsible for the overall care of each individual patient admitted to the surgical service and for the supervision of the resident(s) assigned to the patient. There is a clear chain of command centered on graded authority and clinical responsibility. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

Supervision provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. 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 appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. The level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity.

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. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. Senior residents or fellows should serve in a supervisory role to 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. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

ADMISSIONS

The attending surgeon must be notified of each admission. Each patient is admitted under the name of an attending.

SURGERY

The senior resident must immediately notify and receive concurrence for any patient going to the operating room. Supervision of residents will always meet or exceed hospital policy. Attendings will document their participation in the supervision process. An attending must always be available for consultation and support. Information regarding the responsible attending should be available to residents, faculty members and patients. Site directors of all integrated and affiliated hospitals in the program must assure the program director that these policies are being followed.

The attending surgeon is expected to:

Confirm (or change) the diagnosis.
Approve the operative procedure and procedure timing.

Be immediately available or physically present (as dictated by his/her judgment) during the operative procedure and assure that it is properly carried out. Exceptions are only allowed for life/limb threatening emergencies.
Supervise the postoperative care.
Assure continuing care after the patient leaves the hospital.

Procedures outside the Operating Room

The specific Clinical Activities and Level of Supervision for General Surgery Residency Program is attached to this handbook. This outlines the method of instruction and the level of supervision required before certification to perform activities outside the OR (i.e., central lines, laceration repair, etc.) without direct supervision.

PGY 1 Residents

Must initially be supervised directly.
Must complete the procedure log to be competent to perform the listed procedures with indirect supervision, with direct supervision available.

Transfer

The attending surgeon must be notified of patient transfer to a higher level of care, such as transfer from the floor to the intensive care unit.

End of Life Decisions

The attending surgeon should be informed of and involved in end-of-life decisions, including, but not limited to, do not resuscitate orders and withdrawal of care.

The Department of Surgery maintains a monthly service and on-call schedule that shows faculty coverage for the various services for every single day of the month. The schedule is distributed by email monthly before the start of the new month.

Faculty supervision assignments are sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

If the resident is not able to reach her/his supervising attending physician, (s)he should call these back-up physicians: David Shibata, General Surgery; Trey Eubanks, Pediatric Surgery, Devra Becker, Plastic Surgery; Martin Fleming, Surgical Oncology; Thomas Ng, Thoracic Surgery; Jason Vanatta, Transplant Surgery; Andrew Kerwin, Trauma Surgery; Erica Mitchell, Vascular Surgery.

In certain situations, the residents are expected to consult with the attending physician irrespective of the time of the day or level of their training:

Rotation-Specific Supervision

A Resident is paired with attendings who are direct supervisors and give authority to the individual residents as they progress and are deemed ready to take on more responsibility. On rotations with multiple trainees present, senior fellows, and residents (if present) will supervise junior fellows, residents, and medical students under the guidance of the faculty. Junior residents may supervise medical students.

Supervision of Hand-Offs

Residents discuss all patients who have been admitted or consultations with the surgery faculty. The process includes updating the formal shared rounding list kept on a secure share-drive. Sign-out includes anticipated problems or concerns, laboratory tests and imaging studies that require follow-up and plans for operations. The on-call attending faculty will discuss any concerns with the on-call resident and prepare a communication plan for the on-call night.

The UTHSC General Surgery Residency Program follows the UTHSC institution policy on Patient Handoffs and Transition of Care. For more information on the UT Handoffs and Transitions of Care Policy, please visit the GME website:

https://uthsc.edu/graduate-medical-education/policies-and-procedures/documents/handoffs-and-transition-of-care.pdf

Gaps in Supervision

If for any reason, a resident is unable to contact his or her supervising physician, they are to notify the program director or associate program director immediately.

The program director or associate program director will then activate the faculty- specific chain of command to ameliorate the gap in supervision