Subject: Supervision Policy
References: Clinical Learning and Working Environment policy
Accreditation Council for Graduate Medical Education CPR.VI.

The RUHS Orthopaedic Surgery Residency Program follows the principle that supervision is necessary at all resident levels but recognizes that a delicate balance exists in which graduated responsibility and opportunity to make decisions is vital to the growth and development of surgical judgment by the resident. The principle of graduated responsibility under supervision begins in the PGY-1 year with resident credentialing in critical care skills and progression from specific to general supervision. As residents gain knowledge, proficiency in manual and problem solving skills, and demonstrate acquisition of good judgment, the intensity of supervision decreases to foster independent decision-making.

Basic Orthopaedic Surgery Residency Supervision Policy:

The program recognizes the ACGME's three classifications or Levels of Supervision:

1. Direct Supervision: The supervising physician is physically present with the resident during the key portions of 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 is available to provide appropriate direct supervision.
3. Oversight: The supervising physician is available to provide review of procedure/encounters with feedback provided after care is delivered.

Based on the prerequisites for appointment to GME programs, all residents, regardless of their level of training, are allowed to perform the following activities without direct supervision by the supervising attending physicians:

1. Perform a complete history and physical examination including pelvic exam
2. Dictate procedure notes and operative reports
3. Perform an electrocardiogram, venipuncture, dressing change, IM & SC injections, intravenous catheter, suture removal and other procedures not requiring specific consent of the patient.
4. Write progress notes including the final progress note (or Discharge Summary)
5. Write orders for therapeutic agents on Formulary for adult patients, diagnostic procedures or consultations requested by members of the Medical Staff, or other routine orders such as for diet, activity or condition.
6. Provide healthcare education and obtain consents for procedures in which they will participate.

The first year of residency emphasizes Orthopaedic diagnosis, pathophysiology and pre- and post- operative care. The PGY-1 resident, along with the more senior resident, is involved in the daily presentation of the patient to the supervising surgeons where treatment decisions are finalized. The PGY-1 resident follows the patient to surgery, where he acts as one of the surgical assistants. In less complicated cases, such as I&D, pin placement, arthrocentesis, simple fractures, etc., the junior resident often performs the operation as directed by the attending surgeon.

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

1. Patient Management Competencies:
   a) initial evaluation and management of patients in urgent or emergent situations, including: urgent consultations, trauma, and emergency department consultations; and evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria
   b) formulate principles and assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems.
   c) care for patients with surgical and medical emergencies, multiple organ system trauma, soft tissue wounds.

d) 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 medication, testing and other treatments.
e) develop an understanding of surgical anesthesia, including anesthetic risks and complications.
f) management of patients in cardiac or respiratory arrest (ACLS required)
g) management of patients with major fractures that are displaced.
h) evaluation and management of patients with infections of the spine, pelvis, or extremities

PGY-1 residents required Direct Supervision until proficiency has been demonstrated per their resident logs for:

1. Procedural Competencies:
   a) Closed reduction of fractures and dislocations
   b) Splint and cast application
   c) Emergent wound management
   d) Compartmental Pressure monitoring
   e) Joint Aspiration and Injections
   f) Skeletal Traction Pin Placement
   g) Repair of surgical incisions of the skin and soft tissues
   h) repair of lacerations of the skin and soft tissues
   i) excision of lesions of lesions of the skin and subcutaneous tissues
   j) repair of nail bed lacerations or distal digit amputation injuries that do not require management in an operating room setting.
   k) Incision and drainage of paronychias, felons, or other abscesses of the hand and forearm that do not require management in an operating room setting
   l) Bedside wound debridement
   m) Arthrocentesis
   n) Administration of local anesthetic

PGY-1 residents require Indirect Supervision for:

1. Patient Management Competencies:
   a) evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation and implementation of indicated diagnostic tests and treatment plan.
   b) pre-operative evaluation and management, including history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan.
   c) evaluation and management of post-operative patients including monitoring patients and ordering medications, tests and other indicated treatments
   d) transfer of patients between hospital units or hospitals
   e) discharge of patients from the hospital
   f) interpretation of laboratory results
   g) interpretation of radiographs
   h) consultation of appropriate inpatient services

PGY-1 residents must do three 4-week rotations on the surgical rotations general surgery, surgical intensive care unit, and vascular surgery. In addition, they must do three 4-week rotations to include emergency medicine, internal medical, infectious disease/rheumatology and anesthesia. The remainder of their rotation blocks are devoted to Orthopaedic Surgery.

PGY-2 and PGY-3 residents who demonstrate good performance 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 evaluating surgical patients in the emergency room, initiating preoperative treatment and arranging for further surgical care. In addition, PGY-3 residents are more involved with the technical aspects of the surgery in the operating room.

Fourth year residents are considered the senior/chief of the service and supervise junior residents and medical students. Senior residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while supervising 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 good patient care.

Fifth year residents are considered the chief of the service and supervise junior residents and medical students. Chief residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while supervising 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 good patient care.

Residents must be aware of the supervisory lines of responsibility. If there is a serious concern related to supervision or any other aspect of the training, any resident can bypass the supervisory lines and communicate directly with the Program Director or the Chair of the Department of Orthopaedic Surgery.

Only members of the Medical Staff who have been granted appropriate privileges and who have been selected by the Residency Program Director shall supervise residents.

Documentation of supervised order-writing shall be demonstrated by counter-signature of the resident's note or by referring to the resident's documentation in a separate supervising physician note.

The supervising physician shall personally interview and examine the patient each day to confirm the resident's findings and to evaluate the resident's clinical care.

The supervising physician shall provide direct or indirect supervision for each surgical procedure depending upon the procedural competency of the resident involved. 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.

The supervising physician must approve any admission of a patient to the service. This will allow discussion of the resident's preliminary medical diagnosis and preliminary decision making.

The supervising physician shall be informed of transfer of a patient to another service or to another level of care e.g. ICU, intermediate, etc., or death of a patient.

The supervising physician must approve any recommendation to discharge a patient from the Emergency Room.

The resident shall order consultations and testing on behalf of the supervising physician following discussion with the supervising physician. This must be documented by the resident or by the supervising physician in the order or in the physician's notes.

Any 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 supervising physician shall personally evaluate the patient within one day of the request for consultation.

Operative cases performed by the residents using implantables (plates, rods, prosthesis) require direct or indirect supervision by the supervising physician. Senior level residents who demonstrate proficiency in emergent/urgent cases requiring I&D, fasciotomies, and application of external fixation devices are allowed to perform such procedures with Oversight supervision.

For assessment of resident competencies with regard to the care of operative patients, the Orthopaedic Surgery program utilizes the Milestones and OrthoBullets PASS program which facilitates supervising physician evaluation and assessment of resident competency in various aspects of specific operative cases.

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 program director has indicated the resident is competent in performing such procedure, the resident may then perform such procedures with attending approval but without direct supervision.

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

1. The supervising physician must be available to participate in the care of patients as if residents were not involved; the presence of residents to "cover" patients on in-patient services or to provide care in ambulatory settings does not diminish the standard of availability required of the supervising physician of record.
2. Accept the responsibility for the Orthopaedic Surgery residents assigned to his/her patients.
3. 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.
4. Recognize that the residents and learners are involved in a program designed to help them master the art and science of surgery. Realize that residents have not reached that point in their careers when they can function without supervision by the surgical faculty attending staff.
5. 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 and judgment.