**Brigham and Women’s Hospital**

**General Surgery Residency**

**2019 – 2020 Resident Supervision Policy**

The attending physician has both ethical and legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in that care. Although senior residents require less direction than junior residents and may often supervise them more directly than the attending, even the most senior resident must be supervised. There is an implicit chain of command that emphasizes graded authority and increasing responsibility as experience is gained. The attending surgeon who is ultimately responsible for the patient’s care must make judgments on this delegation of responsibility; such judgments shall be based on the attending surgeon’s direct observation of each resident’s skills and ability.

On every service to which general surgery house staff is assigned, one or more attending surgeons is always immediately available in-house or by telephone to provide supervision, guidance, and education. It is the responsibility of the resident physician to be familiar with how to reach the attending surgeon; it is the responsibility of the attending to ensure his or her availability at all times or to communicate to the residents when he or she has signed out responsibilities to another faculty member. By far the most common cause of conflict between resident and attending is the failure to communicate in a timely and effective manner; if in doubt, it is always best to call the attending.

EXPECTED COMMUNICATION PRACTICES FOR PATIENTS ADMITTED TO SURGICAL SERVICES

1.) For all critical changes in a patient’s condition, the attending will be notified promptly (generally within one hour following evaluation) by the resident caring for the patient. These instances include:

* Admission to the hospital
* Transfer to the ICU
* Unplanned intubations or ventilatory support
* Cardiac arrest
* Hemodynamic instability (including arrhythmias)
* Code
* Development of significant neurological changes (suspected CVA/seizure/new onset paralysis)
* Development of major wound complications (dehiscence, evisceration)
* Medication or treatment errors requiring clinical intervention (invasive procedures), increased monitoring, new medications except Narcan
* First blood transfusion without prior attending knowledge or instruction (before or after operation)
* Development of any clinical problem requiring an invasive procedure or operation for treatment.

2.) The following will be discussed with and approved by the attending before they occur.

* Discharge from the hospital or from the ED
* Transfer out of ICU

3.) The attending should also be contacted if:

* Any trainee feels that a situation is more complicated than he or she can manage
* Nursing or physician staff, or the patient request that the attending surgeon be contacted
* There is a significant change in the medical condition of an attending's patient.

If for some reason the attending cannot be reached, the resident should contact the general surgery attending on call. If the trainee cannot meet his/her duties because of illness or overload, he/she should contact the administrative chief resident and/or the Program Director.

**OPERATIVE PROCEDURES**

It is the policy of the Department of Surgery at all of our institutions that attending surgeons participate in all operative procedures performed, as well as supervise other aspects of each patient’s care. This participation is important, not only in the contact of patient care and administrative responsibility, but also in fulfilling the educational mission of the Department. At Brigham and Women’s Hospital, the attending is required to be present between the opening and closing of the surgical field. However, under appropriate circumstances, senior residents may benefit from the experience of assuming some responsibilities for independently initiating or finishing surgical procedures. The following conditions, however, must apply:

1. Every patient undergoing an operative procedure must have an assigned attending surgeon, identified by name in the medical record.
2. Only the responsible attending surgeon may empower a senior resident to proceed with an operative procedure in the attending’s absence. However, the attending surgeon must remain available to respond in a timely fashion should assistance by the resident be requested.
3. Operating personnel may, at any time, request verification of the attending’s permission to proceed. Concerns regarding the appropriateness of that decision or the subsequent execution of the procedure are to be discussed with the attending surgeon, the Division Chief, or the Department Chair.

**INVASIVE PROCEDURES**

The attending surgeon also has responsibility for all invasive procedures performed upon his or her patients outside the operating room. These include, but are not limited to, central line placement, pulmonary artery catheterization, arterial line placement, and endotracheal intubation. Most procedures are performed either in the Intensive Care Unit or in the Emergency Department although on occasion these procedures are performed in other hospital units, e.g., surgical floors.

**PGY-1 SUPERVISION**

Oversight for PGY-1 residents is provided by a combination of direct and indirect supervision. Indirect supervision includes both situations where the supervising physician is immediately available, and other situations where the supervising physician is not immediately available. The supervising physician can be an attending, a chief resident, or a senior resident who is competent to perform the procedure or care for a patient care situation.

PGY-1 residents provide considerable instruction to enable them to progress to providing patient care without direct supervision. This includes the American College of Surgeons Fundamentals of Surgery Curriculum, which they are required to complete 94 clinical scenarios prior to the start of internship. This curriculum addresses many of the clinical situations commonly encountered by surgical PGY-1’s. The PGY-1’s also complete ACLS certification, as well as intern boot camp, a 10-week course that has extensive simulation practice as well as assessment of competencies, including knot tying, suturing, work on virtual endoscopic and laparoscopic simulators, chest tubes, central lines, airway management, etc.

With this preparation, PGY-1 residents are competent to provide care in the following situations or for the following procedures with indirect supervision:

* Initial evaluation and management of a patient admitted to the hospital
* Preoperative evaluation and management
* Routine evaluation and management of postoperative patients
* Transfer of patients between units or hospitals
* Discharge of patients
* Interpretation of laboratory results
* Basic procedures, such as basic venous access, arterial puncture, placement of nasogastric tubes and urinary catheters
* Management of postoperative complications (i.e., hypotension, hypertension, oliguria, hypoxemia)

Direct supervision is required for more advanced patient care situations and procedures as outlined below. These include the following clinical scenarios and procedures:

* Management of urgent/emergent situations (i.e., trauma, emergency department consultation)
* Management of critically ill patients
* Advanced vascular access (central venous catheters)
* Bedside debridement
* Cardiac or respiratory arrest
* Chest tube placement
* Endotracheal intubation
* Excision of skin or subcutaneous lesions
* Paracentesis
* Repair of lacerations