DIVISION OF SURGICAL EDUCATION
POLICY MANUAL

SUBJECT: Resident Supervision Policy & Specific Lines of Communication

REFERENCE: ACGME Common Program Requirements, VI. B

PURPOSE: To ensure that qualified faculty provide appropriate supervision of residents during all patient care activities. Further to ensure there are pre-established lines of communication and multi-tiered back up available to all residents at all times.

SCOPE: This policy applies to all surgical residents and faculty

NOTE: This departmental policy is also consistent with the PCMH GME Policy

Initial Approval: 22 July 2007

Description of Resident Supervision:

The faculty has ultimate responsibility for all aspects of patient care. All residents are supervised by a faculty member with specific training and privileges for the particular service to which they have been assigned.

As each resident advances through the program, s/he is responsible for acquiring the knowledge and clinical skills needed to undertake progressively greater responsibility for patient management. Residents are expected to carry out clinical duties to the best of their ability, to recognize their own limits and request assistance should any questions arise. Likewise the department expects senior residents and faculty to recognize that each resident has his/her own learning curve and to provide any assistance the resident needs. Typically, junior residents communicate with the more senior resident for assistance. If the senior resident cannot handle the situation then the faculty is called. If the senior resident is not available, all residents may directly contact the faculty at anytime. To facilitate direct communication, all residents are provided contact information for each faculty member.

In addition, there is a multi-tiered, back-up system to ensure appropriate support when patient care duties become unusually difficult. The first layer involves PGY 5 and 6 senior residents, who serve as chief resident in-house each night. They are responsible for guiding more junior residents with difficult clinical situations, and assume clinical duties of junior residents if needed. The second layer involves the surgical critical care faculty. Regardless of service, complex patients frequently develop critical care issues. The critical care surgeons take in-house call to respond quickly to any problem. If needed a second critical care surgeon is also available. A third layer is the non-critical care service faculty who can respond from home. This multi-tier system ensures that immediate support is available for all residents, at all times.

Specific Lines of supervision and communication for a particular service:
Ultimately the division chief is responsible for his/her service and may also be contacted at anytime

Trauma Surgery, Acute Care Surgery & Surgical Critical Care
Junior resident to more senior resident; senior resident to attending
Junior resident to attending
Division Chief: Scott Sagraves, MD, FACS

General Surgery (Green)
Junior resident to more senior resident; senior resident to attending
Junior resident to attending
Division Chief: Walter Pofahl, MD, FACS

Surgical Oncology (Red)
Junior resident to more senior resident; senior resident to attending
Junior resident to attending
Division Chief: Emmanuel Zervos , MD, FACS

Vascular Surgery
Junior resident to more senior resident; senior resident to attending
Junior resident to attending
Division Chief: Charles Powell, MD, FACS

Thoracic Surgery
Junior resident to senior resident; senior resident to attending
Junior resident to attending
Division Chief: Jon Moran, MD, FACS

Plastic Surgery
Resident to attending
Division Chief: Richard Zeri, MD, FACS

Pediatric Surgery
Resident to attending
Division Chief: Pending at present

Transplant Surgery
Resident to attending
Division Chief: Carl Haisch, MD, FACS

Rural Surgery
Resident to attending
Division Chief: Alton Davis, MD, FACS

Colorectal Surgery
Resident to attending
Division Chief: Patrick Brillant, MD, FACS