POLICY FOR SUPERVISION OF ANESTHESIOLOGY RESIDENTS
(Updated October 2011)
ROLES, RESPONSIBILITIES AND PATIENT CARE ACTIVITIES; PROGRESSIVE RESPONSIBILITIES FOR PATIENT MANAGEMENT AND FACULTY RESPONSIBILITY FOR SUPERVISION
(University of Washington Medical Center, Harborview Medical Center, Seattle Cancer Care Alliance, Puget Sound Veteran's Hospital, Seattle Children's Hospital)

Section 1: ROLES, RESPONSIBILITIES AND PATIENT CARE ACTIVITIES

Resident Roles

Residents are physicians in training. They learn the skills necessary for their chosen specialty through didactic sessions, problem-based learning sessions, simulation, reading, and providing patient care under the supervision of the Medical Staff (the attendings) and senior trainees. As part of their training program, residents are given progressively greater responsibility according to their level of education, ability and experience.

Resident Responsibilities and Patient Care Activities

Residents are part of a team of providers caring for patients. The team includes an attending and may include other licensed independent practitioners, other trainees, and medical students. Residents may provide care in both the inpatient and outpatient settings. They may serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services. Anesthesiology residents provide direct care for anesthetized patients undergoing surgical procedures in the operating rooms or off-site procedural areas. Each member of the team is dedicated to providing excellent patient care.

Residents evaluate patients, obtain the medical history and perform physical examinations. They may develop a differential diagnosis and problem list. Using this information, they develop a plan of care in conjunction with other trainees and the attending. They may document the provision of patient care as required by hospital/clinic policy, however most documentation requires an additional attending note and signature. Residents may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed in the operating room or procedure suite under appropriate supervision. Residents may initiate and coordinate hospital admission and discharge planning. Residents should discuss the patient's status and plan of care with the attending and the team regularly. All residents help provide for the educational needs and supervision of junior residents and medical students.

The specific role of each resident varies with their clinical rotation, experience, years of clinical training, the patient's illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training. Please note some residents may be engaged in one or more years of research training during their residency. Only years of clinical training are considered below.

SECTION 2: PROGRESSIVE RESPONSIBILITIES FOR PATIENT CARE - ANESTHESIOLOGY

Anesthesiology Residency is a four-year training period, during which residents assume progressively greater responsibility for patient care and develop independence in patient management. Residents must be supervised (see definitions of supervision section 3) throughout their training by a faculty member, who is ultimately responsible for the patient's care.

Clinical Base Year (CBY) (Post Graduate Training Year 1)

Anesthesia residents are required to participate in one year of basic clinical training (Clinical Base Year) prior to beginning their specific training in anesthesiology (Clinical Anesthesia Years). The CBY includes rotations on both medical and surgical services. In addition anesthesiology residents care for patients on the medical and surgical ICUs, the emergency room, the acute pain service, as well as in-patient and out-patient services and clinics during the clinical base year. They may participate in procedures performed in the clinic, procedure suite or operating room under the supervision of a qualified member of the medical staff or senior trainee.

During the CBY anesthesiology residents are primarily responsible for the care of patients under the guidance and supervision of the attending and senior trainees. They should be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising trainees and/or the attending should be contacted.

Clinical Anesthesia (CA) Years 1- 3 (Post Graduate Training years 2 - 4)

All patient care is under the supervision of an attending physician; residents may provide direct patient care or consultative services. Residents care for patients in the following service areas:

- Operating room - intraoperative care of an anesthetized patient during a surgical procedure
- Intensive care unit - patients with multisystem organ failure
- Emergency room
- In-patient or out-patient Pain Relief Services
- Obstetric unit – care for parturient patients
- Pre-anesthesia clinics
- Post anesthesia Care Unit
- "off-site" areas including the CT & MRI scanners, cardiac cath lab, electrophysiology suite, GI endoscopy suite, interventional radiology department

Residents are expected to evaluate patients under their care, determine the relevant medical and surgical pathologies and co-morbidities and develop an appropriate management plan and carry out the required invasive procedures. Residents may also provide emergency care for patients on wards and in the emergency department, particularly advanced airway management, intravenous and intra-arterial cannulation. Residents will work as part of the patient care team in the operating room, intensive care unit, pain clinic obstetric unit, pre-anesthesia clinic, wards or emergency department.

CA1 (PGY2) Resident Responsibilities

Junior residents are expected to function in the role of a team member requiring direct supervision from attending physicians and senior trainees. CA1 residents are expected to evaluate patients and develop and execute their management plan under close supervision from the supervising attending physician. Residents should be assigned to cases in the operating room appropriate to their level of experience. In the first few months of CA1 residents will care for healthier, ASA1 and 2 patients and patients undergoing minor to moderately complex surgical procedures. Towards the end of the CA1 year residents may care for sicker (ASA3) patients and patients undergoing more complex surgery. Upon occasion, CA1 residents may care for ASA4 patients with direct (hands on) support of their attending.

CA2 (PGY3) Resident Responsibilities

CA2 residents participate in rotations caring for patients in the various subspecialty anesthesia areas (e.g. cardiac, obstetrics, neurosurgery, pediatrics). Residents spend at least 2 months in a subspecialty rotation; towards the end of the first month a greater autonomy for patient care is expected, and residents should be the first point of contact for questions regarding patient care. Supervision by attendings is required and consulted for any questions that residents can not immediately answer. In the general operating rooms CA2 residents care for complex patients undergoing surgery in the general operating rooms.

CA3 (PGY4) Resident Responsibilities

As senior residents, CA3s are expected to assume of a leadership role, coordinating the actions of the team, and interacting with nursing and other administrative staff. Senior residents are expected to develop more autonomy for patient care in the development and execution of their management or treatment plan, although ultimate responsibility for patient care lies with the supervising attending physician. CA3 residents care for the most complex patients in the operating rooms and care for patients having off-site interventional procedures. Along with the attending senior residents provide for the educational needs of any junior residents and students.

SECTION 3: FACULTY RESPONSIBILITY FOR SUPERVISION OF ANESTHESIOLOGY RESIDENTS

- During the supervision of anesthesiology residents faculty may only direct a MAXIMIUM OF TWO anesthetizing locations simultaneously (Anesthesiology program requirement 2008 II.B.2.a).
- 1:2 means one attending anesthesiologist supervising 2 anesthetizing locations with 2 residents or supervising 2 anesthetizing locations with one resident and one CRNA.
- An anesthetizing location includes an operating room, an off-site procedural area, a regional procedure such as placement of an obstetric epidural or peripheral nerve block, or any anesthesia-related procedure carried out on the wards, the emergency room, intensive care unit or other patient care area.
- Faculty are responsible for determining if the level of acuity of a patient's care and or the level of the resident's experience requires closer supervision level than 1:2.

In a training program, as in any clinical practice, it is incumbent upon the individual physician in training to be aware of his/her own limitations in managing a given patient, and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a trainee who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by trainees and trainees must contact this attending when there is any doubt about the need for supervision.

Visiting residents must receive specific approval from the training program to perform any of the procedures below without supervision.

To ensure oversight of resident supervision and graded authority and responsibility, the program uses the 2011 ACGME classification (VI.D. 3 a-c) of supervision as follows:

DIRECT SUPERVISION: – the supervising physician is physically present with the resident and patient at the bedside.

INDIRECT SUPERVISION:
1) with direct supervision immediately available: – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
2) with direct supervision available: – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
OVERSIGHT :– The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

<u>PGY1 (CBY)</u>
During the clinical base year, a PGY1 resident may undertake an anesthesiology rotation in the operating room. In all cases CBY residents require **direct supervision** in the care of the anesthetized patient by an attending anesthesiologist or more senior resident. **Indirect supervision level 1** may be acceptable towards the end of the first month rotation depending on patient acuity and surgical procedure complexity. **DIRECT SUPERVISION** is always required for induction of anesthesia, emergence and for any critical portions of the procedure.
During the CBY year interns rotate on other services and are subject to the supervision requirements for these rotations. However in all cases the supervision of interns will be direct supervision or after evaluation of the resident's abilities indirect level 1 supervision by a more senior physician.
(see also supervision policy for CBY residents on the pain services).

<u>PGY2 (CA1)</u>
In the PGY2 (CA1) year anesthesia residents function at the novice to advanced beginner level and much of the care of anesthetized patients is provided under the **DIRECT SUPERVISION** of the attending anesthesiologist, who is present in the operating room during anesthesia care. As residents gain experience towards the end of the second month of training supervision in the operating room will be

appropriate to the complexity of the patients' co-morbidities and surgical procedure. **INDIRECT SUPERVISION LEVEL 1** will become appropriate as the resident gains experience towards the end of the CA1 year.
DIRECT SUPERVISION is always required for induction of anesthesia, emergence and for any critical portions of the procedure.

PGY3 (CA2)
In the CA2 year residents work mostly in the subspecialty areas and **DIRECT SUPERVISION** is appropriate in the first few weeks of the particular subspecialty rotation. As residents gain more experience **INDIRECT SUPERVISION LEVEL 1** will become appropriate depending on the complexity of the case. **DIRECT SUPERVISION** is always required for induction of anesthesia, emergence and for any critical portions of the procedure.

PGY4 (CA3)
CA3 residents will develop greater autonomy in caring for patients under anesthesia for surgical procedures, and **INDIRECT LEVEL 1 SUPERVISION** is acceptable **EXCEPT** for induction of anesthesia, emergence and for any critical portions of the procedure where **DIRECT SUPERVISION** is always required.

Supervision of Invasive Procedures
OVERSIGHT over the procedure, but without direct indirect supervision applies to the following procedures:
Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, central venous catheter removal, epidural catheter removal, nasogastric tube placement.

INDIRECT SUPERVISION LEVEL 1
The following procedures may be performed under indirect supervision after the trainee has achieved the training level specified.

Procedure / Activity	Training level required for indirect supervision
Arterial puncture / cannulation	PGY 1 (CBY) after 3 - 6 months depending on rotations provided the procedure takes less than 5 minutes to perform.

DIRECT SUPERVISION is required for:

- Induction of general anesthesia
- Emergence from anesthesia
- Critical portions of any anesthetic procedure
- Tracheal intubation
- Supraglottic airway placement
- Fiberoptic tracheal intubation

- Placement of an epidural catheter
- Placement of spinal anesthesia
- Epidural blood patch placement
- Placement of peripheral nerve block
- On and off cardiopulmonary bypass
- Transesophageal echocardiography
- Intrathecal chemotherapy administration
- Lytic nerve blocks
- Procedures performed under fluoroscopy
- Invasive procedures ≤5min in duration (e.g. complicated arterial line cannulation)

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The trainee may attempt ANY of the procedures normally requiring direct supervision in a case where the death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available. The assistance of more qualified individuals should be requested as soon as practically possible.

Resident Review and Promotion Process

The residency program uses a multifaceted assessment process to determine a resident's progressive involvement and independence in providing patient care. Residents are observed directly by the attending staff and their performance discussed regularly. Formal assessments are generally obtained on a monthly basis from supervising physicians, students and colleagues. These assessments include evaluation of the resident's clinical judgment, medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. Annually, the program director and residency review committee determine if the trainee possess sufficient training and the qualifications necessary to be promoted to the next level.

Trainees are evaluated continuously by the attending staff. If, at any time, their performance is judged to be below expectations, the program director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the intervention is not successful, the trainee may be dismissed from the program. If a trainee's clinical activities are restricted (e.g., they require a supervisor’s presence during a procedure, when one would not normally be required for that level of training) that information will be made available to the Medical Director, appropriate medical and hospital staff.

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This document has been reviewed by the Residency Program Director and the Resident Education Committee of the Department of Anesthesiology and Pain Medicine.