Standard Operating Procedure Title: Supervision of Anesthesiology Residents and Other Trainees
Policy Number: C 90
Date Established: 1978 **Date Reviewed:** 7/1/90; 7/14/95
Date Revised: 7/21/95; 3/22/97; 3/6/03; 10/12/03; 4/3/04; 3/7/06; 2/7/2012; 2/8/2013

Consistent with ACGME Common Program Requirements, faculty members shall devote sufficient time to the educational program to fulfill supervisory and teaching responsibilities, demonstrate a strong interest in the education of residents, and administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. ***As required by Anesthesiology Program Requirements, the number of faculty must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. In clinical anesthesia settings, faculty members shall not direct anesthesia care at more than two anesthetizing locations when supervising residents***. ***This policy shall also extend, as appropriate, to other trainees with similar levels of clinical experience, such as student nurse anesthetists.***

Resident Clinical Responsibilities and Levels of Supervision

1. Assignment of clinical responsibilities for each resident shall be based on the following: PGY-level, experience and competence; education objectives; severity and complexity of patient illness/condition; patient safety; and available support services.
2. To provide appropriate resident supervision as well as graded authority and progressive responsibility, faculty supervision will vary in accordance with the resident's training level and clinical competence. Some clinical activities require the presence of the supervising faculty member, e.g., induction of anesthesia. Other aspects of patient care may be supervised directly or indirectly by faculty and/or a more advanced resident or fellow.
3. The following levels of supervision shall be provided by faculty or, when appropriate, fellows or senior residents:
    - **a.** *Direct Supervision* – the supervising physician is physically present with the resident/trainee and patient, e.g., during induction of anesthesia.
    - **b.** *Indirect Supervision 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 when indicated, e.g., routine intraoperative anesthesia care.
    - **c.** *Indirect Supervision 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, e.g., management of acute pain problems.
    - **d.** *Oversight* – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered, e.g., routine preoperative assessment.

4. PGY-1 residents shall receive either direct supervision or, when appropriate, indirect supervision with immediately available direct supervision. Residents assigned to non-anesthesia rotations (medicine, surgery, pediatric and emergency medicine) are supervised by senior residents, fellows or faculty, who provide either direct supervision or indirect supervision with the immediate availability of direct supervision. The final rotation of the categorical PGY-1 year provides anesthesia residents transitioning to clinical anesthesia with highly focused and directly supervised training in basic anesthesia practice. Demonstration of competence in basic anesthesia skill sets is required for residents to transition to indirect supervision of routine aspects

of anesthesia practice, e.g., monitoring and maintenance of anesthesia, at the beginning of the PGY-2 year (CA-1 Year).

5. PGY-3 (CA-2) residents advance to “intermediate resident” status when they have satisfactorily completed the CA-1 year - receiving two successive satisfactory Clinical Competence Reports from the Clinical Competence Committee – and have also completed the following required clinical rotations: Fundamentals of Anesthesia, OB Anesthesia, Post-Anesthesia Care rotation, Comprehensive Pain Service Rotation and Cardiothoracic Anesthesia. Intermediate residents progress onto other subspecialty anesthesia rotations and also begin training as the R1 – “First Call Resident” – at Vanderbilt University Hospital. The R1 position involves coordination of the clinical anesthesia call team, including supervision of junior residents and student nurse anesthetists. Attending faculty members provide direct and immediately available indirect supervision of the R1 and other call team members. Intermediate residents also function in a similar coordinator role on the OB Anesthesia Service.
6. PGY-4 (CA-3) residents, who have progressed satisfactorily throughout all subspecialty rotations during the CA-1 and CA-2 years, thereby completing all required residency elements, advance to the level of “senior resident.” Senior residents manage complex patients and cases with limited faculty supervision and assume increased responsibility for management of perioperative systems of care.
7. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care is based upon each resident’s training and progress in clinical competence. Specific responsibilities in patient care are assigned by supervising faculty members as they consider appropriate for safe and effective patient care. Regardless of the level of supervision, residents must inform and discuss clinically significant changes in patient status or management with supervising faculty members.