Department of Orthopaedics
Resident Supervision Policy

The faculty closely supervises all resident activities. The clinical experience is provided through a team concept carefully supervised by specialty-specific faculty members. Our teaching model involves continuity of care and simple episodic exposure to procedures is not allowed. This team concept facilitates the resident's education and the assumption of graduated responsibility. There is intensive supervision of virtually all resident activities in the operating room, the emergency center, and the outpatient clinics. Our philosophy encourages faculty and residents to use each clinical case as a teaching case. Each resident is given graduated responsibilities such that successful progress through the program allows for the senior resident to make major decisions comfortably, knowledgeably implementing them for safe and effective patient care. We strongly emphasize the development of clinical judgment and selecting the most appropriate treatment option for each particular patient. Our focus is to develop the orthopaedic surgeon's critical judgment in conjunction with proper surgical technique.

The attending physicians are present for all surgical cases and clinics. The chief resident on the service is assigned the responsibility for running the service and being responsible for the care of the patients on the service. This task is accomplished in consultation with the attending staff, which provide immediate and continuing supervision of the chief resident's decision-making processes. A team approach is used to assure continuity of care and continuing supervision of each patient by the attending faculty. The patients are assigned to a specific team, both at University Hospital and the VA Hospital. These teams have permanently assigned staff who are responsible twelve months a year for their activities. Graduated responsibility is given to the residents as they move through the program. At the junior level, the residents are expected to understand the basic diagnosis and pathophysiology of the disease process. By the middle years, they are expected to formulate a differential diagnosis, be able to discuss a variety of treatment options as well as the complications associated with each treatment plan, and perform basic surgical skills. By the time the resident reaches the senior year, he/she is expected to plan and execute treatment for virtually all musculoskeletal problems, under attending supervision. Progression to this stage is facilitated by encouraging each resident to be a teacher. At each level, the resident is encouraged to teach orthopaedics to the resident or student junior to him. As has been often noted, one retains 90% of what one teaches and teaching allows one to identify his/her deficiencies quickly. This philosophy of teaching allows our residents to verify their knowledge base and identify their deficiencies.

Levels of Supervision Employed:
To ensure oversight of resident supervision and graded authority and responsibility, the program will use the following classification of supervision (see Common Program Requirements, July 2011, and the UTHSCSA Supervision Policy).

Direct Supervision – The supervising physician is physically present with the resident and patient.

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.
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, and is available to provide Direct Supervision.

The graduated responsibilities are noted in the Orthopaedic Educational Goals. In addition to the job descriptions outlined by the UTHSCSA GME General Policy of Resident Supervision, brief **specific job descriptions by year of training are:**

PGY-1: The PGY-I resident is primarily responsible for completion of comprehensive history and physicals on all new patients, evaluation of patients in clinic and present problem cases to the faculty and senior residents, and assist in the daily care of patients on the wards. The PG1 resident will always have direct supervision immediately available in-hours (by staff or higher level resident).

PGY-2: The PGY-2 resident is primarily responsible for evaluation and treatment of patients in the emergency center, including non-operative management of fractures and dislocations and acute assessment of major trauma victims.

PGY-3: The PGY-3 resident is expected to develop basic surgical skills and perform most outpatient procedures without direct supervision if approved or with direct supervision if not so approved. This resident spends most of the year on subspecialty rotations and should develop a grasp of the current concepts in these subspecialties.

PGY-4: The PGY-4 resident spends a portion of the year in a concentrated experience in pediatric orthopaedics. The resident develops skills in management of all pediatric orthopaedic problems. Additional exposure to the Orthopaedic subspecialties also occurs during the PGY-4 year. The resident functions more independently of faculty supervision and begins to assume responsibility for independent patient management.

PGY-5: The PGY-5 (chief) resident is responsible for the daily care of all inpatients and for clinic management. Duties include supervision and teaching of junior residents and medical students.

Administrative Chief Resident: Each year, the residents elect a PGY-4 resident as the Administrative Chief Resident for his/her fifth year. Responsibilities begin prior to the end of the elected chief's fourth year with the drafting of the next year's rotation and conferences schedules. The Chief Resident attends full-time faculty meetings and retreats, providing input on the residents' behalf.

Competence is assessed on five (5) levels that approximately parallel the five years of residency training with two (2) subdivisions for each level: 1) performance without direct supervision, and 2) with direct supervision. Approval for performance without direct supervision normally constitutes competency for a supervisory role for that particular level. Although the ability and experience of the individual resident are ultimately used to determine each individual resident's competence, Appendix A provides guidelines that the PD uses for determining the level of competence by level of training for the most common orthopaedic procedures.

Staff surgeons are in the OR for all procedures. The indicated procedures that are clinic, ward, or E.D. based (Level I, attached) are those that could be approved for performance by the resident without direct staff supervision. The approval for such performance without direct supervision is granted by the Program Director, given feedback at either faculty meetings or by written evaluations, after sufficient demonstrations of competence are evident (e.g., 3-5 or more procedures done well). Display of approvals for performance of procedures without direct supervision will be through the New Innovations web site (Procedure Tracker).

Immediate communication by residents with faculty must occur in the event of death, transfer of a patient to intensive care, need for any invasive test or the need for emergent return to the OR.

Clinical Activity	Resident Level	Requirements for Approval to Perform Without Direct Supervision[1]
Level 1 Competence		
Arterial puncture	PGY1+	At the beginning of PGY1 year after initial instruction*
Arthrocentesis	PGY1+	At the beginning of PGY1 year after initial instruction*
Closed reduction of minor fractures and joints	PGY1+	At the beginning of PGY1 year after initial instruction*
Extensor tendon repair	PGY1+	At the beginning of PGY1 year after initial instruction*
Incise/drain abscess	PGY1+	At the beginning of PGY1 year after initial instruction*
Insertion of Foley catheter	PGY1+	At the beginning of PGY1 year after initial instruction*
Insertion of NG tube	PGY1+	At the beginning of PGY1 year after initial instruction*
Joint or soft tissue injection	PGY1+	At the beginning of PGY1 year after initial instruction*
Placement of IV line	PGY1+	At the beginning of PGY1 year after initial instruction*
Suture laceration	PGY1+	At the beginning of PGY1 year after initial instruction*
Venipuncture	PGY1+	At the beginning of PGY1 year after initial instruction*
Venous cut-down	PGY1+	At the beginning of PGY1 year after initial instruction*
Wound debridement and closure	PGY1+	At the beginning of PGY1 year after initial instruction*
Level II Competence		
Arthroscopy of knee	PGY2+	At the beginning of PGY2 year after initial instruction
Arthrotomy	PGY2+	At the beginning of PGY2 year after initial instruction
Bone grafting	PGY2+	At the beginning of PGY2 year after initial instruction
Closed reduction of major fractures	PGY2+	At the beginning of PGY2 year after initial instruction
Joint manipulation	PGY2+	At the beginning of PGY2 year after initial instruction
Local soft tissue coverage procedures	PGY2+	At the beginning of PGY2 year after initial instruction
Open reduction and or fixation of minor fractures	PGY2+	At the beginning of PGY2 year after initial instruction
Osteotomy or Ostectomy	PGY2+	At the beginning of PGY2 year after initial instruction
Partial flexor tendon repair	PGY2+	At the beginning of PGY2 year after initial instruction
Skin grafting	PGY2+	At the beginning of PGY2 year after initial instruction

Clinical Activity	Resident Level	Requirements for Approval to Perform Without Direct Supervision[1]
Level III Competence		
Arthroscopy of ankle	PGY3+	At the beginning of PGY3 year after initial instruction
Carpal tunnel release	PGY3+	At the beginning of PGY3 year after initial instruction
Distant soft tissue coverage procedures	PGY3+	At the beginning of PGY3 year after initial instruction
Flexor tendon repair	PGY3+	At the beginning of PGY3 year after initial instruction
Hand, wrist, or foot arthroplasty or fusion	PGY3+	At the beginning of PGY3 year after initial instruction
Ligament repair or reconstruction	PGY3+	At the beginning of PGY3 year after initial instruction
Major osteotomies or fusions	PGY3+	At the beginning of PGY3 year after initial instruction
Open reduction and internal fixation of major extremity fractures	PGY3+	At the beginning of PGY3 year after initial instruction
Small joint arthroplasty or fusion	PGY3+	At the beginning of PGY3 year after initial instruction
Soft tissue mass excisional / incisional biopsy or needle biopsy	PGY3+	At the beginning of PGY3 year after initial instruction
Level IV Competence		
Arthroscopy of upper extremity	PGY4+	At the beginning of PGY4 year after initial instruction
Major joint arthroplasty	PGY4+	At the beginning of PGY4 year after initial instruction
Nerve repair	PGY4+	At the beginning of PGY4 year after initial instruction
Open reduction and internal fixation of complex fractures such as the acetabulum or proximal humerus	PGY4+	At the beginning of PGY4 year after initial instruction
Spinal fusion without instrumentation	PGY4+	At the beginning of PGY4 year after initial instruction
Tendon transfers	PGY4+	At the beginning of PGY4 year after initial instruction
Level V Competence		
Arterial or venous repair	PGY5	At the beginning of PGY5 year after initial instruction
Posterior decompression of the spine	PGY5	At the beginning of PGY5 year after initial instruction
Spinal fusions with instrumentation	PGY5	At the beginning of PGY5 year after initial instruction
Tendon grafts	PGY5	At the beginning of PGY5 year after initial instruction

[1] The method used to define the competency of a resident to perform procedure without direct supervision will be PGY level. All PG1 residents function under *Direct supervision* until progressed to *Indirect, with Direct immediately available* after "initial instruction" generally, the observed performance of (5) procedures performed competently. (All PG1 residents are never without *Direct immediately available*). PG2-PG5 resident approvals are as indicated, i.e., at the beginning of the indicated years, the resident will be approved to perform any indicated out-of-OR procedure with under *Indirect, with Direct* available supervision (unless the approval is modified or delayed by exception). All OR-based operative procedures by definition (unless emergency) will have *Direct supervision*. Performance without direct supervision generally constitutes competency of a supervisory role for that particular level.

*See approval mechanism, bottom of page 2.
Other procedures may be performed under the direct supervision of properly credentialed staff physicians. An individual resident may have sufficient experience to be competent in one of these procedures by the end of training to be considered for full credentialing, such as lumbar disc surgery, micro vascular surgery, revascularization/replantation, and free tissue transfers.

SPECIFIC POLICIES
INPATIENTS

A. In-Patients

(1) The resident will always be in communication with the responsible attending staff physician with regards to all in-patient matters.

(A) Prior to invasive procedure or test.

(B) On admission of any patient to the ICU-CCU-SICU.

(3) For Critical Care patients, the attending will write a note on the chart within 12 hours of admission.

(4) There must be daily attending staff input on all critically ill patients or more frequently if necessary. Frequency of staff notes otherwise will be dictated by the By-Laws of the training sites.

(5) On non-critical care admissions, the attending will evaluate the patient and write a note on the chart within 24 hours of admission.

(6) The attending physician must make a preoperative notation in the patient's chart on all patients undergoing elective surgery, and a notation on the chart of every patient admitted.

(7) For patients going to surgery for life or limb threatening emergencies, the attending will write a note on the chart at the first opportunity.

(8) For all patients, whether going to surgery or not, the plan of care should be noted by the attending physician in the chart. For patients going to surgery, this plan of care should be noted preoperatively and either signed by the staff physician or should include a note by the resident indicating that he or she discussed the plan with the attending staff who concurs with the plan. In this latter incidence, the attending staff will sign the note discussing the plan at the first opportunity, but no later than 24 hours postoperatively.

(9) The responsible attending physician will be present in the Operating Room at the beginning of every scheduled elective case while the patient is still awake to insure that the patient and the correct operative site are properly identified. In addition, the attending physician will be present and scrubbed for all critical parts of all operations and immediately available in the Operating Room area for the remainder of the procedure. This must be documented by the attending physician in the patient's chart. In life or limb threatening emergencies, the most senior resident available should proceed to the OR without delay after notifying the chief resident and the attending on call. In such emergencies, the responsible staff physician will proceed to the Operating Room at the first opportunity. In such emergencies, the staff physician must insure that each resident understands his or her responsibility to discuss each case preoperatively with the attending staff member. Progression of responsibility in the OR will be determined by the attending physician on a case by case basis. As the resident progresses, the resident will assume more of a role in each case both in decision making and operative technique.

(10) The attending physician will assume all responsibilities for patient care rendered by residents, even if he/she has not yet seen the patient.

B. Out-Patients: The following guidelines will establish continuity of care.

(1) The resident will consult the attending physician on all chronic out-patient problems periodically as indicated by the patient's condition. Depending on the training site, that attending may be required to be physically present in the clinic area during a resident-patient interaction (e.g., VA).

(2) The care of complex patients will always be assumed by the appropriate Staff physician who will oversee all residents who rotate through the Orthopedic Surgery Service.

(3) The attending physician must evaluate all patients prior to scheduling surgery. This applies to both major and minor surgical procedures.

(4) A written consultation is required for every patient seen and discharged from the Emergency Room by an Orthopedic Surgery resident. (At least verbal contact with the attending on an ER case, before discharge from the ER, may be required at the training site [e.g., the VA]). This consultation must be reviewed by the attending physician within 24 hours for review and documentation of appropriateness of care. In addition, any other surgery department guidelines, based on the Residency Review Committee requirements will be followed.

(5) As our residents are advanced learners, they will be expected to know how to do consults and admissions of patients to the hospital.