Supervision of Residents/Chain of Command
Creighton University Department of Surgery
Residency Training Program

Chain of command for Surgery residents at CUMC

PGY1:
The intern on call covers the two general surgery services [red and orange], the trauma service (blue service) and cardiothoracic, vascular, plastics, urology, and neurosurgery patients on the floors and is responsible for admissions and consults to these services on the floor and the emergency department. All patient care issues must be discussed with the in-house senior resident. Issues relating to neurosurgery, urology, and plastic surgery will be discussed with the attending on call for these services as well as informing the senior resident.

PGY2:
This resident is on call for the ICU, CCU, and 4600 [monitored care] and covers all consults and admissions to these units for all surgical services. He/She should discuss the management of these patients with the senior in house resident. Issues relating to neurosurgery and plastic surgery will be discussed with the attending on call for these services as well as informing the senior resident. The PGY2 should contact the senior resident prior to insertion of chest tubes, central lines, and arterial lines. They should also involve the PGY1 residents in these procedures for teaching purposes.

PGY3:
1) These residents rotate on the Head and Neck Surgery service at UNMC where they perform the duties of a senior resident under the direct supervision of the surgical attending staff.

2) While at CUMC, this resident is responsible for all emergency department consults, floor consults and for all trauma patients and oversees the PGY1 and PGY2 residents.

3) At the VA Medical Center, the PGY3 resident acts as a senior resident on the surgical service and has the supervisory and teaching responsibilities of the junior residents on his/her service, manages patients in the clinic and on the inpatient services with greater independence under the supervision of the attending surgeons and the chief resident at the VA Medical Center.

**PGY4:**

These residents primarily rotate on:

1) Vascular Surgery at CUMC where they perform the duties of a senior resident under the direct supervision of the surgical attending staff

2) the private general surgery services at Bergan Mercy Hospital where they perform the duties of a senior resident under the direct supervision of the surgical attending staff

3) The burn/wound care and general surgery services at St. Elizabeth’s Medical Center, where they perform the duties of a senior resident under the direct supervision of the surgical attending staff.
4) At the VA Medical Center, the PGY\textsuperscript{3} resident acts as a senior resident on the surgical service and has the supervisory and teaching responsibilities of the junior residents on his/her service, manages patients in the clinic and on the inpatient services with greater independence under the supervision of the attending surgeons and the chief resident at the VA Medical Center. The PGY4 resident’s role as an administrator is developed during this rotation.

5) In addition they will rotate on the trauma service (blue surgery) where they will function as the chief resident.

**PGY5:** [Chief Residents]

The chief residents are the team managers on the two general surgical services at Creighton University Medical Center and also manage a general surgical/vascular service at the VA Medical Center. They are responsible for the overall day to day care of all patients on their service and act as liaison between the responsible surgeon, the junior resident staff, the medical students and the individual patient. The chief resident designates junior residents on their service to evaluate new patients and consults, and in conjunction with them, formulates differential diagnosis and appropriate investigational and therapeutic plans and then communicates the same to the attending surgeon. The final plans made in conjunction with the attending surgeon are then implemented through appropriate division of responsibility by the chief resident. The chief resident supervises morning rounds and reviews with the
junior residents the current status of each patient and the necessary diagnostic and therapeutic plans for each patient for that day. They are responsible for informing the attending surgeon of any significant changes in the clinical course of the patients. They are also responsible for assigning surgical residents and medical students to the operating rooms based on complexity and educational value of the case. They supervise perioperative management of surgical patients including hemodynamic monitoring and total parenteral nutrition as well as the performance of bedside procedures. They are responsible for managing all trauma patients when on call. The PGY4 or 5 resident is also the team leader for the initial assessment and resuscitation of all trauma patients or other critical general surgical emergencies. The trauma surgery attending is always available on in-house call. The trauma surgery attending is completely in charge of the care of the trauma patient. It is the chief resident responsibility to communicate to the surgical attending the nature of these emergent situations as expeditiously as possible.
**Attending staff**

Ultimately, the attending staff has final responsibilities for appropriate patient care. It is the responsibility of the most senior in house resident on call to contact the attending surgeon for all new consults and significant development in the condition of the patients. This includes the performance of procedures such as arterial and central lines, chest tubes and major investigational procedures.

The attending surgeons are always responsible for existing patients. In the event that the attending surgeons cannot be reached, the issue should be brought to the notice of the attending general surgeon on call or the attending trauma surgeon in-house call. The list of on call attending general surgeons and trauma surgeons, including pager numbers office phone number, cell phone number and home phone number is published as part of the on-call schedule.

In life threatening circumstances when a procedure may be indicated, the most senior resident may perform a critical procedure such as placement of thoracostomy tube for tension pneumothorax while ancillary staff is contacting the attending surgeon.

**Code 99 reporting policy**

The junior and senior surgical residents assigned to the Trauma service (Blue team) are expected to respond to all Code 99 pages during regular duty hours. The junior and senior surgical residents assigned to in house call are expected
to respond to all Code 99 pages after duty hours. If the code is on a surgical patient, the surgery resident must take charge of the code. They should communicate the status of the patient to the surgical attending as soon as possible.

**Trauma Activation Reporting Policy**

The entire trauma team, including junior and senior residents as well as the trauma surgery attending, will respond immediately upon activation of a trauma alert. All members of the trauma team will report to the Trauma Resuscitation Area of the Trauma Center. Complete responsibility and strict supervision of residents is the sole responsibility of the trauma attending on-call.

**Chest Tube, Arterial Line, and Central Line Placement Policy**

Residents may be asked to place chest tubes, arterial lines, or central lines in a patient; however, no chest tube, arterial line or central line is to be placed in a patient except in extreme emergencies without the knowledge of the assigned attending surgical staff member prior to the procedure being performed. Chest tube placement and central line placement by the PGY 1, PGY 2, will be supervised by at least a PGY3 resident. These are procedures that each resident must be tested as proficient prior to unsupervised action. **For all procedures performed in surgical patients the Attending Surgeon must be notified. In the case of Trauma patients the Trauma surgeon will be present.**
Supervision Expectations

**Non OR procedures:**

Indirect supervision is allowed for:

**Patient Management Competencies**

1) Evaluation and management of a patient admitted to the hospital, including:
   a) Initial history and physical exam
   b) Formulation of a plan of care
   c) Specification of necessary tests

2) Evaluation and management of post-operative patients including:
   a) the conduct of monitoring
   b) orders for medications,
   c) testing,
   d) and other treatments

3) transfer of patients between hospital units or hospitals

4) discharge of patients from the hospital

5) interpretation of laboratory results

**Procedural Competencies**

1) performance of basic venous access procedures, including establishing intravenous access
2) placement and removal of nasogastric tubes and Foley catheters

3) arterial puncture to obtain ABGs

Direct supervision, where the supervising physician must be physically present at the start of non-emergent tasks, is required until competency is demonstrated for:

**Patient Management Competencies**

1) Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required).

2) Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac dysrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes.

3) evaluation and management of critically-ill patients, either immediately postoperatively or in the intensive care unit, including:
   
   a) the conduct of monitoring,
   
   b) orders for medications,
   
   c) testing
d) other treatments

e) management of patients in cardiac or respiratory arrest

ACLS required)

Procedural Competencies

1) Performance of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation

2) repair of surgical incisions of the skin and soft tissues

3) repair of skin and soft tissue lacerations

4) excision of lesions of the skin and subcutaneous tissues

5) tube thoracostomy

6) paracentesis

7) endotracheal intubation

8) bedside debridement

Operating Room supervision

Supervision of Surgical Residents in the Operating Room:

An operation may be considered in a framework of six phases:

1) Induction of anesthesia,

2) Initial incision,

3) Confirmation of the original diagnosis,

4) Technical execution of planned procedure,

5) Closure of the wound,
6) Reversal of anesthesia.

The degree of supervision required varies with the phase of the operation and with the experience and skill of the resident involved. The responsible attending will be immediately available in the OR suite during all phases of the operation and will be physically present and scrubbed during the critical phases of the operation. The degree to which personal technical assistance in the Guidelines for Supervising Residents Operating Room is required during a given procedure will be at the discretion of the responsible Attending. This decision will be based upon the Attending’s personal knowledge or experience, past performance and skill of the resident surgeon, the complexity of the case, and the phase of the operation.

For all trauma patients requiring a surgical intervention the attending trauma surgeon is required to be physically scrubbed during the entire case. In the event of a life-threatening emergency in which immediate operative intervention is required, the Senior Surgical Resident (PGY4-PGY5) may proceed to the Operating Room with the patient and initiate whatever lifesaving measures are required, after having notified the responsible Attending.
To ensure that the above policy is followed, adequate resident coverage is provided as follows:

Every Trauma Night the call team consists of:

- Attending surgeon – in house call/
- Chief resident (PGY 4 or 5) - in house call
- Senior resident (PGY 3 or 4) - in house call
- Junior resident (PGY 2) assigned to ICU/CCU/4600 – in house call
- Intern (PGY 1) assigned to admits, consults, and floor – in house call

**Chain of command during business hours**

1) Patient related issues are handled by the respective services. Non critical issues are addressed by the junior residents. They should seek the advice of the senior resident on the service for issues they are unclear about or have minimal experience with, as well as all critical matters. If a senior resident is not available they should contact the attending surgeon responsible for the patient, other attendings on the service, or the on-call attending surgeon, in that order. The senior resident on the service should assist the junior resident with inpatient care issues and should inform the attending surgeon of
patient status in a time frame consistent with the situation.

2) The senior resident on the service should assist the junior resident with inpatient care issues and should inform the attending surgeon of patient status in a time frame consistent with the situation.

Rounds

1) All rounds must be completed by 6:00pm daily by the attending surgeon.

2) Residents that are not scheduled for in-house call will not be expected to make rounds after 6:00pm.

3) If the attending surgeon does make rounds after 6:00pm, they will need to make rounds by themselves or with the in-house resident.