Gastroenterology Fellowship
Creighton University School of Medicine
Supervision Policy
(revised 4-28-2017)

A. Policy:
The Gastroenterology Fellowship Program recognizes and supports the importance of graded and progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising fellows. The goal is to promote assurance of safe patient care, and the resident’s maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient’s care.

B. Definitions:
Levels of Supervision: To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: (core-ACGME)

- **Direct:** The supervising physician is physically present with the fellow and the patient (core-ACGME)
- **Indirect:**
  - 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. (core-ACGME)
  - 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 Director Supervision. (core-ACGME)
- **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (core ACGME)

C. Procedure
The principles which apply to supervision of fellows include:

- The CUMC Gastroenterology Fellowship Program establishes schedules which assign qualified faculty physicians, residents, or fellows to supervise at all times and in all settings in which fellows provide any type of patient care.
- The minimum amount/type of supervision required in each situation is determined by the definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient’s care to the fellow, based on the needs of the patient and the skills of the fellow.
- Fellows serve in a supervisory role of junior residents in their progress toward independence.
- All fellows, regardless of year of training, must communicate with the appropriate supervising faculty member, according to these guidelines:

  **PGY4**
  - Anytime questions arise concerning patient care
  - Any significant change in the patient’s condition (move to CCU, ICU, emergent surgery)
  - DNR status, end of life decision
  - Family request for a meeting concerning patient
  - Request for a leave against medical advice
  - Death of a patient
  - All admissions and new consults
  - All procedures
PGY5:
- Any significant change in patient’s condition (move to CCU, ICU, emergent surgery)
- Family request for a meeting concerning patient
- DNR status, end of life decision
- Request for leave against medical advice
- Unexpected death of a patient
- All admissions and new consults
- All procedures not credentialed

PGY6
- Any significant change in patient’s condition
- Unexpected death of a patient
- All admissions and new consults
- All procedures not credentialed

If the faculty member does not respond in a timely manner, the fellow will then contact the Program Director or Associate Program Directors in his absence.

- All fellows are supervised either directly or indirectly with direct supervision immediately available.
- In every level of supervision, the supervising faculty member must review progress notes, sign procedural and operative notes and discharge summaries.
- Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.
- The attending physician has both an ethical and a legal responsibility for the overall care of the individual patient and for the supervision of the fellow involved in the care of the patient. Although senior fellows may require less direction than junior fellows, even the most senior trainee must be supervised.
- A chain of command that emphasizes graded authority and increasing responsibility as experience is gained must be established. Judgments on this delegation of responsibility must be made by the attending physician who is ultimately responsible for the patient’s care; such judgments shall be based on the attending’s direct observation and knowledge of each fellow’s skills and ability. The attending physician is responsible for supervising both procedures and patient care. In circumstances when decisions and patient treatment are to be administered by the fellow in the absence of the attending physician, such as may occur at night or on weekends, the attending physician must be notified of all decisions and treatments in a timely fashion, to be determined by the fellow based on the circumstances of the case. Fellows can identify the attending on call by reviewing the on-call calendar by logging on to the web based on-call calendar in Amion. It is the responsibility of the fellow to notify the attending under all of the above situations and any other situation that may necessitate supervision by the attending, when he or she is not immediately available. **In no circumstance should the trainee perform endoscopic procedures without direct attending supervision.** A fellow is not required to become involved in the care of non-teaching patients when a consult has not been placed.
- When internal medicine residents and students are rotating within the Gastroenterology division, supervision of patient care falls under the responsibility of the fellow as well as the attending physician.

E. Events to Be Notified:
- Patient mortality
- Patients in shock
- Unexpected adverse event after an endoscopic procedure or during clinical care of a patient in the consult service
- New emergent consults from the intensive care unit or emergency department.
• New consults for hemodynamically unstable patients with gastrointestinal bleeding in the hospital, especially patients in the ICU or Emergency Department.
• Consults regarding patients with esophageal food bolus impaction and foreign body in the gastrointestinal tract
• Any new consults pertaining to patients in shock or hemodynamic instability.
• Any patient consult deemed to be an emergency by the referring physician