Supervision of Fellows

Although the admitting physician is ultimately responsible for the care of the patient, all physicians share in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.
Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

1. Each patient must have an identifiable and appropriately-credentialed and privileged physician who is responsible and accountable for the patient's care. This information must be available to fellows, faculty members, other members of the health care team, and patients.
2. Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
3. Supervision may be exercised through a variety of methods, as defined by the Levels of supervision below.
4. The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.
5. The program must describe how they provide a graduated level of autonomy guided by case acuity and evaluations of the trainee.

Levels of supervision:
To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:
Direct Supervision (type I): the supervising physician is physically present with the fellow during the key portions of the patient interaction.
Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available and on-campus (IIa) or available but not immediately (IIb), ie home call, to the fellow for guidance and is available to provide appropriate direct supervision.
Oversight (type III) – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.
7. The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.
8. Fellows should serve in a supervisory role to residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
9. Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).
10. Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.
11. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.
12. Supervision within the surgical critical care (SCC) year is provided according to Accreditation Council for Graduate Medical Education (ACGME) SCC common program requirements (CPR).
13. In the second year (operative year) of fellowship all programs should follow the guidelines below to ensure the fellow progresses from less autonomy to more autonomy in three phases. The duration of each phase is left to be determined by the individual program based on the fellow's experience and performance;
    a. Phase I: All complex EGS/Trauma work-up/operations and complex trauma activations and resuscitations should have direct supervision (complex EGS for phase I is defined as any case that is listed in the operative curriculum; complex trauma activation is defined as the highest level of activation)
    b. Phase II: Low acuity EGS/Trauma have type III supervision and *all complex* general surgery/trauma operations type IIa/b supervision (Low acuity EGS/Trauma may be defined by individual institutions based on local volume of specific case types)
    c. Phase III: Low to moderate complex EGS/Trauma operations may have type IIa or IIb supervision.
    **All highly complex general surgery/trauma operative cases should have direct supervision for the critical portions. (examples of highly complex EGS or Trauma are giant duodenal ulcer perforation, vascular reconstruction for trauma, or severe liver trauma requiring packing)
14. Progression from one phase to the next should be preceded by a group evaluation of the clinical performance of the fellow. The time-frame for each phase can be delineated by individual institutions.
    a. Phase I may begin during the first year in those programs that provide the fellow the opportunity to have rotations or call on trauma/EGS.
    b. A minimum requirement for progression to Phase III is 20 calls

    c. Programs are encouraged to define complex general surgery/trauma operative cases, both in type and quantity, developing milestones for progression to phase III.

15. Faculty and trainees must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.
16. It should be noted that providing appropriate levels of autonomy is necessary to ensure independent surgeons by the completion of the fellowship and progression through all three phases described above.