MUSC
MEDICAL UNIVERSITY
of SOUTH CAROLINA

ANESTHESIA AND PERIOPERATIVE MEDICINE

SCOPE OF PRACTICE
PGY-1 – PGY- 4 & Chief Resident

PURPOSE

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

SCOPE

This policy applies to all Medical University of South Carolina Anesthesiology residents.

TYPES OF SUPERVISION:

Direct Supervision:

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

Indirect Supervision with Immediate Availability:

The supervising physician is not physically present but is immediately available to provide direct supervision if needed.

Indirect Supervision with Availability:

The supervising physician is available to provide supervision, though not necessarily on-site. They can be reached by phone or electronic communication.

OVERSIGHT

The supervising physician reviews procedures, cases, and patient encounters after they are completed and provides feedback to the resident.

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GUIDING PRINCIPLES:

- Every patient in the clinical environment must have an assigned and privileged Anesthesiology faculty member in charge of their care.
- The attending Anesthesiologist is ultimately responsible for the patient's care no matter the level of supervision.
- The Program director, with guidance from the department's CCC, determines the progression of residents between training years and the level of supervision required.
- Both the resident and attending faculty must be clearly documented as such in the medical record.
- Faculty members are expected to model and exhibit professional conduct.
- Allow progressive autonomy. PGY-1 residents will need more direct supervision than PGY-4 residents which should have significant indirect supervision and oversight when appropriate.

Progressive Responsibilities for Patient Care

Anesthesiology Residency is a four-year training period, during which residents assume progressively greater responsibility for patient care and develop independence in patient management. Residents must be supervised (see definitions of supervision section above) throughout their training by a faculty member, who is ultimately responsible for the patient's care.

PGY-1

- Anesthesiology residents are required to participate in one year of basic clinical training (Clinical Base Year) prior to beginning their specific training in anesthesiology (Clinical Anesthesia Years). The CBY includes rotations on both medical and surgical services. In addition, anesthesiology residents care for patients on the medical and surgical ICUs, the emergency room, the chronic pain service, as well as in-patient and out- patient services and clinics during the clinical base year. They may participate in procedures performed in the clinic, procedure suite, or operating room under the direct supervision of a qualified member of the medical staff or senior trainee.

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- During the CBY, anesthesiology residents are primarily responsible for the care of patients under the guidance and supervision of the attending and senior trainees. Depending on patient acuity and co-morbidities, the supervision varies from indirect with immediate availability to direct. The resident should be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising trainees and/or the attending should be contacted.

Clinical Anesthesia (CA) Years 1- 3 (Post Graduate Training years 2 - 4):

All patient care is under the supervision of an attending physician; residents may provide direct patient care or consultative services. Residents care for patients in the following service areas:

• Operating room - intraoperative care of an anesthetized patient during a surgical procedure
• Intensive care unit - patients with multisystem organ failure
• Emergency room
• In-patient or out-patient Pain Relief Services
• Obstetric unit – care for parturient patients
• Perioperative medicine clinics
• Post anesthesia Care Unit
• Non-operating room areas including the CT & MRI scanners, cardiac cath lab, electrophysiology suite, GI endoscopy suite, interventional radiology department

Residents are expected to evaluate patients under their care, determine the relevant medical and surgical pathologies and co-morbidities and develop an appropriate management plan and carry out the required invasive procedures. Residents may also provide emergency care for patients in the ICU, emergency department, particularly advanced airway management, intravenous and intra-arterial cannulation, neuraxial and regional nerve blocks. Residents will work as part of the patient care team in the operating room, intensive care unit, pain clinic, obstetric unit, perioperative medicine clinic, or emergency department.

PGY-2 (CA-1)

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- CA1 residents are expected to function in the role of an anesthesia team member requiring supervision from attending physicians and senior trainees.

- CA1 residents are expected to evaluate patients and develop and execute their management plan under indirect but immediately available supervision from the attending physician.

- Residents will be assigned to cases in the operating room appropriate to their level of experience. In the first few months of CA1, residents will care for healthier, ASA1 and 2 patients and patients undergoing minor to moderately complex surgical procedures. In the ICU, CA1 residents will be active members of the critical care team under the supervision of the attending anesthesiologist and senior residents.

- Residents will receive direct supervision for all procedures, induction and emergence, as well as key portions of the case. For all other portions of the patient's care, residents will be under indirect supervision with immediate availability.

- Residents should contact their attendings immediately for hemodynamic changes, significant blood loss, or any escalation of care.

- Towards the end of the CA1 year residents may care for sicker (ASA3) patients and patients undergoing more complex surgery, including subspecialty rotations. Upon occasion, CA1 residents may care for ASA4 or 5 patients with direct supervision.

PGY-3 (CA-2)

- CA2 residents participate in subspecialty anesthesia rotations caring for patients in cardiac, obstetrics, neurosurgery, pediatrics, critical care, etc.

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- In the operating rooms and NORA sites, CA2 residents care for complex (ASA3 and greater) patients undergoing procedures and medical care.

- CA2 residents are expected to evaluate subspecialty patients and develop and execute their management plan under indirect but immediately available supervision from the attending physician.

- Towards the end of the first month on a subspecialty rotation, a greater autonomy for patient care is expected, and residents should be the first point of contact for questions regarding patient care.

- Supervision by attendings is required and consulted for any questions that residents can not immediately answer.

- During the CA2 year, residents will transition from direct supervision for procedures and complex case management, to indirect supervision with immediate availability, based on their competency.

PGY-4 (CA-3)

- As senior residents, CA3s are expected to assume a leadership role, coordinating the actions of the anesthesia team, and interacting with nursing and other administrative staff.

- CA3 residents care for the most complex patients in the operating rooms, NORA sites, clinics, and ICU. CA3 residents are expected to develop more autonomy for patient care and in the development and execution of their management or treatment plans.

- CA3 residents, based on their competency, will transition to indirect supervision with availability from their attending on complex cases and procedures.

- Along with the attending, senior residents provide for the educational needs of junior residents and students, and learn to lead the anesthesia care team.

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Chief Resident(s)

- Prepares the monthly resident call schedule and reviews the daily resident deployment (both at least one month in advance).
- Reviews the resident vacation and conference schedule to ensure that the appropriate numbers of resident physicians are available for clinical duties.
- Assists in managing scheduling problems that arise in the event of illness or an emergency.
- Assists in the orientation of new resident physicians.
- Functions as the resident physician spokesperson within the department.
- Attends the Education Committee as the resident representative.

Emergency Care:

Nothing in this policy should be construed as prohibiting the resident from rendering emergency care to a patient to the extent s/he is qualified by training and experience, regardless of whether immediate supervision is available or not.

Resident Expectation for Requesting Additional Supervision:

Residents are expected to practice within their scope of experience and to inform responsible faculty when they need additional help with any aspect of patient care based on their current medical knowledge and skill set level if not already anticipated by the staff. All residents are expected to inform staff during key aspects of any case including induction and intubation, emergence and extubation, and critical events during the case to include but not limited to significant hemodynamic changes, the need for blood products, fluid resuscitation and/or pressors, significant change in patient status, and when any proceduralist or surgeon expresses concerns or requests faculty to be present. If the attending anesthesiologist is unavailable for induction/emergence or key portions (hemodynamic instability, major

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bleeding, etc), the resident should contact the anesthesiologist Doctor of the Day at each location for support.

Documentation of Supervision:

Supervising physicians must document their level of involvement in the resident's training and patient care in the medical record.

Residents are responsible for logging their procedures and documenting their participation and level of supervision in the electronic residency management system.

Competency Evaluation:

Competency evaluations will be conducted by the CCC based on direct observation, feedback from peers, performance during simulations and mock orals, and recommendations made to the Program Director.

Addressing Inadequate Supervision:

Residents and faculty members are encouraged to report any concerns regarding the adequacy of supervision to the program director or designated faculty. Immediate action will be taken to address any potential risks to patient safety.

Residents are responsible for logging their procedures and documenting their participation and level of supervision in the electronic residency management system.

AMENDMENTS OR TERMINATION OF THIS POLICY

Medical University of South Carolina reserves the right to modify, amend or terminate this policy at any time.

The GME policy supersedes all program level policies regarding this area/topic. In the event of any discrepancies between program policies and the GME policy, the GME policy shall govern.

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