UNIVERSITY OF HAWAI‘I AT MĀNOA

JOHN A. BURNS SCHOOL OF MEDICINE

COMPILATION OF RESIDENT/FELLOW SUPERVISION POLICIES and

PROGRESSIVE RESPONSIBILITY

PREPARED FOR HOSPITAL MEDICAL EXECUTIVE COMMITTEES

January 2019

Please contact Dr. Lee Buenconsejo-Lum, Designated Institutional Official, for any questions.

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This document contains excerpts from each GME program’s supervision policies and is being provided to the Medical Staff Leadership at our major teaching hospitals to help ensure appropriate review (for Joint Commission requirements) and to promote improved communication between the hospitals and GME programs.

Please do not distribute this document beyond the appropriate medical staff committee or department.

ACCREDITATION REQUIREMENTS: CONGRUENCE BETWEEN THE ACGME & THE JOINT COMMISSION

Supervision by appropriately credentialed attending physicians (Licensed Independent Practitioner)

• Section VI.A.2.a) of the ACGME Common Program Requirements describes the philosophy for Supervision and Accountability in Graduate Medical Education programs (residencies and fellowship programs).
  "Although the attending physician is ultimately responsible for the care of the patient, every physician shares 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 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."

• Section VI.A.2.a).(1) requirement states that “Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care.”

• Section VI.A.2.c) further defines different levels of supervision "to promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.”
  – Direct supervision, Indirect Supervision with Direct Supervision immediately available, Indirect supervision with direct supervision available, Oversight
  – Programs have specific policies and guidelines per rotation, PGY-level and/or type of procedure
  – Procedures performed in the OR are directly supervised
  – Programs have guidelines & expectations for communication with attendings
  – SUPERB SAFETY model of resident-faculty communication being implemented in many programs this academic year (2017-18)

• Section VI.A.2.d) states "the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care designated to each resident must be assigned by the program director and faculty members.” The ACGME Glossary of Terms defines conditional independence as graded, progressive responsibility for patient care with defined oversight.
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FAMILY MEDICINE (core)

The University of Hawai‘i Family Medicine Residency Program has residents that rotate at various hospitals and clinics throughout the state. Information on the main Family Medicine Inpatient Service at Pali Momi Medical Center is provided below. Note that Family Medicine residents are expected to follow the policies and procedures of the programs they are rotating with, in addition to specific hospital and/or institutional protocols. Examples: The Queen’s Medical Center: Medical Intensive Care Unit (IM Program), Consultation-Liaison Psychiatry (Psychiatry Program) and Outpatient Gynecology at the Queen Emma Clinic (OB Program); Kuakini Medical Center: Geriatrics; Kapiolani Medical Center for Women and Children: Newborn nursery, pediatrics emergency medicine, pediatrics wards, developmental-behavioral pediatrics (Pediatrics program), Labor and Delivery (OB program), etc.

Pali Momi Medical Center

Residents will rotate through Team Care on a schedule determined by the Program Director. At any given time, there will be at least two residents assigned to Team Care. There will always be at least one senior resident (second or third year) on the service, including during night coverage. If the senior resident on service is out of the hospital, a faculty member must be present in the hospital and immediately available to provide direct supervision for the intern as needed.

Supervision:
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. This information should be made readily available to residents, faculty members, hospital staff, and patients or their families. Residents and faculty members should inform patients of their respective roles in each patient’s care.

Appropriate levels of supervision must be assured for all residents who provide care for patients. Supervision is tailored to the training level and individual competencies of the resident as determined through the structured evaluation process of the program by the Program Director and faculty. Depending on the circumstances, supervision may be provided by a core faculty physician, a more senior resident, community attendings, specialty consultants, or emergency room physician. There are four levels of supervision. Below are the definitions for each level, and examples of when that level of supervision might be appropriate:

- Direct Supervision - the supervising physician is physically present with the resident
  - All procedures
  - Interns in the first half of the year when they do H&Ps and see patients in the continuity clinic.
- Indirect Supervision with direct supervision immediately available - the supervising physician is not present but is nearby in the facility.
  - Admissions when the attending is elsewhere in the hospital
Caring for patients in the hospital or clinic prior to reviewing with the attending

- Indirect Supervision with direct supervision available - the supervising physician is not in the facility, but is immediately available by electronic or telephonic means and is able to return to the facility for direct supervision in a reasonable amount of time.
  - Night float management of patients in the hospital
  - Admissions discussed over the phone with attending and then seen and reviewed by the attending the next morning.
- Oversight - the supervising physician is available to review the performance of procedures or encounters and provide feedback to the resident after the care has been provided.
  - Upper level resident discusses the clinical care of a patient in clinic with the attending after the patient has already left the clinic

Residents will track progression of supervisory independence for commonly performed procedures in New Innovations, as well as complete procedural competency credentialing card.

There are some circumstances, which require the immediate notification of the attending physician, these include:

- Admissions to the hospital
- Acute life, organ, or limb threatening decompensation
- Plan to transfer to a higher level of care or another facility
- Any rapid response, code, or BLS/ACLS intervention
- Newly diagnosed Acute MI, CVA, TIA, Delirium, or Fall
- Unexpected critically abnormal vital signs, labs, or imaging results
- Death of a patient
- Critical Patient Safety Sentinel or Near Miss events
- Transfusion reactions, severe allergic reactions or other major adverse drug events

If at any time the resident believes that greater supervision is required, they should immediately notify the upper level resident, chief, attending, associate program director, program director, chair of the department - in that order of preference - until the issue is resolved. General concerns about level of supervision may be anonymously expressed via the anonymous residency email account uhfmonline@gmail.com with password uhfmonline808.

There may also be up to two fourth-year medical students/“sub-interns” on the service working under the direct supervision of the resident staff. “Sub-interns” will function as PGY-1 residents and must have all notes co-signed by the attending physician. “Sub-interns” must wear a nametag at all times. Residents must write a complete progress note (or H&P) on patients seen by a sub-intern.
There may also be first, second, or third year medical students participating in inpatient care at PMMC. However, they are under the supervision of their FM/Primary Care rotation preceptor (usually a non-full time UH faculty physician). They are not supervised by the residents.

The University of Hawaii Department of Family Medicine full-time faculty will serve as the primary teachers for Team Care. Residents may also carry patients with the hospitalist and other community physicians who are non-compensated volunteer faculty.

The purpose of work rounds is to provide UH full-time faculty supervision for the ongoing management of patients on Team Care and will focus on teaching the residents inpatient management skills. A patient’s daily care plan is to be devised between the residents assigned to the case and the patient’s attending physician—if the attending physician is not a core FM faculty attending, this plan is not to be altered by the UH faculty member providing supervision on work rounds.

The Team Care call schedule does not replace any of PMMC’s existing call schedules for unassigned emergency room admits. However, residents on-call for Team Care may be asked to assist in emergency situations under the supervision of attending physicians as outlined under Resident Responsibilities.

1. PGY-1 residents assigned to Team Care will work under the supervision of senior residents.

2. UH full-time faculty will provide 24-hour per day supervision for Team Care residents. This supervision does not supersede or take the place of supervision by attending physicians who have admitted patients to Team Care on their services.

PGY-1 residents are scheduled to take four short calls (under the supervision of a Senior Resident) during the one-month block of inpatient service.

Team Care will be admitting patients from the Emergency Room or as a direct admission to the ICU. The Critical Care specialist should be consulted regarding any ICU admission. Patients already admitted by Team Care who decompensate and require transfer to ICU may be transferred by the resident in consultation with the ICU physician. Residents will continue to place orders and intervene to stabilize the patient under attending supervision. The team care attending will provide an attending to attending sign out to the ICU specialist who will act as a consultant for such transfers.

Admission Procedures

a. Direct admissions of patients from the Physician Center at Mililani: The patient’s primary physician or the clinic provider determining the need for admission (faculty or resident) will contact the resident covering Team Care to request direct admission to the service. Together they will coordinate contacting the nursing supervisor who will obtain a bed assignment and account number. The resident and faculty who saw the patient in clinic are responsible for writing the history and physical and placing
initial admission orders through EPIC when possible. The accepting Team Care resident will write an accept note and then assume management of the patient, under the supervision of the appropriate UH full-time faculty member.

b. Unassigned patients admitted through PMMC Emergency Medicine Department: The Emergency Department will contact the attending physician assigned to cover unassigned admissions through the ER for that day (hospitalist and/or PCM attending). Once the faculty attending accepts the patient, the ER attending physician will give sign out to the residents. The patients will be admitted by the resident under the supervision of the attending physician.

If Team Care is open for admissions from PMMC medical staff and participation is requested, the attending physician is responsible for contacting the resident on-call. If accepted, the patient will be admitted by the resident under the supervision of the attending. It is unacceptable for attending physicians to write orders for “Team Care to evaluate and write orders” (or similar) without first discussing with the resident on-call. If the resident has any questions or concerns about the appropriateness of an admission, they should call the FMIS PCM Faculty attending on call immediately.

If a resident physician feels that attending physician presence is deemed necessary in urgent situations, the residents will request the attending physician (or their on call coverage) come into the hospital. Please refer to the above discussion regarding appropriate levels of supervision and attending notification in Section VI Team Care at Pali Momi Medical Center Family Medicine Inpatient Service (FMIS) Policies and Procedures.

MATERNITY CARE POLICY

REQUIREMENTS FOR CONTINUITY OBSTETRICS PATIENTS. Each resident must follow a minimum of 3 patients for the duration of their pregnancy and deliver them. After all residents have obtained 3 patients, additional patients will be distributed equally. As a practice, we must care for all of the low risk maternity patients who present to our clinic. When one of their obstetrical patients presents to labor and delivery, the resident is the first physician called and manages the patients under the supervision of UCERA OB faculty.

ADMITTING AN OB. When a patient presents to Kapiolani, the nurse will triage the patient and notify the primary resident. If the patient needs to be admitted, that primary resident can call in admission orders, then come in a timely fashion to complete the admission history and physical. *If delivery is imminent, then the primary resident should leave their current rotation after notifying their rotation supervisor and go to the hospital immediately. If the patient is otherwise stable, then the resident can do the admission as soon as possible after they finish clinic/their rotation duties. The primary resident will work under the supervision of the UCERA faculty on OB call (see section 5 Faculty Supervision). If the patient is in the latent phase of labor or a scheduled induction, then the primary resident should write progress notes at least twice a day. The
A resident may return to their rotation/clinic if the patient is stable after the initiation of pitocin (see “Leaving your rotation” section). If the patient is in active labor, a written note is required every 2 hours.

**PCM NEWBORN PATIENTS.** For newborns that will be followed at PCM, send a group text & email to Drs. Hankins, Hixon, and Soin to notify them as soon as you anticipate delivery. The Family Medicine continuity resident that delivers the baby will round on the mother and baby until discharge, if at all possible. If the delivering resident is not available, the FM doing their OB rotation will round on the mother and newborn and write notes. If the FM OB resident is unavailable, the resident on Nursery will round on the baby. In the rare event that the continuity OB resident, the OB wards resident, and the Nursery resident are not available, the PCM attending will work with the Chiefs to identify a resident to round on the baby.

**FACULTY SUPERVISION**

*If the patient is a KAPIOLANI OB PATIENT*
- Whoever is supervising the delivery (attending for delivery), is responsible for post-partum care, including rounding and precepting the FM residents.
- Kap newborns = should go to the Kap Peds/Neo Staff

*If the patient is a PCM OB PATIENT*
- Attending = UCERA: The patient is a PCM patient. UCERA will be billing DELIVERY ONLY charge and we (FM) will bill the ANTEPARTUM ONLY. (i.e., split the fee). The post-partum rounding is included in the delivery charge. The UCERA staff will be responsible to perform postpartum rounds for these patients. The FM resident assigned to the PCM patient will also round and perform the continuity care and will communicate with the UCERA attending, as you would during your OB rotation.
- PCM Newborns = daily rounding by FM attending (AH, LBL, or SH). Please EMAIL (not text) LBL, AH, SH and Desiree to let us know of the delivery and the status of the baby. We (LBL, AH, SH) will figure out who will do the H&P, round and discharge the baby with you based upon availability.

1. **NEWBORNS.** Newborns of Kapiolani FM-OB patients may be placed on the family medicine service if requested by the mother. Otherwise, the Pediatric newborn attending on call will staff the baby. PCM FM-OB patients will be staffed by the PCM attendings (see section 5).

2. **OB CONSULTS.** Consultation with UCERA faculty is mandated in the following situations: high-risk patients (during antepartum care and labor), suspected dystocia, induction/augmentation of labor with oxytocin. VBAC patients should be managed primarily by an obstetrician during labor.

3. **LABOR MANAGEMENT.** During labor, keep the attending and/or OB Chief resident posted on any changes in the patient’s progress. The attending will be present for all deliveries and at any time there is a question or problem arising during labor. Please consult your attending liberally during labor. Should there be any problem in the outcome of the delivery, it is always best to have consulted the attending early,
especially if the obstetrics service is needed for consultation. The phrase to remember is CONSULT EARLY AND CONSULT OFTEN.

**LIMITATIONS**

Know your limitations. Recognize them and work to improve them. Keep short notes on subjects you are not familiar with so that you may ask someone later or look them up. Never attempt a procedure unless you are reasonable confident you know what you are doing and/or have the necessary support and supervision to do so safely. Intellectual honesty and the ability to say "I don't know" or "I'm not certain about that" is critical for patient safety and a basic expectation of professionalism.

**RESIDENT RESPONSIBILITIES**

A. **Responsibilities of the PGY-1**

| UNIVERSITY OF HAWAII FAMILY MEDICINE RESIDENCY PROGRAM |
|-------------|-----------------|-----------------|
| **ROTATION GOALS AND OBJECTIVES** | | |

**Rotation name:** FMIS PGY 1  
**Rotation Goals:** To learn the diagnosis and management of acute and chronic diseases of adults in the hospital setting.  
**Education Setting:** Inpatient, Patient Focused Reading and Discussion.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Competency</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correctly and efficiently manage hospitalized patients independently and within a multidisciplinary team, within the scope of family medicine.</td>
<td>Patient Care</td>
<td>Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Manage a broad range of medical and surgical conditions including the general areas of: Pulmonary, cardiac, endocrine, neurologic, oncologic, hematologic, gastrointestinal, infectious and renal diseases.</td>
<td>Medical Knowledge</td>
<td>Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Incorporate cultural, psychological &amp; family dynamics into the management of the hospitalized patient, including those who are dying.</td>
<td>Interpersonal Skills and Communication</td>
<td>Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Give patient- and condition-specific informed consent for diagnostic and therapeutic interventions including decisions surrounding prolongation of life or termination of support where appropriate.</td>
<td>Interpersonal Skills and Communication, Medical Knowledge, Professionalism</td>
<td>Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Define patient problems and do literature searches (as evidence-based as possible) to answer specific questions related to prognosis, therapy, diagnosis or other areas related to patient care.</td>
<td>Practice Based Learning and Improvement</td>
<td>Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
</tbody>
</table>

**Outpatient Setting:**

The PGY-1 is responsible for efficient and appropriate evaluation of every patient. The appropriate history and physical evaluation should be performed. Appropriate tests should be ordered and the proper disposition suggested. Appropriate charting should be maintained with documentation provided in the chart. In continuity clinics, appropriate charting includes preventive care, a problem list/database, and a medication list.

All PGY-1 residents must have faculty signatures on the chart for all patients. All patients must be discussed with the attending and the encounter form must be signed reviewed by the attending before the
patient leaves the clinic. Faculty must examine all patients for the first six months of training and all complex patients thereafter. Supervision should be sought immediately for seriously ill patients. All procedures must be supervised by an attending physician.

**B. Responsibilities of the Second and Third Year Resident**

<table>
<thead>
<tr>
<th>Rotation name: FMIS PGY 2</th>
<th>Rotation Goals: To learn the diagnosis and management of acute and chronic diseases of adults in the hospital setting.</th>
<th>Education Setting: Inpatient, Patient Focused Reading and Discussion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correctly and efficiently manage hospitalized patients independently and within a multidisciplinary team, within the scope of family medicine.</td>
<td>Competency: Patient Care</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Manage a broad range of medical and surgical conditions including the general areas of: Pulmonary, cardiac, endocrine, neurologic, oncologic, hematologic, gastrointestinal, infectious and renal diseases.</td>
<td>Competency: Medical Knowledge</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Incorporate cultural, psychological &amp; family dynamics into the management of the hospitalized patient.</td>
<td>Competency: Interpersonal Skills and Communication</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Give patient- and condition-specific informed consent for diagnostic and therapeutic interventions including decisions surrounding prolongation of life or termination of support where appropriate.</td>
<td>Competency: Interpersonal Skills and Communication, Medical Knowledge, Professionalism</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Give culturally appropriate support to patients and family in relation to death, dying, disability and loss.</td>
<td>Competency: Interpersonal Skills and Communication, Patient Care, Professionalism</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Define patient problems and do literature searches (as evidence-based as possible) to answer specific questions related to prognosis, therapy, diagnosis or other areas related to patient care.</td>
<td>Competency: Practice Based Learning and Improvement</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Appropriately teach and supervise medical students and residents on the inpatient service.</td>
<td>Competency: Professionalism, Interpersonal Skills and Communication</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rotation name: FMIS PGY 3</th>
<th>Rotation Goals: To learn the diagnosis and management of acute and chronic diseases of adults in the hospital setting.</th>
<th>Education Setting: Inpatient, Patient Focused Reading and Discussion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correctly and efficiently manage hospitalized patients independently and within a multidisciplinary team, within the scope of family medicine.</td>
<td>Competency: Patient Care</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Manage a broad range of medical and surgical conditions including the general areas of: Pulmonary, cardiac, endocrine, neurologic, oncologic, hematologic, gastrointestinal, infectious and renal diseases.</td>
<td>Competency: Medical Knowledge</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Incorporate cultural, psychological &amp; family dynamics into the management of the hospitalized patient.</td>
<td>Competency: Interpersonal Skills and Communication</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Give patient- and condition-specific informed consent for diagnostic and therapeutic interventions including decisions surrounding prolongation of life or termination of support where appropriate.</td>
<td>Competency: Interpersonal Skills and Communication, Medical Knowledge, Professionalism</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
<tr>
<td>Give culturally appropriate support to patients and family in relation to death, dying, disability and loss.</td>
<td>Competency: Interpersonal Skills and Communication, Patient Care, Professionalism</td>
<td>Evaluation Method: Direct Observation by Faculty and Competency Based Evaluation Form</td>
</tr>
</tbody>
</table>
Define patient problems and do literature searches (as evidence-based as possible) to answer specific questions related to prognosis, therapy, diagnosis or other areas related to patient care.

<table>
<thead>
<tr>
<th>Practice Based Learning and Improvement</th>
<th>Direct Observation by Faculty and Competency Based Evaluation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriately teach and supervise medical students and residents on the inpatient service.</td>
<td>Professionalism, Interpersonal Skills and Communication</td>
</tr>
<tr>
<td>Function as the primary supervisor of the lower level residents and medical students and will have a major teaching role</td>
<td>Interpersonal Skills and Communication</td>
</tr>
</tbody>
</table>

**Inpatient Services:**

Please refer to the rotation description on FMIS for specific PGY-2 and PGY-3 responsibilities.

**Outpatient Setting:**

All patients must be discussed with the attending before the patient leaves the clinic. Faculty must examine all complex patients and sign all charts.

All procedures must be directly supervised by an attending physician.
SPORTS MEDICINE FELLOWSHIP

As fellow in this ACGME-accredited Sports Medicine Fellowship training program, the fellow’s clinical activities are always under the supervision of program faculty. During the course of the training year, the fellow is expected to gradually transition from trainee to attending/consulting physician who is able to practice independently in the sports medicine specialty.

The sports medicine fellow is required to be Board-certified/eligible in Family Medicine, Internal Medicine or Pediatrics through completion of an ACGME-accredited primary care residency program. In recognition of having already successfully achieved specific primary care residency training, faculty supervision of clinical activities occurring with patients in the primary specialty may be less direct, at the discretion of the attending supervisory faculty physician.

The fellow will be expected to assume a supervisory and teaching role when working with medical students and medical residents. As a general rule, when students and/or residents, and the fellow are present on the same rotation, the most junior trainee is expected to have first contact with the patient, take a history, perform a physical examination and develop a care plan. The next most senior resident, or fellow, reviews the findings and examines the patient with the junior trainee. In this way, the student, resident and fellow are stimulated to develop critical thinking skills. Modifications of this plan are at the discretion of the attending faculty physician.

The fellow will be monitored regularly by the program director for stress, including mental and emotional conditions inhibiting performance or learning, and substance abuse-related dysfunction. Additionally, faculty and the fellow will be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects. The fellow must complete an on-line presentation on sleep deprivation, i.e., “SAFER.” Upon completion of this educational module, the fellow should provide evidence of completion to the PD.
INTERNAL MEDICINE (core)

SUPERVISION OF RESIDENTS

1. Qualified faculty must supervise all patient care.
2. Each patient will have an identifiable credentialed attending who is ultimately responsible for the patient’s care.
3. Timely communication between residents and faculty supervisors is essential for optimal patient care. This communication may occur in person or over the telephone or through institutionally sanctioned chart forms as is appropriate to the nature and urgency of the communication.
4. Oversight of Clinical and Educational Work Hours and the Working Environment:
   a. Clinical and educational work hours shall be monitored on a regular basis by the Program as well as by HRP.
   b. If any resident finds that they are exceeding the clinical and educational work hours or on-call restrictions, they must notify their immediate faculty supervisor as well as the program director.
   c. If residents feel they are experiencing fatigue to the degree that the safety and welfare of patients may be compromised, they must notify their immediate faculty supervisor as well as the program director, regardless of clinical and educational work hours.
   d. Residents are closely monitored for fatigue on inpatient rotations during which they are considered to be most vulnerable to fatigue. (see Fatigue Mitigation policy)
   e. Backup support systems shall be provided by the supervising faculty and/or Director of Medical Education when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances result in resident fatigue sufficient to jeopardize patient care.

RESIDENT RESPONSIBILITIES ON INPATIENT ROTATIONS (BY POST GRADUATE YEAR (PGY) - LEVEL)

LEVEL 1 RESIDENT RESPONSIBILITIES ON INPATIENT ROTATIONS:

1. Patient Care Responsibilities:
   a. Initial work up of each assigned team care patient should include interview, physical examination and personal review of pertinent admission diagnostic data such as blood smear, urinalysis, gram stain, electrocardiogram, and radiographs.
   b. Either typed or dictated, complete admission history and physical examination must be in the chart within 24 hours of admission. This admission history and physical examination must be completed independently by the Level 1 resident and should not be plagiarized from the supervising resident’s or the attending physician’s note. Level 1 residents should discuss the assessment and plan with their supervising resident or attending before dictating their admission note.
   c. A problem list must be written after the admission examination with oversight by the supervising upper level resident or attending.
   d. Admission orders must be placed immediately after the initial assessment of patients admitted to the hospital. Discharge summaries are the responsibility of the Level 1 resident.
   e. Responsibilities for discharge summaries may be allocated on a case-by-case basis by the upper level resident or Hospitalist attending. Effective teamwork should be employed.
f. Interns are also responsible for typing or dictating the transfer summaries when patients are transferred to another level of care such as skilled nursing level or to another service such as the psychiatry service on Kekela at QMC. All of these notes should be completed in a timely manner and all the off service (interim) summaries should be completed by the end of the last day of the rotation for all patients with a stay greater than 48 hours. Responsibilities for transfer summaries may be reallocated on a case-by-case basis as above.

g. Summaries must be concise, relevant and problem-oriented and should include all positive and important negative diagnostic data. The summary should reflect a clear understanding of the patient’s problems, evaluation and management. **Verbatim cutting or copying and pasting is not acceptable.** If using dictation service, every effort should be made to dictate an accurate and complete summary on first draft as this is immediately sent out to outpatient providers at QMC. (See Section below for the format for dictating a discharge summary).

2. The daily management of the patient must include:
   a. Work rounds each morning as specified in “Resident Schedule While on Inpatient Rotations.”
   b. Progress notes written daily in a problem-oriented format on all assigned patients. On patients being followed by a third-year or fourth-year/Sub-Intern medical student, the student’s note must be corroborated with an independent resident note (including a physical exam, assessment, and plan). Residents must still visit and examine patients being followed by medical students to corroborate students’ findings.
   c. AM and PM hand-over rounds conveying appropriate information about the resident’s patients to the covering resident must be conducted daily as specified in “Resident Schedule While on Inpatient Rotations”.
   d. Prompt attendance at assigned clinics, teaching rounds and conferences is mandatory.
   e. Performance of all appropriate patient care activities during assigned night, weekend and holiday periods is mandatory.
   f. Residents must be present in the assigned hospital or clinic during all scheduled hours unless excused by the associate program director, chief resident, firm advisor, or elective supervisor.
   g. Resident must assist medical students in managing assigned patients. Residents and the students should be communicating daily on the students’ assigned patients. The resident must review, amend as necessary, and countersign the student’s progress notes. One full trainee (MD) note must be completed on each acute patient each day except when the resident team has the day off.
   h. Scholarly Activity Sessions (SAS) attendance and other specifically designated conferences are mandatory except for those on-call for admissions or for patient care emergencies. Attendance at institutional conferences may also be required as long as such attendance does not interfere with patient care activities or conflict with SAS.
   i. The supervising upper level resident, the chief resident or the associate program director may assign additional responsibilities related to patient care or that enhance educational experiences.
   j. Residents must leave their pager turned on and with them at all times, except while on vacation and days off. Residents could personalize their pager greeting to indicate that they are off and who to contact regarding patient-related issues after they leave the hospital. When residents return from their day off, post call or absences due to illness they may change their pager greeting to indicate they are once again available.

**SUPERVISING RESIDENT (LEVELS 2 - 3) RESPONSIBILITIES ON INPATIENT ROTATIONS:**
1. Patient Care Responsibilities:
The resident team and the patient's attending physician SHARE RESPONSIBILITY FOR MANAGING THE PATIENT’S CARE. The supervising resident leads the resident team and is responsible for ensuring that all management decisions lead to the highest quality patient care and for communicating with the attending physician. The attending physician is responsible for supervising and teaching the members of the resident team. The associate program director, DME, chief medical resident, consulting physicians, and others will assist the attending physician as is appropriate for the specific patient.

   a. When no Level 1 resident is available (e.g., none is assigned, the Level 1 resident is ill or busy caring for other patients), the supervising resident will perform the patient care duties normally assigned to the Level 1 resident.

   b. When the Level 1 resident is available, the supervising resident will:

      o Perform a complete and independent admission patient workup which include: history, physical examination and personal review of laboratory data on each newly admitted patient on late shift or call days;

      o Place a typed brief electronic admission note in the chart before leaving the hospital within 24 hours of the patient's admission to the hospital at KMC and on long-call days when rotating through QMC. This note should include a succinct and accurate present illness, physical examination, important laboratory results, and an accurate problem list and assessment. Although this note is generally abbreviated compared to the intern's note, the supervising resident's database on each patient must be complete enough to reflect appropriate patient care. Appropriate patient care and the proper supervision and teaching of other members of the team cannot occur without a complete and accurate database.

      o Complete all death summaries that are concise, relevant and problem-oriented and include all positive and important negative diagnostic data. The summary should reflect a clear understanding of the patient's problems, evaluation and management.

          o Specific to The Queen’s Medical Center, a preliminary cause of death must be noted in the death summary.

          o Specific to Kuakini Medical Center, death summaries should include what was done for all problems as discharge summaries are done.

2. Other Supervising Resident Responsibilities:
The supervising resident has primary responsibility for the resident/student team. In this capacity, he/she is responsible for allocation and prioritization of work and for allotment of time for various activities. The supervising resident is an important role model for the junior members of the team and her/his behavior should at all times be professional and collegial, as well as supportive and nurturing. The supervising resident is primarily responsible for communication with the attending physician.

The supervising resident will:

   a. Read, correct and countersign the admission notes of all medical students (sub-interns, third year medical students).

      o KMC Specific: Upper levels will communicate with hospitals and decide who will countersign admission and progress notes.

   b. Ensure that all resident and student notes are entered in the patient record in a timely manner and meet UHIMRP requirements for appropriate documentation.

   c. Confer with other members of the teaching team and other healthcare professionals after admission
evaluations are complete. The supervising resident should serve as a leader and facilitator in these discussions. Databases should be compared and consolidated and a common problem list, assessment and plan should be agreed upon. The supervising resident is responsible for ensuring that the end product is accurate and complete and reflects the consensus of the teaching team and other healthcare professionals.

d. Communicate with the attending physician after the initial bedside meeting about subsequent care. The supervising resident is responsible for clearly articulating the team’s database, problem list, assessment and plans. She/he is then responsible for obtaining additional information and opinions from the attending physician and incorporating them into the management plan, including diagnostic, therapeutic and discharge plans, and plans for patient and family education, and discussing these plans with the attending physician; round daily with the entire resident/student team (including other healthcare professionals as appropriate and achievable.) Part of these work rounds should be conducted at the bedside. The supervising resident should validate the information (history and physical examination) obtained by the Level 1 resident and/or student in pre-rounds, review new diagnostic data, and lead the ensuing discussion leading to a revised (as appropriate) management plan. Following this, the supervising resident should solicit information and opinions from other healthcare providers, as the situation requires.

e. Communicate with each patient’s attending physician. If the patient is complicated, or if there have been significant changes in the patient's course, or the plan of care or enhanced communication is necessary for any other reason, the resident should communicate with the attending physician in person or by telephone. Prior to contacting the attending physician, the resident should form an opinion with regard to diagnosis, diagnostic and therapeutic plans concerning the specific problem(s). The purpose of the communication is to inform the attending physician of significant changes and to solicit her/his input assistance and concurrence with the plans of the resident team. The frequency of these verbal communications should be determined by the condition of the specific patient.

f. Be responsible for the accurate transmission of information at hand-over rounds and transitions of care.

g. Ensure that he/she and other team members arrive on time and be prepared for all rounds and conferences. Paramount to preparedness is the routine conducting of pre-rounds daily.

h. Notify the chief medical resident regarding closing and/or reopening of team care according to policies of the individual inpatient institutions.

i. Notify the chief medical resident, associate program director, DME, firm director or program director when she/he has questions or problems.

If the upper level resident is unavailable because of continuity clinic, illness or any other factor, the first-year resident is not responsible for those patients admitted by the upper level resident for whom the intern has not assumed responsibility. Another upper level resident, the chief medical resident or an attending physician must cover those patients. If the upper level resident has a potentially unstable patient and must leave for planned absences, e.g., continuity clinic, the resident should sign out that patient to another upper level resident.

**RESIDENT RESPONSIBILITIES FOR NON-TEAM CARE PATIENTS**

The UHIMRP policy regarding Resident Responsibilities for Non-Team Care patients applies to all inpatient teams. The following details the responsibilities of Internal Medicine residents regarding patients who are not on the teaching service (non-team care patients).
1. Code Blue: Residents will respond to all codes in accordance with their assigned duties.

2. Medical Emergencies: In the absence of a Hospitalist, nurses are instructed to call the attending physician and the resident simultaneously for help in emergency situations where immediate attention is essential. The resident should evaluate the patient, provide emergency care, and contact the attending physician who will thereafter be responsible for the patient’s care.
   a. If no such physician is available, the patient’s attending physician may personally call the resident on-call and request assistance, providing to the resident the appropriate information regarding the patient’s condition and the specific type of assistance she/he is requesting. It is not sufficient for the physician to ask the nurse to call the resident.
   b. The resident will provide the requested assistance unless doing so will interfere with clinical care which the resident is then providing to her/his own team care patients.
   c. The resident will provide only the immediate care necessary to allow for the private physician to assume care.
   d. The resident will document in the patient’s chart the request for assistance and the care that he/she provided.
   e. The resident will report each such case to the Chief Medical Resident (CMR), to insure adequate supervision and teaching and to monitor the nature and frequency of such requests.
   f. Hospitalists and in-house critical care physicians share responsibility with the residents for evaluation and care of emergently ill in-patients.
   g. Due to the rapidly expanding role of hospitalist programs at all inpatient institutions, the role of residents with regard to medical emergencies for non-team care patients will be discussed at the beginning of each inpatient rotation by the CMR.

3. In acute but non-emergency situations, nurses should call the attending physician for help with non-team care patients. Medical Team Care physicians must personally contact the resident if they want assistance. Residents should respond to that request, if at all possible. If he/she is engaged in the care of a patient who is more critically ill, the resident may decline. The resident may respectfully decline the request for help if the physician is not a Team Care physician, or if the patient is on another service (i.e., psychiatry, surgery, Ob/Gyn, pediatrics).

4. Death Pronouncements: Residents will assist with death pronouncements of non-team care patients under the following guidelines:
   a. The attending physician has Medical Team Care privileges.
   b. The attending physician personally contacts the resident and requests assistance with the death pronouncement.
   c. The attending physician provides the resident with a minimum data set, including underlying disease, anticipated or unanticipated death, and extent of family preparation for the death.
   d. The resident’s role will be limited to certification of death by the usual criteria, such as lack of pulse, heart sounds and respiration, and fixed dilated pupils.
   e. The resident will not be expected to interact with the family, other than to explain her/his role in a humane manner.
   f. The nurse will be expected to instruct the family with regard to the resident’s role prior to the arrival of the resident. The nurse will direct the family to contact the attending physician to discuss any concerns.
   g. As death pronouncement does not fall within those clinical situations which constitute medical emergencies, the resident will not interrupt his/her patient care or educational activities to attend to a death pronouncement on a non-team care patient. Such a pronouncement should be made only at an appropriate time during the residents’ schedule of activities. While this also applies to
the resident’s own patients, the resident has certain obligations to the family and loved ones of his/her own patients. The resident must use her/his judgment regarding the urgency of meeting with and consoling the family and loved ones of patients for whom he/she has had primary resident responsibility.

h. Due to the rapidly expanding role of hospitalist programs at all inpatient institutions, the role of residents with regard to death pronouncement will be discussed at the beginning of each inpatient rotation by the chief medical resident.

**RESIDENT RESPONSIBILITIES ON AMBULATORY CARE ROTATIONS**

The Queen Emma Clinic (QEC) Block Rotations:

1. Residents must report promptly for all assigned clinic activities during block rotations, continuity clinics and assigned conferences.
2. All notes must be completed within 24 business hours in accordance with the policies of the clinic and/or QMC.
3. All notes must be completed using the specified format in the Electronic Medical Record (EMR). All residents shall receive EMR training prior to commencing activities in the QEC. It is not possible for a resident to participate in patient care at QEC without full ambulatory EMR training and certification.
4. Residents are also responsible for reviewing and updating the electronic chart, including problem lists, medication lists, and past/family/social history sections.
5. Any changes in the schedule during the rotation, including absence from the clinic or limiting the number of patients scheduled, must be pre-approved by your CC Supervisor and MA/Ambulatory CMR.
6. Attendance at UH Department of Medicine Grand Rounds (when associated with SAS) and the Scholarly Activities Sessions lecture series is mandatory. Residents will receive a schedule of other mandatory conferences at the start of their QEC block and other ambulatory rotations.
7. Residents must be available by long-range pager 24 hours a day while on the QEC block rotation unless otherwise approved in advance by the Associate Medical Director.
8. Residents must complete all required assignments as outlined at the start of the rotation to receive credit for the rotation.
CARDIOVASCULAR FELLOWSHIP

OVERSIGHT OF CLINICAL EXPERIENCE AND EDUCATION AND WORKING ENVIRONMENT

1. Clinical Experience and Education shall be monitored on a regular basis by the Program as well as by the Office of the DIO. Fellows are responsible for reporting all clinical experience and education on a contemporaneous basis with reports being completed at least weekly.

2. If Fellows find that they are exceeding the clinical experience and education or on-call restrictions, they must immediately notify their faculty supervisor as well as the Program Director.

3. If Fellows feel they are experiencing fatigue or medical illness to the degree that the safety and welfare of patients may be compromised, they must immediately notify their faculty supervisor as well as the Program Director, regardless of clinical experience and education.

4. Fellows are closely monitored for fatigue on inpatient rotations which they are considered to be most vulnerable to fatigue. Backup support systems shall be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances result in Fellow fatigue sufficient to jeopardize patient care.

5. The Program Director is directly responsible for providing assignments for safe patient care in the event that a Fellow is no longer able to provide this level of care because of fatigue or medical illness.

6. As all Fellows are involved in an advanced level of training, no differences in clinical experience and education or on-call restrictions are applied between trainees at different training levels. Fellows are required to stop all clinical activity when clinical experience and education requirements of 80 hours per week or 24 hours of continuous service are exceeded. The Program Director should be contacted immediately to arrange for alternative patient care coverage.

CLINICAL RESPONSIBILITIES

The Fellows’ ability to care for patients with specific cardiovascular diseases is expected to expand throughout the length of the Program to ensure that the Fellows acquire the competency of a specialist in the field. Fellows will be responsible for the admission, management and coordination of clinical care of patients assigned to them. Inpatient Cardiology care is provided either through the Cardiology Inpatient or Consult Services. Admissions and consults will be limited to 10 new patients per day per Fellow. No Fellow will be responsible for more than 20 patients at a time. Once the Inpatient census is greater than 18 patients (1 resident) or greater than 28 patients (2 residents), the Consult Fellow should be assigned patients to follow. The Consult Fellow is responsible for presenting cases at the weekly imaging conference. Fellows will function in the acute hospital setting, performing or overseeing the performance of complete history and physical examinations, as well as all aspects of ongoing clinical care. Fellows will also perform procedures required for patient care according to Program guidelines and requirements. Fellows will interact with various members of the healthcare team, including physicians from different specialties, residents, medical students, and other medical personnel and ancillary personnel as appropriate to the multi-disciplinary care of their assigned patients.

A Cardiology Selective Internal Medicine Resident(s) and/or Advanced Practice Nurses maybe assigned to the Fellows on the Cardiology Inpatient or Consult Services. Fellows will be responsible for the oversight and
teaching of all team members. Additional clinical support may be provided by advance practice nurses. The Fellows, with direct input from the clinical faculty, will participate in the oversight of the clinical care of the Advance Practice Nurses and Internal Medicine Residents. Fellows will be expected to document or supervise the documentation of clinical care in the electronic medical records; including progress notes, consultations, procedure notes, discharge/transfer summaries and echocardiography, nuclear medicine, and Cardiac CT/MR results. Orders will be entered by the Fellows, an Internal Medicine Resident or an Advance Practice Registered Nurse (APRN) for all patients on the Teaching Services. Attending physician oversight will be provided, however direct order entry by the attending physicians will be discouraged except in emergency situations. The Fellows will be required to perform order entry using the hospital-based computer order entry system, CARELINK®.

When on a specialty service such as the Cardiac Catheterization rotation, the Fellow is responsible for rounding on service patients on a daily basis or assigning coverage to another Fellow when not physically present in the hospital. Attending physician oversight is required on a daily basis, or more frequently as needed.

SUPERVISION OF FELLOWS

To ensure oversight of Fellows’ supervision, the Program uses the ACGME-defined graded levels of supervision.

- Direct Supervision requires that the supervising physician be physically present for all interaction between the Fellow and the patient.
- Indirect Supervision with Direct Supervision Immediately Available requires 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 requires the supervising physician not necessarily be present physically within the hospital but immediately available by means of telephonic and/or electronic modalities, and available to provide supervision.
- Oversight requires that the supervising physician review and provide feedback after the delivery of care by a Fellow.

Fellows are under the direct and indirect supervision with supervision available of a faculty member during all clinical rotations. Inpatient rounds with faculty members occur daily. Faculty members are required to communicate with the Fellows at the time of admission or consultation, then on a daily basis or more frequently as appropriate. Faculty members are responsible for reviewing the Fellows’ or their designee’s history and physical examination, daily progress notes, consultation notes, discharge/transfer summaries and all interpretative studies.

Direct supervision with the physical presence of a faculty member will be required for nonprocedural patient care provided by a Fellow until documentation of clinical competency and appropriate Fellow’s handoff are signed off by the Program Director after observation of at least one Mini-CEX. If signed off by the Program Director, the Fellow may provide care with indirect supervision with direct supervision available. Assessment of cognitive competency by the Program Director will be based on the review of the Mini-CEX and input provided through faculty members. If a Fellow is documented to be clinically competent to provide cognitive
patient care by the Program Director, the Fellow will be allowed to provide admission, in-patient, out-patient and consultative care with indirect supervision with direct supervision available as defined above.

Fellows will require direct observation and supervision of procedures by a faculty member throughout an entire procedure until documentation of competency and sign-off by the Program Director. After the documentation of competency of procedures, the direct presence of faculty members will not be required UNLESS the procedure is:

- transvenous pacemaker insertion
- pericardiocentesis
- transesophageal echocardiograms
- all cardiac catheterization procedures, with the exception of bedside right heart catheterization once signed off by the Program Director
- placement of intra-aortic balloon counterpulsation catheters
- cardiac electrophysiology procedures

These procedures will require the physical presence of a faculty member. Only on an emergent basis (acute change in patient status with resuscitative efforts) with supervisor’s verbal consent, may the Fellow insert a transvenous pacemaker or perform a pericardiocentesis. There will be no other exception to this rule.

TEACHING AND SUPERVISION OF OTHER LEARNERS

The Fellows will be active teachers of residents and medical students. While on the Cardiology Inpatient Service, the Fellows will be responsible for the general oversight and supervision of the University of Hawaii Internal Medicine Residents assigned to the Service in the context of Practice-Based Learning and Improvement. PGY-2 Internal Medicine Residents are required to complete a Cardiology selective by the Internal Medicine Residency Program. A PGY-2 Resident and a PGY-1 Resident may be assigned to the Cardiac Inpatient Service at any time. By way of this process, the Cardiovascular Disease Fellowship is organized to function as an integral component of our ACGME-accredited Residency Program in Internal Medicine. On the Cardiology Inpatient Service, daily bedside rounds are used as the primary teaching tool by which Fellows supervise the Internal Medicine Residents. The Fellows are responsible for reviewing the Residents’ admission, history and physical, daily progress notes and discharge summaries, as well as directing overall clinical care under the supervision of a key clinical faculty member. The Fellows also provide additional supervision for Internal Medicine Residents in procedures for which the Fellows have been previously credentialed to perform independently. While on the Cardiology Inpatient Service, the Fellow is responsible for resident teaching at the Friday 12:30 pm conference.

There is no other specialty Fellows assigned to the Cardiology Inpatient Service. Advanced Care Nurses may be assigned to the Cardiology Inpatient or Consult Services. It is expected that other learners will not interfere with the education of the Fellows.

PROGRESSIVE RESPONSIBILITIES

The Fellows are expected to be able to care for patients with medical problems in an independent fashion, as defined by the ACGME Residency Review Committee for Internal Medicine and the American Board of Internal
Medicine. The Fellows’ scope of care for patients with specific cardiovascular diseases is expected to expand with training.

The first-year Fellow, F1 (or PGY-4 equivalent), is expected to be able to provide cognitive care through diagnostic and consultative services. Diagnoses of patients treated by the Fellows will include: heart failure, acute myocardial infarction, acute coronary syndrome, supraventricular and ventricular arrhythmias, and valvular heart disease.

In addition to cognitive diagnostic and consultative skills, the F1 Fellow is expected to develop level-specific procedural proficiency. Procedural competence will be assessed by a clinical faculty member. While documentation of procedural proficiency will be provided by the faculty member, the Program Director must verify and sign off on a competency attestation prior to allowing the Fellows to perform a procedure without direct faculty presence. The F1 Fellow is expected to be able to provide basic procedural care, including all items identified in the skills section, for basic Cardiology procedures and Echocardiography. The F1 Fellow is expected to be exposed to the performance of left heart cardiac catheterization. Independent performance of left heart cardiac catheterization is not allowed.

The second-year Fellow, F2 (or PGY-5 equivalent) is expected to be able to provide all services of the F1 Fellow and in addition, to perform basic cardiac catheterization, vascular and angiographic procedures, as well as diagnostic and electrophysiological testing, under direct supervision. Direct supervision will require the physical presence of an attending cardiologist throughout the entire performance of these procedures. F2 Fellows are expected to be able to independently provide cognitive diagnostic and management services for disease states such as: congestive heart failure, acute myocardial infarction, acute coronary syndrome, supraventricular and ventricular arrhythmias, and valvular heart disease.

The third-year Fellow, F3 (or PGY-6 equivalent) is expected to have attained the appropriate competency level to perform all the responsibilities of a F2 Fellow and additionally, should be able to perform these responsibilities with indirect supervision.

Indirect supervision will require the immediate availability, but not necessarily the physical presence, of the attending cardiologist during the conduct of the procedure(s), except during the key portions of any procedure(s) when billing is performed. The F3 Fellow is expected to have attained the level of requisite competency to demonstrate and teach a procedure to junior Fellows and Residents.
GERIATRICS FELLOWSHIP

Supervision of Fellows by Attending Physicians and Appropriate Delegation by Supervisors

Fellows are sufficiently and appropriately supervised by faculty geriatricians on all their clinical rotations and are given appropriate decision-making responsibility commensurate with their level of training. The faculty geriatricians encourage independent thinking and clinical management of patients by the fellows, and ensure that the core competencies are incorporated into the education of the fellows. They provide supervision by allowing the fellow to develop the management plan and orders, discussing patient care issues with the fellow daily and providing feedback and teaching. Fellows are expected to have seen the patients, analyzed the information and formulated a management plan prior to rounding with the faculty. Faculty geriatricians directly supervise fellows in all patient encounters and co-sign fellow notes. For new consultations, recommendations are made only after the faculty geriatrician has seen the patient with the fellow and discussed the fellow’s assessment and plan. Fellows are expected to notify the faculty about any major change in a patient’s status, transfer of level of care, medical errors, deaths, etc. guided by the principles of “SUPERB SAFETY”.

Combined teaching-management rounds are regularly conducted on all rotations. A minimum of ten hours a week are spent on these teaching-management rounds each week. The method and frequency of these rounds varies according to the clinical setting.

a. Ambulatory Clinics – patients are seen at each clinic with faculty geriatricians, who spend approximately 10 hours each week in teaching-management rounds.

b. Nursing homes – teaching-management rounds are held 3 times a week, for approximately 10-15 hours each week.

c. Hospital – teaching-management rounds are held daily Monday through Friday, for approximately 10-15 hours each week.

Lines of Responsibility at all Training Sites and Fellows’ Interaction With Other Trainees

There is only one accredited year in the fellowship program. Second and third year fellows are not involved in clinical training in a situation where they would have direct supervisory relationships with the first year fellows. However, second or third year fellows are given increasing levels of autonomy by the faculty with regards to patient care and other fellowship activities.

Fellows’ education will not be compromised by other trainees. However, fellows will be expected to collaborate with their attendings in supervising and teaching other trainees. Level 2 Internal Medicine and Family Medicine residents have a required 4-week rotation in Geriatric Medicine. Fourth year Medical students from the John A. Burns School of Medicine have a 4-week required rotation in Geriatric and Palliative Medicine. When fellows are on the same clinical rotation as medical students and residents, the fellow may be assigned the responsibility to teach and supervise either the medical student or the resident, or both. Although the fellow is always supervised by a faculty geriatrician, the fellow is encouraged to think like an “attending”, as though they actually were fully responsible for the care provided. In this way, the fellow is assisted in transitioning mentally from a trainee to an attending or consulting physician. When students and residents are present on the same rotation with the fellow, they are assigned patients to follow. The most junior trainee (student or resident) is expected to have first contact with the patient, to take a history,
perform a physical examination and to develop a care plan. Then the fellow reviews the findings and examines the patient with the junior trainee. In this way, all trainees are stimulated to develop critical thinking skills, and the fellows develop the teaching skills required as a geriatric medicine specialist.

**Patient Safety:**
Patient safety is an important goal for our Fellowship program. Fellows should be aware of the supervision policies regarding accountability to attending physicians, as well as the importance of collaborating with their attendings as they supervise and teach other trainees. They should follow the principles of “SUPERB SAFETY” for issues encountered during patient care.

Fellows are expected to identify themselves at all times as Dr. _, Geriatric Medicine Fellow. They should explain what a “Fellow” is, as many patients, families and staff do not understand the levels of medical training. The cultures of all rotations need to reinforce patient safety. If they have any concerns about patient safety at a particular rotation site, these should be discussed at the fellows’ meetings.

Safety issues discovered during clinical care can serve as topics for nursing home in-services, be discussed at our QI Conferences, or spark new QI projects that improve care and patient safety at various sites.

**Transitions in Care:**
The fellows and faculty have a system to ensure that information is not lost during changes from the weekdays to weekend and back to weekdays. We call our transitions in care system “The On-Call Curriculum.” Briefly, this system has several components:

1. **Continuity of Care.** Faculty have continuity with patients on the rotation. When faculty take vacation, the fellow assigned to the rotation does not take vacation, to ensure that continuity of care continues with the fellow working with a covering faculty attending.

2. **Effective hand-off of information.** We have developed a multi-layered sign-out system to ensure that information is not lost during transitions in care providers. This system includes:
   a. An IPASS-based electronic log to document all patient-related phone calls during the on-call period.
   b. Two forms of sign-out: The on-call fellow signs out urgent issues via telephone to the rotation fellow, and signs out all patient-related phone calls to the rotation fellow and attending via “esecure” UCERA email which is HIPAA compliant.
   c. Two-way sign-outs: The rotation fellow provides written and verbal IPASS-based sign-out to the on-call fellow before the on-call weekend; and the on-call fellow provides written and verbal IPASS-based sign-out to the rotation fellow at the end of the on-call weekend.
   d. Two-levels of sign-out: In addition to the on-call fellow’s sign-outs, the on-call faculty also provides telephone sign-out to the rotation primary attending at the end of the on-call weekend.

3. **Identification and review of on-call issues and problems.**
   a. Embedded in the IPASS sign-out sheet, is a place to indicate whether or not nursing staff utilized the SBAR (Situation, Background, Assessment, Recommendation) framework when speaking with the on-call physician. This ensures that nursing to physician communication was adequate. This is used to provide feedback to our nursing facilities.
b. Immediate identification and review of on-call problems encountered: The on-call fellow is instructed to immediately email (HIPAA-compliant e-secure email to and from UCERA email addresses only) the PD/APDs if there is a problem encountered while on-call. These emails are then forwarded to the nursing home medical director to address and eliminate such problems in the future.

c. Monthly and Quarterly review of on-call problems and errors: On-call issues and problems are reviewed monthly at the fellows’ meetings.

d. Feedback loops: While the fellows have this feedback loop to raise and address concerns about nursing home systems or staff issues during the on-call periods, the nursing homes also are able to raise and address concerns about the on-call fellows and faculty during the on-call periods. We meet monthly with the administration of KGC and our faculty are the nursing home medical directors at the majority of nursing home sites for the fellowship. This allows smooth and open communication to solve problems that come up.

**Geriatric Medicine Policy Which Defines Fellows’ Responsibility For “Non-Teaching” Patients**

Geriatric Medicine fellows are not responsible for patients not assigned to their teaching service. However, the fellows are expected to respond to calls for help in emergency situations for patients who are not assigned to the Geriatric Medicine service, as follows:

**Medical Emergencies**

If requested, fellows who are present near a medical emergency will respond where prompt intervention may prevent death, loss of function, or damage to an organ or major body part. If you are uncertain about whether or not to respond, it is always in the patient’s best interest to respond first and clarify the appropriateness of the involvement afterwards.

The process is as follows:

a. Respond to a call for help, quickly assess the situation and call for additional assistance.

b. Hospital, clinic or nursing home staff will notify the physicians responsible for the patient and the fellow will provide only the immediate care necessary to allow for the responsible physician to assume care.

c. The fellow will document in the patient’s chart the request for assistance and the care that he or she provided.

d. The fellow will report each such case to their supervising Geriatric Medicine attending physician and to the PD/APDs.

Death Pronouncements: The fellows do not assist with death pronouncements on patients that are not on the Geriatric Medicine teaching service.
ORTHOPEDIC SURGERY (core)

Faculty Responsibility for Resident Supervision and Progressive Responsibility

Although the resident rotates through different hospitals and specialty rotations, uniform principles of supervision and progressive responsibility are practiced in each setting. The assignment of progressive responsibility to residents based upon experience and demonstrated competency is the philosophical cornerstone of the Program. This assignment of progressive authority, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members. Supervision in the setting of graduate medical education has the goals of ensuring the provision of safe and effective care to patients, ensuring each Resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine, and establishing a foundation for continued professional growth. Residents should not be graduated from the training program unless deemed safe to practice independently by the Clinical Competency Committee. The Program Director must state, in writing, that the graduating Chief Resident is able to practice safely and independently in the resident’s Final Summative Evaluation.

Clinical responsibilities for each resident must be based upon level of training, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Each patient will have an identifiable, credentialed (relevant American Board of Medical Specialties Board certification or eligibility; unrestricted Hawaii State Medical License), and hospital-privileged Faculty attending physician who is ultimately responsible for that patient’s care. This information will be available to Residents, other Faculty members and health care providers (who have a need to know, specifically because they are involved in the care of a particular patient, within the framework of HIPAA), and patients. This information is available via the patient medical record, the on-call schedules, and in certain participating sites this information is placed on a sheet on the wall of a patient’s room and updated each (change in nursing) shift. Notwithstanding, Residents and Faculty attending physicians should inform each patient of their respective roles in the care of that particular patient.

Classification of Supervision

The Program uses the following classification of supervision:

**Direct Supervision** – the supervising faculty attending physician (or higher level resident credentialed to perform the procedure) is physically present with the Resident and patient.

**Indirect Supervision with direct supervision immediately available** – the supervising faculty attending physician is physically present within the hospital or other site of patient care and is immediately available to provide Direct Supervision. This supervision should be available to the resident within fifteen minutes.

**Indirect Supervision with direct supervision available** - the supervising Faculty attending physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephone and/or electronic modalities (such as email or texting) and is available to provide Direct Supervision.
Oversight - the supervising Faculty attending physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Outpatient

a) Supervision: Resident outpatient supervision is provided by one and/or two attending surgeons who are in attendance at the Queen Emma Clinic; all new cases are presented to the attending surgeons after a diagnosis and treatment plan is formulated by the resident. Additions and revisions are made as indicated after presentation to the attending surgeon. The resident conducts a timely review of all treatment plans for those patients with chronic problems and those patients being seen on a return basis. The same principles apply to other outpatient settings, as experienced on the following rotations: Tripler and Clinical Specialty rotations (Total Joint, Hand, Pediatrics, Spine, and Sports Medicine). [Direct supervision or indirect supervision with direct supervision immediately available].

b) Progressive Responsibility: The resident is given the opportunity to assume increasing responsibility in the outpatient setting by allowing him/her to diagnose and manage patients based upon accumulated experience and demonstrated competence. A first year resident is more closely supervised (direct supervision) than a fourth year resident. As experience is gained and competence is demonstrated and documented by the Program Director and the Clinical Competency Committee, the resident is given additional responsibilities in terms of the complexity of the case he/she is asked to diagnose and manage.

Inpatient

a) Supervision: Resident inpatient supervision is provided by the attending surgeon in charge of private cases and the assigned attending surgeon on clinic or team care or teaching cases. All cases are supervised by these surgeons and the residents are required to evaluate the patient, establish a working diagnosis and formulate a treatment plan which is presented to the private attending or the attending surgeon in charge of that particular case. The resident then follows his patient with the attending surgeon on a daily basis until the patient is discharged. Follow-up care is provided in the attending surgeon’s office or in the outpatient clinics. At other institutions, various outpatient clinics are involved. Attending surgeons are assigned, on a weekly basis, to cover all new inpatient and emergency admissions. In addition to the daily rounds conducted by the attending surgeon and the residents on inpatients, twice weekly rounds are held with the resident staff by selected attending surgeons. [Patients in stable condition: Indirect supervision with direct supervision available].

b) Progressive Responsibility: Each resident is given the opportunity to assume increasing responsibilities on inpatients assigned to his/her care, based upon accumulated experience and demonstrated competence. Supervision of residents is provided by appropriate faculty (credentialed, privileged and licensed) during all phases of the educational process. The supervisory role of the faculty has an inverse relationship with the experience and demonstrated abilities of the resident. The level of supervision is tailored to fit the needs of each resident within the above-described levels of supervision. This is a progressive process which eventually
culminates in the ability of the Chief Resident to function with only the required level of supervision, as mandated by the ACGME, Medicare and other government agencies.

Operative
a) **Supervision**: Supervision in surgery is provided in all instances. The level of supervision by the faculty may vary from case to case and is tailored to meet the needs of the patient and the particular resident, based upon the difficulty of the procedure and the experience and competence of the resident. [Direct supervision].

b) **Progressive Responsibility**: Progressive responsibilities are determined based upon the complexity of the case and the demonstrated competence of the resident. First and second year residents are often led through a simple or even complex operation, but as their experience and competence increase they are allowed to perform those parts of the operation in which they demonstrate competence. As their experience increases, they are often given the opportunity to perform the entire operation under appropriate supervision. It is expected that the PGY-5 resident will be capable of performing most operations with a minimal amount of supervision.

As per **Program Policy**, Faculty **MUST** (1) MARK the surgical site preoperatively in the pre-op holding area; (2) BE PHYSICALLY PRESENT in the operating room for the "time out"; and (3) BE PHYSICALLY PRESENT in the operating room or at the scrub sink in view of operating room personnel at the time the skin incision is made.

**UNDER NO CIRCUMSTANCES CAN A RESIDENT ENGAGE IN THE MARKING OF THE SURGICAL SITE, OR ANY OPERATING ROOM PROCEDURE (WHICH INCLUDES THE “TIME OUT”) WITHOUT THE ATTENDING OF RECORD PHYSICALLY PRESENT IN THE OPERATING ROOM ITSELF, OR OUT AT THE SCRUB SINK. VIOLATION OF THIS POLICY IN ANY PART WILL RESULT IN IMMEDIATE SANCTIONS, UP TO AND INCLUDING DISMISSAL; AND FOR FACULTY, LOSS OF TEAM CARE PRIVILEGES.**

**Emergency**

a) **Supervision**: During the resident’s second year, he/she is actively engaged in evaluation and management of emergency room patients. Supervision at this level of training includes the attending orthopaedic surgeon on-call to the emergency room, the full-time emergency room physicians, and the senior orthopaedic resident on-call. The level of supervision is commensurate with the PGY-2 resident’s skill, competence, experience, the complexity of the case and the severity of the patient’s condition. [Direct or indirect supervision immediately available, depending upon the severity of the problem and the resident’s experience].

b) **Progressive Responsibility**: As the resident progresses through the program and demonstrates increased experience and competence, he is allowed to assume greater responsibility in terms of the care of emergency room patients. It is assumed that this process will lead to a senior resident who is capable of making appropriate and correct diagnoses and who can successfully manage all types of orthopaedic cases in the emergency room setting.

**PGY-1 Specific Supervision Requirements**

1. Indirect supervision is allowed for:
   i. **Patient Management Competencies**
      a. Evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
      b. Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
c. Evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
d. Transfer of patients between hospital units or hospitals
e. Discharge of patients from the hospital
f. Interpretation of laboratory results

ii. Procedural Competencies
a. Performance of basic venous access procedures, including establishing intravenous access
b. Placement and removal of nasogastric tubes and Foley catheters
c. Arterial puncture for blood gases

2. Direct supervision is required until competency is demonstrated for:
   i. Patient Management Competencies
a. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consolations (current ATLS certification required) evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria
b. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
c. Management of patients in cardiac or respiratory arrest (current ACLS certification required)

   ii. Procedural Competencies
a. Carry-out advanced vascular access procedures, including arterial cannulation, central venous catheterization, temporary dialysis access
b. Repair of surgical incisions of the skin and soft tissues
c. Repair of lacerations of the skin and soft tissues
d. Excision of lesions of the skin and subcutaneous tissues
e. Tube thoracostomy
f. Paracentesis
g. Endotracheal intubation
h. Beside debridement

Circumstances in Which Residents Must Communicate with Supervising Faculty Attending Physicians

Regardless of level of training, Residents must communicate with the appropriate Faculty attending physician immediately whenever the following events or circumstances occur:

a. Any multiple-trauma patient with orthopedic injuries
b. Any acute spinal fractures and spinal cord injuries
c. Any peri-prosthetic infection or peri-prosthetic fracture
d. Any unreducible joint dislocation, open fractures or compartment syndrome
e. Any neurovascular postoperative complications or any dysvascular limb in a trauma patient
f. In general, if there is any substantive change in a patient’s clinical status, such as post-operative complications, any change in neurologic status, cardiac or pulmonary decompensation, acute renal
insufficiency

g. Any death 
h. A patient is transferred to a higher level of care, such as a telemetry unit, or intensive care unit (monitored beds) 
i. Any discussions that involve changes in resuscitation or end of life decisions initiated by a patient, their family, or other health care providers 
j. Falls with associated traumatic injury

If the Faculty attending physician cannot be reached for any reason, and a significant urgent/emergent event is occurring (or has occurred) in an already hospitalized patient, the Resident should contact the most senior level Resident assigned to the rotation, in addition to the Hospitalist on-call; then the Institutional Site Coordinator at the participating site or the Program Director should be contacted. If at The Queen’s Medical Center, the Surgical Officer of the Day should be contacted via the Telecommunications Operator, while on-going attempts are being made to contact the Faculty attending physician.

Residents and supervising faculty should be familiar with The Queen’s Medical Center Chain of Command document and the Rapid Response Team Policy; both documents are in the appendix area of the Orthopaedic Residency Program Curriculum Guide.
OBSTETRICS AND GYNECOLOGY (core)

RESIDENT SUPERVISION
The John A. Burns School of Medicine (JABSOM), as the Sponsoring Institution, follows ACGME Institutional Requirements and ensures that its ACGME-accredited programs are in substantial compliance with the Intuitional, Common and Specialty-Specific Program Requirements and the ACGME Policies and Procedures.

The Ob/Gyn Residency Program conforms to the GME Policy on Supervision located on the JABSOM website at http://jabsom.hawaii.edu/ed-programs/gme/gme-policies/.

If there is any discrepancy between the GME policy and the Ob/Gyn Program policy, the GME policy will supersede the Ob/Gyn Program policy.

1. Faculty are ultimately responsible for the clinical care given to patients. Supervision of trainees may be provided by a combination of upper level residents, fellows and faculty.
2. Levels of supervision are included in the resident Rotation Goals and Objectives by level and by rotation.
3. To ensure oversight of resident supervision and graded authority and responsibility, the program follows the ACGME classification of supervision:
   a. Direct Supervision: the supervising physician is physically present with the resident and patient
   b. 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
      ▪ 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
   c. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

POLICY ON DETERMINATION OF PROGRESSIVE AUTHORITY AND RESPONSIBILITY

CONDITIONAL INDEPENDENCE

1. Rotation goals and objectives are defined for each rotation by level and delineate progressive clinical responsibilities with the appropriate progressive increase in knowledge base.
2. Course Directors and faculty ensure each resident is achieving these goals while on each rotation.
3. Evaluations and skills cards by level and selectively by rotation help monitor appropriate progress.
4. Delineation of Resident Physician Privileges for special procedures (e.g. wet mount: normal saline and KOH preparation for ID fungi, labor induction, wet smear evaluation: fern testing, amniotomy, fetal scalp electrode placement, non-stress test, ultrasound-limited ob) are determined within the first several weeks of residency.
5. The Program Director reviews the procedure experience of all residents monthly to ensure adequate clinical training opportunities are available for each resident.
6. The Program Director reviews skills cards and evaluations during mid- and end-year evaluation sessions to ensure each resident is meeting expectations.
7. Select Chief resident certification forms determine a resident’s knowledge and proficiency to scrub with a faculty attending in the room but not directly supervising the case.

**POLICY DEFINING CLINICAL CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT**

As approved by the UH Ob/Gyn Resident Education Committee - February 10, 2017.

The below protocol defines common circumstances requiring University of Hawaii attending faculty involvement. Residents **MUST communicate with the appropriate supervising faculty in the below circumstances including but not limited to the following:**

1. Escalation of Care - any urgent patient situation which includes:
   a. Patient death
   b. Any time there is deterioration in patient’s medical condition
   c. Patient is in need of invasive operative procedures
   d. Instances where patient’s code status is in question
   e. Faculty intervention is needed
   f. Any change in level of care (e.g. upgrade to ICU status, downgrade to floor status, etc.)
   g. A patient’s condition changes requiring Rapid Response Team activation
   h. Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification: It is expected that the resident will notify the attending as soon as possible after an incident has occurred. If despite the best efforts, the resident cannot reach the assigned attending or designated alternate, then they should refer to the chain of command and notify the next in line (e.g. the program director, medical director of the service or the chair of the department) for guidance. In cases in which the resident is unable to notify the attending, the resident is allowed to provide appropriate and urgent care to the patient.

**NOTE:** Any member of the team should feel comfortable to contact the attending of record at any time for questions of clinical management.

*The policy protocol works in concert with the Levels of Faculty Supervision as defined in the Resident Rotation Goals and Objectives.*

**POLICY ON TRANSITIONS OF CARE**

The Accreditation Council for Graduate Medical Education (ACGME) mandates that “sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.”

To accomplish this, transfers of care are handled in the below manner by departmental faculty and residents:

1. Sign outs are held in a setting away from the L&D floor
2. Attending of the week faculty and residents attend the Sign out session
3. Sign out participants utilize the standardized “Dear Doctor” EPIC electronic form developed by the Ob/Gyn faculty and residents

**POLICY ON L&D TRIAGE OVERFLOW**
Backup System when Clinical Care Needs exceed Resident’s ability

Effective March 1, 2012, the following policy will be in effect to ensure that patient care is not compromised when clinical care needs exceed the Ob/Gyn resident team ability:

1. UH A should be aware of the “flow” on L&D. Residents should keep UH A updated but RN’s can also alert UH A if things are getting hectic.
2. RN’s always informs R2/R3 about triage pt. R2/R3 should assess situation briefly and give RN an ETA to see pt.
3. If no one comes to see pt within that ETA, then the RN can make a decision (based on acuity) to call the pt’s attending to present pt and get orders or if RN feels acuity demands a more timely assessment she can call private attending and UH attending.
4. If the ETA that the resident gives is not acceptable to the RN based on acuity, she should then call the pt attending to see what they want done immediately (and possible involve the UH A concurrently as she is trying to contact the private attending).
5. Option #1: Attending comes into evaluate pt.
   Option #2: Attending can ask RN to have the UH A/B perform some task (FFN, cultures, VE, SSE, bedside scan) and maintain control of pt.
6. If pt is routine, then attending can discharge pt from triage (r/o PTL, UTI, etc.) with orders.
7. If pt is higher risk, then pt will need an evaluation by the resident when free, attending can come in and evaluate personally or attending can transfer care to the UH A to manage (and probable d/c).
8. Option #3: Attending can transfer care to the UH A to eval and management for this admit.
9. Future Plans - Acuity needs to be assessed more objectively but we don’t have a DEFCON system right now, so the treatment team (which includes the RN and doc) needs to determine this based on their best clinical judgment.
10. Chief pts: Chiefs serve as attending (but always supervised by UHP attending)
11. UHP pts: UH A serve as attending
FAMILY PLANNING FELLOWSHIP

Clinical Supervision
There must be adequate patient volume and diversity to train the approved total fellow positions. The clinical experience of inpatient and outpatient care must include a sufficient number and variety of cases to fulfill the educational objectives of the Guide to Learning. Outpatient experience is particularly important and must be carefully organized and closely supervised by the clinical faculty. The fellow must achieve competency in performing all appropriate diagnostic and therapeutic procedures relevant to the clinical practice of the subspecialty. During the course of the educational program, the fellow should be supervised in all clinical activities, including surgical procedures. The fellow must be able to demonstrate basic knowledge and experience sufficient to perform and/or interpret the following procedures:

1. Medical abortion;
2. First-trimester vacuum aspiration, both manual and electric;
3. Second-trimester abortion by both medical induction and dilation and evacuation;
4. Treatment of complications of abortion at all stages of gestation;
5. Methods to confirm uterine and tubal pregnancy including: physical examination, ultrasound and hormonal parameters;
6. Ultrasonography for diagnosis of tubal pregnancy, uterine sizing, intraoperative guidance, diagnosis of uterine perforation and assessment of abnormality of placentation;
7. Anesthesia and pain control, including paracervical block and conscious sedation;
8. Gross and histologic examination of tissue;
9. IUD insertion and retrieval;
10. Insertion and removal of contraceptive implants;
11. All hormonal and barrier methods of family planning;
12. Female sterilization.

FLOW CHART FOR FELLOW CONCERNS
Flow charts depicting the lines of supervision for Family Planning Fellows. If a fellow has a concern or complaint during their fellowship, they can use this diagram to seek resolution.

There are two generalists UH Faculty on site at all times at Kap‘iolani Medical Center. In an emergency, the fellow can seek consultation with these faculty members. Fellows can also take concerns directly to the Fellowship National Office.
MATERNAL-FETAL MEDICINE FELLOWSHIP

POLICY DEFINING CLINICAL CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

As approved by the UH Ob/Gyn Resident Education Committee – February 10, 2017.

The below protocol defines common circumstances requiring University of Hawaii attending faculty involvement. Fellows MUST communicate with the appropriate supervising faculty in the below circumstances including but not limited to the following:

1. Escalation of Care: Any urgent patient situation, which includes:
   a. Patient death
   b. Any time there is deterioration in patient’s medical condition
   c. Patient is in need of invasive operative procedures
   d. Instances where patient’s code status is in question
   e. Faculty intervention is needed
   f. Any change in level of care (e.g. upgrade to ICU status, downgrade to floor status, etc.)
   g. A patient’s condition changes requiring Rapid Response Team activation
   h. Any other clinical concern whereby the fellow feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification: It is expected that the fellow will notify the attending as soon as possible after an incident has occurred. If despite the best efforts, the fellow cannot reach the assigned attending or designated alternate, then they should refer to the chain of command and notify the next in line (e.g. the program director, medical director of the service or the chair of the department) for guidance. In cases in which the fellow is unable to notify the attending, the fellow is allowed to provide appropriate and urgent care to the patient.

NOTE: Any member of the team should feel comfortable to contact the attending of record at any time for questions of clinical management.

The policy protocol works in concert with the Levels of Faculty Supervision as defined in the Fellow Rotation Goals and Objectives.

POLICY ON DETERMINATION OF PROGRESSIVE AUTHORITY AND RESPONSIBILITY

CONDITIONAL INDEPENDENCE

1. Rotation goals and objectives are defined for each rotation by level and delineate progressive clinical responsibilities with the appropriate progressive increase in knowledge base.
2. Course Directors and faculty ensure each fellow is achieving these goals while on each rotation.
3. Evaluations by level and by rotation help monitor appropriate progress.
4. The Program Director reviews the procedure experience of all fellows quarterly to ensure adequate clinical training opportunities are available for each fellow.
5. The Program Director reviews evaluations during mid- and end-year evaluation sessions to ensure each fellow is meeting expectations.
6. As fellows are ABOG certified or eligible with Medical Staff privileges for general Ob/Gyn practice, activities for which they have OB privileges do not require Maternal-Fetal Medicine (MFM) faculty supervision, such as vaginal delivery.
   a. At the Queen’s Medical Center, fellows do not have Medical Staff privileges for general Ob/Gyn thus all activities will be considered fellow level learning and requires direct or indirect supervision.
   b. At the Kapiolani Medical Center for Women and Children, fellows will be supervised (direct or indirect) for fellow level learning activities.

FELLOW SUPERVISION

The John A. Burns School of Medicine (JABSOM), as the Sponsoring Institution, follows ACGME Institutional Requirements and ensures that its ACGME-accredited programs are in substantial compliance with the Institutional, Common and specialty-specific Program Requirements and the ACGME Policies and Procedures.

The Maternal-Fetal Medicine (MFM) Fellowship Program conforms to the GME Policy on Supervision located on the JABSOM website at http://jabsom.hawaii.edu/ed-programs/gme/gme-policies/.

If there is any discrepancy between the GME policy and the (MFM) fellowship policy, the GME policy will supersede the MFM fellowship program policy.

1. Faculty are ultimately responsible for the clinical care given to patients. Supervision of trainees may be provided by a combination of upper level fellows and faculty.
2. Levels of supervision are included in the fellow Rotation Goals and Objectives level and by rotation.
3. To ensure oversight of fellow supervision and graded authority and responsibility, the program follows the ACGME classification of supervision – same as the OB/GYN Residency Program.

POLICY ON TRANSITIONS OF CARE

The Accreditation Council for Graduate Medical Education (ACGME) mandates that “sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.”

To accomplish this, transfers of care are handled in the below manner by departmental faculty and fellows:

- Sign out is direct verbal communication from fellow to attending.
PATHOLOGY (core)

Progressive Responsibility and Supervision
Residents begin the program as novices, and, after four years of pathology residency training, are expected to graduate as competent pathologists with the ability to practice independently. As residents gain knowledge, skills and experience, they are given progressive responsibility with decreasing levels of supervision, moving from direct supervision to indirect supervision and oversight.

| DIRECT SUPERVISION - Per ACGME: The supervising physician is physically present with the resident and patient. |
|---|---|
| **Anatomic Pathology** | **Clinical Pathology** |
| PGY 1 residents must perform and document the requisite 3 procedures for each of the following categories before moving to Indirect Supervision: | Beginning PGY 1 residents must have Direct Supervision: |
| • autopsy prossection, | • during sign out of interpretative tests results, |
| • frozen section specimen processing, and | • when providing consultative services to clinicians, |
| • surgical pathology grossing by organ system | clinical personnel or laboratory staff. |
| PGY 1, 2, 3 & 4 residents must have Direct Supervision when performing the following: | PGY 1, 2, 3 & 4 residents performing certain critical clinical calls always require Direct Supervision or Indirect A Supervision, including a number of specific transfusion medicine calls (e.g. approval of Novoseven transfusion, acute hemolytic transfusion reactions, blood shortage, etc). These will be discussed with the resident at the start of the rotation. |
| • Frozen Section Microscopic Diagnosis | |
| • FNA & CNB Procedure and | |
| • FNA & CNB immediate reading. | |

| INDIRECT SUPERVISION A - Per ACGME: 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. |
|---|---|
| **Anatomic Pathology** | **Clinical Pathology** |
| 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. | The resident provides interpretations or recommendations directly to clinicians, clinical personnel or laboratory staff, only after consulting the supervising pathologist, either in person or over the phone. |

| INDIRECT SUPERVISION B - Per ACGME: With direct supervision available, the supervising physician is not physically present within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. |
|---|---|
| **Anatomic Pathology** | **Clinical Pathology** |
| 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 resident provides interpretations or recommendations directly to clinicians, clinical personnel or laboratory staff, followed by immediate notification to the supervising pathologist, either in person or over the phone. |

| OVERSIGHT - Per ACGME: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. |
|---|---|
| **Anatomic Pathology** | **Clinical Pathology** |
| The supervising physician is available to provide review of procedures/encounters with feedback after care is delivered. | The resident provides interpretations or recommendations directly to clinicians, clinical personnel or laboratory staff, and reviews cases with the supervising pathologist after care has been provided or the next day. |
PEDIATRICS (core)

RESIDENT SUPERVISION

The Pediatric Chief Resident, Pediatric Program Director, and the Hospital Chief of Staff are available 24 hours per day for issues or problems having to do with patient care concerns related to resident involvement. The Pediatric Hospitalists, PICU, ED, and NICU provide 24 hour per day in-hospital attending coverage and are available to provide consultation to residents regarding patient-related issues.

As employees of the Hawaii Residency Programs, Inc., and as a physician in training, residents in the Program provide patient care at all times under the supervision of teaching faculty and/or the patient’s attending physician. Although residents must be supervised by teaching staff in a way that will allow them to assume progressively increasing responsibility for patient care according to their level of training, their ability, and their experience, the faculty and/or attending physician is ultimately the final arbitrator and responsible agent for patient care. As such, the attending must be informed and involved in all substantive status changes or care decisions. The specific degree of responsibility accorded to each resident must be determined by the teaching staff/attending in consultation with the resident and the program. The faculty is committed to simultaneously providing outstanding patient care as well as developing the eventual entrustment of care to the resident as appropriate. Ability to supervise will be determined by the faculty and the program.

A. The following describe the Supervisory Lines of Responsibility for Patient Care in the Program:

Inpatient Wards
Private Patient: PGY-1 → PGY-2/PGY-3 → Private Attending → Chief of Staff (Dr. Loren Yamamoto)
Staff Patient: PGY-1 → PGY-2/PGY-3 → Hospitalist Attending → Hospitalist Division Head (Dr. Jessica Kosut)

Pediatric Chief Resident, Program Director, and Pediatric Attending Hospitalists, NICU, PICU or ED Attendings are also available 24 hours a day for patient care concerns related to resident involvement.

If no PGY-2 or PGY-3 is available for supervision, attendings that are not in-house 24hrs/day must come to the hospital to supervise interns in the initial management of their patients unless arrangement has been made between the Attending Hospitalist and the primary care physician.

Neonatal Services: PGY-1/PGY-2/PGY-3 → Neonatal Fellow/Attending → Division Head (Dr. Charles Neal)
Pediatric ICU: PGY-2/PGY-3 → Pediatric ICU Attending → Division Head (Dr. Rupert Chang)
Pediatric Emergency Department: PGY-1/PGY-2/PGY-3 → Attending → Division Head (Dr. Paul Eakin)
Clinics/Elective Experiences: PGY-1/PGY-2/PGY-3 → Faculty Attending → Division Head (Dr. Gina French)

B. Supervision of Residents

From the ACGME Program Requirements for Pediatrics July 2017:
The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident’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. (Core) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

The supervising attending, through direct observation and with input from the team of educators (senior residents, nurses, etc.) will promote graded autonomy (as deemed appropriate for each individual resident and with regards to patient safety) from the most junior level (i.e. requiring the most oversight) to the level of the graduating senior (i.e. can function without any oversight). The different types of supervision are listed below:

Types of Clinical Oversight from The Pediatric Milestone Project (ABP/ACGME 2012)
Clinical oversight has been described in terms of the following levels of supervision: routine, responsive, direct care, and back stage. The type of oversight is context specific; each trainee may need differing types of supervision based on prior experience and the current clinical situation.

a. **Routine Oversight** - Routine oversight is supervision that is planned in advance, such as rounds or precepting in clinic, where the expectation from the beginning is that every case is reviewed. This type of oversight involves discussion, probing, confirmation, and refinement. In essence, these activities can be encompassed under the broad heading of monitoring.

b. **Responsive Oversight** - Responsive oversight goes beyond the routine and involves an escalation in intensity based on the needs of the patient, the trainee, or the supervisor. “Situation-specific triggers for responsive oversight involve 3 main categories: 1) clinical cues, 2) information from a secondary source, and 3) language discrepancies/inconsistencies in clinical information.” Examples of these categories include, respectively, 1) a presentation about an infant in which “lethargic” is used to describe the general appearance of the infant that the learner assesses as having an upper respiratory infection; 2) the nurse’s triage note differs from the story that the resident is presenting; and 3) the CBC demonstrates a significant left shift in a child with a fever who the trainee describes as fine and plans to send home from the ED without further work-up or follow-up. Prior experience with a trainee can also stimulate responsive oversight, such as when past encounters have demonstrated trainee-specific red flags (e.g., inaccuracies in physical examination).

c. **Direct Care** - When a supervisor feels the need to go beyond responsive oversight, he becomes involved in direct patient care. The latter may be limited to a specific aspect of care or taking over care based on concerns regarding a trainee’s competence. An example is precepting in clinic when the trainee’s recounting of the history and physical examination does not make sense and upon going back
into the room, the supervisor encounters a very sick patient and immediately takes over care based on the trainee’s lack of recognition of illness severity.

d. **Backstage Supervision** - Backstage supervision, unlike the types of clinical oversight described previously, involves checking that is not transparent to the learner. An example is the supervisor who reviews the laboratory values on a patient before coming to rounds, although he knows that these values will be presented during the case discussion.

e. **Retrospective Supervision** - This type of supervision is exercised as a stopgap measure to ensure that elements of prospective supervision did not fail. Retrospective supervision is most appropriate for learners for whom supervision from a distance is warranted. An example of this type of supervision is when a faculty member reviews charts from the prior day’s clinic visits, ensures that documented care is appropriate, and gives either written or verbal feedback to the resident, allowing patient safety and learner professional development to be optimized.

For the supervisor, patient safety, direct observation of a trainee’s skills, prior experience with and knowledge of the trainee’s limits, perceived level of complexity of the task, feedback from others who have worked with the trainee, and the local clinical environment have all been described as playing a role in his ability to grant increasing independence. Trainee confidence and self-efficacy, as well as supervisor “audacity,” were also a part of the supervisor’s decision to provide less intense clinical oversight. The qualitative study by Kennedy et.al. of how supervisors determine the intensity of the oversight provided found that four dimensions are influential: knowledge and skill, discernment (ability to identify limits), conscientiousness, and truthfulness. These four dimensions formed the basis for what they termed “trustworthiness.” (See the milestone on trustworthiness for a detailed explanation).

**RESIDENTS AS SUPERVISORS** - From the ACGME Program Requirements for Pediatrics July 2017:

*The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)*

- **a.** The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. (Core)
- **b.** Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)
- **c.** Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

Supervising attendings, through direct observation and with input from the team of educators as well as from patient families, continually assesses whether residents have the skills required to supervise medical students and junior residents. While these are qualities that are best demonstrated on rotations with resident supervisory roles, the qualities deemed important for a supervisory readiness can be demonstrated in any rotational experience as they are core qualities for successful pediatricians.

The UHPRP end of rotation evaluations are based in the RIME model which allows supervising attendings to comment on a resident’s competence in demonstrating abilities as a **Reporter** (Interviewing Skills, Physical Examination Skills, Written Documentation, Oral Case Presentations), an **Interpreter** (Problem Prioritization, Differential Diagnosis Formation, Processing Clinical Data), a **Manager** (Caring for Individual Patients and/or a Medical Team, Formulating Diagnostic & Therapeutic Plans, Demonstrating Risk/Benefit Decision Making, Incorporating Patient Values into Medical Plan) and an **Educator** (Self-Directed Learning Skills, Positive
Response to Feedback, Critical Reading Skills, Teaching Skills). The Clinical Competency Committee and the UHPRP Program Leadership carefully consider a resident’s performance across the RIME and support advancement of the resident as a supervisor at an appropriate pace following resident demonstration of appropriate Interpreter and Managerial skills.
NEONATAL-PERINATAL FELLOWSHIP

Levels of Supervision

- **Level 1 - Direct**: supervising staff is physically present with the fellow and patient/family.
- **Level 2 - Indirect with immediate supervision available**: supervising staff is within the hospital and is immediately available to provide direct supervision.
- **Level 3 (TAMC Call Shifts) - Indirect with supervision available**: supervising staff is not present in the hospital but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision within a reasonable time frame.
- **Level 4 - Oversight**: supervising staff is available to provide review of procedures and encounters and feedback is provided after care is delivered.

Fellows will receive Level 1 supervision for all skills until the CCC considers them competent to perform the skill under Level 2 (or higher) supervision.
PSYCHIATRY, GENERAL (core)

SUPERVISION POLICY AND PROCEDURE

A. Goals of Supervision

The primary purpose of supervision is to provide sufficient assistance and practical advice for the resident to perform adequate clinical care and to develop therapeutic skills. This may include helping the resident organize the clinical material, validate the diagnosis, clarify the dynamics of the case, and receive guidance in bio-psycho-social treatment for the particular case under supervision.

The second purpose is to provide support to the resident, to assist the resident in increasing self-awareness and ego capacities so that the resident will feel secure and confident in helping his/her patients.

In contrast to the seminars, conferences, or other forms of teaching activities, supervision should provide a laboratory for improving clinical technique. This may be carried out by providing a demonstration of an interview by the supervisor, or reviewing of a videotape or audiotape of the resident's interview, or direct observation of the interview process carried out by the resident with his/her patient so that he/she will have the opportunity to learn how to improve his/her clinical skills.

B. Levels of Supervision

The ACGME has defined three levels of supervision for PGY-I residents as follows:

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

2. 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.

3. 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.

At the beginning of residency, each PGY-I must have direct supervision. A PGY-I may progress to being supervised indirectly only after demonstrating competence in:

- The ability and willingness to ask for help when indicated
- Gathering an appropriate history
- The ability to perform an emergent psychiatric assessment
- Presenting patient findings and data accurately to a supervisor who has not seen the patient
The PGY-I Supervision Level Assessment Form (SLAF) (Addendum B) will document the PGY-I level of competence in the areas described above. The assessment will be based on direct observation by the faculty supervisor.

PGY-II and PGY-III residents are considered to be at an intermediate level. PGY-IV residents are considered to be in the final years of education.

The ACGME permits PGY-II and PGY-III residents in psychiatry to supervise PGY-I residents provided the following requirements are met:

- Both the junior resident and supervising resident should inform patients of their respective roles in that patient’s care; and
- Assignment is based on the needs of each patient and the skills (demonstrated competency in the medical expertise and supervisory capability) of the individual supervising resident.

In addition, an attending physician must always be available to provide back-up supervision, which may be by phone. Other non-physician, licensed, independent practitioners designated by the Program Director may supervise residents. An attending physician must be available to provide back-up supervision as appropriate and as needed.

C. Structured Clinical Observation (SCO)

Purpose:
To assess readiness of psychiatry residents, particularly interns, to start independent overnight calls.

Process:
To make this process consistent and clear, attendings and upper level residents complete a brief feedback form (structured clinical observation or SCO) (Addendum C). Copies of these forms will also be available in the psychiatry ER area.

SCO assesses performance in three key areas: HISTORY, PRESENTATION, and ER MANAGEMENT. HISTORY and PRESENTATION pertain to a specific patient encounter, while ER MANAGEMENT refers to observation of resident’s performance within a specific time (over few hours during a shift, for example). While the HISTORY and ER MANAGEMENT assessment can only be completed by direct observation, the PRESENTATION assessment can be done either by direct observation or via phone.

Each SCO does not have to be filled out completely, as only columns that are pertinent to the evaluation context would need to be completed. For example, an attending assessing a presentation over the phone can complete the PRESENTATION column only. On the other hand, an attending or upper level resident directly observing the resident can complete all areas of assessment. In all cases, we would like at least a brief feedback conversation between the evaluator and the resident being evaluated, immediately after each SCO is completed.

Expectation:
Interns must submit at least 3 SCOs from direct observation (by an attending or upper level resident) and 3 SCOs from phone presentation (with an attending). Once the required number of SCOs is met, additional SCOs are not needed unless the resident desires further feedback using SCOs. Submitted SCOs will be reviewed by the DMEPCS of psychiatry emergency service or his/her designee. If additional supervision/feedback is required, the intern will be notified.

Residents can obtain multiple SCOs within the same shift and should inform the upper level resident or attending when an SCO evaluation is requested. If on-call attendings are not able to perform direct observation, they can complete the SCO immediately after the phone presentation and submit them to the DMEPCS the next day.

Please note that the SCO form can also be used as an instrument to facilitate or document resident feedback in any other psych ER-related setting.

D. Night Float Supervision

Night float weekdays will have a two-resident team involving one intern and one upper level resident. There will be an attending on overnight that will provide supervision by phone. The following guidelines for patient care provided by the intern are as follows:

- All patients seen by the intern will also be seen by the upper level resident.
- The patient’s case will be presented by the intern to the upper level resident prior to presentation to the attending physician.
- The intern will complete documentation, admission orders and/or disposition for the remainder of the patient’s case with as needed assistance from the upper level resident.
- The intern and upper level resident team will discuss all cross coverage calls for training purposes and to assure proper patient care is delivered.
- Initially, interns will not be expected to see patients without direct supervision by the upper level resident; however, once the intern has demonstrated competence they will gradually increase their role and independence.
- Residents will not be allowed to take vacation during night float and a jeopardy system will be utilized for coverage of the upper level resident should they get sick.
- Weekend call shifts (Saturday night and Sunday night, 8p-8a) will only have an upper level resident, who will be indirectly supervised by an attending who is available by phone.

The goal of supervision by the upper level resident is to prepare the intern physician for shifts alone overnight while providing standard of care. Additional benefits include the beginning of a team based approach during the night shifts allowing for improved patient care and a mentorship system among the various levels of training.

The idea will be for the upper level resident to provide supervision and teaching in regards to cross coverage on inpatient units, cross coverage for CL service and urgent CL consults, brief evaluation of patients being transferred from other facilities to the inpatient unit at night, and evaluation of all psychiatric consults in the ED.
This system will be one of working as a team to triage and divide tasks in a way that provides for optimum patient care, teaching and appropriate level of independence. As is currently, the upper level residents will be expected to see every patient that the intern evaluates.

E. **Assignment and Matching of Supervisors**

Supervisors are assigned to the residents by the Program Director.

It is an important consideration to have supervisors with different styles in clinical approach so that the resident will have a balanced opportunity to learn different models of treatment.

- **Individual Psychotherapy Supervisors:**
  Each resident is assigned a psychotherapy supervisor. The resident is expected to contact their psychotherapy supervisor and schedule regular weekly meetings to review the resident’s psychotherapy cases. Each psychotherapy supervisor will be asked to complete a semi-annual evaluation on the resident’s psychotherapy skills.

- **Individual Career Advisors:**
  Each resident is assigned a career advisor. The resident is expected to contact their advisor and schedule regular meetings (monthly meetings are recommended) to assist the resident with areas outside of clinical care, such as career planning, training issues, or personal concerns. The advisor can serve as the resident’s advocate and not as an outside clinical supervisor.

F. **Commitment for Supervision**

Every faculty member agreeing to the supervisory role is expected to set aside at least one hour per week throughout the period of supervision to meet with the resident.

It is the mutual responsibility of the supervisor and resident to meet regularly. If for any reason supervision cannot be carried out, the Program Director should be informed for re-assignment.

G. **Site Supervision**

Please refer to the descriptions of the specific training sites. In general, residents should expect faculty who serve as site supervisors to:

- Be readily reachable and available during work hours and assigned after-hours shifts.
- Role model compassionate, appropriate, and effective patient care; effective interpersonal and communication skills; and professional behavior.
- Role model best practices in contemporary psychiatry, including psychotherapy and psychopharmacotherapy.
- Role model systems-based practice, including effective collaboration with other disciplines and professionals and attention to administrative requirements of patient care.
- Provide supervision on interviewing skills, bio-psycho-socio-cultural formulation, and diagnosis per DSM-5 terminology.
- On inpatient, emergency room and consultation/liaison rotations: conduct regular rounds with all residents and (if applicable) students; systematically review the care of residents’ patients.
On outpatient rotations: systematically review and discuss the care of all patients seen by the residents, and conduct regularly weekly supervision that covers broader psychotherapeutic and psychopharmacotherapeutic issues that arise during outpatient care.
CHILD & ADOLESCENT PSYCHIATRY FELLOWSHIP

SUPERVISION

1. 

   **Goals** – Supervision aims to facilitate fellows’ learning and allows in-depth monitoring of fellows’ progress in achieving the competency-based learning objectives.

2. 

   **Structure** – The Program Director is responsible for assigning Career and Patient Care Supervisors and is responsible for the quality and variety of supervision. Site Coordinators are responsible for assigning Clinical and Administrative Supervisors for fellows on rotation at their sites.

   a. The **Career Supervisor** is assigned for the duration of training and plays a major role in mentoring the fellow’s development as a Child & Adolescent psychiatrist. The Career Supervisor provides guidance with academic and administrative matters over time, including when performance deficits or interpersonal conflicts (with supervisors, other faculty, staff, and peers) occur.

      **Supervisory Goals Include:**

      - Recognizing areas of strength, facilitating further career development in research, teaching, administration, public psychiatry, or sub-specialization (e.g. addiction, forensic, consult-liaison, etc.).
      - Promotion of self-reflection and self-assessment skills.
      - Instilling professional values.
      - Advising the fellow on academic matters.
      - Helping to shape post-residency plans.
      - Collaborating with the Program Director and Evaluation Committee in developing a remediation plan, if necessary.
      - Counseling the fellow and/or referring for further care should there be any stressors that affect performance.
      - Helping the fellow to identify potential areas of research and appropriate research mentors in that field.

   b. **Site Coordinators** have overall responsibility for clinical, educational and administrative supervision of the fellows at their site. They may cover those responsibilities personally or delegate them to other faculty. Site Coordinators assign fellows a minimum of one **Clinical Supervisor** during the rotation. See page 9 for a listing of Site Coordinators.

   c. **Psychotherapy Supervisors:** Fellows will be assigned child and adolescent psychiatry psychotherapy supervisors. A psychotherapy supervisor will be assigned for the duration of the first year and one for the duration of the second year. Additional psychotherapy supervisors may be assigned in response to training needs (e.g. group and family therapy or extra psychotherapy supervision). Fellows may request specific supervisors; senior fellow requests will receive priority.
Supervisory Goals:

- To help the fellow develop psychotherapy skills.
- To help the fellow identify transference and counter transference issues relevant in child psychiatry and to overall increase skills in introspection and self-awareness and self-supervision in preparation for eventual independent practice.
- To facilitate competency-based, effective and practical learning.
- To clarify assumptions, values, and beliefs which could impact upon work with children and adolescents, their families, and other disciplines.
- To support the fellows in dealing constructively with difficult issues (personal and professional).
- To role model and promote professional behavior, effective communication and interpersonal skills, practice-based learning skills and a systems-based approach to child psychiatry.

d. **Research Supervisors:** Fellows are required to conceptualize, design and implement a scholarly project. The project must be presented at Department of Psychiatry Grand Rounds, and described in a written manuscript (ideally published). Dr. Deborah Goebert, Director of Resident/Fellow Research, along with a clinical supervisor recommended by Dr. Goebert for their topical area, will assist the fellow in conceptualization, design, implementation issues, analysis, interpretation, and presentation.

3. **Supervision Requirements** – Fellows have at least two assigned supervisors at any given time. Participation in at least two (2) hours of individual or group supervision per week is mandatory. Fellows are also expected to meet with their Career Supervisors at least monthly.

4. **Commitment to Supervision**

a. The program believes that supervision is essential to effective learning and must be given high priority by fellows and faculty.

b. If, for whatever reason, the supervision experience is not mutually beneficial the supervisor and supervisee are responsible to inform the Program Director as early as possible so that issues may be resolved or other arrangements expedited.
ADDICTION PSYCHIATRY FELLOWSHIP

Supervision

1. Goals of Supervision
   
a) The primary purpose of supervision is to provide sufficient assistance and practical advice for the resident to provide high quality care to those with substance use disorders, and to develop therapeutic skills. This may include helping the residents to organize clinical material, to validate the diagnosis, to develop the formulation from a biopsychosocial perspective, and to recognize when to seek assistance in management of particular case problems.

   b) A second purpose is to provide support to the resident, assisting increased self-awareness and developing confidence in professional competence. As none of the residents will enter this residency by accident, supervision is an opportunity to address the inevitable, powerful issues of counter-transference which are inevitably brought to the program. This is a field in which the intensity of counter-transference determines effectiveness, perhaps more than in any other.

   c) Supervision should provide a laboratory for improving clinical technique. This may consist of the supervisor providing a demonstration of an interview, direct observation of the resident's undertaking an interview, joint review of a videotape of an interview by either the resident or the supervisor, or simply a discussion of the clinical issues. Included in supervision will be modeling of interdisciplinary team participation by the supervisor.

2. Assignment of Supervisors
   
a) Supervisors are assigned from the addiction psychiatry faculty. Senior faculty will provide supplemental supervision on site, and there will be off site supervision as well.

   b) The resident will have a minimum of two supervisors at any one time.

   c) Effort will be made to balance differing styles in clinical approach between the supervisors, so that the resident may learn a variety of models of treatment.

3. Commitment for Supervision
   
a) Every faculty member serving as a supervisor is expected to meet weekly with the resident.

   b) It is the mutual responsibility of the supervisor and the resident to meet regularly. If for any reason supervision cannot be maintained, the program director should be informed and reassignment obtained. Both the quality and the reliability of the supervision will serve as benchmarks for evaluation of faculty and residents.

4. Levels of Supervision
The ACGME has defined three levels of supervision for residents/fellows as follows:

a) Direct Supervision – the supervising physician is physically present with the trainee and patient

b) 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

c) 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.

Although all fellowship candidates have finished an ACGME training program in psychiatry and thus should be intimately aware of the three levels of supervision, at the beginning of residency, the faculty for the fellowship program will review with each resident/fellow these three levels of supervision. All supervisory modalities are used at all of the training sites. Given the advanced status of the fellow, indirect supervision with direct supervision is frequently used particularly in the outpatient sites. However closer supervision is always available if clinically indicated or at the request of the faculty/resident.

E. Transitions of Care

Addiction residents are assigned to patient care areas in complete blocks without transitioning back and forth. They are consultants in the designated sites, all of which are not dependent on the residents for the primary care of patients. When a resident leaves the service, active consultations are transferred to an incoming resident under the supervision of the faculty supervisor, or are managed directly by the supervisor. The residents’ schedules are provided to the sponsoring institutions.
GERIATRICS PSYCHIATRY FELLOWSHIP

Supervision

1. Goals of Supervision
   a. The primary purpose of supervision is to provide sufficient assistance and very practical advice for the resident to perform high quality clinical care to elderly patients and to develop therapeutic skills. This may include helping the residents organize the clinical material, validate the diagnosis, develop a formulation from biopsychosocial perspective, and receive guidance in treatment for the particular case under supervision.
   b. The second purpose is to provide support to the resident, to assist the resident in increasing self-awareness so that the resident will feel secure and confident in helping his/her patient.
   c. In contrast to the seminars, conferences, or other forms of teaching activities, supervision should provide a laboratory for improving clinical technique. This may be carried out by providing a demonstration of an interview by the supervisor, or direct observation of the interview process carried out by the resident with his/her patient so that he will have the opportunity to learn how to improve his/her clinical skills. In addition, the faculty will supervise and model working with a multidisciplinary team.

2. Assignment and Matching of Supervisors
   a. Supervisors are assigned from the geriatric psychiatry faculty. Additional onsite supervision may be provided by geriatric medicine faculty.
   b. Every resident is expected to have a minimum of 2 supervisors at any one time.
   c. It is an important consideration to have supervisors with different styles in clinical approach so that the resident will have a balanced opportunity to learn different models of treatment.

3. Commitment for Supervision
   a. Every faculty member agreeing to the supervisory role is expected to set aside at least one hour per week throughout the period of supervision to meet with his/her resident.
   b. It is the mutual responsibility of the supervisor and resident to meet regularly. If for any reason supervision cannot be carried out, the Program Director should be informed for re-assignments’.
SURGERY, GENERAL (core)

Faculty Responsibility, Resident Supervision, and Progressive Responsibility

Supervision in the setting of graduate medical education has the goals of ensuring the provision of safe and effective care to patients, ensuring each Resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine, and establishing a foundation for continued professional growth. Each patient will have an identifiable, credentialed (relevant American Board of Medical Specialties Board certification; unrestricted Hawaii State Medical License), and privileged Faculty attending physician who is ultimately responsible for that patient’s care. This information will be available to Residents, other Faculty members and health care providers (who have a need to know, specifically because they are involved in the care of a particular patient, within the framework of HIPAA), and patients. This information is available via the patient medical record, the on-call schedules, and in certain participating sites this information is placed on a sheet on the wall of a patient’s room and updated each (change in nursing) shift. Notwithstanding, Residents and Faculty attending physicians should inform each patient of their respective roles in the care of that particular patient.

Ultimately, it is the decision of the Faculty attending physician as to which activities an individual Resident will be allowed to perform, within the context of the Program Director’s assigned levels of responsibility. The Faculty attending physician should delegate portions of care to Residents, taking into account the needs of the patient and the skills of the Resident(s). The clinical responsibilities for each Resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness, and availability of appropriate support services. The overriding consideration must be the safe and effective care of each individual patient.

This document outlines the levels of responsibility for each year of Residency training and describes the types of clinical activities Residents may perform and those for which Residents may act in a supervisory, teaching capacity for more junior level trainees. Annually, at the time of the second semi-annual review, or more frequently as appropriate, Resident level of delegated progressive authority and responsibility, conditional independence, and supervisory role for more junior level Residents and Students in patient care will be determined and assigned by the Faculty and Program Director. This will take into consideration a comprehensive assessment by the Residency Promotion Committee, which makes recommendations to the Program Director, who then makes the final determination. To assist in this evaluative process Faculty attending physician supervisory assignments will be of sufficient duration (in general, at least 2 or more months in length) to allow for the assessment of the knowledge and skills of each Resident and to provide for the delegation of an appropriate level of patient care authority and responsibility.

The provisions of this regulation are applicable to all patient care experiences.

Attending Responsibility:

- Faculty attending physicians are ultimately responsible for the care provided to their patients. This responsibility requires personal involvement with each patient and Residents participating in the care of the patient. Each patient must have a Faculty attending physician whose name is recorded in the patient’s record. Other Faculty attending physicians may, at times, assume responsibility for the care of the patient, in addition to the supervision of Residents involved in that patient’s care.
Residents must ultimately function under the supervision of Faculty attending physicians. Every Faculty attending physician must be accessible and available in person, by telephone, or by other communication device (such as email or texting), and must be able to be physically present within a reasonable period of time defined by the acuity/severity of the patient(s) and the need for an operation or other invasive procedure. If requested by the Resident (who has been previously determined by the Program to be credentialed to perform a task or procedure with indirect supervision), the supervising physician (Faculty attending physician, or a more advanced level Resident who has been given the delegated authority to supervise the Resident level requesting assistance) must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.

Each ambulatory, outpatient medical record must also reflect the Faculty attending physician responsible for the patient.

Faculty attending physicians must document (in the medical record) their involvement in the care of their patients and their approval of Residents’ diagnostic and treatment plans.

Supervision Documentation of Residents:
Some diagnostic and/or therapeutic procedures require a high level of expertise. Although gaining experience in performing such procedures is an integral part of Residency education, it is imperative that such procedures are only performed by those Residents who possess the required knowledge, skill, and judgment to do so, and only under an appropriate level of supervision by the Faculty attending physician, or a more advanced level Resident (PGY-2 or more advanced level Resident) who has been determined by the Program to have met the competency requirements for the particular task at hand. Faculty attending physicians must (prior) authorize performance of all procedures by Residents, with exceptions noted below. Only Residents at the PGY-2 and more advanced levels may obtain informed consent, and only after receiving prior permission from the Faculty attending physician (this discussion between the Resident and Faculty member must be documented in the patient’s medical record prior to the Resident obtaining informed consent, and the Faculty member must co-sign this note within 24 hours).

Excluded from the requirements are procedures that are considered elements of routine and standard patient care. Examples would include peripheral (non-PICC) IV access by PGY-1 or more advanced level Residents; and simple wound debridement, or drainage of superficial abscesses by PGY-2 and more advanced level Residents.

Emergency Situations:
An emergency is defined as a situation where immediate care is necessary to preserve life, or to prevent serious impairment of the health of a patient. In such situations, any Resident assisted by medical center personnel, may perform everything possible to save the life of a patient or save a patient from serious harm. The appropriate attending physician will be contacted as soon as possible. The Resident will document this contact in the patient medical record. See also Section on Informed Consent, in Resident Handbook.

Circumstances in Which Residents Must Communicate With Supervising Faculty Attending Physicians:
Regardless of level of training, Residents must communicate with the appropriate Faculty attending physician immediately whenever the following events or circumstances occur:
• In general, if there is any substantive change in a patient’s clinical status, such as post-operative complications, any change in neurologic status, cardiac or pulmonary decompensation, acute renal insufficiency
• A patient is transferred to a higher level of care, such as a telemetry unit, or intensive care unit (monitored beds)
• Any discussions that involve changes in resuscitation or end of life decisions initiated by a patient, their family, or other health care providers
• Falls with associated traumatic injury

If the Faculty attending physician cannot be reached for any reason, and a significant urgent/emergent event is occurring (or has occurred) in an already hospitalized patient, the Resident should contact the most senior level Resident assigned to the rotation, in addition to the Hospitalist on-call; then the Director of Surgical Education at the participating site or the Program Director should be contacted; if at The Queen’s Medical Center, the Surgical Officer of the Day should be contacted via the Telecommunications Operator, while ongoing attempts are being made to contact the Faculty attending physician.

**Note:** The Faculty attending physician must also be notified immediately for any new admissions (directly to the hospital or through the Emergency Department) or for any new in-patient consultation requests. The most senior Resident assigned to the rotation should also be concurrently notified.

**Evaluation of Residents:**

• Each Resident will be evaluated by Faculty attending physicians (in addition to more senior level Residents, Nursing personnel, and Students; in the case of PGY-2 and more advanced level Residents, any Residents more junior to them will also provide an evaluation if they worked with the Resident under evaluation) at the end of each rotation via the on-line New Innovations system. The evaluations must include any concerns regarding a Resident’s ability or inability to perform at the level of responsibility that would be expected based on year of training.

• All evaluations of Residents will be downloaded semi-annually and a hard copy will be kept on file by the Program. These evaluations will be discussed and reviewed by the Residency Clinical Competency Committee semi-annually, and a collective recommendation will be made to the Program Director, who will make the final determination of Resident progress and any actions needed. The Program Director will meet with each Resident at least semi-annually to review all evaluations with the Resident and to provide formative feedback on progress. The feedback will also incorporate discussion of the Residency Clinical Competency Committee evaluation of the Resident.

• The ultimate responsibility for patient safety resides with the Faculty attending physician responsible for the patient’s care, the attending of record. The Faculty attending physician must decide which level of supervision will be employed within the guidelines listed herein. Any complaints/reports of lapses of supervision will be immediately reviewed by the Program Director and appropriate corrective measures taken.

The purpose of the above policies is to ensure safe, competent, and quality patient care. The Faculty attending physician will maintain the right and responsibility to supervise a Resident more closely, as deemed appropriate. The Faculty attending physician must not allow procedures to be performed at a lower level of
supervision than contained in this policy. Any exceptions to this policy must be addressed with the Program Director.

Classification of Supervision:
The Program uses the following classification of supervision:

**Direct Supervision** – the supervising Faculty attending physician is physically present with the Resident and patient (i.e., within the operating room, in-patient room, ambulatory or Emergency Department examination room, at the bedside).

**Indirect Supervision with direct supervision immediately available** – the supervising Faculty attending physician is physically present 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 Faculty attending physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephone and/or electronic modalities (such as email or texting) and is available to provide Direct Supervision.

**Oversight** - the supervising Faculty attending physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

General Supervision of Residents:
The following physicians have been determined by the Program to possess the appropriate credentials necessary to be acceptable as physician supervisors in the clinical learning environment:

- All General Surgery Faculty attending physicians, including those with adjunct appointments in the Department of Surgery (such as Neurocritical Care Intensivists based in the Neurocritical Care Unit at The Queen’s Medical Center), where “Faculty” is defined as any individual who has been officially granted a University of Hawaii faculty appointment;
- All Emergency Medicine Faculty (all Emergency Medicine faculty appointments reside under the University of Hawaii Department of Surgery);
- All subspecialty Surgery Faculty, including Anesthesiology Faculty (all Anesthesiology faculty appointments reside under the University of Hawaii Department of Surgery); and
- Medical Hospitalists only at Kuakini Medical Center and Straub Clinic and Hospital may provide direct supervision of Residents only for non-surgical, medical issues at night, with the concurrence of the Faculty attending physician of record for a particular patient, and only if the Faculty attending physician or a more advanced level Resident is not immediately available. Examples of such issues include evaluation and management of hyperglycemia, electrolyte abnormalities, cardiac arrhythmias, chest pain, shortness of breath or respiratory insufficiency or hypoxemia, and change in neurologic status.
- PGY-2 and more advanced level Residents (and Surgical Critical Care Fellows, the majority of whom are either in the certification process of The American Board of Surgery or Board-certified at the time they enter Fellowship training here) who have met the competency requirements for a particular
clinical scenario, task, or procedure may provide direct supervision to more junior level Residents for the task or procedure at hand.

**Note:** As a prerequisite, all Faculty attending physicians must be Board-certified by the relevant American Board of Medical Specialties Board, possess a current and unrestricted Hawaii State Medical License, and be appropriately credentialed and privileged in the clinical discipline in which they provide Resident supervision at a particular participating site. Resident supervision by Faculty attending physicians is limited in scope to the area of specialty of the Faculty attending physician. Thus, Anesthesiology faculty supervise Residents only while on the Anesthesiology or SICU rotations (in addition to other appropriately credentialed SICU physicians, such as the Neurocritical Care and General Surgery Faculty with SICU privileges); Emergency Medicine Faculty provide supervision of Residents only in the Emergency Department (in addition to the General Surgery Faculty attending physicians); and subspecialty Faculty, such as Vascular Surgery faculty, only provide Resident supervision for their specialty rotation.

**Supervision of PGY-1 Residents:**
Indirect supervision with direct supervision immediately available until competency is demonstrated is allowed for:

a) **Patient Management Competencies**
   i. Evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
   ii. Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
   iii. Evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
   iv. Transfer of patients between hospital units or different hospitals
   v. Discharge of patients from the hospital
   vi. Interpretation of laboratory results

b) **Procedural Competencies**
   i. Performance of basic venous access procedures, including establishing peripheral (non-PICC) intravenous access
   ii. Placement and removal of nasogastric tubes and Foley catheters
   iii. Arterial puncture for blood gases

During semi-annual reviews by the Residency Clinical Competency Committee, recommendations are made to the Program Director regarding whether or not the PGY-1 Resident has achieved sufficient competence to transition to indirect supervision with direct supervision available for the aforementioned Patient Management and Procedural Competencies. It is expected that by the completion of the PGY-1 year of training a Resident will have successfully met the competency requirements for indirect supervision with direct supervision available for the basic tasks and basic procedural skills outlined above. Moreover, once the Resident has achieved this level of competency for these tasks and procedures, based on the recommendation of the Residency Promotion Committee a Resident may be permitted to supervise more junior level Residents in these areas.
Direct supervision is required until competency is demonstrated for:

a) Patient Management Competencies
   i. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
   ii. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
   iii. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
   iv. Management of patients in cardiac or respiratory arrest (ACLS required)

b) Procedural Competencies
   i. Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
   ii. Repair of surgical incisions of the skin and soft tissues
   iii. Repair of skin and soft tissue lacerations
   iv. Excision of lesions of the skin and subcutaneous tissues
   v. Tube thoracostomy
   vi. Paracentesis
   vii. Endotracheal intubation
   viii. Bedside debridement

During semi-annual reviews by the Residency Clinical Competency Committee, recommendations are made to the Program Director regarding whether or not the PGY-1 Resident has achieved sufficient competence to transition to indirect supervision with direct supervision immediately available for the aforementioned Patient Management and Procedural Competencies. It is expected that by the completion of the PGY-1 year of training a Resident will have successfully met the competency requirements for indirect supervision with direct supervision immediately available for the more advanced tasks and procedural skills outlined above.

In order to meet minimum requirements for consideration to allow a PGY-1 Resident to transition to indirect supervision with direct supervision immediately available, a Resident must have successfully completed either 2 months of the Trauma or SICU rotation (or both), in addition to successful completion of at least 6 months of general surgery experience (an additional month of Trauma or SICU beyond the 2 required months of either, may be accepted in lieu of 1 month of the required 6 month minimum total general surgery experience), and successful certification in ACLS and ATLS, and successful completion of all PGY-1 Boot Camp modules. In order to meet minimum requirements for consideration to allow transition to indirect supervision with direct supervision immediately available for endotracheal intubation specifically, a Resident must also have successfully completed a one month Anesthesiology rotation. It is expected that by the completion of the PGY-1 year of training a Resident will have successfully met the competency requirements for indirect supervision with direct supervision immediately available for the more advanced tasks and procedural skills outlined above.
Supervision of PGY-2 and more Advanced Level Residents:
It is expected that by the completion of the PGY-2 year of training a Resident will have successfully met the competency requirements for indirect supervision with direct supervision available for the more advanced tasks and procedural skills outlined below:

a) Patient Management Competencies
i. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
ii. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
iii. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
iv. Management of patients in cardiac or respiratory arrest (ACLS required)

b) Procedural Competencies
i. Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation.
ii. Repair of surgical incisions of the skin and soft tissues
iii. Repair of skin and soft tissue lacerations
iv. Excision of lesions of the skin and subcutaneous tissues
v. Tube thoracostomy
vi. Paracentesis
vii. Endotracheal intubation
viii. Bedside debridement

Additionally, once the Resident has achieved this level of competency for these more advanced tasks and procedures, based on the recommendation of the Residency Clinical Competency Committee a Resident may be permitted to supervise more junior level Residents in these areas.

Direct supervision (with appropriate documentation) is required for all elective and urgent/emergent operating room procedures, regardless of PGY-level of training, based on both Federal and State Laws that govern Federal- and State-funded health care plans (such as Medicare and Medicaid), and participating site bylaws and policies. However, in acknowledgment of progression towards conditional independence and the transition to the independent practice of surgery, on a case by case basis a Faculty attending physician may allow a Resident in their final years of training (PGY-5) to serve as a Teaching Assistant – and take a more junior level Resident through an operative procedure (with the Faculty attending physician physically present in the operating room).

In this context, Teaching Assistant cases count towards the minimum 750 total case requirement of the American Board of Surgery; but these cases do not count towards the required minimum 150 cases that a Resident must accumulate during the PGY-5 year.

UNDER NO CIRCUMSTANCES CAN A RESIDENT ENGAGE IN SURGICAL SITE MARKING PREOPERATIVELY, THE "TIME OUT" PROCEDURE PRIOR TO ANESTHETIC INDUCTION, OR INITIATE ANY OPERATING ROOM PROCEDURE (SKIN INCISION INCLUDED) WITHOUT THE ATTENDING OF RECORD EITHER PHYSICALLY PRESENT IN THE OPERATING ROOM ITSELF OR OUT AT THE SCRUB SINK.
Supervision Guidelines for the Care of Patients

The University of Hawaii Surgical Residency Program operates on a Team Care system. Every patient on the teaching service has his or her own Team. The captain of that team is always the Faculty attending physician. The team might include a Chief (PGY-5) or a Senior (PGY-4) Resident, an Intermediate Resident (PGY-3), Junior Residents (PGY-1 or PGY-2), Medical Students, and various consultants. Some of the consultants might have house staff of their own. Fortunately, the chain of command is usually self-evident.

Because the Faculty attending physician is always in charge and ultimately responsible, Residents must ensure that he/she is kept informed of the status of patients at regular intervals or whenever a change in condition occurs. It is understood (and in fact recommended) that Junior Residents discuss problems and questions with the more senior level Residents whenever possible before contacting an attending physician, EXCEPT in cases of emergencies. This allows for a rational chain of command to exist and for more senior level Residents to exercise progressive levels of judgment.

In the unusual circumstance in which the chain of command breaks down or communication is difficult and there is a fear of misunderstanding or problems in patient care, the Residents should immediately contact their Director of Surgical Education at the respective hospital, or the Program Director.

Team Care Patient Management

a) All non-operative patients may be admitted to Surgical Team Care at the discretion of the faculty physician having Surgical Team Care privileges (for example, acute diverticulitis, pancreatitis).

b) In the event a patient is admitted through the emergency room by Surgical Team Care and subsequently goes to surgery without surgical resident involvement (generally due to lack of available Residents) then:

i. If anticipated postoperative discharge will be within 48-hours or less (for example, laparoscopic cholecystectomy, appendectomy, uncomplicated incarcerated hernias, etc.), the attending physician should expect that Surgical Team Care will not follow those patients subsequently.

ii. If the patient undergoes operative intervention and requires a high level of acute care (for example, Surgical Intensive Care or Trauma patient) or the anticipated discharge will also be greater than 48-hours, then Surgical Team Care will continue to follow these patients.

c) For all elective cases, if there is no resident assistance (particularly on Wednesdays at The Queen’s Medical Center), then the attending physician can expect that there will be no Team Care coverage provided for that patient during the duration of the hospital stay, with the exception of the occurrence of an acute event necessitating high level care such as Surgical Intensive Care Unit management (for example, pulmonary embolism, acute myocardial infarction, CVA).

d) The Chief and Senior Residents at all of the institutions will assign residents to cases for the following day by 2:00 p.m. Each of the operating room scheduling units will notify the attending physicians in those instances where surgical assistance is not available due to lack of surgical manpower, to provide their own coverage. It would be expected that in this situation, the Surgical Team would also not cover these patients in the postoperative period. For cases added on after the Chief Resident has made the case assignments, the surgical attending must contact the Chief Resident or Senior Resident of that hospital to determine if resident coverage will be available. In many instances when cases are added...
on, the scheduling office does not notify the surgical Chief or Senior Resident and given that they are unaware of this, they may not be in a position to assign resident coverage for these cases. It is imperative, therefore, that there is good communication between the Chief and Senior Resident at each institution and the faculty attending physicians.

e) The Resident assigned to scrub on a case should be the Resident that continues to follow the patient postoperatively for continuity of care, with the exception being times the Resident is not available because of duty hour requirements, vacation, or other forms of leave. In these circumstances the Chief or Senior Resident will ensure that another Resident on the Team evaluates and manages the patient.

f) If Surgical Team Care is not notified at least 30 minutes prior to a patient going to the operating room, there will be no Team Care on that patient.

g) Medical Students:
   i. Chief Resident assigns to cases.
   ii. Chief Resident will discuss patient assigned to Medical Student on a daily basis.
   iii. No Resident follows patient, if only a medical student has been assigned to the case. The faculty attending is responsible in this instance.

h) Residents from Other Institutions:
   From time to time, there may be Residents from other Institutions who are assigned to the various Surgical Teams. Even if these Residents are at the same PGY level as the most senior UH Resident assigned to the rotation, the most senior UH Resident on the rotation functionally serves as the “Chief” Resident for the purposes of this policy. For example, if the most senior UH Resident on the rotation is a PGY-4, and there is a PGY-4 Resident assigned to the rotation from another Institution, the UH PGY-4 Resident serves as the “Chief” Resident. This policy does not provide for “Co-Chief Residents” on any rotation. There is only one “Chief” Resident on any rotation at any given time.

Non-Team Care Guidelines

Non-team care attending surgeons should be able to expect Resident assistance if residents are available, for major operative emergencies, for response to cardiopulmonary arrests and critical emergencies on their hospitalized patients, but not for routine coverage of their patients while in the intensive care units, not for coverage of routine operations (even those designated emergencies such as appendicitis or perforated ulcer), and not to see their patients in the emergency room on a routine basis.

Management of Surgical Patients Admitted to the SICU Resident Teaching Service

a) All patients admitted to the SICU will be managed by the SICU Residents or SCC Fellow(s) if the Surgical Attending of record requests SICU Resident/SCC Fellow Team Care.

   ***For a patient to be on the SICU Resident Team Care Service, a faculty member must be involved in the case who (a) has an appointment (or pending appointment) in the Department of Surgery AND (b) be either Board eligible or certified in Critical Care Medicine, in accordance with The Queen’s Medical Center Intensivist Policy.

b) Trauma and General Surgery Team Residents are responsible to write all admitting and transfer orders for patients admitted to the Neuro ICU or SICU.

c) Trauma and General Surgery Team Residents will follow the patients while in the ICU’s.
d) All orders will be written only by the SICU Residents or SCC Fellow(s) while the patient is in the ICU, with the following exceptions:
   
i. In either **Urgent or Emergent** situations (e.g., hemodynamic instability, impending “Code,” impending respiratory failure, agitated patient at risk of self-afflicted injury, patients requiring active resuscitation, etc.). **ONLY WHEN THE SICU RESIDENTS OR SCC FELLOW(S) ARE NOT AVAILABLE** - i.e., involved in the care of another critically ill patient(s), performing a procedure, etc.
   
   ii. If AFTER teaching rounds orders are not placed within one hour on STABLE patients.

e) SICU Resident and SCC Fellow Teaching Rounds will take place as follows (and as previously agreed upon by the Medical Directors of Neuro ICU, SICU, and Trauma Services):

   8:30 am – 9:00 am    Neuro ICU Teaching Rounds
   9:00 am – 12:00 pm   SICU Teaching Rounds

f) If an SICU Attending, not on the scheduled teaching rotation at the time of the requested consultation, has been consulted to care for a SICU patient the teaching requirement is to conduct rounds with the SICU Residents and SCC Fellow(s) either before **8:30 am or after 12:00 pm**.

g) It is expected that the Intermediate (PGY-3), Senior (PGY-4), and Chief Surgical Residents (PGY-5) assigned to the General Surgery Rotation at The Queen’s Medical Center will provide on-going oversight of the patients in the ICU during the evening hours when they are on-call (6 pm to 6 am) at all times. This may require that they scrub out of cases during this time period to assist their junior residents in the supervision and care of these patients, in conjunction with the SICU attending and/or SCC Fellow.
SURGICAL CRITICAL CARE FELLOWSHIP

SUPERVISION AND PROGRESSIVE RESPONSIBILITY IN THE SICU

At the beginning of the academic year, the new SCC fellow must be supervised by the SCC faculty before performing procedures independently. The number of observations required will depend upon the individual fellow and her/his performance. The observing SCC faculty must sign off on the procedures list and enter it into the computerized system. Surgical residents on the SICU rotation may be signed off by the SCC fellow (PGY-5 or higher once the fellow is cleared by faculty to perform the procedure) or directly by the SCC faculty. Medical students must be monitored for all procedures by residents, fellows or SCC faculty. Percutaneous tracheostomies, gastrostomies, may not be done by residents independently; SCC faculty or fellow presence is required.