



**San Antonio Uniformed Services
Health Education Consortium
San Antonio, Texas**

**SAUSHEC Gastroenterology Fellowship Program
Supervision Policy**

AY 2014-2015

TITLE OF PROGRAM: San Antonio Uniformed Services Health Education Consortium (SAUSHEC), Gastroenterology Fellowship Training Program

SPONSOR: SAUSHEC

PARTICIPATING INSTITUTIONS: University of Texas Health Science Center at San Antonio, TX. Baylor University Medical Center at Dallas, TX; Methodist Specialty and Transplant Hospital, San Antonio TX; Methodist Specialty and Transplant Hospital, San Antonio TX; Gastroenterology Consultant of San Antonio, San Antonio, TX and Scott & White Memorial Hospital, Temple, TX

DATE UPDATED: 1 July 2014

I. **Introduction:** The purpose of this document is to outline the supervision policy for the gastroenterology fellowship training sponsored by the San Antonio Uniformed Services Health Education Consortium (SAUSHEC). Fellowship training in gastroenterology is a three-year program. Successful completion of this fellowship training will allow candidates to be eligible for certification examination in the American Board of Internal Medicine subspecialty of gastroenterology. The curriculum and objectives (Appendix A) are outlined in accordance with Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Graduate Medical Education in Gastroenterology, Common Program Requirements; Effective: 1 July 2014.

II. **Definitions and Responsibilities:**

A. A trainee is defined in this policy as a fellow who has graduated from a medical school and completed post graduate training in internal medicine.

B. A student is someone who is currently enrolled in a medical/osteopathic school.

C. A supervising staff provider is a licensed independent practitioner (LIP) who is credentialed to supervise trainees and students. This is an individual with appropriate training and an unrestricted state license who has privileges in gastroenterology that would allow that individual to practice without supervision at BAMC or Wilford Hall Ambulatory Surgical Center (WHASC). LIPs may supervise trainees and students in the areas of medical care in which they are privileged, if they are approved to do so by the appropriate program director. Supervising staff providers are ultimately responsible for all aspects of their patient's care within each SAUSHEC training hospital.

D. Supervision constitutes any method of staff oversight of patient care for the purpose of ensuring quality of care and enhancing learning; this term does not necessarily require the physical presence or the independent gathering of data about the patient on the part of the supervising staff provider.

E. Direct Supervision. The supervising staff physician is physically present during the entire procedure including the timeout portion of the examination. This level of supervision will be rated at Level I on appendix D, The Level of Supervision Matrix.

F. Indirect Supervision with Direct Supervision during diagnostic examination. The supervising staff physician is physically within the confines of the site of patient care, and is to be present during the examination (withdrawal) portion of the procedure. This level of supervision will be rated at Level II on appendix D, The Level of Supervision Matrix.

G. Indirect Supervision with Direct Supervision Available. The supervising staff physician is physically present within the department and is immediately available at all times to provide direct support if needed. This level of supervision will be rated at Level III on appendix D, The Level of Supervision Matrix.

H. Oversight. The supervising staff physician is available to provide review of procedures or encounters with feedback provided after care is delivered.

III. Trainee Job Descriptions:

A. A first year gastroenterology trainee is responsible for acquiring the skills necessary to become a competent clinical gastroenterologist. They are expected to know gastrointestinal physiology and anatomy and use this knowledge in learning to evaluate and manage patients with acute and chronic gastrointestinal, hepatic, biliary, and pancreatic diseases. They are expected to learn technical skills in the full range of invasive and noninvasive procedures performed by gastroenterologists. They are required to participate actively in the academic program by attending regularly scheduled conferences and providing didactic lectures. They are required to actively participate in the medical education of the house staff and rotating medical students. They are expected to maintain high professional and moral character, military bearing, and excellent physical conditioning. They are expected to develop an original research project pertaining to GI medicine.

B. A second year gastroenterology trainee is responsible for further developing the skills necessary to become a competent clinical gastroenterologist. They are expected to know gastrointestinal physiology and anatomy and use this knowledge in learning to evaluate and manage patients with acute and chronic gastrointestinal, hepatic, biliary, and pancreatic diseases. They are expected to enhance technical skills in the full range of invasive and noninvasive procedures performed by gastroenterologists. They are required to participate actively in the academic program by attending regularly scheduled conferences and providing didactic lectures. They are required to actively participate in the medical education of the house staff and rotating medical students. They are expected to maintain high professional and moral character, military bearing, and excellent physical conditioning. They are expected to further develop an original research project pertaining to GI medicine.

C. A third year gastroenterology trainee is responsible for mastering the skills necessary to become a competent clinical gastroenterologist. They are expected to have an in-depth knowledge of gastrointestinal physiology and anatomy and use this knowledge in learning to evaluate and manage patients with acute and chronic gastrointestinal, hepatic, biliary, and pancreatic diseases. They are expected to master technical skills in the full range of invasive and noninvasive procedures performed by gastroenterologists. Some trainees may choose to train in advanced endoscopic procedures such as endoscopic retrograde cholangiopancreatography (ERCP) or endoscopic ultrasound (EUS). If so, every attempt will be made to train to competence according to established guidelines. They are required to participate actively in the academic program by attending regularly scheduled conferences and providing didactic lectures. They are required to actively participate in the medical education of the house staff, rotating medical students and junior trainees. They are expected to maintain high professional and moral character, military bearing, and excellent physical conditioning. They are expected to complete an original research project pertaining to GI medicine.

IV. General Principles of Supervision:

A. The Gastroenterology Fellowship Program is committed to ensuring patient safety, quality health care, and resident well-being. In keeping with the institution and common requirements of the ACGME, SAUSHEC's Graduate Medical Education Committee (GMEC) promulgates this updated policy and procedures regarding trainee supervision. Careful supervision and observation are required to determine the trainee's ability to gather and interpret clinic information, perform technical procedures, interpret procedures and safely manage patients. Although not privileged for independent practice, trainees must be given progressively graduated levels of patient care responsibility while concurrently being supervised to ensure quality patient care. Each patient must have a responsible supervising staff provider whose name is recorded in the patient record, who is available to the trainee, and who is involved with and takes responsibility for the patient care being provided by the trainees he/she is supervising. This information should also be available to patients. Trainees and supervising staff providers/faculty members of a health care team will inform patients of their respective roles in each patient's care.

B. Supervision of trainees should be organized to provide gradual increase of responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning privileged provider.

V. Lines of Supervision (chain of command):

A. Trainee supervisory lines are divided into clinical and administrative arms. All questions, concerns, and grievances will be handled at the lowest appropriate level of supervision that provides safe and efficient patient care, and satisfactory resolution of any trainee grievances.

B. The clinical supervisory line for trainees will be assigned at the beginning of each rotation

1. Supervisory staff provider will be assigned to trainee at the beginning of each rotation.

2. For outpatient clinic and procedures, supervisory staff provider will be assigned teaching staff (T) to supervise. This typically changes weekly.

C. Supervisory trainee (i.e., PGY 4, PGY 5 or PGY 6) will be assigned to supervise interns, residents, and students. The supervisory trainee will be supervised by the supervising staff provider.

D. All patient care provided by trainees during “away” rotations – required or elective – will be supervised by a staff Gastroenterologist with valid credentials at the particular rotation site.

E. At all times, the supervision of trainees will allow for rapid and reliable communication, and allow for continuous consultation with the supervisory staff.

F. Supervision of trainees will not vary substantially with the time of day or day of the week.

G. The administrative support for trainees is the Gastroenterology Fellowship Program Coordinator.

H. The Gastroenterology Fellowship Program Director has final oversight over all administrative and clinical issues for all trainees.

VI. Staff Supervision Responsibilities for Trainees:

A. Provide the trainee safe, compassionate, and effective supervision of patient care commensurate with the trainee's level of training and demonstrated competence.

B. Provide educational experiences and mentoring that allow the trainee to develop and demonstrate skills in the ACGME general competencies, and practice Gastroenterology by their PGY-6 year at a level expected of a junior staff gastroenterologist and independent practitioner.

C. Provide an atmosphere of mutual respect and professionalism between supervising staff provider and trainee that will facilitate the trainee applying acquired knowledge and talents toward independent practice, requesting assistance when appropriate, asking questions demonstrating intellectual curiosity, and admitting and correcting mistakes or difficulties.

D. Maintain communication channels with the trainee that allows the staff to respond immediately to a request from the trainee for medical staff assistance.

E. Notify trainee immediately of any change in supervisory staff.

F. Notify program director or assistant program director of any conflicts with trainee during supervision to include, but not limited to, issues of professionalism, patient care, and interpersonal and communication skills.

G. Provide the trainee with back-up support or relief from clinical duties with the assistance of Gastroenterology program director when patient care responsibilities are unusually difficult or prolonged, if unexpected circumstances create trainee fatigue or illness sufficient to jeopardize patient care, or to ensure work hour limits as outlined in Duty Hours and Fatigue Management Policy.

H. Assume full responsibility of patient care when required to allow the trainee to fully participate in the scheduled educational and scholarly activities of the program.

I. Provide trainee feedback at mid-block and evaluate trainee performance at the end of supervisory responsibilities. This debrief should include both constructive positive and negative feedback, and is best done immediately following the end of supervision. Therefore, debrief and evaluation may occur on the completion of a clinic, call week, procedure, or crisis management situation. Use formal written evaluations and notification to the program director when suitable.

J. Ensure all trainee entries into medical and gastroenterology records reflect the supervisory staff, and to fully document the extent of their involvement in patient care.

VII. **Trainee Supervision Responsibilities:**

A. Provide safe, compassionate, and effective patient care commensurate with the trainee's level of training and demonstrated competencies.

B. Maintain communication channels with the clinical supervisory chain that ensures immediate medical staff assistance on request.

C. Provide an atmosphere of mutual respect and professionalism between supervising staff physician and trainee that will facilitate the supervising staff's ability to guide, educate, and provide both positive and negative feedback constructively.

D. When in doubt, contact the supervising staff. Notify the supervising staff of any change in patient status.

E. The "heads up" call: It is the trainee's responsibility to err on the conservative side, and notify their supervisory staff of any events not predicted in the pre-operative discussion, or if there is any possibility that patient care may benefit from remote or direct staff consultation. Some, but not all, of the situations in which your supervisory staff should be notified include change in OR room schedule, pre-operative abnormality that will result in delay or cancellation of case, delay in case start, gastroenterologic complications or mishaps, change of gastroenterology plan, difficulty or complication with a procedure, or any time doubt exists about the need for assistance.

F. Senior Trainee Consultation: It is appropriate for junior trainees to consult, receive guidance and supervision from more senior trainees. However, at no time should senior trainee consultation cause delay of supervising staff consultation and/or direct involvement in a crisis situation or when a delay in determination of action might adversely affect patient outcome.

1. Request back-up support or relief from clinical duties from the clinical supervisory chain when patient care responsibilities are unusually difficult or prolonged, if unexpected circumstances create fatigue or illness sufficient to jeopardize patient care, or to ensure work hour limits as outlined in Duty Hours and Fatigue Management Policy.
2. Request back-up support or relief from clinical duties from the clinical supervisory chain to fully participate in educational and scholarly activities of the program.
3. Notify program director of any conflicts with staff, patients, or other health care system providers to include, but not limited to, issues of professionalism, patient care, and interpersonal and communication skills.
4. Attend mid-block feedback session and ensure in-person evaluation at the end of staff-trainee supervision periods. This debrief is best done immediately following the end of supervision and therefore may occur on the completion of an O.R day, call night, procedure, crisis management situation, or rotation. Ensure receipt, review and acknowledgement of written formal evaluations when required.
5. Demonstrate intellectual curiosity, self-development, and practice-based learning. The trainee is expected to complete case specific reading, and be prepared to discuss and have questions prepared for the supervisory staff in order to ensure continued educational development and competence in patient care.
6. Maintain charts, records, New Innovations and/or reports up- to-date and signed at all times.
7. Document verbal consultation with the staff in the medical or gastroenterology record as appropriate, and ensure that all appropriate records are co-signed by the staff of record.

VIII. Supervision Responsibilities for Interns, Residents, and Students:

Trainees (i.e., PGY 4, 5 and 6) will have the responsibility of supervising interns, residents, and students:

A. Resident Supervision (i.e., PGY 1, 2, and 3):

1. Supervision in regards to patient care and the medical record will be the same for interns and residents when rotating in gastroenterology and will not vary by PGY level.
2. May perform history, physical examinations, and consultations without the supervising trainee or staff provider being physically present; however, they are required to discuss their findings with the supervising trainee or staff provider upon completion of examination. The supervising trainee or staff provider must make additions and corrections in the documented history and physical, and co-sign the documentation.
3. All documentation must be legible to those who use the medical record, including the full printed name of any signature that is illegible.

4. After discussion with the supervising trainee or staff provider, orders can be entered on patients in whose care they are participating. These orders will be implemented without the co-signature of the supervising trainee or staff provider.

5. Residents will not be allowed to give independent verbal consultations at any time. Recommendations either need to be written and co-signed or delivered verbally by the supervising trainee or staff provider.

6. Provide educational experiences and mentoring that allow for developing and demonstrating skills in the ACGME general competencies.

7. Provide an atmosphere of mutual respect and professionalism.

8. Provide communication channels that allow the supervising trainee or staff provider to respond immediately to a request for medical staff assistance.

9. Provide immediate notification of any change in supervisory staff.

10. Program director or assistant program director will be given notification of any conflict during supervision to include, but not limited to, issues of professionalism, patient care, and interpersonal and communication skills.

11. Supervising trainee or staff provider will assume full responsibility of patient care, when required, to allow for resident participation in scheduled educational and scholarly activities of the program.

12. Provide feedback at mid-block and evaluate performance at the end of supervisory responsibilities. This debrief should include both constructive positive and negative feedback, and is best done immediately following the end of supervision. Debrief will be reported to the supervisory staff provider who will complete formal evaluation in the New Innovations Evaluation System (NI).

13. Residents (i.e., PGY 1, 2 and 3) are required to have indirect supervision with direct supervision immediately available.

B. Student Supervision:

1. Students may perform history and physical examinations without the supervising trainee or staff provider being physically present but the supervising trainee or staff provider must repeat the interview and physical examination on every patient. Students may not write an official clinic note intended to be entered into the medical record. Students are not allowed to write or enter orders on patients without the co-signature of the supervising trainee or staff provider.

2. Provide educational experiences and mentoring that allow for developing and demonstrating skills in the ACGME general competencies.

3. Provide an atmosphere of mutual respect and professionalism.
4. Provide communication channels that allow the supervising trainee or staff provider to respond immediately to a request for medical staff assistance.
5. Provide immediate notification of any change in supervisory staff.
6. Program director or assistant program director will be given notification of any conflict during supervision to include, but not limited to, issues of professionalism, patient care, and interpersonal and communication skills.
7. Supervising trainee or staff provider will assume full responsibility of patient care, when required, to allow for resident participation in scheduled educational and scholarly activities of the program.
8. Provide feedback at mid-block and evaluate performance at the end of supervisory responsibilities. This debrief should include both constructive positive and negative feedback, and is best done immediately following the end of supervision. Debrief will be reported to the supervisory staff provider who will complete formal evaluation in the New Innovations Evaluation System (NI).
9. Students are required to have direct supervision.

IX. Supervision in Different Patient Care Settings:

A. **Outpatient Clinical Rotation:** On the outpatient clinical rotation, all new and follow-up appointments will be indirectly supervised with direct supervision immediately available with the assigned supervising staff provider. The trainee consultations in all cases are reviewed and signed by a staff physician.

B. **Inpatient Clinical Consultation:** The supervising staff provider will make formal rounds on all patients several times per week in conjunction with the trainee. The trainee may interview and examine patients, and write an appropriate staff note as necessary in the inpatient chart. The supervising staff provider will review the trainee's suggestions as reflected in the chart note during ward rounds. Formal consultation will be placed in patient's records after discussion has taken place between the trainee and staff. In general, most endoscopic procedures will be staffed by the inpatient supervising staff provider, except in situations where he / she may be needed elsewhere, in which case an alternative staff gastroenterologist will staff the endoscopic procedures. This policy will be adhered to at all participating institutions. All new and follow-up outpatient clinical appointments will be indirectly supervised with direct supervision immediately available with the assigned supervising staff provider. The trainee consultations in all cases are reviewed and signed by a staff physician.

C. **Gastroenterology Specific Procedures:**

1. All gastroenterology specific procedures (i.e., inpatient or outpatient) will be performed under the "Direct Supervision", or level I of the Level of Supervision Matrix, of the supervising staff provider at the beginning of fellowship training. When a trainee has achieved

competence in a particular procedure, the level of supervision for routine outpatient procedures will progress to “Indirect Supervision with direct supervision immediately available” , or level II of the Level of Supervision Matrix, and ultimately to “Indirect Supervision with direct supervision available”, or level III of the Level of Supervision Matrix.

2. Inpatient and emergency consultations received after duty hours will be discussed with the on-call attending by phone as soon as a preliminary case formulation is developed. This discussion should not be delayed because of a lack of complete information such as laboratory data or imaging results. Coordination of care with the on-call attending, the endoscopy technician, sedation nurse and other participants in patient care can take time. Thus, early discussion with the on-call attending is essential to ensure timely delivery of care.

3. With very rare exception, all gastroenterology specific procedures for inpatients will be performed under “Direct Supervision” , or level I of the Level of Supervision Matrix, throughout training. This requirement is a reflection of the acuity and co-morbidities of these patients and is intended as an extra layer of patient safety.

4. Advanced endoscopic procedures, including ERCP and EUS, will be performed under “Direct Supervision”, or level I of the Level of Supervision Matrix, at all levels of fellowship training, regardless of the inpatient or outpatient status of the patient. This reflects the inherent complexity and risk associated with these procedures. It should be noted that not all GI staff attending physicians are credentialed to perform ERCP. Therefore, for these procedures the supervision may have to be provided by someone other than the designated GI on-call attending.

D. **Benchmarks for Advanced Procedures:** The following procedures will require direct supervision:

1. Variceal banding
2. Rectal banding
3. Any dilation procedure – esophageal or other ERCP - +/- on initial positioning
4. EUS exam and FNA - +/- on dropping scope
5. Hot snare polypectomy
6. Liver biopsy
7. Capsule endoscopy, manometry studies, pH monitoring (BRAVO/Impedance), smart pill, breath testing – will be over read by staff
8. APC
9. HALO
10. Endoscopic Mucosal Resection (EMR)

E. **Benchmarks for Esophagogastroduodenoscopy (EGD)**: Initially, the following procedures require direct supervision with the assigned supervising staff provider. Trainees will advance in a graduated fashion with increasing responsibility commensurate with the level of skill demonstrated and confirmed by the faculty stating proficiency for each benchmark. When it is determined the trainee has demonstrated technical and sound clinical judgment as evaluated by the faculty, to include Program Director's approval, a competency statement will be placed into trainee training folder. The following benchmarks should be achieved prior to qualifying for competency:

1. Achieving a minimum number of 130 (not less) supervised procedures
2. Understanding the indications, risks, benefits and alternatives to the procedure
3. Obtaining informed consent
4. Appropriate use of pre-procedure antibiotics
5. Appropriate, competent and safe use of sedation and analgesia. All fellows are required to complete the APEQS Sedation and Analgesia module prior to being allowed to independently sedate their patients in either supervised or unsupervised procedures.
6. Ability to safely pass the endoscope to the second portion of the duodenum and retroflexing within the stomach
7. Appropriate and competent use of mucosal biopsy techniques
8. Accurate identification of normal and abnormal findings
9. Appropriate post-procedural management
10. Accurate and thorough communication of findings and future plans to the patient
11. Appropriate recognition and management of sedation and procedural complications
12. The following will continue to require direct supervision, even though competency has been approved by the program director for the above procedures:
 - a. Control of hemorrhage
 - b. Snare cautery polypectomy
 - c. Variceal therapy for actively bleeding patients
 - d. Pyloric or duodenal dilation
 - e. Removal of foreign bodies distal to the esophagus

- f. Placement of a PEG tube
- g. Patients who prove difficult to sedate
- h. Any time that you have doubts about the need to seek assistance
- i. All procedures performed on inpatients will be 100% directly observed by staff regardless of level of rating on the Level of Supervision Matrix.

F. Benchmarks for Colonoscopy: Initially, the following procedures require direct supervision with the assigned supervising staff provider. Trainees will advance in a graduated fashion with increasing responsibility commensurate with the level of skill demonstrated and confirmed by the faculty stating proficiency for each benchmark. When it is determined the trainee has demonstrated technical and sound clinical judgment as evaluated by the faculty, to include Program Director's approval, and rated as a level III on the Level of Supervision Matrix, a competency statement will be placed into trainee training folder. The following benchmarks should be achieved prior to qualifying for competency:

1. Achieving a minimum number of 140 (not less) supervised procedures
2. Understanding the indications, risks, benefits and alternatives to the procedure
3. Obtaining informed consent
4. Appropriate use of pre-procedure antibiotics
5. Appropriate, competent and safe use of sedation and analgesia. All fellows are required to complete the APEQS Sedation and Analgesia module prior to being allowed to independently sedate their patients in either supervised or unsupervised procedures.
6. Ability to safely pass the colonoscope to the cecum and retroflexing within the rectum.
7. Appropriate and competent use of mucosal biopsy and polypectomy techniques
8. Accurate identification of normal and abnormal findings
9. Appropriate post-procedural management
10. Accurate and thorough communication of findings and future plans to the patient
11. Appropriate recognition and management of sedation and procedural complications
12. Once a rating of level III on the Level of Supervision Matrix and a Competency Letter has been placed in the trainee's training folder, the following will require Direct Supervision:

- a. Difficulty advancing the colonoscope
- b. Stricture dilation
- c. Removal of foreign bodies
- d. Patients who prove difficult to sedate
- e. Any time that you have doubts about the need to seek assistance
- j. All procedures performed on inpatients will be 100% directly observed by staff regardless of level of rating on the Level of Supervision Matrix.

G. Benchmarks for Flexible Sigmoidoscopy: Initially, the following procedures require direct supervision with the assigned supervising staff provider. Trainees will advance in a graduated fashion with increasing responsibility commensurate with the level of skill demonstrated and confirmed by the faculty stating proficiency for each benchmark. When it is determined the trainee has demonstrated technical and sound clinical judgment as evaluated by the faculty, to include Program Director's approval, and rated as a level III on the Level of Supervision Matrix, a competency statement will be placed into trainee's training folder. The following benchmarks should be achieved prior to qualifying for competency:

1. Achieving a minimum number of 30 (not less) supervised flexible sigmoidoscopies or colonoscopies
2. Understanding the indications, risks, benefits and alternatives to the procedure
3. Obtaining informed consent
4. Appropriate use of pre-procedure antibiotics
5. Appropriate, competent and safe use of sedation and analgesia. All fellows are required to complete the APEQS Sedation and Analgesia module prior to being allowed to independently sedate their patients in either supervised or unsupervised procedures.
6. Ability to safely pass the lighted scope to examine the inside of the large intestine from the rectum through the descending colon with mucous biopsy.
7. Accurate identification of normal and abnormal findings
8. Appropriate post-procedural management
9. Accurate and thorough communication of findings and future plans to the patient
10. Appropriate recognition and management of sedation and procedural complications
11. All procedures performed on inpatients will be 100% directly observed by staff regardless of level of rating on the Level of Supervision Matrix.

H. **Paracentesis**: Trainees should already be credentialed; however, if not, they will require indirect supervision with direct supervision immediately available until supervisory staff provider confirms proficiency and program director confirms competency.

I. **Endoscopic Procedures Requiring Intravenous Sedative**: All endoscopic procedures requiring the use of intravenous sedative medications will be directly supervised with the supervising staff provider on a 1:1 basis at all institutions until deemed competent for a particular procedure by program director (competency letter). All emergent and inpatient endoscopic procedures will directly supervised as well.

J. **On Call**: Each trainee will be on call at home an average of one week out of five or six. The number of on calls per year will average approximately 10-12 weeks. The supervising staff provider will be on call at all times as per published roster. This policy will be adhered to at all institutions. If emergency endoscopic procedures are required in the evenings or weekends, the trainee on call will have a staff gastroenterologist present during such procedures at BAMC.

X. **Supervision in Emergency Situations**:

A. An "emergency" is defined as a situation where immediate intervention is necessary to preserve the life of, or to prevent serious impairment to the health of a patient.

B. In such situations, a trainee is expected to do what he/she is capable of to save the life of a patient or to save a patient from serious harm. Trainees may perform emergency procedures without prior staff approval when life or limb would be threatened by delay. In this case the most experienced trainee available will perform or directly supervise the procedures. Trainees will make reasonable efforts to obtain assistance from more senior residents and/or appropriate staff available in the hospital and will contact the appropriate attending as soon as possible.

C. The trainee will document emergency patient care rendered (including who was contacted) in the patient's record.

XI. **Trainee Grievances Regarding Supervision**:

A. The program director is responsible for ensuring that trainees are aware that their concerns regarding adequate technical or professional supervision or professional behavior by their supervisors will be addressed in a safe and non-threatening environment per SAUSHEC and ACGME guidelines.

B. The Gastroenterology Fellowship Program will follow SAUSHEC trainee grievance policies and is made available during orientation.

APPENDICES

A. Level of Supervision Matrix

Level of Supervision, Beginning 1 July 2014

	FIRST YEAR					SECOND YEAR					THIRD YEAR			
	PGY4	PGY4	PGY4	PGY4	PGY4	PGY5	PGY5	PGY5	PGY5	PGY5	PGY6	PGY6	PGY6	PGY6
Sedation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
EGD, Dx	II	II	II	II	II	III	III	II	III	III	III	III	III	III
Flex Sig	III	III	III	III	III	III	III	III	III	III	III	III	III	III
Colonoscopy	I	I	I	I	I	III	III	III	III	III	III	III	III	III
Dilations	I	I	I	I	I	I	I	I	I	I	II	II	II	II
Inpatient	I	I	I	I	I	I	I	I	I	I	I	I	I	I
ERCP, EUS	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Liver Biopsy	Each fellow, regardless of status, must present each biopsy to the attending who then determines the level of supervision.													

Explanation of level of Supervision:

Sedation: Fellows are allowed to sedate without Staff presence.

Level I: The Staff person is present for the entire procedure.

Level II: The Staff person is clearly designated, aware of the exact procedure start time, and is available to respond at any time if called. The Staff person reviews the positive and negative findings in each case. For EGD, this means the Staff is present for withdrawal from the duodenum. For a Colonoscopy, the Staff person arrives before the fellow withdrawal from the cecum. For dilations, the Staff must be present prior to wire-balloon placement/dilation.

Level III: The Staff person is clearly designated and is available in the GI department and provides assistance if the fellow calls.

Supervision Rules:

- 1) Staff must be called for all therapeutics beyond biopsying.
- 2) Add-ons (First years) must have non-T staff approval prior to scheduling. The assigned staff name will be placed in the comment section of S3.
- 3) Add-ons (All Fellows) must have non-T staff approval for all anticipated therapeutic/complex procedures. The assigned staff name will be placed in the comment section of S3.
- 4) APEQS sedation training will be completed prior to a 'yes' designator on the fellow supervision matrix.

All increases in levels of supervision will be reviewed at least semi-annually and approved by the clinical competence committee.