Resident Supervision Policy

Anesthesiology is a specialty in that, in the usual circumstance, we deal with patients singly, and have no other concurrent clinical responsibilities. Accordingly, residents are almost always directly supervised in their care of patients. However, there are situations such as resuscitations or the treatment patients in post anesthetic care unit that occasionally require resident service in the physical absence of the attending anesthetist.

- The following guidelines concerning supervision are to be adhered to in the Residency Training Program.

  a) Residents must disclose to patients that they are physicians-in-training and the name of the responsible attending anesthesiologist responsible when introducing themselves. There is no specific anesthetic consent for most perioperative interventions as this is taken to be implied in the surgical consent for operation. Therefore, the lack of any voiced concern over identified resident participation is taken as tacit acceptance of the resident's role in patient care. In the unusual event of patient refusal of resident participation, this request is honored.

  b) Residents are expected to discuss findings and management plans with attending staff for elective and, if at all possible, emergency situations in all instances prior to the initiation of any treatment or procedure. Residents are encouraged to notify and discuss any concerns, however trivial, when in doubt or faced with an unfamiliar scenario.

  c) The overwhelming majority of anesthetic procedures are done in the physical presence of the attending anesthesiologist. The attending anesthesiologist should always be present during critical periods of patient care, induction and emergence from anesthesia, and periods of instability. However, as the resident matures, graded independent performance is allowed to occur. In the operating room milieu, this would follow a logical progression from observed performance of the attending anesthesiologist, to joint performance, and then to resident performance under close scrutiny. It would move from the attending being present at the foot of the bed, to being present in the room, to being present in the operating room complex, and ultimately to simply being present in the hospital. In all cases, the attending anesthesiologist is immediately available to intervene if necessary; there would be no other assigned clinical duties or concurrent responsibilities by faculty which would render them unavailable are tolerated save in life-threatening emergencies.