

Policy on Supervision: Roles, Responsibility and Patient Care Activities for Residents

Department of Medicine Internal Medicine Residency

Philosophy

Residents are physicians in training. They develop and learn the skills necessary for their chosen specialty through didactic sessions, reading and providing direct patient care under the supervision of the Medical Staff (the attending physicians) and more senior trainees. As part of their training program, residents are given progressively greater responsibility according to their level of education, ability and experience.

Levels of Supervision as Defined by the AGCME -Common PRs VI.D.3.

Direct Supervision - the supervising physician is physically present with the resident and patient

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

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

Oversight - the supervising physician is available to provide review of procedures and clinical encounters with feedback provided after care is delivered.

Responsibilities and Patient Care Activities

Residents are part of a team of providers caring for patients. The team includes an attending physician and may include other licensed independent practitioners, other trainees and medical students. Residents may provide care in inpatient, emergency department, and outpatient settings. They may serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services. Each member of the team is dedicated to providing excellent patient care.

Residents evaluate patients, obtain the medical history and perform physical examinations. They may develop a differential diagnosis and problem list. Using this information, they develop a plan of care in conjunction with other trainees and the attending. They may document the provision of patient care as required by hospital/clinic policy. Residents may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed at the bedside, in the operating room or procedure suite under appropriate supervision. Residents may initiate and coordinate hospital admission and discharge planning. Residents should discuss the patient's status and plan of care with the

attending and the team regularly. All residents help provide for the educational needs and supervision of any junior residents and medical students.

The specific role of each resident varies with their clinical rotation, experience, years of clinical training, the patient's illness, and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training.

PGY 1 (Interns)

Interns are primarily responsible for the care of patients under the guidance and supervision of the attending physicians and senior residents. Interns should be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising trainees and/or the attending physician should be contacted. Interns may provide care for inpatients, outpatients, or patients in the emergency department. Interns are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending or senior resident when appropriate.

PGY 2-3 (Senior Residents)

“Senior residents should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.” (RC-IM VI.D.4.c.)

Residents are responsible for the day-to-day management of the patient care team under the attending physician's supervision. On some services that do not have interns, the resident may be primarily responsible for the care of patients under the guidance and supervision of the attending physician and more senior trainees. They may serve as part of a team providing consultative services, or care for patients in the inpatient or outpatient setting or emergency department under the supervision of senior trainees and Medical Staff. These residents may coordinate the actions of the team, as well as interact with nursing and other administrative staff. Along with the attending physician they provide for the educational needs of any interns and students.

PGY 4 (Chief Resident/Clinician Teacher Fellow)

Chief Residents and Clinician Teacher Fellows hold faculty appointments within the Department of Medicine and are fully licensed independent practitioners. Responsibilities are primarily administrative and teaching in nature, although they may participate in the care of patients when appropriate. Chief residents may provide patient care for inpatients, particularly when the patient's illness is severe, when needed to assist more junior residents or during times of significant patient volume. Chief residents may care for outpatients in any settings. PGY-4s participate in administrative committees as required by the Department, coordinate admissions and or transfers from other centers or services, and are responsible for overseeing the education of junior residents and students.

Attending of Record

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged **attending physician of record or licensed independent practitioner** who is ultimately responsible for that patient's care. The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of

patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by individual program policy. The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness. The attending must notify all residents on his or her team of when he or she should be called regarding a patient's status. In addition to situations the individual attending would like to be notified of, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. The *primary* attending physician may at times delegate supervisory responsibility to a *consulting* attending physician if a procedure is recommended by that consultant. This information should be available to residents, faculty members, and patients.

The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Residents and attendings should inform patients of their respective roles in each patient's care.

The attending and supervisory resident are expected to monitor competence of more junior residents through direct observation, formal ward rounds and review of the medical records of patients under their care.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Supervision of Invasive Procedures

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient, and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a trainee who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by trainees. When there is any doubt about the need for supervision, contact the attending physician.

No supervision required

Dressing changes, suture placement and removal, central venous catheter removal, cryotherapy of small skin lesions (<5 mm), anoscopy.

Direct supervision required

Residents require direct supervision by a qualified member of the Medical Staff or a qualified trainee for each of these procedures until they can document successful completion of a specified number of procedures. The number of procedures required to be considered proficient are noted in parentheses next to the description of the procedure.

Resident procedures are recorded in the Department of Medicine on-line evaluation system. The Department of Medicine Residency office can be contacted to determine the resident's status to perform specific procedures, or the resident may access the data management system to provide documentation of their proficiency. If there is any doubt, contact the attending.

Required by the program before performing independently or supervising other practitioners*

Abdominal Paracentesis.....	(3)
Arterial Line Insertion.....	(3)
Arthrocentesis – Knee Joint.....	(3)
Arthrocentesis – Shoulder Joint.....	(3)
Central Venous Line - Femoral.....	(3)
Central Venous Line - Internal Jugular.....	(3)
Central Venous Line - Subclavian.....	(3)
Incision & Drain of Abscess.....	(3)
Lumbar Puncture.....	(3)
Pulmonary Artery (Swan-Ganz) Catheterization.....	(3)
Thoracentesis.....	(3)

Required by the American Board of Internal Medicine for Certification

Advanced Cardiac Life Support*.....	Certified†
Arterial puncture.....	(1)
Pap smear and Endocervical Culture.....	(1)
Peripheral IV.....	(1)
Phelbotomy.....	(1)

* These are the numbers of procedures that a resident must perform safely and competently before being allowed to do the procedure unsupervised or to supervise another practitioner. Except in the case of ABIM-required procedures, this is *not* a number needed to successfully complete the training program.

† Each resident must demonstrate that they were ACLS certified at least once during residency training.

Supervision required by a qualified attending or qualified trainee (e.g., fellow)

- Flexible or rigid sigmoidoscopy
- Exercise tolerance testing
- Colposcopy
- Sedation for procedures (AKA conscious sedation)
- All other invasive procedures not listed above

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available. The assistance of more qualified individuals should be requested as soon as practically possible and appropriate documentation of the emergent medical necessity of the procedure(s) must be made in the medical record. The

appropriate attending practitioner must be contacted and apprised of the situation as soon as possible.

Supervision of Consults

Residents may provide consultation services under the direction of supervisory residents including fellows. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal. The availability of the attending and supervisory residents or fellows should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients.

Residents performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals as determined by each consult service. Any resident performing a consultation where there is credible concern for patient's life or limb requiring the need for immediate invasive intervention **MUST** communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Supervision of Hand-Offs

Each program must have a policy regarding hand-offs. This policy must include expectations of supervision with each type of hand-off situation. As documented in the ACGME's common program requirements, programs must design clinical assignments to minimize the number of handoffs and must ensure and monitor effective, structured handoff processes to facilitate both continuity of care and patient safety.

Circumstances in which Supervising Practitioner **MUST be Contacted**

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members:

1. An unexpected patient death
2. Brain Death Determination or Organ donation
3. Cardiac arrest (code)
4. Patient going to OR for emergent surgery or transfer to another service
5. An unplanned, emergent invasive procedure such as surgery, interventional radiology, cardiac catheterization, or other high-risk invasive procedure
6. Complication of procedure
7. An unexpected transfer to a higher level of care (e.g., transfer to the MICU)
8. Unexpected, significant deterioration in clinical status; for example, new end-organ failure (e.g. unexpected intubation, oliguria, unexpected pressor requirement or increase in dose, substantial increase in FiO₂)
9. A high-risk medical error with or without harm to the patient
10. When the number or acuity of patients or admissions makes it difficult for you to provide safe care.
11. Change in code status
12. Unexpected blood transfusion
13. Missing patient/discharge AMA

Attendings should adhere to the SUPERB model when providing supervision. They should

1. **S**et Expectations: set expectations on when they should be notified about changes in patient's status.
2. **U**ncertainty is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **P**lanned Communication: set a planned time for communication (i.e. each evening, on call nights)
4. **E**asily available: Make explicit your contact information and availability for any questions or concerns.
5. **R**eassure resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **S**eek attending input early
2. **A**ctive clinical decisions: Call the supervising resident or attending when you have a patient whose clinical status is changing and a new plan of care should be discussed. Be prepared to present the situation, the background, your assessment and your recommendation.
3. **F**eel uncertain about clinical decisions: Seek input from the supervising physician when you are uncertain about your clinical decisions. Be prepared to present the situation, the background, your assessment and your recommendation.
4. **E**nd-of-life care or family/legal discussions: Always call your attending when a patient may die or there is concern for a medical error or legal issue.
5. **T**ransitions of care: Always call the attending when the patient becomes acutely ill and you are considering transfer to the intensive care unit (or have transferred the patient to the ICU if patient safety does not allow the call to happen prior to the ICU becoming involved).
6. **H**elp with system/hierarchy: Call your supervisor if you are not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.

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