

GRADUATE MEDICAL EDUCATION

POLICY: RESIDENT SUPERVISION POLICY

GME Policy and Procedure Manual

Department Responsible Graduate Medical Education	Updated 3/2/2016	Effective Date July 1, 2016	Next Review/Revision Date April 2021
Title of Person Responsible Designated Institutional Official	Approved Council: Graduate Medical Education Committee		Date Approved by Council July 1, 2016

POLICY:

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training. Faculty supervision of residents assures resident education. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinical educator is the appropriate supervision of the residents as they acquire the skills to practice independently and simultaneously provide the highest standard of patient care.

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. An appropriate level of supervision is required of all residents during all clinically relevant educational activities.

PURPOSE:

It is the policy of the Graduate Medical Education Committee to follow requirements of the ACGME regarding supervision of residents in accredited training programs. Residents will be supervised by faculty physicians in a manner that is consistent with the ACGME common program requirements and requirements for the applicable residency program. Each program must have a supervision policy.

DEFINITIONS:

1. **Program:** The program consists of residents in training and faculty who perform their evaluations.
2. **Resident:** The term "resident" refers to an individual who is engaged in a graduate training program in medicine (which includes all medicine specialties, e.g.,

family medicine, internal medicine, surgery, psychiatry, radiology, pediatrics, etc.), dentistry, podiatry, or optometry, and who participates in patient care under the direction of the attending physicians. The term “resident” includes individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows.”

3. **Supervision** - Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction. It includes the imparting of the attending physician’s knowledge, skills, and attitudes by the attending physician to the resident and ensuring that patient care is delivered in an appropriate, timely, and effective manner.
4. **Attending Faculty/Physician:** Any M.D.or DO, board certified or eligible, who has been certified by the program as qualified to teach residents and has a faculty appointment at the appropriate university (i.e., UCI College of Medicine, USC, etc.)

SCOPE

- A. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and with each resident who is participating in the care of that patient. Each patient must have an attending physician of record whose name is recorded in the patient chart. It is recognized that other attending physicians may, at times, be delegated responsibility by the attending physician of record. In this case, the attending physician of record is responsible to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending physician at all times and the attending of record, if necessary.
- B. Within the scope of the training program, all residents must function under the supervision of an attending physician. On-call schedules and rotation schedules for each residency program are to be developed on a periodic basis to provide residents with a variety of patient care educational experiences consistent with the program requirements of that particular program. Backup must be available at all times through more senior residents and appropriately credentialed attending physicians. It is the responsibility of each program director to establish categories of all resident activities according to graduated levels of responsibility and appropriate levels of supervision outlined below.

The requirements for on-site supervision will be established by the program director for each residency program in accordance with ACGME, AMA, Joint Commission, and CMS guidelines and should be monitored through periodic departmental reviews, with institutional oversight through the GMED internal review process. The type of supervision (physical presence of attending physicians, home call backup, etc.) required by residents at various levels of training, must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the

application program requirements of the individual departmental, as well as common, standards of patient care.

C. LEVELS OF SUPERVISION

A. **Direct Supervision** - The attending physician is physically present and directly involved in the care/procedure.

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.

In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients

POLICY STANDARDS

Quality graduate medical education can occur only in settings that are characterized by the provision of high quality patient care. As a practical matter, preparing future practitioners to meet patients' expectations for excellence requires they learn in environments epitomizing the highest standards of medical practice. Even more important, as an ethical matter, justifying the participation of residents in the care of patients requires adherence to uncompromised standards of quality medical care.

A. The attending physician of record is responsible for the quality of all of the clinical care services provided to his or her patients.

B. All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education, based on patient acuity and a resident's graduated level of responsibility.

C. Individual department/residency programs will have written guidelines governing supervision of residents; these guidelines will vary according to specialty,

intensity of patient care responsibilities on a given rotation, level of experience, and educational requirements.

- D. Attending physicians directly responsible for the supervision of patient care services provided by resident physicians must be as available to participate in that care as if residents were not involved; the presence of residents to “cover” patients on inpatient services or to provide care in ambulatory settings does not diminish the standards of availability required of the physician of record.
- E. Attending physicians are responsible for determining when a resident physician is unable to function at the level required to provide safe, high quality care to assigned patients, and must have the authority to adjust assigned duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued or, otherwise, impaired.

PROCEDURE

- A. All patient care performed by residents during training will be under the supervision of an attending physician credentialed to provide the appropriate level of care. The specifics of this supervision must be documented in the medical record by the attending physician or resident according to Medical Staff rules and regulations.
- B. The supervising/attending physician must be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency Program Directors must assure this occurs. Residents must know which supervising/attending physician is on call and how to reach this individual.
- C. Inpatient supervision: The supervising/attending physician must obtain a comprehensive presentation from the resident including a history and physical with co-signed attending attestation for each admission. This must be done within a reasonable time, but always within 24 hours of admission. The supervising/attending physician must also require the resident to present the progress of each inpatient daily, including discharge planning. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- D. Outpatient supervision: The requirement to present outpatients is graded based on level of training]. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- E. Consultative Service supervision: The supervising/attending physician must communicate with the resident and obtain a presentation of the history, physical exam and proposed decisions for each referral. This must be done within an appropriate time but no longer than 24 hours after completion by the resident of the consultation request.

All requires supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.

- F. Procedural supervision: The supervising/attending physician must ensure that procedures performed by the resident are warranted, that adequate informed consent has been obtained and that the resident has an appropriate level of supervision during the procedure to include sedation. The level of supervision (according to the four levels outlined previously in this policy) must match both the resident's ability to determine the appropriateness of the procedure and the resident's ability to perform the procedure. The supervising/attending physician's presence for key parts of scheduled surgeries and procedures is governed by both this policy and LBM/MCH "Code of Conduct." All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- G. Emergency supervision: During emergencies, the resident should provide care for the patient and notify the supervising/attending physician as soon as possible to present the history, physical exam and planned decisions. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- H. Each department develops specific guidelines concerning resident supervision and submits them to the GMEC for approval. These must include the following key principles:
1. Clinical responsibilities must be conducted in a carefully supervised and graduate manner, tempered by progressive levels of independence to enhance clinical judgement and skills.
 2. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
 3. Resident supervision must support each program's written educational curriculum.
 4. Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
 5. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
 6. Residents are supervised by teaching staff in accordance with these established guidelines.
 7. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.
 8. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the resident's evaluations of their faculty and rotations by the GMEC.
 9. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for

approval. The appropriate Residency Program Director will submit monthly progress reports to the GMEC until the situation or issue is resolved.

BILLING

Residents and Attending Physicians must follow the billing guidelines outlined by the Centers for Medicare and Medicaid Services (CMS) as it relates to E/M billing for services performed by residents (see CMS Guidelines for Teaching Physicians, Interns, and Residents"). In terms of documentation, attestations, and cosigning notes, the Attending Physician must at a minimum enter a personal notation documenting his or her performance of and/or physical presence during the key portions of the service, and of his or her participation in the management of the patient.

An example of acceptable documentation include:

"I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

"I saw and evaluated the patient. I reviewed the resident's note and agree, except that the clinical picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Examples of unacceptable Attending Physician documentation include:

"Agree with above"

"Rounded, Reviewed, Agree"

"Discussed with resident. Agree"

"Seen and agree"

"Patient seen and evaluated"

A cosignature alone

GENERAL HOUSESTAFF RESPONSIBILITIES

In general, **residents in years R-1 through R-3** are training for core or primary certification in their specialties. On inpatient services, they perform as the coordinators of care for their patients and are expected to obtain and record historical and physical exam data, to initiate diagnostic testing and therapy, and to document care that has been delivered. They are allowed to perform procedures on their patients within the scope of their proficiency and level of training. They must be prepared to report on the progress and status of their patients to residents that are more senior and to faculty attendings that share responsibility for the quality and appropriateness of the care given.

Residents in years R4-R5 may be either pursuing core certification or may be enrolled in a fellowship program. Depending on specialty requirements, they are expected to demonstrate complex problem-solving and management skills and to accept progressively more supervisory, administrative, and teaching responsibilities. While independence in performing these duties is a valuable component of the learning process, no resident at any level may function without faculty backup for consultation and evaluation of performance.

Residents in R-6 positions and above usually represent customized fellowship training. Fellows function essentially as apprentices to one or a small group of attending specialists engaged in

delivery of a narrowly focused, complex, and highly specialized form of patient care. Although fellows may act independently in the general aspects of patient care for which they are already fully trained, they work in subspecialty care under the supervision of their mentor(s) at varying levels of independence according to the complexity of the care, to their stage of development, and to the judgment of their mentor(s).