Internal Medicine Supervision Policy

Addendum to the MHG Resident Supervision Policy 500.01

Effective July 2024

Classification Levels of Supervision:

To promote appropriate resident supervision while providing for graded authority and responsibility, the program will use the following classification of supervision:

Direct Supervision:

1) The supervising physician is physically present with the resident during the key portions of the patient interaction.
    - PGY-1 residents must initially be supervised directly.
    - A supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision.

2) The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision in Patient Care and Clinical Education

Although the attending physician is ultimately responsible for the care of the patient, every physician share in the responsibility and accountability for their efforts in the provision of 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.

The goal of the internal medicine residency program is to create physicians capable of independent medical practice. As such, upon completion of the program each resident will have demonstrated the ability to care for patients with general medical conditions without the need for oversight and modification of their work by faculty. During the residency program, faculty will encourage assumption of independence as expeditiously as the resident's increasing knowledge, experience and professional maturity permit, in keeping with both safe patient care and sound educational principles.

The responsibility of the attending physician for the patient is never relinquished but the amount of freedom to make decisions and implement them and the amount and timing of attending supervision will change depending on an individual resident's demonstrated performance as judged by ongoing faculty performance reviews and ACGME Milestones data as the resident progresses through the program.

PGY1 residents begin the 1st year in a **Direct** supervision classification. As the developmental milestones are achieved, their level of responsibility will increase with a move into supervision classification **Indirect Supervision.**

PGY2/3 level residents are in **Indirect Supervision** classification moving towards **Oversight**.

At any time, the attending physician can designate which supervision level is necessary for that rotation.

Post Graduate Year 1 (PGY-1)

Trainees beginning their PGY-1 year will be closely supervised by their upper year residents and attending physicians. During the first six months of the PGY-1 year, all PGY-1 level residents will have direct supervision of their patients as defined above. PGY-1 level residents will then give a complete presentation of the history, their physical examination findings, interpretation of diagnostic tests, and intended interventions to their supervising resident or attending. The supervising resident or attending will confirm by interview/examination any key portions of history and physical exam and verify the intended interventions with the PGY-1 resident and patient. During the PGY-1 year with successful completion of skills and milestones, the resident may achieve an indirect supervision status. Historically this usually occurs around the mid-year evaluation. The supervising residents and attendings will be notified when an individual PGY-1 level resident has achieved indirect supervision classification.

The PGY-1 resident may carry out many supervised activities to include, but not limited to:

- Obtain a medical history
- Perform both a physical examination and a mental status examination
- Pronounce death
- Interpret the results of commonly used diagnostic procedures, including radiographs and laboratory results
- Write orders for admission, management and discharge
- Write prescriptions
- ALS team leader if has active certification
- Medical student supervision

- They may perform procedures independently once signed off by the internal medicine procedure committee.

Post Graduate Year 2 (PGY-2)

The PGY-2 year is an intermediate year of training in categorical internal medicine residency. The PGY-2 is designated as a supervising resident and should serve in a supervisory role to junior residents. The PGY-2 level resident may perform procedures independently once signed off by the internal medicine procedure committee and are expected to teach these skills to their more junior colleagues. They must present their patients (in person or phone) to their supervising attending within a reasonable time frame and at the end of every shift.

Post Graduate Year 3 (PGY-3)

The third year of categorical internal medicine training is the senior year. Residents at the PGY-3 level are assigned as supervising residents and should serve in a supervisory role to junior residents. The PGY-3 may perform procedures independently once signed off by the internal medicine procedure committee and are expected to teach these skills to their more junior colleagues. They must present their patients (in person or phone) to their supervising attending within a reasonable time frame and at the end of their shift.

Inpatient Admitting Rotations

The attending physician serves as a resource for residents and is available (by phone or in person) for guidance or assumption of care as needed.

Management rounds occur at least once daily on all admitting services and all patients on a teaching service are discussed briefly again at the end of the shift.

A typical care team consists of
- A supervising attending
- One or two supervising residents (PGY-2/3 level)
- Two or three PGY-1 level residents
- and often medical student(s)

Faculty members functioning as attending physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

A hierarchy of increasing authority and responsibility as experience is gained is embedded in the team. The PGY-2/3 level resident should serve in a supervisory role to junior residents and students in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident. Similarly, the supervising attending is expected to provide the appropriate amount of direct resident supervision necessary for safe and effective patient care. Judgments on delegation of responsibility are made by the attending; based on his or her direct observation and knowledge of each team member’s skills and abilities. The degree of supervision may vary with the clinical circumstances and the developmental stage of the resident. Management and Attending

Rounds provide a format for in-depth discussion of clinical presentations, pathophysiology, and management. All major clinical decisions are discussed, and all plans are reviewed with the supervising attending, either in management rounds, when appropriate throughout the day, and at the end of the resident shift.

The supervising physician will interview and/or examine the patient at their discretion, the resident's request, or at the patient's request. The resident will annotate the name of the staff physician in the electronic patient care record and make it available to the supervising staff for their review and co-signature. All medical care delivered by the resident must be documented, supervised, and co-signed by a credentialed physician.

General Rules

- All resident levels can write/dictate daily progress notes on patients for whom they are participating in their care.

- All resident levels can write/dictate discharge/transfer summaries for patients for whom they are participating in their care. It is the responsibility of the resident to discuss discharge plans with the supervising Attending and/or consulting physician prior to discharging the patient.

- All resident levels will be able to identify an available supervising attending, at-all-times, during patient care. A supervising attending will be immediately available on site to provide direct supervision 24/7.

- Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

- Residents service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility.

- Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician writes an order on a resident's patient, the attending or consultant must communicate his or her action to the resident in a timely manner.

Patient Cap

- A first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services.

- A first-year resident must not be assigned more than eight new patients in a 48-hour period.

- A first-year resident must not be responsible for the ongoing care of more than 10 patients.

- When supervising more than one first-year resident, the supervising PGY-2/3 resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period.

- When supervising one first-year resident, the supervising PGY-2/3 resident must not be responsible for the ongoing care of more than 14 patients.

- When supervising more than one first-year resident, the supervising PGY-2/3 resident must not be responsible for the ongoing care of more than 20 patients.

General Outpatient Supervision

Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings to include the internal medicine clinic. All aspects of patient care rendered by resident physicians must receive close supervision.

All aspects of patient care are ultimately the responsibility of the supervising attending. The supervising attending has the right to prohibit resident participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights or responsibilities to: examine and interview; write notes; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement and initialing the change in the written document or entering a corrective statement at the end of the electronic document.

When a resident is involved in the care of a patient it is their responsibility to communicate effectively with their supervising attending regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.

Internal Medicine Continuity Clinic Supervision

During the first six months of the PGY-1 year, all residents will have direct supervision of their patients as defined above. PGY-1 level residents will give a complete presentation of the history, their physical examination findings, interpretation of diagnostic tests, and intended interventions to the supervising attending. The supervising attending will confirm by interview/examination any key portions of history and physical exam and verify the intended interventions with the resident and patient. During the PGY-1 year with successful completion of milestones, the resident may achieve an indirect supervision status. Historically this usually occurs around mid-year evaluation. The internal medicine clinic supervising faculty will be notified when an individual resident has achieved indirect supervision classification.

Second year residents (PGY-2) will give a complete presentation whereas third year residents (PGY-3) may give a brief presentation on all new patients and on any follow-up patients. The supervising attending will interview and/or examine the patient at their discretion, the resident’s request, or at the patient’s request.

Residents must write/enter orders on patients for whom they are participating in their care.

Residents may perform procedures independently after signed off by the internal medicine procedure committee.

The ratio of residents to faculty for ambulatory care is not greater than 4:1.

Resident responsibilities

- Residents are responsible to check their messages and results in Cerner message.
- Messages and results need to be addressed and endorsed within 2 working days.
- Abnormal results need to be forwarded and discussed with the supervising attending.
- When management is changed, or a new order is put in to address the abnormal result, documentation in the form of a Cerner message or free text note must be done the same day.
- Phone communication with patients must be documented the same day.

Specialty Clinic Supervision

Resident supervision regarding patient care and the medical record will be the same for all residents rotating in the medicine subspecialty clinics. Residents may perform history and physical examinations. It is the responsibility of the resident to discuss their findings with the supervising attending immediately upon completion of their examination. The supervising attending will confirm key portions of the history and physical exam.

Residents will write/enter orders on patients for whom they are participating in their care.

Residents may perform procedures independently after signed off by the internal medicine procedure committee.

Mandatory Attending Notifications

To ensure timely communication and patient safety the resident is required to immediately communicate directly (telephone or in person) with their supervising attending physician, regardless of the time of day. Such communication must be clearly documented in the medical record and includes:

- Emergency room consults that will be discharged to home
- Clinic consults that will be discharged to home
- ICU admissions
- ICU transfers from floor or from another hospital
- Discharges to include against medical advice
- Transfers to another hospital, skilled nursing facility, or inpatient rehab center

- Patient death
- Any patient clinical deterioration
- Prior to performing any invasive procedure
- Change in code status
- Any event that may compromise patient safety
- Questions or concerns
- Error in care
- Family request
- Palliative care discussion
- Transition of care within MHG
- Code situation
- Conflict with patient or family
- Conflict with staff member

Documentation

Residents will write/dictate history and physical examination reports, procedure notes, progress notes, and discharge summaries, for patients for which they are assigned and must be reviewed, edited if necessary, countersigned and attestation signed by their attending physician.

Orders: Per ACGME residents must write all orders for patients under their care, with appropriate supervision by the attending physician. These orders will be implemented without the co-signature of an attending or consulting physician. Residents may not order ancillary tests or medications for themselves, other residents, or other hospital staff. This would constitute delivery of unsupervised care.

Progression:

Residents progress in responsibilities by year group (PGY level). Progression to the next year group will depend upon continued demonstration that the resident has achieved the expected competence in each of the six key areas patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and communication and interpersonal skills. This will be accomplished using a variety of competency-based assessment tools to include direct observation by the attending staff, by resident chart review, satisfactory completion of the mini-clinical evaluation exercises, 360 degree rotation evaluations, and by formal rotation evaluations. The progress of every resident is formally reviewed every six months by the Internal Medicine Residency Clinical Competency Committee. A written record of the residents' progress is on file in the Internal Medicine residency administrative office.