Carilion Clinic | VTC School of Medicine
Graduate Medical Education

Medical Education Policy: SUPERVISION – INSTITUTION

Facility: CMC
Initial Approval: July 1, 2011
Revised: January 2021
Sponsor: GMEC

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1. PURPOSE:

   Carilion Medical Center (CMC) recognizes the importance of patient safety in the training of resident physicians within graduate medical education programs. This policy supports high quality care by outlining the supervision requirements for residents, articulating residents' job responsibilities, and outlining attending physician responsibilities. To meet the goals of graduate medical education, CMC graduate medical education programs must ensure that appropriate and graduated supervision is provided to all residents in all clinical settings.

   This policy will also ensure compliance with the CMS guidelines on documentation for teaching physicians.

2. SCOPE:

   This Policy applies to all Accreditation Council for Graduate Medical Education (ACGME), Council on Podiatric Medical Education (CPME), and Commission on Dental Accreditation (CODA) accredited post-graduate training programs sponsored by Carilion Medical Center (CMC).

3. DEFINITIONS:

   3.1 Resident refers to all interns, residents, and fellows participating in accredited CMC post-graduate medical education programs.

   3.2 Program refers to accredited, post-graduate medical education programs sponsored by CMC.

   3.3 Physician refers to clinicians with an M.D., D.O., D.P.M., or D.D.S degree.

   3.4 Supervising Physician or Faculty Member is an appropriately credentialed and privileged physician or licensed independent practitioner (as allowed by each accrediting body) appointed to the program faculty to provide resident education and supervision and who has responsibility for the patient's care.

3.5 Advanced/Senior Resident refers to an upper level resident or fellow who may act as the Supervising Physician for aspects of patient care defined by the program. Each program must define when a resident will be considered an advanced/senior resident.

3.6 Resident supervision is the process of providing oversite and direction to a resident during their care of patients. Supervision may be exercised through a variety of methods to allow residents to progress to graduated responsibility leading to autonomous practice.

3.7 Physically present is the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

3.8 Levels of Supervision

3.8.1 Direct Supervision:

The Supervising Physician is:

3.8.1.1 Direct Supervision with physical presence: The supervision physician is physically present with the resident during the key portions of the patient interaction; or

3.8.1.1.1 PGY-1 residents must initially be supervised directly through with the supervising physician physically present.

3.8.1.1.2 Each program should consult their specialty specific requirements to determine the conditions under which PGY-1 residents may progress to be supervised indirectly.

3.8.1.2 Direct supervision without physical presence: 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.

3.8.2 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.

3.8.3 Oversight:

The Supervision Physician is available to provide review of procedures/encounters with feedback provided after the care is delivered by the resident.

4. PROCEDURE:

4.1 General Principles:

4.1.1 Each patient in the clinical learning environment will have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care.

4.1.2 PGY-1 residents must initially be supervised directly.

4.1.3 Programs will establish schedules that assign qualified faculty members or advanced/senior residents to supervise at all times and in all settings in which residents provide patient care.

4.1.4 The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members.

4.1.4.1 The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.

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

4.1.5 Ultimately, the level of resident participation and responsibility is determined by the attending or consulting physician and is based on the resident's level in the program, job description, documented competency to perform specific procedures, and the specific and unique needs of a given patient as determined by the attending or consulting physician.

4.1.6 All residents, regardless of year of training, must be in communication with the appropriate Supervising Faculty Physician according to policies defined by each program.

4.1.7 In every level of supervision, the attending physician must review, correct as needed, and sign history and physicals, progress notes, procedural and operative notes, and discharge summaries in a timely manner.

4.1.8 In ambulatory settings, a Supervising Faculty Physician must be continuously present to provide and be actively involved in the supervision of care.

4.1.9 Attending physicians have the right to prohibit resident participation in the care of their patients without penalty. When allowing residents to participate in the care of their patients, the attending physician does not relinquish their rights or responsibilities to examine and interview, admit or discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct/change resident medical management and decision-making that is deemed to be inconsistent with the decisions of the attending physician.

4.2 Program Specific Policies and Responsibilities:

4.2.1 Each Program will develop a supervision policy that at a minimum defines the following:

4.2.1.1 Level of supervision (using definitions in 3.6) provided for each clinical assignment.

4.2.1.2 The point in the program when a resident may be considered an advanced/senior resident and the clinical and educational circumstances when an advanced/senior resident may act as the Supervising Physician. Programs should consult and abide by definitions provided by their specialty specific accrediting bodies when available (See section VI.A.2.c).(1) of the ACGME Common Program Requirements).

4.2.1.3 Clinical circumstances and events in which the resident must notify and communicate with the appropriate supervising and/or attending Consulting Physician.

4.2.1.4 The program must define when physical presence of a supervising physician is required.

4.2.2 Programs should review their Supervision Policy on an annual basis and provide revisions, as necessary.

4.3 Resident Duties and Responsibilities:

4.3.1 Admission History and Physical/Consultations
Residents at all levels of training may perform history and physical examinations and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination.

4.3.2 Order and Interpret Diagnostic Studies

4.3.3 Residents at all levels of training may order diagnostic laboratory and imaging studies consistent with the practice of the supervising physician. Each program should develop education for the deployment of advanced imaging modalities. Supervision levels for ordering of these tests will be consistent with best practices and the level of responsibility conferred on the resident by their respective program.

4.3.4 Initiate Treatment in Emergent Situations
Residents at all levels of training may initiate emergent life-saving treatments such as CPR. Immediate efforts to obtain supervision by more advanced/senior residents and attending physicians should be made.

4.3.5 Daily Progress Notes
Residents at all levels of training may evaluate patients and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss

their documented findings and treatment plans with the attending physician on a daily basis, or when there is a change in a patient's condition. Attending and consulting physicians may make additions and corrections in the daily progress notes. Residents will forward their notes to the appropriate supervising attending for their co-signature.

4.3.6 Orders

Residents at all levels of training may write orders on patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending or consulting physician.

4.3.7 Routine Minor Clinical Procedures

Residents may perform routine minor clinical procedures independently or under the supervision of a more advanced/senior resident based on past experience and faculty-assessment of skills. These routine minor procedures include and are limited to the following:

i. Venipuncture
ii. Intradermal skin tests
iii. Suturing of minor lacerations
iv. Splinting
v. Application of dressings and bandages
vi. Placement of peripheral intravenous lines
vii. Removal of superficial foreign bodies
viii. Nasogastric tube placement
ix. Bladder catheterization
x. Transfusion of blood and blood products
xi. Other minor procedures for which informed consent is not required

4.3.8 Invasive Procedures

For the purpose of this policy, invasive procedures are defined as any clinical intervention for which informed consent is required or would reasonably be obtained with the exception of transfusion of blood and blood products.

Each residency program will develop a list of procedures that their residents may be certified to perform independent of the physical presence of the Supervising Physician. The residency program must provide easily accessible verification of such certification to the nursing and medical staffs. This list is updated on a regular basis and must be available via the Carilion EMR (EPIC) to nurses in the clinical setting.

4.4 Attending or Supervising Physician Documentation

Each attending must document a daily progress note on each patient stating that they assessed and agree with the care provided by the treatment team. Attending physicians submitting a bill for E/M services must comply with the documentation standards for teaching physicians as outlined in the Guidelines for Teaching Physicians, Interns and Residents. Dept of HHS, Center for Medicare and Medicaid Services.

4.5 GMEC Oversight

4.5.1 The GMEC will review each program's Supervision Policy on an annual basis.

4.5.2 Concerns about resident supervision will be investigated by the GMEC, as necessary.

Name	Title	Dept./Committee	Date
Daniel Harrington, MD	DIO	GMEC	December 2012
Donald W. Kees, MD	DIO	GMEC	November 2014
Donald W. Kees, MD	DIO	GMEC	January 2018
Donald W. Kees, MD	DIO	GMEC	June 16, 2020
Donald W. Kees, MD	DIO	GMEC	December 15, 2020
Donald W. Kees, MD	DIO	GMEC	January 19, 2021