I. PURPOSE:

The purpose of this policy is to outline the principles for supervision of post-graduate trainees at NYU-Winthrop Hospital.

II. DEFINITIONS:

a. GME – Graduate Medical Education
b. GMEC – Graduate Medical Education Committee
c. ACGME – Accreditation Council for Graduate Medical Education
d. CPME – Council on Podiatric Medical Education
e. CODA – Commission on Dental Accreditation
f. CCC – Clinical Competency Committee

III. POLICY:

It is the responsibility of GME programs to follow requirements of the ACGME, or other applicable accrediting body; including CPME and CODA regarding supervision of house officers and clinical fellows. Trainees must be supervised by appropriately-credentialed and privileged attending physicians in a manner that is consistent with patient care needs and the knowledge and skills of the individual house staff member. House staff shall be given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation. Both house staff and attending physicians will inform their patients of their respective role in that patient’s care. Program Directors are responsible for ensuring that residents and fellows are supervised by teaching staff in a way that provides progressively increasing responsibility according to level of education, ability and experience.

Lines of responsibility for the care of patients shall be made clear to all members of the teaching teams. Lines of supervision will be defined using the following classification of supervision:

1. Direct Supervision: the supervising physician is physically present with the resident and patient.

2. 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.
3. **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.

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

Questions regarding the interpretation of any of the above terms (1-4) should be referred to the Associate Dean of Graduate Medical Education.

**IV. Supervisor Qualifications**

Supervisors may be attending physicians from the Medical Staff, residents in their final year of training within their programs, or residents having completed 3 years of specialty-specific postgraduate training. In this context, the supervisor is essentially the attending physician or in lieu of the attending, a post-graduate trainee in the final year of training when the attending is immediately available by phone and readily available in person when needed. The responsible supervising physician must be made known to the house staff and all members of the health care team in a reliable and easy to access manner.

**V. Attending Supervisor Responsibilities**

a. The attending physician of record is responsible for the quality of care provided to his/her patient and must maintain the same standard of availability as though residents were not involved in that care. When the attending physician of record is a member of the faculty, the faculty member is required to assume the same standard of responsibility and availability as non-teaching attending physicians.

b. The attending physician or his covering Medical Staff physician must be available and easily accessible to provide supervision to the resident.

c. At the core of supervision is clear, concise communication between the resident and supervising physician. Timely communication that is patient-focused must not be encumbered by intimidation or fear of retribution. The Hospital’s escalation policy mandates unrestricted communication between members of the health care team for the benefit of patient care.

d. While supervision of patient care activity clearly poses an opportunity for specific teaching, supervision must always occur even when teaching may not. All attending physicians interacting with residents and/or PA’s/NP’s in the care of their patients have a de facto supervisory role which is distinct from a teaching role.

e. Attending supervisors are expected to be collegial and professional in their interactions with residents. Effective communication is fostered by prompt response with feedback that is constructive and not demeaning.
f. The faculty supervisor assigned for each rotation or clinical experience (inpatient or outpatient) shall provide to the Program Director a written evaluation of each trainee’s performance during the period that the resident or fellow was under his or her supervision.

VI. **House Staff Responsibilities**

a. The resident is responsible to the supervising physician to review patient care plans and situations requiring supervision in a manner consistent with patient need.

b. The resident must accept the supervision and obtain specific supervision as dictated by patient care necessity.

c. While residents in their final year of training may serve as supervisors, timely communication with the attending of record should nevertheless occur.

d. Each program must set guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members, such as (but not limited to):

  - Transfer of a patient to an intensive care unit
  - Taking a patient to surgery
  - End-of-life decisions
  - Patient expiration
  - Any condition in which a resident believes that supervising physician input is warranted.

Each program’s Circumstances and Events will be posted on the home page of New Innovations and should be reviewed and updated by each program annually.

VII. **GMEC Responsibilities**

GMEC is responsible for the monitoring of the clinical learning environment in regard to supervision. Mechanisms by which adequate supervision will be monitored include:

  - Anonymous faculty and rotation evaluations that must include questions assessing adequate faculty supervision, graded authority and responsibility.

House Staff must be able to report inadequate supervision in a protected manner that is free of reprisal, such as:

  - Open Door GME Policy (via phone, email, or walk in)
  - Anonymous Faculty and Resident Evaluations thru New Innovations
VIII. Escalation

In the event of conflict of opinion between the supervisor and the resident, either party may utilize the hospital’s escalation policy to achieve a rapid, patient care based resolution. In the rare event that a supervising physician is unavailable, the resident must utilize the escalation policy to obtain the prompt supervision required. Responsibility for decisions made in the absence of consultation with the responsible attending physician resides with the residents and surrogate supervisors.

IX. Emergency Care

An “emergency” is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient. In such situations, any house staff, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and notified of the situation as soon as possible. The House Staff will document the nature of that discussion in the patient’s record.

X. Progressive Responsibility

As part of the training program, house staff should be given progressive responsibility for the care of patients. The determination of a house staffs’ ability to provide care to patients without a supervisor present, or to act in a teaching capacity, will be based on documented evaluation of the house staffs’ clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the director of the CCC and Program Director to determine which activities the house staff will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the supervisor. Documentation of the clinical skills and procedures which can be performed under indirect supervision with direct supervision available will be accessible with a universal log-in in New Innovations.

Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

XI. Documentation

Documentation of supervision of resident patient care activities may take the following forms:

a. The attending physician or his /her Medical Staff designee who sees the patient on a daily basis should write a progress note in addition to that written by the resident confirming or commenting on the patient care plan.

b. Residents are to note in their progress notes with which supervising physician they reviewed the patient care plan. This must occur on admission and when there is a change in the diagnostic/therapeutic plan.
c. If attending supervisors do not write independent progress notes, they may co-sign the resident notes with comments as needed to document their supervision of the resident. Note that this does not address, however, specific requirements for billing.

d. Attending physicians are encouraged to document in their progress notes the name(s) of residents with whom they reviewed the plan of care.

*Graduate Medical Education Committee: 9/11/2017, 12/17/18*