	Johns Hopkins Medicine <b>Graduate Medical Education (GME) Policies and Forms</b>	<i>Policy Number</i>	P&F022
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	<b>Supervision of Postdoctoral Trainees Policy</b>	<i>Supersedes</i>	02/08/2012

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## **I. OBJECTIVES**

The GMEC subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that provides (a) graded responsibility for residents and fellows in patient care decision-making under adequate supervision, (b) supervisor feedback to residents and fellows concerning their diagnostic and management decisions, and (c) an appropriate balance of education and patient care responsibility with the patient's right to expect a healthy, alert, responsible and responsive physician dedicated to delivering effective and appropriate care. In order to create this type of learning environment, ensure appropriate levels of supervision, and compliance with the *Essentials of Accredited Residencies*, the GMEC strives to ensure that the principles set forth in this policy and these procedures are followed by the residency training programs sponsored by The Johns Hopkins University School of Medicine.

## **II. PRINCIPLES**

- A. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.
- B. Clinical responsibilities must be conducted in a carefully supervised and graduated manner, allowing housestaff to assume progressively increasing responsibility in accordance with their level of education, ability, and experience.
  1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident or fellow must be assigned by the program director and faculty members after assessment of relevant competencies
  2. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific criteria or milestones.
  3. Senior residents or fellows should be given the responsibility for supervising junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- C. Supervision of residents and fellows should foster humanistic values by demonstrating a concern for each housestaff member's well-being and professional development.
  1. Supervision must include timely and appropriate feedback and residents and fellows must be provided with rapid, reliable systems for communicating with supervising faculty.
  2. Supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.

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- D. Faculty members functioning as supervising physicians should delegate portions of care to residents and fellows, based on the needs of the patient and the skills of the resident or fellow. Residents, fellows and faculty members should inform patients of their respective roles in each patient's care.
- E. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.


### **III. LEVELS OF SUPERVISION**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- A. **Direct Supervision** – the supervising physician (senior resident, fellow or faculty member) is physically present with the resident and patient.
- B. **Indirect Supervision** -
  - 1. 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
  - 2. 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.

### **IV. SPECIFIC REQUIREMENTS**

- A. Each Program sponsored by The Johns Hopkins University School of Medicine shall develop and maintain appropriate supervision policies, compliant with ACGME Program Requirements, including an explicit description of the supervision for each activity or rotation and for each level. Each description shall include:
  - 1. The types of supervision, using the terms in III above. If the level of supervision required may change during the rotation, for example **Direct Supervision** until documentation of competency changing to **Indirect Supervision with direct supervision available**, this must be clearly stated.
  - 2. The person(s) providing supervision; if this is defined by position or title, the mechanism for identifying the current responsible individual must be specified.
  - 3. Guidelines for circumstances and events in which trainees must communicate with appropriate attending faculty members, such as the transfer of a patient to a higher level of care, controversies regarding patient management, concerning changes in a patient's condition or end-of-life decisions.
  - 4. Supervisory roles of the trainee, if any.
- B. The following site-specific faculty supervision requirements are applicable.
  - 1. Inpatient Services: A patient care team that may include medical students, interns, residents and fellows, under the supervision of a faculty physician, shall care for patients admitted to the service. Decisions regarding diagnostic tests and therapeutics, although initiated by housestaff, shall be reviewed with the responsible faculty member during patient care rounds.

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- a. Patients shall be seen by the responsible attending and their care shall be reviewed at appropriate intervals. The attending shall document his/her involvement in the care of the patient in the medical record. Housestaff members are required to promptly notify the patient's faculty physician in the event of any controversy regarding patient care or any serious change in the patient's condition.
- b. Faculty members or their designees (covering physicians) are expected to be available, by telephone or pager, for housestaff consultation 24 hours per day for their term on service, on-call day or for their specific patients.
2. Adult and Pediatric Emergency Departments:
  - a. In the Adult and Pediatric Emergency Departments, a faculty member must be on-site 24 hours per day.
3. Clinics and Consultation Services:
  - a. In clinics and consultation services, a faculty member must review overall patient care rendered by housestaff.
4. Intensive Care Units:
  - a. In intensive care units, housestaff decisions regarding patient care, including admission, discharge, treatment decisions, performance of invasive procedures and end-of-life decisions are to be discussed and reviewed by faculty.
5. Supervision of Housestaff in Operating Suites:
  - a. In the operating suites, a surgical faculty member is responsible for the supervision of all operative cases. A surgical faculty member shall be present in the operating room with housestaff during critical parts of the procedure. For less critical parts of the procedure, a surgical faculty member must be immediately available for direct participation.

## **V. MONITORING COMPLIANCE**

- A. The quality of housestaff supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the housestaff's evaluations of their faculty and rotations, review of ACGME surveys and the GMEC's internal reviews of programs. During the Internal Reviews of programs, the GMEC shall request that each program provide a description of the procedures to ensure supervision in the program's clinical settings (including nights and weekends), an explanation as to how the program monitors compliance with its supervision policies, a description as to how the program becomes aware of and responds to exceptions or critical instances of breakdown of supervision and the mechanisms the program has in place to ensure accessibility and availability of faculty.
- B. For any significant concerns regarding housestaff supervision, the respective program director shall submit a plan for its remediation to the GMEC for approval and the program director may be required to submit progress reports to the GMEC until the issue is resolved.