

VIRGINIA COMMONWEALTH UNIVERSITY POLICY ON THE SUPERVISION OF HOUSESTAFF

GENERAL PRINCIPLES

As outlined in the Joint Statement on Resident Supervision issued by the Virginia medical schools, the Medical College of Virginia of Virginia Commonwealth University subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that allows sufficient freedom for housestaff to share responsibility for decision-making in patient care, and yet provides adequate faculty supervision and involvement in order to provide feedback to trainees about their actions, and to address the quality and safety of the care rendered to patients. Housestaff are individuals with a M.D., D.O., or equivalent degree, those with a dentistry degree, and others who meet the qualifications for graduate education/training in a specialty or subspecialty of medicine or dentistry. In order to preserve this type of learning environment for its teaching program, the Department advocates the following principles as elements of its policy on housestaff education and supervision. The provisions of this policy also apply to teaching activities at the Veterans Affairs Medical Center and at other affiliated teaching sites. These other sites may supplement this policy with additional rules as dictated by their own governance structure.

1. Housestaff, working under the authority and supervision of attending faculty, are regarded as the primary coordinators of care for all patients admitted to the teaching inpatient services, emergency rooms, and clinics, and, as such, are responsible for the writing of orders, for the maintenance of records, and for the execution of diagnostic, therapeutic, and discharge plans.

2. Depending on their respective levels of training, it is appropriate and essential that junior housestaff be supervised by more senior housestaff in accordance with site-specific guidelines stated elsewhere in this document.

3. All spheres of housestaff activity will be supervised by attending faculty members who will share responsibility with houseofficers for patient care rendered, and who will have ultimate authority for final decision-making. The structure of housestaff-attending interactions and the form that faculty supervision of housestaff takes will vary according to site and type of patient care setting and are summarized below.

SITE-SPECIFIC HOUSESTAFF SUPERVISION

Inpatient teaching services

1. A patient care team that may include medical students, interns, and residents, under the direction of faculty attending physicians, will care for all patients admitted to the service.
2. Except in unusual circumstances, new patients will be presented to the responsible attending no later than the first full day after admission.
3. Although decisions regarding diagnostic tests and therapeutics may be initiated by the housestaff, these decisions will be reviewed with the attending at intervals in the context of patient care rounds.
4. All patients will usually be seen by the attending and will be reviewed with the attending at

appropriate intervals. The attending may document his/her involvement in the care of the patient in the medical record.

5. Housestaff are required to notify the patient's attending, in a timely fashion independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient's course including unexpected death, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition.
6. Attendings or their designee are expected to be available or responsive, either by telephone or pager, for housestaff consultation, 24 hours a day for their term on service, their on-call day, or for their specific patients.

Emergency department

The Emergency Department will be covered 24 hours a day by a faculty attending on site. Patients will be presented by residents to the ER attendings as dictated by the Department of Emergency Medicine policy regarding trainee supervision.

Clinics and consultation services

Faculty will review patient care rendered by residents in outpatient clinics, and those recommendations given by them on a consultation service.

Intensive care units

Housestaff decisions, including senior resident decisions, regarding admission and discharge of patients from the intensive care units, and involving the performance of invasive procedures, are subject to review by subspecialty fellows and attendings.

Operating rooms

The faculty is responsible for supervision of all operative cases. At a minimum, this means being in the operating room with the housestaff during critical parts of the procedure. For less critical parts of the procedure, the faculty must be immediately available for direct participation.

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 judgement of their mentor(s).

EVALUATION OF RESIDENT PERFORMANCE

Essential areas of professional competence will be evaluated regularly and in writing by attending physicians. These evaluations will be monitored by the program director. Based on the program director's recommendations, housestaff whose performance is judged to be satisfactory will be promoted to the next level usually at the beginning of the next academic year. In case of inadequate performance, the program director or the departmental Housestaff Evaluation Committee may elect to prescribe remedial experiences, or to delay or deny promotion or board recommendation, as appropriate for the deficiencies identified. The mechanisms for documenting resident performance and for initiating remedial or adverse action are described in *Policies and Procedures for the Assessment of Performance of Residents in Graduate Medical and Dental Education*.

PROGRAM SPECIFIC REQUIREMENTS

The department will carry out annual review of this general policy with revisions made as necessary. Each program may supplement the institutional policy with a program-specific policy that may include statements regarding the following:

1. Intensity of attending involvement in each of its own clinical areas, addressing, in particular, inpatient services, outpatient clinics, consult service, and any critical care areas under its purview.
2. Intensity of attending involvement in the operating rooms, and during invasive procedures, as applicable.
3. Duties of the housestaff in seeking attending advice, or direct supervision.
4. General description of the skills and supervisory capacity expected of residents at each year in the program.

Revision approved by Program Directors Council, 5/5/1999

Revision approved by Graduate Medical Education Committee, 7/13/1999

Reviewed Program Directors Council and GMEC December, 2000