

Trainee Supervision Policy
SAUSHEC Infectious Disease Fellowship Program
2014

1. Applicability.

The SAUSHEC Board of Council (Commanders of Brooke Army Medical Center (BAMC) & 59th Medical Wing (59th MDW) and the Dean SAUSHEC) and the Graduate Medical Education Committee (GMEC) of SAUSHEC approved the global policy for trainee supervision, from which this policy was derived. This policy applies to and is tailored to the supervision of internal medicine physicians in training in infectious diseases and establishes minimum requirements for supervision of fellows who provide medical care to patients at BAMC. This instruction applies to all personnel assigned, attached or on contract to BAMC and WHMC. Rotating medical students are covered by the SAUSHEC Institutional Supervision Policy, and rotating internal medicine residents are covered by the SAUSHEC Internal Medicine Residency Supervision Policy.

2. General Principles of Supervision

- a. Fellows are considered by the ACGME to be in their final year of training although the expectation is to have graded levels of responsibility during their 2 to 3 years of training. Supervision constitutes any method of staff oversight of patient care for the purpose of ensuring quality of care and enhancing learning.
 - i. Direct Supervision – the supervising physician is physically present with the resident and patient.
 - ii. Indirect Supervision –
 1. with direct supervision ***immediately available*** – the supervising physician is physically within the treatment facility and is immediately available to provide Direct Supervision.
 2. with direct supervision ***available*** – the supervising physician is not physically present within the treatment facility, but is immediately available by means of telephone and/or electronic modalities, and is available to provide Direct Supervision.
 - iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- b. Careful supervision and observation are required to determine the fellow's ability to manage patients and to perform technical procedures or interpretive procedures. Although not privileged in infectious diseases, fellows must be given graded levels of responsibility while at the same time assuring quality care for patients. Supervision of

fellows will be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning privileged provider. The job descriptions and expectations of the fellows in the 6 ACGME core competencies are outlined in the SAUSHEC ID Curriculum.

- c. The SAUSHEC infectious disease fellowship program director has defined the mechanism by which fellows progressively become independent in specific patient care activities while still being appropriately supervised by medical staff. There exists only one step of partially independent practice which should occur at the 6 month time point (see Appendix 1). The decision to advance a fellow from Level 1 to Level 2 will only occur after that fellow's performance has been reviewed by the clinical competency committee, and it is agreed that progression to the higher level of practice is appropriate. The criteria used for assessing progression from Level I to Level 2 is outlined in Appendix 2.
- d. Ultimately, the supervising staff member is responsible for the care of the patient and for the conduct and performance of all fellows under his or her supervision. This responsibility includes that for actions that the fellow may pursue that would otherwise be within the scope of the fellow's independent privileging as an internal medicine physician (e.g., lumbar puncture, thoracentesis, arthrocentesis, etc.). If the trainee is acting in his or her role as a fellow in infectious diseases, all actions are the ultimate responsibility of the ID attending staff. The only exceptions occur when a fellow willfully disregards hospital policy or the directions of a staff supervisor, conceals his/her intentions or actions from a staff supervisor, or performs medical care outside the scope of normally delegated responsibility without the knowledge and approval of the supervisor. The other exception occurs when ID fellows are privileged by BAMC/59th MDW to perform procedures as internists, and if they are acting as internal medicine primary care physicians (i.e., the procedure is independent of a relationship between the patient and the trainee in his/her role as an infectious disease fellow).
- e. The PD/APD will insure that all supervision policies are distributed to and followed by fellows and the medical staff supervising their fellows. Compliance with the SAUSHEC resident supervision policy will be monitored by the Program Directors who will report issues to the GMEC annually in their Metric reports and during the internal review process and prior to the RRC inspection of the program. These reports will be reported to the governing bodies of BAMC & 59th MDW. Biannually, at the staff clinical competency meeting as outlined above, the PD/APD will determine if fellows can progress to the next higher level of training. This assessment will be documented in their annual assessment of each resident.

3. Fellow Supervision in Different Patient Care Settings

- a. Supervision of Fellows on Inpatient Consult Teams
 - i. All inpatient consultations performed by fellows will be documented in writing with the name of the responsible staff consultant recorded. The responsible staff

consultant must be notified verbally by the fellow doing the consult within an appropriate period of time as defined by the clinical situation and the training level of the fellow performing the consultation.

- ii. Consultation performed on patients with severe acute illness must be reviewed no later than 8 hours after consultation, or immediately if the situation is critical, with the responsible staff, for fellows at all levels of training (see Appendix 1). Consultations performed on patients with lesser severities of illness must be reviewed by staff within 24 hours of the consultation. This review may be telephonic, with the staff ultimately being responsible for the decision whether or not to personally see the patient within 24 hours.
- iii. The consulting staff is responsible for all the recommendations made by the consultant team. If requested by the patient's primary staff, the consulting staff must see the patient.

b. Supervision of Fellows on Outpatient Clinic Assignments

- i. All outpatient visits provided by fellows will be done under the supervision of a staff provider, usually one that is the assigned clinic staff attending for that date. If an alternative attending is engaged (because of absence of the primarily assigned staff, or because of a staff physician's known prior experience with a patient), the supervisory responsibility is that of the alternative staff physician. Progression of fellow responsibility in clinic is annotated in the Appendix 1.
- ii. The staff provider will interview and examine the patient at the staff's discretion, at the fellow's request, or at the patient's request. The staff doctor has full responsibility for care provided, whether or not he/she chooses to personally verify the interview or examination. The name of the responsible supervising staff will be clearly recorded in the patient record.

4. Documentation of Staff Supervision of Subspecialty Consultation for Hospitalized Patients

Staff supervision of subspecialty consultation must be documented in the inpatient record. Date, time, signatures, and signature stamps are required on all notes and orders if not performed electronically. Such documentation may be accomplished by the fellow at the time of the initial recording of the consultation.

5. Supervision of Fellows performing procedures.

A fellow will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the fellow is competent to safely and effectively perform the procedure. The level of supervision required will depend on whether the procedure is being performed in the trainee's role as an infectious disease fellow (e.g., a lumbar puncture to evaluate meningitis), whether privileges for independent performance of the procedure have been granted by the institution (most procedures are

internal medicine specific), and the institution's routine evaluations of provider's competencies (as directed by the Credentials committee [Commander]).

6. Fellow grievances regarding supervision

It is the Program Director's responsibly to insure that fellows are aware that any concerns they have regarding adequate technical or professional supervision, or professional behavior, by supervisors will be addressed in a safe & non-threatening environment per SAUSHEC and ACGME guidelines. The SAUSHEC Infectious Disease program will follow the policies of the SAUSHEC resident grievance policy. Trainee grievance mechanisms (Program Director or APD, Department Chief, Ombudsman, Inspector General) are available to SAUSHEC infectious disease fellows, as insurance that fair and just relationships between fellows and staff can be perpetuated. The SAUSHEC Grievance Policy, a formal declaration of the above mechanisms, is established for the infectious disease fellowship, is clearly stated, is made available to all fellows during their orientation to the Program, and will be kept in the fellow's file with his or her signature.

Program Director
SAUSHEC Infectious Disease Fellowship

Appendix 1. SAUSHEC Infectious Disease Fellowship.
 Level of Supervision, by Activity and Training Level.**

Clinical Encounter	Level of Supervision	
	0-6 months of fellowship	7-36 months of fellowship
Outpatient consultation	1*	3*
Inpatient consultation	2*	3*

*1 = Presentation to attending at time of clinical evaluation (Indirect Supervision with direct supervision immediately available)

*2 = Presentation to attending within duty day, < 8 hours (Indirect Supervision with direct supervision available)

*3 = Chart/record/consult presented to attending, same duty day for outpatients; < 24 h for stable inpatients. Progression at 6 months contingent upon ID Fellowship Competency Committee review and approval.(Indirect Supervision with direct supervision available)

**Any critical or life threatening issues and antibiotic needing immediate approval shall be communicated immediately with the attending in person or telephonically.

Appendix 2. Criteria for progression from Level I to Level 2. Below are the 6 core areas to be assessed by the Clinical Competency Committee at the 6 month time. Competence will be based upon monthly evaluations by attendings, attendings present at the meeting, and input from the program coordinator,

Patient care	Medical interviews, physical examinations, review of pertinent data and procedural skills should be thorough and complete. Decision making should incorporate evidence based medicine backed by sound judgment. Decisions should be made in cooperation with other consultants and the primary care physicians managing the patients including the wishes of the patient.
Medical knowledge	Presence of an in-depth knowledge of these areas with an ability to quote primary literature pertaining to this knowledge. Knowledge includes the breadth of infectious diseases.
Practice-based learning improvement	Seek outside feedback with appropriate responses to improve overall health care delivery. Incorporate information technology available at the institutions to improve the care of their patients and for self-improvement. Ability to implement primarily textbooks and review articles to obtain the breadth of knowledge necessary for performing as an infectious disease physician.
Interpersonal and communication skills	Adequately involve listening, narrative and nonverbal skills to provide education and counseling to patients, families and colleagues while staying connected with all aspects of health care delivery.
Professionalism	Perform to the highest level of professionalism at all times. This includes respect, compassion, integrity, and honesty. They should be committed to self-assessment along with a commitment to their patients, families and colleagues. They should willingly admit errors. Perform the role of teacher and role model as the infectious disease consultant.
Systems-based practice	Competence in the systems used within the various training hospitals for improving health care. Apply considerations of risk-benefit analysis and cost of therapy when caring for their patients, and coordinate patient care with relevant health care systems (e.g. outside laboratories, pharmacy, and home health).