



**San Antonio Uniformed Services
Health Education Consortium
San Antonio, Texas**

Department of Medicine Subspecialty Clinics

**Supervision of Residents
December 14, 2012**

1. Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings to include the medical subspecialty clinics and consultation services. All aspects of patient care rendered by resident physicians must receive close supervision.
2. All aspects of patient care are ultimately the responsibility of the supervising physician. Supervising physicians have the right to prohibit resident and medical student participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights or responsibilities to: examine and interview; write notes; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement and initialing the change.
3. When a resident is involved in the care of a patient it is their responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.
4. The supervising physician is defined as that physician who has immediate oversight responsibility of all aspect of patient care rendered by the residents and may be a staff or fellow.
5. Resident supervision in regards to patient care and the medical record will be the same for all residents rotating in the medicine subspecialty clinics. The supervision of residents in regards to patient care and the medical record will not vary by PGY level in the medicine subspecialty clinics. Residents may perform history and physical examinations, and consultations without the supervising physician being physically present. It is the responsibility of the resident to discuss their findings with the supervising physician upon completion of their examination. The supervising physician will confirm any key portions of the history and physical exam. The supervising physician must make additions and corrections in the documented history and physical, and co-sign the residents' documentation. All documentation by residents and supervising physicians must be legible to those who use the medical record, including signatures. After discussion with the attending staff, residents may write/enter orders on patients for whom they are participating in their care. These orders will be implemented without the co-signature of an attending or consulting physician. Medical

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students may perform history and physical examinations without the supervising physician being physically present but the supervising physician must repeat the interview and physical examination on every patient. Medical students may write the note but it must be reviewed upon completion and co-signed by the supervising resident who must also indicate they have independently examined and interviewed the patient..

6. Residents rotating in the medical subspecialty clinics will not be allowed to give independent verbal consultations at any time. Recommendations either need to be written and co-signed or delivered verbally by the supervising fellow or staff.

7. Procedures: Residents performing procedures in the medical subspecialty clinics that they are not certified to perform unsupervised should be supervised by the physical presence of the supervising physician. In general all first year residents will be certified at the start of the academic year to perform venopuncture, peripheral IV line placement, arterial puncture and nasogastric tube placement unsupervised. The following is a list of additional procedures that are both required for residency training and that are tracked. The number needed is given and the number requiring bedside supervision by a more experienced physician is in parentheses:

- abdominal paracentesis 3 (3)
- arthrocentesis of a joint 3 (3)
- central venous line placement
 - femoral line 5 (5)
 - subclavian line 5 (5)
 - internal jugular line 5 (5)
- lumbar puncture 5 (5)
- thoracentesis 5 (5)
- treadmill test 25 (50)
- endotracheal intubation 5 (5)
- Swan-ganz catheter placement 5 (5)*

Individuals may be certified to perform these procedures unsupervised by the program director only after they have successfully completed the minimum number of required supervised procedures and when a supervising physician has documented that they are competent to perform the procedure. Occasionally a resident has done sufficient numbers of other procedures to be allowed to do them unsupervised (flexible sigmoidoscopy 15 (15), bone marrow biopsy 5 (5), transvenous pacer 5 (5)* etc). These will also be tracked and require certification by the program director. It is the resident's responsibility to document all their procedures in the New Innovations procedure logbook in order to receive credit. All procedures except for venopuncture, peripheral IV line placement, nasogastric tube placement, arterial puncture, or those procedures performed during an emergency such as a code require prior notification of the supervising physician. An electronic and hard copy record of the resident's procedure certification will be maintained on file in the Internal Medicine Residency office. A copy will be given to all the clinics and wards. A written record of certification will be sent with the residents doing away rotations. Medical students are not allowed to perform any procedures unsupervised.

*These may be counted as central lines also.

8. Progression:

Residents progress in responsibilities by year group (PGY level). Progression to the next year group will depend upon continued demonstration that the resident has achieved the expected competence in each of the six key areas patient care, medical knowledge, practice-based learning and improvement, systems based practice, professionalism, and communication and interpersonal skills. This will be accomplished using a variety of competency based assessment tools to include direct observation by the attending staff, by resident chart review, satisfactory completion of the mini-clinical evaluation exercise, 360 degree rotation evaluations, skills stations, portfolios and by formal rotation evaluations.. The progress of every resident is formally reviewed every six months by the Internal Medicine Residency Clinical Competency Committee. A written record of the residents' progress is on file in the Internal Medicine residency administrative office.

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Program Director
SAUSHEC Internal Medicine

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Chairman, Department of Medicine