DEPARTMENT OF THE ARMY
WOMACK ARMY MEDICAL CENTER
FORT BRAGG, NORTH CAROLINA 28310

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Graduate Medical Education

POLICY ON SUPERVISION OF RESIDENTS IN A MILITARY GRADUATE MEDICAL EDUCATION (GME) PROGRAM

1. HISTORY. This is the second printing of this publication.

2. REFERENCE.

a. AR 351-3, Professional Education, and Training Programs of the Army Medical Department, 15 October 2007.

b. ACGME, Section II-Institutional Requirements, 1 July 2007.

c. TJC Accreditation Manual for Hospitals, Current Edition October 2009.

d. MEDCEN Reg 40-36, Credentials Policy, 9 June 2009.

e. AR 40-68, Clinical Quality Management, 22 May 2009

f. DOD 4000.19-R, Interservice and Intergovernmental Support 9 August 1995.

g. AR 601-141, The Army Health Professions Scholarship Program, 19 September 2006.

3. DEFINITION OF TERMS. These terms are defined to conform to the administrative and Command structures at Womack Army Medical Center**.** The Womack Army Medical Center will indicate in the institutional documents reference (d) the individual(s) specifically designated to fulfill the responsibilities described.

a. *Army Teaching Facility (ATF).* Womack Army Medical Center.

b. *Board Certified.* A diplomate of a specialty board approved by the American Board of Medical Specialties (ABMS) or Board Of Specialties (BOS).

c. *Board Eligible.* An individual who has completed an approved residency program in which the training, education, and experience would be expected to result in formal acceptance by the appropriate ABMS or BOS specialty board.

d. *Director of Medical Education (DME).* An institutional official having the authority and the responsibility for oversight and administration of GME programs. The official responsible for GME programs at Womack Army Medical Center is the Director of Medical Education**.**

e. *Graduate Medical Education (GME).* The process by which clinical and didactic experiences are provided to residents/healthcare trainees in order to enable them to acquire the skills, knowledge, and attitudes/behaviors that is important in the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident/health care trainee, facilitating the resident/health care trainee professional and personal development, and ensuring safe and appropriate care for patients. The GME programs focus on the development of clinical skills, attitudes/behaviors, professional competencies, and an acquisition of detailed factual knowledge in clinical specialties.

f. *Graduate Medical Education Committee (GMEC).* The institutional committee composed of the DME, Program Directors and at least one resident representative whose charter is to monitor and advise on all aspects of GME in the institution. All GMEC members, including the resident, are voting members when hearings related to adverse actions are conducted.

g. Institutional *Clinical Authority (ICA).* The official designated in institutional documents as having responsibility for the quality of care provided by LIPs, health care trainees. The ICA at Womack Army Medical Center is the Deputy Commander of Clinical Services.

h. Institutional *Document.* The organizational document that defines the structure and the chain of authority and accountability for the institution sponsoring GME.

i. Institutional *Governing body (IGB).* The authority ultimately responsible for the quality of health care delivery provided and the effective functioning of activities related to graduate medical education when provided. The IGB at Womack Army Medical Center is the Commander**.**

j. LIP. A licensed independent privileged provider who is authorized to make independent decisions related to beneficiary health care management based on his/her recognized scope of practice.

k. Resident. An individual engaged in GME and participates in patient care under the direction of an attending. The term “resident” includes individuals in approved subspecialty graduate medical education programs who historically have been referred to as “fellows.”

l. Supervision. The responsibility of an attending/LIP is to enhance the knowledge of the health care trainee/resident while ensuring patient safety and quality care. Such responsibility is exercised by observation, consultation, and direction, and includes the imparting of knowledge, skills, and attitudes/behaviors to health care trainees/resident and the assurance that care is delivered in an appropriate, timely, and effective manner. Supervision implies face-to-face contact with health care trainees/resident in the presence of the patient.

4. GENERAL.

a. This policy outlines the institutional requirements for supervision of residents as prescribed by the Office of the Surgeon General (OTSG), the Accreditation Council for Graduate Medical Education (ACGME), other educational healthcare accrediting organizations and The Joint Commission (TJC).

b. All Army GME programs must adhere to the requirements of the ACGME, other educational healthcare accrediting organizations and TJC.

(1) The ACGME and other educational healthcare accrediting organizations requires residents to be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. This process is an underlying educational principle for all GME, regardless of specialty.

(2) The TJC requires those responsible for governance to establish policy, promote performance improvement, and provide for organizational management and planning. Under TJC guidelines, Womack Army Medical Center governing body or authority ultimately is responsible for the quality of care the hospital provides. To carry out this responsibility, the governing body or authority provides for the effective functioning of activities related to GME, as well as quality patient care delivery, performance improvement, risk management, medical staff credentialing, financial management; and professional graduate education, when provided.

(3) OTSG requires that the Army medical facility staff while participating in the training program will supervise residents. Their involvement in patient care will be governed by the Army medical facility’s quality assurance program (AR 40-68).

c. Documentation of patient care for the purposes of third-party billing is governed by guidelines defined by payers and the Tricare Management Activity (TMA), and is not covered by this document.

d. Pursuant to TJC standards, in hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities. There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.

e. The intent of this document is to ensure patients are cared for by clinicians and health care trainees who are qualified to deliver care and that the care will be documented in the patient's record. This is fundamental both for the provisions of quality patient care and for the provision of education and training for future health care professionals. The fact that medical, surgical, and mental health care is increasingly delivered in outpatient settings requires that these principles be as relevant to outpatient as they are for inpatient settings.

f. It is assumed that quality patient care and educational excellence are mutually enhancing.

g. The US Army approach to resident and health care trainee supervision requires careful accommodation of unique local resources and patient care issues, as well as ACGME, other educational healthcare accrediting organizations, TJC and OTSG requirements.

5. SCOPE.

a. Attending, as a licensed independent practitioner, is responsible for the care provided to their patients. This responsibility requires personal involvement with each patient and each resident participating in the care of the patient. Each patient must have an attending whose name is recorded in the patient record**.** "Staff available", "discussed with", "and seen with", will be used by the resident to delineate the type of involvement. Other attendings, may, at times, assume responsibility for the care of the patient and supervision of the residents. It is the responsibility of the attending to ensure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending at all times.

b. Residents must function under the supervision of an attending. A responsible attending must be available to the resident in person or by telephone or other telecommunication device and be able to be present within a reasonable period of time as defined by department/service chief. Trainees and staff must be informed and understand the department's standards for staff availability. Each service must publish "call schedules" that indicate the responsible attending and reliable methods to contact the attending.

c. Training programs must permit residents to assume increasing levels of responsibility, commensurate with their individual progress, level of training, and experience, skills, knowledge, and judgment. These components of overall competency must be communicated in a timely fashion to both the trainee and appropriate attendings.

d. Womack Army Medical Center must adhere to current accreditation requirements of the ACGME, other educational healthcare accrediting organizations and TJC for matters pertaining to resident training programs, including the level of supervision provided. It is also expected that the requirements of the various certifying bodies, such as the member boards of the American Board of Medical Specialties (AMBS), will be incorporated into Army training programs and fulfilled through program level policy that ensures each graduate will be eligible to sit for a certifying examination.

e. The provisions of this document are applicable to all patient care services, including inpatient and outpatient services, and the performance and interpretation of diagnostic and therapeutic procedures.

f. In order to ensure quality patient care and provide opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is required that an appropriately privileged attending be available for supervision during clinic visits. Patients followed in more than one clinic will have identified attendings for each clinic. Attendings are ultimately responsible for ensuring the quality of care provided to their patients.

g. Program Directors must ensure that their training programs provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment that is consistent with proper patient care, the educational needs of residents, and the applicable program requirements.

6. RESPONSIBILITIES. Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings. The administrative organization and titles may vary but the following functions must be assigned.

a. Attending. The attending is responsible for, and must be personally involved in the care provided to individual patients in inpatient and outpatient settings. When a resident is involved in the care of a patient, the responsible attending must continue to maintain a personal involvement in the care of the patient. The attending is expected to fulfill this responsibility, at a minimum, in the following manner:

(1) Attendings must be knowledgeable of the graduated levels of responsibility for residents rotating on their service.

(2) Each attending must be available to direct the care of every patient and provide appropriate resident supervision based on the nature of the patient's condition, the likelihood of significant changes in the treatment plan, the complexity of care, and

the experience and judgment of the residents being supervised. Medical, surgical or mental health services must be rendered with attending supervision of the residents readily available or be personally furnished by the attending. Confirmation of resident supervision will be documented in progress notes entered by the attending or reflected within resident notes, “seen with”, “discussed with” or “staff available”. Each outpatient record must reflect an attending by name and indicate if the case was discussed with the attending or another attending or more senior resident. All patients seen by residents in their Post-graduate Year One (PGY-1) must be discussed with an attending or more senior resident, with this discussion documented by name in the patients record.

(3) For patients admitted to an inpatient service, the attending must assess the patient within 24 hours of admission and document in a progress note their concurrence with the resident’s initial diagnosis and treatment plan and any modifications or additions to this plan. Attendings must be personally involved in the care of patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the involved residents. This must be documented by a note by the attending. At a minimum, this documentation of attending involvement must be present every third day for ward patients, when there is a significant change in the patient condition or treatment plan, and daily in intensive care settings.

(4) When consultation is requested, the specialty attending will supervise the consultation, designated by “seen with”, “discussed with”, and “staff available”. The consulting attending will meet the patient or arrange appropriate follow up and will remain involved in the consultation process as long as the service is requested by the attending responsible for the care of the patient.

(5) For outpatients, all new patients to the clinic for which the attending is responsible should have the level of supervision documented by “seen with”, “discussed with”, or “staff available with” at that initial visit. This must be documented in the chart via a progress note by the attending or reflected in the resident’s note to include the name of the attending and the nature of the discussion, “seen with”, “discussed with”, and “staff available”. Return patients should be seen by the attending with such frequency as to ensure that the course of treatment is effective and appropriate. This must be documented in the record via a note by the attending or reflected in the resident’s note. All notes must be signed, dated, timed.

(6) The attending, in consultation with the resident, will ensure that discharge, or transfer of the patient from an inpatient service of the medical center or clinic has appropriate documentation of the supervision, based on the specific circumstances of the patient’s diagnoses and therapeutic regimen. This may include specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by countersignature of the discharge summary or clinic discharge note.

b. Program Directors. The Program Director is responsible for the quality

of the overall education and training program in a given specialty and for ensuring that the program is in substantial compliance with the policies of the respective accrediting or certifying body. The Program Director defines the levels of responsibility for each year of training by preparing a document describing the types of clinical activities that residents may perform and those for which residents may act in a teaching capacity for more junior residents. The assignment of graduated levels of responsibility will be made available to staff as appropriate and maintained on file at the service/department and the GME Office. This information will also be provided annually to each resident and documentation of receipt must be maintained in training file. Annually, at the time of promotion, or more frequently as appropriate, this document will be provided to the relevant service chiefs, along with a list of residents assigned to each year or level of training. The residency Program Director must provide annually in June assurance that individual residents are prepared for advancement to the next higher level of post-graduate medical education and any exceptions for individual residents, as applicable.

c. Resident. Residents must not attempt to provide clinical services or do procedures outside of the graduated level of responsibility for which they are trained. Each resident must make all efforts to communicate to the attending significant issues as they relate to patient care. Such communication should be documented in the medical record. Failure to function within graduated levels of responsibility may result in adverse action.

7. DOCUMENTATION OF SUPERVISION OF RESIDENTS.

a. The medical record must clearly demonstrate the active involvement of the attending. Documentation requirements for evaluation and management and ongoing care for inpatients and outpatients must be included in departmental policies appropriate to specialty needs. Documentation required for third-party billing is governed by guidelines defined by payers.

b. Some diagnostic or therapeutic procedures require a high-level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents who possess the required knowledge, skill, and judgment, and under an appropriate level of supervision by attendings. Attendings will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the attending. Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Supervision for these types of activities is addressed through the provisions under graduated levels of responsibility.

c. Attendings will provide appropriate supervision for the patients' evaluation and management decisions and for procedures. For elective or scheduled procedures, the attending will evaluate the patient and write a pre-procedural note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedures performed.

d. During the performance of such procedures, an attending, or more senior resident, will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending, within the context of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident, and of the complexity of the specific case.

8. EMERGENCY AND URGENT SITUATIONS.

a. 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 resident, consistent with the informed consent provisions of the institution, is permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending will be contacted and appraised of the situation as soon as possible. The resident will document the nature of this discussion in the patient's record.

b**.** An urgent situation is defined as one where expeditious intervention is required to prevent deterioration of the patient's condition or to relieve suffering. In urgent situations involving diagnostic or therapeutic procedures with significant risk to the patient, the resident must consult with and obtain approval from an attending that will be available to assist or to advise as appropriate. The attending will determine as soon as possible, based on the circumstances of the case and the resident's level of experience, whether to be physically present (direct supervision) or to be available by telephone or other communication device (indirect supervision). If circumstances do not permit the attending to write a pre-procedural note, the resident's note will include the name and the level of involvement "discussed with" or "seen with" of the responsible attending. The note will indicate that the details of the case, including the proposed procedure, were discussed with and approved by the attending.

9. PRIVILEGING RESIDENT AS INDEPENDENT PRACTITIONERS. Residents who are appointed outside the scope of their training program must be licensed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for appointment, and are subject to the provisions contained in Army Regulation 40-68, Quality Assurance Administration. Specialty privileges, which are within the scope of the resident's current training program, will not be granted.

10. EVALUATION OF RESIDENTS AND ATTENDINGS.

a. Each resident will be evaluated according to the general competencies. Written evaluations will be in accordance with the certifying bodies and the institutional policy. Written evaluations will be available to and discussed with the resident and maintained by the Program Director.

b. If at any time a resident's performance or conduct is judged by the Program Director to be detrimental to the care of a patient(s), action will be taken to ensure the safety of the patient(s). Additional actions will be IAW the institutional due process policy for residents.

c. Annually, each resident will complete an anonymous written evaluation of attendings and of the quality of their training program. Such evaluations will include the adequacy of clinical supervision by the attendings. The Program Director will review the evaluations. The Program Director will provide feedback to the attendings to identify areas where improvements can be made.

d. All written evaluations of residents and attendings will be kept on file by the residency Program Director, in an appropriate location and for the required timeframe according to the guidelines established by their respective ACGME Residency Review Committee or other accrediting or certifying agencies.

11. MONITORING PROCEDURES. The Commander is responsible for ensuring that the institution fulfills all responsibilities within this section. Monitoring of appropriate attending supervision will be accomplished in a number of fashions to include:

a. The Graduate Medical Education Committee (GMEC) will document and discuss any citations regarding resident supervision on all Internal Residency Reviews or Residency Review Committee reports. The GMEC will suggest methods for correction and follow-up for such citations and forward these to the Deputy Commander of Clinical Services and Commander for review and approval.

b. The chair of the GMEC will report to the Commander any internal or external review issues regarding resident supervision. This report allows a direct linkage of the GMEC and credentials chairpersons.

c. The Deputy Commander of Clinical Services and DME along with all other members of the Risk Management Committee will participate in discussion of all cases involving residents to determine if there are issues of the availability of appropriate levels of supervision or violations of the graduated levels of responsibilities. The DME will report pertinent issues to the GMEC.

d. Program Directors will monitor supervision of diagnostic and therapeutic procedures involving residents to ensure consistency with the graduated levels of supervision as established by the Program Director.

The proponent of the publication is the Graduate Medical Education Office. Users are invited to send comments and suggested improvements on a DA Form 2028, Recommended Changes to Publications and Blank Forms, directly to the proponent.

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