



UC IRVINE SCHOOL OF MEDICINE INTERNAL MEDICINE RESIDENCY PROGRAM

SUPERVISION POLICY

The Internal Medicine Residency Program fully endorses and adheres to the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements for Supervision (section VI.A.2, effective July 1, 2017) and the UC Irvine Graduate Medical Education institutional Supervision Policy.

Supervision in the setting of graduate medical education provides safe and effective care to the patients, while ensuring that each resident has the opportunity to display growth and gain mastery in the six ACGME core competencies, which is a requirement for graduation from the training program. By the time of the completion of training, the resident should be able to provide patient care competently and safely in Internal Medicine without direct supervision.

- I. Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.
 - A. This information must be available to residents, faculty members, other members of the health care team, and patients.
 - B. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
- II. The program must demonstrate that the appropriate level of supervision is in place for all residents. This should be based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

Educational Goals and Objectives with Respect to the Competencies of Residents at Each Level of Training

1. **Level I:** Non-supervisory (PGY1 or as defined by the Clinical Competence Committee). Before the house officer can move into a supervisory role, he or she must demonstrate attainment of the competencies represented in the following objectives:

This house officer must achieve the role of **reporter and interpreter** and demonstrate a capacity to become an excellent manager.

- A. Patient Care: The house officer must:
 - i. be able to carry out all assignments agreed to in consultation with senior residents and faculty.
 - ii. be able to provide clinical care in all settings in a relatively independent manner for most common internal medicine problems with only moderate supervision from senior house



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officers and faculty.

- iii. demonstrate appropriate awareness of his or her limitations.
- iv. demonstrate the ability to conduct competent medical interviews and physical examinations.
- v. demonstrate the ability to engage in informed discussions of clinical options for evaluation and treatment.
- vi. demonstrate the ability to identify key clinical factors and pattern groupings in the process of medical decision making.
- vii. demonstrate a willingness to consider cost and social issues in the process of medical decision making and patient care.
- viii. demonstrate the ability to perform all basic required procedures (including ACLS), to provide informed consent for those procedures and to interpret the results of those procedures.
- ix. demonstrate the ability to document patient care in an effective and competent manner

B. Medical Knowledge: The house officer must:

- i. demonstrate appropriate knowledge of basic and clinical science.
- ii. demonstrate commitment to learning and to the educational process.

C. Practice-based Learning Improvement: The house officer must:

- i. demonstrate insight into his or her own knowledge deficiencies.
- ii. be able to define the concept of practice-based learning.
- iii. be able to define methods for incorporating practice-based learning into his or her educational strategies.
- iv. demonstrate commitment to the process of practice-based learning.



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- v. demonstrate command of medical knowledge management including information resources and retrieval, critical appraisal, and practice application.

D. Interpersonal & Communication Skills: The house officer must:

- i. demonstrate knowledge of the importance of highly developed interpersonal and communication skills to the provision of competent and compassionate medical care.
- ii. demonstrate the ability to develop effective therapeutic relationships with patients, their families, and their significant others or designated representatives for making health care decisions.
- iii. demonstrate appropriate flexibility and the ability to understand and incorporate formative feedback.
- iv. demonstrate incorporation of the 5E's of communication into interaction with both patients and colleagues.
- v. understand the role of consultants and the importance of effective and personal communication.
- vi. demonstrate the ability to communicate effectively with colleagues and other members of the health care team.

E. Professionalism: The house officer must:

- i. demonstrate understanding of the broad definitions of professionalism, including altruism, medical ethics, and the professional role.
- ii. act in a professional manner in relations with patients, colleagues, related health professionals and all others involved in the provision or process of care.
- iii. demonstrate the importance of confidentiality and of patients' rights.
- iv. demonstrate circumspection in word and deed.



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- v. demonstrate commitment to learning from mistakes, honesty, compassion, and commitment to quality.
- vi. demonstrate the ability to recognize deficiencies in peers and provide formative feedback.

F. Systems-based Practice: The House officer must :

- i. demonstrate an understanding of the contexts and constraints of the health care delivery system.
- ii. demonstrate the ability to apply knowledge of the health care delivery system to improve individual and community health.

2. **Level II** (PGY2 through PGY3 or as defined by the Clinical Competence Committee): Level II assumes achievement of all Level I Competencies in addition to the following. This resident should achieve the roles of manager and educator.

A. Patient Care: The house officer must:

- i. demonstrate the ability to move from identifying key clinical factors and patterns to consistently making accurate and rationale differential diagnoses and plans.
- ii. be able to consistently make appropriate decisions under the supervision of faculty.
- iii. be able to teach procedures to those medical learners under his or her supervision.
- iv. demonstrate the ability to provide compassionate and competent end-of-life care or treatment of pain.
- v. demonstrate the ability to identify and address opportunities for disease prevention and health promotion.

B. Practice-based Learning Improvement: The house officer must:

- i. demonstrate commitment to enhancing the learning of colleagues and patients through practice-based learning strategies.
- ii. demonstrate skill at identifying appropriate practice-based learning opportunities and at identifying appropriate resources and questions.



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- C. Interpersonal and Communication Skills: The house officer must :
- i. demonstrate the ability to lead effectively and to assume responsibility.
 - ii. demonstrate ability to create an environment which fosters respect for patients, colleagues, and the educational process.
- D. Systems-based Practice: The house officer must:
- i. demonstrate an ability to work within and lead a health care team
 - ii. demonstrate understanding and the ability to implement process improvement, FOCUS-PDCA, root cause analysis and quality measures.
- E. Teaching: The house officer must :
- i. demonstrate effective clinical teaching skills with special respect to the Microskills of clinical teaching.
 - ii. create a nurturing environment which emphasizes the importance of learning and is conducive to learning.
- F. Organization Skills: The house officer must:
- i. demonstrate commitment to the process of team orientation and management.
 - ii. demonstrate commitment to an organizational process which places appropriate emphasis on time commitments to patient care, education and personal time as well as equity in the team setting for distribution of assignments, patient care, learning and personal time.
 - iii. ensure adherence to work hours regulations and the policies and procedures of the Program.
3. **Level III.** (Prepared to Practice Independently) The house officer is ready for graduation and has consistently demonstrated competence in all areas. The house officer can practice independently and has demonstrated the requisite knowledge, skills and attitudes required to



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perform as an independent practitioner of Internal Medicine. This house officer must be an excellent **manager**.

- III. To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:
- A. Direct Supervision: The supervising physician is physically present with the resident and patient.
 - B. Indirect Supervision 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.
 - C. Indirect Supervision 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.
 - D. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- IV. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
- A. The Program Director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
 - B. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
 - C. Senior residents should serve in a supervisory role to 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.
 - D. Each resident must know the limits of his/her scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
- V. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

In addition to the ACGME Common Program Requirements for Supervision, the Graduate Medical Education Committee endorses the following specific institutional requirements for its clinical sites:

In ambulatory, urgent care, and emergency room sites the following requirements must be met:

1. All housestaff will be able to identify an available supervising attending at all times during patient care.
2. An attending faculty shall be present and available to housestaff during the entire



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duration of any ambulatory clinic session or outpatient procedure.

3. An attending faculty or licensed housestaff physician will review all patients under the care of an unlicensed housestaff physician.
4. Academic units will comply with applicable HCFA, Medicaid, and health plan regulations regarding the supervision of housestaff and the care of patients.
5. Academic units will comply with the ACGME Common Program Requirements for Supervision as described in this policy.
6. Each academic unit will assign a specific attending faculty to be responsible for supervision in that unit's ambulatory sites. This individual, along with the residency program director, will be responsible for ensuring compliance with this policy.

In inpatient sites the following requirements must be met:

1. All housestaff will be able to identify an available supervising attending at all times during patient care. Attendings must be immediately available to housestaff and must be able to provide direct consultation regarding patient care when necessary.
2. Each day and more often as medically appropriate, the Attending physician (or his/her Attending back-up) will supervise and document care of all hospitalized patients assigned to his/her service. The documentation shall adequately reflect the patient's condition and treatment plan; the note shall be dated and timed.
3. An attending physician will personally see and supervise inpatient consultations referred to his/her service and ensure appropriate documentation.
4. Each patient's attending physicians shall coordinate in supervising evaluations, treatment, and procedures provided or performed by house officers in training.
5. No medical staff shall leave patients in the charge of residents in training without appropriate supervision and attending coverage.
6. Academic units will comply with applicable HCFA, Medicaid, and health plan regulations regarding the supervision of housestaff and the care of inpatients.
7. Academic units will comply with the ACGME Common Program Requirements for Supervision as described in this policy.
8. Each academic unit will assign a specific attending faculty to be responsible for supervision in that unit's inpatient sites. This individual, along with the residency program director, will be responsible for ensuring compliance with this policy.

A. Supervision

1. Supervision by faculty members must be provided for all patient care activities in which residents are engaged and in accordance with ACGME requirements for supervision. Supervision must be continuous and direct with reliable systems for communication.
- B. In the continuity clinic, continuity faculty will review each case on a real-time basis for residents at all levels. Faculty will generally be responsible for the supervision of 2 residents and never more than 3 residents. Faculty will not regularly care for their own patients independently when supervising 2 or more residents.



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C. On the inpatient services:

1. Senior residents (residents in the final years of training), fellows, or faculty members will be physically present at all times to supervise PGY1 residents, or as defined by the ACGME, “direct supervision (will be) immediately available in-house”
2. Faculty members will see all patients every day and as often as needed to ensure the highest quality patient care and education.]
3. Attendings of record or an alternative and informed faculty member will be immediately available at all times to assist in the care of patients. Attendings of record will be immediately available by phone if they are not physically present in the hospital or as defined by the ACGME, “direct supervision (will be) immediately available”.
4. The program will maintain mechanisms to ensure that faculty is available and that in the event faculty cannot be reached, chief residents are continuously available. In addition, the ICU nocturnist will be on-site and immediately available for in-person supervision for any patient in which the resident needs assistance or is worsening in clinical status. All patients requiring evaluation for transfer to the ICU will be evaluated in-person by the ICU nocturnist at night.
5. Attendings of record will not be assigned duties which would prevent their presence or attention during the time of their attending assignments.
6. In-house attendings will be provided at each institution at all times.
7. Residents will be regularly reminded of the importance of daily interactions and supervision by faculty and being continually aware of their limitations and the professional responsibility to seek help from more senior residents, fellows, or faculty members. They will be **required to** inform their attending of any changes in status or consents required such as:
 - i. Significant changes in patient clinical status
 - ii. Changes in code status
 - iii. Procedures requiring consent including code status, blood product administration, invasive procedures that require written consent.



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D. Procedures: Direct supervision for all procedures is required for all residents not entered into intranet database

Resident will be allowed to have indirect supervision once "signed off" in the database as follows:

- required to have completed 5 of each type of procedure (LP, para, central line, etc.) competently, have signatures of their supervisor to sign off that they are able to perform the procedure independently without supervision (and must be entered into the UCI competency database as per institution requirements). Residents who are not yet signed off always require direct supervision
- Once signed off, resident can perform the procedure on services without direct supervision
- If there is any question of whether the procedure should be performed, or if there is any concern for potential complications, the resident is expected to notify the relevant fellow/attending/nocturnist immediately.