

NORTH CAROLINA BAPTIST HOSPITALS, INC.  
POLICY AND PROCEDURE

From: Physician Services

Approved by: \_\_\_\_\_

Associate Dean for Graduate  
Medical Education

Prepared by: Physician Services

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President, NCBH

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Chair, Board of Trustees

**SUBJECT: SUPERVISION OF HOUSE STAFF**

**I. POLICY**

It is the policy of North Carolina Baptist Hospitals, Inc. that all house staff be supervised by an attending physician and that an attending physician be assigned to and be personally responsible for the evaluation and treatment of each patient at North Carolina Baptist Hospitals, Inc.

An attending physician, as defined in the Bylaws, Rules and Regulations of the Medical Staff of North Carolina Baptist Hospitals, Inc. is a faculty member of Wake Forest University School of Medicine who admits and care for hospital patients and who assumes all the functions and responsibilities of the medical staff, including where appropriate, emergency service care and consultation assignments. It shall include those individuals who are responsible for the care of patients in whatever specialty they fulfill, whether it be pathology, anesthesiology, radiology, or any other field of medicine contributing to the care of patients.

**II. PURPOSE**

The purpose of this policy is to develop guidelines for achieving high quality patient care and educational standards. It is essential for the quality of patient care, patient satisfaction and patient safety, that an attending physician render sufficient personal and identifiable medical services to provide continuity, coordination and control of patient care. High educational standards also require the attending physician's active involvement in the supervision and training of residents and medical students.

**III. PROCEDURES**

The attending physician is ultimately accountable for all patient care provided by residents in training. The attending physician must be aware of all resident performed procedures. In general, the degree of attending involvement in patient care will be commensurate with the type of care that the patient is receiving and the level of training, education and experience of any medical trainee(s) involved in the patient's care. The intensity of supervision required is not the same under all circumstances; it varies by specialty, level of residency training, the experience and competency of the individual resident, and the acuity of the specific clinical situation. For example, an attending may provide less direct personal care of a patient seen for routine care when supervising a senior level resident, and may provide more direct personal care of a patient receiving complex care when supervising a junior level resident. Medical care teams frequently are involved in the management of patients and many different physicians may act as the attending

physician at different times during the course of a patient's illness. When another attending physician assumes responsibility for a patient's care the identity of the responsible physician must be communicated to the resident in a timely manner. Within the medical care team, the faculty attending physician must provide personal and identifiable service to the patient and/or appropriate medical direction of the resident when the resident performs the service as part of the training program experience. The following are specific instances in which involvement of the attending physician is required:

For inpatient care:

- a. Review the patient's history, the record of examinations and tests, and make frequent reviews of the patient's progress; and
- b. Personally examine the patient; and
- c. Confirm or revise the diagnosis and determine the course of treatment to be followed; and
- d. Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by, residents or others, and that the care meets a proper quality level; and
- e. Be present and ready to perform any service that would be performed by an attending physician in a non-teaching setting when a major surgical procedure or a complex or high risk medical procedure is performed; and
- f. Be recognized by the patient as his/her personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization; and
- g. For major surgical or other complex medical procedures, the attending physician must be immediately available to assist the resident who is under the attending physician's direction.
- h. The decision to admit, transfer to another service, or discharge an in-patient:
  - i. An attending physician's decision shall be required to authorize elective and urgent admissions.
  - ii. An attending physician's decision shall be required to disapprove elective and urgent admissions.
  - iii. When an in-patient is to be transferred to another service, the attending physician or a designee of the referring service shall inform the patient of the change in service prior to the transfer. The receiving service shall assign a new attending physician who shall accept responsibility for patient care.
  - iv. An attending physician's decision shall be required to authorize an in-patient's discharge.
  - v. No Code or DNR orders shall be issued only by an attending physician. In extenuating circumstances the order may be issued by the attending physician verbally, by telephone, such verbal-telephone order shall be signed within twenty-four hours of issuance by the attending physician.
  - vi. When a procedure is completed on a patient, the following should be performed on the chart:

- a. a progress note stating informed consent obtained and signed for the procedure
- b. performed and the indication
- c. anesthesia utilized and prep if appropriate
- d. any findings and/or complications
- e. a comment on the condition of the patient following the procedure
- f. time and date procedure was done
- g. supervision or attending physician for the procedures
- h. personnel in attendance when the procedure is performed.

For outpatient care:

The extent and duration of the attending's physical presence will be variable, depending upon the nature of the patient care situation, the type and complexity of the service, and the individual skill level of the resident involved in the patient's care. The responsibility or independence given to residents should depend on their knowledge, manual skills and experience. Attending supervisors must be available at all sites of training. For physician services furnished in an outpatient setting, the attending physician must:

- a. Supervise residents who furnish services to the patient;
- b. Assure that these services are appropriate;
- c. Confirm proper coding for details of the visit.

General guidelines for all services:

1. Residents will be supervised by attending staff physicians who hold membership in good standing on the Medical Staff of North Carolina Baptist Hospitals, Inc.
2. All patients seen by the resident staff will have an assigned attending physician who is responsible for signing the progress and procedures notes, and summary sheets.
3. History and physicals, discharge summaries, and operative notes will be co-signed by the designated faculty or attending physician.
4. The attending physician will write or review and co-sign an admission note within 24 hours on all patients admitted by the resident at any level. All patients are admitted to a designated attending physician who is notified by the resident on the service.
5. All members of the house staff may write orders. Members of the medical staff have ultimate responsibility for the patients and may cancel or change orders written by house staff and may also write orders themselves.
6. The program director will ensure direct and document proper supervision of residents at all times.
7. Residents will be provided with a rapid and reliable system of communication with supervisor by reason of pagers and call schedules.

8. Each department will provide the attending staff the educational goals and objectives for each rotation of the house staff in addition to the role and responsibilities for patient care activities of the house staff during the time of the rotation. These goals and objectives of the rotation must be presented to the house staff at the beginning of the rotation. Upon completion of the rotation the house staff will complete the evaluation of the rotation in anonymous fashion and provide it to the program director in a timely fashion. Attending must complete the rotation evaluation of the house staff in regard to his/her performance during the rotation related to decision making, progressive involvement in specified patient care activities and other areas designated in the evaluation form. The attending must complete this evaluation of the rotation in a timely fashion and provide it to the program director. Feedback to the house staff must occur in a timely fashion or at least during the semi-annual evaluations by the program director.
9. As part of their educational program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without an attending physician present, or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge and technical skill.
10. The residency program director will define the levels of responsibilities for each year of the educational program by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. Documentation of the assignment of graduated levels of responsibility is provided annually at the time of promotion, or more frequently as appropriate.
11. A document listing the graduated levels of resident responsibility and a list of the residents assigned to each year or level of training, will be provided to the Chiefs of Professional Service through the Director of the Office of Physician Services annually. Within the document, the Residency Program Director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents, if applicable.

House Staff responsibilities:

1. As a minimum, each house staff physician must meet the qualifications for resident eligibility as outlined in the *Essentials of Accredited Residencies in Graduate Medical Education* in the AMA Graduate Medical Education Directory.
2. The position of House staff physician entails participation in care at levels commensurate with the house staff physician's degree of advancement and competence, under the general supervision of appropriately privileged attending teaching staff. This includes, but is not limited to:
  - a. participating in safe, effective and compassionate care;
  - b. developing an understanding of professional, ethical, socioeconomic, system based practice and medical/legal issues that affect aspects of patient care and graduate medical education;
  - c. participating in the educational activities of the training program and, as appropriate, participating in institutional orientation programs, education programs, continuous quality improvement teams and other activities involving the clinical staff;
  - d. participating in institutional committees in which the house staff physician will be a voting member;
  - e. performing these duties in accordance with the established practices, procedures and policies of the institution and those of its programs, clinical departments and other

institutions to which the house staff physician is assigned, including, among others, state licensure requirements and occupational health and safety requirements.

3. Participate, under supervision, in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their discipline.

Reference: Joint Commission on Accreditation of Hospitals, 2002  
Accreditation Council on Graduate Medical Education 2002-2003

1996; reviewed 9/99; revised 8/02