SUBJECT: Resident Responsibility

INTENT: Responsibilities for patient care by any individual resident will be determined by the faculty based on the resident's demonstrated capabilities.

POLICY STATEMENT: Graduate Medical Education is based on the principle of progressively increasing levels of responsibility in caring for patients under the supervision of the faculty.

DESCRIPTION:

1. Residents at each individual year level will have a description of what their responsibilities are and what level of supervision will be provided. Each program is responsible for developing a description specific to their particular discipline. A general description of resident activities as they progress through the residency is included below:

GRADUATED LEVELS OF RESPONSIBILITY

Graduate medical education is based on the principle of progressively increasing levels of responsibility, in caring for patients, under the supervision of the faculty. The faculty is responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. Factors considered in this evaluation include the resident's clinical experience, judgment, professionalism, cognitive knowledge, and technical skills. These levels are defined as postgraduate years (PGY) and refer to the clinical years of training that the resident is pursuing. The requirements for training in the primary care specialties such as pediatrics, internal medicine and family practice call for three years of training. Other specialties such as anesthesia and ob/gyn require four years of training. Most surgical specialties call for five or more years of training. Programs leading to subspecialization after core programs range from one to three years. This training, traditionally called fellowship, includes considerable autonomy especially in the tasks already mastered in the core program. At each level of training, there is a set of competencies that the resident is expected to master. As these are learned, greater independence is granted to the resident in the routine care of the patient at the discretion of the faculty who, at all times, remain responsible for all aspects of the care of the patient. Examples of expected competencies and responsibilities for each level follow.

For purposes of consistency, levels of supervision are defined as follows:
Direct Supervision: The supervising physician faculty member is physically present with the resident and patient.

Indirect Supervision:

1. with direct supervision immediately available – the supervising physician faculty member is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

2. with direct supervision available – the supervising physician faculty member 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.

Oversight: The supervising physician faculty member is available to provide review of procedures/encounters with feedback provided after care is delivered.

PGY I – Individuals in the PGY I year are supervised by senior level residents or faculty either directly or indirectly with direct supervision immediately available. If indirect supervision is provided, such supervision must be consistent with RRC policies and specific criteria which PGY-1 residents must meet in order to be eligible for indirect supervision must be established. Examples of tasks that are expected of PGY I physicians include: perform a history and physical, start intravenous lines, draw blood, order medication and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room and perform other invasive procedures such as arterial line or central line insertion under the direct supervision of the faculty (or senior residents at the discretion of the responsible faculty member). The resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. With the assistance of an assigned mentor or the program director, the first year resident must develop and implement a plan for study, reading and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care.

PGY II – Individuals in the second post graduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first year residents. The PGY II may
perform some procedures with indirect supervision (such as insertion of central lines, arterial lines) once competency has been documented according to established criteria. Specific procedures allowed with indirect supervision at the PGY-II level will vary with training program and must be guided according to published criteria established by the faculty and program director. The PGY II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in his/her selected specialty and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching the PGY I and medical students the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY II should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

PGY III – In the third year, the resident should be capable of managing patients with virtually any routine or complicated condition and of supervising the PGY I and PGY II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. Individuals in the third post graduate year may perform additional diagnostic and therapeutic procedures with indirect supervision once competency has been documented according to established criteria. Specific procedures allowed with indirect supervision at the PGY-III level will vary with training program and must be guided according to published criteria established by the faculty and program director. The PGY III can perform progressively more complex procedures under the direct supervision of the faculty. It is expected that the third year resident be adept in the use of the literature and routinely demonstrate the ability to research selected topics and present these to the team. At the completion of the third year, the resident should be ready to assume independent practice responsibilities in those specialties requiring three years of training. In those specialties requiring longer training, the resident should demonstrates skills needed to manage a clinical service or be a chief level resident.

PGY IV – Individuals in the fourth post graduate year assume an increased level of responsibility as the chief or senior resident on selected services and can perform the full range of complex procedures expected of their specialty under the direct or indirect supervision of the faculty. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing the service and supervising junior residents and students. The resident should have mastery of the
information contained in standard texts and be facile in using the literature to solve specific problems. The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. The PGY IV should begin to have an understanding of the role of the practitioner in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

PGY V – The fifth year resident (generally surgical residents), under the supervision of the faculty, takes responsibility for the management of the major surgical teaching services. The PGY V can perform most complex and high risk procedures expected of a physician with the supervision of the attending physician. The attending physician should be comfortable allowing the PGY-V resident to manage all common problems expected to be encountered during independent practice. During the final year of training the resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice. The PGY V gives formal presentations at scientific assemblies and assumes a leadership role in teaching on the service. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.

FELLOWSHIP TRAINING – Individuals engaged in training beyond the core program are expected to be competent in the skills learned in the core residency. They should be focused on becoming proficient in the skills defined by the subspecialty they are pursuing. As they progress through the training program, they are given progressive responsibility in the skills that make up the information content of the specialty at the discretion of the faculty.

ALL YEARS – Residents at every level are expected to treat all other members of the health care team with respect and with a recognition of the value of the contribution of others involved in the care of patients and their families. The highest level of professionalism is expected at all times. Racial, ethnic or cultural slurs are never acceptable. Treat all others with the respect and consideration you would expect for yourself. Ego and personality conflicts are not conducive to good patient care. Long hours and the stress of practice can precipitate conflict. The resident should be aware of the situations where this is likely to happen and try to compensate by not escalating the situation.

The resident is expected to develop a personal program of reading. Besides the general reading in the specialty, residents should do directed reading daily with regard to problems that they encounter in patient care or in the operating room. The resident is responsible for reading prior to performing or assisting in procedures that the resident has not yet had the
Residents are expected to attend all conferences at the services and program level. The conference program is designed to provide a didactic forum to augment the resident’s reading and clinical experience.

Residents at all levels should have a strong commitment to patient safety and professionalism. All training programs must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. In addition, the program must be committed to and responsible for promoting patient safety, and the program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

**ALL PROGRAMS, ALL YEARS**

**Transitions of Care**
Programs must design clinical assignments to minimize the number of transitions in patient care. All training programs must develop and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Residents must be competent in communicating with team members in the hand-over process. These policies must be reviewed each year by all programs and updated as appropriate. Following any changes, the policy must be submitted to the GME office for approval.

**Required Communication**
In each training program, there will be circumstances in which ALL residents, regardless of level of training and experience, must communicate with appropriate supervising faculty. Programs must identify and set guidelines for these circumstances - for example - unexpected escalation of care to an ICU, and these guidelines must be available in writing for all residents and discussed at the beginning of new rotations, as applicable.

Last Review and Approved: Graduate Medical Education Committee
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