## POLICY

Lines of Responsibilities

## PURPOSE

To establish lines of responsibility for patient care, resident supervision and to delegate responsibility for medical student teaching.

## PROCEDURES

1. **Supervising resident runs the service and performs the following:**
   a. Doing a thorough, directed History and Physical on all patients admitted, writing a summary in the form of a resident admit note, and formulating and recording a diagnostic and therapeutic plan for the patient after staffing patient with attending or service/call.

2. **Evaluating emergency room consultations(Admitting Resident):**
   a. It is the responsibility of the resident to determine if the Emergency Room Patient requires admission to the hospital. If the resident and the emergency room attending physician agree that the patient can be treated and followed up as an outpatient, then the resident should arrive for this. However, if there is disagreement (i.e., the emergency room attending feels admission is necessary but the resident thinks outpatient treatment is adequate), then the internal medicine attending is contacted for the final decision.

3. **Communicating with the attending regarding plans for the patient:** The resident should have a plan formulated at the time of calling the attending. This plan may, of course, be subject to alteration dependent upon further information, which the attending is able to provide. In cases of conflict with the attending, while it is advisable to proceed with the plans of the attending, the resident should consider it part of his/her function to review the appropriate data and literature so as to resolve the conflict. If review of data
does not provide resolution, then with the agreement of the resident and the attending, other specialty consultation may prove helpful.

4. **Delegating responsibility for carrying out the plans for the patient.** The supervising resident will be held responsible for the care of patients on his service. This is obtained via daily work rounds early in the morning, daily “check out” rounds in the afternoon, as well as communication throughout the day with the other members of his/her team. The supervising resident is not expected to perform the “nuts and bolts” of patient care, but should see to it that plans are executed efficiently by his/her interns and medical students.

5. **Medical student teaching.** This involves critical review of the medical student’ H & P’s and presentations, as well as providing teaching regarding pathophysiology, therapy, etc. on patients on the service. This is done on both a formal and informal basis.

6. **It is the responsibility of the supervising resident to coordinate the care of the patient, especially when there are multiple consultants offering opinions.** This may involve a good deal of communication with consultants. If a consultant’s advice is not taken, it should be stated in the chart why this is the case and the reasons should be defensible.

7. **The supervising resident must be available to provide backup for the intern in managing complicated and critically ill patients.** Service numbers are capped at 20. If admissions reach this level backup support is called in and patients will be admitted to different service after notifying attending and chief resident.

8. **It is the function of the supervising resident on call at night and on weekend to provide emergency medical or medical sub-specialty consultation for patients on non-medical services.** After seeing the patient, she should communicate with the appropriate attending or GIM resident. It is not the resident's function to see non-urgent consults or to provide non-urgent opinions on patients followed by medical or medical specialty consultants.

9. All senior residents on service are supposed to write a quick review summary on each patient twice a week documenting “problems list” and plan of care.

**THE RESIDENT ON ELECTIVE**

The job of the resident on the subspecialty service is to learn. This is usually accomplished by seeing ambulatory and hospitalized patients with problems related to that subspecialty and reading and discussing with the attending about those problems. The consulting resident should also complete the consults and discuss the findings and plans with the attending in a timely manner, and then review any pertinent literature pertaining to that particular problem. It is recommended that the resident supplement this experience with reading as recommended by the attending and the core curriculum.

In interaction with the medical services, it should be remembered that the function of a consultant is to offer an opinion and/or suggestions, unless further action is requested by the primary service. The consulting resident provides daily consultative notes. On non-medical patients the consulting resident may take a more direct role in patient care as needed.
It should be noted that it is not the function of the consulting resident to be the intermediary between the consulting attending and the primary medical service.

The other major function of the consulting resident is to act as the supervising admitting resident as indicated on the call schedule.

Residents on “primary care” electives at St. Vincent’s take a “hands on” role in patient care. In addition to consults, the primary care resident should complete a history and physical on patients admitted to their attending physicians with problems pertinent to the subspecialty being studied. The resident should also follow these patients daily and perform any procedures, write progress notes and orders, and obtain consultations as needed under the supervision of the attending physician. The resident should follow the consults closely as well. Despite all these duties, the primary care consulting resident’s main job, as with other consulting residents is to learn. He should not be expected to be a mini-attending” and duties such as taking calls from outpatients, functioning as a general medical physician on consults, or spending large portions of time on private patients of the attending who do not have problems pertinent to his subspecialty, should be avoided.

Program Director

____________________________________

__Revised September 24, 2009
__Reviewed April 6, 2010