INSTITUTIONAL GME POLICY--SUPERVISION
Approved by GMEC – September 28, 2012

Each residency program is required to maintain a policy on supervision of residents which complies with ACGME requirements. Resident supervision will be reviewed regularly by the Supervision Subcommittee of the GMEC and at least annually by the Sponsoring Institution during each program’s annual program review.

Resident supervision must:
1) Support safe and effective patient care;
2) Be consistent with the educational needs of the resident; and
3) Provide progressive responsibility appropriate to the residents’ level of education, competence and experience.

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner) who is ultimately responsible for that patient’s care. This information should be available to residents, faculty members and patients. Residents and faculty members should inform patients of their respective roles in each patient’s care.

To ensure oversight of resident supervision and graded authority and responsibility, programs must use the following classification of supervision as defined by the ACGME.

- **Direct Supervision** – the supervising physician is physically present with the resident and patient.
- **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.
- **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.
- **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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.

The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Senior residents or fellows should serve in a supervisory role of 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.

Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available and in accordance with Specialty-Specific Program Requirements.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.