Policy on Supervision and Accountability – Based on Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements (CPR)

A. Programs must provide a professional, respectful, and supportive environment that is free from mistreatment, abuse, and coercion of residents, fellows, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory, supportive, and respectful manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of residents/fellows and faculty regarding episodes of inappropriate and unprofessional behavior, especially when exhibited toward a trainee who is requesting supervision and guidance in the patient care setting.

B. The safe and appropriate care of each patient underlies all guidelines for supervision in medical education. Although the attending physician is ultimately responsible for the care of the patient, every physician involved in a patient's care shares in the responsibility and accountability for their individual actions. Each resident/fellow and faculty member must inform each patient of their respective role in that patient's care. *[ACGME CPR, VI.A.2.a).(2)]* Effective programs, in partnership with their Sponsoring Institution, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. The degree of supervision for a resident/fellow is expected to evolve progressively as the resident/fellow gains more experience. The level of supervision for each resident/fellow must be commensurate with that resident's/fellow's level of independence in practice, and will be influenced by the complexity, acuity, and urgency of the patient's condition. *[ACGME CPR, VI.A.2.b).(1)]*

C. Depending upon each trainee's level of independence in practice, supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow, recognizing a trainee's progress toward independence. However, certain activities require the physical presence of the supervising faculty member, and each program must clearly define these activities. *[ACGME CPR, VI.A.2.d)]*

D. Levels of Supervision

1. To promote responsible and safe resident/fellow supervision, each program must define the appropriate levels of supervision for their specialty's common types of patient interactions. *[ACGME CPR, VI.A.2.f)]* The privilege of progressive authority, responsibility, conditional independence, and eventually a supervisory role in patient care must be assigned by the program director and by faculty members whose supervision assignments have been of sufficient duration to assess the knowledge and skills of each trainee. *[ACGME CPR, VI.A.2.e)]* While providing for graded authority and responsibility, the program must use the following classifications of supervision *[ACGME CPR VI.A.2.c)]:*

   i. Direct Supervision - The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction, *OR, if the supervising physician and/or patient is not physically present with the resident/fellow, the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology,* (although some RRCs may choose not to permit this). All PGY1 residents must initially be supervised directly. *[ACGME CPR, VI.A.2.c).(1)]* Additional information on Direct Supervision may be found here. (CTRL-click)

ii. Indirect Supervision - The supervising physician is not providing physical or concurrent visual or audio supervision, but is immediately available to the resident/fellow for guidance and is available to provide appropriate direct supervision should that be required. *[ACGME CPR, VI.A.2.c).(2)]*

iii. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. *[ACGME CPR, VI.A.2.c).(3)]*

E. Procedures - For procedural/case supervision, each department will develop specific guidelines describing the mechanism for resident supervision in accordance with ACGME and Joint Commission requirements. These must include the following key principles:

1. Clinical responsibilities must be conducted in carefully supervised and graduated manner, tempered by progressive levels of independence to enhance clinical judgment and skills.
2. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
3. Resident supervision must support each program's written educational curriculum.
4. Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
6. Residents are supervised by faculty physicians in accordance with these established guidelines.
7. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.
8. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the residents' evaluations of their faculty and rotations, and via the GME Supervision Survey.
9. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval. Monthly progress reports will continue to be submitted until the situation or issue is resolved.

F. For a list of resident/fellow and attending physician patient care activities and supervision responsibilities, please CTRL-click on the following link:

Appendix L: Resident and Attending Physician Patient Care Activities and Supervision Responsibilities for Non-Operating Room Procedures

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