UTRGV School of Medicine	**Category:** Graduate Medical Education **Effective Date:** August 2014 **Last Review/Revision Date:** May 2025, November 12, 2020 **Page 1 of 5**
Title: Supervision and Accountability Policy	
References: ACGME Institutional Requirements; ACGME Common Program Requirements–Residency; ACGME Common Program Requirements–Fellowship	

I. Purpose

A. Graduate medical education (GME) is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.

B. GME has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice.

C. Supervision in the setting of GME provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth (CPR Section 6).

D. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their effort in the provision of care. GME must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care (CPR Section 6).

II. Scope

A. This policy establishes supervision guidance for all residents participating in Accreditation Council for Graduate Medical Education (ACGME)-accredited programs sponsored by The University of Texas Rio Grande Valley (UTRGV) School of Medicine (SOM).

B. Each UTRGV GME program must define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care that is consistent with this institutional policy (CPR Section 6).

III. Definitions

A. Attending of Record (Attending): The single identifiable physician ultimately responsible and accountable for an individual patient's care, who may or may not be responsible for supervising residents or fellows. In the clinical learning environment, an identifiable appropriately credentialed and privileged primary attending physician (or licensed independent practitioner as approved by RC) who is responsible and accountable for that patient's care.

B. Resident: An individual enrolled in an ACGME-accredited training program, and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each Review Committee (RC). The term "resident" includes all residents and fellows.

IV. Policy:

Effective programs, in partnership with the Sponsoring Institutions, must define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care (CPR Section 6). Programs must meet the following:

- Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.

Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients.

Levels of Supervision:

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

1. *Direct Supervision* (CPR 6.7):

    a. the supervising physician (or "supervisor" if specialty RC permits supervision by non-physicians) is physically present with the resident during the key portions of the patient interaction; or,

    b. the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

    c. **PGY-1** residents must initially be supervised directly only as described above. (Program must further comply with the conditions specified in the specialty requirements under which PGY-1 residents progress to be supervised indirectly). (CPR 6.7.a)

    Program must further comply with any additional specialty specific classification requirements outlined by the applicable RC, including whether the RC permits option b.

2. *Indirect Supervision*: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

    a. *Oversight*: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

V. Roles and Responsibilities:

Resident education is progressively graduated in both experience and responsibility with primary attention to the benefit, and safety of the patient. The specific clinical responsibility of each resident varies with PGY-level, clinical rotation, experience, duration of clinical training, the patient's illness, and the clinical demands placed on the team and the availability of support services. In such an environment, each physician participating in the clinical training environment will have a specific and defined roles and responsibilities:

A. Attending Physicians are responsible for:
    a. Assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patent and/or as indicated by individual program policy. The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness;

    b. The attending must notify all resident on the team of when he or she should be called regarding a patient's status. In addition to these situations, the individual attending should include in their notification all situations that require attending notification per program or hospital policy;

    c. The attending must delegate portions of care to residents based on the needs of the patient and the skills of each resident (CPR 6.9.b) and in accordance with program and/or hospital policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring that appropriate supervision is occurring and is responsible for the patient's care. The attending and supervisory resident are expected to monitor competence of more junior residents through direct observation, formal ward rounds and review of the medical records of patients under their care.

B. Program Directors are responsible for:
    a. Demonstrating the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation (CPR 6.6);

    b. Defining when physical presence of a supervising physician is required (CPR 6.8);

c. Assigning the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident (CPR 6.9).

d. Establishing faculty supervision assignments of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility (CPR. 6.11);

e. Setting 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 decision (CPR 6.10);

f. Evaluating each resident's abilities based on specific criteria, guided by the Milestones (CPR 6.9.a);

g. Monitoring resident supervision at all participating sites and;

h. Communication and monitoring residents, faculty, clinical and operational leadership to ensure these guidelines are understood.

C. Residents: The following is a general outline of patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of their clinical assignments unless otherwise specified by their program director.
   a. Residents of ALL levels:
      i. Supervised by an attending physician.
      ii. Must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence (CPR 6.10.a).
      iii. Are provided progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident assigned by the program director and faculty members.
   b. Junior Resident (PGY-1): PGY-1 residents must initially be supervised directly (as defined above) by an attending or senior resident when appropriate. The RC may describe conditions under which PGY-1 residents progress to be supervised indirectly (CPR 6.7.a-b.). PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior residents. They should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion.
   c. Senior Residents: Senior residents as defined by the RC may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Senior residents serve in a supervisory role to medical students, junior and intermediate residents in recognition of their progress toward independence, based on the needs of the patient and the skills of the individual resident (CPR 6.9.c.).

VI. Emergency Procedures:

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. In an emergency to preserve life or prevent serious impairment to health, residents shall be permitted to implement life support services. Notification must be made to the supervising physicians as soon as possible. The responsibilities of the attending physician to the patient and to the residents are not changed by these circumstances.

VII. Program Policies:

Program policies must meet the educational objectives and patient care responsibilities of the training program. Each UTRGV-sponsored ACGME-accredited program must establish and maintain its own written program-specific supervision policy consistent with this institutional policy and the respective ACGME Common and specialty-/subspecialty-specific Program Requirements (IR 4.10. a). Each program must demonstrate that the appropriate level of supervision in place for all residents based on each resident's level of training and ability, as well as patient complexity and acuity. In addition, the policy must also address:

A. Method used by the program to inform patients, residents, faculty members, and other members of the health care team of patient's assigned attending physician (CPR 6.5).
B. Any RC specific conditions and the achieved competencies under which PGY-1 residents' progress to be supervised indirectly.
C. A comprehensive list of each clinical activities/procedures with the appropriate level of supervision for each PGY-level, which includes any consideration specified by Specialty-Specific program requirements.
D. A comprehensive list of all specific circumstances and events in which residents must communicate with appropriate supervising faculty members.
E. The required frequency of verbal communication by a resident performing consultations on patients with their supervising attending.
F. The duration of faculty supervision assignments to demonstrate that faculty have sufficient time to assess the knowledge and skills of each resident (CPR 6.11).
G. The required process for hand-off situations and the expectations for transition from direct to indirect supervision when conducting patient transfers.
H. Actions the resident should take in the event the supervising attending physician cannot be contacted.
I. Method for residents to report inadequate supervision and accountability in a protected manner that is free from reprisal (IR 3.2.d.1.)

Reporting Adverse Events: The resident must report any complication, near miss, or patient problem/safety issue to the supervising faculty. In addition, residents and faculty are strongly encouraged to utilize the relevant institutional event reporting at one's participating site (CPR 6.2).