UTRGV School of Medicine	**Category:** Graduate Medical Education **Effective Date:** August 2014 **Last Review/Revision Date:** November 12, 2020 **Page 1 of 3**
Title: Supervision Policy for GME Learners	
References: ACGME Institutional Requirements (IR, focused revision effective July 1, 2018); ACGME Common Program Requirements–Residency (CPR-R, focused revision effective July 1, 2020); ACGME Common Program Requirements–Fellowship (CPR-F, new requirements effective July 1, 2019)	

I. Premise

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 (where "residents" refers to both residents and fellows) 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 (CPR-R Int A).

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 (CPR-R Int A).

C. All physicians share responsibility for promoting patient safety and enhancing quality of patient 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-R VI.A.1.).

D. 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-R VI.A.2.a)).

II. Purpose

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. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. 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-R VI.A.2.a)).

III. Definitions

A. Clinical Supervision: A required faculty activity involving the oversight and direction of patient care activities that are provided by residents.

B. Faculty: Any individuals, including non-physicians, who have received a formal assignment to teach resident and fellow physicians. Faculty members ensure that patients receive the level of care expected from a specialist in their field of expertise. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety (CPR-R II.B.).

C. Program Director: The physician leader within a GME program who is designated with ultimate responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care (CPR-R II.A.4.).

D. Resident: Any physician in an ACGME-accredited GME program, including residents and fellows.

E. Site: Organization providing educational experiences or educational assignments.

F. Levels of Supervision (CPR-R VI.A.2.c)):

1. *Direct Supervision*:

    a. the supervising physician 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 with the supervising physician physically present with the resident during the key portions of the patient interaction.

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. 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 (CPR-F VI.A.2.c).(2).(a)).

    b. 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 (CPR-F VI.A.2.c).(2).(b)).

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

IV. **Protocol**:

A. Each UTRGV-sponsored ACGME-accredited program must establish its own written program-specific supervision policy consistent with this institutional policy and the respective ACGME Common and specialty-/subspecialty-specific Program Requirements (IR IV.I.2.).

B. 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. Supervision may be exercised through a variety of methods, as appropriate to the situation (CPR-R VI.A.2.b).(1)).

C. 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 (CPR-R VI.A.2.d)).

1. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
2. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
3. Senior residents or fellows should serve in a supervisory role to 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.

D. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s) in a timely fashion (CPR-R VI.A.2.e)). At a minimum, these circumstances will include:

1. Admission of or consultation for an unstable or critical patient,
2. Transfer of patient to a higher level of care,
3. Code team activation,
4. Change in resuscitation status,
5. Patient or family dissatisfaction,
6. Patient requesting discharge, in particular if against medical advice, or
7. Patient death.

E. Faculty supervision assignments must be 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-R VI.A.2.f)).

F. At a minimum, faculty bear responsibility for:

1. Routinely reviewing resident documentation in the medical record.
2. Being attentive to compliance with site requirements such as problem lists, medication reconciliation, and additional defined documentation priorities.
3. Providing residents with constructive verbal and written feedback as appropriate.
4. Serving as a role model to residents in the provision of patient care that demonstrates professionalism and exemplary communication skills.