**MARSHALL UNIVERSITY SCHOOL OF MEDICINE**
**GRADUATE MEDICAL EDUCATION**

# POLICY ON RESIDENT/FELLOW SUPERVISION

## SECTION 1. PURPOSE OF POLICY

The purpose of this policy is to ensure that the graduate medical education training programs within the Marshall University Joan C. Edwards School of Medicine have a defined process for supervision by a medical staff member of each Resident/Fellow in carrying out patient care responsibilities. This policy also ensures that all graduate medical education training programs have specific guidelines for circumstances and events when Resident/Fellows are to communicate with the supervising physicians. This policy also outlines the need for program guidelines to define what the Resident/Fellow should do in emergencies.

## SECTION 2. POLICY STATEMENT

2.1. All post-graduate medical education trainees at the Marshall University Joan C. Edwards School of Medicine (MUSOM) are supervised by a qualified supervising physician who also has clinical privileges in the area they are supervising.

2.2. Supervision in the setting of graduate medical education has the following goals:

2.2.1. Ensuring the provision of safe and effective care to the individual patient.

2.2.2. Ensuring each Resident/Fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine.

2.2.3. Establishing a foundation for continued professional growth.

2.2.4. Ensuring Resident/Fellows know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

## SECTION 3. CLASSIFICATIONS OF SUPERVISION

3.1. To ensure appropriate Resident/Fellow supervision and oversight, graded authority, and responsibility, the program must use the following classifications of supervision:

3.1.1. **Direct Supervision**: the supervising physician is physically present with the Resident/Fellow and patient.

3.1.2. **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.

3.1.3. **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.

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

3.2. The program must delineate whether direct, indirect (available in house or at home), or oversight supervision is required for each Resident/Fellow and experience, and where this is provided by a supervising physician or another higher level Resident/Fellow.

3.3. PGY1 Residents should be supervised directly; or indirectly with direct supervision immediately available (on premises) and ensure compliance with their ACGME program requirements when a PGY1 may be supervised indirectly with direct supervision immediately available.

3.4. F1 trainees must be supervised in compliance with their ACGME program requirements.

## SECTION 4. SUPERVISION OF RESIDENT/FELLOWS

4.1. The description of the role, responsibilities, and patient care activities of each Resident/Fellow are to be program-specific and are to be documented for each residency-training program and available for faculty and Resident/Fellow review. Each program is to have a mechanism in place to make decisions about the promotion of trainees in that particular program, such as a Clinical Competency Committee.

4.2. All Residents/Fellows provide patient care under the auspices of supervising physician appropriately credentialed and privileged in their specialty and who serves as the physician of record or as the treating physician of the patient. The Program Director must ensure, direct and document adequate supervision of Resident/Fellows at all times.

4.3. Resident/Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.

4.4. The GMEC is responsible for monitoring residency programs' supervision of Resident/Fellows and to ensure that supervision is consistent with:

4.4.1. The provision of safe and effective patient care.

4.4.2. The education needs of the Resident/Fellows.

4.4.3. Progressive responsibility appropriate to the Resident/Fellow's level of education, competence, and experience;

4.4.4. The applicable common and specialty/subspecialty specific program readily identifiable and accessible supervising physician for all services available 24/7. The Resident/Fellow must provide the patient with the supervising physician's name whenever requested, including the name of the covering physician.

## SECTION 5. SUPERVISION OF PROCEDURAL COMPETENCY

5.1. Each program is responsible for defining the level of competence for each Resident/Fellow, and communicating this to the appropriate site of care delivery. Programs must develop procedures for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.

5.2. Graded responsibility must be accorded surgical or procedural trainees in order for them to advance to independence practice at the completion of their training program.

5.3. For Pre and Post-Operative Patient Care, the supervising physician is responsible for the decision to perform an invasive procedure/surgery, the readiness for discharge, and the post-op follow-up. The program must delineate which aspects of the post-op outpatient follow-up care may be delegated to the Resident/Fellow with only oversight supervision.

## SECTION 6. OUTPATIENT SUPERVISION

General guidance for residency supervision in the outpatient setting are provided by specific ACGME program guidelines. As a rule, it is expected that the supervising physician must be physically present (direct supervision) during the critical of key portions of the patient service for all Residents/Fellows unless the Primary Care Exception is in effect.

## SECTION 7. NOTIFICATION OF SUPERVISING PHYSICIAN

Each department must develop specific guidelines for circumstances and events in which Resident/Fellows must communicate with appropriate supervising faculty members. The guidelines should include the following:

7.1. Guidance for Resident/Fellows to know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

7.2. Specific guidelines for PGY1 Residents who should be supervised either directly or indirectly with direct supervision immediately available and for Resident/Fellow progression for indirect supervision, with direct supervision available.

7.3. Instances when Residents/Fellows (level specific) are to contact the supervising physicians are to be specified by each department. A service may designate additional times when their Residents/ Fellows are required to notify the supervising physician. Specific instances may include but not be limited to:

7.3.1. A patient death or other adverse event;

7.3.2. An identified patient error;

7.3.3. The transfer of a patient to a higher level of care;

7.3.4. For consultation when the Resident /Fellow believes is a difference of opinion or concern about patient care that requires supervising physician involvement;

7.3.5. A patient to be designated DNR/DNI.

## SECTION 8. EMERGENCY SUPERVISION

Each department must develop specific guidelines concerning emergency supervision during emergencies. During emergencies, the Resident/Fellow should provide care for the patient and notify the supervising physician as soon as possible to present the history, physical exam and planned decisions. All required supervision must be documented by the Resident/Fellow and/or the supervising physician according to Medical Staff rules and regulations.

**Effective Date: July 1, 2013**

Approved by GMEC: April 16, 2013:
Approved by DIO: May 23, 2013