INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Resident Supervision and Accountability

gme-adm-0027

About This Policy

Effective Dates:
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Responsible University Administrator:
Senior Associate Dean for GME

Policy Contact:
GME Assistant Director Emilie Leveque
eleveque@iu.edu

Scope

This policy applies to all Indiana University School of Medicine (IUSM) Graduate Medical Education (GME) resident physicians.

Policy Statement

IUSM must ensure that all GME programs provide both appropriate supervision for each resident and a work environment that promotes proper patient care, resident educational needs, and ACGME Program Requirements.

The supervising faculty has both an ethical and a legal responsibility both for overall patient care and for the supervision of residents involved in patient care. IUSM expects that all faculty will adhere to federal guidelines and policies regarding resident supervision. Furthermore, supervising faculty for required clinical learning experiences must hold an IUSM faculty appointment.

In the clinical learning environment, each patient must have an identifiable, appropriately credentialed/privileged supervising physician (or licensed independent practitioner as specified by each review committee) who is ultimately responsible for patient care. This information must be available to residents, faculty, health care team members, and patients. Residents and supervising faculty must inform each patient of their respective patient care roles when providing direct clinical care.

When providing clinical patient care, residents and supervising faculty must demonstrate appropriate levels of resident supervision. Programs must provide resident job descriptions, common clinical task and procedure lists, and required levels of resident supervision for each clinical task and procedure taught. Supervision may be exercised through a variety of methods, as appropriate to the situation.

Programs must ensure that individual residents receive the appropriate level of supervision based on level of training and ability, as well as patient complexity and acuity. Each program's Clinical Competency Committee (CCC) will determine individual resident competency for clinical tasks and procedures. The program must define when physical presence of a supervising physician is required. PGY-1 residents must initially be supervised directly.

For instances in which the hospital supervision policy differs from the IUSM supervision policy, the stricter of the two policies will be applied (**see Related Information**).

Programs must establish a chain of command that emphasizes graded authority and increasing resident responsibility over the course of training. Although senior residents require less direction than junior residents, even the most senior must be supervised. Judgments on this delegation of responsibility must be made by the supervising faculty; such judgments shall be based on the supervising faculty's direct observation and knowledge of individual resident skill and ability and as appropriate, CCC recommendations.

Programs must use the following classification of resident supervision:

Direct Supervision:

The supervising physician is physically present with the resident during the key portions of the patient interaction; or, 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.

Indirect Supervision:

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to provide direct supervision or guidance.

Oversight:

The supervising faculty is available to review procedures/encounters with feedback provided after care has been delivered.

Telehealth/Telesupervision:

Each ACGME Review Committee may define unique requirements regarding telehealth and telesupervision (see **Related Information**). Programs must incorporate any unique requirements in program policies for resident supervision.

Reason For Policy

The purpose of this policy is to describe the guidelines for resident supervision.

Procedure

Progressive Authority and Responsibility

a. 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.
b. Residents must be supervised by qualified teaching staff in a way that will allow them to assume progressively increasing responsibility for patient care according to their level of training, their ability, their experience, and the severity and complexity of the patient's illness.
c. The level of responsibility accorded to each resident must be determined by the teaching staff. The program director must ensure, direct, and document adequate supervision of residents at all times.
d. The program director and CCC must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
e. Faculty members functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
f. 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.

Communication with Supervising Faculty

a. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty members.
b. 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.

c. Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available. (Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.)

Faculty Oversight

a. Faculty supervision assignments must 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.
b. The supervision of residents must be accomplished through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
c. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty at all training sites.

MedHub Supervision Portal

Programs are asked to update the Supervision Portal twice each year. We recommend considering how the process fits into the overall purpose and responsibilities of the CCC in evaluating trainee progress within a training program, but I don't know that we have an exact timeline and audit process at this point.

Definitions

ACGME is the Accreditation Council for Graduate Medical Education.

A resident is an IUSM resident or fellow, or a non-IUSM resident or fellow electively rotating through IUSM and provides clinical care as part of a GME program.

Implementation

The Designated Institutional Official (DIO) for GME is responsible for implementation of this policy.

Oversight

Policy authority for this document resides with the Graduate Medical Education Committee. The DIO and the Graduate Medical Education Committee are responsible for oversight. This policy will be reviewed every three years or more often if deemed necessary.

History

1. Policy gme-adm-0027 approved by GMEC and published on 12 June 2013.
2. Policy reviewed, updated, and approved by GMEC on 24 May 2017.
3. Policy updated for formatting 02 March 2018.
4. Policy updated for formatting 27 June 2018.
5. Policy updated 14 December 2021
6. Policy reviewed and updated 8 February 2022
7. Policy approved by GMEC 16 March 2022.
8. Policy updated 13 April 2023.