BAPTIST MEMORIAL MEDICAL EDUCATION

GRADUATE MEDICAL EDUCATION
POLICY AND PROCEDURE MANUAL

Effective Date: January 2014	**Supervision and Accountability Policy**
Last Review/Revision: March 2020; March 2021, September 2022, October 2022, April 2025	
Reference: BMME0023	

PURPOSE: To establish a process and set guidelines for the purpose of standardization of supervision and accountability of trainees (Fellows, Residents and Students) under the oversight of Baptist Memorial Medical Education ("BMME").

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. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of undergraduate (medical student) and graduate (resident and fellow) medical education provides *safe and effective care to patients; ensures each resident's and fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.*

Each patient must have an identifiable and appropriately credentialed and privileged attending physician who is responsible and accountable for the patient's care.

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

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. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

The program must demonstrate that 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.

The scope of this policy is to define supervision and accountability in the context of patient safety, not to ensure compliance with various billing and coding requirements which may vary by payer and geographic location.

PROCEDURE:

Supervision Standards for Fellow and Resident Physicians and Students in the Patient Care Settings

General Requirements:

Fellow Physicians have completed a core residency in a specialty such as Family Medicine, Internal Medicine or General Surgery. Fellows are supervised by appropriately credentialed and privileged attending physicians. Each program may provide a list of specific procedures and/or clinical tasks which may be performed by the fellow under indirect supervision or oversight (see definitions below). The program is responsible for maintaining a current accounting of procedural competencies and level of supervision required and for ensuring that all supervising physicians comply with these guidelines.

Resident Physicians have graduated from medical school and are supervised by appropriately credentialed and privileged attending physicians. Each program may provide a list of specific procedures and/or clinical tasks which may be performed by the resident without direct supervision. The program is responsible for maintaining a current accounting of procedural competencies and level of supervision required and for ensuring that all supervising physicians comply with these guidelines.

Medical Students are supervised by appropriately credentialed and privileged attending physicians. Procedures performed by medical students must be directly supervised by the student's supervising physician. Specific clinical skills such as history and limited physical (not breast or genitalia) may be performed without direct supervision at the discretion of the supervising physician once competency by the student has been established. The medical school is responsible for ensuring that all supervising physicians comply with these guidelines.

Physician Assistant Students are supervised by appropriately credentialed and privileged attending physicians or other approved, credentialed, and privileged Advanced Practice Provider (APP). Procedures performed by Physician Assistant students must be directly supervised by the student's supervising physician or APP. Specific clinical skills such as history and limited physical (not breast or genitalia) may be performed without direct supervision at the discretion of the supervising physician or licensed and credentialed APP. The school is responsible for ensuring that all preceptors comply with these guidelines.

Levels of Supervision:

Per the ACGME, "physically present" is defined as, "The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient while the resident performs a face-to-face service." The program must define when physical presence of a supervising physician is required.

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

- Direct Supervision
    - The supervising physician is physically present with the resident during the key portions of the patient interaction and PGY-1 residents must initially be supervised directly;
        - The supervising physician is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
    - Telecommunication technology for direct supervision must not be used for the management of with invasive procedures.

- 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.

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

  Additional Definitions**.** When used in this policy, the following words, and all forms of these words, have the meaning below:

  - Milestones-description of performance levels residents are expected to demonstrate for skills, knowledge and behavior in the six Core Competency domains.

  - Conditional Independence –graded, progressive responsibility for patient care with defined oversight.

  - Independent Practice- enter autonomous practice within core specialty

********** Please see attached grid for specific guidelines **********

Additional guidelines for residents and fellows:

Progressive Authority and Responsibility

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow/ resident must be assigned by the program director and faculty members:

- The program director must evaluate each resident/ fellow's abilities based on specific criteria, guided by the Milestones.
- Faculty members functioning as supervising physicians must delegate portions of care to residents/ fellows based on the needs of the patient and the skills of each resident/ fellow.
- 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.
- Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
- Each resident/ fellow must know the limits of their scope of authority, and the circumstances under which the resident/ fellow is permitted to act with conditional independence. Within the BMME system, the circumstances when the resident must communicate with the appropriate supervising faculty include:

  - ICU admissions to the inpatient service
  - Transfer of patients to a higher level of care, e.g. from the floor to the ICU, or critical change in a patient's status, e.g. cardiac or respiratory arrest
  - Change in DNR status
  - Patient or family dissatisfaction
  - Patient requesting AMA discharge
  - Patient death

- All residents and fellows are expected to progress during their residency period. Residents failing to demonstrate satisfactory progression will be subject to guidelines contained in the BMME "Resident Evaluation, Promotion and Dismissal Policy."

Responsibilities

General

- All patient care must be supervised by qualified faculty with appropriate credentials and privileges.
- Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident/ fellow and to delegate to the resident/ fellow the appropriate level of patient care authority and responsibility.
- PGY-1 level residents must be supervised directly, until determined by CCC to meet established advancement criteria, with approval of the program director and faculty, in order to be eligible for indirect supervision.

Faculty Responsibilities

- Routinely review fellow and resident documentation in hospital and clinic medical records; documenting care and attestation as required by Medicare for documentation and billing.
- Provide fellow and resident physicians with appropriate and constructive feedback.
- Serve as role models to residents and fellows, demonstrating professionalism and exemplary communication skills in patient care.
- Round daily on inpatients being cared for by residents and fellows or urgently, as dictated by circumstances or at the request of residents or fellows.

Resident / Fellow Responsibilities

- Residents and Fellows are responsible for knowing the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.
- Residents and Fellows must write or dictate daily notes on patients under their care as appropriate. All orders must have dates and times.
- Residents and Fellows must discuss patient care decisions with the attending physician as appropriate.

Fellows Independent Practice Intent

Fellows who have previously completed residency programs have demonstrated sufficient competence to enter autonomous practice within their core specialty. This option is designed to enhance fellows' maturation and competence in their core specialty. This enables fellows to occupy a dual role in the health system: as learners in their subspecialty, and as credentialed practitioners in their core specialty. Hours worked in independent practice during fellowship still fall under the clinical and educational work hour limits.

Program –Level Supervision Policies and Procedures

Each program is required to establish a written Program Specific supervision policy consistent with GME Institutional policies, ACGME Common and Specialty /Subspecialty –specific Program Requirements, and applicable ACGME Review Committee requirements. Program must use the AGME levels of Supervision and the

BMME GME Patient Care Supervision schema below and must demonstrate that appropriate Levels of Supervision are in place. Program –Specific policies and procedures must include the following:

- The Program Director will define the mechanisms by which residents can be deemed competent to perform procedure(s) under Indirect Supervision and Oversight. Lists of approved clinical activities should be maintained for each resident so that they can be made available for review by all patient care personnel.
- Guidelines for circumstances and events in which residents must communicate with the supervising faculty. These guidelines should be specific to patient situations, resident level, who is to be contacted (by position) and what to do if the contact does not respond.
- A description of clinical responsibilities for each resident based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The applicable ACGME Review Committee may specify optimal clinical workloads.
- Education for residents and faculty on supervision policies and procedures including the ACGME requirement that residents and faculty members should inform patients of their respective roles in each patient's care.

Programs must annually review faculty supervision assignments and the adequacy of supervision levels. A copy of each programs' current supervision policy should be submitted to the GME office. Compliance with these requirements will be monitored by the GMEC through periodic audits, review of annual program evaluation meeting minutes, and the internal review process.

Oversight, Mechanisms to Report Supervision Violations.

BMME must oversee the supervision of residents consistent with this Policy and Program specific policies. Trainees are encouraged to report incidents of inadequate supervision at Baptist Memorial Hospital or any of its participating sites. Reports may be made to the Program Chief resident, The GME Chief resident (as available), the GMEC Resident Forum representatives, the Program Director, Department Chair, Associate DIO, DIO, or by emailing contacting the office of GME. Resident reports of inadequate supervision may be submitted without fear and recrimination or reprisal.

Direct Supervision – the supervising physician is physically present with the resident/ fellow during the key portions of the patient interaction or the supervising physician 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 the resident for guidance and is available to provide appropriate direct supervision.	Oversight – the supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.

*Note: these guidelines represent the lowest degree of autonomy allowed; however, all trainees are advanced along the progressive autonomy continuum in accordance with Clinical Competency Committee, Program Director, and supervising physician approval.

SUPERVISION GUIDELINES	Fellow	Resident Physician	Medical Student or Physician Assistant Student
OPERATING / DELIVERY ROOM	Indirect Supervision-The program must define those physician tasks for which fellows must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.	Direct Supervision-PGY-1 residents must initially be supervised directly. Indirect Supervision-The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.	Direct Supervision by Supervising Physician
NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)	Direct Supervision - Fellows may advance to Indirect Supervision upon approval by attending physician. Indirect Supervision	Direct Supervision. Residents may advance to Indirect Supervision upon approval by attending physician. Indirect supervision	Direct Supervision by Supervising Physician
EMERGENCY DEPARTMENT	Indirect Supervision	Indirect Supervision	Direct Supervision by Supervising Physician
EMERGENCY CARE - Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted.	Indirect Supervision	Direct Supervision. Residents may advance to Indirect Supervision upon approval by attending physician.	Direct Supervision by Supervising Physician

INPATIENT CARE / New Admissions	Indirect Supervision	Indirect Supervision	Direct supervision by Supervising Physician, Fellow, or Senior Resident
INPATIENT CARE / Continuing Care	Indirect Supervision	Indirect Supervision	Direct supervision by Supervising Physician, Fellow, or Senior Resident
SUPERVISION GUIDELINES	**Fellow**	**Resident Physician**	**Medical Student or Physician Assistant Student**
INPATIENT CARE / Intensive Care	Indirect Supervision	Indirect Supervision	Direct Supervision
INPATIENT CARE / Hospital Discharge and Transfers	Indirect Supervision	Indirect Supervision	Direct Supervision
OUTPATIENT CARE	Indirect Supervision Oversight supervision may be allowed for fellows or senior residents in the continuity clinic (primary care exceptions)Independent Practice	Indirect Supervision Oversight Supervision may be allowed for fellows or senior residents in the continuity clinic (primary care exceptions)	Direct supervision by Supervising Physician, Fellow, or Senior Resident
CONSULTATIONS - Inpatient, Outpatient, and Emergency Department	Indirect Supervision	Indirect Supervision	Direct supervision by Supervising Physician, Fellow, or Senior Resident
RADIOLOGY / PATHOLOGY	Indirect Supervision	Indirect Supervision	Direct supervision
ROUTINE BEDSIDE and CLINIC PROCEDURES	Oversight upon approval by CCC, PD, supervising physician and local hospital privileging by laws. Independent Practice	Oversight upon approval by CCC, PD, supervising physician and local hospital privileging by laws.	Direct supervision
DOCUMENTATION: Notes	Fellows may write notes in the medical records but these notes must be attested to by the supervising physician daily	Residents may write notes in the medical records but these notes must be attested to by the supervising physician daily	May write notes in the medical records but student notes do not meet daily documentation requirements

DOCUMENTATION: Orders	Can place orders	Can place orders	May pend orders but these must be signed by an attending physician, fellow, or resident before these orders may be acted upon