RUTGERS HEALTH

Policy Name:	Supervision			
Section #:	3.2	**Section Title:**	Clinical Learning Environment	
Approval Authority:	GMEC		**GMEC Approved:**	5/17/2019
Responsible Executive:	DIO		**Revised:**	8/20/2021, 8/26/2024, 10/17/2025
Responsible Office:	Office of Clinical and Health Affairs, Rutgers Health		**Contact:**	Institutional Coordinator

1. **Reason for Policy**
   To establish compliance that meets Rutgers, state, federal, and accreditation regulations.

2. **Applicable ACGME Institutional Requirements**
   3.2.d Supervision and Accountability

3. **Resources**
   - **i.** Accreditation Council for Graduate Medical Education Institutional Requirements
   - **ii.** Accreditation Council for Graduate Medical Education Common Program Requirements
   - **iii.** Committee of Interns and Residents (CIR) Collective Bargaining Agreement
   - **iv.** Rutgers University Policies
   - **v.** New Jersey Board of Medical Examiners
   - **vi.** American Board of Medical Specialties

4. **Scope**
   The scope of this policy applies to all residents and fellows participating in Rutgers Health programs.

5. **The Policy**
   I. The clinical responsibilities for each resident/fellow must be based on PGY-level, patient safety, resident/fellow education, severity and complexity of patient illness/condition and available support services. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed, and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. This information should be available to residents/fellows, faculty members, and patients. Residents/fellows and faculty members should inform patients of their respective roles in each patient's care.

   II. Each program must demonstrate the appropriate level of supervision for all residents/fellows who care for patients and compliance with program specific requirements. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. 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/fellow can be adequately supervised by the immediate availability of the supervising faculty member or resident/fellow physician, either at the site, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident/fellow delivered care with feedback of the appropriateness of that care.

III. To ensure oversight of resident/fellow supervision and graded authority and responsibility, each program must use the following classification of supervision:
   A. Direct Supervision
      1. The supervising physician is physically present with the resident/fellow and patient.
   B. Indirect Supervision:
      1. With direct supervision immediately available
         a. the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
      2. With direct supervision available
         a. 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.
   C. Oversight
      1. the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident/fellow must be assigned by the Program Director and faculty members. The Program Director must evaluate each resident's/fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria (e.g. milestones, evaluation tools, procedural requirements, etc.). Faculty members functioning as supervising physicians should delegate portions of care to residents/fellows, based on the needs of the patient and the skills of the residents/fellows. 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.

V. Each sponsored program is to establish schedules which assign qualified faculty physicians, residents, or fellows to supervise residents and fellows, at all times and in all settings, in which resident or fellows provide any type of patient care. The type of supervision to be provided is delineated in the residency/fellowship program curriculum's rotation description.

   Each program must set guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members. Each resident/fellow must know the limits of their scope of authority, and the circumstances under which they are permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

VI. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and delegate to them the appropriate level of patient care authority and responsibility.

VII. Residents and Fellows have the following mechanisms to report inadequate supervision and accountability, involving themselves or their colleagues:
   A. In acute situations, where patient care may be immediately threatened, the resident has the discretion to contact the faculty, chief resident, the program director, or the DIO or designee, as they see appropriate. The person contacted will contact the supervising attending or the Chief Medical Officer for the clinical site as appropriate; alternatively, they may offer guidance to the resident.

   B. For situations where patient care is not immediately threatened, the resident may contact

any of the named individuals above directly or other resources including:

1. The Associate Dean/Chief Academic Officer
2. The event reporting system for the site involved
3. GME through their website, anonymous reporting link, e-mail, etc. See also Rutgers Health GME Policy, “Policy on Mechanisms for Confidential Reporting.”

VIII. Process:

A. Program Directors are responsible for establishing a detailed written policy describing resident/fellow supervision at each level of training. Program policies must be reviewed and approved by the relevant DIO or designee.

B. The requirements for on-site supervision are established for and by each program in accordance with ACGME guidelines, monitored through departmental and GMEC special program reviews. Programs’ policies for supervision must ensure that supervision is consistent with:
   1. The provision of safe and effective patient care.
   2. Educational needs of residents.
   3. Progressive responsibility appropriate to residents’/fellows’ level of education, competence, and experience.
   4. All applicable Common and specialty/subspecialty-specific Program Requirements.

C. It is required that residents/fellows have the ability to report regarding adequacy of supervision and appropriateness of clinical workload. They may also voice their concerns regarding supervision in institutional internal surveys or on the ACGME resident survey. When specific episodes of inadequate supervision or accountability are reported, the Program Director will review the situation and report on the event to the DIO or designee and the involved resident/fellow (if identified). The program director may close the incident without further action or counsel the faculty involved, remove the faculty member from involvement with the residency program or report to the Chair or equivalent for further action.
   1. The analysis of any medical error or near-miss event includes a review to decide whether or not supervision contributed to the situation. When a root cause analysis (RCA) involving a resident/fellow is conducted, the resident/fellow shall participate in the RCA and the possibility of supervision as a contributing factor to the medical error or near miss will be assessed.
   2. The identity of the resident/fellow will not be revealed except to necessary parties. Any action taken by a faculty member, resident/fellow or other person against the resident reporting the event can subject the person to actions as described above.

D. The sponsoring institution monitors all citations and policies related to supervision including but not limited to ACGME site visits, special program reviews, housestaff reports, program policies, etc.