Graduate Medical Education Policy	Institutional Supervision
Facility/Sponsor	CMC/GMEC
Policy Origin Date	July 2011
Revision Date	January 2026

PURPOSE

The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows.

Carilion Medical Center (CMC) recognizes the importance of patient safety in the training of resident physicians within graduate medical education programs. This policy supports high quality care by outlining the supervision requirements for residents, articulating residents' job responsibilities, and outlining attending physician responsibilities. To meet the goals of graduate medical education, CMC graduate medical education programs must ensure that appropriate and graduated supervision is provided to all residents in all clinical settings.

This policy is not intended to address issues regarding billing for clinical services.

SCOPE

This policy applies to all Accreditation Council for Graduate Medical Education (ACGME), Council on Podiatric Medical Education (CPME), and Commission on Dental Accreditation (CODA) accredited graduate medical education programs sponsored by Carilion Medical Center (CMC).

DEFINITIONS

Resident refers to all interns, residents, and fellows participating in accredited CMC post-graduate medical education programs.

Advanced/Senior Resident refers to an upper-level resident or fellow who may act as the Supervising Physician for aspects of patient care defined by the program. Each program must define when a resident will be considered an advanced/senior resident, and programs should consult and abide by definitions provided by their specialty specific accrediting bodies when available (See section six of the ACGME Common Program Requirements). This may include the admitting physician, a physician covering the admitting physician, or a consultant who is providing care for a specific aspect of a patient's illness. Programs will define the clinical situations when the Supervising Physician may be an advanced/senior resident.

Supervising Physician or Faculty Member is an appropriately credentialed and privileged physician or licensed independent practitioner (as allowed by each accrediting body) appointed to the program faculty to provide resident education and supervision and who has responsibility for the patient's care.

Resident Supervision may be exercised through a variety of methods. Some activities require the physical presence of a Supervising Faculty member. For many aspects of patient care, the Supervising Physician may be an advanced/senior resident or fellow. Other portions of care provided by a resident can be adequately supervised by the appropriate availability of the Supervising Physician or Faculty Member who is either in the institution or available by telephone or other electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. Therefore, each program will use the following definitions of supervision:

Direct Supervision: The Supervising Physician: 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 the resident for guidance and is available to provide appropriate direct supervision.

Oversight: The Supervision Physician is available to provide review of procedures/encounters with feedback provided after the care is delivered by the resident.

PROCEDURE

1. General Principles:
    a. Each patient in the clinical learning environment will have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care.
    b. PGY-1 residents must initially be supervised directly.
    c. Programs will establish schedules that assign qualified faculty members or advanced/senior residents to supervise at all times and in all settings in which residents provide patient care.
    d. 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.
    e. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
    f. 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.
    g. Ultimately, the level of resident participation and responsibility is determined by the attending or consulting physician and is based on the resident's level in the program, job description, documented competency to perform specific procedures, and the specific and unique needs of a given patient as determined by the attending or consulting physician.
    h. All residents, regardless of year of training, must be in communication with the appropriate Supervising Faculty Physician according to policies defined by each program.
    i. In every level of supervision, the attending physician must review, correct as needed, and sign history and physicals, progress notes, procedural and operative notes, and discharge summaries.
    j. In ambulatory settings, a Supervising Faculty Physician must be continuously present to provide and be actively involved in the supervision of care.
    k. Attending physicians have the right to prohibit resident participation in the care of their patients without penalty. When allowing residents to participate in the care of their patients, the attending physician does not relinquish their rights or responsibilities to examine and interview, admit or discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct/change resident medical management and decision-making that is deemed to be inconsistent with the decisions of the attending physician.
    l. For this policy, invasive procedures are defined as any clinical intervention for which informed consent is required or would reasonably be obtained with the exception of transfusion of blood and blood products.

m. Each residency program will develop a list of procedures that their residents may be certified to perform independent of the physical presence of the Supervising Physician. The residency program must provide easily accessible verification of such certification to the nursing and medical staff. This list is updated on a regular basis and must be available via the Carilion EMR (EPIC) to nurses in the clinical setting.

2. Resident Duties and Responsibilities:
    a. Admission History and Physical Consultations: Residents at all levels of training may perform history and physical examinations and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination.
    b. Order and Interpret Diagnostic Studies: Residents at all levels of training may order diagnostic laboratory and imaging studies consistent with the practice of the supervising physician. Each program should develop education for the deployment of advanced imaging modalities. Supervision levels for ordering these tests will be consistent with best practices and the level of responsibility conferred on the resident by their respective program.
    c. Initiate Treatment in Emergent Situations: Residents at all levels of training may initiate emergent life-saving treatments such as CPR. Immediate efforts to obtain supervision by more advanced/senior residents and attending physicians should be made.
    d. Daily Progress Notes: Residents at all levels of training may evaluate patients and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss their documented findings and treatment plans with the attending physician every day, or when there is a change in a patient's condition. Attending and consulting physicians may make additions and corrections in the daily progress notes. Residents will forward their notes to the appropriate supervising attending for their co-signature.
    e. Orders: Residents at all levels of training may write orders on patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending or consulting physician.
    f. Routine Minor Clinical Procedures: Residents may perform routine minor clinical procedures independently or under the supervision of a more advanced/senior resident based on experience and faculty-assessment of skills. These minor routine procedures include and are limited to the following:
        i. Venipuncture
        ii. Intradermal skin tests
        iii. Suturing of minor lacerations
        iv. Splinting
        v. Application of dressings and bandages
        vi. Placement of peripheral intravenous lines
        vii. Removal of superficial foreign bodies
        viii. Nasogastric tube placement
        ix. Bladder catheterization
        x. Transfusion of blood and blood products
        xi. Other minor procedures for which informed consent is not required
        xii. Invasive Procedures
3. Attending or Supervising Physician Documentation

a. Each attending must document a daily progress note on each patient stating that they assessed and agree with the care provided by the treatment team. Attending physicians submitting a bill for E/M services must comply with the documentation standards for teaching physicians as outlined in the Guidelines for Teaching Physicians, Interns and Residents. Dept of HHS, Center for Medicare and Medicaid Services, ICN 006347 March 2017.

4. Program-Specific Policies
    a. Each Program will develop a supervision policy that at a minimum defines the following:
        i. Level of supervision provided for each clinical assignment.
        ii. Point in the program when a resident may be considered an advanced/senior resident and the clinical and educational circumstances when an advanced/senior resident may act as the Supervising Physician.
        iii. Clinical circumstances and events in which the resident must notify and communicate with the appropriate supervising and/or attending Consulting Physician.
        iv. The program must define when the physical presence of a supervising physician is required.
        v. Programs should review their Supervision Policy on an annual basis and provide revisions, as necessary.
5. GMEC Oversight
    a. The GMEC will review each program's Supervision Policy on an annual basis. Concerns about resident supervision will be investigated by the GMEC, as necessary.

Designated Institutional Official	Reviewing Committee	Date Approved
Daniel Harrington, MD	GMEC	December 2012
Donald Kees, MD	GMEC	November 2014
Donald Kees, MD	GMEC	January 2018
Donald Kees, MD	GMEC	June 16, 2020
Arthur Ollendorff, MD	GMEC	March 18, 2025
Arthur Ollendorff, MD	GMEC	January 20, 2026