# Purpose

The purpose of this policy is to identify to the residents and supervising physicians the aspects of patient care that require progressive levels of responsibility for residents as well as oversight/supervision by upper levels and/or supervising physicians, and to document the educational role of the supervising physician. The clinical responsibilities for each resident must be based on postgraduate year (PGY)-level, patient safety, resident education, severity and complexity of patient illness/condition and available support.

# Policy

The Psychiatry Residency program has established a written program-specific supervision and accountability policy consistent with this Sponsoring Institution (SI) policy and the specialty/sub-specialty specific Program Requirements and the Common Program Requirements.

# Procedure

Procedures for each training program will be developed at the program level and subject to Graduate Medical Education Committee (GMEC) review and approval. Each program will be responsible for the annual distribution of its specific policy to its trainees and teaching faculty.

**Accreditation Council for Graduate Medical Education (ACGME) Requirements appear in Bold Font and are footnoted.**

## General Supervision

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

**Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (6.5.) (Core)**

**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. Supervision may be exercised through a variety of methods, as appropriate to the situation. (6.6.) (Core)[1]**

- Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident (upper level) 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 (upper level) resident physician, either on site or by means of telecommunications 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.

- Medical services must be rendered under supervision of a qualified physician. Documentation of this supervision is entered into the electronic medical record (EMR) by the supervising physician or reflected within the resident's progress note at a frequency appropriate to the patient's condition.
- The resident's note shall include the name of the supervising physician with whom the case was discussed. The supervising physician countersigns and adds an addendum to the resident's note detailing his/her involvement and supervision. The supervising physician shall review the progress notes and provide constructive commentary on content. These progress notes shall be countersigned in a timely fashion. The supervising physician shall provide an addendum to both inpatient and outpatient progress notes detailing his/her involvement and oversight as needed.
- The supervising physician oversees the care of the patient and provides the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.
- The supervising physician advises the residency program director if he/she believes a change in the level of the resident's responsibility and supervision should be considered. The supervising physician fosters an environment that encourages scientific inquiry by the resident and encourages the resident to call or inform the supervising physician of significant or serious patient conditions, or significant changes in a patient's condition.
- Residents should be given progressive responsibility for the care of their patients. The determination of a resident's ability to provide adequate care or to act in a teaching capacity as an upper level will be based on documented overall evaluation of the resident competency as determined by the clinical competency committee and recommended/approved by program director. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the supervising physician.
- Residents assigned to rotations with community specialists, either inpatient or outpatient, will be involved with the care of those patients under the supervision of these community physicians.
- In an emergency (defined as a situation where immediate care is necessary to preserve the life, or prevent serious impairment to the health of a patient), all residents, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The resident will contact the supervising physician as soon as possible to apprise him/her of the situation, and the resident will promptly document the patient encounter in the patient's medical record.

# Levels of Supervision

**To promote appropriate resident 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. (6.7.)

  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.

- **PGY-1 residents must initially be supervised directly, only as described in the above definition. (6.7a.) (Core)**

### 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.[2]**

**The program must define when physical presence of a supervising physician is required. (6.8.) (Core)[3]**

At DCH, Direct Supervision applies within the first 24 hours of every patient admission to the hospital AND at CCHS, Direct Supervision applies to all patients in the first six months of training.

During night calls, Interns will be supervised directly by upper-level resident (PGY-2, PGY-3, or PGY-4) with attending physician on call and available to provide appropriate direct supervision if needed.

“Physically present” is defined as follows: The teaching physician is in the same room as the patient and/or performs a face-to-face service.

# Patient care responsibility per PGY level

**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. (6.9.) (Core)**

**The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. (6.9.a.) (Core)**

**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. (6.9.b) (Core)**

**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. (6.9.c.) (Detail)[4]**

Residents should be given progressive responsibility for the care of their patients. The determination of a resident’s ability to provide adequate care or to act in a teaching capacity as an upper level will be based on documented overall evaluation of the resident’s competency as determined by the clinical competency committee (CCC) and recommended/approved by program director. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the supervising physician.

# Communication with Supervisor

**Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (6.10.) (Core)**

**Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (1.10.a) (Outcome)[5]**

**Faculty supervision assignments must be of sufficient duration to assess the knowledge and**

**skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (6.11.) (Core)[6]**

Residents must communicate by phone call or text the attending physicians immediately or ASAP in case of emergency in the following situation:

1. Patient in the ED;
2. New admission or new transfer to attending service;
3. Acute change of patient condition to the worse;
4. Transfer of patient to a higher level of care within the hospital premises or to an outside hospital;
5. Patient discharge, either planned or Against Medical Advice (AMA);
6. Need to consult other specialty unless emergency;
7. Need to perform a procedure on the patient unless emergency;
8. Patient expired;
9. An event that is a patient safety event that results in death, permanent harm, or severe temporary harm.

The supervising physician (including faculty and preceptors) has the responsibility to enhance the knowledge of the resident and ensure the quality of care delivered to each patient by any resident.

Residents are to familiarize themselves with this policy and the resident must be aware of his/her level of training, his/her specific clinical experience, judgement, knowledge, technical skill, and any associated limitations.

The resident must not independently perform procedures or treatments, or management plans that he/she is unauthorized to perform or lacks the skill and training to perform. The resident is responsible for communicating to the supervising physician any significant issues regarding patient care and patient safety.

# Outpatient Supervision

- A supervising physician is defined as a member of the teaching faculty, a fellow, or a community-based provider. For outpatient office visits and outpatient procedures that are provided by residents in our Psychiatry Medicine Practice (PMP) sites, these services must be overseen by a supervising physician, however, the level of oversight may vary depending on PGY level and by payer. This distinction is clarified below.
- For each outpatient encounter (office visit and procedure), a supervising physician must: 1) ensure that services provided are appropriate; 2) review with the intern/resident the patient's progress notes and provide constructive feedback regarding history, physical examination, diagnosis, assessment/plan and billing, and 3) document the extent of his/her participation in the review and direction of services provided to the patient. This review must occur before or shortly after the conclusion of each visit.
- The supervising physician must be present during every encounter for all Medicare patients regardless of level of resident training. This includes all office visits (regardless of the level of evaluation and management (E/M) code) and all procedures.
- During the performance of all outpatient diagnostic and therapeutic procedures, a supervising physician must be present during all critical or key portions of the procedure, regardless of level of procedure or level of resident training.
- During the PGY-1 intern's first six months of training, a supervising physician must be physically present for the key portions of every outpatient office visit encounter between the patient and the intern, regardless of payer. After successful completion of the first six months of training as a PGY-1, for all non-Medicare patients, a supervising physician does not have to be present during the outpatient office visit encounters that are low or mid-level E/M codes for either new or established patients.

- First-year residents must check-out every patient encounter with an attending physician during the second six month of PGY-1.

## Inpatient Supervision

- For patients admitted to the inpatient team, the supervising physician must meet the patient early during care (within 24 hours of admission, including weekends and holidays). This personal involvement in the patient's care must be personally documented in a history and physical, or progress note within 24 hours of admission.
- The supervising physician's progress note will include findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed, dated, timed, and reflect ongoing supervision of the resident.
- Supervising physicians are involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the level of the trainee. The supervising physician shall review and cosign all progress notes and provide comments on content of the note including history, physical exam and assessment/plan in a timely manner.

# References

[1] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, pp. 41-42.

[2] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, pp. 42-43.

[3] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, p. 43.

[4] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, p. 43.

[5] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, p. 43.

[6] ACGME Program Requirements for GME in Psychiatry (2026), Section 6, p. 43.

# Scope

This policy applies to all residents and supervising physicians associated with the Psychiatry Residency Program.

Approved by April 1, 2026, Graduate Medical Education Committee meeting.