

# POLICY FOR SUPERVISION OF GERIATRIC FELLOWS

## A. Purpose

This policy addresses fellow's responsibilities for patient care and progressive responsibility for patient management and faculty responsibilities for supervision. This policy guides programmatic support, mentorship, and guidance in the supervision of physicians-in-training. The overarching goal is to facilitate clinical and scholarly education, provide safe and excellent patient – centered, culturally competent healthcare, and permit sufficient autonomy for fellows to develop into independent practitioners.

## B. Application

This policy is extrapolated from UND School of Medicine & Health Sciences GME policies set forth by the GME committee as it applies to all trainees in residency programs sponsored by the University of North Dakota School of Medicine and Health Sciences.

## C. Policy

1a. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed attending physician who is ultimately responsible for that patient's care. This information should be available to fellows, faculty members, and patients.

1b. Fellows and faculty members should inform patients of their respective roles in each patient's healthcare.

2. The fellowship program provides the appropriate level of faculty supervision based on fellow's pre-existing knowledge and skills as well as acquired knowledge, skills and attitudes progressively formulated during fellowship training. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member, while other portions of healthcare provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member, either within the institution or with telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. *In all instances, fellows have the option of real – time supervision should they need this level of faculty input for uncertain or difficult patient healthcare.*

3. **Levels of Supervision.** To ensure oversight of fellow's supervision, graded authority, and progressively independent responsibility, the program use the following faculty supervision classifications:

3a. **Direct Supervision** – the supervising physician is physically present with the fellow and patient.

3b. **Indirect Supervision with direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

3c. **Indirect Supervision with direct supervision available** – 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.

3d. **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow is assigned by the program director and faculty members.

4a. In situations where fellows report faculty divergence in the progressive independence of the trainee, the Program Director will remediate and standardize the fellow's clinical status in consultation with the Geriatrics Education and Promotions Committee.

4b. The program director evaluates each fellow's abilities based on specific criteria. Evaluations are guided by local, regional, and national standards-based criteria, including ACGME competencies and AGS – ADGAP entrustable professional activities and geriatric milestones.

4c. Faculty members functioning as supervising physicians delegate portions of care to fellows based on the patient needs and fellow's skills.

4d. Fellows serve supervisory roles of IM and FM residents in recognition of their progress towards independence, based on patient needs and the skills of each fellow.

5. The geriatric medicine fellowship has guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to another health care setting or transitions to end-of-life care due to medical futility.

5a. 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. For example, fellows can not unilaterally evoke a Do not resuscitate order nor can they over-ride another practitioner's orders unless evidence exists for imminent and serious patient harm.

6. Faculty provide sufficient duration of fellow's supervision to properly assess the knowledge, skills, and attitudes of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

7. The initial clinical responsibilities for each fellow is based on pre-fellowship recommendations and experiences, pre-clinical examination, fellowship orientation, patient safety, residency education, as well as patient concerns such as illness severity, complexity and patient preferences.

7a. Progressive clinical responsibilities for each fellow is based on acquisition of knowledge, skills and attitudes defined in the Geriatrics Fellowship Curriculum that embraces EPAs and Milestones essential to becoming a fully independent practitioner of Geriatric Medicine.