Levels of Supervision
The ACGME has defined levels of supervision regarding patient care. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed/privileged attending physician who is ultimately responsible for that patient’s care. This information is readily available to residents, faculty members, and patients via key plate, notices on boards in central patient care areas, in patient rooms, the service schedule and call schedules (available through UAB paging at 205-934-3411, the UAB MIST operator at 1-800-UAB-MIST or 934-6478, posted in the residents’ lounge on the 5th floor of the WIC and in L&D, and in each division’s administrative areas). Residents and faculty members should inform patients of their respective roles in each patient’s care. The supervising physician may be the attending, fellow, or upper level resident, depending on the clinical scenario and the PGY of the resident. The designated ACGME classification for levels of supervision for residents is outlined below:

**Direct Supervision** – the supervising physician is physically present with the resident and patient.

**Indirect Supervision:**
1. **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.
2. **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.

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

Interns (PGY-1 residents) are supervised either directly or indirectly with direct supervision immediately available. There is no situation where an intern will be participating in clinical care where there is not this level of supervision available.

During daytime working hours (0730-1700 Monday-Friday) each service has faculty and fellows in the hospital and in each outpatient facility immediately available to provide direct supervision as needed. At night and on the weekends, there are two faculty and/or fellows in the hospital immediately available for direct supervision in L&D and MEU. The gynecology services have faculty and fellows on call that can provide indirect supervision by telephone and are available to come in to directly supervise when necessary. In urgent situations, the L&D and MEU attending or fellow are available for direct supervision until the gynecology attending arrives. At all times, at least 1 junior (PGY-2) and/or 2 senior residents (PGY-3 and PGY-4) are also available for direct supervision. See Appendix C for details of supervision by service.

**Attending Notification Policy**

**ESCALATION OF CARE:** Any urgent patient situation should be discussed immediately with the supervising attending or fellow. This includes:

- Death
- Deterioration of condition (including deterioration of fetal condition)
- Invasive operative procedures (all operating room procedures must be directly supervised by an attending or fellow)
- Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan
Instances where patient’s code status is in question and faculty intervention is needed

**In addition, patient transfer on any Ob/Gyn service to or from a more acute care setting (floor to ICU and vice versa, L&D to floor and vice versa, MEU to floor, etc.) should be discussed promptly with the supervising attending or fellow for approval.**

Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If the attending in house does not respond promptly, the resident should ask the charge nurse to assist in locating the attending. If the on call attending (for gynecology services) does not respond promptly, the resident should notify the attending or fellow in house covering L&D or the MEU for assistance. The Medical Emergency Team (MET) should be utilized freely in urgent situations. The resident should notify the program director, the medical director of the service, the division director or the chairman of the department as needed for urgent guidance if the other options are not available.

Faculty Supervision of Residents: Program Structure

The chain of command applies to both clinical and administrative issues. Decisions regarding patient care should be reviewed with upper level residents. In general, residents should consult the team member directly above them. Final decisions regarding management should be discussed with the senior team member, who will discuss the plan with the fellow and/or attending. Urgent patient care issues should be discussed immediately with the fellow and/or attending (see above). Consultation should be used freely within the chain of command, as this is optimal for learning, teaching, and patient care. Chief residents are expected to provide leadership throughout the residency.

If questions or problems arise with a particular assignment, resident, or schedule, then this matter should be addressed with one of the Administrative Chief Residents. If a satisfactory resolution cannot be achieved, then the issue can be referred to the Residency Program Director. The GME administrative office of University Hospital may serve to resolve administrative disputes, grievances, or problems that cannot be managed by the Department of Obstetrics and Gynecology Administrative and Educational System.

1. General Considerations
   a. The Ob/Gyn residents are supervised by attending physicians who make up the faculty of the residency program.
   b. Supervision takes place in all facets of training and during all rotations
   c. Supervision is provided by:
      i. In-house faculty 24-hours a day
      ii. Individual attending physicians
   d. Faculty supervising the residents receive guidance regarding the competency of the resident through updates from the RExEC and as promotion to the next PGY level occurs. Each faculty is expected to also make his/her own determination of the degree of involvement in patient care for each resident based on the complexity of each patient and the abilities of the resident.

2. Faculty
   a. Physicians in the Department of Ob/Gyn are considered to be working faculty if they have full-time unrestricted Hospital privileges.
   b. The designation of faculty dictates these physicians are responsible for teaching, evaluating and supervising the residents; therefore, they have the privilege of having resident physicians assist them with patient care.
   c. Resident supervision of patient care by the faculty falls into four broad categories
      i. Private patients of the faculty physicians and medical transports
      ii. Patients of the resident’s continuity-of-care clinic
iii. Patients admitted through Emergency Room otherwise “unassigned”
iv. Patients on the Obstetric services who are the responsibility of the faculty on service, on call or in clinic.

d. Faculty and fellow physicians are responsible for resident supervision during the care of patients.
e. The Chairman of the Department makes the final determination as to which physicians are designated faculty and the extent of their supervisory roles.
f. The Chairman seeks counsel and advice about resident supervision from
   i. Residency Program Director
   ii. Resident Executive Education Committee
   iii. Residents
   iv. Division Directors
   v. Nursing Staff
   vi. Hospital Administration
   vii. House Staff GME
   viii. Dean’s Counsel on Graduate Medical Education
   ix. Annual reports from the Education Office
   x. Anonymous reviews of faculty and curriculum by residents

3. **Supervision of Private Patients**
   a. These are the patients of the faculty physicians.
   b. These patients comprise the majority of the patients seen at UAB and participating hospitals.
   c. Each of these patients has a private attending physician before entering the hospital; if not, one is assigned.
   d. The patient’s attending physician is responsible for supervising the residents who care for their private patients.
   e. The upper level residents are consulted by lower level residents regarding patient care questions. If additional feedback is needed, the upper level resident will speak directly to the attending and discuss an alternative plan of care.
   f. The attending is the sole judge of the degree of responsibility the resident will have in caring for their private patient.
   g. Private patients are seen by the residents on these rotations and others:
      i. UAB Obstetrics
      ii. UAB Gynecology/Urogynecology Service
      iii. Reproductive Endocrinology and Infertility
      iv. Gynecologic Oncology
      v. Medicine: Inpatient and Outpatient
      vi. Oncology Clinics
      vii. Night Float
      viii. Continuity Clinics
      ix. Brookwood Women’s Health, Eastern OBGYN (St Vincent’s East), GYN Ambulatory

4. **Supervision of the Continuity-of-Care Clinics**
   a. This is the resident’s outpatient Continuity Clinic with the sole purpose of teaching ambulatory care.
   b. Residents are supervised by the faculty teaching team
      i. Dr. Margaret Boozer is the primary attending in the continuity clinic and Director. Her primary job is resident education in ambulatory care and supervision of the continuity clinic on a weekly basis throughout the academic year.
c. When the clinic is open, there is always a teaching faculty team leader present to supervise the residents.
d. The faculty is responsible for evaluating and determining the degree of involvement for each resident based on the complexity of each patient and the abilities of the resident.
e. Faculty approves and supervises the scheduling of all clinic surgery after discussing the patient’s workup with the resident.

5. Supervision of “Unassigned” Patients
   a. Unassigned patients are those with no pre-assigned physician at the time of admission and become the patient of the faculty member taking call for the particular day or night (GYN attending of the week for days M-F, or GYN on-call attending at night and weekends).
   b. These patients receive care from the residents under the supervision of the faculty member who has been assigned to the patient.

6. Supervision of Patients on the Obstetric Services
   a. These patients are the responsibility of the faculty member on service (postpartum patients, antepartum or High Risk Obstetric patients) or the faculty member assigned to cover the MEU and/or L&D.
   b. The upper level residents are consulted by lower level residents regarding patient care questions. If additional feedback is needed, the upper level resident will speak directly to the attending and discuss an alternative plan of care. All patients admitted and discharged to the inpatient Obstetric service are discussed with the attending and seen and evaluated by the faculty. There are always at least 2 faculty or fellows in house to provide direct supervision of patient care.
   c. Patients seen in the OBCC are evaluated by the residents who are supervised by the faculty in clinic that day. The faculty member is available to directly supervise care as needed and reviews the medical record and plan for each patient before discharge from clinic.
   d. The faculty is ultimately responsible for evaluating and determining the degree of involvement for each resident based on the complexity of each patient and the abilities of the resident.

7. Bedside Procedures
   a. Bedside Procedures and Level of Training: PGY 1 Resident—direct supervision by upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated; PGY 2 and Higher Resident—direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated.
   b. It is the policy of University Hospital that all GME PGY1 trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the senior resident, fellow or attending; PGY2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the senior resident, fellow or attending as needed.
   c. The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.
   d. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure.
e. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.

f. **The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.** In non-urgent situations, the resident should not hesitate in asking for a senior resident, fellow, attending, interventional service, or surgical service to take over the performance of the procedure. The procedure should be aborted and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

8. **Mentoring**
   a. All residents are encouraged to select a faculty member to serve as an individual mentor.
   b. All residents are assigned to a vertical mentoring team comprised of a resident at each PGY level and a faculty member.
   c. This faculty mentor serves as a role model and confidant, in addition to supervising the growth and development of the individual resident.
   d. Residents should see the mentoring program handbook on the resident web site at http://www.uab.edu/medicine/obgynresidency/academic-curriculum/curriculum-program/18-academic-curriculum/academic-curriculum/79-formal-mentoring-program for the schedule of meetings and forms to be completed.

9. **Transitions of Care Policy:**
   a. **Hand-off communication entails direct communication between the off-going provider / team member currently caring for the patient and the upcoming provider / team taking over the care of the patient; face-to-face and phone-to-phone are two such methods of direct communication. We strongly encourage residents/fellows and faculty to identify a quiet area to give report that is conducive to transferring information with few interruptions.**
   b. Off-going provider will have at hand any required supporting documentation or tools used to convey information and immediate access to the patient’s record.
   c. All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality and privacy.
   d. Providers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed.
   e. The patient will be informed of any transfer of care or responsibility, when possible.
   f. The effectiveness of the program’s hand-off process will be monitored through direct observation and multi-perspective surveys of resident/fellow performance. The program will review hand-off effectiveness at least annually during the annual program evaluation meeting.
   g. More details regarding transitions of care/hand-offs, specifics by service, including templates are available in Appendix D.