Residents and attendings should inform patients of their role in the patient’s care.

• Faculty functioning as supervising physicians should delegate portions of that care to resident physicians.

• Viscera residents or fellows should serve in a supervisory role of patient care.

• The supervising physician in patient care delegated to each resident must be assigned by the program director and faculty.

• The resident is responsible for knowing the limits of his/her scope of authority.

• Programs must set guidelines for circumstances and events where residents must communicate with appropriate supervising physicians.

• Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of the resident and delegate the appropriate level of patient care authority and responsibility.

• In particular, during the PGY 1 year, residents must have supervision level 1 or 2a (see below).

• Levels of supervision: In the development and description of systems to oversee the care in the confines of the site of patient care, the resident must be appropriately involved (see below).

1. Direct Supervision—The supervising physician is physically present with the resident and patient

2. Indirect Supervision:
   a. Direct supervision immediately available: The supervising physician is physically within the confines of the site of patient care and immediately available to provide direct supervision.
   b. Indirect supervision—The supervising physician is not physically present within the confines of the site of patient care; is immediately available by phone, and is available to provide direct supervision.

3. Oversight—The supervising physician is available to provide surge of medical encounters with feedback provided after care is delivered.

• rosters, averaged over a 7-week period.

• Duty periods: Duty periods (PGY 1) must not exceed 16 hours in duration.

• Intermediate-level and senior residents (PGY 2 and above) may be scheduled to work a maximum of 24 hours of continuous duty (24 hours) in the hospital. Programs must encourage residents, as professionals, to use alertness and management strategies to maintain alertness in the context of patient care responsibilities. Strategies such as alertness and management strategies to maintain alertness in the context of patient care responsibilities. Strategies such as alertness and management strategies to maintain alertness in the context of patient care responsibilities.

• The supervising physician is physically present with the resident and patient.

• The resident is responsible for knowing the limits of his/her scope of authority.

• Programs must set guidelines for circumstances and events where residents must communicate with appropriate supervising physicians.

• Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of the resident and delegate the appropriate level of patient care authority and responsibility.

• In particular, during the PGY 1 year, residents must have supervision level 1 or 2a (see below).

• Levels of supervision: In the development and description of systems to oversee resident supervision and graded authority and responsibility, each program must use the following classifications of supervision.

1. Direct Supervision—The supervising physician is physically present with the resident and patient.

2. Indirect Supervision:
   a. Direct supervision immediately available: The supervising physician is physically within the confines of the site of patient care and immediately available to provide direct supervision.
   b. Indirect supervision—The supervising physician is not physically present within the confines of the site of patient care; is immediately available by phone, and is available to provide direct supervision.

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