Definitions

Resident:
A physician who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee. Note: The term “resident” includes all residents and fellows including individuals in their first year of training (PGY1), often referred to as “interns,” and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows.”

As part of their training program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill. 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. Residents are responsible for asking for help from the supervising physician (or other appropriate licensed practitioner) for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

Attending of Record (Attending): An identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

Supervision
To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

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

2. Indirect Supervision:
   a) 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.
b) 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 come to the site of care in order to provide Direct Supervision.

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

Clinical Responsibilities and Patient Care Activities

The specific role of each resident varies with their clinical rotation, the patient’s illness and the clinical demands placed on the team. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

PGY-6,7 (Chief Residents) Chief residents may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. They must provide all services ultimately under the supervision of an attending physician. Chief residents should serve in a supervisory role of medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the chief resident; however, the attending physician is ultimately responsible for the care of the patient.

Attending of Record

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged primary attending physician (or licensed independent practitioner if approved by your RRC) who is ultimately responsible for that patient’s care. The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by individual program policy. The attending must notify all residents on his or her team of when he or she should be called regarding a patient’s status. In addition to situations the individual attending would like to be notified of, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. The primary attending physician may at times delegate supervisory responsibility to a consulting attending physician if a procedure is recommended by that consultant. For example, if an orthopedic surgeon is asked to consult on a patient on the medicine service and decides the patient needs a joint aspiration, the medicine attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the medicine resident who may perform the joint aspiration. This information should be available to residents, faculty members, and patients.

The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to chief residents assigned to the service, but the attending must assure the competence of the chief resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring
that appropriate supervision is occurring and is ultimately responsible for the patient’s care. Residents and attendings should inform patients of their respective roles in each patient’s care.

The attending and chief resident are expected to monitor competence of more junior residents through direct observation, formal ward rounds and review of the medical records of patients under their care.

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

**Supervision of invasive procedures**

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a resident who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents. When there is any doubt about the need for supervision, the attending should be contacted.

The following procedures may be performed with the indicated level of supervision:

**Direct supervision required for the first 3 months of fellowship training, afterwards indirect supervision required:**
- Transcutaneous or open aortic balloon pump placement
- Fiberoptic bronchoscopy
- Sedation for procedures (AKA conscious sedation)*

**Direct supervision always required by a qualified member of the Medical Staff:**
- Epicardial pacemaker placement
- Surgical procedures performed in the operating room
- All other invasive procedures not listed above

*Unless the fellow has taken a sedation course approved by the medical center, in which case they may provide sedation independently

Fellows may begin surgical cases performed in the clinic or operating room on a case-by-case basis after discussion with the attending.

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.

**Supervision of Consults**
Fellows are part of a team of providers caring for patients. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students. Fellows may provide care in both the inpatient and outpatient settings. They may serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services. Each member of the team is dedicated to providing excellent patient care.

Fellows evaluate patients, obtain the medical history and perform physical examinations. They are expected to develop a differential diagnosis and problem list. Using this information, they arrive at a plan of care or a set of recommendations in conjunction with the attending. They document the provision of patient care as required by hospital/clinic policy. Fellows may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed in the clinic, operating room or procedure suite under appropriate supervision. Fellows may initiate and coordinate hospital admission and discharge planning. Fellows discuss the patient's status and plan of care with the attending and the team regularly. Fellows help provide for the educational needs and supervision of any junior residents and medical students. This includes supervision of residents in the performance of appropriate procedures.

Fellows, under the attending's supervision, are frequently responsible for the day-to-day management of the patient care team, particularly in the intensive care unit and for teams providing consultative or diagnostic services. They may also provide care for patients in the outpatient setting or emergency department under the supervision of an attending. Fellows coordinate the actions of the team; interact with nursing and other administrative staff.

**Supervision of Hand-Offs**
Details are outlined in the Department of Surgery Hand-Off Policy.

**Circumstances in which Supervising Practitioner MUST be Contacted**
There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. These include any critical change in patient status, patient updates, relaying patient management decisions, and whenever the resident is unsure of the next step to take in patient management.

**Resident Competence & Delegated Authority**
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. The program director must evaluate each resident’s abilities based on specific criteria.

The training program uses a multifaceted assessment process to determine a fellow's progressive involvement and independence in providing patient care. Fellows are observed directly by the attending staff throughout clinical training. Formal assessments are generally obtained from supervising physicians, residents and students on a monthly basis. Fellows are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to
manage the care of a patient. In addition, fellow performance is discussed at the Division Faculty meetings. Direct feedback regarding the fellow’s performance is provided regularly by the program director. Annually, the fellowship program director and the Division faculty determine if the trainee possess sufficient training and the qualifications necessary to be promoted to the next level.

Trainees are evaluated continuously by the attending staff. If, at any time, their performance is judged to be below expectations, the fellowship program director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the intervention is not successful, the trainee may be dismissed from the program. If a trainee’s clinical activities are restricted (e.g., they require a supervisors presence during a procedure, when one would not normally be required for that level of training) that information will be made available to the appropriate attending and hospital staff.

**Faculty Development and Resident Education: Supervision and Progressive Responsibility**

Residency programs must provide faculty development and resident education on best practices around supervision and the balance of supervision and autonomy. One best practice to consider is the SUPERB SAFETY model:

Attendings should adhere to the SUPERB model when providing supervision. They should

1. **Set Expectations:** set expectations on when they should be notified about changes in patient’s status.
2. **Uncertainty is a time to contact:** tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **Planned Communication:** set a planned time for communication (i.e. each evening, on call nights)
4. **Easily available:** Make explicit your contact information and availability for any questions or concerns.
5. **Reassure resident not to be afraid to call:** Tell the resident to call with questions or uncertainty.
6. **Balance supervision and autonomy.**

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **Seek attending input early**
2. **Active clinical decisions:** Call the supervising resident or attending when you have a patient whose clinical status is changing and a new plan of care should be discussed. Be prepared to present the situation, the background, your assessment and your recommendation.
3. **Feel uncertain about clinical decisions:** Seek input from the supervising physician when you are uncertain about your clinical decisions. Be prepared to present the situation, the background, your assessment and your recommendation.
4. **End-of-life care or family/legal discussions:** Always call your attending when a patient may die or there is concern for a medical error or legal issue.
5. **Transitions of care:** Always call the attending when the patient becomes acutely ill and you are considering transfer to the intensive care unit (or have transferred the patient to the ICU if patient safety does not allow the call to happen prior to the ICU becoming involved).
6. Help with system/hierarchy: Call your supervisor if you are not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.

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