Roles, Responsibilities and Patient Care Activities of Fellows

*Neonatal Perinatal Medicine*

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**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 (or “supervisor” if your RRC permits supervision by non-physicians) 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 within 15-30 minutes.

   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**

The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The specific role of each resident varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

Please note some residents may be engaged in one or more years of research training during their fellowship. Only years of clinical training are considered below.

**PGY-4 (Junior Fellows)**

PGY-4 fellows are primarily responsible for the care of patients under the guidance and supervision of the attending physician. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. First year fellows may supervise PGY-1 -3 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient. When questions or concerns arise that the PGY-4 cannot adequately address, the attending physician should be contacted in a timely fashion. PGY-4 fellows are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending when appropriate.

**PGY-5 (Intermediate Fellows)**

Intermediate fellows may be directly or indirectly supervised by an attending physician but will provide all services under supervision. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. They may supervise PGY-1 -3 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

**PGY-6 (Senior Fellows)**

Senior fellows 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. Senior fellows should serve in a supervisory role of residents and medical students, in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior 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 availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness. 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 senior residents assigned to the service, but the attending must assure the competence of the senior 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 supervisory 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 by a qualified member of the medical staff (i.e. a supervising physician, or non-physicians licensed independent practitioner, is physically present during the procedure)

- Resuscitation of preterm infants < 28 weeks gestation
- High-order multiple deliveries < 34wks (e.g. triplets, quads, etc.)
- Resuscitation of an infant with known congenital anomalies who are likely to require intensive resuscitation (e.g. congenital diaphragmatic hernia, pleural effusion(s), omphalocele, neck mass, etc.)
- Evaluation of a new admissions who is clinically unstable (100% oxygen, rapidly deteriorating, in need of emergent intubation)
- Evaluation of a rapidly deteriorating patient (e.g. unstable saturation on 100% oxygen, hypotension not responding to treatment, unstable cardiovascular status)
- Endotracheal intubation of patients with a known or suspected difficult airway (e.g. retrognathia, Pierre Robin sequence, neck mass, etc.)
- Cardioversion (medical or electric)
- Initiation of extracorporeal membrane oxygenation (ECMO)
- Problems with uncommon technologies (e.g. CRRT, ECMO, peritoneal dialysis)
- Chest tube placement*
- Dilutional or double volume exchange transfusion*
- Pericardiocentesis*
- Cerebrospinal fluid (CSF) reservoir tap*
- Intraosseous line placement*
- Cut downs for line placement*
- Femoral venous line placement*
- Prenatal consultation of expectant mother at borderline of viability (< 26 weeks gestation)*

* For these procedures direct supervision is required until competency has been established. Competence is defined as having successfully completed a given procedure under direct supervision by an Attending Physician. Each procedure must be signed off on by the supervising party, and this documentation is kept in the Fellow’s Procedure Log, maintained on MedHub. The number of supervised procedures required for each procedure has been established by the program and is available in the procedure log in MedHub. Once competency has been established the resident may perform the procedure with indirect supervision.

**Indirect supervision** required with direct supervision immediately available by a qualified member of the medical staff

- Resuscitation of preterm infants > 28 weeks gestation
- Delivery with documented intrapartum distress who are likely to require resuscitation
- Routine/non-emergent endotracheal intubation
- Needle thoracentesis
- Suprapubic bladder tap
- Paracentesis
- Change in ventilator management from conventional to high-frequency oscillatory ventilation (HFOV)
- Initiation of inhaled nitric oxide (iNO)
- Umbilical artery and vein catheter placement
- Percutaneous arterial line (PAL) placement
- Percutaneous Indwelling Central Catheter (PICC) placement
- Procedural sedation
- Circumcision

**Oversight** required by a qualified member of the medical staff

- Phlebotomy
- Placement of peripheral intravenous lines (PIV)
• Arterial puncture
• Nasogastric tube placement
• Lumbar puncture
• Bladder catheterization
• Wound care and suturing of lacerations
• Incision and drainage of superficial abscesses
• Simple supernumerary digit ligation
• Routine ventilator management
• Nutritional support (e.g. feeding order or TPN changes)
• Preparation for non-emergent transport or transfer to another ward

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
Residents may provide consultation services under the direction of supervisory residents including fellows. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care and/or as indicated by individual program policy. The availability of the attending should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient’s illness. Information regarding the availability of attendings should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals within 12 hours. Any resident performing a consultation where there is credible concern for patient’s life or limb requiring the need for immediate invasive intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members in a timely manner include:

• Prenatal consultation of an imminent delivery at < 28wks.
• Prenatal consultation for infants with known significant congenital anomalies with risk for imminent delivery.
• Evaluation and disposition of any infant in the Emergency Room at Children’s or UW.

If the NICU attending does not respond in a timely manner, the resident is to call or page the NICU Director. If neither the NICU attending on call or NICU Director responds in a timely manner, the resident should contact the Jeopardy Attending.
Supervision of Hand-Offs

The Neonatal Perinatal Medicine fellowship has a policy regarding hand-offs. The policy includes expectations of supervision with each type of hand-off situation. In accordance with the ACGME's common program requirements, our program has designed clinical assignments to minimize the number of handoffs. Standard handoff times occur twice daily at both academic NICUs at 0700 and 1600. Measures to ensure and monitor effective, structured handoff processes to facilitate both continuity of care and patient safety are in effect. These includes the use of face-to-face handouts at a standard time in a private location with minimal distractions, the ability of the oncoming resident to ask questions, and the availability of computerized handoff tools (NeoData list, CORES, etc.). The program ensures that residents are competent in communicating with team members in the handoff process through attending modeling to junior fellows and through direct observation of resident handoffs by attendings.

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 circumstances include any time a procedure requiring direct supervision is to be performed, so that the supervising faculty member knows to be present in the NICU. Additionally, the resident should communicate with the supervising faculty member regarding any procedure requiring indirect supervision not specifically discussed at sign out rounds. Other instances in which the resident must contact the attending include notified in advance of impending deliveries involving: 1) <30 weeks gestation fetus; 2) multiple gestation delivery; 3) delivery with known fetal anomalies; 4) delivery with documented intrapartum distress; 5) complicated maternal medical problem regardless of gestational age. In addition, the attending must be contacted for any significant deterioration in a patient condition, and when changes in ventilator modes are being considered. A decision by the attending to be present for procedure and deliveries requiring indirect supervision will be made after taking various impacting issues into consideration, including the level of the resident and available in-house ancillary support.

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. Objective assessment methods used to assess patient care and medical knowledge competencies include: 360° Evaluations, Structured Clinical Observations, Medical Simulation, Neonatal-Perinatal SITE scores, Procedure Logs, and Didactic lectures evaluations. Criteria used to make determinations regarding progressive responsibility and the ability to serve in a supervisory capacity are included as part of the semi-annual evaluation of the resident by the Clinical Competency Committee (CCC). Recommendations from the CCC are provided to the Program Director.

Faculty Development and Resident Education around 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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