Roles, Responsibilities and Patient Care Activities of Residents

Ophthalmology Residency Program

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VAPSHCS

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 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 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 within 15-30 minutes.
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.

Ophthalmology Residents most frequently provide care for patients in the outpatient setting; however, they may provide direct patient care or consultative services for patients admitted to the inpatient wards. They may participate in surgical procedures performed in the clinic, procedure suite, and the operating suite. They provide all services under the supervision of an attending physician or a qualified senior trainee (i.e., fellow).

**PGY-2 (Junior Residents)**

PGY-2 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior residents. They should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion. PGY-2 residents are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending or senior resident when appropriate.

**PGY-3 (Intermediate Residents)** Intermediate residents may be directly or indirectly supervised by an attending physician or senior resident but will provide all services under supervision. They may supervise PGY-1 and PGY-2 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

**PGY-4 (Senior Residents)** Senior 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. Senior 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 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 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. 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 in the clinic and operating room setting, 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 require supervision by a qualified individual until the trainee has achieved the training level specified:

**Procedure & Training level required for independent performance:**

<table>
<thead>
<tr>
<th>Clinic-based diagnostic testing including:</th>
<th>PGY2</th>
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<tbody>
<tr>
<td>Ophthalmic examination</td>
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<td>Schirmer testing</td>
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<tr>
<td>All forms of visual field testing (tangent screen etc.)</td>
<td></td>
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<tr>
<td>All neuro-ophthalmic testing (color vision etc.)</td>
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Refraction  
Epilation    

PGY2  
PGY2
Hyfrecation, eyelashes
Cryotherapy, benign eyelid lesions
Culture, corneal
Culture, conjunctival
Contact lens fitting
Eyelid laceration repair
Lateral canthotomy and cantholysis
I & D of complex ocular wounds
Removal of foreign body from cornea, conjunctiva, eyelid
Removal of benign eyelid lesions <5mm
Retrobulbar or regional anesthetic blocks
Application of tissue glue to eye or eyelids
Subconjunctival or subTenon’s injection
Chalazion excision or injection
Punctal plugs
Anterior chamber paracentesis
Nasolacrimal duct intubation
Laser capsulotomy
Laser iridotomy or iridoplasty
Laser suture lysis
Laser pan-retinal photocoagulation
Focal or grid macular laser
Laser cyclophotocoagulation
Intraocular injection
Retinal or ciliary body cryotherapy

Direct supervision required by a qualified member of the medical staff
Sedation for procedures, Surgical procedures performed in the operating room, all other invasive procedures not listed.

Hyfrecation, eyelashes
Cryotherapy, benign eyelid lesions
Contact lens fitting
Removal of benign eyelid lesions <5mm
Anterior chamber paracentesis
Focal or grid macular laser
Intraocular injection
Retinal or ciliary body cryotherapy

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

Eyelid laceration repair
Lateral canthotomy and cantholysis
**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 and supervisory residents or fellows 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 and supervisory residents or fellows 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, which is typically daily. 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 include: when a patient requires admission an/or surgery. If the supervising physician does not respond within a half hour, the resident may then contact the other attending on call. If they cannot reach any of the attendings on call, they should next attempt to contact either the Chief of Service at the hospital site and/or the Program Director.

The resident should contact the attending on call for any diagnostic or therapeutic decisions that they do not feel comfortable managing, and any patients requiring admission and/or surgery.

**Supervision of Hand-Offs**

Hand off of patients are expected in the following ways:

1. A daily email from the resident team on call should go out to all residents, the Director of Consult Services, the Residency Program Director, any other attending involved in patient care the night before and the heads of clinical care coordination at the Eye Institute at Harborview and Harborview/ 4 West (e.g. Barb Petro and Matt Lecornu) as well as the Puget Sound VA and Seattle Children’s Hospital as needed. This email should describe the clinical care the night before as well as specific follow up needs for each patient. The primary team at each facility should be contacted directly at 750AM if a patient requires immediate attention/ hand off to discuss the treatment plan.
2. All inpatients who require on-going ophthalmic care should be placed in the CORES system.
3. Regular rounding on the inpatient service should take place daily with the Director of Consult Services.
4. Any patient that requires follow up at our additional training sites (eg VA, SCH, UWMC) requires a direct conversation between the resident and a provider at that site to discuss the patient’s disposition and plan of care.

**Circumstances in which Supervising Practitioner MUST be Contacted**
The Senior Resident on call must contact the Supervising Practitioner for all patients who require admission to the hospital or surgery.

**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 Ophthalmology residency program uses a multifaceted assessment process to determine a resident’s progressive involvement and independence in providing patient care. Residents are observed directly by the attending staff and their performance discussed regularly. Formal assessments are generally obtained on a monthly basis from supervising physicians, students and colleagues. These assessments include evaluation of the resident’s clinical judgment, medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. The core competencies are routinely evaluated.

Quarterly, the Program Director meets with the R2 residents. Semiannually, the Program Director meets with R3 and R4 residents. These meetings include a review of the resident’s progress after the Program Director meets with the Residency Evaluation Committee (REC) to review the progress of all residents. The REC also makes recommendations to the Program Director about overall progress and specific concerns. Annually, the Program Director and Chairman will determine if the trainee possesses sufficient training and the qualifications necessary to be promoted to the next level. If there are concerns about promotion, the Faculty will convene to discuss and make a consensus decision. Any resident in danger of not being promoted will be notified after the REC has made its recommendation.

Trainees are evaluated continuously by the attending staff. If, at any time, their performance is judged to be below expectations, the 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 supervisor’s presence during a procedure, when one would not normally be required for that level of training) that information will be made available to the Medical Director, appropriate medical and hospital staff.
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.

Current date 10/2013