Definitions

**Laboratory Medicine Resident:** A physician who is engaged in a graduate training program in Clinical Pathology (or in combined Anatomic and Clinical Pathology and who is actively participating in a rotation overseen by the Department of Laboratory Medicine) and who participates in provision or management of laboratory services under the direction of Laboratory Director. Fellows in Hematopathology meet this definition, but have their own supervision policy as specified by the Division of Hematopathology.

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 Laboratory Director for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic, therapeutic or laboratory procedure, or what to recommend as 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 direct 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.

**Laboratory Director:** An identifiable, appropriately-credentialed and privileged physician or doctoral scientist qualified to serve as a Laboratory Director under the Clinical Laboratory Improvement Amendments Final Rule 42CFR493.1443, and holding a service appointment in the Department of Laboratory Medicine that includes the term Director in the title. The Laboratory Director is ultimately responsible for the management of the relevant clinical laboratory and for the supervision of residents involved with the laboratory.

**Direct Patient Care:** Patient care activities that involve the writing of orders that implement or alter patient management, provision of advice directly to a patient, or performance of clinical procedures on a patient. In general, Laboratory Medicine residents only provide direct patient care as part of Transfusion Medicine responsibilities, or when obtaining bone marrow biopsies as part of Hematopathology services.

**Indirect Patient Care:** Provision of laboratory services, interpretations of laboratory results, and recommendations on use of the laboratory or laboratory results to an attending of record or to members of a health care team who are under the ultimate supervision of an attending of record. The attending of record has the final responsibility for deciding how to use these services, interpretations or recommendations in the care of the patient. Most clinical activities of Laboratory Medicine Residents are indirect patient care.
**Supervision**

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

1. **Direct Supervision** – A supervising physician or Laboratory Director is physically present with the resident and patient. For written interpretation of laboratory specimens and/or results that will appear as a report in the patient’s records, a supervising physician or Laboratory Director is physically present with the resident during final review of the specimens or data, and co-signs the final report before release.

2. **Indirect Supervision:**
   
   a) *with direct supervision immediately available* – the supervising physician or Laboratory Director is physically within the hospital or other site of patient care and is available within 15 minutes to provide Direct Supervision.

   b) *with direct supervision available* – the supervising physician or Laboratory Director may not be physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities and either is available to come to the site of care in order to provide Direct Supervision, or delegates supervision to a qualified on-site physician or Laboratory Director.

3. **Oversight** – the supervising physician or Laboratory Director is available to provide review of direct or indirect patient care 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, and duration of clinical training. Each defined rotation should have a document delineating both objectives and resident responsibilities. Flexible rotations (“Acting Directorships”) should have responsibilities delineated in the Acting Director Proposal form. Resident responsibilities may include completion of processes normally assigned by written laboratory policy to medical technologists or other non-physician staff when various barriers prevent timely completion by the assigned person (e.g., inability to reach the provider to report a critical value). These functions should be carried out according to policy with oversight supervision.

The following is a guide to the specific resident responsibilities by year of Laboratory Medicine training. Residents must comply with the supervision standards of the service on which they are rotating.

**CP-1 (Junior Residents)**

Residents in their first year of clinical pathology training may be PGY-1 (both CP-only and AP-CP tracks), PGY-2 (AP-CP track) or PGY-3 (AP-CP track). CP-1 residents carry out their responsibilities under the guidance and supervision of the attending physician or Laboratory Director, a fellow (Hematopathology) or a senior fellow (Microbiology or Chemistry), or a senior resident. They should generally be the point of first contact when questions or concerns arise in their assigned rotation. However, when questions or concerns persist, supervising residents, fellows and/or the attending physician should be contacted in a timely fashion. For direct patient care activities, CP-1
residents are initially directly supervised by an attending, fellow or senior resident when appropriate and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above). For indirect patient care activities, other than interpretive reports that are placed into the patient record, CP-1 residents are initially indirectly supervised with direct supervision available. Upon demonstration and documentation of appropriate competency, they may progress to oversight supervision.

**CP-2 (Senior Residents)** Residents in their second year of CP-training are in their final year of CP training if in the AP-CP track. They may be PGY-2 (CP-only track), PGY-3 (AP-CP track) or PGY-4 (AP-CP track). Senior residents may be directly or indirectly supervised for direct patient care. They will continue to be directly supervised on written interpretations that are entered into the patient chart. Laboratory management and informal (not placed into the chart) recommendations regarding selection or interpretation of laboratory tests are subject to oversight supervision, with progressively graded responsibilities as merited. Senior residents must provide all services ultimately under the supervision of an attending physician. Senior residents should serve in a supervisory role of junior residents in recognition of their progress towards independence. However, the attending physician is ultimately responsible for the care of the patient.

**Laboratory Director**
Each clinical laboratory has a Laboratory Director who has final responsibility for the availability, accuracy and timely reporting of laboratory results used in patient care. The Laboratory Director is also responsible for all aspects of the educational experiences of residents who rotate through the laboratory, including providing appropriate direct or indirect supervision, as well as oversight, as appropriate.

**Monitoring of resident competency**
Laboratory Directors and supervisory residents/fellows are expected to monitor competence of more junior residents through direct observation, retrospective review and formal call rounds.

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 authority and responsibility.

**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. The attending of record has ultimate responsibility for determining how laboratory results, reports and recommendations are used in prescribing the care of specific patients under his or her care.

**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 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 a given 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**
Bone marrow aspiration

**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 the Laboratory Director or supervisory residents, including fellows. Such consultations are normally informal, with recommendations being provided in person, by telephone or by e-mail. These consults are not formally documented in the patient’s medical record. However, a record of the consultation should be created in the Resident’s’ On-Call Database, including patient identity; requesting physician or medical staff member; key issue(s) or question(s); background, including selected clinical history as appropriate; Laboratory Director and/or supervisory resident/fellow contacted; resolution and recommendations; and follow-up to document the outcome. These records are reviewed regularly by the Program Director and/or appropriate Laboratory Director to assure all such consults receive at least oversight supervision. At least the first three informal consultations handled by a resident must be done under direct supervision by a senior resident, who will provide a written assessment of general competency. A resident may progress to oversight supervision after demonstrating acceptable competency during direct supervision.

**Formal consultation**

A formal consultation may be undertaken upon receipt of a written consultation request, or after a verbal request by the attending of record for a written note in the medical record. Such consults should include a focused review of the patients’ medical record and laboratory results. In some instances, a targeted patient interview and physical exam may be appropriate. All conclusions should be written and reviewed with a Laboratory Director prior to being included as a note in the patient’s chart. The Laboratory Director should co-sign the note.
Supervision of Hand-Offs

Residents should make all reasonable efforts to complete personally all cases and responsibilities that they are assigned, thereby minimizing handing off of patient-related responsibilities. An exception to this occurs when patient care and safety require expedient completion of the responsibility, while duty hour requirements prevent the resident from continuing to work on the issue. (Note that a resident is expected to continue working to complete a pending task beyond the end of the assigned shift, provided that this can be done without violating duty hours.)

In the event that a resident must hand off a time-critical responsibility to avoid a duty hours violation, a formal transfer must occur to the accepting resident. The hand-off has both a written and a verbal component. There is a template for the written hand-off in the Residents On-Call database, a copy of which should be completed for each transfer of care and kept in the database as a permanent record of the transfer. The verbal component should include the information in the written component and must be done in person, or by telephone to assure that the accepting resident has an opportunity to ask questions. The handovers should be further noted in the records of the transferring and accepting residents. A resident's first transfer of care must be done under direct supervision. Once competency has been demonstrated, oversight supervision is exercised by regular faculty review of the written handoff forms in the on-call database.

Circumstances in which Supervising Practitioner MUST be Contacted

In instances where a resident provides direct patient care, as opposed to recommendations to other providers who are providing the direct care, the resident must always consult with an attending physician or other approved supervisory physician (e.g., transfusion medicine fellow), unless the resident is operating under a well-defined protocol, such as a transfusion reaction investigation. When working under a defined patient care protocol, any deviations from the protocol require consultation with a supervisory physician.

Resident Competence & Delegated Authority

Residency training in clinical pathology (CP) differs in many ways from the internal medicine model that underlies many recommendations of the ACGME. Two that are particularly relevant for assumption of graduated responsibility are: (1) that CP training typically comprises only 18 total months for residents in an AP-CP track; and (2), that during this time, residents must master multiple subdisciplines that have discipline-specific competencies and milestones. This requires that residents begin making relatively independent decisions very early in training for each subdiscipline in order to be prepared for independent practice at the completion of residency training. Early assumption of independent decision-making, with oversight supervision, does not create unacceptable risks to patient safety, since these decisions are not translated directly to patient management, but are conveyed as recommendations to the health care team that is responsible for direct patient care. These resident decisions are thus subject to review by the primary care team (which has its own supervisory structure) before any action is initiated.

Decisions as to the timing and amount of independent decision making are rotation-specific and determined by the attending level faculty responsible for the rotation. In the case of acting directorships, where increased resident responsibility is appropriate, the acting director proposal should delineate the level of resident oversight and independence, as determined by the faculty
advisor(s) for the rotation. Where this is dependent upon achievement of milestones, this should be specified in the timetable for the acting directorship.

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**: Specify when residents should notify them about laboratory deviations from expectations.
2. **Uncertainty is a time to contact**: tell resident to call when they are uncertain of a diagnosis, procedure or plan of action.
3. **Planned Communication**: set a planned time for communication regarding medical decisions. This may differ from times for planned communication regarding administrative decisions.
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 decision to make that could affect patient management. 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. **Errors/risk management or legal discussions**: Always call your attending when there is concern for a significant laboratory error or legal issue.
5. **Transitions of care**: Call the attending in instances where a complex case is being handed over to another resident, so that the attending can provide additional continuity.
6. **Help with system/hierarchy**: Call a supervisory physician if you are not able to carry out your duties or meet your responsibilities because of system problems or unresponsiveness of consultants or other providers.

Current date
July 1, 2013