Roles, Responsibilities and Patient Care Activities of Fellows

*Rheumatology*

*University of Washington Medical Center*
*Harborview Medical Center*
*Seattle Veterans Administration Medical Center*

**Definitions**

**Fellow:**
A physician who is engaged in a graduate training program in rheumatology and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee.

As part of their training program, fellows, who have already completed 3 years of internal medicine training, 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. Fellows 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 fellows involved in the care of the patient. The attending delegates portions of care to fellows based on the needs of the patient and the skills of the fellow.

**Supervision**

To ensure oversight of fellow 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 during the key portion of the visit.

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) *without 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 of Rheumatology Fellows

The clinical responsibilities for each fellow 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. Fellows must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director. It should be remembered that rheumatology fellows are board eligible and soon to be certified or are already certified in internal medicine and are capable of caring for patients with rheumatic diseases which falls under the umbrella of their internal medicine scope of practice.

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

PGY-4-5 Fellows

PGY-4-5 (several of our fellows have done Chief Residencies prior to their fellowship Hereafter known as F1 or Junior Fellows) fellows are primarily responsible for the care of patients under the guidance and supervision of the attending physician. 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, the attending physician should be contacted in a timely fashion. All patients on consult and clinic services are staffed by an attending physician. In the clinic, an attending is immediately available for staffing F1 patients. The F1 is expected to provide a full clinical presentation especially during the first 6 months of fellowship and thereafter the presentation can be in a more abbreviated form. Patients are then seen by the attending who reviews the salient points of the history and the examination with the F1. With regard to consult patients, the attending physician is required to see consult patients with the F1 within 24 hours of the initial review by the F1 and again salient history and examination is performed. For urgent patients, staffing will take place as soon possible. The F1 is an important educator of medical student and residents on the inpatient consultation services.

PGY-5-6 (Hereafter known as F2 or Senior Fellows)

F2 fellows provide less consultative care and are generally engaged in research activities. They will cover the consult services for the F1 when on vacation but continue in clinic 1-2 times per week. Patients seen in either venue are still supervised by the attending physician in a similar timetable as the F1 fellows but the F2 fellows are expected to be more adept reflecting on the assessment and developing the diagnostic and treatment approach. Presentations are shorter and more directed and attending physician time in the room or at the bedside is briefer than the F1 attending assessments. The balance between supervision and autonomy is a delicate one and in rheumatology is manifested by pull back by the attending i.e. allowing the fellow to demonstrate most of the thinking and the attending do less and less speaking.

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 fellow is expected to be greater with less experienced residents and with increased acuity of the patient's illness. The attending must notify the fellow 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 the fellow of all situations that require attending notification per program or hospital policy.

The attending may specifically delegate portions of care to the fellow based on the needs of the patient and the skills of the fellow and in accordance with hospital and/or departmental policies. Fellows and attendings should inform patients of their respective roles in each patient's care.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow 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 fellow requires supervision, this may be provided by a qualified member of the Medical Staff or by a trainee who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by trainees. When there is any doubt about the need for supervision, the attending should be contacted.

**No supervision required**
Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, skin punch biopsy

**Temporary supervision required**
Arthrocentesis and joint injection
Soft-tissue aspiration and injection

Fellows will need to demonstrate their ability to perform the above procedures or produce certification of competence from their previous internal medicine program before they can perform an arthrocentesis or injection independently. Program certification will typically take place during their 6 weeks of fellowship and after the arthrocentesis and injection workshop done with simulation that they attend as part of their first month of training. Fellows are always encouraged to have an attending present during a procedure. Fellows are expected to maintain a list of all procedures performed for review by the program director.

**Emergency Procedures**
It is recognized that in the provision of medical care unanticipated and life-threatening events may occur. The fellow may attempt any of the procedures normally requiring supervision in a case where the death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available. Again, all fellows after their third month are board certified internists.
Supervision of Hand-Offs
We recognize that hand-offs are important process in maintaining quality care of patients. On the inpatient consult services, all patients are keep listed on the electronic medical record under a rheumatology specific label. The weekend call team may not know the patients in which case a direct contact either by phone and in person between the service fellow and he covering team is required at 5 pm on Friday. It will include all patients on the service and any needs anticipated over the weekend. Patients without active rheumatologic issues may not need to be seen over a weekend. If the weekend coverage team is asked to consult on a patient over the weekend, again direct contact between the consults team and the service fellow either by phone or in person once the weekend is over (generally 8 am on Monday). The coverage team is expected to update the list of patients in the electronic medical record. This same procedure is required of all service fellows handing off to the covering F2 fellow when going on vacation.

Circumstances in which Supervising Physician MUST be Contacted
In rheumatology, there are rare circumstances and events in which residents must communicate with an appropriate supervising physician. For rheumatology fellows, these may include a significant change in the status for which rheumatology has primary responsibility. This might include for example a thromboembolic event or a change in mental status in a patient with lupus, or sudden onset of shortness of breath in a patient with vasculitis. Any event for which a fellow feel uncertain or uncomfortable is one where a faculty member should be contacted. Fellows should have access to pager numbers, cell phone numbers, and home phone numbers of the responsible attending. If the primary attending physician cannot be contacted, then the program or associate program director should be called/contacted. For concerns during regular hours, if the primary attending physician cannot be contacted, any available attending in clinic or in office can and will be a resource for the fellow.

Fellow 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 assessments methods used to evaluate the level of fellow clinical competency for patient care and medical knowledge include but are not limited to direct observation by the program director, observational assessment of members of the Fellowship Committee, peer resident evaluation, Mini-CEX, In-service examination results, case presentation conference, post clinic conference interactions, and patient and staff assessment of fellow interactions.

Direct feedback regarding the fellow’s performance is provided by the program director and the fellowship evaluation committee chair two times yearly as per ACGME requirements.
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 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 appropriate attending, clinic and hospital staff.

Faculty Development and Fellow Education around Supervision and Progressive Responsibility

Division Supervision and Promotion policy is discussed at F1 orientation meeting the first week of fellowship. The Division of Rheumatology also holds a quarterly Division Meeting and it is in this venue that faculty and fellow education occurs on important issues such as AIDET communication skills, evaluating the 6 competencies, using the Mini-CEX, etc.

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