Roles, Responsibilities and Patient Care Activities of Residents

Anesthesiology Critical Care Medicine (ACCM)

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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.

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.

ACCM fellows are resident physicians in either the PGY-4 or -5 year of training. They learn the skills necessary for the practice of Critical Care Medicine through didactic sessions, reading and providing patient care under the supervision of the attending staff. As part of their training program, they are given progressively greater responsibility according to their level of education, ability and experience.

ACCM trainees have generally completed a residency in Anesthesiology, Emergency Medicine, Obstetrics, or General Surgery. Some ACCM trainees are participants in a combined Anesthesiology and Critical Care Medicine training program, and are considered fellows during the last 3 months of their PGY-4 year and their entire PGY-5 year. All ACCM fellows are engaged in a program of study intended to qualify them for subspecialty board certification.

**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:**
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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 10 – 15 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

Responsibilities and Patient Care Activities

ACCM 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. ACCM fellows generally provide care in the inpatient setting, but may occasionally provide care in the outpatient setting. 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.

ACCM 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 will 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 intensive care units, operating room or procedure suite under appropriate supervision. Fellows may initiate and coordinate hospital admission and discharge planning. Fellows should 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.

Generally, fellows in Critical Care Medicine provide direct patient care for patients in the intensive care unit. However, they may be assigned to teams providing care for inpatients or outpatients (including the emergency department), or teams providing diagnostic or consultative services. Fellows always provide care under the supervision of an attending physician.

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 fellows and with increased acuity of the patient’s illness. The attending must notify all fellows 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
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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 the consultant recommends a procedure.

The attending may specifically delegate portions of care to fellows based on the needs of the patient and the skills of the fellows and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior and senior residents to fellows assigned to the service, but the attending must assure the competence of the fellow before supervisory responsibility is delegated. Over time, the fellow 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. Fellows and attendings should inform patients of their respective roles in each patient’s care.

The attending and fellow 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 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 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 (and fellows). When there is any doubt about the need for supervision, the attending should be contacted.

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

Oversight required by a qualified member of the medical staff

Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, central venous catheter removal, abdominal paracentesis, arterial puncture/catheterization, lumbar puncture, nasogastric intubation

Direct supervision required by a qualified member of the medical staff for at least 5 discrete events, following which indirect supervision is allowable: *

Subclavian central venous catheterization
Pulmonary artery catheterization
Thoracentesis
Thoracostomy tube placement

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

All procedures listed above, after initial direct supervision metrics achieved
Central venous line placement by internal jugular and femoral approaches
Point of care vascular, thoracic, or abdominal ultrasound
Tracheal intubation
Extubation of the trachea in high-risk patients
Elective cardioversion
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Direct supervision required by a qualified member of the medical staff for the first 6 months of training plus 5 discrete events:

- Gastroesophageal balloon tamponade

Direct supervision required by a qualified member of the medical staff at all times:

- Tranesophageal echocardiography
- Temporary pacemaker placement
- Intracranial pressure monitor placement
- Percutaneous tracheotomy
- Fiberoptic bronchoscopy (other than for tracheal intubation)

All other invasive procedures not listed above

* Supervision requirements vary depending on the primary specialty of training. For example, Anesthesiology residency graduates do not require direct supervision of tracheal intubation, whereas graduates of Emergency Medicine, Surgical or Obstetrics programs require direct supervision throughout fellowship training. Likewise, supervision requirements may be waived in certain circumstances, depending on previous training. For example, if a trainee has previously completed a Fellowship in Cardiac Anesthesiology, or has passed the competency examination for perioperative tranesophageal echocardiography, supervision of this procedure by an attending physician will not be required. Likewise, trainees who have completed two or more years of training in general surgery may not require direct supervision during tube thoracostomy.

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 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

ACCM fellows may provide consultation services. 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. The availability of the attending and supervisory 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 fellows should be available to residents, faculty members, and patients. ACCM fellows performing consultations on patients are expected to communicate verbally with their supervising attending at the time of the initial consultation and at least once daily for the duration of consulting services. Any fellow 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 fellow will communicate with the supervising
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attending as soon as possible. Fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which ACCM fellows performing consultations must communicate with appropriate supervising faculty members include instances when the patient’s condition has changed in such a way that the consulting service is asked for additional and timely input.

Supervision of Hand-Offs

Each program must have a policy regarding hand-offs. This policy must include expectations of supervision with each type of hand-off situation. As documented in the ACGME’s common program requirements, programs must design clinical assignments to minimize the number of handoffs and must ensure and monitor effective, structured handoff processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the handoff process.

Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which fellows must communicate with appropriate supervising faculty members. These circumstances vary depending on the specific rotation that the fellow is assigned to. At a minimum, fellows must communicate with faculty members about decisions to implement comfort care or withdraw invasive support, news about unexpected patient deaths, decisions about transfer of patients to another service or hospital, and prior to performing any invasive procedures that require direct or indirect supervision. If the attending physician does not respond in a timely fashion, the fellow may contact the service chief for the rotation in question. Individual rotations may have additional “must call” criteria beyond those listed here.

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 ACCM program director will evaluate each fellow’s abilities based on competency-based criteria. Competencies will be evaluated by direct faculty observation during clinical rotations, and the fellow will be rated as “needs attention”, “developing as expected”, or “ready for independent practice”. Areas that need attention will be identified by the program director and discussed with the fellow, and a remediation plan will be created. Specific competencies related to patient care are as follows:

Fellows will be able to:

- Gather all information from a variety of sources, including medical records, transfer summaries and family members.
- Modify differential diagnosis and care plan based on clinical course and data as appropriate.
- Recognize disease presentations that deviate from common patterns and that require complex decision making.
- Incorporate pathophysiological reasoning along with the results of clinical research into care decisions.
- Safely and effectively perform advanced ICU procedures such as bronchoscopy, thoracostomy, and percutaneous tracheostomy.
- Effectively teach and supervise residents in the performance of central venous and arterial catheterization, airway management and other procedures.
- Demonstrate sufficient practical and basic science knowledge to evaluate complex or rare
presentations of critical illness.

- Demonstrate knowledge of the major clinical research findings underpinning routine ICU care.
- Demonstrate understanding of the physiology of critical illness and implications for outcome.

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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