Roles, Responsibilities and Patient Care Activities of Resident Trainees

Dermatology

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Definitions:

**Resident:**
Residents are physicians engaged in a graduate training program in medicine, and who participate in patient care under the direction of attending physicians. They learn the skills necessary for their chosen specialty through didactic sessions, reading and providing patient care under the supervision of the Medical Staff (the attendings) and senior trainees. As part of their training program, residents are given progressively greater responsibility commensurate with their judgment, knowledge, technical skills and clinical experience. 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.

**Attending of Record (Attending):** An identifiable, appropriately trained, credentialed, and privileged 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 competence and 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.

   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 review procedures/encounters and provide feedback after care is delivered.

**Responsibilities and Patient Care Activities**
Residents are part of a team of providers caring for patients. The team includes an attending physician and may include other licensed independent practitioners, other trainees and medical students. Residents may provide care in both the inpatient and outpatient settings. 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.

Residents evaluate patients, including obtaining medical histories and performing physical examinations. They may develop a differential diagnosis and problem list. Using this information, they develop a plan of...
care in conjunction with other trainees and the attending. They may document the provision of patient care as required by hospital/clinic policy. Residents 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 at the bedside, in the operating room or procedure suite under appropriate supervision. Residents may initiate and coordinate hospital admission and discharge planning. Residents discuss the patient’s status and plan of care with the attending and the team regularly. All residents help provide for the educational needs and supervision of any junior residents and medical students. 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.

The specific role of each resident varies with their clinical rotation, experience, years of clinical training, patient safety, severity and complexity of patient illness/condition, and available support services. 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 residency. Only years of clinical training are considered below.

Dermatology residents are part of a team of providers. They primarily provide care for patients in the outpatient setting, including emergency department. However, they may also provide care for inpatients through consultative services or while serving on a medical or surgical service. Dermatology residency training begins no earlier than the PGY 2 year. Though dermatology residents may have completed previous clinical training in another residency, the designation below of “PGY 2, 3, or 4” refers to the 1st, 2nd, and 3rd years of dermatology residency training.

**PGY 2-3**
Intermediate residents may be supervised by a senior resident or qualified member of the medical staff (attending); all services provided are supervised. Residents are provided progressive graduated responsibilities as merited. Along with the attending, they provide for the educational needs of non-dermatology residents and medical students.

**PGY 4**
Senior residents may provide direct patient care and consultative services with progressive graded responsibilities as merited and may be directly or indirectly supervised. They may supervise intermediate residents, non-dermatology residents and medical students. They must provide all services ultimately under the supervision of an attending physician who is responsible for all care provided.

**Attending of Record**
In the clinical learning environment, each patient will 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. The availability of the attending to the resident is related to the clinical experience, judgment, knowledge and technical skills of the resident and the acuity of the patient’s illness. The attending will notify all residents on his or her team of when he or she should be called regarding a patient’s status.

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 and review of the medical records of patients under their care.

Faculty supervision assignments are 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 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, contact the attending.

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

Visiting residents must receive specific approval from the training program to perform any of the procedures below without supervision.

**Direct supervision required by a qualified member of the medical staff for entirety of training**
- Mohs micrographic surgery
- Laser procedures
- Cosmetic procedures
- Sedation for procedures (AKA conscious sedation)
- All other invasive procedures not listed below

Trainees require direct supervision by a qualified member of the Medical Staff or a qualified trainee for each of these procedures until they have completed the training specified after which each procedure will be performed under indirect supervision.

**Direct supervision required for the first 2 months of clinical training**
- Punch biopsies
- Shave biopsies
- Intralesional injections
- Electrocautery
- Paring of hyperkeratotic lesions
- Partial thickness debridement
- Cryotherapy therapy for lesions > 5mm
- Aspiration or incision and drainage of abscesses

**Direct supervision required for the first year of clinical training**
- Excisional biopsies of skin lesions > 6mm
- Phototherapy prescription
- Excision/removal of complex lesions or those involving the eye lid
- Full-thickness debridement

**No supervision required**
- Dressing changes
- Suture placement and removal
- Cryotherapy of small skin lesions (<5 mm)
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 attending of record who 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 is appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity and complexity 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 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. 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. If the designated attending does not respond in a timely manner, a predetermined list of backup attendings is available for the resident.

Supervision of Hand-offs
Patient care hand-offs occur at change of rotation and following night and weekend home call. Patient care responsibilities are transferred to on-call residents and supervising attendings through verbal and written communication. It is expected that documentation of a new consultation by the night/weekend on-call resident and attending be forwarded to the daytime resident and supervising attending. At change of rotation, written communication is expected between residents. The communication of patient information is overseen by the attending of record to ensure proper and safe hand-offs occur.

Circumstances in which Supervising Practitioner MUST be Contacted
There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. Residents consulting for patients of high level acuity (e.g., admitted to the intensive care unit; febrile and immunosuppressed patients; acutely ill in the emergency department) must communicate with the attending physician responsible for supervising the resident at that time. If the supervising attending does not respond in a timely manner, the resident should contact an alternate attending dermatologist preferably at that clinical site, or failing that, the Chief Resident.

Resident Competence & Delegated Authority
The residency program uses a multifaceted assessment process to determine a resident's progressive graded responsibility and independence in providing patient care. Residents are observed directly by the attending staff and their performance discussed regularly. Formal numerical assessments are generally obtained on a bi-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 patients. The Residency Program Director conducts semi-annual reviews with each resident. Annually, the Program Director determines if the trainee possess sufficient competence necessary to be promoted to the next level. The residents complete an in-training examination annually that assesses their dermatological knowledge. This is used to compare their
level of knowledge to their peers across the country and identify knowledge gaps.

The attending staff evaluates residents continuously. 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 resident fails to follow that plan, or the intervention is not successful, the resident may be dismissed from the program. If a resident’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 and hospital staff.

**Faculty Development and Resident Education around Supervision and Progressive Responsibility**

The residency program engages resident trainees early in training regarding supervision and progressive responsibility. The trainees are instructed to reach out to supervising attendings at any and all times they require/desire assistance, a new plan of care is necessary due to changes in patient status, or any time they are uncertain regarding clinical decisions. Attending supervisors are likewise instructed to set expectations of when to be notified, create an environment in which residents are encouraged to call for supervision at any time they are uncertain or have a question, develop a communication schedule with the resident trainee, and be available for any concern.

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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