Roles, Responsibilities and Patient Care Activities of Residents

**EMERGENCY MEDICINE RESIDENCY**

Training Sites: The University of Washington Medical Center (UWMC), Harborview Medical Center (HMC), Seattle Children’s Hospital (SCH) and Valley Medical Center (VMC)

In the non-emergency department settings, the emergency medicine residents perform at the expected level of same level residents on the rotating service except when specifically noted in the goals and objectives of the rotation.

In the emergency department settings, faculty are ALWAYS present and available to discuss any clinical issues with the emergency medicine residents and other residents and fellows rotating in the emergency departments.

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 in the emergency department 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. This is applicable for non-emergency medicine rotations ONLY.

c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. This is applicable for non-emergency medicine rotations ONLY.

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.

Attending physicians are present and available for immediate consultation in all of the emergency departments. It is the expectation of the Division of Emergency Medicine that any year resident will go to the supervising attending immediately for any clinical concern. In the emergency departments at Seattle Children’s Hospital and at Valley Medical Center, residents are not expected to supervise other residents or students in any capacity. At these sites, residents are expected to be responsible for the patients they see solely under the supervision of the attending faculty. At Seattle Children’s Hospital, residents may be assisted in the care of their patients by Pediatric Emergency Medicine fellows but they will present all cases to emergency medicine trained faculty prior to disposition or at any earlier time they desire faculty guidance.

PGY-1 (Junior Residents)

PGY-1 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-1 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.

In the Emergency Departments, junior residents are directly supervised at all times by the attending in the area of practice or by EM3 or EM4 residents.

As new practitioners, EM1s are closely supervised by attendings and EM3s or EM4s. EM1s present patients after evaluation and prior to ordering diagnostic studies to the attending or EM3 or EM4 in the HMC ED or UWMC ED. All patients get presented to an emergency medicine trained attending prior to discharge or admission.
EM1s will provide comprehensive care of the non-critically ill patients in the emergency department. They will be expected to participate in major resuscitations and the care of critically ill patients as part of the greater team providing support as directed.

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

Teaching responsibilities for EM2s in the clinical area is limited to teaching and assisting EM1s and fourth year medical students in minor procedures such as IV access and placement of foley catheters. EM2s direct base station calls to the emergency department from EMS and from AIRLIFT NORTHWEST.

The focus of the EM3 year is to refine their clinical skills and efficiency, to continue to enhance their medical knowledge, and to further develop their knowledge and skills in the area of systems-based practice. EM3s become proficient in the management of critically ill patients by treating a large number of patients and by assuming responsibility for the care of the majority of the sickest patients. EM3s direct resuscitations and perform the most complicated and difficult emergency medicine procedures including cricothyrotomy and thoracotomy under direct attending supervision. EM3s routinely plan and begin to carry out diagnostic evaluations and treatment before presenting their patients to an emergency medicine trained attending. EM3s may supervise fourth year medical students and interns working at the University of Washington and HMC EDs. EM3s direct base station calls to the emergency department from EMS and from AIRLIFT NORTHWEST.

**PGY-4 (Senior Residents)** Senior residents are directly supervised. They may provide direct patient care or supervisory care, 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.

The focus on the EM4 year is to demonstrate skill in the full spectrum of activities common to emergency physicians practicing in any clinical setting while still being supervised. This includes the direct provision of clinical care, supervision of the care provided by junior house officers, clinical and didactic teaching, and serving as a resource to handle administrative issues. EM4s will be assigned responsibility for supervising and teaching junior house officers. EM4s preferentially will be given fourth year students to supervise over EM3s. EM4s will work closely with nursing staff addressing administrative and patient flow problems, and will be responsible for daily lab/xray follow up and collection of CQI data. They will present all cases to emergency medicine trained faculty prior to disposition or at any earlier time they desire faculty guidance. EM4s supervise and assist EM2s and EM3s in directing base station calls from AIRLIFT NORTHWEST and Medic One.

While at the community ED site (VMC), 4th year residents will be expected to function at the level of a practicing community attending, managing patient flow and overseeing the appropriate use of available resources, all under the direction of the ED attending.
Attending of Record
In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged **primary attending physician** 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 present at a patient’s bedside. 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. For example, if an orthopedic surgeon is asked to consult on a patient on the medicine service and decides the patient needs a joint aspiration, the medicine attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the medicine resident who may perform the joint aspiration. 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 and review of the medical records of patients under their care.

Faculty supervision includes the need 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, this should be discussed with the attending in the area responsible for the patient in question.

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

Direct supervision required by a qualified member of the medical staff until certified at which point indirect supervision with the attending immediately available to return to the area is appropriate.
This includes any procedure which is routinely performed on stable patients including but not limited to those listed below:

- Arterial Lines
- Dislocation Reduction
- Foley Catheter Placement
- Simple and Complex Laceration Repair
- Laryngeal Mask Airway
- Lumbar Puncture
- Measuring compartment pressures
- Paracentesis
- Peripheral IV Access
- Procedural Sedation
- Regional Anesthesia
- Slit Lamp Exam
- Splinting
- Thoracentesis
- Tube Thoracostomy
- Tonometry of Globe
- Ultrasound Guided Procedure: Abcess I&D
- Ultrasound Guided Procedure: Arthrocentesis
- Ultrasound Guided Procedure: Central Line and peripheral IV access
- Ultrasound Guided Procedure: Nerve Block
- Ultrasound Guided Procedure: Paracentesis
- Ultrasound Guided Procedure: Thoracentesis
- Ultrasound: 2nd and 3rd trimester
- Ultrasound: Aorta
- Ultrasound: Deep Venous Thrombosis
- Ultrasound: Echo Cardiogram
- Ultrasound: First Trimester Pregnancy Transabdominal
- Ultrasound: First Trimester Pregnancy Transvaginal
- Ultrasound: Gall Bladder
- Ultrasound: Ocular
- Ultrasound: Soft Tissue
- Ultrasound: Trauma Fast
- Uncomplicated Vaginal Delivery

Direct supervision required by a qualified member of the medical staff at all times includes this list of procedures as well as any procedure in which the patient is in critical condition with significant risk of death or disability which may not be listed here:

- Adult Medical Resuscitation
- Adult Trauma Resuscitation
- Cardiac Pacing
- Central Venous Access
- Cricothyrotomy
- Deep Peritoneal Lavage
- Endotracheal or Nasotracheal Intubation
- Needle thoracostomy
- Pediatric Medical Resuscitation
Faculty are always present in the emergency departments and it is expected that residents will discuss any medically indicated procedures with the faculty before the procedure is performed for most procedures beyond the straightforward nursing procedures such as IV access or Foley placements unless the procedure is an emergency procedure as noted below.

**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 as dictated by the rotating service. Residents do NOT perform consultations while rotating on service in the emergency department. 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.

**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 residents must communicate with appropriate supervising faculty members.

Faculty supervise the residents at all times in the emergency department clinical areas and are responsible for all patient management in the emergency department. The emergency departments at all sites are staffed at sufficient levels to insure adequate clinical instruction and supervision, as well as efficient, high quality clinical operations therefore it is expected for residents to discuss any concern with a faculty member immediately.

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. Residents are evaluated based on the EM specific milestones and assessed to determine competence through the Competence Review Committee based on these milestones.

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. **S**et Expectations: set expectations on when they should be notified about changes in patient's status.
2. **U**ncertainty is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **P**lanned Communication: set a planned time for communication (i.e. each evening, on call nights)
4. **E**asily available: Make explicit your contact information and availability for any questions or concerns.
5. **R**eassure resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.
1. **S**eek attending input early
2. **A**ctive 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. **F**eel 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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