Roles, Responsibilities and Patient Care Activities of Residents

Orthopaedic Hand & Microvascular Surgery Fellowship

University of Washington Medical Center
Harborview Medical Center
Seattle Children’s Hospital

Definitions

Residents:
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.”

Fellows in hand surgery are physicians who have completed their accredited residency training in orthopaedic surgery, plastic surgery, or general surgery. In each case, the fellows have completed at least five years of core residency training, and are board eligible prior to beginning their hand surgery fellowship. At the inception of fellowship, the fellows already have basic training in fracture repair, wound management, soft tissue repair (including nerves, tendons, vessels), and the diagnosis of common hand conditions. During the fellowship program, they learn added complex skills that complement their core training through didactic sessions, reading, and patient care under the supervision of the medical staff (attendings). As part of their training, they are given progressively greater responsibility according to their level of education, ability, and experience. They are already experienced in the orthopaedic and plastic problems of hand and upper extremity surgery that relate to their core residency program. The fellowship program allows them to apply for a Certificate of Added Qualification in Hand Surgery (administered by their respective American Board of Medical Specialties Board) after completing a twelve-month accredited program.

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 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) The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.

   b) 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**

The fellows are part of a team of providers caring for patients. They provide uniform quality of care for patients at the University of Washington System Hospitals. The team includes an attending as well as other licensed independent practitioners, trainees, and medical students. The fellows may provide care in both in-patient and outpatient settings. The may serve on a team providing direct patient care or as part of a team providing consultation or diagnosis services. Each member of the team is dedicated to providing excellent patient care. The fellows evaluate patients and obtain 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 document the provision of patient care as required by hospital/clinic policy. Fellows may write order for diagnostic studies and therapeutic interventions as specified in the Medical Center bylaws, rules and regulations. They may interpret results of laboratory and other diagnostic testing. They request consultation for diagnostic studies, evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed in the clinic, operating room, or procedure suite under the appropriate supervision. They are expected to function with the greatest level of independence in areas where they are already fully trained, in their primary specialty. Fellows may coordinate and initiate hospital admission and discharge planning. Fellows 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. Fellows provide care for outpatients (including those in the emergency department) and inpatients (including ICU). They provide direct care, or may be part of a team providing consultative or diagnostic services. They provide all services under the supervision of an attending.

**PGY- 6 (Senior Residents)** Senior residents may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, 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.

**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 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 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 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 that consultant recommends a procedure. 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, 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 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, the attending should be contacted.
Residents may perform invasive procedures as appropriate for the level of their abilities. These procedures are performed in the emergency department, and in other inpatient and outpatient settings. These procedures include but are not limited to:

- Closed reductions of fractures and dislocations
- Splinting and casting
- Injecting and aspirating joints
- Wound care and suturing

In the operating room, residents should perform procedures under direct supervision or with direct supervision immediately available. On occasion, procedures are done by the resident in the operating room that otherwise would be performed in the Emergency Department or on the ward (such as dressing changes). These procedures may be performed either under direct supervision or with supervision available. In emergent situations, the resident should act in the best interest of the patient. Supervision guidelines for emergency situations are provided below.

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

**Direct supervision required by a qualified member of the medical staff**
- Complex microsurgery including free tissue transfer
- Complex trauma cases involving multiple extremity fractures
- All other invasive procedures not listed

**No supervision required by a qualified member of the medical staff**
- Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, arterial puncture/catheterization, arthrocentesis and joint injection, punch biopsies of the skin, placement of casts/splints, relocation of joints or fractures, application of traction devices, irrigation and debridement of complex wounds. They may also perform the treatment for surgery for arthritis, arthroscopy, fractures, routine microsurgery, and soft tissue repair such as joints or capsules without supervision as these are covered in the primary residency.

**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 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. Residents must call their supervisor (attending) in any situation when they are uncertain or have questions as to the best management of a patient. This must occur in a timely manner such that patient care is never compromised. Guidelines for supervision should be made clear for each rotation. If there is any question as to who to contact or if there are discrepancies in opinions, and attending is always available and should be contacted.

Urgent and emergent situations must be communicated to the attending immediately. This includes, but is not limited to patients with compartmental syndromes, fractures and/or dislocations with vascular injuries, and other conditions require urgent/emergent intervention. Urgent and emergent matters must be communicated in real time with direct discussion. The resident and the attending should agree upon the method of communication but it must include some form of acknowledgement of receipt of information. For example, a text message or an email with an unknown time of review by the attending is an unacceptable manner in which to convey urgent information.

**Resident Competence & Delegated Authority**
The program director and faculty members must assign the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident.

**Fellow Review and Promotion Process**
The fellowship program uses a multifaceted assessment process to determine a fellow’s progressive involvement and independence in providing patient care. Fellows are observed directly by the attending staff throughout clinical training. Formal assessments are generally obtained from supervising physicians before and after completing a clinical rotation. Fellows are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. Direct feedback, regarding the fellow’s performance, is provided by the program director. Annually, at the completion of each rotation the program director and the division faculty determine if the trainee possesses sufficient training and qualifications to proceed to the next rotation. At the of the fellowship program, the program director and division faculty evaluate the fellow to determine if they are able to apply for and take the Certificate of Added Qualification in Hand Surgery examination.

**Faculty Development and Resident Education around Supervision and Progressive Responsibility**
The attending staff evaluates trainees continuously. If, at any time, their performance is judged to be below expectations, the fellowship director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the interventions is not successful, the trainee may be dismissed from the program. If a trainee’s clinical activities are restricted (e.g., they require a supervised 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.

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**.

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