Roles, Responsibilities and Patient Care Activities of Residents

Medical Genetics

University of Washington Medical Center, Seattle Children’s Hospital

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 (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 (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. *(programs may wish to add their own defined response time – e.g., “within 15 – 30 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**
The Clinical Genetics Residency is a two-year training period, during which residents assume progressively greater responsibility for patient care and develop independence in patient management. Residents must be supervised throughout their residency by a faculty member who is ultimately responsible for the patient’s care.

**Fundamental Clinical Training**
Genetics Residents are required to have completed two or more years in an ACGME accredited program prior to beginning their specific training in Clinical Genetics, in accordance with the requirements of the American Board of Medical Genetics. In the past, this requirement was usually fulfilled by a traditional 3-4 year residency in Pediatrics, Internal Medicine or Obstetrics-Gynecology; however, completion of a first residency is no longer required. We do not offer a formal combined residency program with other UW residencies at this time. Residents who apply for the Clinical Genetics program are responsible for fulfilling the fundamental clinical training requirements.

**Year 1 of Clinical Genetics (PGY3 or above)**
Clinical Responsibilities Include: Taking a history, family history, performing a physical exam, literature search, forming a preliminary assessment and plan, and documenting the evaluation. The final plan is made with input from the attending. This may be done in the inpatient or outpatient setting. The resident does genetic counseling under direct supervision. In the laboratory, clinical responsibilities include learning about the diagnostic lab methods used and participating in the interpretation of genetic test results. The resident does not sign the lab reports, which is done by the lab based personnel. Procedures may include: skin biopsy under the supervision of an attending.

Clinical Genetics residents are required to complete 12 months of core rotations in the following: 3 months each of UW Genetic Medicine Clinics, Seattle Children’s Hospital Genetics (outpatient and inpatient consultations), Biochemical Genetics (outpatient, and inpatient consultations), and one month each of Prenatal Genetics, Molecular Diagnostics, and Cytogenetics. They may participate in procedures performed in the clinic under the supervision of a qualified member of the medical staff. During the first year of training devoted to Clinical Genetics, the residents are primarily responsible for patient care under the guidance and supervision of the attending.

**Year 2 of Clinical Genetics (PGY4 or above)**
Clinical Responsibilities Include: the same as for a 1st year resident, but graded responsibility with the senior resident taking a greater role in the formulation of the diagnostic and therapeutic plan, and performing the majority of the counseling and followup with the patient, still under the direct or in some cases, indirect but available supervision of the attending physician.

Clinical Genetics Residents are required to complete 6 months of rotations in 2 month blocks chosen from the following: UW Genetics Medicine Clinics, Seattle Children’s Hospital...
Genetics, Biochemical Genetics. The remaining six months should include at least ½ day of clinic per week, continued attendance at clinic conferences, with the remainder of the time devoted to research activities.

All patient care is under the supervision of an attending physician, residents may provide direct patient care or consultative services. Residents are expected to evaluate patients, determine the relevant pathologies, develop a differential diagnosis, and a diagnostic and therapeutic approach. If there are expected out-of-pocket costs to the patient, these should be addressed with the patient.

Residents are expected to take a greater role in genetic evaluation, counseling and generating a care plan (still under supervision), while caring for more complex patients with unknown or multiple genetic issues. Residents are expected to demonstrate greater familiarity with the medical literature, and ability to marshall resources to answer difficult questions of diagnosis or management.

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.

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.

**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.

**PGY- (as defined by RRC) (Intermediate Residents)**

Intermediate residents may be 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.

**PGY- (as defined by your RRC) (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 (or licensed independent practitioner if approved by your RRC) 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 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, 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 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, the attending should be contacted.

The following procedures may be performed with the indicated level of supervision:
Direct supervision required by a qualified member of the medical staff

Skin biopsy

Direct supervision required by a qualified member of the medical staff for the (INDICATE TIME PERIOD of Clinical Training OR other measure of competency such as number of successful procedures, credentialed to perform, etc.)

Skin biopsy—direct supervision required for first 3 biopsies.

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

Skin biopsy for 4th biopsy and subsequent.

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

Oversight required by a qualified member of the medical staff

None

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 (within 24 hours). 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.

Additional specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members include: for a patient seen in the intensive care unit, on an inpatient unit, or emergency department, the supervising physician
should be contacted immediately before or after seeing the patient. The supervising physician should also be contacted by the resident at any time at the request of an attending on another service. If the attending does not respond in a timely manner, then the clinical service chief should be contacted, and if not available, the division chief.

**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. For example, if a patient is seen in the intensive care unit, on an inpatient unit, or emergency department, the supervising physician should be contacted immediately before or after seeing the patient. If the attending does not respond in a timely manner, then the clinical service chief should be contacted, and if not available, the division chief.

**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 assessed for their patient care and medical knowledge core competencies continuously by the attending staff. Evaluations are completed at the end of each rotation in MedHub. Objective assessment methods include performance on national in-service board examination for medical knowledge. If their performance is below expectations, the program director (or her designee) will meet with the trainee to develop a remediation plan with expected milestones for improvement. If the trainee fails to follow the remediation plan, or the intervention fails, the trainee may be dismissed from the program. If a trainee’s clinical activities are restricted more than expected for that level of training, the information will be made available to the Medical Director, the GME office, and medical/hospital staff as deemed appropriate by the Program Director.

**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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