Roles, Responsibilities and Patient Care Activities of Residents

UNIVERSITY OF WASHINGTON NUCLEAR MEDICINE RESIDENCY

UNIVERSITY OF WASHINGTON MEDICAL CENTER
HARBORVIEW MEDICAL CENTER
VA PUGET SOUND HEALTH CARE SYSTEM (SEATTLE)
SEATTLE CANCER CARE ALLIANCE
SEATTLE CHILDRENS MEDICAL CENTER AND HOSPITAL
SWEDISH MEDICAL CENTER

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, including ABNM-eligible acting instructors, 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
It is the policy of the Nuclear Medicine Division that all resident patient care activities are supervised by attending staff or acting instructor. To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision
   The supervising attending physician (or licensed independent practitioner including ABNM-eligible acting instructor) 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 (response time within 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**

(Nuclear Medicine has three levels of training: NM1 which follows PGY1 in ACGME, RCPSC or AOA patient care residency or 2 years of GME residency, with USMLE 3 passing score; NM2 which follows successful completion of NM1 year or completion of another ACGME/RCPSC/AOA residency (eg., Internal Medicine, Family Practice, etc.); and NM3 which follows successful completion of NM2 year or which follows completion of ACGME or RCPSC Radiology Residency).

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.

**Exercise Stress Testing**
Resident must perform 25 EST procedures with direct attending physician or teaching associate presence and show proficiency before he/she can perform exercise stress testing procedures with indirect supervision.

**Vasodilator Stress Testing**
Resident must perform 20 vasodilator stress tests with direct attending physician or teaching associate presence and show proficiency before he/she can perform testing procedure with indirect supervision.

**Lymph Mapping Procedures**
Resident to perform 4 lymph mapping procedures with direct attending physician presence and show proficiency before he/she can perform lymph mapping procedures with indirect supervision.
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.

**NM-1 (Junior Residents)**
NM-1 residents are primarily responsible for the diagnosis and 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 diagnosis and care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion. NM-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. The attending physician is ultimately responsible for the care of the patient.

**NM-2 (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 NM-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

**NM-3 (Senior Residents)**
Senior residents may be directly or indirectly supervised. They may provide direct patient diagnosis and 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 including ABNM-eligible acting instructor) who is ultimately responsible for that patient’s care. The attending physician or acting instructor 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 where the individual attending would like to be notified, 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 nuclear medicine is asked to
consult on a patient for the neurosurgery service and decides the patient needs shunt access, the
neurosurgery attending may delegate supervisory responsibility to the nuclear medicine attending
to supervise the neurosurgery resident who may perform the shunt access. 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 in Nuclear Medicine:**

*Therapy with radiopharmaceuticals*

**Direct supervision required by a qualified member of the medical staff in Nuclear Medicine or
allied specialty (e.g., Neuroradiology, Fluoroscopy, or Neurosurgery) for the access of intrathecal
space or cerebrospinal fluid diversionary systems:**

*CSF Shuntograms, Radionuclide Cisternograms or CSF leak studies*

**Indirect supervision required with direct supervision immediately available by a qualified
member of the medical staff for the performance of all cardiac stress procedures:**

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

*All other Nuclear Medicine procedures performed during normal clinic hours (e.g. Lymphoscintigraphy, Lymphangiography, rTSH or lothalamate injections, dacryocystography).*

Oversight required by a qualified member of the medical staff:

*All Nuclear Medicine procedures performed in after clinic hours with exception of those procedures for which, as above, either direct or indirect supervision with immediately available status applies.*

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, where waiting 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 consulting 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 (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 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: during first experience of “on-call” activities regarding requests and acceptances for procedure performance by Nuclear
Medicine Technologists until such time that attending physicians deem that resident’s experience is satisfactory to independently screen and set up procedures. However, all “on-call” studies will continue to be finalized in interpretation only with attending supervision. If attending is not reachable by page, the next step is to use home telephone, followed by emergency cell phone list which is kept by the Department of Radiology. If attending is still not responsive, then chief of hospital section, division head, and finally hospital chief of service (Radiology) will be the order of contact.

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 hand-offs and must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-off process. Nuclear Medicine, as it is not a direct patient care specialty most of the time, does not deal with complicated “hand-offs” between trainees and/or practitioners. However, it is the policy for after hours “on-call” studies ordered toward end of clinic hours that the resident and/or attending in the clinic will communicate with the “on-call” resident to make that person aware of the after-hours study ordered by the requesting service.

Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. These include:
- All “on-call” studies
- All events in which there is patient harm or death.

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. (Objective measurements of medical knowledge and patient care progress are assessed by program director with emphasis on faculty evaluations. Average evaluation score must be 2.0 and above {scale: 1 needs attention; 2 developing as expected; 3 at/above R level}, patient evaluations, and ABNM in training exam performance in which score must be 50% or greater).
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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