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, pathology, 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 (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 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 AP and AP/CP Residents (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 available (see definitions above) by an attending, fellow, senior resident (PGY3 or PGY4 AP/CP resident or PGY2 AP only resident), or Pathology Assistant when appropriate. Specifically, PGY1 residents must be directly supervised during the performance of at least the three initial procedures in the following areas: autopsies (complete or limited), gross dissection of surgical pathology specimens by organ system, frozen sections, and fine needle aspirate biopsies and interpretation.

PGY-2 AP/CP Residents (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-3 and PGY-4 AP/CP and PGY-2 AP only Residents (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 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.

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 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 for the first three procedures
- Fine Needle Aspiration Biopsy

**Supervision of Consults**

Residents may provide consultation services under the direction of attending physician or 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. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients.
Specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members include:
- Frozen section/intraoperative consultations
- Consultations with clinicians/members of a clinical team when providing diagnostic information

**Supervision of Hand-Offs**

Anatomic pathology rotations and responsibilities are structured to minimize the frequency of hand-offs. Hand-off of anatomic pathology cases occurs when a resident switches service or takes leave/vacation. Pending cases (cases which have been reviewed by an attending pathologist but have additional histological sections, studies, etc. pending that will not be completed until the resident is off service) are to be documented in writing (transfer of care form and/or email), including what studies are pending on the case, and the written documentation and slides given to the attending of record.

**Circumstances in which Supervising Practitioner MUST be Contacted**

Residents must communicate with supervising attending pathologist when providing intra-operative consultations/frozen sections and when providing diagnostic information to clinicians before a pathology report is finalized.

**Resident Competence & Delegated Authority**

Due to the nature of Anatomic Pathology, residents work very closely with attending pathologists in providing patient care. As such residents are evaluated based on direct one-on-one interaction at sign out of surgical pathology cases and formative feedback is provided on an ongoing basis. Faculty also provide a summative evaluation based on ACGME competencies at the end of each rotation which is the basis for determining progressive responsibility and conditional independence for the resident at that point in their training. Residents also meet with their assigned advisor for their mid year evaluation and at least two other times in the year (Fall and Spring) where the residents progress in training are discussed along with general career goals. The Program Director reviews all resident evaluations to ensure residents are progressing in their training appropriately.

**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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