Supervision Policy
Rules, Responsibilities and Patient Care Activities of Fellows
Pediatric Gastroenterology Fellowship Program
Seattle Children’s Hospital
University of Washington Medical Center

Definitions:

**Fellows:**
As part of their training program, fellows are given graded and progressive responsibility according to the individual fellow’s clinical experience, judgment, knowledge, and technical skill. Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Fellows are responsible for asking for help from the supervising physician for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic 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 trainees involved in the care of the patient. The attending delegates portions of care to fellows based on the skills of the fellow.

**Supervision:**
To ensure oversight of fellow supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision – the supervising physician is physically present with the fellow 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.
   b) *with direct supervision available* – the supervising physician is not physically present at the 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

PGY-4: 1st year fellows:
1st year fellows are primarily responsible for the care of patients under the guidance and supervision of the attending Gastroenterologist. 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, attending physician should be contacted in a timely fashion. PGY-4 fellows are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending when appropriate.

PGY-5 and PGY-6: 2nd and 3rd year fellows (senior fellows):
Senior fellows may be directly or indirectly supervised by an attending physician but will provide all services under supervision. They will directly be supervised during any and all Specialty Gastroenterological procedures, by the appropriately credentialed and privileged attending. They may supervise PGY-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

They may provide directly 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 fellows should serve in a supervisory role of medical students, junior and intermediate residents in the 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 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. The availability of the attending to the fellow is expected to be greater with less experienced fellows and with increased acuity of the patient’s illness. The attending must notify all fellows 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 fellows all situations that require attending notification per program or hospital policy. The primary attending physician may at times delegate supervisory responsibility to another attending physician as indicated or needed.

Responsibilities and Patient Care Activities

Fellows are part of a team of providers caring for patients. The team includes an attending and may include other license independent practitioners, other trainees and medical students. Fellows provide care in both the inpatient and outpatient settings. They serve on a team providing direct patient care and are part of a team providing consultative, diagnostic, or procedural services.

Evaluation and Medical Care of Inpatients and Outpatients:
Fellows evaluate patients, obtain the medical history and perform physical examinations. They document the provision of patient care as required by hospital/clinic policy. Fellows may write orders for diagnostic studies and therapeutic interventions. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in
procedures performed at the bedside, in the clinic, operating room or procedure suite under appropriate supervision. Fellows may initiate and coordinate hospital admission and discharge planning. Fellows discuss the patient's status and plan of care with the attending and the team regularly.

Fellows generally provide care for outpatients seen in clinic, or provide consultation for inpatients (including ICU patients) with gastrointestinal disorders. When assigned, they may provide direct patient care (including in ICU). They may provide care or consultation in the emergency department. They provide all services under the direct supervision of an attending physician.

**Supervision of invasive procedures**

**Invasive Procedures:**
The fellow is expected to perform a pre-procedure history and physical and obtain informed consent for all patients undergoing endoscopic procedures or liver biopsy. The fellow should then discuss the case with the attending to ensure that the appropriate procedures are planned. If needed, moderate sedation is administered either by the fellow or by the RN, under direction of an attending physician.

Following completion of the endoscopy or liver biopsy, the fellow is responsible for completing a report for the medical record in the format required for each teaching hospital. The fellow should review the report information with the attending to assure accuracy. All endoscopic images should be printed for placement in the patients’ chart. Additional paperwork, including orders or pathology request forms, may need to be completed.

Endoscopy or Liver Biopsy Routine:
1) Pre-endoscopy history and physical
   The history (and physical as appropriate) should be reviewed even if a previously completed note is available within the past 30 days.
2) Informed consent
3) Immediate pre-procedure paperwork
4) Discuss case with attending
5) Moderate sedation, if required
6) Perform endoscopy or liver biopsy
7) Complete report in required form for medical record – written and dictated
8) Label endoscopic images
9) Complete other post-procedure paperwork
   -Orders (inpatient and outpatient)
   -Pathology requisition forms
   -Consults, radiology requests, prescriptions as needed
   -Post-procedure counseling of family and follow-up plans

**Pathology Follow-Up:**
The fellow is responsible for checking the pathology results for patients under their care during each rotation. They review results along with the endoscopy report or liver biopsy report to determine appropriate follow-up. These results are discussed with the attending, as appropriate, and follow-up plans are completed.

Pathology routine:
1) Review pathology reports
2) Discuss results with attending, as appropriate
3) Communicate results to patient at follow-up clinic appointment or via telephone
**Other Duties:**
The fellow is also responsible for aiding in the supervision of medical students and residents. They should assist with performing inpatient consults and the management of the consultation service. Some attending faculty may require that the fellow prepare a brief talk on a topic appropriate for the consultation service. (See “Review and Promotion” section)

Training and responsibilities are graduated according to the seniority in the Pediatric GI Fellowship program, skills of the fellow, and clinical situation. In all cases, however, specialty invasive procedures are preferred under the direct supervision of a credentialed and privileged attending Gastroenterologist.

**Hours:**
The fellow is on-duty for clinical rotations from 8:00 AM through 6:00 PM on weekdays, and weekday evening call Monday – Thursday for most rotations. Weekend call is covered by the fellows once monthly during the first year and approximately every three weeks in the second and third years. All evening and weekend consults should be discussed with the attending physician.

**Supervision of Clinical Activities**

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. Supervision will be provided by a qualified member of the Medical Staff. In all cases, the attending physician is ultimately responsible for the provision of care by trainees.

**No supervision required**
- Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, and nasogastric intubation

**Direct supervision always required**
- All endoscopic procedures, liver and rectal biopsies, manometric procedures, pH probe placements, capsule endoscopy procedures and administration of moderate sedation.

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow 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**

Fellows may provide consultation services, but the attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision as appropriate for optimal care. The availability of the attending should be appropriate to the level of training, experience and competence of the consult fellow 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. Fellows performing consultations on patients are expected to communicate verbally with their supervising attending prior to instituting the consultative recommendation, at least once daily. Any fellow performing a consultation where there is credible concern for patient’s life or morbidity 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 fellow will communicate with the supervising attending as soon as possible. Fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

**Chain of command for Supervision**

Supervision of Inpatient Patient care and emergency room consultations:
- Fellow will review care plan with the inpatient attending physician.
  - Transplant/liver service attending
  - GI attending
- In the event that the inpatient attending is not available in a timely fashion, backup will be provided by the clinic physician
- In the event that the IP attending and clinic attending are not available coverage will be provided by the Program director/Division Head.

Supervision of the Outpatient (OP) patient Care/Consultations:
- The fellow will review the patient care plan with the assigned clinic attending.
- In the event that the OP clinic attending is not available in a timely fashion, back-up will be provided by the IP attending.
- In the event that the IP attending and clinic attending are not available coverage will be provided by the Program director/Division Head.

Supervision of procedures:
- Direct supervision of procedures will be provided by the attending assigned to that procedure/procedure block time.
- In the event that the procedure attending is not available in a timely fashion, back up will be provided by the IP attending.
- In the event that the IP attending and clinic attending are not available coverage will be provided by the Program director/Division Head.

Supervision for weekend and night call:
- Supervision of fellow activities on weekend and during night call will be provided by the assigned attending.
- In the event that the attending assignee is not available, coverage will be provided by the Program director/Division Head.

**Supervision of Hand-Offs**

Hand-offs between attendings, attendings and fellows, and between fellows will be under the direct supervision of the handing-off attendings. Whenever possible the receiving attending and fellow will be present for the hand-off simultaneously.
Resident Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence and a supervisory role in patient care delegated to each fellow is assigned by the program director and faculty attendings. The fellows’ abilities will be assessed by direct observation by the attending faculty. Progressive independence will be allowed when the fellow has demonstrated mastery of the competencies at the lower levels. Procedural ascertainment of competence starts with the fellow observing a given procedure. This is followed by incremental increasing performance of the procedure by the fellow under direct supervision of the attending, with repetition until mastery of the correct technique and hence, able to proceed to more complicated techniques. Medical Knowledge competence will be assessed by the fellows’ ability to formulate appropriate differential diagnosis and management plans. Yearly assessment via the in-service exam will be performed.

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 will 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.**

**Fellows/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.

August, 2013