Roles, Responsibilities and Patient Care Activities for Sub-Specialty Trainees

Pediatric Hematology/Oncology Fellowship

Seattle Children's Hospital
Seattle Cancer Care Alliance

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.” For the purposes of this document the term “resident” and “fellow” are interchangeable.

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 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 available within 15 minutes to provide Direct Supervision.
   
   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 the subspecialty resident engages in approximate two years of focused scholarly training during their fellowship training. Only the clinical training responsibilities are considered below.

**Year 1**
The resident should acquire knowledge in diagnosis, treatment, and care of children with hematologic and oncologic diseases. The resident has patient care and supervisory responsibilities (of PGY-1 and PGY-2 residents) while rotating on the general hematology-oncology inpatient service; patient care and consultant responsibilities on the general hematology-oncology outpatient service and patient care responsibilities on the inpatient bone marrow transplantation service. The resident will also participate in a half-day weekly continuity clinic during which they will follow a primary cohort of patients throughout their subspecialty training. The resident will be expected to maintain a procedure log to be reviewed by their clinical mentor. The resident will actively participate in education of patients, families and medical professionals. The resident will develop and demonstrate teaching skills through presentations during inpatient ward month, continuity clinic meetings and/or divisional meetings. The resident will acquire knowledge of the research opportunities inside and outside the Division. This knowledge is gained through participation in conferences and patient care rounds at Seattle Children’s Hospital, the Fred Hutchinson Cancer Research Center and the University of Washington Medical Center. Such knowledge will allow the resident to select a research area and mentor by the beginning of the second year. The opportunity to participate in clinical care is also an opportunity to recognize the roles and importance of all components of the patient care team. The resident will acquire knowledge of the services and supportive care personnel necessary to operate a hematology-oncology program. The resident will acquire practice-based learning and improvement skills through participation in Tumor Board, HematoPath conference, and Standard Practice Committee meetings.

**Year 2**
The second-year resident spends the bulk of their time in research-related activity. The resident will continue to gain knowledge of hematologic and oncologic disorders and complications of therapy for such disorders by participation in half-day weekly continuity clinic and continued night and weekend supervisory coverage of the oncology inpatient service. The second year resident continues to expand their teaching and presentation skills through presentations at Continuity clinic conference, Division Conference and other patient care venues. Their skill in teaching and presentation occurs at laboratory, divisional, regional and national meetings.

**Year 3**
The resident will continue to gain knowledge of hematologic and oncologic disorders and complications of therapy for such disorders by participation in half-day weekly continuity clinic and continued night and weekend supervisory coverage of the oncology inpatient service. The resident is now a senior clinician among the residents and provides both direction and insight into care of patients and understanding options for care. The resident will demonstrate a thorough understanding of teaching skills through presentation of clinical and research data at such venues as the Division Conference, Standard Practice Committee meeting, Tumor Board or Continuity Clinic Conference. The third year resident will broaden scholarly activities by participating in workshops on bioethics, grant and manuscript writing, core statistics and participation in the monthly journal club. The third-year resident will actively engage in decision-making about future career opportunities, direction of their research and the role that they will play in clinical medicine. The resident will acquire knowledge of clinical and research administrative process and provide understanding of management issues. Residents will provide critique, recommend potential improvements and assist in implementing changes for all three facets of the program, patient care, research and teaching.

**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 a procedure is recommended by that consultant. For example, if a patient requires a lumbar puncture, the attending may delegate supervisory responsibility to another oncology attending so that the primary attending can continue with additional clinical responsibilities.

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. Over time, the 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 is expected to monitor competence of 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**
- Sedation for procedures
- Bone marrow harvest
- All other invasive procedures not listed below

**Direct supervision required by a qualified member of the medical staff for the first 3 months of fellowship**
- Bone marrow aspirate and biopsy
- Lumbar puncture
- Central line removal
- Intrathecal administration of medications (including chemotherapy) via lumbar puncture or through indwelling cerebral catheter (e.g., Ommaya)

**Indirect supervision required with direct supervision available by a qualified member of the medical staff after the initial 3 months of fellowship training**
- Bone marrow aspirate and biopsy
- Lumbar puncture
- Central line removal
- Intrathecal administration of medications (including chemotherapy) via lumbar puncture or through indwelling cerebral catheter (e.g., Ommaya)

**Oversight required by a qualified member of the medical staff**
- Phlebotomy, placement of peripheral intravenous lines, arterial puncture, bladder catheterization, suprapubic tap, wound care and suturing of lacerations, skin biopsies, incision and drainage of superficial abscesses.

**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**

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 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 should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending 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:

New diagnosis of malignancy
Life-threatening hematologic disorder
Life-threatening complication of cancer/immunosuppressive therapy

If supervisory faculty member does not respond in a timely manner the resident is instructed to request assistance from faculty member actively assigned as attending to alternative oncology service.

**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.

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Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members:
- Patient death
- Life-threatening consequence of current therapy
- New diagnosis of cancer or life-threatening hematologic disorder
- Admission to hospital, family/patient refusal of therapy or request for discharge against medical advice

If supervisory faculty member does not respond in a timely manner the resident is instructed to request assistance from faculty member actively assigned as attending to alternative oncology service.

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.

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, residents and students on a monthly basis and from assigned clinical mentors on a quarterly basis. Residents are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. In addition, resident performance is discussed at the biannual Division Faculty meeting. Direct feedback regarding the fellow's performance is provided by the program director (or designee) biannually. Annually, the fellowship program director and the Division faculty determine if the trainee possess sufficient training and the qualifications necessary to be promoted to the next level.

Trainees are evaluated continuously by the attending staff. If, at any time, their performance is judged to be below expectations, the fellowship program director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the intervention is not successful, the trainee may be dismissed from the program. If a trainee’s clinical activities are restricted (e.g., they require a supervisor’s 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.

Faculty Development and Resident Education around Supervision and Progressive Responsibility

The training programs provides faculty development and resident education on best practices around supervision and the balance of supervision and autonomy during the annual program meeting. Specifically, the SUPERB SAFETY model is reviewed and discussed:

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) input using the SAFETY acronym.

1. **Seek attending input early**

2. **Active clinical decisions:** Call the 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.

**Current date**

August, 2013