Policy on Supervision: Roles, Responsibility and Patient Care Activities for Residents and Fellows

Physical Medicine and Rehabilitation

Definitions

Residents and Fellows:
Physicians who are engaged in graduate medical education in PM&R, pediatric rehabilitation medicine, spinal cord injury medicine, and sports medicine, and who participate in patient care under the supervision of the attending physicians and licensed independent practitioners.

As part of their education program, residents and fellows are given graded progressive responsibility according to the individual’s clinical experience, judgment, knowledge and technical skill. Each resident and 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. Residents and fellows 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:
An identifiable, appropriately-credentialed and privileged attending physician or licensed independent practitioner who is ultimately responsible for the management of the individual patient and for the supervision of residents and fellows involved in the care of the patient. The attending delegates portions of care to residents and fellows based on the needs of the patient and the skills of the residents and fellows.

Supervision:
To ensure oversight of resident and 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 resident or 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 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
Residents and fellows are part of a team of providers caring for patients. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students. Residents and fellows may provide care in both the inpatient and outpatient settings. They may serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services. Each member of the team is dedicated to providing excellent patient care.
Residents and fellows evaluate patients, obtain the medical history and perform physical examinations. They may develop a differential diagnosis and problem list. Using this information, they develop a plan of care in conjunction with other trainees and the attending. They may document the provision of patient care as required by hospital/clinic policy. Residents and fellows may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, specialized nursing care, and social services, and evaluation and treatment by occupational therapists, physical therapists, psychologists, rehabilitation counselors, speech/language pathologists, and therapeutic recreation specialists. They may participate in procedures performed at the bedside, in the operating room or procedure suite under appropriate supervision. They may participate in prescription of orthoses and prostheses with attending supervision. Residents and fellows may initiate and coordinate hospital admission and discharge planning. Residents and fellows should discuss the patient's status and plan of care with the attending and the team regularly. All residents and fellows help provide for the educational needs and supervision of any junior residents and medical students.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident and fellow must be assigned by the program directors and faculty members. The clinical responsibilities for each resident and fellow are based on PGY-level, patient safety, resident/fellow education, severity and complexity of patient illness/condition and available support services. The specific role of each resident or fellow 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 and fellows must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

**PGY 1**
Primarily responsible for the care of patients under the guidance and supervision of the attending and senior residents or fellows. They may provide care for inpatients, outpatients, or patients in the emergency department. They may participate in procedures performed in the clinic, procedure suite or operating room under the supervision of a qualified member of the medical staff or senior trainee. They should 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 or fellows and/or the attending should be contacted. PGY 1 residents are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available. PGY-1 residents participate in a variety of rotations, including in emergency medicine, internal medicine, neurology, anesthesia/pain, orthopedic surgery, and in physical medicine and rehabilitation. Each of these programs must assess the independence of each PGY-1 resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available. These different rotations necessitate different sets of skills. That is, if a PGY-1 resident is deemed to have progressed to indirect supervision with supervision immediately available while on the internal medicine service, this may not be the case in a subsequent rotation such as emergency medicine. When PGY-1 residents are assigned to physical medicine and rehabilitation rotations, second- or third-year (or higher) residents or other appropriate supervisory physicians (e.g., subspecialty fellows or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on-site to supervise these first-year residents.

**PGY 2-3 (Intermediate Residents)** Intermediate residents may be directly or indirectly supervised by an attending physician or senior resident or fellow but will provide all services under supervision. They may serve as part of a team providing rehabilitation care for inpatients, consultative services for inpatients, or care for patients in the outpatient setting. These residents may coordinate the actions of the team, and interact with nursing and other administrative staff. They may supervise PGY-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.
**PGY4 (Senior Residents including the Chief 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. They may serve as part of a team providing rehabilitation care for inpatients, consultative services for inpatients, or care for patients in the outpatient setting. 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.

Documentation requirements for inpatient residents (at any level) include the following:

Residents must write at least a holding admission note on the day of admission. A complete note must be on the chart within 24 hours of admission. A note must be written on the day of discharge. All inpatients should have notes written Monday through Friday, and Saturday or according to service requirements. In some patients that have had a significant alternation in medical status multiple chart notes on a single day may be required to document the changing status.

Discharge Summary: All discharge summaries should be dictated or typed within 24 hours of discharge. A note should also be placed in the chart or electronic medical record on the day of discharge if the discharge summary is not immediately available. It is important that copies of the discharge summary be forwarded to the referring physician or agency to allow them to maintain continuity of care after discharge.

Off-Service Notes – An off-service note or interim summary is required whenever a resident is leaving a rotation. Because of the nature of the rehabilitation process and the conditions being treated, patients may be in the hospital for a considerable period of time. To optimize the continuity of patient care, a succinct yet thorough off-service note is essential. In addition, the on-call handoff information should be updated and provided to the incoming resident so that priorities of care can be rapidly established. (See On-Call Policy).

**ACGME accredited Fellows: PGY 5 or 6**

Fellows 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. Fellows may be responsible for day to day management of patients under attending supervision for inpatients, consultations, and outpatients. The fellows may coordinate the actions of the team, and interact with nursing and other administrative staff. Along with the attending they provide for the educational needs of any junior residents and students.

The Sports Medicine Fellow has additional responsibilities re: sports teams and sporting event medical coverage under the attending physician’s supervision to include caring for athletes on the sidelines of sporting events, in the training room, and in the medical tents of mass participation endurance sporting events. The level of supervision is:

- Autumn high school football coverage: graded supervision from initially direct to eventually indirect supervision as the season proceeds and the attending determines that the fellow’s knowledge and skill are commensurate.
- Collegiate sporting events: direct supervision
- Training room coverage: direct supervision
- Mass participation endurance events: direct supervision for initial summer and autumn events. Later events will have a mix of direct supervision and indirect supervision with direct supervision immediately available.

**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 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 or fellow is expected to be greater with less experienced residents or fellows and with increased acuity of the patient’s illness. The attending must notify all residents and 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 residents and fellows 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 physical medicine and rehabilitation service and decides the patient needs a joint aspiration, the PM&R attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the PM&R resident or fellow who may perform the joint aspiration.

The attending may specifically delegate portions of care to residents and fellows 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 or fellows assigned to the service, but the attending must assure the competence of the senior resident or fellow before supervisory responsibility is delegated. Over time, the senior resident and fellow 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, fellows, and attendings should inform patients of their respective roles in each patient’s care.

The attending and supervisory resident or fellow 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 fellow and delegate to him/her the appropriate level of patient care authority and responsibility. Faculty will review the goals and objectives for rotations with the residents and fellows.

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 or fellow requires supervision, this may be provided by a qualified member of the medical staff or by a resident or fellow who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents and fellows. When there is any doubt about the need for supervision, the attending should be contacted.

Oversight required by a qualified member of the medical staff

- Dressing changes
- Suture removal
- Central venous catheter removal
- Nasogastric tube removal
- Arterial puncture

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

The following procedures require the resident or fellow to discuss the assessment of the patient and plan the procedure with the attending, who is available for direct supervision if concerns arise:

- Electrodiagnostic studies (PGY 3 and 4)
• Interrogation of a baclofen pump/confirmation of titration (PGY 2,3,4)

Direct supervision required by a qualified member of the medical staff required

The following procedures require the presence of the supervising physician:

• Sedation for procedures
• Axial injections
• Phenol motor point blocks
• Botulinum toxin injections or anesthetic blocks for spasticity
• Refill of baclofen pump
• Trigger point injections
• Arthrocentesis/joint injection
• All other invasive procedures not listed.

Emergency Procedures
It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident or 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
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 and fellows performing consultations on patients are expected to communicate verbally with their supervising attending each day. Any resident or fellow 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 or fellow will communicate with the supervising attending as soon as possible. Residents or fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

An initial consult note should be placed in the patient’s chart within 24 hours. Consulting residents and fellows should see their patients frequently in order to be knowledgeable about the day-to-day status of their patients – in particular, any medical complications that affect the patient’s treatment and therapy. If a consult is requested on the weekend, the on-call resident or fellow should determine if the patient needs to be seen (e.g. assist with management) or if it can be deferred until Monday (e.g. request for inpatient transfer). The on-call resident or fellow should notify all members of the consult service of the request by email. Consult residents and fellows should also be available to the therapists for consultation as needs arise. Therapy orders must be rewritten upon any major change in patient’s status. Therapy orders must include precautions. Consult patients should be reviewed with the attending during formal consult rounds or on an ad-hoc basis according to the urgency of the consult. Attendings are responsible for providing written documentation when they have reviewed the consult and seen the patient.
Circumstances in which the supervising practitioner must be contacted
There are specific circumstances and events in which residents and fellows must communicate with appropriate supervising faculty members. These include: new admissions, new consults, uncertain diagnoses, need for obtaining urgent consults on an inpatient, need for diagnostic or surgical procedures, transfers off service, deaths or complications of care, significant change in a patient’s condition and DNR or other end of life decisions. In the situation of a deteriorating patient, consultative assistance from medicine or surgery should be obtained while concurrently seeking the attending’s support. Attendings are expected to be available to residents and fellows by pager or telephone from 8 a.m. to 5 p.m., Monday through Friday. The on-call schedule applies to other hours. If an attending is out-of-town, cross-coverage is always provided. If no attending can be readily identified to handle a patient problem, the resident or fellow should contact the chief of service, the Residency or Fellowship Program Director or the Chair.

The Sports Medicine Fellow has additional responsibilities to contact the supervising attending physician during sporting event coverage when there is indirect supervision for situations when emergency medical services are contacted, the athlete is to be transported to the hospital, or intravenous fluids are to be administered to a runner in the medical tent.

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