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 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**
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-4 (Sports Medicine Fellow)**

Fellows are part of a team of providers responsible for patient care. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students. Sports medicine fellows provide care primarily in the outpatient setting.

Fellows are physicians-in-training. They learn the skills necessary for their chosen specialty through didactic sessions, literature review, and provision of patient care under the direct supervision of the medical staff (i.e. attending physicians). As part of their training program, fellows are given progressively greater responsibility according to their level of education, ability and experience.

Sub-specialty trainees, having completed a residency in Family Medicine, are generally referred to as fellows. Fellows are engaged in a program of study intended to qualify them for subspecialty board certification.

Fellows evaluate patients, obtain the medical history, and perform physical examinations. They are expected to develop a differential diagnosis and problem list. Using this information, they arrive at a plan of care or a set of recommendations in conjunction with the attending. They will document the provision of patient care as required by hospital/clinic policy. 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, physical/rehabilitation therapy, specialized nursing care, and social services. They may participate in procedures performed in the 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 help provide for the educational needs and supervision of any junior trainees and medical students.

**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 if approved by your RRC) 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 an orthopedic surgeon is asked to consult on a patient on the medicine service and decides the patient needs a joint aspiration, the medicine attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the medicine resident who may perform the joint aspiration. 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 for the

1. **Direct supervision ALWAYS required**
   - Sedation for procedures (AKA conscious sedation)
   - All other invasive procedures not listed below

2. **Direct supervision required for the first 2 PROCEDURES AT EACH JOINT OR OTHER SITE:**
   - Arthrocentesis
   - Casting/Splinting

3. **Direct supervision required for the first 3 PROCEDURES:**
   - Relocation of fractures or dislocations
   - Exercise stress testing (i.e. treadmill stress tests)
   - Cardiopulmonary exercise testing (i.e. CPET)
   - Musculoskeletal ultrasound

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

1. **Indirect supervision for first 2 PROCEDURES**
   - Placement of peripheral intravenous catheters
   - Suture placement and removal
   - Arterial puncture/catheterization

No supervision required (oversight without direct supervision)

1. Dressing changes
2. Anoscopy
3. IV catheter removal

**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**

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 performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals, typically on the same day as the consultation. 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:

1. Management or triage question regarding a student athlete in the ICA training room patient staffed by the fellow.
   a. If the attending of record is not available for urgent matters, another team physician/sports medicine faculty member may be contacted to provide supervision.
2. Management or triage question regarding s student athlete injury or ill during a sporting event covered by the fellow.
   a. If the attending of record is not available for urgent matters, another team physician/sports medicine faculty member may be contacted to provide supervision.
3. Any attending physician clinic staffed by a fellow
   a. If the attending of record is not available for urgent matters, another team physician/sports medicine faculty member may be contacted to provide supervision.
4. Any mass event (i.e. marathon) clinic in which the fellow provides medical coverage
   a. If the attending of record is not available for urgent matters, another event staff physician may be contacted to provide supervision.

**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.

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

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members.

1. The fellow must communicate with supervising faculty members, either directly or indirectly, when delivering care for student athletes at the ICA training room clinic
2. The fellow must communicate with appropriate supervising faculty when covering a mass event (i.e. marathon)
3. The fellow must communicate with the appropriate supervising faculty when covering sporting events regularly staffed by the faculty member.

If the attending of record is not available for urgent matters in any of the above circumstances, another team physician/sports medicine faculty member could be contacted to provide supervision.

**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. Supervising physicians provide formal assessments. Fellows are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. In addition, fellow performance is discussed at faculty meetings on a regular basis. Direct feedback regarding the fellow’s performance is provided by the program director on a structure bi-annual basis and additionally on an as-needed basis. Such feedback and evaluation is guided by the sports medicine fellowship RRC and ACGME requirements.

The attending staff evaluates trainees continuously. 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**

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.

*August, 2013*