Roles, Responsibilities and Patient Care Activities of Residents and Fellows

Transplant Hepatology Fellowship Program

University of Washington Medical Center
Veterans Affairs Medical Center

Definitions

**Resident:**
A physician who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners).

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.

**Fellow:**
A physician who is engaged in a graduate training program in a subspecialty of internal medicine (in this case, gastroenterology and hepatology) and who participates in patient care under the direction of attending physicians.

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 (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 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 trainees.

**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 (or non-physician "supervisor") 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 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 fellow are based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. The specific role of each 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. Fellows must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

Please note some fellows may be engaged in one or more years of research training during their fellowship. Only years of clinical training are considered below.

**PGY-7 (or PGY-6 and PGY-7 if the fellow completed a Chief Residency in Internal Medicine prior to beginning GI Fellowship)** 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 should serve in a supervisory role of medical students, junior and residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the Senior Fellow; 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 availability of the attending to the fellow is expected to be greater with less experienced fellows (i.e. junior 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 attending may specifically delegate portions of care to fellows based on the needs of the patient and the skills of the fellows and in accordance with hospital and/or departmental policies. The
attending may also delegate partial responsibility for supervision of Junior Fellows to Senior Fellows assigned to the service, but the attending must assure the competence of the Senior Fellow before supervisory responsibility is delegated. Over time, the Senior 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. Fellows and attendings should inform patients of their respective roles in each patient’s care.

The attending and supervisory fellow are expected to monitor competence of more junior residents and fellows 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 fellow 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 fellow requires supervision, this may be provided by a qualified member of the medical staff or by a fellow who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by fellows. 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 GI Attending**

*Percutaneous Liver Biopsy*

**Indirect supervision required with direct supervision available by a GI or Hepatology Attending**

*Capsule Endoscopy* (Fellow will have taken a capsule endoscopy tutorial course and/or read cases from the teaching file before being allowed to read capsules with indirect supervision).

*Paracentesis* (Fellow will be allowed to perform this procedure with indirect supervision once the attending has ascertained that the fellow received the proper training and is deemed competent through prior training during Internal Medicine Residency).

**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**
Residents and Junior Fellows may provide consultation services under the direction of supervisory Senior Fellows. Junior Fellows may supervise Internal Medicine Residents. 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 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 at regular time intervals (at a minimum on a daily basis for all patients with active GI or Liver issues). 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 and fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

If the attending on service does not respond in a timely manner, the fellow should contact attendings who are on call for the time period in question. For example, for weekend/holidays, attendings on call include a General GI Attending, a Therapeutic GI attending, and a Hepatology Attending. The General GI Attending should be contacted as a first step; if this attending cannot be reached, then the Therapeutic Attending and/or the Hepatology Attending should be contacted. For call during the week, if the attending on service at one site cannot be contacted, the backup should be attendings based at the same site. Attending contact information is listed on the GI Bulletin Board Roster at the GI Division website (www.uwgi.org).

Supervision of Hand-Offs

Hand-offs are an essential part of effective and safe patient care. For all GI consult services, direct communication between the fellow(s)/residents on the consult service and the covering fellow (verbal through in person or via phone) must occur for all patients that are deemed unstable and potentially requiring a procedure for the coverage time period. In these situations, a clear plan of action should be communicated to the covering fellow, and all questions regarding courses of action and therapeutic options discussed. The most common example of this is in the case of an actively bleeding patient in the ICU who is being resuscitated and will require urgent endoscopy. For hand-offs of stable patients on the consult service, a written hand-off (either through email or via the CORES program at UWMC and HMC) is recommended, although direct verbal communication by in person communication or phone is also acceptable. These hand-off policies are expected to be carried out on a daily basis at the end of the workday. All consult recommendations that require specific actions, such as instructions regarding resuscitation of unstable patients and preparation instructions for endoscopic procedures, should be directly communicated to the primary team in person or via telephone as well as through the electronic medical record.

Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which residents or fellows must communicate with appropriate supervising attendings. These include situations where an endoscopic procedure is urgently needed, such as in patients with fulminant hepatic failure; and any other clinical situation where timely provision of consultative or procedural services are required.
**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 members. The program director evaluates each fellow's abilities based on specific criteria.

Each fellow's clinical and procedural abilities are evaluated based on specific criteria that is monitored through the faculty evaluations of fellow performance. The program director and the associate program director assess fellow performance and provide feedback to each fellow during the semi-annual meetings. The Fellowship Clinical Competency Committee reviews all fellow performance on a biannual basis. Progress in attaining competency in the 6 core competencies of the ACGME is measured through structured questionnaires and analysis of evaluations. Medical Knowledge is measured through performance on the GTE exam taken annually, along with faculty evaluations. Patient Care skills are evaluated through direct observation by faculty, nurses, patients, and the program administration. Specific measures of endoscopic competencies are based on a milestone based system that uses objective criteria such as cecal intubation rates and times, faculty assessments of competency, and completion of core instructional modules such as simulator training, training videos, and attendance at hands-on training sessions using animal models.

**Faculty Development and Fellow Education around Supervision and Progressive Responsibility**

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 fellow 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 fellow not to be afraid to call:** Tell the fellow to call with questions or uncertainty.
6. **Balance supervision and autonomy.**

Fellow should seek supervisor (attending or senior fellow) input using the SAFETY acronym.

1. **Seek attending input early**
2. **Active clinical decisions:** Call the supervising fellow 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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