

Roles, Responsibilities and Patient Care Activities of Fellows

UW SLEEP MEDICINE FELLOWSHIP

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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) 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.
 - 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

Inpatient consultation
Outpatient clinical care
Home based on-call night coverage for the sleep lab
Interpretation of sleep studies
Scoring of sleep studies
Patient preparation (hook-up) for polysomnography

The clinical responsibilities for each fellow are based on 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. Fellows must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

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, and residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the 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 (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 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 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 fellows based on the needs of the patient and the skills of the fellows and in accordance with hospital and/or departmental policies. Over time, the 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 fellow are 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 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 qualified member of the medical staff

None

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

None

Oversight required by a qualified member of the medical staff

Patient preparation (hook-up) for polysomnography (directly supervised by technologist)

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 may provide consultation services under the direction of 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 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 fellows should be available to residents, faculty members, and patients. Fellows performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals (within 8 hours of encounter). Any 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 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.

Supervision of Hand-Offs

Sleep medicine is primarily a consultative outpatient specialty. As such hand-off of care for inpatients may occur if a fellow will be absent for instances such as vacation or at the end of a rotation. In these situations, the fellow on-service must communicate the names, relevant clinical information and follow-up items for each patient being followed to the attending **and** the covering or incoming fellow prior to relinquishing responsibility for the patient's care. This may occur by phone conversation, in person, or by email. The attending and incoming fellow must be given reasonable opportunity to obtain clarification on any details prior to the fellow relinquishing responsibility.

Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. In the case of an acute medical emergency concerning a patient having a sleep study in the sleep lab, the on-call fellow must contact the consult attending. If the consult attending does not respond in a timely manner, any Harborview sleep medicine attending can be contacted via pager or phone. Supervising faculty members must also be contacted regarding outpatients who may be at impending risk for death or irreversible loss of function and prior to responding to patient medical concerns that the fellow does not have or feel competent to respond to independently. If the supervising faculty member does not respond in a timely manner, any sleep medicine attending at the clinical site can be contacted via pager or phone.

Fellow Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. The program director must evaluate each fellow's abilities based on specific criteria. The program director uses the following assessments of patient care and medical knowledge competencies to make this evaluation: direct observation of the fellow's performance in sleep clinics and sleep study interpretations sessions, structured chart review, faculty evaluations, sleep technologist evaluations, structure observation (Mini-CEX), clinical teaching assessment form, and self evaluations. Criteria used to make these determinations include the ability to competently perform a sleep medicine history and physical, create a differential diagnosis, select appropriate tests and treatments, interpret sleep study results, communicate with team members to facilitate care and document clinical care.

Faculty Development and Resident Education around Supervision and Progressive Responsibility

Attendings should adhere to the SUPERB model when providing supervision. They should

1. **S**et Expectations: set expectations on when they should be notified about changes in patient's status.
2. **U**ncertainty is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **P**lanned Communication: set a planned time for communication (i.e. each evening, on call nights)
4. **E**asily available: Make explicit your contact information and availability for any questions or concerns.
5. **R**eassure resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

Fellows should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **S**eek attending input early
2. **A**ctive 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. **F**eel 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. **E**nd-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. **T**ransitions 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. **H**elp 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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