Supervision and Responsibilities of
Pulmonary, Critical Care and Sleep Medicine Fellows[1]

[1]The term "house officer" as it appears in this document refers to any clinical fellow in the Pulmonary, Critical Care and Sleep Medicine fellowship program at the University of Nebraska Medical Center.

Introduction:

This section policy on supervision is subordinate to UNMC policies on supervision of house officers and is designed to supplement specific information as it pertains to subspecialty residents in the Pulmonary, Critical Care and Sleep Medicine Fellowship Program.

Graduated Responsibility:

The philosophy of education that has pervaded the U.S. health care system as it evolved has included graduated responsibility for all house officers culminating in the final year in which a high level of individual responsibility is achieved prior to graduation. Supervision and education are provided by faculty who may be full-time academicians in schools of medicine, highly qualified practitioners who voluntarily contribute their time and knowledge to the program, or combinations of the two. Supervision and education are also provided by the house officers, one to another as they progress through their program with a major responsibility shouldered by the senior house officers or chief residents in their final year.

While the need for graded responsibility in the provision of patient care is an important tenet of the educational system, it is critical that the education of house officers be accomplished in a high quality, expeditious and cost-effective manner.

University of Nebraska Medical Center house officers in the Pulmonary, Critical Care and Sleep Medicine fellowship program are physicians with an M.D. or D.O. degree and who have, at a minimum, a Nebraska Temporary Education permit which permits practice in the training program and many have unrestricted Nebraska licenses. They enter with Board-eligibility in Internal Medicine and continue to add special skills and knowledge that will allow them to become fully certified Pulmonary Diseases, Critical Care Medicine and with supplemental training, eligible for certification in Sleep Medicine. The house officers utilize their superiors as consultants as their ability to assume more responsibility is developed and the need for direct supervision declines. They become competent to make judgments of increasing complexity and to perform procedures of increasing difficulty throughout their house officer training. The outcome of this philosophy of education produces a physician who has had responsibility for self-learning, for teaching, for graded responsibility in patient care and for obtaining consultation when appropriate.

Relationship Between House Officers and Faculty:

The supervisory relationships that exist between faculty and house officers can be at several levels.

Inexperienced house officers require a greater level of supervision and the physical presence of a faculty member in the role of either the "attending physician" or the "consulting physician" to ensure that patients are receiving optimal care.

In order to qualify as an "attending physician," the teaching physician must at a minimum:

> review the patient's history, the record of examinations and tests in the institution and make frequent reviews of the patient's progress; and
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> personally examine the patient or see the patient; and
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> confirm or revise the diagnosis and determine the course of treatment to be followed;
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> and either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by house officers and that the care meets a proper quality level; and
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> be present and ready to perform any service that would be performed by an attending physician in a non-teaching setting when a surgical or medical procedure is performed; and
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> be recognized and/or accepted by the patient as his/her personal or responsible physician, or a member of the personal physician's group and be personally responsible for the continuity of the patient's care, at least throughout the period of illness or hospitalization.

Some specialists provide their services to patients from a site that is remote from where direct patient care is rendered. These "consulting physicians" provide expertise that is critical to the successful provision of patient care by the "attending physician."

In order to qualify as a "consulting physician," the teaching physician must, at a minimum:

> either perform the consulting physician's services required by the patient or supervise the procedure so as to assure that appropriate services are provided by house officers and that the care meets a proper quality level; and
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> be present and ready to perform any service that would be performed by a consulting physician in a non-teaching setting when a surgical or medical procedure is performed.

As house officers progress satisfactorily in their training, they must be granted graded responsibility commensurate with their abilities. In this setting, house officers may provide patient care under the supervision of, but without direct participation by, the attending physician. Under these conditions, the attending physician, although fully responsible for the care of the patient, is considered to be fulfilling an administrative/educational role.

Participation, for the purpose of this document, is defined as the attending physician being physically present on site during the delivery of health care. Participation includes supervision. On the other hand, a faculty member does not have to be physically present to supervise a house officer and, therefore, supervision does not imply participation. **The faculty cannot bill a patient for services rendered unless there is participation in patient medical care.**

PROGRESSIVE RESPONSIBILITY:

House officer education must continue to be progressively graduated in both experience and responsibility with due attention to the benefit and safety of the patient. Development of mature clinical judgment requires that each house officer be involved in the decision-making process. This process should be determined by each program and individualized commensurate with the clinical circumstance and the abilities of the house officer.

Progressive responsibility for "first decision" making prior to faculty involvement is important for the maturation of each house officer, whereas "final decision" making after involvement is the province of the faculty. In the process of allowing a house officer the opportunity to make the "first decision," the attending physician must ensure that the process does not delay the provision of cost-effective and expeditious care.

It is appropriate and desirable that house officers who are more senior have responsibility for supervision and education of those house officers junior to them. House officers' roles and supervisory relationships should be defined in writing by each program.

Faculty must supervise the total care for each hospitalized patient as well as the admission and discharge process and must follow program policy. There must be documented knowledge of every hospitalized patient as indicated by, at a minimum, initials or signature on the attending History and Physical, daily progress notes, procedure reports and the discharge summary.

Faculty have authority for patient care; however, both faculty and house officers at all levels have individual responsibility for their actions in patient care.

EMERGENCIES: In an emergency situation to preserve life or prevent serious impairment to health, house officers shall be permitted to implement life support services and notify the attending physician as soon as possible. The responsibilities of the attending physician to the patient and to the house officer are not changed by these circumstances.

ADMISSIONS AND DISCHARGE: House officers may admit patients to and discharge them from the hospital under the authority of, and only with the consent of, the appropriate faculty member. The only exception is an emergency where delay of permission could result in injury or loss of life. Appropriate faculty member(s) must be informed of all admissions, transfers and discharges.

QUALITY MONITORING: The overall quality of patient care is the collaborative concern of house officers, faculty, nursing staff and the administration. Clearly defined

and carefully reviewed Quality Monitoring should regularly determine that the institutional standards are being met.

CRITICAL DECISION AREAS: In areas of the hospital where rapidity of critical decisions or interventions are common, a supervisory attending will always be available for consultation.

CONSULTATION SERVICE: A readily available consultation service should be provided by each department and/or division. All consultations given by house officers must be reviewed by a faculty member in a timely manner and any necessary revisions conveyed promptly.

AMBULATORY CARE: Every house officer must have the opportunity to participate in ambulatory care. Designated faculty must be available on-site, or readily available according to their respective RRC special requirements, for supervision of house officers in such settings.

EVALUATION: Evaluation is an integral part of supervision. Each department will prepare an evaluation system to monitor the progress of each house officer as he/she progresses through clinical rotations. At a minimum, a formal written evaluation by a designated supervisory faculty member will be made on each house officer at the completion of each assigned rotation and will be discussed with the house officer. These evaluations will be forwarded to the Program Director who is ultimately responsible for ensuring adequate supervision and evaluation of each house officer within the program. Evaluations, every four months, are required by the UNMC, with direct personal review by the Program Director at least every six months. Written evaluations must include an assessment of the house officer's progress, performance, dedication, aptitude, capabilities, quality of patient care and qualifications to assume increasing levels of responsibility. If deficit areas are identified, these should be documented in writing by the Program Director who will ensure appropriate remedial action be taken.

In addition to the above, house officers must have an opportunity to evaluate their faculty in writing.

PROGRAM POLICY:
The development, implementation and enforcement of this policy is the responsibility of the program director. Oversight for the compliance of individual programs is the responsibility of the Graduate Medical Education Committee acting on behalf of the Dean of the College of Medicine.

Departmental policies on supervision should include description of the role, responsibilities and patient care activities by level of house officers in the program. The policy should describe the means by which the program makes decision about a resident's degree of independence in patient care and procedural duties. These policies should be provided to all hospitals at which the residents are assigned.

Level of Responsibility

1 = Must perform under direct supervision
2 = Can perform independently, supervise subordinates

Procedure

	F1	F2	F3
Airway Management			
Bag and Mask Ventilation	2	2	2
Oral Endotracheal Intubation	1	2	2
Nasal Endotracheal Intubation	1	1	1
Endotracheal Intubation over bronchoscope	1	1	1
Use of positive pressure ventilation:			
Initiation of controlled mandatory ventilation	2	2	2
Initiation of intermittent mandatory ventilation	2	2	2
Initiation of pressure support ventilation	2	2	2
Initiation of inverse ratio ventilation	1	2	2
Initiation of permissive hypercapnea	2	2	2
Use of respiratory care techniques;	2	2	2
Withdrawal of mechanical ventilatory support including use of liberation protocol	1	2	2
Use of reservoir masks for delivery of supplemental oxygen	2	2	2
Use of Non-invasive Positive Pressure Ventilation including continuous positive airway pressure (CPAP) and Bi-level positive airway pressure	1	2	2
Use of humidifiers, nebulizers, and incentive spirometers	2	2	2
Perform flexible fiber-optic bronchoscopy	1	1	1
With BAL	1	1	1
With biopsy techniques	1	1	1
Management of pneumothorax (needle insertion and drainage system)	1	2	2
Pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume studies, lung volumes, and diffusing capacity,	2	2	2
Interpretation of arterial blood gases	2	2	2

Procedure	F1	F2	F3
Supervision and interpretation of exercise studies	2	2	2
Diagnostic and therapeutic procedures:			
Thoracentesis	2	2	2
Paracentesis	2	2	2
Arterial catheterization	2	2	2
Central Venous catheterization	2	2	2
Femoral Vein catheterization	2	2	2
Foley catheter insertion	2	2	2
Lumbar puncture	2	2	2
Nasogastric intubation	2	2	2
Peripheral venous access	2	2	2
Closed pleural biopsy	1	1	1
Examination and interpretation of:			
Sputum	2	2	2
Bronchoalveolar lavage fluid	2	2	2
Pleural fluid	2	2	2
Insertion of thoracostomy tube and drainage system	1	1	1
Management of pleural fluid drainage	1	2	2
Pleurodesis	1	1	1
Insertion of pulmonary artery balloon flotation catheter including interpretation of data	1	1	1
Emergency cardioversion	2	2	2
Renal replacement therapy	1	1	1
Intracranial pressure monitoring	1	1	1
Operation of bedside hemodynamic monitoring systems	1	2	2
Nutritional support	2	2	2
Quality improvement activities in the intensive care unit	2	2	2
Inhalation challenge studies	2	2	2