University of Rochester Internal Medicine Critical Care Fellowship
Policy on Supervision of Patient Care Delivered by Fellows

General Principles:

The internal medicine critical care program provides fellows with continuous opportunities to develop their clinical skills and permits trainees to assume progressively greater responsibility for patient management in proportion to their demonstrated clinical proficiency. Faculty and other health team members have a duty to support fellows in their efforts to grow into capable, independent practitioners by assessing fellows' knowledge and skills, delegating portions of clinical care to fellows based on these observations, and reporting to the program director and Clinical Competency Committee about fellows' progress so that informed decisions can be made about the level of responsibility granted to each fellow.

Faculty and other health team members are simultaneously obligated to ensure patient well-being through appropriate supervision of less-experienced physicians. To that end, fellows must inform patients and families about their role within the care team, accept that final decisions about patient care always rest with the attending physician, and defer to faculty members' authority to make changes to their plans of action when necessary. Nonetheless, it is expected that when faculty members exercise their right to modify a fellow's decision that they will discuss the clinical reasoning and/or medical evidence that justifies such a change with the fellow so that the latter may learn from the experience.

ACGME-Defined Levels of Supervision:

The types of supervision referred to in this policy include:

Direct Supervision: the supervising physician is physically present with the fellow and patient

Indirect Supervision – With Direct Supervision Immediately Available: the supervising physician is physically present within the hospital or other site of patient care, and is immediately available to provide Direct Supervision

Indirect Supervision – 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 provide Direct Supervision

Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

Expectations for Supervision – Non-Invasive Patient Care Activities:

Because internal medicine critical care fellows have successfully completed an internal medicine or emergency medicine residency, upon entry into the program they are immediately permitted to engage in non-invasive patient care activities under indirect faculty supervision of either type and to supervise residents, medical students, and other trainees on all clinical services. Non-invasive patient care activities are deemed to include (but are not necessarily limited to) taking a patient's history, performing a physical exam, ordering laboratory or radiologic studies, performing bedside ultrasound, formulating a prioritized differential diagnosis, ordering medication or other treatment, requesting consultations, and

communicating with patients and families about diagnosis, prognosis, and treatment options. Fellows are expected to demonstrate insight into the limitations of their own knowledge and skills and to seek guidance when necessary. In the event that a fellow's practice indicates that he or she is not able to appreciate these boundaries, an expectation of direct supervision may be implemented by the program director and/or Clinical Competency Committee until the fellow is able to demonstrate convincingly the satisfactory development of this awareness.

Identification of Supervisor – Non-Invasive Patient Care Activities:

Every patient at every care site is assigned to an appropriately-credentialed attending physician who bears the ultimate responsibility for that patient's care. This information is available to all members of the health care team via the attending field in the patient's medical record. It should be noted that on nights and weekends a different, on-call partner of the daytime attending physician may be responsible for the patient. Access to information about which attending is responsible for each service at any given time is available by calling the page office or consulting the online paging system.

Critical care fellows are supervised by the current attending physician of the team to which they are presently assigned. In many cases, this person is the attending of record for patients admitted to the ICU under the joint care of that attending and the fellow. However in other circumstances the critical care team is acting as a consultant service for an attending of record who is not an intensivist or the fellow may be rotating on a non-ICU service. When the attending of record is not the same person as the attending leading the fellow's current team, the fellow's direct supervisor is the latter. During off hours this may be a different, on-call partner of the daytime attending physician for that team. This person may identified by calling the page office or consulting the online paging system.

For patients who are being evaluated in the emergency department who do not have an inpatient attending physician of record, the fellow's direct supervisor is the attending who is on call at that time for the service in whose capacity the fellow was asked to evaluate the patient.

Expectations for Communicating With Supervisor – Non-Invasive Patient Care Activities:

All new patient evaluations must be discussed with the attending. If the attending is not in the hospital and the fellow determines that the patient is stable, this may wait until the next routine communication point between the fellow and attending. In several circumstances, delaying interaction with the attending is not appropriate. Events that MUST be communicated to the attending as soon as possible include:

- uncertainty on the part of the fellow about what to do
- young patient who is severely ill, even if responding appropriately to treatment
- patient deteriorating, even if the fellow is certain that management is correct
- plan for an invasive procedure other than a typical central venous catheter or arterial line
- intent to initiate pharmacologic paralysis, inhaled Flolan, prone positioning, and/or ECMO
- consideration of therapeutic hypothermia
- decision to call a consultation not previously discussed
- unexpected cardiac arrest
- unexpected patient death
- unexpected significant patient deterioration of any kind

Expectations for Supervision and Identification of Supervisor – Invasive Procedures:

By virtue of their prior training in internal medicine or emergency medicine, fellows are permitted to perform select invasive procedures under indirect supervision of either type immediately upon arrival to the program. These select procedures include drawing venous or arterial blood, placing peripheral IV lines, inserting enteral feeding or decompression tubes, placing urinary catheters, and performing Pap smears or cervical cultures. Provided they hold an unexpired American Heart Association Acute Cardiac Life Support provider credential, fellows may also proceed under indirect supervision to lead resuscitative efforts for patients in cardiac arrest. This permission extends to placing an intraosseous catheter and performing needle decompression of a tension pneumothorax, emergency pericardiocentesis, emergency cardioversion, transcutaneous pacing, or defibrillation as indicated according to the ACLS algorithms. As in the case of non-invasive patient care, fellows are expected to be aware of the limits of their knowledge and skills and to seek guidance as appropriate. Should a fellow's actions demonstrate lack of such insight, the program director and/or Clinical Competency Committee may implement an expectation of direct supervision until the fellow has become proficient in identifying the boundaries of his or her capabilities.

At the time of fellowship enrollment, all fellows are expected to engage in all invasive procedures other than those explicitly identified above only under direct supervision. Acceptable supervisors for invasive procedures include faculty members, advanced practice providers holding hospital credentials to perform the procedure in question independently, or fellows who have been previously deemed competent to perform the specific procedure under indirect supervision. During the period of direct supervision, fellows should seek feedback about their performances from their supervisors, log the procedures performed, and collect supervisor attestations for those procedures deemed by the supervisor to have been proficiently completed. Supervisors attest to having provided the requisite supervision in the medical record via counter-signature of the fellow's procedure note.

Upon demonstration of competence in a procedure via a number of supervisor attestations satisfactory to the program director, the fellow will be granted the privilege to perform that procedure under indirect supervision of either type and to supervise others. The procedures that fellows are eligible to be credentialed to perform under indirect supervision of either type via the above mechanism include arterial lines; central venous lines in the internal jugular, subclavian, or femoral sites (each credentialed separately); hemodialysis catheters (credentialed in each site separately based upon the combination of credentials for dialysis catheters AND credentials for central venous line placement at the intended site); lumbar puncture; paracentesis; and thoracentesis. Fellows may not proceed to perform procedures without direct supervision nor to supervise others until their MedHub records reflect this permission.

Additional invasive procedures including (but not limited to) airway management (including the components of anesthetic induction, direct or video laryngoscopy, and endotracheal intubation), bronchoscopy, determination of death by brain criteria, elective cardioversion, elective pericardiocentesis, placement of thoracostomy tubes, pulmonary artery catheterization, and transvenous pacemaker placement require direct supervision for the duration of the fellowship.

In the event of a true emergency, fellows may perform any procedure that is necessary to save a patient's life under indirect supervision, even if they would not typically have permission to do so. A true emergency is defined as a clinical scenario that is sufficiently dire that the procedure does not require, nor is it appropriate to delay to administer, sedative or analgesic medications.