

Fellow Supervision Policy
Pulmonary and Critical Care Medicine Fellowship
SAUSHEC
Last Revised - July 2012

1. The purpose of this document is to provide highlight instructions and expectations with regards to supervision of patient care within the Pulmonary and Critical Care Medicine (PCCM) Fellowship Program (the fellowship). These policies align with and do not replace those found in the SAUSHEC Trainee Supervision Policy ([link](#)) and the ACGME Common and PCCM Program Requirements ([links](#)). More detailed supervision policies for clinical rotations may be found in that rotation's curriculum; this document provides core definitions and requirements.
2. Fellows are internists who, having successfully completed residency training, pursue additional training in Pulmonary and/or Critical Care Medicine. Fellows provide specialty care for patients requiring pulmonary consultative services (outpatient and inpatient), and also provide primary and consultative critical care in medical and surgical intensive care settings. Fellows perform these duties throughout their three years of training; the fellowship does not differentiate in the job descriptions of fellows for each year group, although there is graded authority and responsibility as further outlined below.
3. On the PCCM service, each patient has an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care. For fellows, the supervising physician is the attending for that particular clinical rotation who serves as the appropriately credentialed and privileged provider. Fellows, in turn, are expected to provide appropriate supervision to residents when residents are part of the patient care team.
4. Levels of supervision [Reference: ACGME Program Requirements in PCCM VI.D.3.]
 - a. Direct supervision – the supervising physician is physically present with the fellow and patient.
 - b. Indirect supervision 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.
 - c. 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.
 - d. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

5. Supervision during Core Clinical Rotations

a. Medical Intensive Care Unit (MICU)

i. Supervision

1. The attending physician assigned to the MICU serves as the responsible physician for the care of all patients in the MICU. This physician provides direct or indirect supervision to the fellow and residents as determined by the needs of the patient.
2. In general, the attending provides direct supervision during morning bedside rounds, when procedures dictate (see *Procedures*), and whenever requested by the fellow, resident, patient, or other member of the multidisciplinary care team. The attending is free to provide additional direct supervision at any time.
3. In general, the attending may provide indirect supervision with direct supervision immediately available during daytime hours outside of the situations previously described.
4. In general, the attending provides indirect supervision with direct supervision available during nighttime hours. Further information on communication and availability after hours is discussed below.

ii. Notification

1. The supervising attending must be notified immediately of any significant decline in a patient's status, change in the goals of care (i.e. comfort care only), or death.
2. An attending may request immediate notification for other issues at his/her discretion.

iii. Admissions/Evaluations

1. Residents on the MICU service are expected to discuss admissions to the MICU with the fellow or attending at the time of initial evaluation, and must do so within two hours of admission.
2. The fellow should make an assessment and discuss the case with the supervising attending in a timely manner based on the acuity of the patient's issues. Both fellows and attending should be available to arrive at the MICU within 30 minutes to direct care of unstable patients.
3. If the case does not require emergent attention, the fellow should discuss the case with the supervising attending within four hours if urgent attention is required or within 12 hours if the patient has stabilized with initial intervention.

iv. Do Not Resuscitate (DNR) [Reference: BAMC Memo 40-168, dated 15JUN11]

1. Only privileged physicians who are members of the medical staff (i.e. attending physicians) may write DNR orders.
2. Licensed physicians in Graduate Medical Education (i.e. residents or fellows) may transcribe a verbal DNR order from a privileged physician only after appropriate, thorough evaluation of the patient, discussion

with the patient and/or family/surrogate, and approval after discussion with the attending.

3. The attending is expected to discuss with the patient/family/surrogate, document, and co-sign/re-write the DNR order within 24 hours.

b. Pulmonary Clinic

- i. The attending physician(s) assigned to the outpatient consult service provide direct or indirect supervision with direct supervision immediately available to all fellows seeing patients in the outpatient setting.
- ii. New patients: the supervising attending must physically see and evaluate all new patients seen by fellows.
- iii. Follow up patients: selected follow up visits by outpatients with pulmonary fellows must be reviewed in person with the faculty and the outpatient record must have a faculty signature as proof of supervision. Patients with the following problems must have their case reviewed by an attending physician: pulmonary nodules, pulmonary masses, patients receiving immunosuppressive therapy other than corticosteroids, and patients with other rare and serious pulmonary disorders.
- iv. The supervising staff will interview and/or examine patients at their discretion, the fellow's request, or the patient's request.
- v. The supervising faculty must review and co-sign all clinic encounters.
- vi. Telephone consultations: telephone consultations and other patient care that occurs remotely (email, etc.) regarding radiographic tracking or other complex situations as outlined in section iii. Above requires the co-signature of an attending physician.
- vii. Pulmonary Function Testing: Simple pulmonary function testing (spirometry, lung volumes, DLCO, or six-minute walk testing) does not require faculty co-signature once the fellow has successfully completed the Pulmonary Function Testing clinical rotation. Attending physicians are always available to review such testing at their discretion or the fellow's request.

c. Inpatient Consults

- i. The attending physician assigned to the inpatient consult service provides direct or indirect supervision with direct supervision immediately available to all fellows seeing patients on the inpatient consult service.
- ii. Fellows must review all inpatient consults with faculty. The faculty should enter a brief note commenting on the assessment and plan and generate a computer signature on all inpatient consults.

6. It is recognized that the above list is not exhaustive. For other instances and medical conditions for which common sense and judicious practice dictates notification to the supervising attending, it is expected that the fellow will take responsibility and communicate effectively his/her findings, interpretation, and intended interventions in a timely manner.

7. Procedures

- a. Fellows may perform procedures with indirect supervision from faculty if they are certified to perform the procedure independently. All other procedures must be directly supervised by the physical presence of a physician who is certified to perform the procedure independently.
- b. The program director provides fellows certification to perform a procedure with indirect supervision. A determination of competency may come from appropriate records (such as certification from residency program), hospital-approved credentials, or after successfully meeting competency expectations following direct supervision and documentation from supervising attending physicians. An electronic and hard copy record of the fellow's procedure certification will be maintained on file with the fellowship program.
- c. Because individual fellows attain certification of specific procedures at different points in their education, any concerns or questions regarding certification should be directed to the program director (or supervising physician during non-duty hours.)
- d. Fellows are expected to request direct supervision and attending assistance with any procedure for which he/she is not comfortable, regardless of certification status. As with any clinical situation, fellows, attending, patients, or other members of the multidisciplinary care team can request direct supervision be provided by the attending physician.

8. Transitions in care

- a. Schedules providing fellows and attending responsible for the various PCCM services are made available to all members of the health care team through the program documents accessible on the New Innovations website, on the amion.com website, and through the main hospital communications desk (210-916-2500).
- b. Fellows are expected to demonstrate the ability to work with colleagues, faculty and the larger health care system in order to provide continuity of care and maximize patient safety.
- c. When participating in an outside rotation (based outside of SAMMC/WHASC), away at a conference or course, or on leave, fellows and faculty are required to identify a colleague to manage their continuity clinic patients during their absence (a "surrogate"). Information on clinical surrogates will be provided to the Clinic Manager, NCOIC, Service Chief, Program Coordinator, and Program Director.
- d. As all fellows and attending physicians receive TeamSTEPPS training, they are familiar with the core concepts of effective hand-over communication for patient care using the SBAR (Situation, Background, Assessment, and Recommendation) framework. The Program encourages the use of the SBAR framework when transitioning responsibility for patient care.
- e. During the night to day transition in shifts while working in the MICU, attending physicians will be present along with the fellows to monitor and provide feedback on the quality of the hand-over process.