SUPERVISION POLICY

Roles, Responsibilities and Patient Care Activities of Fellows

HEMATOLOGY-ONCOLOGY FELLOWSHIP PROGRAM

REQUIRED TRAINING SITES
University of Washington Medical Center
Harborview Medical Center
Puget Sound Blood Center
Seattle Cancer Care Alliance
VA Puget Sound Health Care Services

Definitions

Fellow
A physician who is engaged in a graduate training program in hematology and medical oncology and who participates in patient care under the direction of attending physicians as approved by the Program Requirements for GME in Hematology and Medical Oncology. Hematology-Oncology Fellows have satisfied the requirements (including procedures) for residency training in the specialty of Internal Medicine.

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 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 fellows involved in the care of the patient. The attending delegates portions of care to fellows based on the needs of the patient and the skills of the fellows.

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 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.

General 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.

Hematology/Oncology fellows are engaged in two years of research training during their fellowship. During that time they maintain a continuity clinic and may participate in other clinical activities with direct and indirect supervision and oversight by attending physicians.

First-Year Fellows (PGY-3, PGY-4, PGY-5)

PGY-3: Level for ABIM Research Pathway Fellows entering **first** year of fellowship training
PGY-4: Level for traditional pathway fellows (completed three-year Internal Medicine Residency)
PGY-5: Level for those who completed a traditional pathway fellowship in Internal Medicine and served as chief resident or were credited for additional pre-fellowship training (i.e., non-ACGME fellowship training in heme-onc area)

First-year fellows primarily manage or consult on inpatients and outpatients, perform or observe procedures and participate in or observe laboratory and transfusion services on various rotations at the University of Washington Medical Center (UWMC), Harborview Medical Center (HMC), Puget Sound Blood Center (PSBC), Seattle Cancer Care Alliance (SCCA) and Puget Sound VA Healthcare Services (VAPSHCS). Assigned attending physicians in hematology/oncology or related specialties (e.g. laboratory medicine, radiation oncology, surgery, gynecologic oncology) supervise the fellows during their rotations at each of these locations and on each inpatient and outpatient rotation.

The attending physician is responsible for the clinical care of patients and management of the service but graduated responsibilities are delegated to the fellow based on their skills and abilities. The knowledge base, experience level and competence of first-year fellows are usually limited. As each fellow gains more experience, knowledge and skills, either during a one-time rotation or when the fellow returns for a subsequent month on a specific rotation, the attending physician will increase the level of responsibility and expectations and decrease the level of direct supervision (to indirect supervision and oversight) commensurate with the fellow's performance, skills and maturity. A similar process of ongoing assessment and evaluation by attending physicians will determine when the fellow can take on additional responsibilities for primary management and decision-making with indirect supervision and oversight for their continuity clinic patients.

During most of the clinical rotations and in continuity clinic, the fellow will be expected to gain proficiency and competence in performing various procedures. The key procedures include bone marrow aspiration/biopsy, lumbar puncture, intrathecal chemotherapy administration via lumbar puncture or Ommaya reservoir access, administration of chemotherapy by all routes, serial measurements of tumor masses, paracentesis, thoracentesis and skin biopsy. Some of these procedures initially require direct supervision by the attending physician until the fellow is deemed competent, at which point indirect supervision and oversight are acceptable (see below). Other procedures (e.g. sternal bone marrow and bone marrow harvest) require direct supervision on every occasion and some skills acquired as a board-eligible internal medicine specialist (e.g. skin biopsy, thoracentesis and paracentesis) do not require direct supervision.

Second-Year Fellows (PGY-4, PGY-5, PGY-6)

- **PGY-4:** Level for ABIM Research Pathway Fellows entering **second** year of fellowship training
- **PGY-5:** Level for traditional pathway fellows
- **PGY 6:** Level for those who served as chief resident or were credited for additional pre-fellowship training (i.e., non-ACGME fellowship training in heme-onc area)

Second-year, senior fellows may participate in any of the rotations outlined for the first clinical year, either as an initial experience or a repeat rotation. In addition, fellows continue to see their own panel of outpatients in their weekly half-day continuity clinic.

For all rotational, procedural and continuity clinic experiences, the levels of attending physician direct and indirect supervision and oversight and the approach to progressive, graduated responsibilities for the second-year fellow will adhere to the policies as outlined above for **First-year fellows**. The fellows will be directly or indirectly supervised by an attending physician but will provide all services under supervision. Fellows may supervise residents and/or medical students on selected rotations; however, the attending physician is ultimately responsible for the care of the patient.

Third-Year and Beyond Fellows (PGY-5, PGY-6, PGY-7)

- **PGY-5:** Level for ABIM Research Pathway Fellows entering **third** year of fellowship training
- **PGY-6:** Level for traditional pathway fellows; PGY-6 may include research pathway fellows in their **fourth** year of fellowship
- **PGY-7:** Level for those who served as chief resident or were credited for additional pre-fellowship training (i.e., non-ACGME fellowship training in heme-onc area); PGY-7 may include Research Pathway fellows in their **fifth** and final year of fellowship and may also include non-ACGME senior fellows

Third-year, senior fellows in the traditional pathway and Research Pathway fellows who have 1 or 2 additional years of research and clinical commitments (4 or 5 years of training), maintain an ongoing half-day weekly continuity clinic where they see new and returning outpatients. The attending physicians in clinic are ultimately responsible for the care of patients managed by fellows in their continuity clinic panel.

For all procedural and continuity clinic experiences, the levels of attending physician direct and indirect supervision and oversight and the approach to progressive, graduated responsibilities for senior fellows will adhere to the policies as outlined above for **First-year fellows**. The fellows will have progressed from less direct to indirect supervision and oversight by an attending physician, who is ultimately responsible for clinical services and fellow supervision. Fellows must proactively seek and achieve a more independent role in patient management as they approach the completion

of formal training so they will be prepared for primary, independent responsibilities as a board eligible hematologist/oncologist after graduation from fellowship.

Site-Specific Clinical Responsibilities

UWMC Inpatient Leukemia Service

The focus of this rotation is on the evaluation, diagnosis and management of patients with leukemia, aggressive hematologic malignancies, aplastic anemia and patients with complications after stem cell transplantation. During their initial rotation on this service, the fellow is expected to work closely with and under the **direct supervision of the attending physician** for new patient work-ups, including the diagnostic evaluation and procedures, initial medical stabilization, and formulation of the therapeutic plan based on evidence-based literature, guidelines and/or experimental protocols. The fellow will participate in laboratory and pathology review and be responsible for chemotherapy ordering and administration by all routes, with direct and indirect supervision by the attending physician.

The fellow will perform bone marrow aspiration/biopsies and intrathecal chemotherapy under the direct supervision of the attending physician until deemed competent (see below). Additional procedures within the scope of hematology/oncology practice (i.e. serial measurements of tumor masses, paracentesis, thoracentesis and skin biopsy) will be **indirectly supervised (or directly, if needed)** and overseen by the attending physician in order to provide teaching and to document skill and proficiency. The fellow is also responsible for the discharge summary and other key documentation elements in addition to providing communication with the referring physician and transitional information for handoffs to the outpatient clinic when the patient is discharged.

During subsequent rotations, the more experienced and competent fellow will be given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to take a more active role in housestaff teaching and supervision in collaboration with the attending physician.

UWMC Inpatient Hematology Consult Service

The focus of this rotation is for fellows to learn the evaluation diagnosis and management of a wide variety of consultative hematologic issues. Although the focus is on non-malignant hematologic problems, such as cytopenias, bleeding and thrombosis with an emphasis on laboratory medicine and hematopathology, consultations will also include patients with hematologic malignancies. During their initial rotation on this service, the fellow is expected to work closely with and under the **direct supervision of the attending physician** for new consult patient work-ups, including the diagnostic evaluation, procedures (particularly bone marrow aspiration and biopsy), formulation of the therapeutic plan based on evidence-based literature, guidelines and/or experimental protocols. The fellow will participate in laboratory and pathology review with supervision by the attending physician. The fellow is also responsible for initial and ongoing documentation, providing communication with the referring physician and transitional information for handoffs to the outpatient clinic.

During subsequent rotations, the more experienced and competent fellow will be given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to take a more active role in housestaff teaching and supervision in collaboration with the attending physician.

UWMC Medical Oncology Clinics and Inpatient Consult Service
The goal of this rotation is to provide an ambulatory care experience in which fellows see a breadth of oncology patients. Fellows attend multidisciplinary clinics in lung/head and neck, genitourinary and testicular cancer and liver cancer where patients are evaluated in conjunction with medical, radiation and surgical oncologists. In addition, fellows attend subspecialty clinics with exposure to radiation oncology and neuro-oncology. The fellow also provides coverage for inpatient medical oncology consultations with **direct supervision by the attending physician** on the inpatient medical oncology service. On selected weekends, the fellow provides coverage for the hematology consult service and inpatient leukemia service at UWMC, with direct and indirect supervision and oversight by the attending physicians for the respective services.

Under the **direct and indirect supervision of an attending physician**, the fellow evaluates from two to four new patients per day in clinics, orders appropriate staging and diagnostic studies, performs therapeutic and diagnostic procedures such as thoracentesis, paracentesis and bone marrow biopsy, formulates a plan of treatment and co-manages patients with their attending physician during the month. The fellow is also expected to evaluate patients for their eligibility for clinical research protocols. This may involve an explanation of the study and alternative treatments, patient enrollment on the study, and coordination of the treatment program. Cases requiring multidisciplinary management are an integral component to this rotation.

During this rotation, the more experienced and competent fellow will be given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician.

UWMC Inpatient Blood and Marrow Transplant (BMT) Service
The goal of this month-long rotation is for the fellow to learn the theory, indications, treatment approaches, complications and outcomes of autologous and allogeneic BMT and to develop confidence and clinical expertise in the care and management of transplant recipients. The fellow is responsible for the intake, daily management, diagnostic and therapeutic decision-making, in consultation with and **direct and indirect supervision by the attending physician**. The fellow works directly with nursing, pharmacy, social services, transition team and the outpatient clinic providers to provide seamless communication and handoffs to the clinic. The fellow performs procedures, such as bone marrow aspiration/biopsies, lumbar puncture, intrathecal chemotherapy administration, serial measurements of tumor masses, and skin biopsies, with direct and indirect supervision and oversight as indicated. The fellow is responsible for daily progress note documentation, disposition and discharge summaries.

During this one-time rotation, the fellow is given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to lead a patient care conference, data review conference or multidisciplinary care rounds in collaboration with the attending physician.

HMC Consult Service
This is a monthly rotation with a primary focus on developing effective consultation skills and enhancing medical knowledge across a wide variety of hematologic and oncologic disorders. During their initial rotation on this service, the fellow is expected to work closely with and under the **direct and indirect supervision of the attending physician** for new patient consult and outpatient clinic work-ups, including the diagnostic evaluation and procedures, diagnosis and

formulation of the therapeutic plan based on evidence-based literature, guidelines and/or experimental protocols. The fellow will participate in laboratory and pathology review and be responsible for chemotherapy ordering and administration by all routes, with direct and indirect supervision and oversight by the attending physician. The fellow is also responsible for initial and ongoing documentation, providing communication with the referring physician and transitional information for handoffs to the outpatient clinic.

During their initial rotation, the fellow is expected to demonstrate basic knowledge, understanding and approach to the diagnosis and management of patients with benign hematologic diseases and the diagnosis, staging, and management of patients with malignant hematologic disease and solid tumors. The attending physician will provide more **direct and indirect supervision** for fellows during their first month on this rotation.

During subsequent rotations, the more experienced and competent fellow will be given graduated levels of responsibility for diagnostic work-ups of inpatient consultations and for primary decision-making regarding procedures and management with more **indirect supervision**, oversight and final approval by the attending physician. The **more experienced fellow** will also be expected to take a more active role in housestaff teaching and **supervision in collaboration with the attending physician**. A similar process of ongoing assessment and evaluation by attending physicians will determine when the fellow is competent to take on additional responsibilities for primary management and decision-making with indirect supervision and oversight for patients seen in the HMC clinic.

PSBC Transfusion Medicine Service
For this one-time rotation, the fellows are expected to learn the theory, indications, applications and rational utilization of blood products in addition to gaining a basic understanding of immunohematology, apheresis procedures and laboratory methods for hemostasis and thrombosis. Under the direct supervision of attending physicians and laboratory directors, the fellows have the opportunity to see patients in the hemophilia clinic and assess patients with bleeding and thrombotic disorders of platelets and coagulation proteins. The fellow is responsible for reviewing orders for blood components from several hospitals and providing consultation to physicians on the management of bleeding, transfusion reactions and antibody related clinical issues under the **direct and indirect supervision of the attending physician**. When the fellow is on the UWMC Transfusion Service, he/she observes and participates in management and transfusion support of complex surgical cases under the supervision of the attending physician. The fellows also take call and provide consultative services to the hospitals and physicians served by PSBC. Over the course of the month, the **attending physician will delegate graduated levels of responsibility** to the fellow as deemed appropriate for their development and skills.

SCCA Clinic Blocks
The goal of this rotation is to provide an ambulatory care experience in which fellows see a breadth of oncology patients. Fellows attend month-long multidisciplinary clinics in: (a) lung/head and neck and sarcoma; (b) gastrointestinal and genitourinary cancers; (c) breast cancer and gynecologic malignancies; (d) lymphoma and melanoma; (e) hematologic malignancies. Fellows also gain experience in palliative care, kidney cancer, stem cell transplantation, post-transplant long term follow-up and apheresis/cellular therapy. In all of these clinics, the fellow is **directly and indirectly supervised by the attending physician(s)**. The fellow evaluates from two to four new patients per day, orders appropriate staging and diagnostic studies, performs therapeutic and diagnostic procedures such as thoracentesis, paracentesis and bone marrow biopsy, formulates a

plan of treatment and co-manages patients with their attending physicians during the month. The fellow is also expected to evaluate patients for their eligibility for clinical research protocols. This may involve an explanation of the study and alternative treatments, patient enrollment on the study, and coordination of the treatment program. The fellow is also responsible for initial and ongoing documentation, providing communication with the referring physician and transitional information for handoffs to the inpatient services when patients require hospitalization.

During each clinic block rotation, the more experienced and competent fellow will be given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician.

SCCA Outpatient Blood and Marrow Transplant (BMT) Service
The goal of this month-long rotation is for the fellow to learn the theory, indications, treatment approaches, complications and outcomes of autologous and allogeneic BMT in the outpatient setting and to develop confidence and clinical expertise in the care and management of stem cell donors and transplant recipients. Donor evaluations include history and physical screenings for related donors and unrelated donors referred from the National Marrow Donor Program. Each ambulatory clinic team functions as a multidisciplinary unit, but they also interact closely with providers on the inpatient BMT services and with referring physicians in the community. Under **direct and indirect supervision and oversight by the attending physician**, the fellow is responsible for the intake, daily management, diagnostic and therapeutic decision-making. The fellow also works directly with nursing, pharmacy, social services and the transition team. The fellow is responsible for initial and ongoing documentation, providing communication with the referring physician and transitional information for handoffs to the inpatient services when their patients are admitted. The fellow performs procedures, such as bone marrow aspiration/biopsies, lumbar puncture, intrathecal chemotherapy administration, serial measurements of tumor masses, and skin biopsies under direct or indirect supervision and oversight as outlined below.

During this one-time rotation, the fellow is **given graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to lead a patient care conference, data review conference or multidisciplinary care rounds in collaboration with the attending physician.

VA Puget Sound Health Care System (VAPS) Services
Rotations to the VAPS occur on multiple months during the first and second clinical years. The VAPS rotation includes inpatient hematology/oncology consultative services, inpatient and outpatient BMT services and a number of outpatient hematology/oncology clinics. For inpatient consults and outpatient clinics, the primary focus is on developing effective consultation, evaluation and management skills to enhance medical knowledge and clinical expertise across a wide variety of hematologic and oncologic disorders. On the BMT service, the fellows also learn and apply knowledge on the indications, treatment approaches, complications and outcomes of autologous and allogeneic BMT, including the evaluation and management of stem cell donors and transplant recipients.

The Marrow Transplant Unit **attending physician provides direct and indirect supervision** and oversight for the fellows working with BMT patients and donors. The fellow is responsible for the intake, daily management, diagnostic and therapeutic decision-making of BMT inpatients. The fellow also works directly with nursing, pharmacy, social services and the transition team. The fellow is responsible for initial and ongoing documentation, providing communication with referring physicians and for handoffs between the inpatient and outpatient services when indicated. With subsequent rotations to the VAPS and with growing experience on the BMT service, the fellow is given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to lead a patient care conference, data review conference or multidisciplinary care rounds in collaboration with the attending physician.

During their initial rotation on the VAPS inpatient consultation services and in the clinics, the fellow is expected to work closely with and under the **direct supervision of the attending physician** for new patient work-ups, including the diagnostic evaluation and procedures, diagnosis and formulation of the therapeutic plan based on evidence-based literature, guidelines and/or experimental protocols. The fellow will participate in laboratory and pathology review and be responsible for chemotherapy ordering and administration by all routes, with **direct and indirect supervision** and oversight by the attending physician. The fellow is also responsible for initial and ongoing documentation, providing communication to referring physicians and transitional information between the inpatient services and the outpatient clinics.

During subsequent rotations, the more experienced and competent fellow will be given **graduated levels of responsibility** for diagnostic plans and for primary decision-making regarding procedures and management with more indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to take a more active role in housestaff teaching and supervision in collaboration with the attending physician. A similar process of ongoing assessment and evaluation by attending physicians will determine when the fellow can take on **additional responsibilities for primary management and decision-making with indirect supervision** and oversight of patients seen in the outpatient clinics at VAPS.

Continuity Clinics (SCCA, HMC and VAPS)
The continuity clinics provide fellows with hands-on experience in the longitudinal care (for at least 6 to 12 months) of patients with a broad mix of benign and malignant hematologic disorders and solid tumors. State-of-the art services are available at the various continuity clinic sites, including but not limited to, pathology, diagnostic radiology, genetic counseling, tumor registries, radiation oncology, oncologic nursing support, pain management, palliative care, dietetic services, social services, rehabilitation, psychiatric, and surgical services.

Under the **direct and indirect supervision of an attending physician**, the fellow evaluates one or two new patients and sees roughly four return patients per each half-day weekly clinic. The fellow orders appropriate staging and diagnostic studies, performs therapeutic and diagnostic procedures such as thoracentesis, paracentesis and bone marrow biopsy, formulates a plan of treatment and co-manages patients with their attending physician during follow-up and longitudinal care. The fellow is also expected to evaluate patients for their eligibility for clinical research protocols. This may involve an explanation of the study and alternative treatments, patient enrollment on the study, and coordination of the treatment program. The fellow is responsible for initial and ongoing documentation, providing communication with referring physicians and ensuring seamless handoffs and transition between the inpatient services and the outpatient clinics.

With increasing knowledge base, experience, clinical skills and maturity in managing continuity clinic patients, the more experienced and competent fellow will be given **graduated levels of responsibility** for primary decision-making, procedures and management with indirect supervision, oversight and final approval by the attending physician.

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 for providing fellow education.

The availability and direct supervisory roles of the attending physician are expected to be greatest for the inexperienced fellow and with increased acuity of the patient's illness. The attending supervision and availability may be less with more experienced fellows and/or for patients without acute or serious problems. Progressive, graduated responsibility is appropriate for fellows who have previously rotated onto a service, who are later in the month of a one-time rotation and who have acquired cumulative knowledge, competence and expertise through prior exposures to specific diagnoses and clinical scenarios in their longitudinal continuity clinic.

The attending must notify all fellows and residents 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 policies of the hospital, clinic and/or Division. 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 a patient on the hematology/oncology service requires a sternal bone marrow aspiration, the hematology/oncology attending may consult the Hematology consult attending physician and delegate supervisory responsibility of that procedure to the hematologist to supervise the fellow who may perform the sternal bone marrow aspiration. Information about this delegation of supervisory roles should be made available to fellows, faculty and patients.

The attending physician may specifically delegate portions of the patient's care to a fellow based on the needs of the patient and the skills of the fellow and in accordance with hospital, clinic and/or departmental policies. The attending may also delegate partial responsibility for supervision of

internal medicine residents to a fellow assigned to the service, but the attending physician must assure the competence of the fellow before supervisory responsibility is delegated.

Over time, the experienced fellow is expected to assume an increasingly larger role in patient care and clinical decision making. The attending physician remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Fellows and attending physicians should inform patients of their respective roles in each patient's care.

The attending physician is expected to monitor skill acquisition, growth in knowledge base, increasing competence and ability to assume progressive graduated responsibilities of the 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 qualified member of the medical staff for the duration of ACGME fellowship.

1. Sternal marrow aspiration
2. Bone marrow harvest under spinal or general anesthesia
3. All other invasive procedures not listed in this policy

Direct supervision required by a qualified member of the medical staff for at least the first three (3) procedures; then with indirect supervision (i.e. a qualified member of the medical staff is immediately available).

Completion of three (3) of the following supervised procedures must be successfully completed, with program director sign-off in MedHub, before the fellows can perform unsupervised procedures (except as noted below under "No supervision required.")*

1. Bone marrow aspirate and biopsy from the posterior iliac crest
2. Intrathecal administration of medications (including chemotherapy) via lumbar puncture or through indwelling cerebral catheter (e.g., Ommaya)
3. Sedation for procedures (AKA moderate sedation)**

*If the attending physician feels the fellow is not competent after three (3) procedures with direct supervision, the attending may require the fellow continue to have direct supervision until deemed proficient and competent.

The fellow must have completed the moderate sedation training course and gained certification as approved by the medical center. Once signed off on three (3) moderate sedation procedures, subsequent procedures require ***indirect supervision* by a sedation-credentialed physician, nurse practitioner, or physician assistant with privileges at the facility. The fellow must contact the supervisor in advance of initiating moderate sedation to review the patient condition, indication for the procedure, need for moderate sedation, and immediate availability of the supervising provider. The supervisor must be identified in the sedation documentation, and the conversation must be documented in the EMR, including the statement that the contact provider is credentialed and available for the procedure (see **Amendment A** hereto for the complete policy).

No supervision required

- Abdominal paracentesis
- Anoscopy
- Arterial puncture/catheterization
- Arthrocentesis
- Central venous catheter maintenance and removal
- Central venous line placement by subclavian, internal jugular and femoral approaches
- Dressing changes
- Lumbar puncture
- Nasogastric intubation
- Phlebotomy
- Ordering of chemotherapy drugs, biological products and growth factors
- Administration of chemotherapy, bio-logical/growth factors by multiple routes
- Placement of peripheral IV catheters
- Skin biopsy
- Suture placement and removal
- Thoracentesis
- Sedation for procedures (AKA moderate sedation), after successfully completing the required training and/or obtaining appropriate credentials
- BM aspirate/biopsy from posterior iliac crest (after competency sign-off)
- IT chemotherapy administration via lumbar puncture or Ommaya reservoir (after competency sign-off)

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

Fellows provide consultation services under the direction of supervisory attending physicians. 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. The availability of and supervision by the attending physician should be appropriate to the level of training, experience and competence of the consult fellow. Attending supervision and availability are expected to be

greater for inexperienced fellows and/or with increasing acuity of the patient's illness. The more experienced and competent fellow will be given progressive graduated levels of responsibility for diagnostic plans, procedures and management decision making with more indirect supervision, oversight and final approval by the attending physician. The more experienced fellow will also be expected to take a more active role in housestaff teaching and supervision in collaboration with the attending physician. Fellows performing consultations must communicate the name of their supervising attending to the services requesting consultation.

Information regarding the availability of attendings should be available to fellows, faculty members, and patients. Fellows performing consultations on patients are expected to communicate verbally with their supervising attending per the "Consultation Guidelines" below. Any fellow performing a consultation where there is credible concern for patient's life or limb requiring the need for immediate diagnostic and/or therapeutic intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention. The consult fellow should communicate with the supervising attending prior to the patient's discharge from the hospital, clinic or emergency department to address whether there are any concerns regarding the patient's safety. 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.

Consultation Guidelines

The fellow will:

1. Assist the service requesting consultation to determine if the urgency of the question should be escalated.
2. Ensure that all consults are staffed with attending physician (i.e. at least discussed with the attending physician, who agrees) within time frame below.
3. The timing for initial visit and staffing is determined by acuity and consequences of delay:
    a. **Routine:** Seen and staffed, at the least by phone, by the following day.
    b. **Urgent:** Seen promptly and staffed, at least by phone, within 12 hours.
    c. **Emergent:** Seen within one hour and staffed with attending immediately.
    d. The Attending must be available at all times to answer questions
4. Consulting service will personally contact a member of the primary team after the initial consult and with any subsequent important recommendations.
5. Recommendations and consult physician names must be clearly documented in the record.
6. Let the primary team know when the consult service will see the patient for follow-up, and what events to call about in the interim.
7. If the consult service agrees to accept responsibility for an aspect of the patient's care, this should be noted by a written order from the consult service.
8. If the patient will not be seen again, indicate that the consult service has signed off in the patient's medical record.
9. Ensure appropriate follow-up care pertinent to the specialty. If the patient requires outpatient follow-up with the consult service, indicate the time frame & best mechanism for arranging follow-up.
10. If the 1° service is uncomfortable with recommendations, they should seek further input, including calling the consult attending physician.
11. In high-risk cases, consider getting input directly from the consult attending physician.
12. The service requesting a consult is responsible for continued follow-up, as deemed appropriate, on consult recommendations unless specific arrangements have been made to transfer aspects of the patient's care to the consult service.

13. If the primary service chooses not to accept a significant recommendation from the consulting service the rationale for not following a recommendation should be documented in the medical record.
14. Consulting service should document acknowledgement of review i.e. "consult appreciated."
15. Every effort should be made to identify needed consults toward the beginning of the stay to limit avoidable delays in discharge.
16. All consultations are the responsibility of the attending physician. Attendings are responsible for advice given by other members of their team, even if they have not personally seen the patient.

Guidelines for "Curbside" Consults

1. Questions should be straightforward.
2. If a given consultant is questioned more than once about a patient, a formal consultation should be considered.
3. If the complexity of the question is not clear to the primary service, the option of informal or formal consultation should be offered to the consulting team.
4. **<u>The name of the curbside consultant should not be included in the chart without permission.</u>**

Consultation Documentation Guidelines

1. The consult request must be documented in the medical record, standing orders <u>cannot</u> be used
2. The physician requesting the consult and the issue for which the consult was requested must be documented
3. Consult result must be communicated to the physician who <u>requested</u> the consult

Supervision of Hand-Offs

Attending physicians on service rotations and in the continuity clinics are responsible for supervising and monitoring the fellows' compliance with policies and practices that minimize handoffs and ensure the seamless transition and communication of patient care from one provider/team to another provider/team. The structured handoff processes that facilitate both continuity of care and patient safety are summarized in the individual site descriptions in the "Clinical Responsibilities" section of this document (see above), in the site-specific goals and objectives (curricula) documents for each rotation (distributed at the start of the month), and in the "Hematology/Oncology Fellows' Handbook", which is updated annually.

The "Hematology/Oncology Fellows' Handbook" lists e-mail addresses, phone numbers and text paging information for providers, patient care coordinators and scheduling coordinators at the different sites of practice. In addition, since fellows are involved with hospital transfer requests and admissions to UWMC and HMC, information is provided on the function of and contact information for the UW Transfer Center. The "Handbook" also describes expectations for communications with referring physicians and clinics, discharge summary documentation requirements and the use of specific templates that have been designed to ensure seamless handoffs (e.g. for the BMT services at SCCA and UWMC). Consultation documentation requirements and communication are also summarized along with information regarding special referrals (e.g. to palliative care service and hospice). Lastly, because fellows on SCCA outpatient clinic rotations are responsible for overnight calls from SCCA outpatients and their caregivers, the "Handbook" outlines the processes for

documentation in ORCA, provider notification by e-mail and referral to the UW Transfer Center if hospitalization is required.

Circumstances in which the Supervising Attending Physician MUST be Contacted

There are specific circumstances and events for which fellows must communicate urgently with appropriate supervising faculty members. These include, but are not limited to:

- Patients in clinic or in the outpatient departments that present with or develop persistent, unstable vital signs, acute mental status/neurologic changes, acute cardiopulmonary distress/decompensation, acute severe allergic/anaphylactoid signs or symptoms or other clinical manifestations representing a potential threat to life or limb
- Inpatients on clinical services that develop major changes in clinical status, including unexpected acute, life- or limb-threatening complications or conditions that require rapid response or "code blue" intervention, transfer to a critical care unit or result in death
- Emergent consult requests regarding patients with serious bleeding, thromboembolic or other life-threatening events, and/or who require emergent surgical or invasive interventions with the need of blood product support
- Oncologic emergencies such as spinal cord compression, tumor lysis syndrome, severe hypercalcemia or other metabolic derangements, superior vena cava syndrome or other life- or limb-threatening vascular events, cardiac tamponade or other threatening cardiopulmonary complications, life threatening sepsis or other serious infectious complications, and severe or life-threatening bleeding
- Any situation in which the family or primary caregiver for the patient, or a consulting service/physician, requires personal interaction/communication with the supervising attending physician for case review, management plan discussion and/or determination of major changes in care plan (e.g. conversion to "do not resuscitate" status)

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 and faculty evaluate each fellow's abilities based on specific criteria, including the following:

- Direct supervision and critique of clinical practice skills, including bedside evaluations, new patient history and physical documentation, progress and clinic note documentation, and feedback based on a teaching, evaluation and feedback tool called PCLEAT (Patient Clinical Evaluation Assessment; for patients with non-malignant hematologic disorders, solid tumors and malignant hematologic disorders)
- Direct supervision and critique of procedural skills, performance and complications. The attending physician is responsible for deeming a fellow competent to perform procedures without direct supervision (as applicable and outlined above) following completion of at least 3 supervised procedures
- Direct supervision and critique of knowledge and skills interpreting laboratory, pathology, hematopathology, radiological and other diagnostic data
- Direct supervision and critique of communication and interpersonal skills, including the ability to discuss with patients and families a new and serious diagnosis, detailed evaluation and management plan and prognostic information

- Direct evaluation and critique of skills involving systems based practice, including interactions and communications with physician and provider peers, attending and referring physicians, nurses, social workers and other members of the health care team
- Direct evaluation and critique of skills involving the rational decision-making and evidence-based use of diagnostic tests, non-pharmacologic therapeutic modalities, chemotherapy and other drug treatments, supportive care and ancillary services
- Formative evaluation and feedback for the fellow is provided by attending physicians at the end-of-rotation meeting with face-to-face review. The faculty also provide global ratings of the fellow's performance through the MedHub evaluation system
- Support and ancillary staff on certain rotations provide feedback on fellow performance using 360-degree evaluation forms
- Patient reviews of fellow performance are obtained in continuity clinics
- Formal assessment of fellow knowledge base and gaps is provided by in-training examinations in hematology (through the American Society of Hematology) and medical oncology (through the American Society of Clinical Oncology)
- On certain rotations, case presentations and board-review type questions are provided to test the fellows' knowledge base and clinical decision-making skills
- The program director meets with individual fellows during the semi-annual reviews and additional meetings, as indicated, to address proficiency, competency, progress in knowledge base and toward independence with greater autonomy and graduated responsibility
- Progressive graduated responsibility and autonomy are delegated to the fellow based on the cumulative evaluations and critiques from attending physicians, the program director and their performance record on clinical rotations and in their continuity clinic

Faculty Development and Fellow Education around Supervision and Progressive Responsibility

The hematology/oncology fellowship program strives to provide ongoing faculty development and fellow education on best practices around supervision and the balance of supervision and autonomy. For this goal, the program will adhere to the **SUPERB** and **SAFETY** models.

SUPERVISION POLICY
Hematology-Oncology Fellowship Program

Attendings should adhere to the **SUPERB** model when providing supervision. Attendings 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 fellow 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 fellow not to be afraid to call: Tell the fellow to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

Fellows should seek attending input using the **SAFETY** acronym. Fellows should:

1. **S**eek attending input early
2. **A**ctive clinical decisions: Call the supervising 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. Help with system/hierarch**Y**: 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.

AMENDMENT A (p. 1 of 2)

<u>Supervision of ACGME Hematology/Oncology Fellows providing Moderate Sedation</u>

ALL Cases

ACGME Fellows need to:

1. Complete the UW Moderate Sedation Training Program and ACLS requirement to gain certification in moderate sedation.
2. Perform at least 3 moderate sedation procedures under the direct supervision (in the room) of a sedation credentialed physician, nurse practitioner or physician assistant who has privileges at the facility. The supervising provider will be identified in the sedation documentation and will co-sign the Moderate Sedation Pre-procedure Assessment powernote (or equivalent paper document) accordingly. .

ELECTIVE Cases

1. Once signed off on 3 moderate sedation procedures, subsequent procedures require indirect supervision with direct supervision immediately available (within the building) by a sedation credentialed physician, nurse practitioner or physician assistant that has privileges at the facility. The fellow is required to contact (in person or by phone) the sedation credentialed physician/ARNP/PA prior to initiating moderate sedation to review the patient condition, indication for the procedure, need for moderate sedation, and immediate availability of the supervising provider. The conversation must be documented in the EMR including that the contact provider acknowledge that they are credentialed and available for the procedure. The supervising provider will be identified in the sedation documentation.
2. All providers (fellow, attending physician, nurse practitioners, physician assistants) performing a moderate sedation procedure must perform the procedure in an approved area of the facility and have a sedation trained nurse present to administer the sedation medications and monitor the patient's condition. This RN should not have any major involvement in the procedure itself.

AMENDMENT A (p. 2 of 2)

Supervision of ACGME Hematology/Oncology Fellows providing Moderate Sedation

UNANTICIPATED/EMERGENT NEED FOR SEDATION in the absence of a sedation credentialed provider

1. At **HMC**, an ACGME Fellow or Senior Resident who has been certified through the Moderate Sedation Training Program may perform unsupervised moderate sedation administered by a sedation trained RN. In the absence of one of these individuals, call the STAT nurse and/or anesthesia for an emergent consultation.

2. At **UWMC**, an ACGME Fellow or Senior Resident who has been certified through the Moderate Sedation Training Program may perform unsupervised moderate sedation administered by a sedation trained RN. In the absence of one of these individuals, call anesthesia for an emergent consultation.

3. At **SCCA,** an ACGME Fellow who has been certified through the Moderate Sedation Training Program may perform unsupervised moderate sedation administered by a sedation trained RN.

Requests for exceptions to these conditions need to go through the respective Medical Director & the OMSA Board