PULMONARY, CRITICAL CARE AND SLEEP MEDICINE FELLOWSHIP
SCOPE OF PRACTICE

Scope of Practice in Pulmonary, Critical Care & Sleep Medicine Fellows

This document pertains to fellow rotations at Tampa General Hospital, James A Haley Veterans Hospital, and Moffitt Cancer Center. This program is part of the fellowship training program in Pulmonary, Critical Care and Sleep Medicine Program at the University of South Florida. All ACGME and The Joint Commission (TJC) guidelines pertaining to the graduate medical education apply to this rotation.

In keeping with ACGME and TJC guidelines, the faculty and program director are responsible for providing fellows with direct experience in progressive responsibility for patient management. All patient care at provided by fellows will be provided under direct and indirect faculty supervision. Supervision must be documented in the medical record in accordance with the Pulmonary, Critical Care and Sleep Medicine Program at the University of South Florida compliance guidelines.

Pulmonary and Critical Care fellows, post graduate year IV, V, and VI, function under the supervision of the attending staff of the Pulmonary/Critical Care Medicine program.

The Fellows are expected to evaluate patients in in-patient and out-patient settings, devise treatment plans, write orders and prescriptions and discharge patients from the hospitals or clinics with the concurrence of the staff.

At Tampa General Hospital the lines of responsibility are that the internal medicine house staff on the MICU rotation will initially assess the patient admitted to that unit. The Pulmonary Disease/Critical Care Medicine Fellow will then be called and will come to the bedside to assess the patient, regardless of the time of day. The attending faculty member will be called by the MICU Fellow and use his/her judgment as to how quickly to return to the unit and participate in bedside evaluation and therapy. If any patient care dispute arises between the Internal Medicine Resident and Fellow, the attending faculty member will resolve it immediately. Both the Fellow and the faculty member will round with the Internal Medicine house staff assigned to the MICU during every weekday and during weekend days according to the call schedule that has been established for the
month.

All admission to the MICU are discussed with the Pulmonary Fellow, including the Pulmonary/Critical Care Medicine Fellow on call at night. If there are any difficulties or questions regarding patient management then the responsible Pulmonary Disease Critical Care Medicine Fellow will come to the unit and re-evaluate the patient. Likewise, the attending physician responsible for the MICU patients will be notified.

The members of the consult team may consist of medical students and Internal Medicine residents. The Fellow will assign the initial work-up of a newly consulted patient to one of the junior members of the team. After initial evaluation the consult Fellow will in turn evaluate the patient and formulate the appropriate questions regarding diagnosis and patient management for the subsequent bedside rounding by the attending faculty physician. This will be done within 48 hours of the consultation, sooner if the patient is deemed to be seriously ill. The attending faculty member has ultimate authority regarding diagnostic and therapeutic procedures to be utilized in answering other questions posed by each consultation.

I. Pulmonary and Critical Care Fellows (first, second, and third year) can take actions and perform procedures listed in this paragraph without direct supervision. They may perform history and physical examinations and write orders and prescriptions in all pulmonary and critical care areas, including the intensive care units. After suitable training and evaluation they may perform independent (indirect supervision) exercise testing, thoracentesis, small and large bore tube thoracostomies, pulmonary function testing interpretation, exercise testing interpretation, polysomnography and multiple sleep latency test interpretation.

2. Final interpretation of exercise tests, polysomnography, pulmonary function tests, methacholine challenge testing, and multiple sleep latency tests will be by an attending physician.

3. All first, second, and third year pulmonary and critical care Fellows will have direct supervision when performing routine (ie non emergent) bronchoscopy with and without biopsy, routine (ie non emergent) therapeutic bronchoscopy, percutaneous tracheostomy, and pleural biopsy. Fellows may perform emergent diagnostic bronchoscopy as well as therapeutic procedures to remove bronchial mucus obstruction when competency criteria has been met and approved by the supervisory attending. However, in emergency life threatening situations
Pulmonary and Critical Care Fellows can perform unsupervised cardio-version, temporary cardiac pacemaker lead insertion, endotracheal intubation, diagnostic bronchoscopy, and therapeutic bronchoscopy to remove bronchial mucus obstruction, pulmonary artery catheterization, as well as central venous access, arterial line insertion, and renal dialysis and vascular line insertion, and tube thoracostomies and the attending will be notified and assist as appropriate.

4. Intravenous sedation: Pulmonary and Critical Care Fellows may administer intravenous sedation (conscious sedation) and medications under the supervision of a pulmonary attending, credentialed for intravenous sedation.

5. Pulmonary and Critical Care Fellows are authorized to order restraints for patients. The patient criteria for using restraints will be met in order to ensure patient safety with minimum risks.
At the James A. Haley Veterans Administration Hospital the Fellow assigned to the MICU will serve as a junior attending, supervising the activities of the medical students and house staff. However, all patient care decisions are ultimately the responsibility of the attending faculty physician.

The internal medicine house staff on the MICU rotation will initially assess the patient admitted to that unit. The Pulmonary Disease/Critical Care Medicine Fellow will then be called and will assess the patient at the bedside during the workweek. The attending faculty member will be called by the MICU Fellow and use his/her judgment as to how quickly to return to the unit and participate in bedside evaluation and therapy. If any patient care dispute arises between the Internal Medicine Resident and Fellow, the attending faculty member will resolve it immediately. Both the Fellow and the faculty member will round with the Internal Medicine house staff assigned to the MICU during every weekday and the attending will round during weekend days according to the call schedule that has been established for the month. All at night and weekend admissions to the MICU are discussed with the Pulmonary Fellow. If there are any difficulties or questions regarding patient management then the responsible Pulmonary Disease Critical Care Medicine Fellow will come to the unit and re-evaluate the patient. Likewise, the attending physician responsible for the MICU patients will be notified. All new admissions to the MICU service will be staffed in person by the appropriate attending faculty member no later than within 24 hours of the admission.

The members of the consult team may consist of medical students and Internal Medicine residents. The Fellow will assign the initial work-up of a newly consulted patient to one of the junior members of the team. After initial evaluation the consult Fellow will in turn evaluate the patient and formulate the appropriate questions regarding diagnosis and patient management for the subsequent bedside rounding by the attending faculty physician. This will be done within 72 hours of the consultation, sooner if the patient is deemed to be seriously ill. The attending faculty member has ultimate authority regarding diagnostic and therapeutic procedures to be utilized in answering other questions posed by each consultation.

1. Pulmonary and Critical Care Fellows (first, second, and third year) can take actions and perform procedures listed in this paragraph without direct supervision. They may perform history and physical examinations and write orders and prescriptions in all pulmonary and critical care areas, including the intensive care
units. After suitable training and evaluation they may perform independent (indirect supervision) exercise testing, thoracentesis, small and large bore tube thoracostomies, pulmonary function testing interpretation, exercise testing interpretation, polysomnography and multiple sleep latency test interpretation.

2. Final interpretation of exercise tests, polysomnography, MSLT, pulmonary function tests, methacholine challenge testing, and multiple sleep latency tests will be by an attending physician.

3. All first, second, and third year pulmonary and critical care Fellows will have direct supervision when performing bronchoscopy with and without biopsy, therapeutic bronchoscopy, percutaneous tracheostomy, and pleural biopsy. However, in emergency life threatening situations Pulmonary and Critical Care Fellows can perform unsupervised cardio-version, temporary cardiac pacemaker lead insertion, endotracheal intubation (facilitated by metal blade, glidescope, or bronchoscope), pulmonary artery catheterization, chest tube placement, as well as central venous access, arterial line insertion, and renal dialysis and vascular line insertion, the attending will be notified and assist as appropriate.

4. Intravenous sedation: Pulmonary and Critical Care Fellows may order intravenous sedation (conscious sedation) and medications only under direct the supervision of a pulmonary attending, credentialed for intravenous sedation.

5. Rapid Sequence Intubation medications: Pulmonary and Critical Care fellows, who had completed RSI training and who are approved/certified by anesthesia service, can order RSI medications to facilitate endotracheal intubations.

In emergent situations the Pulmonary Disease/Critical Care Medicine Fellow is expected to participate in cardiopulmonary resuscitation or any other emergency on a new patient and without the request of the attending physician, per hospital policy. Otherwise, there are no patient care responsibilities with non-teaching patients.

At each of these rotations, the level of responsibility and goals will depend on the experience and year of training of the Fellow.
At the H. Lee Moffitt Cancer Center there is occasionally an internal medicine resident and student assigned to the consult rotations. The Special Care Unit service is an ICU rotation with an assigned faculty attending and fellow. There is another pulmonary consultation service that evaluates patients throughout the hospital and has an assigned faculty attending and fellow.

The Fellow assigned to the SCU will serve as a junior attending. However, all patient care decisions are ultimately the responsibility of the attending faculty physician. The Fellow will assign the initial work-up of a newly consulted patient to one of the junior members of the team if there is a resident or medical student on the rotation. After initial evaluation the consult Fellow will in turn evaluate the patient and formulate the appropriate questions regarding diagnosis and patient management for the subsequent bedside rounding by the attending faculty physician. This will be done within twenty-four hours, sooner if the patient is deemed to be seriously ill. The attending faculty member has ultimate authority regarding diagnostic and therapeutic procedures to be utilized in answering other questions posed by each consultation.

I. Pulmonary and Critical Care Fellows (first, second, and third year) can take actions and perform procedures listed in this paragraph without direct supervision. They may perform history and physical examinations and write orders and prescriptions in all pulmonary and critical care areas, including the intensive care units. After suitable training and evaluation they may perform independent (indirect supervision) exercise testing, thoracentesis, small and large bore tube thoracostomies, pulmonary function testing interpretation, exercise testing interpretation, polysomnography and multiple sleep latency test interpretation.

2. Final interpretation of exercise tests, polysomnography, pulmonary function tests, methacholine challenge testing, and multiple sleep latency tests will be by an attending physician.

3. All first, second, and third year pulmonary and critical care Fellows will have direct supervision when performing routine (ie non emergent) bronchoscopy with and without biopsy, routine (ie non emergent) therapeutic bronchoscopy, percutaneous tracheostomy, and pleural biopsy. Fellows may perform emergent diagnostic bronchoscopy as well as therapeutic procedures to remove bronchial mucus obstruction when competency criteria has been met and approved by the supervisory attending. However, in emergency life threatening situations Pulmonary and Critical Care Fellows can perform unsupervised cardio-version, temporary cardiac pacemaker lead insertion, endotracheal intubation, diagnostic
bronchoscopy, and therapeutic bronchoscopy to remove bronchial mucus obstruction, pulmonary artery catheterization, as well as central venous access, arterial line insertion, and renal dialysis and vascular line insertion, and tube thoracostomies and the attending will be notified and assist as appropriate.

4. Intravenous sedation: Pulmonary and Critical Care Fellows may administer intravenous sedation (conscious sedation) and medications under the supervision of a pulmonary attending, credentialed for intravenous sedation.

5. Pulmonary and Critical Care Fellows are authorized to order restraints for patients. The patient criteria for using restraints will be met in order to ensure patient safety with minimum risks.

Scope of Practice Statement for Pulmonary & Critical Care Medicine Fellows who are moonlighting in the Special Care Unit at H. Lee Moffitt Cancer Center

Pulmonary and Critical Care Fellows, post graduate year IV, V, and VI function under the supervision of the attending staff of the Pulmonary, Critical Care, and Sleep Medicine program at the University Of South Florida College Of Medicine. While moonlighting at H. Lee Moffitt Cancer Center the fellows are expected to participate in the care of the Special Care Unit patients and also to respond to emergent consultations throughout the hospital. Like the standard at other hospitals the emergent non ICU consultations will be relayed to the Fellow by a direct phone call from the requesting attending physician. Pulmonary and Critical Care fellows may perform history and physical examinations and write orders in the critical care areas. In emergency life threatening situations the Fellows (moonlighters) can perform unsupervised cardioversion, temporary cardiac pacemaker insertion, endotracheal intubation, pulmonary artery catheterization, as well central venous access, arterial line insertion, renal dialysis, and other vascular line insertions. They may also, while they are moonlighting, place emergent thoracostomy tubes.

All first, second year, and third year pulmonary critical care fellows after competency criteria met may perform emergent fiberoptic bronchoscopy, the attending will be notified and assist as appropriate. Senior or third year fellows may perform diagnostic bronchoscopy as well as therapeutic procedures to remove bronchial mucus obstruction when competency criteria has been met and approved.
The moonlighting fellow will also be able to order restraints for patients. The patient criteria for using such restraints will be met in order to ensure patient safety with minimum risk.

Emergent request for floor consultations or transfers to the Special Care Unit will be provided by a physician to physician telephone call. The fellows will be approved to treat the usual complex illnesses occurring in intensive care patients such as arrhythmia, heart failure, electrolyte disturbances, uncontrolled hypertension, hyperglycemia, among other disease entities.

Presentation and discussion of patient care issues will be accomplished by interaction between the on-call pulmonary and critical care USF attending physician and the moonlighting fellows at the H. Lee Moffitt Cancer Center.
There are no non-teaching patients at the H. Lee Moffitt Cancer Center, the James A. Haley VA Hospital, or Tampa General Hospital.

In emergent situations the Pulmonary Disease/Critical Care Medicine Fellow is expected to participate in cardiopulmonary resuscitation or any other emergency without the request of the attending physician, per hospital policy. If consultation is specifically requested the usual guidelines will be followed and the attending physician will be involved. Otherwise, there are no patient care responsibilities with non teaching patients.

At each of these rotations, the level of responsibility and goals will depend on the experience and year of training of the Fellow.

**1st Year Fellows:**

1. Expected to become familiar with the role of a consultant in non ICU patients.
2. Will assume more independent responsibility for intensive care unit patients as the year progresses.
3. Is looked upon as a time to gather knowledge to form a very strong foundation in the CORE competencies and the CORE curriculum.
4. By the end of the first year, it is expected that the Fellow will comfortably don the role of a consultant with a good deal of expertise in the subspecialty.
5. In the outpatient setting, the Fellow will be given more responsibility in the interaction and work-up of patients. In the first year of this interaction, the Fellow and faculty member often will interact with patients together in the outpatient arena.
6. Will be mentored to either assume a previous research project or present a research project and work towards approval by the University IRB Committee. There may be a lengthy time to establish the IRB approval if the Fellow is starting a new project so that there will be accommodations for that Fellow to continue throughout the 3 years for completion of the project.

**2nd Year Fellows:**

1. Will assume more responsibility for patient care, in both inpatient and outpatient settings.
2. They will be encouraged to develop a specific interest with regard to Pulmonary and/or Critical Care Medicine.
3. Attend College of Medicine Lecture Series given and open to all house staff and faculty with regard to critical evaluation of the literature and data as well as establishing a research career.
4. Will continue research projects, present a research project, and develop a QI/PS project.
5. In the outpatient setting, the Fellow will be given more responsibility in the interaction and work-up of patients. In the second year of this interaction, the Fellow and faculty member often will interact with patients together in the outpatient arena.

**3rd Year Fellows:**

1. The Pulmonary, Critical Care Medicine Fellow is encouraged to serve as a true consultant to the other physicians.
2. Will be Board eligible to take the Pulmonary certifying examination. Most of the Fellows do so and therefore become ABIM certified in Pulmonary Diseases before graduating from the program.
3. Expected to be able to speak to peers and serve as an instructor for the physicians via presentations at courses and meetings. Training is geared towards encouraging Fellows to establish reputations as the type of consultant who will ultimately serve as a major asset to the community and ideally be the type of physician who is asked to care for families of other physicians.
4. By 3rd year, the Fellow will see the patient first, formulate a treatment plan and present the information to the responsible faculty attending. Effort is made to give the Fellow a first-hand experience seeing patients referred by other pulmonologists and patients who have difficult outpatient diagnostic problems.

In the out-patient setting the Fellow will be given more responsibility in the interaction and work-up of patients. By the 3rd year the Fellow will see the patient first, formulate a treatment plan and present the information to the responsible faculty attending. Also effort is made to give the Fellow a first-hand experience seeing patients referred by other pulmonologists and patients who have difficult out-patient diagnostic problems. In the first and second year of this interaction the Fellow and faculty member often will interact with patients together in the out-patient arena.
I agree with the above,

Kimberley Cao, MD  
Program Director  

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