

RESIDENT SUPERVISION DEPARTMENT OF UROLOGY (Revised 12-31-2011)

Section I. Introduction

The Urology Department has adopted the general supervision policy as provided by the UTHSCSA-GMEC. A link to the UTHSCSA GMEC site is provided:

<http://www.uthscsa.edu/gme/policies.asp>

The purpose of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's ethical, professional and personal development while ensuring safe and appropriate care for patients.

Careful supervision and observation are required to determine the trainee's abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, trainees must be given graded levels of responsibility while assuring quality care for patients. Supervision of trainees should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider.

Section II. Definitions

The following definitions are used throughout the document:

Resident – a professional post-graduate trainee in a specific specialty or subspecialty

Licensed Independent Practitioner (LIP) – a licensed physician who is qualified usually by board certification or eligibility to practice his/her specialty or subspecialty independently

Medical Staff – an LIP who has been credentialed to provide care in his/her specialty or subspecialty by a hospital

Staff Attending or “Staff” – the immediate supervisor of a resident who is credentialed in his/her hospital for specific procedures in their specialty and subspecialty that he/she is supervising

Section III. General Guidelines

Written descriptions of this resident supervision policy are distributed annually and are made readily available in the residency handbook to all residents and faculty/attending physicians for the Urology residency program.

The following standards are recognized in the guidelines.

ACGME Common Program Requirements on Resident Supervision:

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member.

For many aspects of patient care, the supervising physician may be a more advanced

resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

Levels of Supervision - To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

a) **Direct Supervision** – the supervising physician is physically present with the resident and patient.

b) **Indirect Supervision:**

(1) 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.

2) 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.

c) **Oversight** – the supervising physician is available to provide review of procedures and/or encounters with feedback provided aftercare is delivered.

TJC (JCAHO) Standards:

- At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges in that health care system. ***This is a standard integrated policy for all rotations. On-call schedules and rotation schedules for Urology are developed to give residents an organized experience which provides a variety of patient care educational experiences consistent with the guidelines of the Urology Review Committee. Backup is available at all times through more senior residents and appropriately credentialed attending staff physicians.***

- Written descriptions of the roles, responsibilities, and patient care activities of the residents, by level, are available to medical faculty and to health care staff. ***The roles and responsibilities of residents per year and rotation are available for unrestricted access on the Urology Department web site. At UH and STVHCS, those clinic and ward processes and procedures that urology residents are “approved” to perform without immediate presence of the staff can be found on the procedure tracker in New Innovations.***

- The descriptions identify mechanisms by which the faculty site supervisor and program director make decisions about an individual resident’s progressive involvement and independence. ***Graded Responsibility and Progression to Independent Practice: Careful supervision and observation are required to determine the trainee’s abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, trainees are given graded levels of responsibility while assuring quality care for patients. Supervision of trainees is graded to provide gradually increased responsibility and maturation into the role of a***

judgmentally sound, technically skilled, and independently functioning credentialed provider. At each Urology training site, the residents are supervised by the attending staff who are themselves responsible to the Site Supervisor regarding their involvement with the resident training. These providers will determine the competency of the residents' procedural techniques and adequacy of their evaluation and management of ambulatory and hospitalized patients.

Progression to independent practice (the "approved" performance of processes or procedures without the immediate availability of staff) is determined by the Program Director in conjunction with Core Teaching Faculty, and is codified at monthly scheduled faculty meetings. Such approvals generally follow the progression through postgraduate years as outlined below, unless, by exception, the Program Director indicates that a resident requires more training before such approval occurs. Progression through training is further documented to ACGME through the Milestones reporting scheme beginning with the 2013-2014 academic year.

- Delineation of order-writing privileges, including which orders if any must be countersigned. *No countersignature is necessary for U-1 through U-4 Urology residents unless specific orders are restricted to attending staff by the Bylaws of individual health care institutions. See below.*

Section IV. Procedures

A. Residents will be supervised by credentialed providers ("staff attendings") who are licensed independent practitioners on the medical staff of the UTHSCSA teaching hospital in which they are attending. The staff attendings must be credentialed in that hospital for the specialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.

B. The UTHSCSA Urology Program Director defines policies in the discipline specifying how trainees in that program progressively become independent in specific patient care activities in the program while still being appropriately supervised by medical staff.

Because Urology residency is an advanced surgical specialty with residents having had at least 1 year of prerequisite surgery training, all residents are responsible for all aspects of daily patient care and may write orders without co-signature from senior staff. The Program Director maintains a listing of resident clinical procedural activities that are expected to be learned by year of training, the required level of supervision for each activity, and any requirements for performing an activity without direct supervision. The Program Director of Urology will submit the listing of clinical activities by postgraduate year to the Office of the Associate Dean for Graduate Medical Education (GME) and to the Graduate Medical Education Committee (GMEC) for review.

C. Annually, the Urology Program Director will review the job descriptions and listing of resident clinical activities and make changes as needed. The Program Director will submit any new job descriptions and their updated listing of clinical activities by postgraduate year to the Office of the Associate Dean for Graduate Medical Education (GME) and to the Graduate Medical Education Committee (GMEC) for review.

D. The Program Director will ensure that all supervision policies are distributed to and followed by trainees and the medical staff supervising the trainees. Compliance with the UTHSCSA resident supervision policy will be monitored by the Program Director.

E. Annually, the Program Director will determine if residents can progress to the next higher level of training. The requirements for progression to the next higher level of training will be determined by standards set by each Program Director. These include documentation of sufficient numbers of operative cases for the training level, adequate time on clinical services and acceptable evaluations as described in the section on resident evaluations. This assessment will be documented in the annual evaluation of the trainees.

Specific Details of Procedures by Training Year:

Each resident at these levels will become facile performing outpatient procedures. Initially, all procedures will be performed under direct supervision of an attending physician with or without the assistance of a more senior level resident scrubbed in for the case. As the senior staff becomes convinced that the resident is capable of performing the steps with appropriate pre-procedure planning, consent counseling, local anesthesia use, instrument handling, surgical technique, follow-up planning and documentation/coding, the resident will be given more independence. In determining the competence of a given resident to do these procedures, the complication rate, patient evaluations and 360 evaluations by ancillary staff may also be considered. No specific number of cases is required to prove proficiency since the learning environment will always be supervised. All procedure clinics will be supervised on site by at least one attending physician independent of the number of more senior residents available. Independent practice with respect to bedside and clinic procedures is the expected goal of the residency. Attending *presence* for procedures may be required by individual institutional regulations but the residents will be allowed to progress to independence in performing procedures *without the attending actually scrubbing in* for the case, if the residents have been judged competent to do so based upon previous training. All cases in the OR will have attending presence and residents will be given graded responsibility until they are judged capable of performing the procedure independently. Daily or weekly operative evaluations will be reviewed with the residents in the process of this progression. *During the chief resident year (U-4), residents will be expected to be able to teach basic urologic operations in the clinic, at the bedside and in the OR to the more junior residents with the attending staff monitoring progress but not actually scrubbed in on the cases.*

Starting in 2009, the Urology RRC and ACGME have adopted a minimum case number system for presumed competency in several general areas of Urologic Surgery. Logs of these numbers will be monitored monthly and additional numbers required of the individual residents if in the opinion of the teaching faculty, the resident requires additional training prior to being judged competent to perform the procedures independently. Case log numbers for each resident are monitored and discussed at the monthly faculty meeting.

PGY-1, PGY-2 Non-Urology residents

Supervision Level: Direct by U-1 (PGY-2/3) through U-4 (PGY-5/6) Urology Residents

Indirect by faculty with direct supervision available

Documentation of complete competence in General Surgical procedures is available from the general surgery service.

U-1 (PGY-2 , PGY-3) Urology Residents

Routine ward & clinic procedures learned during General Surgery for which no direct supervision is required for Urology residents:

Supervision Level: Indirect by U-2 to U-4 residents and faculty with direct supervision available

Line placement (arterial, venous, central)

Incision & drainage of abscesses and fluid collections

Uncomplicated urinary catheterizations

Procurement of blood and urine samples for laboratory studies

Cutaneous lesion biopsy/ excisional biopsy procedures under local anesthesia

Catheter irrigations

Procedures for which specific instruction is given at the beginning of residency (U-1 year). At the completion of this training, all Urology residents are deemed competent to perform:

Supervision Level: Indirect by U-2 to U-4 residents and faculty with direct supervision available

Local anesthesia for genital, urethral and bladder biopsies

Genital cutaneous lesion biopsy, excision

Dorsal slit for phimosis/paraphimosis

Reduction maneuvers for paraphimosis

Irrigation and treatment of priapism

Detorsion maneuvers

Suprapubic aspiration & tube placement

Urinary catheterization including complex with fluoroscopy or cystoscopy

Removal of ‘stringed’ ureteral stents

Procedures that are learned during this year of training. Competence for independent practice will be documented as described above.

Supervision Level: Direct by U-2 to U-4 residents and faculty

At this level, the resident will be introduced to the basics of GU minor procedures under direct supervision of the clinic attending staff and senior residents. The following list contains the types of procedures that will be learned or perfected at this level with further skills in these developed over the course of the rest of the residency.

Outpatient Clinical Procedures

Cystoscopy

Cystoscopy with retrograde pyelography

Bladder biopsy

Endoscopic removal of foreign objects

Transrectal Ultrasonography

- Prostate Biopsy
- Penile and scrotal surgery
 - Local excision of minor lesions
 - Circumcision
 - Vasectomy
 - Meatotomy
 - Other minor ablative/ biopsy procedures
- Suprapubic cystostomy
- Cystography, antegrade & retrograde pyelography, fluoroscopy
- Ultrasonography
- Complex urethral catheterization
- Newborn circumcision
- Lysis of penile skin bridges (pediatric)

Competency to perform procedures independently will be documented in New Innovations. Minor Procedure Documentation Forms for this can be found in the appendix to this document.

U-2 (PGY-3, PGY-4) and above.

A few more complex clinic procedures are added at this level in addition to those of the lower level. By the end of the U-2 year, nearly all outpatient procedures should be mastered with further honing of skills through graduation. Competence for independent practice will be documented as described above.

Additional Outpatient Clinical Procedures

Supervision Level: Direct by faculty until skills mastered then
Indirect by faculty with direct supervision available

- Transurethral needle ablation of prostate
- Dilation/ablation of urethral strictures
- Placement of fiducial seeds for RT planning
- Ureteral stent placement
- Urodynamics procedures

Section V. Supervision of Trainees in the Inpatient Setting

A. All lines of authority for inpatient care delivered by inpatient ward or ICU teams will be directed to a credentialed staff provider. The attending staff provider has the primary responsibility for the medical diagnosis and treatment of the patient. Trainees may write daily orders on inpatients for whom they are participating in the care. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Attending staff may write orders on all patients under their care.

Trainees will follow all local teaching hospital policies for how to write orders and notify nurses and will follow verbal orders policies of each patient care area.

B. General job descriptions of trainees by year of training:

The Urology program will have PGY-1 and PGY-2 rotators from other services assigned to various Urology services throughout the year. The descriptions below are adopted from the UTHSCSA-GMEC descriptions of work activity by these residents. The

Urology Team at all institutions functions as a unit with the most senior resident directing the activities of the more junior residents. All patients admitted to the Urology service are considered patients of the Urology Team and not an individual resident. The named attending for an individual patient is ultimately responsible for that patient's care and will direct the team activities through direct communication with the residents.

1. Postgraduate year 1 (PGY1) resident:

Supervision Level: Direct by U-1 (PGY-2/3) through U-4 (PGY-5/6) Urology Residents

Indirect by faculty with direct supervision available

A PGY1 resident will take a complete history and physical examination (H&P) on all new admissions to the teaching service requiring an H&P and will document them on the approved hospital forms in the patient's chart or in a computerized clinical record. After discussion with the attending physician and supervising resident, the PGY1 will write an assessment and initial management plan and institute a therapeutic intervention. The PGY1 resident, under the supervision of the senior resident and attending physician, will participate in daily rounds and write daily progress notes which include an interim history and physical exam, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, there will be timely communication by a member of the resident team with the attending. The house staff and attending must communicate with each other as often as is necessary to ensure the best possible patient care. The PGY1 resident may be responsible for completion of discharge summaries. Transfer notes and acceptance notes between critical care units and floor units, when required, can be written by the PGY1 resident. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems, and physical examination findings. The supervising resident and the attending must be involved to ensure that such transfer is appropriate. All PGY1 residents, when leaving an inpatient team, must write an "off-service" note summarizing pertinent clinical data about the patient. The new resident team must notify the attending physician of the change in resident teams and review the management plan with him/her.

2. Postgraduate year 2 (PGY2 or U-1) residents:

Supervision Level: Direct by U-2 (PGY-3/4) through U-4 (PGY-5/6) Urology Residents

Indirect by faculty with direct supervision available

PGY2 residents, when assigned to the service, will take responsibility for organizing and supervising the teaching service in concurrence with the attending physician and will provide the PGY1 residents and medical students under his/her supervision with a productive educational experience. In this role, they work directly with the PGY1 residents in evaluating all new admissions and reviewing all H&Ps, progress notes, and orders written by the PGY1 resident daily. ***They will also supervise, in consultation with the attending physician, all minor procedures performed by the PGY1 and for which they have been judged to be able to perform independently (see PGY-1 procedures above).*** PGY2 residents may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies. PGY2 residents must maintain close contact with the attending physician for each patient and notify the attending as quickly as possible of any significant changes in the patient's condition or therapy. All decisions related to invasive procedures, contrast radiology, imaging modalities, and

significant therapies must be approved by the attending.

3. Postgraduate year 3 (PGY3 or U-2) and above (U-3, U-4) residents:

Supervision Level: Direct by U-3 or U-4 Urology Senior/Chief Residents

Indirect by faculty with direct supervision available

PGY3 residents will follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3 residents may perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the attending or patient care area policies. They will also be available to provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other residents. They will assume direct patient care responsibilities when needed to assist more junior residents during times of significant patient volume or severity of illness.

C. Staff supervision of care for hospitalized patients must be documented in the inpatient record. Documentation requirements for inpatient care are outlined below. These are the minimal requirements and may be more stringent depending on the UTHSCSA teaching hospital.

D. Documentation that must be performed by staff and by trainees

Documentation, in writing, by staff must be made to show concurrence with the admission, history, physical examination, assessment, treatment plan, and orders.

Concurrence with major therapeutic decisions, such as “Do Not Resuscitate” status, when any major change occurs in the patient’s status, such as transfer into or out of an intensive care unit must be in accordance with hospital policies. Documentation, in writing, by trainees must also be in accordance with hospital policies.

Section VI. Supervision of Trainees on Inpatient Consult Teams

Supervision Level: Direct by U-3 or U-4 Urology Senior/Chief Residents

Indirect by faculty with direct supervision available

All inpatient consultations performed by PGY-1 to PGY-3 trainees will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the trainee doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team.

Section VII. Supervision of Trainees in Outpatient Clinics

Supervision Level: Direct by faculty

All outpatient visits provided by trainees will be conducted under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff’s discretion, at the trainee’s request, or at the patient’s request. The staff doctor has full responsibility for care provided, whether or not he/she chooses to verify personally the interview or examination.

Section VIII. Supervision of Trainees in the Emergency Department

Supervision Level: Direct by U-3 or U-4 Urology Senior/Chief Residents

Indirect by faculty with direct supervision available

The responsibility for supervision of trainees providing care in the Emergency Department (ED) to patients who are not admitted to the hospital will be identical to that outlined in the schema for outpatient supervision above. The responsibility for

supervision of trainees who are called in consultation on patients in the ED will be identical to that outlined in the schema for consultation supervision above. Consulting staff should be notified appropriately of ED consultations.

Section IX. Supervision of Trainees Performing Procedures

Supervision Level: Indirect by faculty with direct supervision available

A trainee will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the trainee is competent to perform the procedure safely and effectively. Residents (U-1 through U-4) in the Urology training program are deemed competent to perform certain procedures without direct supervision (Listed above). In these instances, trainees may perform routine procedures that they are deemed competent to perform for standard indications without prior approval or direct hands-on assistance of staff. However, the resident's attending staff of record will be ultimately responsible for all procedures on inpatients. In addition, residents may perform emergency procedures without prior staff approval or direct supervision when life or limb would be threatened by delay. All outpatient procedures will have the staff of record documented in the procedure note, and that staff will be ultimately responsible for the outpatient procedure.

Section X. Specialty-Specific Additions or Exceptions to This Policy

None