Definitions

Resident:
A physician who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee. Note: The term “resident” includes all residents and fellows including individuals in their first year of training (PGY1), often referred to as “interns,” and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows.”

As part of their training program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill. Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Residents are responsible for asking for help from the supervising physician (or other appropriate licensed practitioner) 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 (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

Supervision
To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision – the supervising physician (or “supervisor” if your RRC permits supervision by non-physicians) is physically present with the resident 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. (programs may wish to add their own defined response time – e.g., “within 15 – 30 minutes”)
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.

Clinical Responsibilities

The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The specific role of each resident 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. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

Please note some residents may be engaged in one or more years of research training during their residency. Only years of clinical training are considered below.

PGY-2-3 (Junior Residents)
PGY-2-3 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior and/or chief residents. They should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion. PGY-1 residents are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending or senior resident when appropriate.

These residents provide care for patients at the 5 different rotating Seattle area hospitals. They may work with or, in some situations, lead the Urologic Surgical team providing care for patients in the inpatient setting (including ICU), outpatient settings and the emergency department. They may provide consultative services. All services are supervised by an attending physician.

PGY-5 (as defined by RRC) (Senior Residents) Senior residents may be directly or indirectly supervised by an attending physician or senior resident but will provide all services under supervision. They may supervise PGY-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

PGY-6 (as defined by your RRC) (Chief Residents) Chief residents may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. They must provide all services ultimately under the supervision of an attending physician. Senior residents should serve in a supervisory role of medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient.
Attending of Record
In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged primary attending physician (or licensed independent practitioner if approved by your RRC) 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/or as indicated by individual program policy. The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient’s illness. The attending must notify all 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 residents all situations that require attending notification per program or hospital policy. 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 an orthopedic surgeon is asked to consult on a patient on the medicine service and decides the patient needs a joint aspiration, the medicine attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the medicine resident who may perform the joint aspiration. This information should be available to residents, faculty members, and patients.

The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient’s care. Residents and attendings should inform patients of their respective roles in each patient’s care.

The attending and supervisory resident are expected to monitor competence of more junior residents 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 resident 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 resident requires supervision, this may be provided by a qualified member of the medical staff or by a resident who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents. When there is any doubt about the need for supervision, the attending should be contacted.

The supervision requirements for Surgery Residents (R1-R2) rotating on the Urology Service may be found under the guidelines for General Surgery.
Visiting residents must receive specific approval from the Program Director or Delegates to perform any of the procedures below without supervision.

The following supervision requirements relate to Urology Surgery Residents (R2+):

**No supervision required for the following procedures:**
Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture placement and removal, central venous catheter removal, anoscopy, nasogastric intubation, abdominal paracentesis, arterial puncture/catheterization, removing chest tube, thoracentesis, I & D of complex wounds, central venous line placement by subclavian or jugular approach, chest tube placement, Swan-Ganz placement

**Supervision for the urology R2 by attending or chief resident for the following procedures under local anesthetic:**
- Difficult catheterization.
- Dilation of urethral strictures.
- Cystoscopy.
- Suprapubic transcutaneous tap or catheter insertion.

**Direct supervision by an attending**
- Surgical procedures performed in the operating room with general or spinal anesthesia
- Sedation for procedures (e.g. conscious sedation)
- All other invasive procedures not listed.

Please reference appendix I for an expended list of procedures which may be performed with the indicated level of supervision by PGY.

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident 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**

Residents may provide consultation services under the direction of supervisory residents including fellows. 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 and/or as indicated by individual program policy. The availability of the attending and supervisory residents or fellows should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient’s illness. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending within 12 hours of seeing the consult,
depending upon the urgency of the consult and the stability of the patient. Residents are to discuss all consultations at regularly time intervals, depending upon the discussion with the attending. Any resident performing a consultation where there is credible concern for patient's life or limb requiring the need for immediate invasive intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members include:

1. Patients requiring any surgical procedure
2. Attendings from other specialties who might requests a direct consultation with the urology attending on call
3. Any proposed admission
4. Any proposed patient transfer
5. All unanswered questions that might assist in the efficient disposition of patient care

Should the urology on-call attending not be immediately available, the resident should alternatively contact the urology attending on-call at another hospital. If that attending is not available, then the program director should be contacted; next in line would be the chairman of the department. There is a published on-call list (with attendings beeper numbers, cell phone and home phone information) for every week which is scheduled out at least 1 month in advance and is circulated to the entire department at least 5 days prior to the beginning of every calendar month.

Supervision of Hand-Offs

Residents are expected to conduct professional, safe and articulated hand-offs whenever there is a transition from one resident to another. Prior to the hand-offs, chief residents round with the junior resident in order to clarify all on-call orders, procedures and “if-then” maneuvers for each patient. Residents are instructed on the process of and expectations for hand-offs during annual orientation which is reinforced every quarter. The department provides for the required face-to-face hand-offs every quarter in an environment that is conducive to sharing information. These “Switch Dinners” help residents rotating onto a new service understand the nuances of that service and the in-patient service. Chief residents are in charge of overseeing these Switch Dinners.

Circumstances in which Supervising Practitioner MUST be Contacted

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members:

1. Any proposed admission
2. Any proposed patient transfer
3. Any consults
4. Any potential surgery
5. Any change of patient status
6. Any unanswered questions that might assist in the efficient disposition of patient care.
**Resident Competence & Delegated Authority**

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director must evaluate each resident’s abilities based on specific criteria.

1. Direct observation by faculty
2. 360 degree evaluations required quarterly after each rotation
3. Face-to-face, all-faculty resident evaluation sessions which occurs quarterly
4. Feedback sessions on medical knowledge on rounds, consultation and during operative procedures
5. Annual American Urological Association (AUA) In-Service examination
6. Case-based resident presentations
7. Annual Resident Presentations
8. Abstract and Podium presentations on research projects
9. Annual Urology Research Day
10. Journal Club sessions

**Faculty Development and Resident Education around Supervision and Progressive Responsibility**

Residency programs must provide faculty development and resident education on best practices around supervision and the balance of supervision and autonomy. One best practice to consider is the SUPERB SAFETY model:

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

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **S**eek attending input early
2. **A**ctive clinical decisions: Call the supervising resident or 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. **End-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. **Transitions 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/hierarchy**: 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.

**November 14, 2012**


**LEVELS OF SUPERVISION**

<table>
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<tr>
<th>The trainee will not be performing the procedure</th>
<th>Faculty Present (Direct)</th>
<th>Faculty in hospital and available for consultation (Indirect with direct supervision immediately available)</th>
<th>Faculty out of hospital but available by phone (Indirect with direct supervision immediately available)</th>
<th>Supervising Resident Present (Direct)</th>
<th>Supervising Resident in hospital and available for consultation (Indirect with direct supervision immediately available)</th>
<th>Supervising Resident out of hospital but available by phone (Indirect with direct supervision available)</th>
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**NON-PROCEDURAL ACTIVITIES**

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<th>PGY-3</th>
<th>PGY-4</th>
<th>PGY-5</th>
<th>PGY-6</th>
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<tr>
<td>Admit patients to this service</td>
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<td>Perform History and Physical Examination for patients on this service</td>
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<td>Treat and Manage patients on this service</td>
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<tr>
<td>Make referrals and request consultations</td>
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<td>Provide consultations within the scope of his or her expertise</td>
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<td>Supervise Allied Health Professionals on this service</td>
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**PENIS**

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<td>Amputation, partial</td>
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<td>Amputation, complete with perineal urethrostomy</td>
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<td>Amputation, complete with inguinal lymphadenectomy</td>
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<td>Repair penile injury</td>
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<td>Insert penile prosthesis</td>
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<td>Shunt</td>
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<td>Venous stripping &amp; ligation for impotence</td>
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<td>Reduction of Para-phimosis</td>
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Corporal Aspiration | 3/4 | 3 | 3 | 3 | 3 |

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<td>Filliform &amp; follower dilation</td>
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<td>Hypospadias repair, 1(^{st}) stage</td>
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<td>Epispadias repair, urethral construction</td>
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<tr>
<td>Biopsy, needle</td>
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**Repair of fistula:**

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**Operations for incontinence**

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**DIAGNOSTIC PROCEDURES**

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August, 2013