Supervision Policy

Training Program Policies ? Supervision Policy

Every resident is to participate in safe, effective and compassionate patient care under supervision commensurate with his or her level of advancement and responsibility.

The Department of Radiation Oncology at UCSF requires that every patient must have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient?s care. This information is available to residents, clinical fellows, faculty and patients. Residents, clinical fellows, and faculty should inform patients of their respective roles in each patient?s care. At every encounter with the patient, each member of the radiation oncology team relates their name and role (i.e. attending, resident, fellow, medical student) to the patient and the patient?s family. In addition, every member of the radiation oncology team wears a nametag at all times while in the hospital/clinic that identifies their name and respective role.

The Radiation Oncology Program at UCSF and the program director must monitor resident supervision at all participating sites.

To ensure oversight of trainee supervision and graded authority and responsibility, the Radiation Oncology Residency Training Program uses the following classification of supervision:

- **Direct Supervision:** The supervising physician is physically present with the trainee and patient.
- **Indirect Supervision:** With direct supervision immediately available ? the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
  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.
- **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident and clinical fellow is assigned by the program director and faculty. After each rotation the attending physician completes an evaluation on the E*Value system that addresses the resident?s performance in all 6 ACGME competency domains and documents that the Goals and Objectives of the rotation that pertain to the PGY level of the resident have been met. The program director reviews all evaluations including the written documentation that all Goals and Objectives have been met for each rotation and then allows the privilege of progressive responsibility and conditional independence. The program director evaluates each trainee?s abilities based on specific criteria of the 6 ACGME competency domains and the ACGME program requirements for Radiation Oncology.

The Radiation Oncology Program at UCSF assures that the appropriate level of supervision is in place for all residents who care for patients.

Faculty members functioning as supervising physicians delegate portions of care to residents and clinical fellows based on the needs of the patient and the skills of the trainees. The first encounter for every patient in our Radiation Oncology department is the new patient consultation at which time a full History and Physical (H+P) examination should be performed by the resident (PGY-2 through PGY-5) under either **direct or indirect supervision with direct supervision immediately available**. The resident will then convey and recount the H+P to the attending physician and the attending will confirm the findings directly with the patient through discussion and examination. If the attending?s findings differ from the residents, the differences will be discussed so that improvements in the resident?s H+P techniques can be taught and implemented.

The attending evaluates each trainee?s abilities in H+P performance by direct observation and specific criteria. This evaluation is required in the form of the Mini-Clinical Evaluation Exercise (CEX) that takes place once during every clinical rotation. The attending will observe the resident do a focused H+P for about 15 minutes, and then provide verbal feedback. Written feedback is documented through the E*Value system that includes numerical evaluation and comments on medical interviewing, history-taking, physical examination, humanistic qualities/professionalism, clinical judgment and synthesis, counseling, and organization skills. These evaluations are required for each rotation and are reviewed by the program director at her individual semi-annual meetings with each resident as well as by the Program Evaluation And Improvement Committee (PEIC).

Supervision is also provided in the important aspect of formulating and executing a care plan for each patient. Supervision in treatment planning incorporates progressive authority and responsibility, conditional independence, and supervisory roles in patient care. PGY-2 and PGY-3 residents are expected to exhibit competencies in detailed history and physical examinations and demonstrate knowledge of anatomy, epidemiology and the natural history of cancer. They are expected to learn the appropriate staging studies (laboratory, diagnostic imaging, etc.) and use this information to accurately assess and stage the patient. It is during

these years that residents learn the indications for therapy. PGY-2 and PGY-3 residents work with the attending faculty to obtain consents, simulate patients for treatment, and learn appropriate fields used to treat the cancer taking into consideration the natural history of disease. They learn the concepts of drawing blocks and normal critical tissue constraints. PGY-2 and PGY-3 residents perform the patient simulation and set-up in close collaboration with the attending, generally under **direct supervision or indirect supervision with immediately available direct supervision** by the attending. PGY-2 and PGY-3 residents should review imaging studies together with the attending and work closely with the attending in delineating the tumor volumes to be treated and the normal structures to be avoided.

During their PGY-4 and PGY-5 years **indirect supervision** replaces some**direct supervision** in accordance with the resident?s experience and progress. Residents should continue to expand on the knowledge and skills gained in the first two years. While they are under constant supervision of attendings and do not have the privileges to sign treatment plans, they must develop independence in making treatment decisions and in radiation planning. PGY-4 and PGY-5 residents are expected to formulate more complex treatment plans that include precise dosing schedules, radiation oncology technologies, discussion of therapeutic options, and combined modality care that may include surgery and/or chemotherapy. The attending discusses these aspects of the care plan with the resident after the H+P has been completed. PGY-4 and PGY-5 residents should set up the patient themselves first, preferably under **indirect supervision** with **direct supervision immediately available** by the attending, and then seek input from and approval by the attending. PGY-4 and PGY-5 trainees should complete the tumor volume and normal structure delineations independently, under **indirect supervision with direct supervision immediately available** by the attending and then review these with the attending prior to transferring these volumes to the dosimetrists for treatment planning.

In formulating a care plan, the ability of the resident to synthesize data from published studies and the literature must be formally assessed through the Critical Appraisal Exercise (PBLI). This formal exercise and evaluation takes place once per rotation and is documented in E*Value. The evaluation is based on specific criteria including the ability of the resident to refine the question, use logical and focused search strategy, summarize the study into clinically relevant metrics, critically appraise the study, and discuss limitations of current evidence. These evaluations, completed for each rotation, are reviewed by the program director at her individual semi-annual meetings with each resident as well as by the Program Evaluation And Improvement Committee (PEIC).

Progressive authority and responsibility, conditional independence, and supervisory roles in patient care also take place during care of patients on-treatment and in follow-up. For example, PGY-2 and PGY-3 residents generally see on-treatment and follow-up patients directly with the attending under**direct supervision or indirect supervision with direct supervision immediately available**. PGY-4 and PGY-5 residents should progress towards seeing on-treatment and follow-up patients independently under **indirect supervision with direct supervision immediately available** and then reporting their findings and assessment to the attending, before the attending physician sees the patient.

Finally, during their months as chief resident, the resident acts as the primary contact for referring teams and develops the skills to triage critical patients. This is done under **indirect supervision with direct supervision immediately available or with direct supervision available.**

Progressive authority and responsibility, conditional independence, and supervisory roles in patient care are reflected in rotation goals and objectives that are updated and distributed to all residents and faculty yearly. Details of specific expectations differ among disease sites and are reviewed in detail in our goals and objectives. Faculty evaluate residents based on their assessment of the ability of the resident to meet the goals and objectives of the rotation specific to their year of training, as the skills residents are expected to demonstrate evolve and progress over the course of training.

Senior residents or clinical fellows serve in a supervisory role of junior trainees in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual trainee. Junior trainees seek guidance from senior residents in treatment planning and formal presentations such as Morbidity and Mortality. The chief resident also supervises medical students who rotate in our Radiation Oncology department, orienting the students to our department, and assigning the students new patient consults; residents at any level may assist with the students? case presentations to the attending.

Each resident and clinical 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. Each trainee must be aware of his or her limitations. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible faculty physician may result in the removal of the Housestaff member from patient care activities. The Radiation Oncology Communication Policy outlines the specific critical changes in a patient?s condition that require the resident to notify the attending promptly (generally within 1 hour following evaluation).

The following procedures are in place to ensure that the appropriate level of supervision is in place for all residents who care for patients:

- Attending physicians are required to review and sign all dictations performed by trainees, including all History and Physicals, Operative Reports, and Discharge Summaries. Reviews and signatures are documented in the electronic medical record system. The dictated note is required to document direct supervision of the H+P.
- Attending physicians are required to generate a care plan with the resident under direct supervision. The attending is required to document completion of this task in a ?care plan? note in the electronic medical record system.
- Attending physicians are required to approve patient set-up at the time of simulation before the CT is performed. The attending physician is required to document their physical presence anddirect supervision of the set up and simulation in a ?simulation note? in the electronic medical record system.
- Each service has a Goals and Objectives document that is distributed to all residents and faculty once yearly, updated each year, and reviewed annually by the program director and the Program Evaluation And Improvement Committee. These Goals and Objectives are formulated for each PGY year and reflect progressive authority and responsibility, conditional independence, and supervisory roles in patient care.
- The Department of Radiation Oncology publishes on-call schedules with pager numbers and home and/or cell phone numbers. These are posted at various locations and are distributed throughout the department by e-mail; they are also available on the Radiation Oncology intranet website.
- An attending physician takes call weekly along with a resident on call, and this faculty member carries a pager. All patients seen emergently after hours or on weekends are

required to be seen by both a resident and an attending physician, and the attending physician must approve films and treatment prescriptions prior to emergency treatment.

- The Department of Radiation Oncology requires a daily email to be sent to all Radiation Oncology Clinical Staff detailing which attendings and residents are out of clinic on that day and their respective covering physicians. This email is sent under the subject line ?Huddle report.?
- The Department of Radiation Oncology designates a rotation of chief residents who, in this position, exercise progressive authority and responsibility, conditional independence, and supervisory roles as they act as the primary contact for referring teams and develop the skills to triage critical patients.
- Attending physicians must be called whenever any trainee feels that a situation is more complicated that he or she can manage. The Communication Policy outlines the specific critical changes in a patient?s condition that require the resident to notify the attending promptly (generally within 1 hour following evaluation).
- The Department of Radiation Oncology requires that an appropriately credentialed Medical Staff member is always available to the Housestaff member in an oversight position outside of normal clinical hours such as during the evenings, nights, and weekends. The attending physician must provide appropriate supervision based on the nature of the patient?s condition, the likelihood of major changes in the management plan, the complexity of care and the experience and judgment of the Housestaff member being supervised.
- The Department of Radiation Oncology requires that each attending evaluate each trainee?s abilities in H+P performance by direct observation and specific criteria. This evaluation is required in the form of the Mini-Clinical Evaluation Exercise (CEX) that takes place once during every clinical rotation. These evaluations are required for each rotation and are reviewed by the program director at her individual semi-annual meetings with each resident as well as by the Program Evaluation And Improvement Committee (PEIC).
- The Department of Radiation Oncology requires that the ability of each resident to synthesize data from published studies and the literature in order to formulate radiation plans must be formally assessed through the Critical Appraisal Exercise (PBLI). This formal exercise and evaluation must take place one per rotation and is documented in E*Value and is based on specific criteria detailed in the evaluation. These evaluations, completed for each rotation, must be reviewed by the program director at her individual semi-annual meetings with each resident as well as by the Program Evaluation And Improvement Committee (PEIC).
- The Department of Radiation Oncology requires that faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility. Clinical rotations are scheduled in blocks of 3 months, whenever possible. 1 of the 3 months may be used as elective time. However, 2 consecutive months of clinical service is the minimum acceptable block in any rotation.
- The Department of Radiation Oncology complies with the written policies and procedures at UCSF, including the supervision policies and procedures specified in the Institutional Requirements of UCSF.

Back to Training Program Policies [1]

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Links
[1] https://radonc.ucsf.edu/training-program-policies