Dermatology Residency Program

SUPERVISION REQUIREMENTS

1. Definitions and Responsibilities.

   a. PGY-2 and PGY-3 residents are considered intermediate level residents. PGY-4 residents are considered senior level residents. Only PGY-3 and PGY-4 dermatology residents participate in inpatient consultation. PGY-2 dermatology residents only care for patients in clinic during normal duty hours. All medical students, interns or other PGY rotators require direct supervision.

   b. “Supervision” constitutes any method of oversight of patient care for the purpose of ensuring quality of care and enhancing learning. Supervision may occur through a variety of methods and are defined using the ACGME and SAUSHEC classification of direct supervision, indirect supervision with direct supervision immediately available or with direct supervision available and oversight.

      (1) Direct Supervision – the supervising physician 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.

         (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 provide Direct Supervision.

         Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

   c. Supervision is conducted by a licensed physician at all times in the clinic. The supervisor in most cases will be a credentialed staff physician provider; however, may, at times, be a senior level resident, who has been promoted to PGY-4. A PGY-4 may supervise a PGY-2 or PGY-3; however, when a senior level resident is supervising any junior resident the senior resident will still fall under the mandatory supervision requirements noted below in section 11.

   d. Supervision policies and the attendant documentation will meet SAUSHEC, SAMMMC and WHASC requirements.

   e. All residents are responsible to evaluate and care for patients of all ages who are referred for disorders of the skin, hair, nails, and mucous membranes. This includes but is not limited to, recognition and management of medical dermatologic issues, surgical treatment of benign and malignant skin lesions, laser and other light based therapy, phototherapy, photodynamic therapy, patch testing and cosmetic procedures to include laser therapy, botulinum toxin, soft tissue

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augmentation, sclerotherapy and scar revision. Residents will perform with less supervision and more autonomy as they progress in training from intermediate level residents to senior level residents as detailed in the supervision policy below. In addition to the clinical care detailed above, senior and intermediate level residents are responsible for clinical teaching of rotating medical students, other rotators, and non-dermatology residents while in clinic. Senior level residents may be responsible for clinical teaching of those previously mentioned, as well as, other dermatology residents on an assigned basis.

2. All resident physicians will introduce themselves to the patient as a resident physician and ensure that the patient is aware of their role and identify the supervising staff of record which will be assigned every day according to the dermatology daily schedule.

3. All outpatient visits provided by trainees will be done under the supervision of a staff provider. For PGY-2 residents, 100% of patient visits will have direct supervision by the staff provider or chief resident prior to assessments, diagnostic procedures, recommendations and therapeutic plan being rendered. This also includes any rotating medical students, interns and residents.

PGY-2 residents initially will perform procedures under the direct supervision of a staff member or chief resident until the procedural competency checklist is signed off and the staff designates the resident competent at each individual procedure. Each resident will maintain a copy of their procedural competency log and have it available for all staff and resident supervisors. Surgical excisions will be directly supervised until the consensus of the surgical faculty using direct observation determines that a resident is technically competent to perform excisions with conditional independence. This will occur at different times for different residents and will depend on the specific procedure to be performed (body location, size of lesion, type of closure). All excisions will be discussed with supervising staff prior to their initiation regardless of the resident’s ability or level. Once a PGY-2 resident is deemed capable of performing procedures with conditional independence, the procedure may be performed with indirect supervision but with direct supervision immediately available at all times.

4. Promotion to the PGY-3 level and PGY-4 level will not occur until all staff members agree that the resident can manage common dermatologic disorders and simple diagnostic and therapeutic procedures without direct supervision. Each resident is discussed at the end of the year and promotion to the next level is only recommended when the Clinical Competency Committee members approve promotion. The decision to promote a resident will be based on the faculty’s collective observation and evaluation of the resident’s performance in clinic and on the laser and surgical service. All residents who are promoted are capable of performing minor diagnostic procedures required for inpatient consultation, specifically bedside shave and punch biopsies.

5. At both WHASC and SAMMC, once a resident is promoted to the PGY-3 and PGY-4 level, the resident no longer requires direct supervision for all patients seen in clinic. A list of conditions which require direct supervision regardless of residency year group follows this paragraph. For those cases in which direct supervision is not required, the resident has the option to staff the patient using indirect supervision. During normal clinic hours, direct supervision will always be immediately available. Direct supervision will be utilized at the request of the patient, resident or staff provider. The staff physician has full responsibility for care provided, whether or not he/she chooses to personally verify the trainee interview, examination or laboratory data.
All resident notes will be forwarded to, reviewed by and cosigned by the supervising physician so as to guarantee oversight of all resident delivered patient care. All patient encounters including teleconsultations must be signed off by the staff provider.

6. Inpatient Consults (PGY-3/4s): All cases will be at least indirectly supervised by a staff physician before the consult result or recommendations are considered valid. Resident physicians are responsible to discuss every case with the supervising physician within two hours of the initial consult. Direct supervision will be available at all times and rendered in a timely manner if the patient, resident physician, consulting staff physician or supervising staff physician requests it. The name of the supervising physician will be documented in writing on the initial consult. The consulting staff is responsible for all the recommendations made by the consultant team. All consult patients must be physically seen for confirmation of the history and physical findings within 24 hours of the consultation by the supervising physician. The supervising physician must sign off the initial consult in the Electronic Medical Record (EMR). Any resident on consults or inpatient rotation at either facility is considered to be competent to perform biopsies and sample collection at the bedside with indirect supervision and direct supervision immediately available as any dermatology resident on call will have successfully completed the procedural competency checklist.

7. Transition in Care (TIC) / Hand-offs of Patients on the Inpatient Consult Service: An inpatient log is maintained by the consult resident detailing patient demographics, diagnoses, hospital course and other important background information. This log is reviewed by the inpatient resident with the resident on call over the weekend/holiday prior to the first night of call. TICs will be evaluated by the Attending Physician on inpatient service or the residency Program Director, as appropriate. Staff on the inpatient service also reviews this log with the on-call staff for the weekend/holiday. On the morning after the weekend/holiday, the resident who was on call for the weekend/holiday ensures that the log is updated and verbally reviews it with the incoming inpatient resident. Similarly, the staff member who was on call will verbally review the log with the new on-call staff member and assure the consult log is updated appropriately.

8. Transition in Care (TIC) / Hand-offs of Outpatients: When a resident is on an away rotation (UTSW in Dallas) or graduates from the program, the resident will create a log of patients who require close follow up while/after they are gone. This log is then given to the resident who will follow them to UTSW or as designated by the Program Director. That resident is responsible for seeing the patient or following up on any outstanding items while the patient’s resident is in Dallas or after the resident graduates. All residents designate a surrogate prior to going on leave. This surrogate fields urgent phone calls and lab results until the resident returns to duty.

9. Staff discretion: Occasions may arise when it is in the program, patient, or resident’s best interest to temporarily increase the level of supervision. The designated staff may, at any time, declare that staffing requirements for a particular type of patient, clinic session, or resident panel for that session has changed as long as these changes reflect closer supervision rather than less.

10. If it is felt, because of academic or clinical deficiencies, that continued close supervision of a particular resident is required, this should be coordinated with the program director and the resident’s advisor. In such case it may be more appropriate to document the in-house remediation or consider formal probation.
11. For all residents the following patients need direct supervision before the patient leaves the clinic:
   a. **Initiation** of Isotretinoin
   b. **Initiation** of all phototherapy (UVB, UVA, PUVA) or photodynamic therapy
   c. **Initiation** of any systemic therapy except antibiotics including:
      (1) Prednisone
      (2) Systemic antifungals
      (3) Immunosuppressive or immunomodulatory medications such as methotrexate, azathioprine (Imuran), mycophenolate mofitil (Cellcept), cyclosporine (Neoral or Sandimmune)
      (4) Systemic retinoids
      (5) Plaquenil
      (6) Dapsone
      (7) All Biologics
      (8) Other systemic therapies or change in systemic regimen
   b. All surgeries before cutting (including ED&C’s)
   c. All chemical peels, botulinum toxin, sclerotherapy, and fillers
   d. Patients **not responding to therapy** or who represent **diagnostic dilemmas**
   e. **Initial** laser therapy for all units, **every CO₂ laser treatment**, or if treatment **protocol changes**
   f. **Initial** visit on all patients under 12 years old
   g. Any pigmented lesion that will not be biopsied
   h. **Any patient with a history of melanoma**
   i. Any consult for a skin lesion that will not be biopsied
   j. Service academy physical consultations
   k. MEPS consultations
   l. Any patient referred by commanders to have evaluation for tattoo removal
   m. Inpatient consultations
   n. Other: Residents are encouraged to staff cases freely even if they ”don't have to.”

Supervision of cases where attending staff do not directly see the patient will come through chart review.

12. Staff Confirmation of Trainee Procedural Competencies. When requested by hospital nurses or other personnel with need to know, attending staff physicians must verify whether residents can perform medically-necessary procedures without direct faculty or senior resident supervision. Attending staff can comply with this Medical Staff requirement by the following measures:

   a. All cosmetic, laser and surgical procedures will be staffed by a faculty member prior to the procedure.

   b. Residents will demonstrate professionalism by informing their attending physician and other hospital personnel, when they are not approved to perform a procedure without direct supervision by a senior resident or staff physician.

When necessary, hospital nurses and other personnel will telephone/page the attending staff physician (who is available 24/7) to confirm whether a resident is approved to perform a procedure without direct faculty supervision.
13. **Supervision in Emergency Situations.**

   a. An “emergency” is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient.

   b. In such situations, any resident is expected to do everything possible to save the life of a patient or to save a patient from serious harm. Residents will make all reasonable efforts to obtain assistance from more senior residents and/or any staff available in the hospital and will contact the appropriate attending as soon as possible.

   c. The resident will document all aspects of any emergency patient care rendered, (including who was contacted) in the patient’s record.

14. **Trainee Grievances Regarding Supervision.**

   a. The program director is responsible for ensuring that residents are aware that their concerns regarding adequate technical or professional supervision or professional behavior by their supervisors will be addressed in a safe and non-threatening environment per SAUSHEC and ACGME guidelines.

   b. The residency program will follow SAUSHEC resident grievance policies should residents have concerns regarding their level of supervision. If a resident feels uncomfortable discussing their concern with the program director, they may take their concerns to the SAUSHEC Associate Dean of GME, an ombudsman or their service chief. These grievance mechanisms must ensure that fair and just relationships between residents and teachers are perpetuated.