Title:	**Supervision of Residents**	Index Number:	**OBSGYN-Residency Program-005**	
Scope of application:	**Housestaff**	Original: **07.10.2014**	Last Review: **08.04.2019**	Next Review: **08.04.2022**

1. *Policy*

1.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.
1.2. Residents and faculty members should inform patients of their respective roles in each patient's care.
1.3. Some activities require the physical presence of the supervising faculty member.
1.4. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.
1.5. 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.
1.6. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

2. *Levels of Supervision*

2.1. Direct Supervision (see Appendix A for procedures requiring supervision)
  2.1.1. The supervising physician is physically present with the resident and patient.
2.2. Indirect Supervision
  2.2.1. 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.
  2.2.2. 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.
  2.2.3. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

3. *Supervision Requirements*

3.1. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
3.2. Senior residents should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.
3.3. 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.
3.4. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

4. *Surgical Cases Performed by Residents*

4.1. Table 1 lists the range in the number of surgical cases that our residents perform during their four years of training. These figures include cases in which the resident was either the primary surgeon or first assistant.

Procedure	Range in No. of Cases
Obstetrics	
Spontaneous Vaginal Delivery Episiotomy Repair	200 50-75
Forceps and Vacuum Delivery	15
Cesarean Delivery Obstetric Ultrasound Circumcisions	145 50 30-50
Gynecology	
Endometrial Biopsy Transvaginal Ultrasound Abdominal Hysterectomy	10-15 50 35
Vaginal Hysterectomy	15
Laparoscopic Hysterectomy	15
Laparotomy	50-75
Operative/Diagnostic Hysteroscopy	40
Laparoscopy	60
Cystoscopy	10
Abortions	20
Surgery for Urinary Incontinence/Pelvic Reconstruction	25
Surgery for Invasive Cancer	25

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5. *Signatures*

Reviewed and Concurred by	Name	Signature	Date
Professor and Chairperson, Department of Obstetrics and Gynecology	Anwar Nassar, MD		April 8, 2019
Associate Professor and Residency Program Director, Department of Obstetrics and Gynecology	Fadi Mirza, MD, FACOG		April 8, 2019

Appendix A

I. No supervision required

- Dressing changes
- Suture and staple removal
- Vaginal pack removal
- Central venous catheter removal

II. Supervision required

Service and Procedure	**Training level required for independent performance with supervision**
Obstetrics	
Uncomplicated spontaneous vaginal delivery	PGY1, after two month on Obstetrics (AUBMC or RHUH)
Complicated spontaneous vaginal delivery	PGY2
Uncomplicated episiotomy/laceration repair	PGY1, after first 6 months on Obstetrics
Interpretation of fetal heart rate tracing	PGY1, after first 6 months on Obstetrics
Gynecology	
Simple outpatient procedures (pelvic exams, pap smears, IUD insertion)	PGY1
Minor gynecologic procedures (endometrial biopsies, dilatation and curettage)	PGY2
Complex outpatient procedures (hysteroscopy, dilatation curettage, marsupialization, etc.)	PGY3
Major gynecologic procedures	PGY4