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Updated: 1/8/2025

SCOPE OF PRACTICE

General Surgery Residency
Director of Program: Adham Saad, MD
USF Health Morsani College of Medicine
University of South Florida

This document pertains to resident rotations under the auspices of the General Surgery residency program at **Tampa General Hospital, Moffitt Cancer Center, Bay Pines VA Hospital,** and **James A. Haley VA Hospital**. All Accreditation Council of Graduate Medical Education (ACGME), Joint Commission (JC), Agency for Health Care Administration (AHCA), and CMS guidelines pertaining to graduate medical education apply to this scope of practice.

The purpose of this policy is to ensure that residents are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members to ensure effective oversight of resident supervision.

Each resident and faculty must inform each patient of their respective roles in patient care. Residents 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 must communicate with the supervising faculty in the following circumstances:

I. Emergency Care Rendered by Trainee: In the event that a trainee provides emergency care to a patient, they must document the care rendered and the patient's response to the care. The supervising physician must be notified as soon as possible, and appropriate faculty oversight will be required to review the care delivered. This documentation should be included in the patient's medical record.

II. Patient Upgrade to Higher Level of Care: If a trainee is involved in the decision to upgrade a patient to a higher level of care (such as from a general ward to an ICU), they are responsible for documenting the reasons for the transfer, including the changes in the patient's condition that prompted the escalation. The trainee must communicate with the supervising physician before initiating the transfer and ensure that all relevant patient information is relayed to the receiving team.

III. Unexpected Patient Death: In the case of an unexpected patient death while under the care of a trainee, immediate notification of the supervising physician is required. The trainee must document the sequence of events leading up to the patient's death. Formal review will be conducted at the weekly morbidity and mortality/QI conference.

IV. Unexpected Complication or Event Report: Trainees must report any unexpected complications or adverse events that occur during patient care to the supervising physician as soon as possible. A detailed report of the event should be documented in the medical record. These events will be reviewed to ensure proper follow-up and to provide educational opportunities.

V. Patient or Staff Request to Speak with Attending: If a patient or a member of the healthcare team requests to speak directly with the attending physician, the trainee must attempt to facilitate this communication promptly. The trainee is responsible for informing the supervising physician.

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VI. Trainee Harm or Threatened Harm: If a trainee is harmed or feels threatened while providing patient care, they must immediately remove themselves from the situation if possible and notify their supervising physician and program director. A report should be made detailing the circumstances of the incident, including any physical or psychological harm. The program director will ensure that appropriate steps are taken to safeguard the trainee and provide support as needed.

Supervision may be provided by more senior residents in addition to attendings. However, all patient care must be provided under a credentialed and privileged attending physician. The attending physician is ultimately responsible for management of the individual patients and the supervision of the residents involved in the care of the patient. Supervision must be documented in the medical record in accordance with the General Surgery Residency program at the University of South Florida compliance guidelines.

Residents and faculty can report concerns regarding inadequate supervision on the GME website or the hospital reporting system. Any reports will be protected from reprisal. This document is available on the GME website for all residents, faculty, other team members, and patients.

The program follows the ACGME classification of supervision as noted below. The supervising physician can refer to a faculty, fellow, or resident that has been given supervisory privilege. These supervisory levels are used throughout the Scope of Practice document.

Direct Supervision

1) The supervising physician is physically present with the Resident during the key portions of the patient interaction.
2) The supervising physician and/or patient is not physically present with the Resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision

1) The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the Resident for guidance and is available to provide appropriate direct supervision.

Oversight

1) The supervising physician is available to provide review of procedures/encounters with feedback after care is delivered.

The residency program has a curriculum for providing knowledge and performance competence that includes (procedure training, simulation, number of procedures that need to be completed before obtaining indirect supervision). Annual decisions about competencies are made by the program's clinical competency committee to ensure a successful transition and preparation for the next PGY level. All residents need to maintain current ACLS training.

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	Supervising Physician present (Direct)	Supervising Physician is not providing physical or concurrent visual or audio supervision but is immediately available (Indirect)	Supervising physician is available to provide a review of procedures/ encounters with feedback after care is delivered (Oversight)				
Designated Levels	1	2	3				
Bedside Procedures				**PGY1**	**PGY2**	**PGY3**	**PGY4**	**PGY5**
Incision and drainage				1	2	3	3	3
Simple laceration repair				1	2	3	3	3
Focused Assessment with Sonography for Trauma				1	1	2	3	3
Arterial catheter placement				1	1	2	3	3
Central venous catheter placement				1	1	2	3	3
Rigid proctoscopy				1	1	2	3	3
PA catheter placement				1	1	2	3	3
Flexible bronchoscopy				1	1	2	3	3
Complex laceration repair				1	1	2	3	3
Percutaneous tracheostomy				1	1	1	2	3
Percutaneous endoscopic gastrostomy				1	1	1	2	3
Diagnostic Peritoneal Lavage (DPL)				1	1	1	2	3
Resuscitative thoracotomy				1	1	1	2	3
Patient Management Procedures				**PGY1**	**PGY2**	**PGY3**	**PGY4**	**PGY5**
Perform H&P and develop plans for outpatient general surgery patients				2	2	2	2	3
Perform H&P and develop plans for inpatient general surgery patients				2	2	2	2	3
Pre-operative evaluation and management				2	2	2	2	3
Post-operative evaluation and management				2	2	2	2	3

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Designated Levels	1	2	3				
Transfer of patients between hospital units or hospitals				2	2	2	2	3
Discharge of patients from the hospital				2	2	2	2	3
Interpretation of laboratory results				2	2	2	2	3
Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)				1	2	3	3	3
Evaluate trauma patients in the ER and supervise their resuscitation (ATLS certified)				1	1	2	3	3
Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes				1	2	2	2	3
Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments				1	2	2	2	3
Management of patients in cardiac or respiratory arrest (ACLS required)				1	2	2	2	3
Write orders for restraints				1	2	2	3	3
Administer conscious sedation				1	1	2	2	3
Procedural Competencies				**PGY1**	**PGY2**	**PGY3**	**PGY4**	**PGY5**
Performance of basic venous access procedures, including establishing intravenous access				2	3	3	3	3
Placement and removal of nasogastric tubes and foley catheters				2	3	3	3	3
Arterial puncture for blood gases				2	3	3	3	3

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Designated Levels	1	2	3				
Perform advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation				1	2	2	2	3
Repair of surgical incisions of the skin and soft tissues				1	2	2	2	3
Repair of skin and soft tissue lacerations				1	2	2	2	3
Excision of lesions of the skin and subcutaneous tissues				1	2	2	2	3
Tube thoracostomy				1	2	2	2	3
Paracentesis				1	2	2	2	3
Endotracheal intubation				1	2	2	2	3
Bedside debridement				1	2	2	2	3
Endoscopy				1	2	2	3	3

Signed by:
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Adham Saad, MD, FACS
Program Director, General Surgery Residency

Effective Date

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