Updated: 3/19/2024

SCOPE OF PRACTICE

Urogynecology and Reconstructive Pelvic Surgery
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This document pertains to fellow rotations under the auspices of the Urogynecology and Reconstructive Pelvic Surgery Program at Tampa General 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 fellows 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 fellow and faculty must inform each patient of their respective roles in patient care. Fellows must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Fellows are responsible for requesting help from the supervising physician regarding unexpected complications or event reports and whenever patients or staff request to speak with the attending. Fellows must communicate with the supervising faculty in the following circumstances: transfer of care to or from the urogynecology service, decisions for surgery or procedures, admission to the hospital, and consultations.

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 Female Pelvic Medicine and Reconstructive Surgery 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	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	The supervising physician is available to provide review of procedures/encounters with feedback after care is delivered.

The fellowship program has a curriculum for providing knowledge and performance competence that includes procedure training. Annual decisions about competence 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.

	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	See below for level of supervision required for each procedure and year of training		
CORE PROCEDURES				**PGY-5**	**PGY-6**	**PGY-7**

• Do pertinent history and physical examination & develop diagnostic and therapeutic plans for:
  ○ Ambulatory
  ○ Preoperative and hospitalized patients on the FPMRS service
• Provide ongoing care for ambulatory patients with pelvic floor disorders.
• Performance of office procedures:
  ○ Urodynamics
  ○ Bladder installations
  ○ Bladder catheterizations
  ○ Endometrial biopsy
  ○ Vulvar biopsy
  ○ Cystoscopy
  ○ Intradetrusor onabotulinum toxin
  ○ Peripheral nerve evaluation
  ○ Percutaneous tibial nerve stimulation
  ○ Pessary fitting
• Recognize and provide proper management for postoperative emergencies.
• Provide consults to physicians in other specialties, regarding pelvic floor disorders in their patients.
				2	2	3

SEDATION				**PGY-5**	**PGY-6**	**PGY-7**
• Local anesthesia				1	2	2
Floor Procedures				**PGY-5**	**PGY-6**	**PGY-7**
• Voiding trials • Foley catheter insertion and removal • Pessary fitting • Placement and removal of vaginal packing				1	2	3

	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	See below for level of supervision required for each procedure and year of training		
Operative Procedures				**PGY-5**	**PGY-6**	**PGY-7**

• Operative Cystoscopy
  ○ Bladder biopsy
  ○ Stent placement
  ○ Retrograde pyelogram
  ○ Intradetrusor chemodenervation
• Abdominal surgery
  ○ Surgical entry into the abdominal cavity via open or endoscopic technique
  ○ Laparoscopic port placement
  ○ Robotic surgery docking and instrument placement
  ○ Hysterectomy, bilateral salpingo-oophorectomy, tubal ligation
• Vaginal surgery
  ○ Hysterectomy, bilateral salpingo-oophorectomy
  ○ Excision of vaginal masses and cysts
  ○ Repair of obstetric anal sphincter injury (primary or wound revision)
• Pelvic organ prolapse repair: vaginal, laparoscopic, or open
  ○ Anterior/posterior colporrhaphy
  ○ Perineorraphy
  ○ Paravaginal repair
  ○ Vaginal vault suspension (uterosacral, sacrospinous, sacrocolpopexy, iliococcygeus suspension)
• Surgery for stress urinary incontinence
  ○ Urethral bulking
  ○ Placement of retropubic or transobturator midurethral sling
  ○ Pubovaginal sling
  ○ Burch urethropexy
• Surgery for urge urinary incontinence, urinary retention, or neurogenic bladder
  ○ Placement of sacral neuromodulator leads and pulse generators
• Placement of suprapubic catheters, and wound drains
• Anal sphincteroplasty
• Vesicovaginal fistula repair
• Rectovaginal fistula repair
• Repair bladder and bowel lacerations
• Ureteric implantations
• Psoas hitch, Boari flaps
				1	1	2

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Urogynecology and Reconstructive Pelvic Surgery

Effective Date