UNIVERSITY of SOUTH FLORIDA
Morsani College of Medicine
Department of Radiology

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SCOPE OF PRACTICE

IR Integrated Residency Program
Director of Program: Glenn Hoots, MD
USF Health Morsani College of Medicine
University of South Florida

This document pertains to Resident (PGY2-5) rotations under the auspices of the IR Integrated Residency at Tampa General Hospital, Moffitt Cancer Center, Haley VA, Bay Pines VA, and Johns Hopkins All Children's 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: any critical finding that may result in patient irreversible damage or death, any unexpected finding, finding that would change patient management, and prior to any invasive procedure. All patient care must be provided under a credentialed and privileged attending physician. 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 IR Integrated Residency 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 who has been given supervisory privilege. These supervisory levels are used throughout the Scope of Practice document.

Responsibilities

Residents: Residents are responsible for providing patient centered care and recognizing that the individual patient needs required variable levels of supervision. Residents must recognize they are part of a team and may participate in all facets of patient care if the demonstrate the appropriate level of knowledge, skill, experience, and judgment. The resident must also recognize the limitations of their ability and seek the guidance of the attending physician. Each member of the team must provide the highest level of care for any given patient. Residents should also strive to become independent and demonstrate their knowledge level, procedural skill, and professionalism by engaging in patient care and increasing their responsibility as they progress through training.

Attending physicians: Attending physicians are ultimately responsible for the care of the individual patient. In providing quality care, the attending physicians are obligated to delegate patient care tasks to the resident physicians according to the ability, knowledge, and experience of the resident in a variety of patient circumstances. This requires the attending physician to continuously assess the needs of the patient and the competence and ability of the resident during all phases of patient care. The attending physician must recognize the appropriate level of supervision and must provide that supervision to care for the patient and educate the resident. The attending physician is also obligated to document the resident physician role in diagnostic and therapeutic invasive procedures and appropriately direct the informed consent of patients prior to procedures.

Supervision requires communication and designation of supervisory roles. The roles of the attending physician and resident physician must be communicated to the patient and all members of the patient care team. The attending physician and facility are responsible for publishing and updating an accurate call schedule according to hospital and site service obligations. The call schedule will be published and accessible for the resident physicians, attending physicians, nurses, and other members of the health care team.

Residents are not permitted to perform independently in the residency until their PGY-3. Residents will not be scheduled on independent diagnostic radiology call until that time. The resident must be cleared by the PD and CCC for independent overnight call by demonstrating competency in the interpretation of commonly performed imaging procedures and medical knowledge of common conditions encountered on overnight diagnostic radiology call. If the CCC/PD feel a resident is not prepared, the resident will be notified during semiannual reviews. A learning plan will be developed, and call schedule delayed until the CCC/PD indicates the resident is prepared for independent call.

Attending notification: Faculty should be notified if the following occur:
• Degradation of patient clinical status – change from floor to ICU admission
• Code Blue or patient death in patient post-procedure that was unexpected
• Complication following procedure that is unexpected
• Potential transfer of patient from outside facility to TGH for Radiology/Interventional Radiology care
• Emergent situation when other clinical services are not available for decision making
• Ambulatory patient referred to ER post procedure
• Ambulatory patient being admitted for inpatient care following recent procedure
• Ambulatory patient or faculty requesting to speak to on-call physician with unexpected complication

Emergency situations: In life threatening emergency situations, the primary obligation is to the immediate care of the patient and all physicians should provide emergency care within their ability. Supervision may not be immediately available in these unforeseen circumstances, and the resident physician may attempt life and limb saving procedures when supervision is not available. The resident and attending physician team should anticipate emergency circumstances and attending assistance should be available as soon as possible. In the event of emergency care rendered by residents, the attending physician must be notified of the situation as soon as possible.

Consultative patient care: Residents engaged in vascular and interventional radiology are expected to provide consultative care under the direction of faculty attending physicians and with the assistance of attending designated practitioners (i.e., Nurse Practitioners; APRNs and Physician Assistants: PAs). The attending physician responsible for the patient consultative service must consider the training level, experience and skill of the resident physician involved in the consultation and provide the appropriate level of supervision based upon the acuity of the patient problem.

Patient Hand-off and transfer of care: Transfer of patient care responsibility must be done according to site specific requirements. In general, the attending physician should be involved in the hand off process whenever possible and should supervise novice residents in the transfer of patient care. Call schedules, rotation schedules and procedure schedules should be created with an emphasis of minimizing patient hand-offs whenever possible.

Review of Resident Supervision: Supervision of residents and assessment of resident capability is a continuous process. Attending physicians are expected to give daily feedback to resident physicians and continuously determine the resident capability for progressive independence in providing excellent patient care. The program will also use formal mechanisms to include global end of rotation evaluations, semi-annual review of progress, milestone assessment and multifaceted feedback mechanisms such as 360-degree evaluations. Review of resident progress and promotion to the next level of training will be assessed by the program director and clinical competence committee. If the resident is not meeting expectations, the resident will be notified of their underperformance and will be subject to remediation, formal and informal discipline, and dismissal according to USF GME policy.

Procedural Rotations

The purpose of this policy is to ensure that residents are provided adequate and appropriate levels of supervision during 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/fellow is assigned by the program director and faculty members to ensure effective oversight of resident supervision.
Each resident must know the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence. Residents are responsible for asking for assistance from the supervising physician when they are dealing with a complex clinical scenario, when they are dealing with a severely ill patient with an acute medical issue, when their procedural skills are insufficient for the task at hand or if they are unsure of the optimal treatment plan. 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 University of South Florida compliance guidelines.

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

IR procedures

For interventional radiology procedures performed in the IR department and suites, all procedures require an attending physician to perform the “time-out” prior to the procedure. Therefore, all procedures in the IR labs require at least a supervision level of 1/2.

All IR Residents will require direct supervision (level 1) for the first two months in the IR suites during procedures – which occurs as a PGY-4 resident in the current block schedule. Independent home IR call will not begin until PGY-5 year. As confidence in the abilities of the resident by the faculty increases, the supervision level will increase to level 2 for all procedures. Procedures should not begin without an attending physician in the department – nor should “time out” be permitted without attending present by current TGH guidelines.

Low risk procedures, which are only performed on the floor, can be performed with Indirect Supervision or Oversight after demonstrating competency with these procedures during Level 1 supervision. Informal and formal evaluations will be given to notify residents of their capabilities for these low-risk procedures.

The following procedures can be performed by IR residents after normal hours after faculty have given feedback the resident is prepared to perform them on the floor (Oversight). The faculty on-call should be made aware if any of these procedures are being performed:

- Central venous catheter manipulation (tunneled or non-tunneled)
- GI tube manipulation (G tube, GJ tube, J tube)
- Tunneled central venous catheter removal

Inpatient consults

Inpatient consults will be performed without attending physicians present; however, all stat consults will be reviewed with the faculty immediately after the evaluation of the patient either in person or by phone. Routine consults can be reviewed daily and rounding performed when clinical schedule permits.

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 residency program has a curriculum for providing knowledge and performance competence that includes procedural training and simulation. 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		
Designated Levels	1	2	3		

CORE PROCEDURES	PGY-2	PGY-3-5	PGY-6
Perform patient care and procedures in outpatient setting	1	2	2
Admit patients and complete inpatient H&P for general ward service	1	3	3
Remove or manipulate central venous catheters	1	3	3
Admit patients to ICU and complete H&P for ICU level of care	1	2	2
Treat and manage common medical conditions	1	3	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		
Designated Levels	1	2	3		
Make referrals and request consultations				1	2	3
Provide consultations within the scope of his/her privileges				1	2	3
Initiate and manage mechanical ventilation for 24 hours				1	1	1
Perform any procedures in the IR procedural suite				1	1,2	1,2
SEDATION				**PGY-2**	**PGY-3-5**	**PGY-6**
Conscious Sedation				1	1	1
Local anesthesia				1	2,3	2,3
Specific Procedures				**PGY-2**	**PGY-3-5**	**PGY-6**
Image guided drainage abscess/fluid				1	1,2	2
Arterial access/angiogram				1	2	2
Arterial embolization/stenting				1	1	2
Removal of existing drains/biliary/nephrostomy				1	3	3
Fistulagram and intervention				1	1	1,2
Suprapubic and gastric tubes				1	2	2
Venous access/venogram				1	2	2
Venous intervention (stent/embolization)				1	1,2	2
Non-vascular visceral access (biliary/renal)				1	1,2	1,2
Biopsy – Image guided				1	2	2
Central venous catheter placement				1	1,2	2
Arterial/Venous thrombolysis				1	1	1,2
Portal Intervention (TIPS/variceal embolization)				1	1	1,2
Delivery of transarterial radiopharmaceuticals and chemoembolics				1	1	1,2
Removal of tunneled catheters				1	2,3	3
IVC filter placement/removal				1	1	1

Glenn Hoots, MD
Program Director, IR Integrated Residency

6/20/2025
Date