SCOPE OF PRACTICE
Supervision Policy #10

Pathology Anatomic & Clinical Program
Director of Program: Evita Henderson-Jackson, MD
USF Health Morsani College of Medicine
University of South Florida

This document pertains to resident rotations under the auspices of the Pathology Anatomic & Clinical Program at the following hospitals: Moffitt Cancer Center, Tampa General Hospital, James A Haley VA Hospital, BayPines VA Hospital, Hillsborough County Medical Examiner Office, OneBlood and USF Health. 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 following definitions are used in this document:

Resident: A professional post-graduate trainee in the specialty of anatomic & clinical pathology.

Licensed Independent Practitioner (LIP): A licensed physician who is qualified usually by Board certification or eligibility to practice independently within the discipline of anatomic & clinical pathology, anatomic pathology only, or clinical pathology only.

Medical Staff: A LIP who has been credentialed by a hospital to provide care in the specialty of pathology.

Faculty Attending: The immediate supervisor of a Resident who is credentialed by his/her hospital or healthcare facility to perform consultative medicine and procedures specific to the specialty of pathology

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. Residents and faculty members should inform patients of their respective roles in each patient's care as applicable. 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. All residents, unless transferring from another pathology residency program, will enter the program at supervisory Level 1-2. Residents transferring from another program will transfer in at the appropriate PGY level, but supervisory level may be adjusted based on early evaluation feedback.

Residents in pathology are supervised by credentialed providers (Faculty Attendings) who are LIPs on the medical staff at one of the University of South Florida's affiliated teaching centers. The Faculty Attendings must be credentialed in that center for the care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising Faculty Attending is ultimately responsible for the care of the patient. Grossing and Autopsy procedures may be supervised by Pathology Assistants and senior residents as described in the current ACGME Program Requirements (see Appendix A).

The Program Director for the Residency Program in Anatomic & Clinical Pathology specifies how trainees in that program become progressively independent in specific patient care activities in the program while being appropriately supervised by medical staff. Graduated levels of responsibility are delineated by a job description for each year of training. These Resident supervision policies follow The Joint Commission (JC) policies on resident supervision as applicable for hospital settings. These policies delineate the role, responsibilities and patient care activities of residents and delineate at what level of training a Resident may perform certain procedures and under what circumstances under which they may do so, and what entries must be cosigned by Faculty Attendings. The procedures performed by residents are listed below [Table].

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. Residents are encouraged to communicate with supervising attending physician any time that he/she feels the need to discuss any matter relating to patient care. Residents are responsible for asking for help from the supervising physician under the following circumstances: all after hour frozen section requests, notification to clinician or patient of new malignant diagnosis, performance of an autopsy, if any error or unexpected serious adverse event is encountered any time and if the resident is uncomfortable with carrying out any aspect of patient care for any reason. Supervision may be provided by more senior residents in addition to attending physicians. 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 affiliate hospitals' guidelines.

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.

Direct Supervision	The supervising physician is physically present with the resident during the key portions of the patient interaction; or 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 provided after care is delivered.

The residency program has a curriculum for providing knowledge and performance competence that includes procedure training and number of procedures that need to be completed before obtaining indirect supervision. 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. This policy is distributed to and are followed by

trainees and supervising medical staff. Compliance with the policy is monitored by the Program Director for the Residency Program in Anatomic & Clinical Pathology. The policy is also posted electronically in New Innovations

	Supervising Physician present (Direct)	Supervising Physician not present but is immediately available (Indirect)	Supervising Attending/ resident provide review/feedback after delivery of care (Oversight)				
Designated Levels	1	2	3		See below for level of supervision required for each procedure and year of training		
Surgical Pathology[1]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**
Review of clinical information				2	2	3	3
Gross evaluation				1*	2	3	3
Formulation of diagnostic assessment				2	2	3	3
Communication of results with physicians and patients				1	2	2	3
Frozen Section and Intraoperative Consultation[2]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**
Gross examination and selection of sections				1	2	2	3
Touch preparations				1	2	2	3
Diagnostic assessment				1	2	2	3*
Reporting				1	2	2	3*
Autopsy Pathology[1]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**
Review of clinical information				2	2	3	3
Gross and microscopic examination				1*	2	2	3
Preparation of autopsy report				2	2	2	3
Fine Needle Aspiration and Bone Marrow Biopsy Procedures[1]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**

	Supervising Physician present (Direct)	Supervising Physician not present but is immediately available (Indirect)	Supervising Attending/ resident provide review/feedback after delivery of care (Oversight)				
Designated Levels	1	2	3		See below for level of supervision required for each procedure and year of training		
Review of clinical information				2	2	3	3
Patient informed consent				1	2*	3*	3
Perform procedure				1	1*	2	3
Documentation in electronic medical record				1	2*	3	3
Diagnostic interpretation				1*	2*	3	3
Clinical Pathology/Consultative[3]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**
Review of clinical information				2	2	2	3
Interpretation of diagnostic test				1*	2	2	3
Formulation of assessment and plans				1	2*	2	3
Communication with clinical provider				1	2	2	3
On-Call Encounters[3]				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**
Review of clinical history				N/A	1	2	3
Interpretation of specialty-specific diagnostics				N/A	1	2	3
Formulation of assessment and plans				N/A	1	2	3
Communication of results/plan with provider				N/A	1	2	3

N/A = Not applicable

[1]Residents are not allowed to independently certify diagnostic material (surgical, autopsy, bone marrow, cytology reports) per current College of American Pathologists (CAP) accreditation standards. Residents (PGY-3) however, may completely prepare a case to include the written report, which then is completely reviewed and ultimately certified by an attending physician.

[2]Oversight regulations are subject to individual hospital guidelines for intraoperative consultative work by residents. While residents may render frozen sections diagnoses as appropriate, final case certification must be completed by an attending physician.

[3]Residents are not allowed to independently certify diagnostic material per current CAP accreditation standards

*PGY1 residents perform at level 1 supervision status within the first 3 to 6 months of residency for and progress to level 2 supervision status by the latter 6 months of their PGY1 year; PGY2 residents perform at level 2 supervision status within the first 3 to 6 months of their residency and progress to level 3 supervision status with exception of FNA performance which transitions from level 1 to level 2 supervision status during the PGY2 two month cytology rotation block; PGY3 residents transition from level 2 supervision status to level 3 supervision status for providing informed consent during their one month cytology block; and PGY4 residents perform at level 2 supervision status within the first 3 to 6 months and progress to level 3 supervision status by the latter 6 months of their PGY4 year in diagnostic assessment and reporting

June 25, 2025

Evita B Henderson-Jackson, MD — Date
Program Director, Pathology Anatomic & Clinical

APPENDIX A:

ACGME ANATOMIC & CLINICAL PATHOLOGY PROGRAM REQUIREMENTS (IN EFFECT 7/2021)

Supervision and Accountability

Although the attending physician is ultimately responsible for the care of the patient, every physician share in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner) who is responsible and accountable for the patient's care.

This information must be available to residents, faculty members, other members of the health care team, and patients. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. "Physically present" is defined as follows: The teaching physician is in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. The program must define when physical presence of a supervising physician is required.

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision: the supervising physician is physically present with the resident during the key portions of the patient interaction; or 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.

PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a)

Each PGY-1 resident must be directly supervised during performance of, at least, his or her three initial procedures in the following areas, if offered by the program: apheresis; autopsies (complete or limited); bone marrow biopsies and aspirates; fine needle aspirations and interpretation of the aspirate or, frozen sections; and gross dissection of complex surgical pathology specimens by organ system.

Only a surgical pathology fellow, a resident who has completed at least 12 months of anatomic pathology education, a pathologist's assistant, or an attending pathologist may directly supervise the gross dissection of surgical pathology specimens and/or autopsies.

Only a blood banking/transfusion medicine fellow, a clinical hematology-oncology fellow, a clinical nephrology fellow, a resident who has completed at least 12 months of clinical pathology education, including core training in apheresis, or an attending physician credentialed for apheresis may directly supervise apheresis.

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 provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.