RADIATION ONCOLOGY RESIDENCY
SUPERVISION POLICY

This policy is intended to guide the activities of radiation oncology residents in insuring that patient care activities in which residents participate are appropriately supervised and documented during the course of their training. This supervision should begin with the resident's initial contact with the attending physician and the patient and continue through all contact the resident has with the patient. All residents' patient care activities are to be conducted within the scope of the radiation oncology residency program.

Residents are provided with prompt reliable systems for communication and interaction with supervisory physicians. They are supervised by attending physicians in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience. The schedules for attending physicians are structured by the program director to ensure that supervision is readily available to resident's on duty, particularly during on-call periods. The level of responsibility accorded to each resident is determined by the radiation oncology faculty.

I. Work Day Supervision –

a. All radiation oncology residents function under direct supervision during the routine work day, generally 7:00am to 5:30pm, Monday through Friday. Residents are responsible to see all consults, re-consults, patients under treatment and follow-up patients with the attending physician.
b. All aspects of treatment planning and implementation must be supervised and approved in writing by the responsible faculty.
c. The faculty must document his or her presence for all areas of supervised work.
d. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending faculty member will be available for supervision during clinic hours.
e. Patients followed in more than one clinic will have identifiable attending faculty for each clinic. Attending faculty members are responsible for ensuring the coordination of care that is provided to patients.
f. Patients with problems must be brought to the attention of the attending physician. The attending physician is responsible for the daily management of the patient.

II. After Hours Supervision –

a. All emergencies will be jointly evaluated by the resident and attending staff on call and for the first emergency treatment given outside the regular working hours, both the resident and staff on call must be present.
b. Scheduled weekend treatments should be attended by both the staff and resident if the resident is in his/her first 6 months of training. Beyond the first 6 months, residents alone may supervise off-hour treatments which are a continuation of a treatment course already begun.

Consults - In-patient

Requests for in-patient consults are received either by the call director secretary or the appropriate faculty physician secretary. The resident is notified of the consultation and he/she is responsible for seeing all consults and obtaining the appropriate clinical information, imaging and pathologic studies. The initial part of the in-patient consult form should be completed with a history and physical examination and a review of systems form. This is then presented to the appropriate faculty physician who will see the patient, together with the resident, within 24 hours of departmental notification. A decision regarding patient management is made and the consult form and billing forms are completed. All notes placed in the patient chart are to be date and time stamped. A copy of the consult is left on the patient's hospital chart, one copy is placed in the radiation oncology chart. Once the patient has been seen, a complete history and physical must be dictated within 24 hours. The billing slip with the patient’s name, medical record number, birth date, diagnosis code and level of service must be placed in the billing department mailbox for completion insurance verification and chart production.

Consults - Out-patient

Requests for out-patient consultations are received by the appropriate faculty physician secretary. Patients are scheduled to be seen in the out-patient clinic area at designated times. A daily schedule for patient consultations, simulations, setup of new patients, and patients under treatment is provided for each staff physician and resident. The out-patient consultation is seen first by the resident and then jointly with the faculty member. A complete history and physical is dictated at that time. The resident should ensure that all relevant clinical records, radiology exams and pathology reports are available at the time of consultation whenever possible. Outside pathology slides for each patient accepted for treatment in the Department of Radiation Oncology must be reviewed at HUP. Outside radiology exams to be reviewed at HUP must be submitted to Radiology for consultation with the appropriate reports and forms. Release forms for pathology slides, reports, medical records, x-rays, scans, etc., should be obtained from the patient when appropriate.

All patients who are new to the outpatient clinic should be seen by, or discussed with, the attending faculty at that initial visit. The staff practitioner must document this in the chart via a progress note (or addendum to the resident note).

History and physical examination

History and physicals are dictated on all patients seen in consultation. The residents should obtain a complete history and perform a complete physical examination before the faculty physician sees the patient. Pocket dictaphones are provided for each resident. All signs and symptoms pertinent to the patient's problem must be noted. Dimensions of palpable nodes or masses must be described and recorded accurately. Pertinent negative findings should be also be recorded. At the completion of the history and physical examination, the patient should be staged by the appropriate staging classification for the primary disease site for ALL patients. The disease type, stage and date of diagnosis should be recorded on all history and physicals. Diagrams should be completed indicating the nature and extent of the primary and regional disease where appropriate. At the completion of the history and physical, a summary of the salient points of the patient's

history and disease status, as well as recommendations and plans for treatment should be described. The dictation tape is given at the end of each day to the designated secretary for coordination of transcription. Completed dictations will be returned to the resident for signature and corrections. Each dictation must also be countersigned by the responsible staff physician.

Treatment Planning

Scheduling of new patients

All appointments (simulations, set-ups, CT scans for planning purposes only) for new patients beginning treatment must be scheduled through the chief or assistant chief therapist . In their absence, a designated person may schedule new patients. In order to schedule a patient, the resident must have the patient's full name, the faculty member responsible for the patient, the area to be irradiated, whether simulation or machine time is required, whether the patient has received prior radiotherapy, and their location (if an in-patient). The resident should also indicate any special circumstances such as contrast medium or special calculations. For IMRT cases, the appropriate requests forms are to be completed and submitted for approval, and the treatment parameters form for the physicist and dosimetrist should be completed in a timely manner with faculty supervision.

For in-patients at Presbyterian Hospital or other outside facilities, the resident should inform the appropriate person at that institution of the appointment and coordinate the transportation by an ambulance. For in-patients at HUP, the resident should inform the therapists of the patients location so they may arrange for in-house transport. The resident should ensure that any scheduled appointments do not conflict with the attending faculty's schedule so that the faculty or a covering physician is present as required for all procedures.

Simulation appointments are usually given at one hour. Appointments for simulation on the fluoroscopic simulator and CT simulator for treatment planning are scheduled through the chief therapist, as are all appointments for set-ups, special procedures (such as TBI, general anesthesia cases, stereotactic radiosurgery) and outpatient HDR brachytherapy procedures.

New set-up times are assigned each afternoon. Patients generally begin treatment on that day or on the following day provided unless a specific order requesting an alternate start date is written in the chart.

Initiation of treatment

Simulation is the process by which the various treatment field outlines and orientations are determined. Either a modified diagnostic x-ray unit with fluoroscopy or a CT simulator is employed. The simulator imitates the treatment field but is not capable of delivering a treatment. Simulation of new patients is performed by the resident, radiation therapist, and faculty physician. Completed simulation films or DRRs must be checked and initialed both by the faculty physician and the resident prior to scheduling the patient for treatment on the treatment machine. For treatment plans to be developed by dosimetry or physics, the resident must delineate the target volume using the patient contour and

simulator films. The target volume should include the primary/regional disease, as well as appropriate margins, and should be labeled with the appropriate ICRU-defined label. The target volume, as well as critical structures where a specified dose can be tolerated should be indicated on simulation films. These structures include the lens of the eye, the spinal cord, lung, kidney, etc.

Faculty approval of the target volume must be obtained by the resident. If cerrobend blocks or multileaf blocking are to be employed in the treatment, the resident will draw the appropriate blocks on the simulator films or on the CT reconstruction. This must be approved by the faculty physician before blocks are implemented. The dosimetrist will then apply the treatment plan to provide an optimum treatment plan as instructed by the resident and faculty. The dosimetrist will present this plan to the resident for approval. The resident is responsible for the review of the plan with the faculty physician. At this time, both physicians should initial the plan and specify dose per fraction, as well as the total dose to which the treatment should be carried. The isodose lines to be recorded in the treatment chart should also be indicated. For IMRT plans, dose

At the time of the initial setup of the treatment plan, both the resident and faculty physician will be present. If set-ups are performed by the "doctor of the day", the resident is responsible for viewing the set-up either with that faculty or within 24 hours of the set-up. The resident should perform any clinical set-ups with faculty supervision. Port films will be obtained and will be reviewed and signed by both physicians.

Consents

Consent for treatment is required for all patients prior to simulation. No patient will be treated without a consent form having been completed and signed. The consent may be obtained by the resident or attending faculty either at the time of consultation or prior to simulation. The time necessary to obtain consent should be scheduled so that simulation is not delayed. Therefore, patients signing a consent form prior to simulation should be asked to come in at least one-half hour before the assigned simulation time, and the faculty and resident should be available for this.

Consent forms are located in the nursing stations and consist of two part: a general consent form and a site specific insert for side effects and complications. The signed consent should be given to the chief therapist or the simulator therapist. Consent must be obtained within 30 days of the start of treatment. A new consent is required for every new treatment site or retreatment.

Patient Examinations - Examination of patients under treatment

All patients under treatment are examined on a weekly basis in the treatment area both by the resident and faculty physician. If a patient is being treated more than once per day, these exams should be performed every five treatments. Patients who are having problems during treatment are examined as often as necessary. A nurse should be present for all biopsy procedures, pelvic examinations, and wherever else indicated. X-rays and laboratory studies are requested through the nurse. Except for special instructions from the attending physician, all patients receiving radiation should have a CBC obtained several days before their weekly visit.

Each attending physician has a specific day to see patients under treatment. Once the patient has been checked in at the reception desk, the nurse will then obtain his/her weight, check the laboratory reports or recent test results and place the patient in an examining room. The resident will then be notified that the patient is ready. At the time of the examination, the radiation dose should be recorded, as well as physical findings, side effects, or problems encountered. If a change in the treatment plan (i.e. cone-down, electron beam appointment, change in blocks, resimulation, or target plan) is indicated, this should be scheduled with the chief therapist as soon as possible. Advance planning is required in order to keep the patient on schedule.

When a patient is suspended from treatment, the nurse and appropriate technician should be notified personally and the date at which treatment is to resume should be indicated by a written order on the prescription sheet. The chart should be given to the chief therapist.

Telephones, as well as an area to dictate, are available in the treatment area and use of the nurses station should be kept to a minimum by resident or faculty physicians. In-house consults may be seen in the treatment area provided that this is scheduled with the nurse at a convenient time. At the completion of treatment, the patient is examined, and a follow-up appointment is scheduled through the nurse for a time determined by the physician.

Chart Completion

At the completion of treatment, a treatment summary is dictated by the resident with details concerning both external beam and intracavitary or interstitial therapy. This will include a brief history of the patient, the region treated, the dates of treatment, the daily dose, the total dose and number of fractions for each treatment region or course, any problems encountered during treatment, and arrangements for follow-up care.

Completion notes are to be dictated the same day the patient has finished! This and all follow-up notes should indicate where and when the patient is to be seen in follow-up. For instance, a completion note should state, "The patient will be seen for follow-up in radiation oncology in 4 weeks, and is also scheduled to be seen by medical oncology at that time".

Follow-up clinic

At the completion of treatment or discharge from the hospital, patients are given follow-up appointments. Each attending physician is assigned a specific day to see follow-up patients. Patients are examined both by the attending physician and the resident and follow-up notes are dictated at the time the patient is seen. In general, out-patients undergoing x-rays or other imaging studies on the day of follow-up will hand carry any films to the follow-up clinic where they will be reviewed both by the resident and attending physician. For digital images, the resident is responsible for retrieving these from the PACS system. The staff room is available for discussions and telephone calls for residents and staff physicians and this area should be utilized rather than the nurses station.

Return outpatients should be seen by and discussed with the attending faculty at such a frequency as to ensure that the course of treatment is effective and appropriate. The medical record should reflect the degree of involvement of the attending faculty, either by

physician progress note (or addendum), or the resident's description of attending involvement.

Night and Weekend Call

The resident on call schedule is prepared by the chief resident(s) subject to review and approval by the program director. All residents are included in the call schedule. Emergency consults, such as spinal cord compression, superior vena caval syndrome, or brain metastases, must be evaluated by the on call resident immediately following the request for consultation. The on call attending staff will also evaluate the patient. The on call resident is responsible for treating emergency patients, as well as others who have already been started on emergency treatment and require continuing treatment through the weekends or holidays. A consult sheet must be completed on all emergency in-patient consults and placed on the patient chart. The resident on call will also dictate a history and physical on the emergency consult and this should be given to the appropriate attending physician secretary who will ultimately be managing the patient. Residents can take call from home nightly provided that they live no more than 1 hour from the hospital. The resident will be contacted via their pager, and must have this pager on their person at all times while on call.

The on call schedule is given to each resident and staff physician for each month. Changes in the on call schedule should be given to the on call secretary as soon as possible. Changes made within a week of the upcoming on call should be relayed directly to the hospital page operator, departmental phone receptionist and on call attending. In general, the on call period is one week at a time.

In-Patient Issues Admissions

Admissions are scheduled through the admissions office. It is the responsibility of the resident to follow admissions and notify the resident on call of potential admissions or problems. All residents should notify the resident on call of any patients who should be checked for any reason during the weekend or weekday evening.

Removal of Brachytherapy Sources - HUP Departmental Policy

The attending and resident who performed the implant or insertion are responsible for its removal and for rounding on such patients if they are in-patients over a weekend and for taking any off-hours calls on these in-patients. The resident and faculty should leave their pager information on the patients hospital room and chart.

Medical Records

Residents are responsible for dictating operative reports for intracavitary and interstitial procedures on the same day as the procedure. The resident is responsible for the admitting history and physical which should include the chief complaint, history of present illness, personal history, family history, social history, systems review, physical examination, provisional diagnosis, proposed study, and intended plan of treatment. The resident is responsible for all required hospital and operating room forms prior to admission. The resident is also responsible for progress notes during the patient's in-patient stay.

Patients who are receiving radiation while in the hospital should have weekly notes placed on their in-patient chart. This is generally done on the on-therapy examination day. The note should summarize the patient's progress as well as any complications of therapy and recommendations for alleviation. The current radiation dose as well as ultimate therapeutic plans should also be summarized.