

UW GME Approved Supervision Policy Template

Revised 03/31/2026

TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY

Last updated: September 03/31/2026

Please reference complete [UW GME Institutional Supervision and Accountability Policy](#) for additional definitions and background.

Pediatric Otolaryngology-Head and Neck Surgery Fellowship

Seattle Children's Hospital and University of Washington

Responsibilities and Accountability

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information will be available through clear labeling in the electronic health record to fellows, faculty members, other members of the health care team, and patients.

The Pediatric Otolaryngology Fellowship fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

The program will provide the appropriate level of supervision for each fellow based on each fellow'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.

As part of their education program, fellows are given graded progressive responsibility according to the individual's clinical experience, judgment, knowledge, and technical skill. Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.

Supervision Definitions

To promote oversight of fellow supervision while providing for graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision:
 - a. the supervising physician (attending, faculty) is physically present with the fellow and patient during the key portions of the patient interaction; or,
 - b. the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
2. Indirect Supervision:

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

3. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Resident Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.

Clinical Responsibilities

Fellows

Fellows may be *directly or indirectly supervised*. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Fellows should serve in a supervisory role to medical students, junior and senior residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the fellow; however, the attending physician is responsible for the care of the patient.

Levels of Supervision for Common Specialty Clinical Activities and Invasive Procedures

The following procedures may be performed with the indicated level of supervision:

Direct supervision required by a qualified member of the medical staff:

1. All procedures performed in the operating room.
2. Degree of supervision to be determined by the Clinical Competency Committee and supervising faculty through the course of the year.

Indirect supervision required with direct supervision available by a qualified member of the medical staff for basic otolaryngology procedures including:

1. Incision and drainage of lateral neck abscesses
2. Fiberoptic nasal endoscopy and laryngoscopy
3. Drainage of peritonsillar abscess
4. Tracheostomy tube changes
5. PET removal

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6. Nasal packing
7. Micro-otoscopy with cerumen removal or foreign body removal
8. Biopsies of superficial head and neck lesions

Circumstances and Events in which Supervising Faculty Member (s) MUST be Contacted

There are specific circumstances and events in which fellows must communicate with appropriate supervising faculty members.

1. Any significant change in patient status, including significant instability of vital signs.
2. Admission of patient.
3. Patient leaving hospital AMA.
4. Patient transfer to higher acuity (ICU, Telemetry, etc.).
5. Significant neurologic changes.
6. Intubation/CODE event, death.
7. Change in status of free flap, limb-threatening event (loss of pulses, etc.).
8. Unplanned loss of drain.
9. Hematoma, excessive drain output.
10. Significant wound dehiscence.
11. Medical/treatment error.
12. Any request by other providers for attending notification.
13. Consultation/care regarding immunosuppression.
14. Complex decision making around initiation of new therapies, procedures for diagnosis or treatment (IR, scan, antibiotics, etc.).
15. Direct supervision is requested or a Patient Advocate is involved for any reason.
16. Change in medical directive (code status).

Supervision of Consults

Fellows performing consultations on patients are expected to communicate verbally with their supervising attending daily. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care. Information for the attending on call is available to residents, fellows, faculty, and hospital through the hospital intranet in addition to the paging operator who has the up to date call schedule. Stable consults may have intermittent follow-up up by the consultant team and thus less frequent updates.

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as

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possible. An example of this may be an emergency surgical airway that must be performed immediately before a supervising physician arrives.

Faculty Supervision Assignment

Faculty supervision assignments are of 1-month duration on the Gold and Purple rotations and 3-month duration on the Elective rotation and therefore are of sufficient length to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.

Supervision of Handoffs

Fellows may be supervised directly or indirectly when conducting hand-offs.

Faculty must assess fellow readiness to move from direct to indirect supervision when conducting hand-offs and patient transfers.

Fellows conducting hand-offs are expected to conduct professional, safe, and articulate handoffs whenever there is a transition of care from one fellow/resident to another, or one team to another. In general, most handoffs are conducted by members of the residency team, between the resident team on-service and the on call residents and the hospitalist teams. Prior to handoffs, a senior resident will round with the team to clarify all on call orders, procedures, and “if then” scenarios that come up for each patient. These details are communicated to the resident accepting care, as well as recorded in the patient list available to all trainees that is maintained in the Epic electronic medical record that includes patient info, the patient summary, to do list, primary contacts, measurements of illness severity, and escalation plans. Fellows will also participate in and oversee hand-offs between residents and to the hospitalists. The process includes both verbal communication as well as the electronic handover form. The goal of standardizing our handoffs is to maintain efficiency and effectively communicate about our complicated patient population.

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