

Veterans Affairs Medical Center (VAMC) Rotation

The chief of the teaching service for the rotation is Katherine Kendall, MD, a member of the faculty of the Division of Otolaryngology at the University of Utah who practices head and neck oncologic surgery. Other faculty members also treat patients in the areas of general otolaryngology. Consultants to the VA may be called upon with sufficient advance notice to help cover surgery in other subspecialties. This rotation provides a comprehensive, mentored exposure to the care of patients in these areas. Residents rotate through the VAMC three times during the R2 year and once during the R4 year. The first two R2 rotations are one month in length; the third is two months. The R4 rotation is four months in length.

The VAMC rotation is designed to deliver the greatest opportunity of resident-to-resident teaching of all the rotations. Senior residents instruct and oversee junior residents one-on-one with appropriate faculty supervision as they both develop skills to practice autonomously in an increasing fashion. Because the outpatient clinic and operating rooms are not run concurrently, each resident has the opportunity to longitudinally follow a patient from his/her initial clinic presentation, through the operation, and into the postoperative follow-up. The inpatient and consultation services are run by the R4 with assistance from the junior resident, under faculty supervision. Rounds are performed twice a day. Most consultations are seen in the otolaryngology clinic.

Didactic teaching at the VAMC is informal and structured around patients' outpatient and surgical visits. The VAMC residents also participate in the Head and Neck Tumor Board where VA otolaryngology patients are presented. Additionally, VAMC residents are required to participate in all formal didactic sessions at the University as otherwise outlined in this Handbook.

While the otolaryngology service at the VAMC is busy, it tends to be less so than other rotations. VAMC residents are expected perform visits to the Hearing and Balance Center, reading, research, and other intellectual pursuits as their schedule allows.

VAMC Orientation

Residents are expected to read and be familiar with the portions of the resident manual prior to beginning their rotation at the VA. Any questions or concerns about how the service functions should be answered by the residents who are on the VA service, the chief residents, or any faculty member who covers the VA.

In the days prior to beginning the rotation, the residents should ask their counterparts who are currently at the VA for any updates or changes in the functioning of the VA. This communication primarily involves the outgoing chief resident and the incoming chief resident. However, the junior residents should also communicate any pertinent information. Communication between the residents is expected to include logistical and functional components of the rotation as well as patient care concerns, such as a summary of any current inpatients, the operative schedule, and the passing along of any results that need to be reviewed.

The first day of the service, the residents should expect a brief overview of the VA rotation by the faculty member at the VA on the first day of the service. The chief of the Otolaryngology—Head and Neck Service is also available and may also provide an orientation, if possible.

VAMC Goals and Objectives

The VAMC rotation is run in accordance with the core competencies for otolaryngology residency program requirements. Residents are also expected to meet the general otolaryngology program goals and objectives for their training level.

The R2 resident will meet and develop competency in the following areas by meeting objectives in the six core ACGME competencies:

Patient Care:

1. Develop independence in outpatient, inpatient, consultation, and surgical services and procedures.
2. Progress from close supervision by the senior resident with attending oversight when taking a history and performing a physical examination, determining a diagnosis, and formulating a treatment plan to being able to perform these functions with minimal input.
3. Develop basic surgical skills during minor procedures and progress towards performing as first assistant in major surgical cases or as primary surgeon in appropriate cases after competence has been determined by the attending.
4. Become proficient in: excision of skin lesions, myringotomy, tonsillectomy, adenoidectomy, tracheostomy, arterial ligation, uvulopharyngopalatoplasty, direct laryngoscopy/microlaryngoscopy, neck abscess drainage, septoplasty, turbinate surgery, epistaxis management, flexible fiberoptic laryngoscopy, rigid nasal endoscopy, otologic microscopy, pneumatic otoscopy, rigid esophagoscopy, skin grafts, fine needle aspiration, and peritonsillar abscess drainage.

Medical Knowledge

1. Become knowledgeable about disease processes in the VA patient population.
2. Obtain an understanding of the basic management of disorders encountered in the general practice of an otolaryngologist—head and neck surgeon.
3. Determine when referral to a subspecialist is necessary.

Practice-Based Learning and Improvement

1. Develop teaching and evaluation skills through working with medical students.
2. Effectively educate patients and other healthcare professionals about otolaryngic disease, treatment, and prevention.

Interpersonal and Communication Skills

1. Develop communication skills when interacting with patients across the socioeconomic spectrum.
2. Gather patient data in preparation for morning rounds and learn to communicate this information effectively to the chief resident, attendings, consulting medical services, and allied health professionals.
3. Develop skills for effective dictation and/or transcription of clinical notes.

4. Meet all requirements for timely completion of medical records.

Professionalism

1. Demonstrate compassion, integrity, and respect for others and for a diverse patient population.
2. Demonstrate responsiveness to patient needs that supersedes self-interest.
3. Show respect for patient privacy and autonomy.

Systems-Based Practice

1. Develop competency in delivering health care in different physical settings (outpatient clinic, inpatient rooms, OR, ER).
2. Demonstrate sound decision making to deliver cost-effective and safe patient care.
3. Present cases at monthly Morbidity and Mortality conference to develop skills necessary to identify system errors and suggestions for systemic change.

The R4 (chief) resident will meet and develop competency in the following areas by meeting objectives in the six core ACGME competencies:

Patient Care:

1. Demonstrate mastery in the proper ordering of diagnostic and imaging modalities.
2. Independently evaluate new patients and present them to the attending with an appropriate treatment plan.
3. Demonstrate mastery of all in-office procedures and will be prepared to act as surgeon in most operations.
4. Manage the otolaryngology service (outpatient clinic, inpatient ward, consultation service, and surgical booking).
5. Provide one-on-one supervision for the R2.
6. Closely monitoring the R2's activities and making appropriate assignments for patient care and conferring with the attending to evaluate the R2's progress and determine when to provide decreased or increased supervision.
7. In the OR, the R4 will act as primary surgeon under attending surgeon supervision on most cases and instruct the R2 throughout the procedure.
8. Demonstrate proficiency in: rhinoplasty/ revision rhinoplasty, reduction of nasal fractures, otoplasty, rhytidectomy, forehead and brow lift, blepharoplasty and other periorbital procedures, extratemporal facial reanimation, soft tissue expansion, skin resurfacing techniques, canalplasty, middle ear exploration, mastoidectomy, tympanomastoidectomy, meatoplasty, repair of perilymphatic fistula, maxillectomy (with or without orbital exenteration)/partial maxillectomy/intraoral resection/oral cavity resection/composite resection/glossectomy, arytenoidectomy/arytenoidopexy, mandibulectomy/mandibulotomy, neck dissection, cricopharyngeal myotomy, reconstruction of vascular malformations (lymphatic, venous, hemangioma), Zenker's diverticulectomy, treatment of laryngeal clefts and tracheoesophageal fistulas, thyroidectomy, and endoscopic and open sinus surgeries.

Medical Knowledge

1. Achieving mastery of the basic anatomy, pathophysiology, evaluation, and treatment methods of the disorders of the head and neck.
2. Be able to discuss controversies of various management options.
3. Be able to discuss all appropriate medical and surgical interventions for the VA patient presentation.

Practice-Based Learning and Improvement

1. Demonstrate superior teaching and evaluation skills through working with medical students and junior residents and assessing their performance.
2. Develop awareness of weaknesses of junior residents and bringing them to the attention of the attending or the PD as appropriate.
3. Effectively educate patients and other healthcare professionals about otolaryngic disease, treatment, and prevention.
4. Develop organizational and leadership skills
5. Hone independent decision-making skills

Interpersonal and Communication Skills

1. Demonstrate mastery of communication skills when interacting with patients across the socioeconomic spectrum such as self-pay cosmetic patients and uninsured trauma patients.
2. Lead rounds and teach the R2 how to communicate information effectively to attendings, consulting medical services, and allied health professionals.
3. Demonstrate mastery of effective dictation and/or transcription of clinical notes.
4. Meet all requirements for timely completion of medical records and oversee the same for junior residents.

Professionalism

1. Demonstrate compassion, integrity, and respect for others and for a diverse patient population.
2. Demonstrate responsiveness to patient needs that supersedes self-interest.
3. Show respect for patient privacy and autonomy.

Systems-Based Practice

1. Develop mastering of delivering health care in different physical settings (outpatient clinic, inpatient rooms, OR, ER).
2. Demonstrate mastery of the safe and cost-effective use of diagnostic and imaging modalities.
3. Present cases at monthly Morbidity and Mortality conference to develop skills necessary to identify system errors and suggestions for systemic change.
4. The junior resident will work with and the chief resident will coordinate care with the other members of the otolaryngology team, including mid-level providers, nurses, ancillary staff, and other physicians.

VAMC Resident, Faculty, and Program Evaluation

Residents will be evaluated by the faculty at the VA through their interaction through clinic care activities. This includes an evaluation of residents in the clinic, the operating room, and in any

patient care activity. The specifics of the evaluation process are as explained in the “Goals and Objectives” section.

The residents should expect feedback at the midpoint of the rotation at the VA and at the conclusion of the rotation. This feedback may come from any of the faculty members at the VA or the department chairman.

The residents will have the opportunity to evaluate the faculty, the VA rotation, and the residency program through the existing feedback system. For any concerns that may arise on the VA rotation, the resident should inform any of the faculty, the chief of the service, the division chair, or the VA department chief.

VAMC Resident Supervision

An attending faculty member from the University of Utah will supervise residents at all times during the rotation. This includes supervision in the clinic, the OR, on the wards, and on call. The level of supervision may vary from case to case, day to day, and resident to resident; however, the usual expected level of supervision includes attending presence in the clinic and in the operating room. In addition, the faculty member is expected to be present whenever needed on the wards or on call.

Clinical Service Guidelines

Clinic

- In the early part of the year, grab the senior resident for anyone you have a question about. The senior resident should see all pre-op patients.
- The attendings are required to be present during clinic. We are not allowed to ‘run’ a clinic without attending coverage, unless the patient is a quick pre-op or post-op visit.
- Scheduling is done in two ways:
 - o Book an ‘outpatient scheduling request’ from the orders menu. Flag ‘Tammy Jackson’ (or whoever the girl at the front desk happens to be when you’re there).
 - o Just go tell Tammy to schedule the patient. This is the preferred method for patients who need a follow-up appointment out of clinic. The VA changed their policy so patients will only get ONE phone-call if you only put in an order, but Tammy will birddog them if you talk to her personally.
- Specific clinics:
 - o Buchmann’s Friday clinic is mainly for pre- and post-op cancer patients.
 - o Kendall will see the voice and swallow patients.
 - o Skedros will see sleep apnea. **Make sure these patients are coming in with sleep studies if they need them**
 - o Gurgel will see our ear patients.

All resident vacations and absences must be submitted in writing to the VA chief of otolaryngology, Dr. Kendall, at least six weeks prior to the date in question. Other travel dates such as conferences or job or fellowship interviews must receive authorization from Dr. Kendall as soon as you become aware of them. If a resident is going to be absent, the clinic needs to be scaled back by 1/3 30 days prior to the resident absence.

Equipment

Scopes

- Scopes are in Vickie's office. When you use the scope, you're supposed to wipe it down with the provided red sponges and place it back into the container. Write the patient's last name and last 4 of their SSN on the provided tab and put a red plastic cover on the whole deal. Carry the scope down the hallway to the clean room.
- After hours: Use the above procedures, but you have to page the scope tech. The number is on the door. Do this or get in trouble.

OR

- Microscope: Make sure the scope is balanced on the day of the surgery and that all the proper lenses are in the room. The staff is pretty good about this.
- Argon laser: We use an Argon laser for stapedectomy. *CALL THE WEEK BEFORE and verify that the laser is available to us. Sometimes Ophtho needs it.
- CO2 laser: This is ours and pretty much available when we need it. There is no laser tech, so you must know all the settings that you need for your surgery.
- STEALTH: This is ours and reliable. No need to load the scans on beforehand. The staff is good about having the equipment ready.
- Laryngoscopy equipment: Dr. Kendall needs three things from the U for any laryngoscopy case: 1) The Bouchayer laryngoscope, 2) The light source for the laryngoscope, and 3) her FULL set of laryngoscopy instruments.
 - o CALL THE WEEK BEFORE and tell the staff you need these things borrowed from the U.
 - o CALL STEPHEN and make sure he knows that we need these instruments
 - o THE NIGHT BEFORE you must go down to sterile processing (someone at the front desk can take you) and check that you have all the instruments.
 - o We have an order in for a set of all this stuff that's dedicated entirely to the VA so hopefully this won't be a concern in the future.

OR Scheduling

Wait list

- The surgical wait list is maintained on the Chief's computer in Excel format. Save this daily and email it to yourself.
- Update the wait list a few times a month to make sure patients who are 'on hold' are getting the work-up they need to be 'active'.

Pre-Op

- All patients over 60 years old need: 1) An EKG, 2) A CXR and 3) basic labs within 1 year of the surgery date.
- ALL patients need a H and P and signed consent PRIOR to their surgery, which is good for 30 days.
- Patients with sleep apnea will (almost) ALWAYS stay overnight. Schedule them as such.
- SICU admissions after surgery need to be requested at the time of scheduling the case to make sure there's a bed. There is a section for this when you do the scheduling.
- At the pre-op appointment, go to the 'Orders' tab and open 'Pre-Op SDS'. This will give you an order set to provide surgery information (attending, the procedure, etc.), orders for pre-op

labs and testing, and pre-op antibiotics. THIS DOES NOT COUNT AS SCHEDULING A CASE.

Scheduling

- Vista (> 2 weeks before the surgery): Instructions for scheduling in Vista are in each resident room. It's straightforward if you follow the directions.
- OR Late Consult (< 2 weeks before surgery): If you can't schedule the case in Vista, it's probably because it's too close to the surgery date. Put in an 'OR Late Consult' request under the 'Consults' tab.

Day of Surgery

- All patients need an 'Update to H&P' in the computer.
- All sites must be marked. Bilateral surgery must be written on the patient's wrist band.
- A time out is performed in Pre-op, as well as after the patient is intubated.

Post-Op

- A note called 'Discharge Instructions' should be written for patients going home the same day.
- Patients being admitted will need orders. Click 'Admit to 1 manual delay' in the orders tab. This will let you use the ENT order set and it will be activated when the patient arrives on the floor.
- ALL patients need an immediate post-op note, discharge medications, and a follow-up appointment order.