In response to the special focus section on patient safety and quality improvement, I am writing to introduce a potentially new area of focus for quality improvement regarding resident education. I am a resident physician in a program that depends on a consortium of 4 hospital systems for training, 3 of which are private hospitals. I have no background in economics, but I have been perceptive enough during my training to recognize that economics drives the health care system and that administrative decisions are often based on costs. One recent trend as a means to improve efficiency and save costs is the ambulatory surgery center (ASC). Many procedures within otolaryngology are outpatient but currently occur within the hospital. As Meltzer et al demonstrate, even thyroid and parathyroid surgery can be safe as an outpatient procedure. As such, our specialty is primed to function within ASCs. I have experienced this firsthand, as 2 hospitals within our consortium have opened ASCs and a third is scheduled to do so. Unfortunately for me, this means that cases may go uncovered as residents tend to hospital-based procedures. I cannot help but wonder how ASCs affect the resident training experience.

One of the challenges of working with residents is balancing efficiency with education. We are, after all, inherently inefficient. I like to think that the desires of hospitals to improve efficiency and costs through ASCs account for resident education, but I am not naïve to the fact that they likely do not. Residents seem to be caught in the middle of a virtual tug-of-war between education and health care economics. The increase in ASCs nationwide is a good indication of who is winning. So how can education and economics be effectively balanced?

Ishii et al demonstrated that ASCs can be integrated into an academic health system, but not all academic health systems have the resources to easily integrate ASCs. The literature is lacking in its evaluation of the effects of ASCs on resident training, and this trend is still too new to get any quality data. The question of how resident training is affected by ASCs is a prospective study waiting to happen. As a trainee who aspires for a career in academics, I hope that the future tips the scales of hospital priorities back toward resident education. While ASCs may improve the economics of a hospital in the short term, poorly trained residents will certainly not.

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centric environment, which makes us look at what patients prefer. My experience has been that when patients are given the choice of avoiding an inpatient hospital stay, they will choose to go home the same day if that is a safe option.

Economics are a factor not just for hospitals and health plans but also for our patients who have higher copays.

The education of residents should not be determined by the venue in which surgery is being performed but, rather, by the needs of residents to get good training as deemed by the Accreditation Council for Graduate Medical Education (ACGME) Otolaryngology Subsection. Issues concerning residency training should be brought to the Review Committee. Many of our head and neck procedures are already done on an outpatient basis, and this is the new reality that training programs should consider.

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Effects on Swallowing When Treating Unilateral Vocal Fold Palsy
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My colleagues and I read with great interest the paper by Cates et al,1 and we agree with their results. In fact, we would like to stress and share our own results, as iatrogenic vocal fold palsies, especially postthyroidectomy, are quite common in our region.2 In the last 2 years, in a tertiary university voice clinic and in private practice, we saw a lot of patients with iatrogenic unilateral vocal fold palsy, and most of them were postthyroidectomy. As the majority of these patients were nonvocal nonprofessionals, their main concern was their debilitating dysphagia, rather than their non-career-threatening dysphonia. In fact, out of these patients, more than half had abnormal swallowing scores on the 10-item Eating Assessment Tool, and more than a third—especially the older group (>60 years of age)—had at least 1 hospital admission in the first 12 months postsurgery with aspiration pneumonia.

After injection medialization, all the patients remain well and are grateful about the fact that they can swallow better, particularly fluids, as shown on their markedly improved swallowing scores but even more on the fact that they no longer get aspiration pneumonias. Just a “statistical” reminder: aspiration pneumonia is a major cause of morbidity and mortality in almost all neurologic diseases and a major cause of frequent hospital readmissions.3,4

As a result, it would not be unreasonable to advocate this operation primarily as a dysphagia-improving surgery and secondarily as a voice-improving one!

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