Otolaryngologists’ Role in Redeployment During the COVID-19 Pandemic: A Commentary

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Abstract

As otolaryngologists, we identify as subspecialists and fellowship trained surgeons and may even identify as “super-subspecialists.” The likelihood of redeployment and drawing upon knowledge learned during our post-graduate year 1 (PGY-1) training seemed exceedingly unlikely until physician resources became scarce in some healthcare systems during the COVID-19 pandemic. More now than ever, it is evident that our broad training is valuable in helping patients and in allowing the otolaryngologist to meaningfully contribute to the larger healthcare community, especially while the majority (70-95%) of elective care is delayed. With our skill set, otolaryngologists are poised in supporting various aspects of hospital wards, intensive care units, emergency departments, and beyond.

Discussion

Over the last several weeks of the COVID-19 pandemic, physicians across all practice settings volunteered or were required to redeploy to areas in need, such as emergency departments (EDs), hospital wards, intensive care units (ICUs) and virtual hubs. Initially, many believed that only a dire situation would necessitate the mobilization of otolaryngologists since the first waves of
deployed physicians included internists, infectious disease physicians, pulmonologists, cardiologists and family practitioners. However, many in the otolaryngology community were called to serve outside of one’s normal practice.

Although many otolaryngologists completed a dedicated general surgical internship, it is difficult to imagine the skills, knowledge and experiences learned during that time would be called upon decades later. Working outside of one’s comfort zone during the COVID-19 pandemic may provoke understandable anxiety. The otolaryngology community prides itself on delving deeper and learning more about various aspects of our field through research, patient experience and surgical innovation. With incredible depth of knowledge from the skullbase to the clavicles, many otolaryngologists appropriately deferred the broader scope of medical management to pre-operative outpatient clinics, primary care providers, hospitalists and consulting services.

Despite the highly specialized medical expertise and associated elective case load, otolaryngologists fulfill helpful and often necessary roles beyond our field during the COVID-19 pandemic. Many otolaryngologists found themselves more “available” for redeployment compared to other healthcare providers due to the cancellation of elective surgeries, decline in referrals, and transition to telehealth visits.

Some overburdened health systems needed physicians to fill gaps for emergency physicians, hospitalists or intensivists who were either quarantined, overworked or otherwise unavailable. Though an otolaryngologist cannot fully replace any of these physicians, our skill set enables us to help in many of those settings.

It is estimated that 2.21% percent of ED visits are otolaryngology related. Redeployment to the emergency room therefore may be a natural transition. For EDs overwhelmed with COVID-19...
patients, a surgical pod annex staffed by the otolaryngologist is an additional way to streamline
and offload the ED demands. Epistaxis, peritonsillar abscess, and facial trauma are common ED
visits. Oftentimes the exam and intervention necessitate high-risk aerosol generating procedures
(AGPs). Examination of these patients by a trained otolaryngologist limits unnecessary exposure
of other ED personnel. Additional benefits of this streamlined specialty approach include
reduction of personnel required for the procedure, minimal use of the coveted personal protective
equipment (PPE), and potentially diminished aerosolization of the virus. Furthermore, EDs
benefit from having an airway expert available when the otolaryngologist is working a shift.
Notable benefits are shorter time to intubation, streamlined surgical airway management, and
minimal time spent performing otolaryngologic associated AGPs.

Though an otolaryngologist may not be able to provide independent comprehensive care for
patients in the ICU or inpatient setting, we serve useful roles within a pyramid team structure
managed by a critical care physician. During our internships and residency, otolaryngologists
spent countless hours rounding on surgical wards and ICUs. In addition, many otolaryngologists
continue to provide call coverage to local small or large metropolitan hospitals including
inpatient consulting services. By providing care in familiar inpatient settings to lower acuity
patients and assisting with procedures including airway management, otolaryngologists provide
much needed support to our critical care and hospitalist colleagues as they deal with an influx of
unstable COVID-19 patients.

Ultimately areas of redeployment for the otolaryngologist will vary based on individual
institution and practice needs as well as the stage along the pandemic curve. By nature of a
pandemic it is a moving target that will change, sometimes on a weekly basis. Additional
examples for redeployment include testing stations where the otolaryngologist can easily swab
the nasopharynx. With increasing employee exposures, occupational health services had to expand. If given appropriate education to include a script and algorithm, the otolaryngologist can easily fill this role. Depending on resources, an otolaryngologist may even find her/himself supporting the health system through non-medical jobs to include transport and environmental services.

Lastly, redeployment provides the opportunity to serve the community while maintaining some financial stability. During the COVID-19 pandemic, most otolaryngologists experience a 70-90% reduction in surgical volumes, especially in states where government decree placed a hold on elective procedures and a delay in semi-urgent procedures. Outpatient otolaryngology visits, even with a robust telehealth program, created obstacles to include: technology shortcomings on the patient side, costs on the provider side, HIPAA compliance issues and most of all, inability to perform necessary physical exams or office based nasal endoscopy and laryngoscopy. In-office AGPs for semi-urgent patients were further limited by the relative shortage of PPE. An abundance of COVID-19 virus residing in the upper aerodigestive tract increases the risk of many otolaryngologic procedures. With some exceptions such as aggressive head and neck malignancy, most otolaryngology operations can be deferred until resources and safety protocols are established. This decreased volume carries significant negative economic impact and financial strain to many physician practices. Redeployment to other roles provides the ability to offset some of this lost revenue for the health system and ultimately the provider.

Conclusion
Redeployment of otolaryngologists whether by choice or necessity occurred during the COVID-19 pandemic. As productive, adaptable members of the wider medical community, we must embrace our skill sets and broader medical knowledge. Doing so provides opportunities to help the larger healthcare community while potentially alleviating the financial strain for one’s practice and those around us.


