

# **WHO WAS DOCTOR FIRESTONE?**

## **A Survival Guide and Summary of What Every Surgical Intern Should Know**

**17<sup>th</sup> Edition**

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UCLA Department of Surgery

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Welcome to the UCLA Department of Surgery and the beginning of your surgical internship. Your surgical training constitutes an extraordinary period in your life; one of tremendous personal and professional growth. You will make friendships and professional relationships which will long outlast your surgical training. You will both experience and witness major life events. You will save lives, lose sleep, age, see and do extraordinary things, and probably learn more during these years than any other period in your life. UCLA has a legacy of training world leaders in surgery, and you are now part of this incredible tradition. It is a privilege to be here, and it is our privilege to have you here.

This seventeenth edition builds upon an idea originated by Doctors Sarkar, Borud, and Walker. It was later revised and enhanced by Drs. Toyama, Dunn, Blinman, Rigberg, Foster, Heisler, Anselmo, Yoon, Duffy, O'Connell, Lavu, Brenner, Jim, Donahue, Schnickel, Agopian, McGory Russell, Morris, Vardanian, Juillard, Lewis, Chen, Chestovich, Burruss, Girgis, Kelley-Quon, Lawson, and now Kadera and Rochefort.

Contained within this survival guide are some practical gems that have served generations of interns before you well. Let it not be said, "I wish someone had told me this at the beginning of my internship!"

The information presented here should not be misconstrued to reflect official policy of UCLA, the Department of Surgery, any particular attending or House Staff (except the ones who wrote it). It is just an offering of wisdom to help you navigate sometimes seemingly incomprehensible situations, and help you succeed in this coming year.

## **SOME INTRODUCTORY TRUISMS AND UCLA PHILOSOPHIES**

### **1. ALWAYS CALL YOUR SENIOR (a.k.a. "FILL THE BOAT")**

Senior residents, and ultimately attendings, are responsible for the patient care provided on their services. They are eager to know about existing and potential problems concerning patients. *Always* call your senior or chief with new problems, nagging doubts, or patients who "just don't look right." Get your questions answered and your doubts allayed. There should be no surprises on morning rounds. Don't be in a sinking boat alone. Fill the boat, starting with your senior resident. It is far worse to deal with the aftermath of not calling your senior, than to talk to a sleepy or grumpy chief in the middle of the night.

A patient's hematocrit is 24; the intern decides to transfuse, and decides there is really no reason to trouble the senior. When the patient sees the blood hanging he panics, "Crap! I'm bleeding to death!" He calls his wife, "I'm bleeding to death! Come quickly!!" The hysterical wife pages the attending, demanding to know "Why aren't you doing anything? My husband is bleeding to death!" The attending has spoken with the senior who knew nothing about the transfusion and thus the attending knows nothing. He mutters unconvincingly, "Err, I'll check into it." Meanwhile, the patient is becoming short of breath because he has CHF and is becoming fluid overloaded by the transfusion. Later that night he requires emergent intubation for respiratory distress. His family loses trust in the attending. The attending thinks the chief is incompetent, and the intern is labeled as "dangerous." Everyone loses.

**Do not rely on text messaging. Think of them as FYI messages that don't require a response. If you need a response from your senior resident, page or call them. Phone conversations allow rapid 2-way communication.**

**If your senior does not respond to your page do not assume they got the page!** Do not assume they are comfortable with the information, and have *chosen* not to respond. Page them again. **Hammer page them, if necessary. Call their cell phone, (make sure you always have this on your signout list). Have the page operator page/call them until you speak with them in person.** If you find yourself starting central lines, a-lines, ordering STAT labs, starting drips, or calling consults, your senior should already know about it.

As an aside, if you can't reach someone, the Page Operator is your best friend (extension 66766). It is perfectly acceptable to call them and say "I need to reach Dr. Smith, and he hasn't responded to my pages." This does two things. First, the page operator will page and call every five minutes until they get a response. Second, it clearly documents that you were trying to reach the individual. There is no way they can come back later and say "I had my pager on all night but it didn't go off." Keep in mind, pagers are like cell phones, there are areas where they do not get reception. So if someone does not respond to pages, they are most likely not getting them.

## 2. ALWAYS ASK FOR HELP

Asking for help is never a sign of weakness. It demonstrates confidence and self awareness. Ask for help if you don't know how to do something. Ask for clarification if you are not sure what your seniors want you to do or expect of you. You will not know everything—nobody does. That is why you are here. You will NEVER be faulted for asking. Always bump problems you cannot handle up the chain of command.

## 3. ANSWER YOUR PAGES PROMPTLY

You will be paged *a lot*. The sound of your pager going off may elicit a litany of curses and eventually cause PTSD. You should still answer all pages promptly. You will learn how to prioritize, but do not ignore pages.

When nurses cannot get a hold of you, they will document in their notes "Doctor X paged at 9pm. No response." Sometimes they will then page your senior/chief or (yikes!) your attending. Then you will get a lot more pages. Worse yet, the nurse may page no one else, and important information (e.g., low urine output, abnormal vitals, increased pain, etc.) falls through the cracks, and patients have bad outcomes.

Nurses are sometimes confused about whom to page. Even if you don't recognize the name of the patient, ALWAYS CALL BACK. It takes two minutes to help the nurse page the correct person, you receive fewer pages, they are extremely thankful, and you have helped patient care.

*Why are there so many numbers?* Back in the days of wooden ships and iron men, pagers weren't alphanumeric. You probably won't have to deal with this unless you are at OV or the VA, but pages from another physician may contain the phone extension (e.g., 56170) followed by the PGY year so you know who is paging (e.g. 5617011111 (intern), 5617033333 (R3), 5617099999 (attending), etc.).

#### **4. TELL IT LIKE IT IS: Get the right information and DON'T LIE!**

Interns function as Information Managers. The team relies on you for timely and accurate data so that the right decisions can be made. Just because CareConnect says that the urine output on a healthy 25-year-old guy was 200 cc for 24 hours doesn't mean that's correct. Just because no nasogastric output was documented, doesn't mean there isn't 800cc sitting in the canister. This is how it works: the Care Partners/LVNs collect vitals, empty urinals and JP drains, and hoard the information in their pockets. Then they go on break. Five minutes before end-of-shift at 7AM, they madly enter the numbers into the computer. It's your responsibility to know your patients, scrutinize the data, and check with nurses to make sure it's accurate. This is a vital part of getting ready for rounds, and also helps identify gaps in patient care that need to be addressed to ensure that our patients are safe and receiving good quality care.

#### **Review all vitals, I/O's, labs and studies; if something does not make sense, is missing or looks wrong, call the nurse & verify or go see the patient yourself.**

There is sometimes the temptation to fudge details you have missed, because once reminded, you feel stupid that you missed what is clearly a relevant piece of information. For example, the chief asks, "Did he pass gas?" You don't know, but mumble "Uh sure, yeah." If the chief takes your word for it, and proceeds to feed Mr. Ileus, you may end up with emesis on your face. Chiefs know you work hard and don't expect you to know everything. Just say, "I forgot to ask" or "I don't know." **Don't lie.** If you lie and the trust is broken, it is almost impossible to repair.

#### **5. ENGAGE IN DAMAGE CONTROL**

You will make errors and encounter complications. We all do. Good surgeons know how to avoid trouble, but also know what to do when they blunder into it. You must pay to play. When you make a mistake, don't make excuses, and above all, **don't lie about it.** Change the way you do things to avoid the mistake in the future. Accepting blame also means discussing what happened with your patients. Always ask your senior to be involved in any such discussion.

#### **6. PLAY NICE WITH OTHERS**

Every year, interns get into trouble with nurses and ancillary staff for behavior that they perceive as disrespectful. People will address you as "Doctor," then ask you to perform duties that are beneath your level of education, training and dignity. At times what you are asked to do is frustrating, demeaning and belittling. This can be especially and painfully obvious at the VA. **Remember that respect breeds respect.** So, rather than yell at the nurse who calls you at 03:00 to tell you that a patient wants to resume her birth control pills, just say, "I'll take care of it," and move on to the next page. Getting mad wastes your energy. Worse, you will soon acquire a reputation among the nurses for being a Big Pompous Ass. And there are those among the nursing staff who delight in calling Big Pompous Asses all night and torturing them with trivia. Remember, a nurse is not a doctor. You can't expect them to perform at your level. The nurses can be your greatest ally, especially in the ICU. Make friends with them and do it early. If you have a bad interaction with a nurse – fix it. Be the bigger person, apologize. There will be moments when you are filled with blind rage. Do not act on this rage. Do the opposite. Be exceedingly polite and work through the problem.

If you treat everyone respectfully, someday, someone will remember who you are, and they will go out of their way to do nice things for you. They will feed you late at night, your STAT labs will get drawn super STAT, and people will smile at you and thank you. They might even throw you a farewell party at the end of your rotation (yes, it has happened).

Remember, most nurses have been here a lot longer than you and what they say about you to the faculty can carry a lot of weight. More importantly, they can really help you too. We all get angry and lose it sometimes. Just remember that **we are all working together as a team to deliver the best patient care possible**.

Good manners also extend to fellow interns and residents, perhaps more so than anyone else. The medical world is **small**—everyone knows everyone and institutional memories are long. Remember that "please," and "thank you," always go a long way.

## **7. BE A TEAM PLAYER**

You are in the trenches with your fellow interns and residents. So take care of each other. You will carry each other through residency. Do not dump your work on others, and be willing to help each other even if it isn't your problem. Do NOT try to take cases away from a fellow intern or scut them out. Remember: we don't get much free time. Prioritize your colleagues – they will be much more willing to do you a favor if you have already done one for them.

## **8. OWN YOUR EDUCATION**

While much of your time as an intern will be spent gathering information and passing it along to others, always remember that your primary reason for being here is to learn to be an outstanding physician and surgeon. Therefore, always keep in mind that you (yes, YOU) can use the information you gather to make decisions and formulate plans for your patients. In other words, synthesize those vitals with your physical exam, lab values and x-rays and all of a sudden, it is clear what is wrong with your patient and what you need to do. Then, when informing your chief about a patient's recent deterioration, instead of rambling off a load of digits and then pausing for a response, you can state what you think is going on and what you want to do about it. Also remember that what on the surface appears as "scut" is important and can be an educational opportunity. Your practice in surgery begins now. An example:

The trauma R1 follows up on radiology readings of CT scans. You can either ask the radiology resident to call you after they've read the scans to tell you their findings, or you can go to the reading room and read it with them. The former makes you a diligent intern; the latter makes you more adept at reading CTs than some radiologists.

In general, you do not need to examine patients prior to rounds – the chief/senior resident will examine everyone on morning rounds. We know what we are looking for. This does not mean you cannot also examine the patient or change their dressings. You have to examine hundreds of patients before you develop trust in your own hands. Do you know what an acute abdomen feels like? Distention? Peritonitis? Examine your patients; look at their wounds for yourself.

## 9. BE PUNCTUAL

Be on time. Do not ever be late to M&M or grand rounds. Your tardiness will be noted by Dr. Donahue and the senior attendings sitting in the front row. If you are late, do not walk in with a coffee and croissant. Come in quietly. This applies to resident/intern conferences, team/attending rounds, and the OR. You should never arrive to a case or conference *after* your attendings.

## 10. BE PREPARED

You are expected to gather the vitals and In's & Out's prior to morning *and* afternoon team rounds, and make sure that they are correct, despite what CareConnect spits out. Preparing for afternoon rounds means following up on what was ordered in the morning: results of studies, recommendations from consulting teams; Did the patient eat okay? Did he urinate after the Foley was removed? Did he respond to fluid boluses? And so on. Prepare for afternoon rounds just like you prepare for morning rounds. If you changed diet orders on a patient at 7 am, by the time you round again at 4:30 pm, you should know whether the patient tolerated his or her diet. **You should know your patients better than anyone else on your service.** You are expected to know not only their post-op/hospital day, diet, and antibiotics, but also their current medications and labs. When you complete your morning tasks, go through each of your patients to check their medication lists, make sure they are on their home medications (if applicable), check if any new culture results are available, check the final radiology reads for radiographic studies that you've reviewed as a team (CXR's), and read consult notes from other services. ***Be organized:*** You do *not* need to memorize everything, but you should have your way of keeping track of all patient information. Your system can be your own, as long as it works.

If you know ahead of time you will be operating, review the patient's history, labs and imaging. Know what operation you are doing, review the relevant anatomy and know how the operation is done. Have the imaging studies open and ready to review before the attending walks in the room.

## 11. DOCUMENT OFTEN, ACCURATELY & COMPLETELY

You will at some point in your career be involved in a lawsuit and documentation can save you. Always document that you have obtained consent for any surgical procedure (central line placement, chest tube, removal of tunneled catheters, etc.), then write a procedure note when you are done. It's easy – CareConnect has templates.

If you get called to see a patient who is not doing well (e.g. chest pain or respiratory distress), go see them. Then document what you found (vitals, exam, etc.) and any interventions you made (after discussing the problem with your senior/chief resident) and the outcome.

***Important:*** Please dictate or type all discharge summaries and inpatient consultations, sign them and send the consultations to the appropriate attending for addendum in a timely fashion. Attendings' OR privileges get suspended if discharge summaries are delinquent. This actually happens, and the attendings get very angry at you AND your chief. All consultations must include the name of the requesting physician. When dictating discharge summaries, "resume all home meds, vicodin and colace" is not adequate. You must dictate *all* medications that the patient is discharged on.

## **12. SEE THE PATIENT**

Go see the patient BEFORE calling your senior/chief—*unless the patient is coding*. You will learn more from trying to assess the situation and formulating your own plan and *then* corroborating your ideas with your seniors than by having them tell you what to do all the time. When you call your chief to report that the patient's potassium is 6.7 and you have not seen the patient, requested a repeat lab draw, stopped the D5 1/2NS + 20KCl, or requested an EKG, the conversation will not go well.

Likewise, you should never refuse to see a patient when requested to do so by the nurse. Many times, the problem is not serious, but it can also be life-threatening. For instance, sedative requests for agitated patients from frustrated nurses are an invitation for disaster; your Ativan order will ensure that Mr. Hypoxemia will need to be intubated...if the nurse examines him frequently enough.

Now that we have electronic medical records, patient myths are constantly perpetuated by the cut and paste note method: a two second exam personally by you often rights two years of wrong notes when you discover Mr. Occlusion had a right BKA, not a left BKA.

## **13. BE HELPFUL**

If a nurse or consulting physician has paged you in error (i.e., you're the vascular intern & they want the consult resident or they want the trauma intern), please BE HELPFUL and direct them to the appropriate consult service/resident. To our medicine colleagues, all surgeons are the same. Why else do they address us all as, "Surgery, right?" Sometimes you will get asked by nurses about another service's patient or how to do something they are unfamiliar with. Instead of hanging up on them or dismissing them, try to help them resolve their problem. If you're nice to them, nurses will respect your need for sleep and try to avoid paging you.

## **14. BE EFFICIENT**

Learn to prioritize and multi-task. Some things are not important, while others are life-and-death. For example, you should probably check the CXR on the patient with the decreasing O2 sats before you take the staples out of Mr. Bill's abdominal incision. It will take some time, but these things become clear. Also, it is important to take care of tasks early if they require follow-up. Ordering a CXR after writing all of your notes does not make much sense. Figure out how to arrange your work so that there are other tasks to do while waiting for results.

The following list is a reasonable order for conducting your daily activity. Group tasks together, so you don't have to go back to do things. In general, your priorities should be:

1. Ensuring OR cases start on time (H&P, consent, site marked, etc).
2. Discharges
3. Same day studies/consults

4. Notes, routine patient care, dictations, etc. Get your notes done! Don't wait until the end of the day, or worse, put them off till the next day.

## **15. SIGN OUT**

This is a CRITICAL part of medical care, especially given work hour restrictions. You should outline what is worrisome for each patient and clearly identify the on-call senior/chief. A good signout list should include: location of patient, patient's medical ID number, attending involved, diet, active issues, and what needs to be followed up. All service signouts are generated from CareConnect. The intern is responsible for ensuring all patients and consults are on the list.

## **16. CROSSCOVERING AT NIGHT**

Learn to "tuck" patients in for the night. You should cruise by and see any patient that was worrisome during the day and all ICU patients once during the night, not just the ones the nurses call you about. You must make notes as to what happened so the sign out in the morning is complete and clear. Consider yourself an active continuation of the day team – you are not just “putting out fires.” The day team is not expected to have every last little thing done before leaving, so expect that there will be studies to follow-up or transfer orders to write. If you are the night intern and you cannot get a hold of your senior for a sick patient, the trauma chief is always available to help. Always. Even for urology patients.

## **17. THE PASSARO DIRECTIVE**

This rule is most applicable to the VA, but applies to all hospitals, and will follow you through your career. In brief, it is: All requests for assistance, "oh, by the way," "just wanted you to know," "you don't really need to see him," "maybe you could just cruise by," “wanted to give you a heads-up” or “wondering if you could just lay your hands on the patient,” are actually cries for help and should be staffed as a formal consult. If you go see a patient that some medicine resident says is having rebound tenderness and you find a patient sitting up eating ravenously and asking to go home, consider it a victory. However, before the year is over, you absolutely will have true stories like these:

In the middle of an incredibly hectic day of patient discharges, admissions, clinic and OR at the VA, the ER resident pages to say, "We have this old guy brought in unresponsive from home...yeah, yeah I know that's not a surgical problem, but we put a Foley in and feces started coming out of the Foley. We just wanted to give you guys a heads-up. Do you think you could just cruise by sometime and see him – it's not really an emergency." The intern, wise to the ways of the ER, sprints downstairs where he finds an elderly man tachypneic at 44 bpm, cold, blue, hypotensive with a pressure of 80, and unresponsive. A nurse volunteers the information that an admission blood gas had a pCO<sub>2</sub> of 68, "so he must be a CO<sub>2</sub> retainer – you know, from COPD or something." The intern intubates the patient, and with the help of a fellow intern, starts 3 more IV access sites, calls the senior, starts antibiotics, etc., etc. The intern and senior flog the patient all day and night in the ICU, and the patient survives . . .

You are asked to “review a CT scan” and render an opinion. A 67 year old patient with a history of a double lung transplant and a 16 hour history of abdominal pain and vomiting comes to the ER at 10 pm. His CT scan shows multiple pancreatic cysts and biliary dilatation, both of which have been seen in the past. The admitting medical service calls you to ask what should be done about these CT findings. After

looking at the CT, the resident refers the medicine team to the C Surgery Service for further management. The next morning at 11 am, the C Surgery Service resident is contacted about this patient, who was “seen by surgery” the night before. They are concerned about his increasing pain, unrelieved with 10 mg morphine. The C Surgery resident sees the patient, and finds him to have peritoneal signs. A review of the final CT read from earlier that morning suggests a complete bowel obstruction, which was missed by the on-call radiology resident. The patient is red-lined to the OR, and 20 cm of dead bowel is resected, secondary to adhesions from his prior appendectomy. Had the resident the night before seen the patient, he might have recognized that the patient’s problem was not related to pancreatic cysts or biliary dilatation. ALWAYS SEE THE PATIENT, even if it’s not specifically requested.

You should *never* refuse to see a consult when asked by another service. "A consult is a cry for help." No matter how ridiculous you think the consult is, the requesting team is asking for your help. Do not underestimate their need for help or your ability to provide it, even as an intern.

### 18. NEVER TRUST THE LIVING

Quality patient care rests entirely upon knowing what is really going on. The best way to figure that out is to examine radiographs, feel abdomens, and listen to lungs. Descriptions of clinical findings often differ greatly from reality ("It's just some cellulitis" can frequently mean a severe life-threatening necrotizing soft tissue infection). You will be able to recognize these distinctions much better than your Medicine and ER colleagues who rarely see these presentations.

When a nurse calls and says Mr. Glomerulosclerosis has a potassium of 3.2, DOUBLE CHECK the lab before repleting potassium. Check and double check before you remove drains or diurese or bolus fluids. Removing an NG tube from a post-gastrectomy, esophagojejunostomy patient on POD 0 does not make sense, and yet you may be asked to do so (or think you are asked to do so). Double check with the chief to be sure.

**Remember, you are highly educated and have a brain.** Just because your chief or the attending asks you to do something does not mean you proceed as a mindless zombie. Your superiors make errors, and you are the last line of defense. Your chief may ask you to start a patient in renal failure on prophylactic Lovenox – you might be the last line of defense between them and a certain death from hemorrhage. Never trust the living.

### 19. EIGHTY HOURS

Remember that we are physicians with strong commitments to patients’ well being and not shift workers. Nevertheless, we have taken great steps to ensure compliance with the ACGME work hour restrictions. Compliance requires tremendous efficiency and detailed sign-outs to ensure excellence in continuity of care. You must keep track of your hours on a regular basis to ensure that this will remain an accredited program. And, you must stay within the restrictions. However, this does not mean that you should leave at 18:00 when three trauma MVAs roll in at 17:45. You can stay to help stem the tide and tidy things up to a point; you'll just need to remind the chief to let you out a little earlier on a slower day. If you are in danger of violating your work hours, you MUST let the seniors know IMMEDIATELY. Only if you let them know can the problem be fixed. If you don't let them know, your chief will be called into Dr. Donahue's office to discuss YOUR work hours. You do not want this. Do not lie when you log your hours. If there is a problem with work hours, we want to know about it so the issue can be addressed in a timely fashion.

## 20.MEDICAL STUDENTS

Like everywhere else, the students here present a spectrum of knowledge, motivation, and attitude. Some will astound you with their appallingly poor work ethic and disdain for you, their patients, and their fellow students. Others will function at a higher level than interns. Most surgical services at UCLA do not have a structured or well-defined role for students. It's to your advantage to incorporate them into your team, provide them with patients to follow, and communicate your expectations. Students can be a tremendous help in your daily work, but you **MUST** help them by making them feel like a part of the team, providing guidance and feedback and giving them meaningful and educational tasks (not just scut). The senior will set the tone; some will be very involved with the students and others not so. Either way you can make a big difference to their experience. Remember what it was like for you as a medical student. Assign tasks that are appropriate for medical students, but remember, shit rolls uphill. You are ultimately responsible. Just because you have assigned pre-rounding responsibilities to the STUD, doesn't mean that you don't need to review and ultimately be responsible for all the numbers too. Your protest, "I thought the student did it" will fall on disdainful ears.

Remember that the third mission of an academic career is teaching. You have a responsibility to teach what you can, and may be surprised to find how much you have learned. Teaching medical students doesn't mean preparing a formal ppt presentation. A good resource to find appropriate med student level surgical questions is **Surgical Recall**. Easy teaching opportunities include assigning the medical student to research a clinical question that came up on rounds or picking an important paper for them to present to the team. Encourage students to scrub in and do **SOMETHING** in the OR, even if it's just to apply steri strips and dressings. The surgical clerkship is often their only opportunity to do anything hands on during their 3<sup>rd</sup> year rotations and they want to be helpful in the OR. Make sure to give them structured feedback as needed throughout the rotation.

Should you encounter a student having significant difficulties, such that you are planning to give them a very poor evaluation (or failing grade), it is imperative to notify the UCLA Surgery Clerkship coordinators early – preferably while the student is still on your service. The school has avenues to intervene for students having trouble. Furthermore, if they are going to fail, the school needs to cover their bases and make sure that it is justified, and thus it is best to notify them early.

## 21.DRESS CODE

Appearance is a huge part of professionalism. As a general rule, you should dress for the job you want (i.e. attending surgeon) and not the job you have (lowly intern). You can never go wrong in dress clothes and a clean white coat; always have some available. The unshaven, ragged-appearing, dirty intern looks as if he/she cannot handle the job.

**VA:** Service-dependent, but dress clothes mandated for Monday and Friday clinics for general/vascular surgery.

**UCLA:** No advice may be safely given, but certain services allow scrubs daily: Trauma (L/A), CT, Liver Transplant, Ortho, Plastics, Urology, Neurosurgery. Ask your chief and the prior R1 for specific expectations. **NO ONE SHOULD COME TO WEDNESDAY MORNING CONFERENCE IN SCRUBS, EXCEPT THE TRAUMA TEAM.** Dress clothes should also be worn for attending rounds, clinics, and service conferences at UCLA. Scrubs can be obtained in the men's and women's locker rooms on the 3rd floor of RRMC. You will be assigned a locker in the OR at RRUMC (for categorical general surgery residents) and a locker in the B level of RRUMC.

**Olive View:** Scrubs are supposed to be worn inside the hospital only. Don't let Dr. Bennion see you wearing OV scrubs in the parking lot. The OR staff requires that you wear only OV scrubs while in the OR there. They will make you change into those funny looking paper scrubs if they catch you in UCLA scrubs. You pay a refundable scrub deposit for these items. You are required to dress up for all of the general surgery clinics and conferences, including those when you are post-call and if Dr. Bennion is on call over the weekend. The rules on the plastic surgery service are more relaxed and usually fellow dependent.

**White Coats:** White coats are provided by UCLA and can be exchanged on the "B" level in the RRMHC hospital building. You will be given 2: keep them clean and exchange them when they're not. Unlike some of those swanky east coast programs, we do not expect our interns to look like ice cream vendors. White pants are relegated to the tropical vacation pile where they belong and short coats are worn by medical students only. Some R1s have a habit of ditching their white coats and walking around in scrubs only. This is against hospital policy, scrubs outside the OR and OR lounge must be covered. Best to cover with a white coat. A UCLA monogrammed fleece is not a replacement for a white coat, regardless of whether you are in scrubs or dress attire.

## **22. READING**

Yes, reading is essential. There will be time to read. And read you must: Your formal education is over. Doctors must be in large part self-taught. None of us could have come so far without the ability to direct our own learning. Read a little each day. Try to read for at least 15 minutes during the day, and do this while at the hospital (between cases, while waiting for studies, any free time).

Some useful online sources:

The SCORE curriculum ([www.surgicalcore.org](http://www.surgicalcore.org) or link via [surgery.ucla.edu/resident](http://surgery.ucla.edu/resident)): Great reference for surgical technique and general surgery as a whole. The content is continually expanding, and this has become a centerpiece of our surgical education.

UptoDate – link is on Mednet home page. Awesome for quick references and medical information. Can also install the app on your smartphone

[www.mdconsult.com](http://www.mdconsult.com) - this is accessible from most UCLA computers. You can easily perform Medline searches and review journal articles, plus there are full textbooks including Sabiston.

[www.surgerylinx.com](http://www.surgerylinx.com) - this website has the most recent abstracts from various surgical journals. It's a good way to stay on top of the literature. You can even have them email you daily updates.

[www.websurg.com](http://www.websurg.com) – this website has a large collection of teaching materials for laparoscopic surgery

## **23. PRACTICE YOUR KNOTS**

It is expected that at some point in the not too distant future, an attending will throw a stitch at you and say "tie that." How you respond in that moment will often dictate your level of involvement in the remainder of the case. You could spend it slamming down knot after knot, or you could find your arms aching from retraction. Truth be told, there is no single greater surgical skill which showcases our technical abilities. You could know your anatomy better than Henry Gray himself; if you can't

tie knots you might as well be a pediatrician.

What can you do about this? That's easy – PRACTICE. Practice every day. Practice between cases. Practice when you're waiting for your seniors to round. But even before your hours of practice, you must first learn the correct way to tie. Otherwise, you will create erroneous muscle memory that you will need to quickly remedy in Jay Lee's OR. Ask your attendings early on about correct knot-tying technique. Dr. Hiyama is particularly good at teaching operative technique, so take advantage of your hernia cases with him.

Many interns learned to tie knots in medical school, but haven't tried in several months. It would be prudent to re-learn this skill, and practice often. If you think you can do a pretty good two-handed knot with 0-silk, try with smaller suture. Then try monofilament. Then try one-handed. Then try with gloves on. Then try your non-dominant hand. Then try tying in a deep hole (like say, the pelvis.) Then try monofilament you can barely see. In fact, keep practicing until you can do it without thinking. Until you can tie a 7-0 prolene, one-handed, with your non-dominant hand and your eyes closed, you're not done practicing.

## 24. USE TECHNOLOGY TO YOUR ADVANTAGE

Take notes on your smart phone. There are several very useful apps such as *iOS Notes*, *Evernote* and *NoteMaster* that you should start using as an intern. These programs allow you to create notes and store pictures and pdfs that are sync'd with your computer and phone. Start creating notes for how to do each operation you are involved in, general disease processes, pre and post op evaluations, etc.

Build on these notes for your entire training and they will be your guide for your written and oral boards.

Many of us have unsuccessfully tried to take handwritten notes in small binders that we would inevitably misplace, forget at home or not have on hand in the OR. We all carry our smartphones everywhere. Get in the habit of inputting everything you learn into one of these programs. You will look like a superstar if you walk into an attending's OR fresh out of your lab years and still remember how they like to do a hernia repair because you referenced your notes from intern year.

Use the *UCLA Residency Mobile App* and the *UCLA Antibiotics Guidelines*. The mobile app allows you to send pages from your phone and check the education schedule. There are some service guidelines there and the site is always being improved. The UCLA Antibiotics Guidelines are hospital specific guidelines to treat particular strains of infections rampant at UCLA. The guidelines can be accessed through the Mobile app or on the Mednet homepage.

## 25. USE SOUND TEXTING ETTIQUITE

Texting your senior's cell phone can be a useful way of communicating non-urgent information. However, as an intern, you may not always know what non-urgent actually means and your texts also may not be delivered. An easy rule of thumb is that **if you send a text about ANYTHING, you need to receive a confirmation text from the recipient to ensure it was delivered**. You should never send a text saying "Ms. Johnson is hypotensive and tachycardic but stable. Just wanted to give you an FYI." with no response from your senior. Even worse is when it's done in the middle of the night and your senior wakes up in the morning to find a 4hr old text with critical information, even though you thought the patient was fine. Some seniors prefer to be paged for anything late at night to

avoid text messaging snafus, so be sure to clarify how they want to manage texting.

## **SOME KEYS TO SUCCESSFUL PATIENT CARE**

### ***ICU BASICS:***

**1. Talk to the nurses.** They are generally knowledgeable and have been with the patient all day. Many have been taking care of ICU patients for years. *You will learn a lot from them!* They know what's been going on, why, and when (i.e., why vent settings were changed without your knowledge, what has been coming out of which tube, why some hardware is different than it was on morning rounds, what consultants mumbled about on their rounds, etc.) Being a nice guy is especially true with ICU nurses. Remember that the nurses are on *your team* and will try to do their best for *the patient*.

**2. Tell the nurse when you write an order.** This ensures that it won't be missed and will be done in a timely manner, and allows you to avoid being paged later when a nurse is unable to decipher your cryptic instructions.

**3. Read the chart.** Sometimes this is the only place that attendings and consultants will leave their wisdom. You will look foolish when you page ID in the afternoon only to realize that they left their recs in a note written 2 hours ago. Read the chart and read it often.

**4. Write transfer orders early in the day.** This saves you time, and increases the likelihood that the patient will be moved during daylight hours. Giving a call to "Bed Control" will also give your patient that best chance of getting out of ICU before the other patients.

**5. Avoid touching the ventilators.** This is apparently punishable by death. The Respiratory Therapists jealously guard the vents from others - this is a ridiculous rule, but that's the way it is. When you write ventilator change orders, specify whether or not you want an ABG. An ABG is not necessarily required for every ventilator change, but nurses will draw them "just in case" unless you tell them not to. Lest you get the wrong idea about the RT's: They are very helpful and usually will take the time to explain any questions. But they want you to leave their vents alone. You are allowed to change the FiO<sub>2</sub>, but only that!

### ***CONSULTS:***

Whether or not to call a consult depends on attending preference and economics. Consults are expensive, and sometimes can lead down a seemingly overaggressive path (e.g., the infectious disease consult for management of complicated diverticulitis that recommends the patient be placed on 4 IV antibiotics for one month, with weekly CT scans until all inflammation is gone). NEVER request a consult without the approval of the chief or attending. In addition, ask whom you should consult. The surgery attendings often consult specific attendings or groups.

Good manners dictate that you call consults as early as possible. When you are the one taking calls, you will invariably be consulted at five p.m. for a problem that has been stewing all day. You can't prevent the medicine or peds residents from doing it to you, but don't be a hypocrite and dump on your fellow doctors. **Always have a reason or specific question to be answered before calling.** It is poor form to call a Cardiologist and say "Er, my team told me to consult you...what? Yes I think the heart is involved...what's their name? Uh, hang on a second...is it Mr. Smith? Or, no wait!" Get your facts organized before you pick up the phone. If you don't understand the reason for the consult, clarify this before you call. Similarly, if someone calls you with a consult and doesn't know why they're calling, go see the consult, but you can **politely ask them to find out the specific question they want you to answer.**

At the VA, obtaining a consult may be fraught with obstacles. While Medicine has no problem calling you at 1700 on Friday night to check their patient's decubitus ulcers, they are Endangered Species Candidates whenever you need them. All will deny that they are on call -- if they answer the page. Instead, go directly to the medicine chief resident if you have problems. That will usually bring results. And don't forget to fill out the Consultation Request Form in the computer.

On the flip side, if you are called to DO a consult yourself, be conscientious, courteous, prompt and complete. GO SEE THE PATIENT in a timely fashion (this usually means ASAP if the consult sounds bad, or within an hour otherwise). Do a complete H&P, review all the pertinent labs, meds, studies, and then CALL YOUR SENIOR or attending to examine/review the patient. If the consult sounds truly emergent (ie free air, pneumothorax, necrotizing fasciitis, etc) tell your senior **immediately** so they can evaluate the patient with you and possibly intervene immediately. Once you have formulated a plan close the loop of communication and page/call back the requesting service to give your recommendations. **Unlike medicine consults, surgery consults are usually requested to find out if an urgent intervention should be performed, don't rely on your consult note to relay this information.** Write a consult H&P, including your assessment and plan. Don't leave it for later, or you won't get to it.

### ***PROCEDURES***

RIs are supposed to be supervised for central line placements. You will be enrolled in a one-day course to learn the proper technique, and receive some technical pearls. In addition almost any senior resident will gladly teach you the right way to do lines. You will become quite proficient at this during your intern year and will be able to place lines in the sickest patients on the planet. That's right, the hypotensive pre-liver transplant with an INR of 4 and 5,000 lonely platelets circulating will be your bread and butter. In addition, don't forget to write a very brief note after any procedure. Be sure to check a chest x-ray (and document the results) after every line placement--or placement attempt!

### ***BOOKING CASES FOR THE OR***

In medicine, and in life, there are documents for everything. There will be countless opportunities to book cases for the operating room, and it will often be your responsibility to make sure all the *i*'s are dotted and the *t*'s are crossed.

***Dropping a slip:*** This is the first step. It requires an OR booking slip (available at the front desk of the OR), with the patient's sticker applied to the front. You need to fill it out the case status (blue = elective, green = urgent < 6 hours, red = emergent). When in doubt, clarify with your senior the case status. The elective hernia repair should not be booked in the same way as the acutely incarcerated and strangulated hernia repair.

***Update the H&P:*** In order to get in to the OR, the patient must have an H&P less than 30 days old

If there's not one in CareConnect, you will need to redo it. You can fill it out the night before, pend the note and update vitals, PE, etc when you see the patient the next day. Do not complete the H&P before the patient enters the hospital. This is unethical and a big red flag for the medical record auditors and nursing staff, and it will be reported to Dr. Donahue.

**SCIP note:** This is a quick template note in CareConnect that must be filled out before every surgery documenting that there is an H&P and what the plan is for perioperative antibiotics. Make sure you do not sign the SCIP note before seeing the patient. The nurses will notice and report it to Dr. Donahue (seriously, it's also a big deal to them).

**Surgical and blood consents.** These must be signed prior to the patient going to the OR. Consents can be done in clinic at the time of consultation and scanned in or saved as an electronic document in iMed Consent, but more often are done the same day of surgery by the resident performing the case. Occasionally you will be asked to consent a patient for another resident who is running behind, and this is fine. However, **you should aim to consent every patient you operate on.** This helps you build a relationship with the patient and allows you to take ownership of the case and articulate your understanding of the complications associated with a given operation.

The consent form is simply documentation of a conversation that the attending/resident has had with the patient regarding the surgery and its risks. **It also never expires, contrary to what the PTU nurses might say.** If the patient seems confused or you don't know what to include in the consent, ASK YOUR CHIEF. Consents cannot include any abbreviations. At UCLA, patients need to sign a new blood consent prior to every surgery.

**Mark surgical site.** Do this if it is a sided operation (e.g. left below knee amputation) with a marker. If not sure, it never hurts to mark the site. If nothing else, it shows your attending that you've been there before they have. At the VA, you will be asked to mark the patient for every operation, even an appendectomy, gallbladder, etc. Yes, this makes no sense, and no, you will not be able to change this policy.

In general, patients will need to be packaged for the OR (i.e. H&P, NPO status, labs OK, pacemaker issues, consent signed and on chart). If these are not done, the patient will not be allowed into the OR and you will have committed the most mortal of sins: **"Delaying the Case."** Nothing incites a surgeon's wrath more than delaying the case. Avoid it at all costs.

#### **FLOOR CARE:**

**Blood Draws:** Order AM labs in the afternoon (and order then for 3AM), after you've seen the results from that morning and discussed whether the patient needs additional labs. Think about what you need: remember to ask your team and if in doubt ask yourself, "Will this result alter the patient's treatment?" If the answer is no, don't order the lab. This means, no matter how tempting, do not order labs repeating every AM for 7 days.

It is often faster to do it yourself if you didn't plan ahead or need a result in a hurry. At the VA, there is a morning and afternoon blood draw. If you miss these, your STAT labs are going to be delayed. Keep in mind, nurses can start IV's, but sometimes cannot draw blood. **If an ABG is needed on the floor, 99% of the time, you have to do it yourself.**

**Radiology Studies:** Order these early. You can also call the radiology department to ensure that the order was received, call the tech to politely emphasize the urgency of the study, go down to radiology to pick up the oral contrast yourself or talk to the attendings as needed (they are usually here by 8:30 am).

**Discharges to Other Facilities:** Call a discharge planner or the service's nurse coordinator. They already know all about the facilities, transportation, etc. This is what they do. Use them! They will tell you what is required for transfer. The catch is that they only work banker's hours so you need to think ahead of time if you are coordinating a discharge over the weekend or after hours.

EVERY INTERFACILITY TRANSFER REQUIRES A D/C SUMMARY IN THE CHART. If there is any chance that the patient may be transferred, dictate or type a stat d/c summary. Even if the patient doesn't leave that day, the summary can always be updated. If the patient is held up for lack of one, you will be the one everyone will blame.

### **SOME USEFUL RESOURCES:**

The following departments at UCLA are excellent, and will save you untold hours if you make proper use of them.

**Physical Therapy:** The therapists will work with your patient Monday through Friday, but only over the weekend on rare occasions due to limited staffing. Try to initiate consults before Friday afternoon, and remember to re-consult with a formal order in the chart whenever a patient changes levels of care (i.e., moving from the ICU to the floor.) If you want PT to see the patient that day, you must order the request before 7am.

**Nutrition:** They can provide a wealth of useful information regarding feeding formulas, caloric needs, goal tube feed rates, special formulas for renal/hepatic failure, etc.

**Pharmacy:** Sometime during the first week, pick up an antibiotic dosing card from any UCLA floor satellite pharmacy. If you have any medication or dosing questions, especially during the first few weeks, call the pharmacists. They are friendly and willing to help. They know dosing, side effects, PCA forms, and overdose protocols. They can also give you information on patients' past medication history from previous hospitalizations.

**Social Work:** "Not just for discharges anymore!" The social worker can also help with the 'difficult' patient during his/her hospitalization.

**Discharge Planner:** To know them is to love them, especially on Trauma and Neurosurgery. Call them as soon as you even consider a patient might need discharge to another facility. If you can figure this out several days before the patient is ready to leave, this will save time and get your patient out of the hospital faster.

**Home Health Coordinator:** Although these intrepid warriors on the front lines of decreasing hospitalization costs have been known to work miracles for a Saturday morning discharge on Friday at 1645, they will love you more if you give them more warning. If you think a patient will go home in a few days and needs dressing changes, TPN, antibiotics, nursing visits etc., give home health a call. They will set up everything for you and they won't get angry if you have to delay a few days at the end.

### **TYPICAL DAY FOR AN INTERN:**

**5:15 am** Pre-round: Get sign-out from the night team. Obtain vitals, Ins/Outs, labs for all patients

(make sure CareConnect is correct), examine key/concerning patients. Most of the teams now have Nurse Practitioners to help with these tasks.

**6:00 am** Team rounds. The Chief or senior resident will tell you how they want the patient presented and will examine the patient with you.

**6:45 am** Pre-op. Generally the whole team will go here at the end of rounds. If rounds are running behind, a few members might be sent down early to get things started. Please see above “Booking cases for the OR” for the items which are required.

**7:00 am** Breakfast. Just like you’ve been doing your whole life. This may be the only meal you get all day, so eat up!

**7:30 am** Do floor work – discharges and consults first. Finish daily progress notes. Go to OR or clinic when appropriate. Usually clinics don't start until 8:00 or 8:30AM so you will have some time to do floor work and eat.

**9:00 am** Follow-up on labs, studies, patient status, etc. Do not transfuse patients before checking with your chief resident/attending.

**1:00 pm** Pre-round for afternoon rounds. Know vitals, I/O’s, labs since morning rounds. Follow up on any radiologic studies done that day. Get readings from attending radiologists-- they can also teach you how to interpret the images if you're nice and interested. Follow up on consults; if the patient has been seen, know the recs. If not, know why they haven’t been seen yet.

**5:00 pm** Sign out

**Morning Rounds:** Morning rounds are all business; fast, effective team rounds require good participation from all team members.

**SOME TIPS:** Listen to the conversation between the patient and chief resident, make mental notes of their physical exam and the anticipated plan. When your chief says to the patient, “Sure you can have Strawberry Quik with your meals,” it probably means that you can place a scut box saying “advance diet.” Confirm those plans that can be immediately executed and those that need attending approval.

You can help to speed things along on rounds by making sure dressing change supplies are immediately available at the bedside, perhaps in a pocket or with the medical student). When your senior begins examining the patient, don’t just stand there like a bunch of construction workers – participate! Help get the patient positioned properly, strip the drain, and remove dressings on POD2. This speeds things along, and helps everyone get done in time for a nice breakfast, which keeps everyone on the team happy. A good rule of thumb is that if you find yourself standing still and waiting, you should probably be moving and doing something useful instead.

Make sure you keep a scut list--forgetting is easier than remembering, and the excuse “I forgot” works once—maybe. When you see an empty box on your scut list, you should be overcome by an incredible urge to finish the task, check off that box, and win the game by the end of the day.

**Afternoon Rounds:** These generally occur once the chief is out of clinic/OR. Finish up floor work and update signout for night team. You lead rounds. Know if your patients moved rooms (which

occurs frequently). You know your patients best, and you are the one who has all the information. Do not save nasty surprises for rounds! If something exciting happens during the day, let your senior resident know. It is bad form to start PM rounds by saying, "Mr. Richards had several episodes of V. fib today and required urgent treatment by the code team." **This information should be communicated in real time to your senior resident, even if this means going into the OR and telling them in person.** If it is getting late and your seniors are all stuck in the OR or clinic, it is usually a good idea to round on your own and update the team.

**Go to the OR:** Remember this is a surgery residency, not medicine. Although it might be tempting to finish up all your work and surf on Facebook, you should use any extra time in the day to make yourself known in the operating room. If you have some free time, ask if you can scrub in – no one will tell you no. Aside from giving you a chance to see how cases are done, you can participate, see anatomy and pathology, and will generally be seen as a superstar.

**Write Post-op Orders:** This is a lost art. Back in the glory days of surgery residency, interns were expected to come to the OR and write all post-op orders. Few, if any, seniors will chastise you for not doing this nowadays, but considering the amount of extra help we have now for inpatient care, there is no reason it can't be done. It is a wonderful feeling to finish a long case and find that your intern has graciously started the orders. Aside from being a big help, it shows that you have already thought about what the patient's management plan will be.

***THERE IS ALWAYS HELP AVAILABLE:***

There will come a time when you are presented with a patient who will enthusiastically try to die on your watch. If you find yourself confronted with such a patient, don't be the hero. You are never left alone, call for help. Fill the boat. And, don't forget to call your own senior. Experience shows that UCLA surgery residents are true blue commandos and will come right in without question if you sound the alarm.

**In the case of an emergency that you need help with (e.g. code blue) there is always a Trauma Chief (p95551, x76455) and Trauma R3 (p95550, x76454) in house – they are always available to help out while you are waiting for your senior to come in from home. There is also always a SICU attending and usually a SICU fellow in house. If you have a patient who needs to be transferred to the ICU, let them know early and they will help you.**

***RADIOLOGY READS:***

There is always a radiologist on call, and despite the fact that they are busy at night, you should call them if you have questions (if the study was important enough to do in the middle of the night, it is

important enough to be interpreted in the middle of the night). On call radiologist residents sit in the GI radiology reading room (find out where that is during your first week). Read with them and learn something.

During the day, **Dr. Barbara Kadell** is the queen of abdominal imaging. A Kadell radiology read is rarely second guessed. Be exceedingly polite and courteous to Dr. Kadell. She is an important ally to the surgeons and her reads often change our surgical management.

While as a senior resident you will likely be more skilled than most of the radiology residents at reading abdominal films, as a junior resident you are still learning. As an absolute rule, ALWAYS review films first, and then talk with the radiologists directly about a film prior to telling your chief the results.

Even for a seemingly simple CXR, you want to confirm your findings with a radiologist. If you tell your chief the patient's CXR "looked fine" and it turns out he had some subtle finding that you missed, your credibility instantly drops. If you tell your chief that the CXR, read with a radiology resident, "looked fine" then anything missed can be attributed to the faulty preliminary (resident) read," and you're off the hook. Even for simple films, check with a radiologist.

### ***CONFERENCES:***

There are weekly conferences held at Westwood which include: Morbidity and Mortality, Grand Rounds/Visiting Professors/Core Curriculum, and Intern Conference/Resident Skills Labs/Chief Rounds. In general, all residents will be together for the first 2 hours. The third hour varies by the level of training. These will all be combined on each Wednesday morning from **7am-10am** in CHS in the 7th floor conference room (73-105). DO NOT BE LATE!! Again, only the trauma team should be wearing scrubs.

Attendance at conferences is mandatory. Put your pager on vibrate and do not get out of your seat (except on assigned breaks) "UNLESS YOU HAVE DYSENTERY, AND ONLY IF IT IS A SEVERE CASE." You will be beheaded by Dr Hiatt if your pager makes a noise or you leave to answer a page. Remember, this is protected time and the page can be returned on breaks between sessions, or after conference. If there is a nurse practitioner on your service, ask them if they can cover the service pager while you are in conference.

Most services will have their own conferences and/or teaching rounds such as U, C, Peds, Vascular, Trauma, Olive View, etc. A complete schedule of conferences for all services is on the surgery department website at [www.surgery.ucla.edu/resident](http://www.surgery.ucla.edu/resident)

### ***SOME OTHER THINGS:***

**CASIT:** The Center for Advanced Surgical and Interventional Technology (CASIT) is a research facility with 3,700 sq. ft. including a *Da Vinci* surgical robotic surgery system, a human patient simulator, laparoscopic surgical simulators and laparoscopic training tools. This sounds very cool, and it is! You can go down there (on the "B" level of Ronald Regan, around the corner from the call rooms) at any time to practice your skills, and during the R1-2 years you may have monthly assigned modules to complete. The door requires key card activation which you can request from the staff of CASIT.

**ABSITE:** At UCLA, considerable weight is given to the American Board of Surgery In-Training Examination. It occurs once per year in late January. Our advice is to take it seriously and spend some time studying. Your daily tasks as an intern will not prepare you for it. Here are some good sources for review:

The ABSITE Review by Steven Fiser. A very dense book of useful information. A good outline to guide your studies.

General Surgery Review by Martin Makary. An outline format with high yield information.

Prior ABSITE questions – ask your senior residents for some review materials that are usually circulated by e-mail. Spend some time after the exam to write down questions/topics that you can recall from the test. This is invaluable for next year's studying.

SESAP 15 (most recent version). Question bank can be accessed online.

**LOGGING CASES AND HOURS:** Part of your professional responsibility as a surgeon is to log your cases and hours. You need to do this WEEKLY (there will be an email reminder – do it immediately). If you don't complete them in a timely fashion, the education office tells Dr. Donahue and Dr. Agopian. You don't want your first meeting with your program director to be about the fact that you are unable to log your hours. Instructions for logging cases will be distributed to you. Always keep a sticker and write on it the date, case, and attending surgeon. Don't fall behind on logging your cases.

**EVALUATIONS:** At the end of every rotation you will have the opportunity to ANONYMOUSLY evaluate your attendings and the rotation as a whole. Please be honest and forthcoming on these evaluations. Dr. Donahue and the education office are very committed to making this residency program a great experience for everyone. However, it is hard for them to make changes on the service if they don't have documented evidence of problems from our evaluations. We promise you can be honest and no one will be able to figure out who you are. You are safe!

### ***SO WHO REALLY WAS DR. FIRESTONE?***

Not too long ago, the page operator would send out an overhead message saying “paging Dr. Firestone to the third floor” if there was a fire on the third floor. Legend has it there was a poor resident whose real name actually was Dr. Firestone and she spent the bulk of her training running up and down the stairs trying to answer these pages. “But what does this story have to do with my intern year?” you may ask. “Is Dr. Firestone a metaphor for life? Am I really a firefighter?” Stay tuned!!

**If you have any questions or concerns, please let us know.**

**We are happy to help.**

**Welcome, and enjoy the year!**