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American Academy of Otolaryngology—Head and Neck Surgery June 2013—Vol.32 No.06

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American Academy of Otolaryngology—Head and Neck Surgery

June 2013—Vol.32 No.06

Official Statements of Leadership Candidates

The Academy will conduct its 2013 annual Leadership selection with online balloting, in an effort to streamline the voting process and increase participation.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor, the *Bulletin*

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Article Submissions Author guidelines are online at www.entnet.org/press/bulletin/ and AAO-HNS members are encouraged to submit articles via email to bulletin@entnet.org. *Bulletin* staff will contact the author at the completion of the editorial review process for any article submitted.

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Lessons of Leadership from Lincoln

James L. Netterville, MD
AAO-HNS/F President

This *Bulletin* issue is packed with items you will want to know about.

Since last month, general registration has opened for the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠, and the May BOG Spring Meeting & OTO Advocacy Summit now boasts success. The BOG offered a powerful program including the Presidents Forum that introduced the two individuals who stand for President-Elect this year, **Marvin P. Fried, MD,** and **Gayle E. Woodson, MD**. Following the BOG, the Summit provided briefings on legislative issues with U.S. Representative Phil Roe, MD (R-TN), and U.S. Representative Mike Burgess, MD (R-TX). The next day, Members met with their Members of Congress and/or staff (more than 120 Capitol Hill visits were pre-scheduled) to talk about legislative matters key to the quality practice of otolaryngology—head and neck surgery. Read more about Academy legislative activities on **pages 34 and 35**.

The Foundation continues its push for quality with the guideline summary on **page 14** taken from this month's journal supplement topic, "Clinical Practice Guideline: Improving Voice Outcomes after Thyroid Surgery." This summary will be a great resource to have at hand.

On **page 22**, read the second article spotlighting the Academy's International Program innovations—this time focusing on events planned for our Annual Meeting in Vancouver, BC, September 29–October 2.

This also is the time of the year when you may preview the 2014 FY Proposed Budget on **page 12** that reflects our strategy in several new areas. Presenting the budget to the membership is both a responsibility and privilege for your leaders.

What and Who Will Make a Good Leader?

The Academy and Foundation candidates' statements are the centerpiece of this issue and are as vital to our legacy as our strategy and budget. I am always awed by the caliber of you, my colleagues, in everything you undertake. What I have observed is that I can never really predict who will become an outstanding leader among other leaders. I have been surprised by the emergence of a person who can listen as well as speak and who evolves an even-handed approach to challenges, respecting each point of view that he/she meets as a contribution to the dialogue. So, it may be that in the process of accepting a nomination, developing a platform statement, and ultimately in the act of volunteering for the challenge, that a good leader is really made.

Thanks to the actor Daniel Day Lewis, many of us have a new appreciation of Abraham Lincoln's masterful leadership skills. In connection with that film, I recently came upon an article (Vozza, S, *Entrepreneur*, www.entrepreneur.com/blog/225284, accessed May 1, 2013), emphasizing four lessons learned from Lincoln about leadership. I paraphrase these here as we look for our future society leader:

A leader:

1. **Says no to "yes" men.**

Lincoln chose his cabinet from among his rivals, not his close friends and admirers. The men he picked were eager to share opposing points of view. Lincoln encouraged their challenges. He used the opportunity to reflect and debate. It gave him the confidence to make an informed decision on an issue.

2. **Is decisive.**

One outcome of so many opinions within the leadership circle was that debate was constant and might have led to constant discussion without resolution. Lincoln had the skill to gather the facts needed and to know when he had enough information to deliberate. At that point, he sought solitude to make a decision he knew he could stand by.

3. **Connects with people on a personal level.**

Lincoln knew the value of liberal arts. He studied not just law, but mathematics, art, and philosophy. He used nature's lessons to learn wisdom as well. The movie illustrates this skill as Lincoln draws from these studies to make a point about human rights with two young telegraph office clerks, "Euclid's first common notion is this: 'Things which are equal to the same thing are equal to each other.'"

4. **Looks for inspiration in unlikely places.**

Now we know that Lincoln as Honest Abe was trustworthy, but he was not standoffish and stuffy. He engaged with people as a storyteller and a jokester and looked for commonality. He made himself approachable as a human being and to underline his common man accessibility, he kept regular office hours for citizens to visit.

So, I look forward to our election with anticipation that I will again witness this evolution within our own Membership. To all who have stepped up as candidates, I wish you the very best of luck and hope that you will find the experience a good one no matter the outcome. And for all of us *Bulletin* readers, I think you will find this issue excellent reading. (See a brief video statement from the President-Elect candidates now on the Academy website at www.entnet.org, as well.)

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David R. Nielsen MD

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

A wise father once counseled his son, "It's better to earn respect than to demand it." Early in my career, I remember seeking advice from my father regarding the challenges I faced in moving to a new area, starting a solo practice from scratch, and feeling like I had to prove myself anew with every patient, hospital, health plan, and referring physician. As a fellowship-trained practitioner, I was using new tools and technology unfamiliar to those who were charged with approving my skills and hospital privileges. My father sagely observed, "It sounds like your trouble is you want a good reputation before you have earned it." I have never forgotten that. I was humbled to consider the many scientists and clinicians far more brilliant and accomplished than I, with exceptional skills, patience, and understated manner, who labored consistently and tirelessly for decades before realizing the acknowledgement and recognition they deserved.

Respect for the members of our specialty collectively has always been disproportionately strong. At a recent multidisciplinary meeting, a CEO colleague from another specialty complimented *you*, our members, as a surgical specialty that in her perception, and in the minds of her members, always seemed to be the best and brightest in the community, on the medical staff, or on the committee they served. While this compliment is subjective and qualitative, it's a nice change from the competitive stresses we often feel as a specialty as we mix in the medical/surgical world with overlapping skill sets. This overlap can lead to collaboration and cooperation as related specialists work together and accelerate progress through sharing perspectives and approaches, or it can lead to turf battles with attempts to exclude competition.

Many of our members feel they have spent too much of their careers fighting battles over their hospital privileges or the recognition of their training, experience, and medical skills. Such struggles have often been caused by the failure of a few outside our profession to understand the history of otolaryngology—head and neck surgery and the broad scope of services we have provided for more than a century.

In the first half of the previous century, clinical research and care for allergies, surgical management of facial traumatic and cosmetic deformities, and surgical care for head and neck tumors, including diseases of the thyroid and parathyroid, were all primarily the purview of otolaryngologists. Over time, scientific advances in antimicrobials, anesthesia, and immunology were made, war and battlefield conditions demanded new approaches, and new specialists arose with parallel skill sets and competing competencies. In the boom of medical science that took place in the last half of the 20th century, turf battles have arisen and still smolder today over some of this clinical territory.

We can be proud of the members of our society whose leadership, standards, ethics, and focus on patient-centered care have garnered the respect of colleagues who individually and institutionally have become our allies, friends, and collaborators. While some associations are made up of homogeneously skilled members from the same residency training and specialty background, other societies are organized on treatment of diseases, organ systems or anatomy, regardless of specialty training or background. And too, some AAO-HNS members join societies of other specialties who share in the care of our patients, such as allergists, endocrinologists, general surgeons, pediatricians, plastic surgeons, pulmonologists, and others. When one of our members is elected to leadership in these combined specialty areas, it is a matter of great moment that strengthens our desire to maintain focus on bringing our collective skills to bear on the patient's problem rather than on arguments with colleagues about the "right to treat."

Several years ago, **Gerald M. Healy, MD**, a lifelong Academy member and leader, was elected chair of the Board of Regents of the American College of Surgeons and later its president, the first otolaryngologist to fill that role. **Gregory W. Randolph, MD,** has just been elected chair, Endocrine Surgery Committee of the American Association of Clinical Endocrinologists, whose members include both adult and pediatric endocrinologists and endocrine surgeons. This is the result of years of work and respect gained by consistent excellence. Dr. Randolph is the first otolaryngologist elected to this key position, which helps to set the educational program for these specialty physicians. Increasingly collegial and cooperative work is taking place between the American Academy of Asthma, Allergy, and Immunology and our members who also belong to and lead the American Academy of Otolaryngic Allergy. We see evidence of cooperation among plastic surgeons of different training programs working together to strengthen standards for cosmetic and reconstructive surgery and hope for similar success in collegiality in the future.

One of the likely long-term results of healthcare delivery reform tied to global health outcomes will be the elimination of irrelevant turf battles. Increased team-based care will be brought about by the actual evidence of quality care documentation being required of all physicians. We stand for the highest standard of healthcare and a patient-centered focus. We congratulate our members for their leadership skills and collegiality and consensus building that strengthens team-based collaborative care and is recognized by others outside of our specialty. We hope this trend will continue.

How Doctors Can 'Follow the Money' as Finance Committee Members

I wake at 5 am and read "Money and Investing" in the *Wall Street Journal*, which my family affectionately calls the "Monkey Business" section since there are so many financiers being indicted, agencies being rebuked, and businesses in trouble. Like physicians, financiers have their own language, using terms such as FASB, GAAP, and depreciation,* with which physicians need to become familiar if we are to be effective in helping to influence the financial policies of our hospitals. For years, doctors did not want to talk about money for fear that it would taint their work, but with the money available for hospitals decreasing, we better overcome our hesitation.

In my September 2012 *Bulletin* article, "How to be a Better Hospital Board Member," I highlighted that to be an effective medical leader you need to go to the finance committee (FC) to "follow the money." I cannot overemphasize this, since most hospital financial decisions are already determined at the FC long before the governing body meets. The money available will determine your hospital's strategic plan, equipment investment, physician compensation, and development of new programs. In other words, by the time most doctors arrive at board meetings, these decisions have been made. Since many FCs meet without physicians, one could ask, "How do non-doctors make good decisions regarding funding patient care?" If the answer scares you, it should.

Finance committees generally meet once a month. A good FC report is circulated at least 24 hours in advance and includes:

1. Balance Sheet—gives assets and liabilities and indicates if the hospital is growing/shrinking.
2. Cash Flow Statement (CFS)—includes patient accounts receivables, pledges, inventories, bond costs, and vested benefits. The CFS is critical since no business should go bankrupt with money in the bank.
3. Operating Indicators—presents monthly and year-to-date inpatient/outpatient volumes, surgeries, case mix indicators, staffing levels, expenses per weighted patient days, and other ratios such as days in account receivables, the debt/service coverage, and risk contract gains/losses.
4. Audit Committee Report—discusses the accountant's review of the hospital "books" and conflicts of interest.
5. Investment Committee Report—outlines the hospital's investment strategy. If there are special investments (hedge funds), a comparison report and a risk analysis is recommended.

*Terms

- **FASB** (Financial Accounting Standards Board)
- **GAAP** (Generally Accepted Accounting Principles)
- **Depreciation** (decreased asset value allocated over time)

The problem with most hospital FCs is that there can be hidden problems. First, losses may cause a "who shall live and who shall die" choice for doctors. Second, doctors do not understand that there can be positive cash flow, but negative operating results caused by the institution using up the plant/equipment (depreciation) for daily use and not reinvesting in replacing old equipment/facilities. Third, nonprofit accounting is different from corporate accounting according to GAAP. For example, a pledged gift can be listed as an immediate asset even though the money has not been received—making assets appear larger than they are in reality. Fourth, most doctors are never given the management report from the independent accountants. This report gives an honest opinion about how the hospital is really doing and how it is managed. Most administrators would rather pull their teeth than allow doctors to read it; however, physician board members are entitled to see it. If your hospital does not have doctors on the FC or audit committee then be prepared for potentially serious problems.

David R. Edelstein, MD
Chair, BOG Socioeconomic & Grassroots Committee

Edelstein's Rules for How to Be a Better Finance Committee Member

1. Doctors need to be on the FC and understand business (most chairpersons are not chosen for their financial acumen).
2. Have 100 percent attendance.
3. Get the FC handouts at least 24 hours in advance and read them—carefully.
4. Find a friend in accounting or finance to call upon if you do not understand something.
5. Insist that there are physicians on the audit committees. Most administrators will resist, since this is where stark reality and the management letter is discussed.
6. Be sure that the investments are reasonable and low risk. Alternative investments can be rewarding, but have higher risk and less liquidity.
7. Perpetually inquire about indicators and their meaning.
8. Ask about contracts with insurance companies and vendors. Hospitals have huge inventories and are you sure they are controlled?
9. Ask to see the conflict of interest documents. You may be surprised.
10. Ask questions when you do not understand and wait for answers.

OHS: Hospitals and Otolaryngology in the Byzantine Era

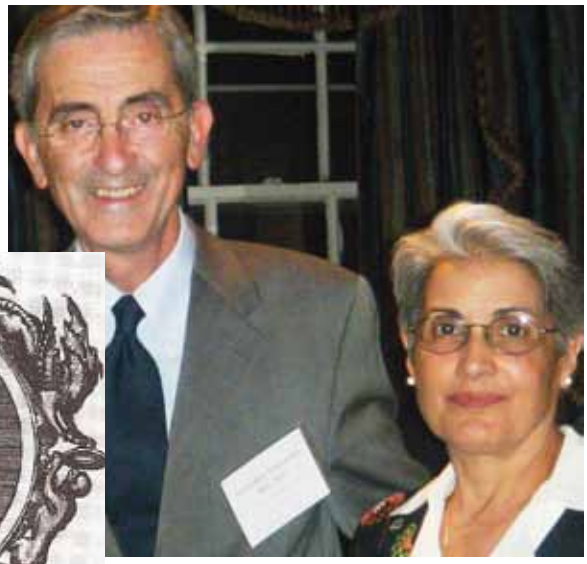
Aristides Sismanis, MD
Past-president, Otolaryngology Historical Society

The Byzantine era (AD 330-1453) is misunderstood and often overshadowed by the history of ancient Greece and Rome. Recent research, however, has revealed that Byzantium played a significant role in the evolution of Western civilization, including the medical field.

The early adoption of Christianity as the official religion of the state provided the proper environment for addressing the needs of the sick. Between the years AD 400 and 1204, there was remarkable development of hospitals. Monastic documents, or *typika*, give significant information on the bylaws, organization, and structure of Byzantine hospitals.

A typical hospital was a square building with a central fireplace surrounded by four pillars, which supported a cupola with vents to release the smoke. Four aisles of sickbeds were connected to the central part of the building. In the 12th century, the Pantocrator Hospital of Constantinople had 50 beds organized in five *ordinoi* (wards). Five beds were surgical, five medical, eight ophthalmological/intestinal, 12 gynecologic, and 20 general. The Emperor Manuel I Komnenos, or Kaloioanis, (AD 1143-1180) was a physician himself and practiced in the Pantocrator hospital. Some of his subjects had the opportunity to receive treatment from their Emperor!

Since the official language of the state was Greek, physicians had easy access and comprehension of Hippocrates' and Galen's treatises. In otolaryngology, Byzantine physicians made contributions that were significant for their time. Oribasius of Pergamon (AD 320–400), a personal physician of the Emperor Julian the Apostate, describes reconstruction of the pinna and nose in his book *About Colobomas of the Nose and Ear*.



Aristides Sismanis, MD, past president, Otolaryngology Historical Society, now professor and department chair, Hippokration Hospital, Athens, Greece, with Mrs. Sismanis.

Paul of Aegina, a 7th-century Byzantine Greek physician and surgeon, author of the medical encyclopedia *Medical Compendium in Seven Books*, unrivaled in its accuracy and completeness.

Aetius of Amida (AD 527-564), chief physician of Emperor Justinian, wrote 16 books on medical practice. For cleaning the ear canal, he recommends irrigation with *otochytes* (a type of syringe) or with *milotris* (cotton tip applicator). His description of tonsillectomy is rather clear and detailed. He describes removal of foreign bodies from the respiratory and upper digestive tracts, as well as management of thyroid lesions.

Alexander of Tralles (AD 525-605), brother of the famous architect Anthemius, who built the church of Hagia Sophia in Constantinople, described a type of trumpet inserted in the ear canal for hearing improvement. Paul of Aegina (AD 625-690) excelled in surgery. He published seven books describing tonsillectomy, laryngotomy, and thyroid procedures. For lateral atresia of the ear, he recommends excision with *scolopomachairio* (scalpel); however, for medial atresia, he suggests caution. He also describes techniques for reconstruction of colobomas of the ear and lips: "We remove the cicatricial area and after undermining the flaps of the skin we bring them together and suture."

> Between the years AD 400 and 1204, there was remarkable development of hospitals. Monastic documents, or typika, give significant information on the bylaws, organization, and structure of Byzantine hospitals.

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Proposed 2013-2014 Combined Budget

Gavin Setzen, MD
AAO-HNS/F Secretary-Treasurer

Budgeting for FY14 presented a new challenge as staff leadership worked with the members of the Finance and Investment Subcommittee (FISC) to develop a proposed combined AAO-HNS/F budget for the next fiscal year, July1, 2013, through June 30, 2014 (FY14). Budget guidance for FY14 began with the prioritization of strategic issues that were identified during the Boards of Directors strategic planning sessions in December 2012 and the legal requirement for a balanced budget.

Several new endeavors were included as priorities for the strategic plan and the proposed FY14 budget included these new activities. While the strategic plan addressed the trends that are shaping the future of medicine, for example: increasing continuing education needs; increasing sub-specialization; increasing the needs for research, quality and evidence-based medicine; the budget also took into account critical ongoing programs (such as our annual meeting) and the increasing need for cost-effectiveness.

In early spring, the FISC reviewed financial results for the first six months of the FY13 budget year and we were pleased to see that AAO-HNS/F was projecting a favorable budget year. The 2012 annual meeting netted positive results and staff continues to identify cost savings. This was all done under the leadership of **David R. Nielsen, MD**.

The budget planning process involved each of the business units of AAO-HNS/F submitting their budget to the financial team, which works with them to assure the revenue and expenses are in line with the mission and priorities of AAO-HNS/F. The financial team is composed of Brenda Hargett, CPA, chief operating and financial officer (COO); Lynn Frischkorn, director of budgeting and special projects; and Carrie Hanlon, CPA, senior director of financial operations.

The financial team presented the proposed budget to the FISC for an initial review in early March and then a final proposed budget in late March. Once reviewed and approved by FISC, the proposed FY14 budget was presented to the Executive Committees (EC) of the Boards of Directors (BOD) recommending their endorsement for approval by the BOD. The EC endorsed the FY14 proposed budget during their April meeting. In May, the BOD

AAO-HNS/F Combined Budgets	Approved Budget FY13	Proposed Budget FY14
Revenue:		
Dues/Membership	$6,500,000	$6,500,000
Royalties	2,135,700	2,120,000
Corporate & Individual Support	835,000	800,000
Meetings	7,404,000	7,318,900
Products & Program Sales	1,520,000	1,424,150
Miscellaneous	185,600	170,200
Dividend and Interest	543,800	271,000
Funds Released from Restrictions	625,900	958,750
Total Revenue	**$19,750,000**	**$19,563,000**
Direct Operating Expenses:		
Office	$514,100	$393,950
Occupancy (DC office rent)	200,000	200,500
Travel & Entertainment	691,100	667,400
Meetings	2,490,350	2,416,450
Printing & Production	1,023,200	873,850
Connectivity & Software	363,500	362,600
Consultants & Professional Fees	2,899,500	2,949,750
Grants	657,400	625,000
Total Direct Operating Expenses	**$8,839,150**	**$8,489,500**
Allocated Costs:		
Salaries & Benefits	7,988,000	7,954,100
Occupancy	1,653,000	1,652,000
Support	1,269,850	1,467,400
Total Allocated Costs	**$10,910,850**	**$11,073,500**
Total Expenses	**$19,750,000**	**$19,563,000**

reviewed and conditionally approved the FY14 budget that is presented here for our membership.

Highlights of the FY14 Budget

The budget has been prepared on a cash basis. This basis is important to reflect the ability for an organization to meet its true financial obligations, regardless of whether the cash outlay is a true "expense" or merely balance sheet accounting. The FY14 budget prioritizes the direction of the Board and is based on conservative estimates of both revenues and expenses.

The budget for FY14 is presented at $19.56 million, slightly lower than the FY13 budget of $19.75 million.

Nearly 70 percent of FY14 revenue, $13.82 million, is budgeted to come from two major areas: membership dues and annual meeting revenue. Membership dues are remaining flat, but the Annual Meeting revenue is budgeted to slightly decrease. Another major area of revenue that is budgeted lower is product and program sales, a result of fewer subscriptions to the Home Study course. Royalties also continue to be a significant source of revenue. As presented overall revenues are down as compared to FY13; this will be a challenge as we prepare budgets in the future.

In order to balance the budget with an expected decrease in revenue, the operating expenses had to be thoroughly reviewed, streamlined, and affirmed as they relate to the strategic plan.

The expenses for the AAO-HNS/F are separated into two areas. The first area includes direct operating costs relating to each business unit; these are costs directly related to carrying out the priorities of the strategic plan and other on-going mission-related programs.

The second area, allocated costs, relates to staffing and benefits, as well as operating costs incurred for the good of the whole organization, such as occupancy and building-related expenses, and organizational-wide HR, financial, and IT cost. While the allocated costs have increased due to inflation, contractual commitments, and salary adjustments, the direct operating expenses have been streamlined and tightened as much as possible to present a balanced budget.

The complete budget is available to any Academy member who requests it in writing. Email requests to Brenda S. Hargett, CPA, CAE, COO, to bulletin@entnet.org.

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Clinical Practice Guideline: Improving Voice Outcomes after Thyroid Surgery (a Summary)

Sujana S. Chandrasekhar, MD; Gregory W. Randolph, MD; Michael D. Seidman, MD; Richard M. Rosenfeld, MD, MPH; Peter Angelos, MD, PhD; Julie Barkmeier-Kraemer, PhD, CCC-SLP; Michael S. Benninger, MD; Joel H. Blumin, MD; Gregory Dennis, MD; John Hanks, MD; Megan R. Haymart, MD; Richard T. Kloos, MD; Brenda Seals, PhD, MPH; Jerry M. Schreibstein, MD; Mack A. Thomas, MD; Carolyn Waddington, MS, FNP, CORLN; Barbara Warren, PsyD, Med; and Peter J. Robertson, MPA.

This month, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) publishes its latest clinical practice guideline focusing on improving voice outcomes after thyroid surgery as a supplement to *Otolaryngology–Head and Neck Surgery*. This month's journal and a copy of the guideline are now available at http://oto.sagepub.com/.

The following summary presents an outline of the guideline; we encourage all interested parties to read the guideline in its entirety. The intent of this offering is to alert members to the availability of this new multidisciplinary clinical practice guideline so that the complexities of the problem can be fully described and understood. The summary provides an introduction to the topic and the purpose of developing the guideline followed by each of the guideline's key action statements and related action statement profiles.

For more information about the AAO-HNSF's other quality knowledge products (clinical practice guidelines and clinical consensus statements), our guideline development methodology, or to submit a topic for future guideline development, visit: http://www.entnet.org/guidelines.

Introduction

Thyroidectomy (surgical removal of all or part of the thyroid gland) may be performed for clinical indications that include malignancy, benign nodules or cysts, suspicious findings on fine needle aspiration biopsy, dysphagia from cervical esophageal compression, or dyspnea from airway compression. Other indications for thyroidectomy include multinodular goiter, Hashimoto's and other types of thyroiditis, and thyromegaly with significant cosmetic compromise. Additional surgery may involve neck dissection or completion thyroidectomy, based on the extent of disease and final pathology results. Surgeons performing thyroidectomy include otolaryngologists and general surgeons.

Thyroid surgery rates have tripled over the past three decades. Between 118,000 and 166,000 patients in the U.S. undergo thyroidectomy each year for benign or malignant disease.[1] Thyroidectomy is performed on patients of both genders, but more commonly on women. Thyroid cancer is the most common malignancy of the endocrine system, and the cancer with the fastest-growing incidence among women. It is estimated that 36,550 women and 11,470 men (48,020 total) in the U.S. were diagnosed with thyroid cancer in 2011,[2] with 56,000 projected in 2012.[3] Palpable thyroid nodules occur in three percent to seven percent of the population; ultrasound indicates that the actual prevalence of thyroid nodules is up to 50 percent. On fine needle aspiration biopsy (FNAB), five percent of thyroid nodules are malignant and 10 percent are suspicious. FNAB has increased the identification of malignancy in nodules from 15 percent to 50 percent predominantly due to increased detection of small papillary cancers.[4] The incidence of thyroid cancer in the U.S. rose from 3.6 per 100,000 in 1973 to 8.7 per 100,000 in 2002—a 2.4-fold increase.[5] It is the fifth most diagnosed cancer in women, whom it affects more than three times more commonly than it does men. Although peak incidence is between ages 45 and 49 in women and 65 and 69 in men, thyroid cancer accounts for 10 percent of all malignancies diagnosed in young people between the ages of 15 and 29.[6] Mortality from thyroid cancer remains low at 0.5 per 100,000.[5] The overall numbers of thyroid surgery continue to increase: in 2007, U.S. Agency for Healthcare Research and Quality (AHRQ) statistics indicated that 37.4 thyroidectomies were performed per 100,000 population. Both increased detection and growing U.S. population (from 281 million in 2000 to 309 million in 2010) enable estimates of thyroid surgery in 2012 of between 118,000 and 166,000.

The goals of thyroid surgery remain: complete removal of the abnormal thyroid and any involved lymph nodes, preservation of parathyroid gland function, and maintenance or improvement of voice and swallowing. Reduction in quality of life (QOL) after thyroid surgery is multifactorial, may include the need for lifelong medication, thyroid suppression, radioactive scanning/treatment, temporary and permanent hypoparathyroidism, temporary or permanent dysphonia postoperatively and dysphagia.[7-11] Voice disturbance may be identified at least temporarily in up to 80 percent of patients after thyroid surgery, but prevention, evaluation, and management are incompletely defined.[8] About one in 10 patients experience temporary laryngeal nerve injury after surgery with longer-lasting voice problems in up to one in 25.[12] Although temporary hoarseness is not uncommon in any surgery that involves general anesthesia, the potential for laryngeal nerve injury in thyroid surgery mandates greater concern when hoarseness occurs after this type of procedure.[13]

The most common site of injury is damage to one or both recurrent laryngeal nerves (RLN), which are close to the thyroid gland and are the main nerves that control vocal fold mobility. The other nerves of major interest, and frequently less directly addressed during thyroid surgery, are the bilateral superior laryngeal nerves (SLN), injury to which can impair the ability to change pitch and reduce voice projection.[14] Another less common surgical cause for post-thyroidectomy voice change is cervical strap muscle injury.[15,16] Non-surgical causes may include laryngeal irritation, edema, or injury from airway management.[9]

Between 1993 and 2007 the performance of total (over partial) thyroidectomy more than doubled to nearly 40 percent of cases, and that will continue to grow.[17] Total (or bilateral) thyroidectomy puts twice the number of SLNs and RLNs at risk. This clinical practice guideline (CPG) seeks to provide guidance to minimize post-thyroidectomy voice impairment in the setting of the increasing number and extensiveness of thyroidectomies being performed by diversely trained and experienced surgeons.

This document is intended for all clinicians who diagnose or manage adult patients with thyroid disease for whom surgery is indicated, contemplated, or has been performed. Key terms used in this guideline are as follows:

- *Thyroidectomy* is defined as a surgical procedure performed to partially or completely remove the thyroid gland. This term may include total thyroidectomy, or partial thyroidectomy, which includes subtotal thyroidectomy and hemithyroidectomy.
- *Voice outcomes* include the patient's own perceptions of their vocal quality, the perceptions of others, and objective voice-related measurements.
- *Vocal folds*, also known as the vocal cords, are twin infoldings of mucous membrane covering the upper surface of each vocalis (or thyroarytenoid) muscle, which extend from the midline, anterior attachment to the thyroid cartilage projecting posteriorly to the vocal process of the arytenoid cartilage.[18] The vocal folds vibrate, modulating the flow of air being expelled from the lungs during phonation. They consist of epithelium and lamina propria overlying the vocalis muscle.
- *Vocal fold mobility disorders* as used in this document include paresis or hypomobility, which are synonymous with vocal fold weakness, and paralysis, which is immobility of the fold.
- *Voice impairment* can range from aphonia, which is absence of phonation, to dysphonia, which could include persistent or intermittent breathiness, hoarseness, reduced volume, vocal fatigue, and/or pitch change.

Although thyroidectomy procedures may be performed in all age groups, this guideline is limited to adults (aged 18 and older). In a review of AHRQ's Healthcare Cost and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS) data from 2003 to 2004, the majority of adult patients (78.8 percent) undergoing thyroid surgery were between 18 and 64 years old, 17.9 percent were between ages 65 and 79 years, and 3.3 percent were 80 years old or older.[19]

Purpose

As defined by the Institute of Medicine (IOM), CPGs are "statements that include recommendations intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." They are based on a thorough review of the best evidence available at the time of writing, as evaluated by a multi-disciplinary panel with representation by as many stakeholders as possible. CPGs are intended to enhance clinician and patient decision-making by collating current best evidence into an explicit and transparent action plan.[20]

The purpose of this guideline is to optimize voice outcomes for adult patients aged 18 years or older after thyroid surgery. The target audience is any clinician involved in managing such patients, which includes, but may not be limited to, otolaryngologists, general surgeons, endocrinologists, internists, speech-language pathologists, family physicians and other primary care providers, anesthesiologists, nurses, and others who manage patients with thyroid/voice issues. The guideline applies to any setting in which clinicians may interact with patients before, during, or after thyroid surgery. Children younger than 18 years are specifically excluded from the target population; however, the panel understands that many of the findings may be applicable to this population. Also excluded are patients undergoing concurrent laryngectomy. Although this guideline is limited to thyroidectomy, some of the recommendations may extrapolate to parathyroidectomy as well.

Actions considered by the guideline development group (GDG) were broadly classified into laryngeal examination, voice assessment, nerve

management, and interventions. The group agreed that voice outcomes could potentially be improved:

1. Preoperatively, with examination of the larynx, baseline preoperative voice assessment, and appropriate counseling and education for realistic expectations;
2. Intraoperatively, with targeted communication among the members of surgical team, proper anesthetic preparation including avoidance of laryngeal trauma during intubation and avoidance of paralytic agents where indicated, surgical techniques geared to optimize voice outcomes by preventing injury as well as by recognizing and managing injury, use of adjuvant medications during surgery, and defining a role for intraoperative nerve monitoring; and
3. Postoperatively, with baseline postoperative laryngeal examination and voice assessment, setting expectations for recovery, knowing when and to whom to refer, and discussion of options for rehabilitation of voice impairment.

This guideline is intended to focus on quality improvement opportunities judged most important by the GDG. It is not intended to be a comprehensive guide for managing patients undergoing thyroid surgery. In this context, the purpose is to define useful actions for clinicians, regardless of discipline, to improve quality of care and voice outcomes. Conversely, the statements in this guideline are not intended to limit or restrict care provided by clinicians based on the assessment of individual patients.

Although there is evidence to guide management of many aspects of thyroid surgery, there is no evidence-based, multi-disciplinary, CPG that specifically deals with improving voice outcomes. This guideline is warranted because of known practice variations in the care of patients who undergo thyroid surgery and the large impact voice impairment can have on a patient's QOL and functional health status.

STATEMENT 1. BASELINE VOICE ASSESSMENT:

The surgeon should document assessment of the patient's voice once a decision has been made to proceed with thyroid surgery. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Establish a baseline, improve the detection of preexisting voice impairment, establish expectations about voice outcomes, educating the patient, facilitates shared decision-making. Prioritize the need for preoperative laryngeal assessment and more in-depth voice assessment.
- Risk, Harm, Cost: Anxiety, cost of assessment tool, patient and provider time.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: Perception by the GDG of a current underassessment of voice prior to surgery.
- Intentional Vagueness: The proximity of the assessment to the day of surgery is not specified because there was no consensus among the guideline group and there was no data to support the choice of one time-point over another. The group agreed that any change in voice would warrant a new assessment.
- Role of Patient Preferences: Selection of assessment methods.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 2A. PREOPERATIVE LARYNGEAL ASSESSMENT OF THE IMPAIRED VOICE:

The surgeon should examine vocal fold mobility, or refer the patient to a clinician who can examine vocal fold mobility, if the patient's voice is impaired (as determined by the assessment in Statement 1) and a decision has been made to proceed with thyroid surgery. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Assess mobility of vocal fold, potential diagnosis of invasive thyroid cancer, influence the decision for surgery, extent of surgery, intraoperative technique, preoperative patient counseling, distinguish iatrogenic from disease-related paralysis/paresis.
- Risk, Harm, Cost: Misdiagnosis (false positive/ false negative), cost of examination, patient discomfort, resources, access, anxiety.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: None.
- Role of Patient Preferences: Limited.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 2B. PREOPERATIVE LARYNGEAL ASSESSMENT OF THE NON-IMPAIRED VOICE:

The surgeon should examine vocal fold mobility, or refer the patient to a clinician who can examine vocal fold mobility, if the patient's voice is normal and the patient has (a) thyroid cancer with suspected extrathyroidal extension, or (b) prior neck surgery that increases the risk of laryngeal nerve injury (carotid endarterectomy, anterior approach to the cervical spine, cervical esophagectomy, and prior thyroid or parathyroid surgery), or (c) both, once a decision has been made to proceed with thyroid surgery. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Assess mobility of vocal fold, potential diagnosis of invasive thyroid cancer, influence the decision for surgery, extent of surgery, intraoperative technique, preoperative patient counseling, distinguish iatrogenic from disease-related paralysis/paresis.
- Risk, Harm, Cost: Misdiagnosis (false positive/false negative), cost of examination, patient discomfort, resources, access, anxiety.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: Even though the prevalence of preoperative vocal fold paresis is low, the consequence of not knowing this prior to surgery could result in substantial morbidity or mortality. For this reason, the GDG was willing to accept a large number of normal examinations in return for an occasional abnormal finding.
- Intentional Vagueness: The timing of assessment relative to surgery is not stated to allow clinicians flexibility in decision-making, although the guideline development group agreed that the assessment should take place as close to the surgery as possible. The word suspected is used due to the difficulty of identifying extrathyroidal extension through physical exam and imaging.
- Role of Patient Preferences: Limited.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 3. PATIENT EDUCATION ON VOICE OUTCOMES:

The clinician should educate the patient about the potential impact of thyroid surgery on voice once a decision has been made to proceed with thyroid surgery. *Recommendation based on preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade B, RCTs on the value of patient education in general regarding surgery. Grade C, studies on the incidence of voice impairment following thyroid surgery in particular.
- Benefit: Facilitate shared decision making, establish realistic expectations, help patients recognize voice changes postoperatively.
- Risk, Harm, Cost: Anxiety.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: Generalize evidence about the benefits of patient education to this circumstance.
- Intentional Vagueness: None.
- Role of Patient Preferences: Patient can decline information.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 4. COMMUNICATION WITH ANESTHESIOLOGIST:

The surgeon should inform the anesthesiologist of the results of abnormal preoperative laryngeal assessment in patients who have had laryngoscopy prior to thyroid surgery. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Allow anesthesiologist to select proper tube, allow anesthesiologist to optimize airway management, identify potential problems with intubation and extubation, plan postoperative care and monitoring, may prevent anesthetic-related voice disturbance.
- Risk, Harm, Cost: None.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: The guideline development group felt that even though the recommendation followed best practice there was a perception the action was not universally performed.
- Intentional Vagueness: Timing of discussion is not specified but should occur before the patient enters the operating room.
- Role of Patient Preferences: None.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 5. IDENTIFYING RECURRENT LARYNGEAL NERVE:

The surgeon should identify the recurrent laryngeal nerve(s) during thyroid surgery. *Strong recommendation based on a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade B, RCTs and retrospective cohort studies.
- Benefit: Optimize voice outcome, protect the RLN, preserve laryngeal function, reduce incidence of RLN injury.
- Risk, Harm, Cost: Inadvertent RLN injury, extended operative time, false identification of another structure as the RLN.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: None.
- Intentional Vagueness: None.
- Role of Patient Preferences: None.
- Exclusions: Thyroid surgery limited to the isthmus.
- Policy Level: Strong recommendation.

STATEMENT 6. PROTECTION OF SUPERIOR LARYNGEAL NERVE:

The surgeon should take steps to preserve the external branch of the superior laryngeal nerve(s) when performing thyroid surgery. *Recommendation based on preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Preserves vocal projection and high frequencies.
- Risk, Harm, Cost: May leave superior pole thyroid tissue.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: None.
- Intentional Vagueness: The steps taken to preserve the nerve are purposefully not specified in the statement to emphasize the important issue is preserving the nerve, which may or may not be identifiable during surgery. Therefore, it is the attention to the nerve that is important.
- Role of Patient Preferences: None.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 7. INTRAOPERATIVE EMG MONITORING:

The surgeon or their designee may monitor laryngeal electromyography (EMG) during thyroid surgery. *Option based on one RCT and observational studies with a balance of benefit versus harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C.
- Benefit: Added information regarding neurophysiologic status of the RLN (specifically when the nerve is injured), potential improved accuracy in nerve identification, potentially avoiding transient/temporary nerve.
- Risk, Harm, Cost: cost of endotracheal tube and probe, capital equipment costs, education of key personnel including anesthesia, nursing, surgeon and technician, misinterpretation (both false positive/false negative), may instill a false sense of security in identifying nerve.
- Benefit-Harm Assessment: Equilibrium.
- Value Judgments: None.
- Intentional Vagueness: None.
- Role of Patient Preferences: None.
- Exclusions: None.
- Policy Level: Option.

STATEMENT 8. INTRAOPERATIVE CORTICOSTEROIDS:

No recommendation can be made regarding the impact of a single intraoperative dose of intravenous corticosteroid on voice outcomes in patients undergoing thyroid surgery. *No recommendation based on observational studies with limitations and a balance of benefit vs. harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade D, observational studies with concerns over methodology and clinical importance.
- Benefit: Uncertain effect on short-term voice improvement or shortening the duration of vocal fold paralysis or paresis.
- Risk, Harm, Cost: Hyperglycemia.
- Benefit-Harm Assessment: Balance of benefit vs. harm.
- Value Judgments: None.
- Intentional Vagueness: None.
- Role of Patient Preferences: None.
- Exclusions: None.
- Policy Level: No recommendation.

STATEMENT 9. POSTOPERATIVE VOICE ASSESSMENT:

The surgeon should document whether there has been a change in voice between two weeks and two months following thyroid surgery. *Recommendation based on systematic reviews, clinical practice guidelines, and prospective, observational studies*

with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate Evidence Quality: Grade C, cohort studies on the prevalence and duration of voice changes after thyroid surgery and the underreporting of voice changes if not specifically sought.
- Benefit: Identification of significant voice impairment and early institution of counseling and/or voice rehabilitation; avoidance of patient anxiety.
- Risk, Harm, Cost: Cost of assessment tools/examinations.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: The guideline development group believes that post-operative voice assessment is not being performed universally, in the identified time frame.
- Intentional Vagueness: The documentation time is stated as between two weeks and two months because there is no evidence on the optimal time, but the GDG suggests that the evaluation should be late enough to overcome transient postoperative changes but early enough to allow effective intervention.
- Role of Patient Preferences: No role in documenting the outcome, but a significant role in the choice and extent of outcome assessment.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 10. POSTOPERATIVE LARYNGEAL EXAMINATION:

Clinicians should examine vocal fold mobility or refer the patient for examination of vocal fold mobility in patients with a change in voice following thyroid surgery (as identified in Statement 9). *Recommendation based on preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C, QOL data, early intervention data, diagnostic maneuver.
- Benefit: Detect nerve injury, gain information regarding prognosis, institute rehabilitation as needed.
- Risk, Harm, Cost: misdiagnosis (false positive/ false negative), cost of examination, patient discomfort, resources, access, anxiety, by restricting this recommendation to only patients with a voice change some nerve injuries may be missed.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: None.
- Intentional Vagueness: The timing of the examination is not specified, but should occur expeditiously after the identification of a voice change, as identified in Statement 9.
- Role of Patient Preferences: Moderate, based on patient self-perception of voice postoperatively, based on type of examination of larynx, based on physician determination and patient consent.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 11. OTOLARYNGOLOGY REFERRAL:

The clinician should refer a patient to an otolaryngologist when abnormal vocal fold mobility is identified after thyroid surgery. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade C, before- and after- studies showing voice improvement after surgical intervention.
- Benefit: Awareness of the opportunities for early surgical intervention, confirmation of the laryngeal findings, determination of appropriate treatment plan, facilitates shared-decision making, facilitates coordination with speech-language pathologist in care of patient.
- Risk, Harm, Cost: Cost, time, access.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: None.
- Intentional Vagueness: None.
- Role of Patient Preferences: None.
- Exclusions: None.
- Policy Level: Recommendation.

STATEMENT 12. VOICE REHABILITATION:

Clinicians should counsel patients with voice change or abnormal vocal fold mobility after thyroid surgery on options for voice rehabilitation. *Recommendation based on systematic reviews and observational studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate Evidence Quality: Grade B, systematic reviews on the benefits of counseling in general on healthcare outcomes; Grade C observational studies on the effectiveness of interventions for voice rehabilitation.
- Benefit: Facilitates informed decision making; reduces anxiety; improves awareness of options for rehabilitation.

- Risk, Harm, Cost: None for counseling. Cost for implementation of voice therapy may be significant, depending on patient's insurance status.
- Benefit-Harm Assessment: Preponderance of benefit.
- Value Judgments: Benefits seen in clinical studies from pursuing these options have been extrapolated to a beneficial effect from counseling the patient and increasing awareness.
- Intentional Vagueness: None.
- Role of Patient Preferences: Substantial regarding the method and extent of counseling provided.
- Exclusions: None.
- Policy Level: Recommendation. b

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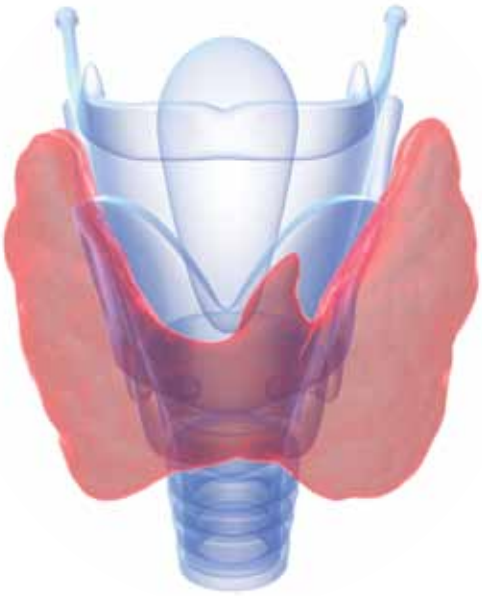

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Initiation of Cochlear Implant Program at an Urban Public Hospital: A Committee Report

Candice C. Colby, MD
Charles E. Moore, MD
Emory University School of Medicine
for the Diversity Committee

During the past 30 years, cochlear implants have been widely successful in the management of severe to profound sensorineural hearing loss in both adults and children worldwide. According to the National Institute on Deafness and Other Communication Disorders, as of December 2010, roughly 219,000 people worldwide have received cochlear implants; in the United States, this accounts for nearly 42,600 adults and 28,400 children[1].

Unfortunately, these figures represent less than 10 percent of those eligible to receive a cochlear implant. The two main factors that limit access to this technology include lack of knowledge throughout the community and with primary care physicians, and the burden of cost associated with these devices. The majority of implants currently placed are for patients with private pay insurance in developed countries. Insurance compensation (including private pay, Medicare, and Medicaid) often does not cover the complete cost of the operation or rehabilitation[2, 3], which has caused even large tertiary care centers to close due to excessive cumulative financial losses[3].

Grady Memorial patient works on rehabilitation.

The financial burden associated with cochlear implantation has significantly limited access to this rehabilitation program, particularly in the case of publicly funded hospitals. Treatment can easily cost $40,000-50,000[4], including more than $20,000 for the device[5]. However, evidence indicates that these costs are typically outweighed by the resulting benefits, such as reduced costs of special education[4] and improved quality of life[6]. Hearing rehabilitation also allows for improved socialization (less isolation), particularly for adult and/or elderly patients who may not be capable of learning American Sign Language (due to a learning disability, poor dexterity, limited transportation, etc.).

The Grady Memorial Hospital Cochlear Implant team, headed by Dr. Rebecca Blakenhorn, AuD (in blue scrubs), Drs. Candice Colby, and Charles Moore (far right). Implant surgeon Dr. Douglas Mattox not pictured here.

The otolaryngology department at Grady Memorial Hospital has attempted to initiate a cochlear implant program with the help of our cochlear implant specialist, Rebecca Blankenhorn, AuD. Grady Memorial Hospital is a 919-bed facility, the largest hospital in Georgia, and the public hospital for the city of Atlanta. It is the fifth-largest public hospital in the United States and serves a large proportion of low-income patients. We have successfully activated our first implant recipient, an 80-year-old man with longstanding sensorineural hearing loss. Unfortunately, Medicare has reimbursed only $6,453, which clearly does not cover even the cost of the implant. It will not be economically feasible to continue providing this service to our patients, limiting their access to this valuable technology.

We hope to continue working toward developing a program to provide this service to our patient population, while balancing the clinical and financial implications. An insightful article written by **Brian J. McKinnon, MD,** has given a supply-chain and revenue management business model that outlines parameters that may lead to a successful, sustainable program[3]; the transition to this model reduced the net loss per case at his institution by 96 percent. Key components to this model include cost reduction through selection of a single external-processor cochlear implant combination and contracting with a single supplier to maximize volume discounts, surgical cost reduction by practice opened when requested, and revenue management with a dedicated accounting, preauthorization, and collections system. However, compensation rates must be reevaluated (particularly by Medicare and Medicaid) if this technology is to become universally available. Currently, Medicaid coverage of cochlear implantation varies by state, and may cover only half of the cost[3].

Cochlear implants have proven safe, successful, and cost-effective, yet there continues to be a disparity in the publicly insured deaf population, largely due to lack of immediate profitability. We will continue our attempt at working toward a cochlear implant program in our public institution based on the supply chain and revenue management business model outlined above, and hopefully develop a financially sustainable operation to support this patient population.

See references in online version of this article.

Academy Reaches Out to International ENTs

By M. Steele Brown
With the International Steering Committee

This year, our AAO-HNSF Annual Meeting & OTO EXPO℠ in Vancouver, B.C., Canada, is designed with a decidedly international flair. At present, 1,205 international Academy members—10 percent of total membership—hail from 88 countries outside the United States. Throughout the years, representatives from more than 117 countries have participated in the meeting.

Benefits for International Members

"Our overarching goal is to engage international attendees, who don't necessarily belong to the Academy, in a way that's meaningful for them so that they feel they gain worthwhile benefits out of their Academy experience as potential members, not just as attendees," said **James E. Saunders, MD**, Coordinator-elect for International Affairs. To do this, the Academy offers many services for members via the web.

"Web-based benefits like AcademyU® and patient information materials, many translated into Spanish, transcend physical meeting boundaries and provide useful information resources for international members," Dr. Saunders said. He cited webcasts as an example of the Academy reaching out to those who can't physically make it to the meeting, but still want to participate.

Honoring Guest Countries

At the Opening Ceremony, President **James L. Netterville, MD**, will honor Canada, Kenya, Nigeria, and Thailand. "Canada is obviously one of our honored countries because we are meeting on Canadian soil," said Catherine R. Lincoln, CAE, MA, Senior Manager for International Affairs. "With regard to Kenya and Nigeria, Dr. Netterville has led many medical missions to both countries. Thailand was chosen because it has an exceptional community of otolaryngologists."

Special Programming for International Attendees

For the first time, as part of the Academy's continued global outreach, our 2013 meeting will offer a new International Assembly, as well as a rich array of other events for foreign attendees.

"Through the International Steering Committee (ISC) and its 22 Regional Advisors, we gather otolaryngology leaders from around the world to put together global programming for the annual meeting," said AAO-HNSF Coordinator for International Affairs **Gregory W. Randolph, MD**.

"The committee includes representatives from global bodies, such as IFOS (International Federation of Oto-Rhino-Laryngological Societies), which interact with otolaryngologists in every corner of the world," he said, "That is so our leadership on international programming can keep its finger on global trends. Working with our 54-member International Corresponding Societies (ICS) network, we developed programming that relates to different regions and brings it under the umbrella of the new International Assembly."

'United Nations-style' International Assembly

According to Dr. Saunders, the new International Assembly scheduled for 2:00 pm–4:00 pm on Tuesday, October 1, will underpin those events.

"It is an opportunity for people from a variety of countries to get together in a 'United Nations-style' assembly where we can honor our visitors, share issues with each other, and find common ways to make our specialty better, not just in one country, but around the world," Dr. Saunders said. "For us, it's a matter of rising to the challenge and accepting the responsibility of international leaders."

J. Pablo Stolovitzky, MD, Regional Advisor for Latin America and past chair, Board of Governors, said "The International Assembly will serve as an opportunity for the leaders of the various societies that come to the annual meeting to gather and share their thoughts."

At the assembly, Academy leaders will recognize our International Visiting Scholars and International Travel grantees (overseas otolaryngologists studying in North America).

The assembly will honor residents taking part in the Academy's first-ever Resident Exchange Program with Latin America. Dr. Stolovitzky is encouraged by this outreach, coordinated by **Mark J. Zafereo, MD**, the ISC Young Physicians representative. Programs involved in the exchange are MD Anderson, Houston, TX, the Universities of California (Davis), Mississippi, Oklahoma, and Texas (San Antonio), and hospitals in Argentina, Colombia, Mexico, and Venezuela.

International Caucus for Women in Otolaryngology

Dr. Randolph and **Susan R. Cordes, MD**, chair of the Women in Otolaryngology (WIO) Section, will launch a first-time International Women's Caucus, inviting women presidents and secretaries general of International Corresponding Societies to confer with Academy women leaders.

"That is exciting, because this new caucus is a great chance to further networking between U.S. and international women otolaryngologists abroad," Dr. Randolph said. "Events like this help WIO leaders form relationships that strengthen the specialty as a whole."

Dr. Cordes said many events are open to international women attendees such as the WIO Section Luncheon, with featured speaker **Christina M. Surawicz, MD**, of Seattle's Harborview Medical Center, as well as the WIO Section General Assembly, the WIO committee meetings, and miniseminars.

"Our WIO program at the annual meeting is intended to meet the needs of all women in otolaryngology, regardless of practice type or geographic location," she said. "Our intent is to strengthen our specialty throughout the world by uniting women (and like-minded men) to recognize and fully use the resources and talents of all women

otolaryngologists. Throughout the year, women otolaryngologists around the world are encouraged to maintain communication via our WIO Facebook group."

Regional Caucuses, Global Health Symposium, and More

Dr. Randolph said upcoming events include caucuses for Africa, Middle East, Latin American, and International Academic Members. "These gatherings allow individuals from a given region to meet Academy leaders and U.S. members who are interested and active in the region," he said.

In addition, Dr. Randolph said other events under the International aegis include the Global Health 2013 Symposium, International Reception, Humanitarian Forum, and meetings of the International Journal Editors and International Speakers Bureau.

The symposium—an academic event put on by Dr. Randolph and several regional advisors—offers an around-the-world summary of the specialty.

"Our regional advisors talk about their particular region before introducing distinguished individuals as their own 'goodwill ambassadors,' " he said. This is an honorary title for which each guest speaker receives a certificate by the Academy leadership.

"For the Humanitarian Forum, U.S. ENTs show their work around the world," he said. "During a two-hour presentation, we get a chance to hear and see really intriguing stories."

Live Webcast to Latin America

Dr. Stolovitzky revealed that, as part of the "Globalizing the Academy" initiative, the Academy will launch the first-ever live broadcast from the annual meeting to several Latin American countries.

"This webcast on Sunday, September 29, will include a miniseminar and four instructional courses—all translated into Spanish—with a real-time feed for questions and answers from participants," he said. "This project will not only enhance the Academy's international outreach, but also allow Latin American ENTs increased access to the largest gathering of otolaryngologists in the world."

"They really value the continuing education provided via the annual meeting and this gets back to the Academy being an international leader," he said. "Those who participate will have the recognition that they took part in this event hosted by the American Academy, and that name carries great weight in Latin America. Our international colleagues have a lot of respect for the education we offer."

International Reception

The final event—the International Reception—will take place the last night of the annual meeting and celebrates and honors international visitors.

At the reception, Dr. Netterville as Academy President will toast the four guest countries, and President-elect **Richard W. Waguespack, MD**, will unveil his guest country choices for 2014 in Orlando, FL. We invite all international guests to wear their national dress or a lapel pin with their country flag or society emblem.

Dr. Randolph said a DJ with lively dance music and an array of desserts are on tap for the event. "It is a wonderful opportunity to have fun, to dance, and enjoy each other's company," he said.

Impact Otolaryngology after Retirement

To meet the responsibilities to our members, further the Academy's mission, and encourage future physician leaders, AAO-HNSF relies on a broad range of support, including private philanthropy, corporate sponsorships, and foundation grants. Without reliable revenue streams beyond dues, the foundation of a thriving organization cannot continue to grow in the long term.

We ask that each of our members consider a planned gift during 2013 to ensure that bedrock programs of the AAO-HNSF are supported in perpetuity for the good of the specialty. Planned giving provides AAO-HNSF the flexibility to carry out our mission at the highest level, to respond to new opportunities, and to take the risks necessary to flourish.

When planned giving is paired with members' annual giving, Academy donors are simultaneously securing today's operations and affirming the future endeavors of the Foundation. Both donations provide valuable tax incentives and solidify members' commitment to today and the promise of tomorrow.

Giving to the future

The Hal Foster, MD Endowment, AAO-HNSF's endowment, creates a reliable revenue stream—something that we can count on year in and year out—even when the economy fluctuates. Those who donate to the Hal Foster, MD Endowment become an integral component of the history and future of the Academy and are recognized for their impact in the lobby of AAO-HNS headquarters in Alexandria, VA.

Your planned gift, whether it is a life insurance policy, bequest, or charitable gift annuity, ensures the future of the Academy for the next generation of otolaryngologists. Many members have chosen to pursue planned giving as an opportunity to give back to their Academy and specialty and invest in young physicians' futures. Providing the next generation of otolaryngologists with essential education and practice resources, the opportunity for humanitarian travel, resident medical research grants, and advocacy support is critical to the future of the Academy.

The Academy has faced serious hurdles during the last decade with healthcare delivery and payment reform, changes in technology, and developing comprehensive patient and physician education platforms. The next generation of otolaryngologists will have their own set of obstacles to address and we need your help to ensure they are equipped to weather any storm.

Our forebears handed us a legacy. What has the Academy meant to your career in otolaryngology-head and neck surgery? Are you willing to pay it forward to the next generation with planned giving?

Contact the Foundation's Development Department today to discuss which planned giving vehicle is best for you at mmcmahon@entnet.org or 703-535-3717.

Did You Know?

AAO-HNSF has worked with dozens of life insurance plans and can directly connect you with a financial group to expedite your life insurance policy or other planned giving.

"When the next generation comes along we don't want to hand them today's AAO-HNS, we want to hand them tomorrow's AAO-HNS, with the financial strength, with the endowment necessary so that they will not be at the mercy of macro- and microeconomic changes. We want to make sure that they have what they need."

-David R. Nielsen, MD, EVP/CEO

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To receive the first section on time, registration with payment must be RECEIVED by August 5, 2013. Registration closes September 6, 2013. A $200 late registration penalty will be applied to all registrations **RECEIVED** after September 6, 2013.

Official Statements of Leadership Candidates

Candidates for President-elect (VOTE FOR ONE)

The Academy will conduct its 2013 annual leadership selection with online balloting, in an effort to streamline the voting process and increase participation. The official candidate statements are published below. Early next month, you will receive an email instructing you on the voting process. To ensure you can participate, you must be a member in good standing, and the Academy must have an active email address for you. To update your profile, log in at http://www.entnet.org/Community/memberProfile.cfm.

Marvin P. Fried, MD

Identify two strengths and vulnerabilities of our Academy and explain how you would propose to leverage those strengths and overcome those vulnerabilities to ensure future stability and success of the organization.

As your next Academy president, I would vigorously protect what I view as our AAO-HNS/Foundation's greatest strength: its power of unification. Inside the Academy's "house" we are all otolaryngologists first, and despite our diversity, we live under the same roof with common goals and issues. The Academy has the resources to make a difference by speaking for otorhinolaryngology-head and neck surgery to government and the public on socioeconomic issues and policies that affect us all. The rapidly changing healthcare landscape necessitates that our Academy continue collaborating with other medical organizations, defining quality healthcare in unison, and projecting our voice as one.

Our Academy's annual meeting, the world's largest otolaryngology educational venue, represents a second strength I would fortify. Let us bring together private practitioners, academicians, specialists, generalists, scientists, clinicians, Americans, and international guests to create a powerful and effective learning environment. I want to utilize technology so that all of us will efficiently acquire and share this knowledge which is most pertinent to our professional daily lives and practices. This can only enhance patient care and the high esteem for otolaryngology.

Vulnerabilities become reality if the future eludes our current conscience. We cannot afford to lead from behind or react instead of being proactive. If elected, I would engage our subspecialty to find commonalities. Such communication would yield many rewards, including allowing our Academy to provide the best possible representation in meeting the challenges of the Affordable Care Act. I also aim to lead in obtaining tort reform, allocating care to the newly insured, providing stratified care for our aging population, and developing cost-effective approaches. To do less is to leave us vulnerable to the politics of those outside of our profession.

In the context of the Academy's Strategic Plan, what changes do you envision will be necessary in our Academy during the next three to five years in order to meet the educational, research, advocacy, and fiscal challenges presented by evolving healthcare policy and legislation?

I hope to engage our grassroots as never before, energizing and involving patients, our biggest advocates, in ensuring a future of quality care so that the best and brightest physicians continue our heritage. All of the aforementioned must be considered if we are to fulfill our destiny.

Educational advancement involves innovation in the way physicians learn through new materials that respond to the individual physician's needs using the most advanced technologies as well as collaboration with other societies. Learning takes place yearlong, not simply once a year.

The Academy should nurture and enrich the CORE process by working with subspecialty societies to support research on all levels. I would also advocate for continued strong governmental NIH support, particularly of the NIDCD. I personally feel that a focus on patient safety (simulation training, for example) is an area in which otolaryngology takes a leadership role.

I am confident that my background of working with our subspecialty societies, innovating in teaching approaches, profitably managing the finances of a large academic department, overcoming traditional town-gown barriers, fostering collegiality, and enhancing the careers of those who have come within my purview, have given me the tools to lead our Academy during these challenging times. I am honored to be considered for this role and will work tirelessly to make a difference.

Candidates for President-elect (VOTE FOR ONE)

Gayle E. Woodson, MD

Identify two strengths and vulnerabilities of our Academy and explain how you would propose to leverage those strengths and overcome those vulnerabilities to ensure future stability and success of the organization.

The greatest strength of the American Academy of Otolaryngology—Head and Neck Surgery is its pre-eminence in otolaryngology education, with the world's best otolaryngology meeting, and its diverse continuing medical education offerings. Another important strength is that its membership includes a high percentage of the practicing otolaryngologists in this country. This confers authenticity when the organization speaks for the specialty.

Our educational programs are challenged by exponential increases in knowledge and the ability for anyone to have access to information from any point in the world through a wide variety of media. Increasingly, our patients may learn of some important advance before we, as physicians, have had time to read about it in our journals. We are bombarded with information from email alerts from various sources and can easily find quick answers to many questions through search engines. As other sources of information become timelier and more accessible to our members, our products then become less valuable. And although we continue to have the best otolaryngology meeting in the world, we may have fewer attendees as financial pressures reduce the time available for educational activity.

Many medical organizations are losing members as physicians face greater fiscal challenges and dues increase. Currently, most practicing otolaryngologists do choose to maintain membership in our Academy. But we must never take this for granted. The rapid changes in our healthcare system are confusing and threatening. Our Academy is poised to offer vital assistance to physicians during these uncertain times. We must be effective in collective action, such as determining the quality measures that will be used to assess our practice.

In the context of the Academy's Strategic Plan, what changes do you envision will be necessary in our Academy during the next three to five years in order to meet the educational, research, advocacy, and fiscal challenges presented by evolving healthcare policy and legislation?

The future of the American Academy of Otolaryngology—Head and Neck Surgery is critically dependent on maintaining relevance to its members. To do so, we must adapt to the changing demographics of its membership and the explosion in the technology of information transfer.

We must become more accessible and rapidly responsive to our members. Questionnaires are not very effective in identifying issues. Additionally, most members are not aware of the helpful resources currently available on our website, despite notifications via newsletters and email. The website should be more interactive and personalized. Members could pose questions and express concerns more spontaneously and get information "just in time." Social media should be explored as a means to drive traffic to the website and highlight available resources.

A thorough evaluation of our teaching and learning methods is warranted to ensure that our educational products are compatible with changing modes of communication. A broader issue is the extent to which our educational products incorporate accepted principles of adult education. Licensing boards and hospital credential committees will increasingly require specific CME or even Maintenance of Certification, and so it will be important to assure that we offer content relevant to those requirements.

Finally, the output of our committees and task forces is vital to achieving the goals of our Academy. Increasingly, we will need to rely on teleconferencing to deal with time-sensitive issues in a cost-effective manner.

Candidates for Director At-Large (Academic) (VOTE FOR ONE)

In your view, what are the three most important elements of the Academy's current Strategic Plan and how would you propose advancing them?

Michael D. Seidman, MD

It would be an immense honor to be your next Director at Large and to serve you and the AAO-HNS. As your Director at Large, I would focus on advocacy, unity, and quality. I will be vigilant in efforts to grow our practices, enhance research and quality, strengthen advocacy efforts, and ensure a united voice to best serve our members. These activities are necessary to advance issues germane to our patients and practices. I have participated in diverse roles in the Academy for more than 20 years; the AAO-HNS is part of my core and identity. As past chair of the BOG, I worked tirelessly to:

1. Aggressively advocate for what is right for our patients and practices.
2. Ensure fair reimbursement.
3. See that our practices are not chiseled away by our allied health colleagues.
4. Lobby ferociously for fair practices in medical liability.
5. Build bridges and forge healthy relationships among our subspecialists.

As a Director at Large, I will continue these efforts. The wonderful opportunities afforded to me by working nationally for our profession are energizing. There is no better way to "give back" to the profession I love than by engaging in activities that strengthen our mission and advance our strategic vision.

David E. Tunkel, MD

The key element of the AAO-HNS strategic plan is development of evidence that guides our medical and surgical decision-making. Disease-specific outcome measures, with data collected from literature and input of membership, provide support for our diagnostic and therapeutic endeavors, many of which are pressured by third parties. The AAO-HNS can provide resources to develop practice guidelines and measure our outcomes in major medical centers and at the grassroots. Next, the AAO-HNS provides a multifaceted approach to educate physicians and patients—through a vibrant national meeting, the Academy *Bulletin* and journal, and a host of timely educational products. Third, the AAO-HNS advocates for otolaryngologists and perhaps more importantly for our patients in this evolving medical climate. Advocacy is easy when we have clear evidence of improved patient outcomes and quality of life. Members can propose topics for practice guidelines, and should provide comment and review during the development of such documents. Of course, members should continue to explore educational opportunities at home and at meetings. Simply said, the AAO-HNS should continue to support research that defines quality and optimizes patient care, spread this word through traditional and 21st century educational approaches, and represent the interests of members and our patients.

Business Meeting Notification

The AAO-HNS Business Meeting is preliminarily scheduled on September 28, from 11:00 am–11:30 am and will be at the Vancouver Convention Centre, Room 1. It is open to all members. Please join us.

Candidates for Director At-Large (Private Practice) (VOTE FOR ONE)

In your view, what are the three most important elements of the Academy's current Strategic Plan and how would you propose advancing them?

Rick A. Friedman, MD, PhD

The three most important elements of the Academy's Strategic Plan are advocacy, research and quality, and education and knowledge. I would be committed to educating patients and legislators/policy makers about the complexities and associated skill sets required for each of us to provide quality care for our patients with diseases of the head and neck, among the most common afflictions in our country. This two-tiered educational process will lead to greater support and awareness from our patients and policy makers facilitating fair policies and reimbursement from both governmental and private payers. The latter two elements, research and quality, and education and knowledge, go hand-in-hand. As a basic and clinical scientist in our field, I believe that we, as a specialty, can and do distinguish ourselves in our research efforts. I would continue to advocate for the AAO-HNS/F, its affiliates, and the NIH to support clinical outcomes research and basic science advancements, which ultimately lead to the highest level of patient care and innovative medicine. Lastly, with the rapid advances occurring in our field, I will advocate for enhanced, standardized, and up-to-date educational activities for our practicing members and our residents, fellows, and medical students in training.

Karen T. Pitman, MD

The strategic plan is a dynamic document, revised annually by our elected leaders to ensure the Academy's focus, work plan, and efforts are timely and relevant. Three important elements of this plan are education and knowledge, research and quality, and unity. These elements inform much of what is important to members and contribute to the toolbox the Academy aims to provide to members so they can effectively deal with changes currently happening in the way we practice and are reimbursed for the quality patient care for which we are committed.

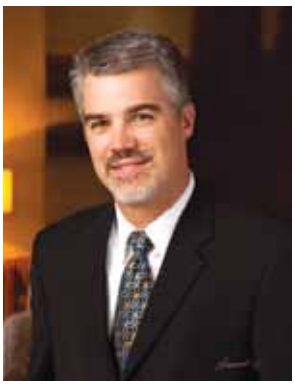
Other critical aspects of the strategic plan are providing the resources to support every member's ability to meet the requirements of certification and licensure, and to continue to develop evidence-based patient care guidelines. Education is the thread that connects every part of the strategic plan and to that end making members aware of all the Academy has to offer on the educational front is an important goal. Whether for maintenance of certification, continuing education credit, resources for training residents or much, much more, the Academy will continue to invest significant resources and enlist member volunteers to provide top-notch educational materials on a variety of platforms that serve our members' varied learning styles.

AAO-HNS 2013 Annual Election – Electronic Ballot

All eligible voting members of the Academy for whom we have an active email address, will receive a personal email in advance of the ballot's "go live" date. This email will contain your confidential password to access the electronic ballot. For those eligible members for whom we do not have an email address on record, you will receive a letter in the mail with your personal confidential password. Members who wish to receive a paper ballot must submit a request in writing to executiveservices@entnet.org or call the Academy at 1-703-836-4444 and request to speak to someone in Executive Operations. The AAO-HNS election ballot goes "live" on July 8, 2013 and closes on August 22, 2013.

Candidates for Audit Committee (VOTE FOR ONE)

What is your particular experience or interest that would make you an effective member of the Audit Committee of the Academy?



Richard R. Orlandi, MD

My motivation for this role is simple: ensuring the ethical and efficient use of our valuable Academy members' dues and other contributions. Our Academy provides exceptional value for its members, but these services come at a significant price. Our members should expect that their dues and donations are spent with maximal effectiveness.

I have benefited from many responsibilities that have yielded financial experience. Most recently I have been appointed medical director for a 200,000 square-foot multispecialty clinic with an annual budget of more than $25 million. I am well versed in poring over detailed financial reports in order to make sure that every dollar is being spent effectively and in accordance with established policies.

I have had the honor of working with many altruistic and ethical leaders. Nonetheless, there was a common saying in my residency: "Don't trust your mother." Independent financial oversight is crucial to ensure that disbursements are consistent with the high ethical standards that our Academy members deserve. Based on my motivations and experiences, I am confident that I am well qualified for this role.

I appreciate the honor of this nomination and, if elected, pledge to the members my best efforts in carrying out this responsibility.

Jerome W. (Jerry) Thompson, MD, MBA

I would be honored to serve on the AAO-HNS Audit Committee. I received an MBA with emphasis in Finance from UCLA. I've held several positions to prepare for financial leadership responsibilities, including as treasurer of the county medical society for four years and past president. Also, I have previously served on the AAO-HNS Audit and RVU committees. In addition, I have held numerous positions with the American Society of Pediatric Otolaryngology (ASPO): Finance Committee, COIN Representative, Audit Committee (Chair), Local Arrangements Committee, CME Committee (Chair), Secretary and Past President. Currently, I serve on the Grant Review Committee of the Juvenile Diabetes Research Foundation (JDRF). This is a national non-profit organization in which I assist in awarding $50 million in grants every year for research. The Governor appointed me to serve on the State of Tennessee Board of Communication Disorders and Sciences Committee (2008-2010). I am currently Chairman, Department of Otolaryngology, U.T. Health Science Center and former Associate Dean, Graduate Medical Education, U.T. Health Science Center (1997-2000) responsible for a budget of $60 million and supervised 900 residents campus-wide. If elected, I will work closely with the committee to be responsive to the members and help safeguard the Academy.

Special Thanks To Our IRT Partners

We extend a special thank you to the partners of the AAO-HNSF Industry Round Table (IRT) program. Corporate support is critical to realizing the mission of the Academy, to help our members achieve excellence and provide the best ear, nose, and throat care through professional and public education and research. Our partnerships with these organizations who share this mission allow the Academy to continue to provide the programs and initiatives that are integral to our members providing the best patient care.

AAO-HNSF IRT INDUSTRY ROUND TABLE

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Candidates for Nominating Committee (Academic) (VOTE FOR TWO)

What do you see as the priorities of the Nominating Committee in selecting the future leaders of our Academy?

Ellen S. Deutsch, MD

AAO-HNS members will face many challenges in the years ahead, but we have the benefit of a community with wisdom, talent, and enthusiasm. Throughout the years, I have had the privilege of working alongside a wide variety of dedicated, skilled members of the AAO-HNS community, as we have continually improved the quality of our patient care, our educational practices, and our research. The Nominating Committee is responsible for looking within our community to identify candidates who are the "best of the best;" those who are visionary, passionate, collaborative, and committed to representing the varied interests of Academy members.

I have served on a variety of AAO-HNS committees and I've served in leadership roles in several national and international professional societies; these experiences have helped me understand leadership qualities. Our leaders will need to understand how to make the best use of rapidly evolving technologies, and the socioeconomic context in which we function, in order to enable otolaryngologists to provide the best care for our patients. I would be honored to have the opportunity to dedicate my longstanding interest and experience toward the evaluation, recommendation, and nomination of the future leaders of the AAO-HNS.

Christine B. Franzese, MD

The Nominating Committee's priority is to select visionary, forward-thinking, and engaging leadership candidates that comprise a slate of officers that accurately reflects the diversity of the entire organization while maintaining balance among subspecialties, practice types, age, and gender.

Maintaining balance is essential to success, and as a former program director and former president of the SUO-Otolaryngology Program Directors Organization, I understand how critical this is. The success of the program is represented by the success of its graduates and the fundamental knowledge that graduates employ represents the strength of the program, the balance of exposure among the different subspecialties, and the acquisition of the nuanced tools of the business of medicine while thriving in academia.

This same balance needs to be maintained when selecting qualified leadership candidates for such a large and varied organization. Having been involved in leadership roles in single subspecialty and multispecialty organizations, I feel these experiences and insights have given me a balance that will serve our organization well in harnessing our diverse strengths and ensuring our leadership accurately reflects our membership. Serving on the Nominating Committee would be an honor and a privilege, one I hope the membership finds me worthy of.

Stacey Ishman, MD, MPH

Like many of you, the Academy has always served as my professional home. I appreciate the efforts put forth to improve practice (and reimbursement), to broaden research, and to focus us on quality. The ultimate job of the Academy leadership is to assure that we can provide patients with safe, evidence-based care. Toward that end, I think the Nominating Committee must select leaders who are focused on the education of our members while understanding the social and economic issues that we are facing as academic and private practitioners alike. We need leaders who have committed their time to furthering these goals as educational presenters, as researchers, as legislative advocates, or as Academy committee members. An ideal candidate must also have the vision to continue to position the Academy at the forefront of the quality and patient outcome efforts while being aware of the need for the diverse perspectives that are necessary to represent our broad constituency.

In summary, I believe we must select physician volunteers who have a commitment to service, an understanding of the issues affecting medicine, and the integrity and passion to carry out this important work.

Brian Nussenbaum, MD

The role of the AAO-HNS Nominating Committee is "to provide the voting membership of the AAO-HNS with a slate of candidates that have been determined to be the 'best of the best' to carry on the leadership of the Academy." I see this responsibility as critically important, especially in these rapidly changing times for medicine. I believe that successful leadership of our organization is not about individual leaders, but rather the leadership team that represents the collective interests and concerns of all otolaryngologist-head and neck surgeons from diverse backgrounds. The strength of the leadership team is based on the collective intelligence and fortitude of its members, and the commitment to the organization's core values. The ideal Academy members who compose the leadership team will include those who come from diverse backgrounds, have demonstrated dedication to our specialty, and have a clear vision for the continued success of otolaryngology. These individuals are humble, thoughtful, flexible, trustworthy, confident, altruistic, and inspiring. If elected, I will ensure that the Academy membership is provided with a slate of candidates that would all be outstanding leaders to build the team with and represent otolaryngology-head and neck surgery with honor and integrity.

Candidates for Nominating Committee (Private Practice) (VOTE FOR TWO)

What do you see as the priorities of the Nominating Committee in selecting the future leaders of our Academy?

Ajay E. Chitkara, MD

Though otolaryngologists represent a relatively small proportion of physicians in this country, our membership is extremely diverse. This variability in our membership demands the combination of experience, adaptability, and vision in our leadership corps.

Future leaders of our Academy must have diverse and practical experiences, which provide a basis for future direction. Experience in clinical practice (academic or private), fosters an understanding of the challenges we confront on a daily basis. Experience in local, regional, and national organizations provides the foundation crucial for our leadership.

Adaptability is an important characteristic for those at the helm of our Academy. The practicing otolaryngologist in 2013 is confronted with a plethora of regulatory, compliance, and technological changes—current and future. This evolving nature requires our Academy, and its leadership, to progress forward with the continuously changing playing field.

In the context of the changing healthcare landscape, it is imperative that leaders of our Academy provide an astute vision by which to navigate our specialty. Building upon experience and adaptability, clarity of vision will provide the best opportunities for our membership and our patients as we forge through this rapidly evolving era in medicine.

Lisa Perry-Gilkes, MD

"Without vision the people perish." The honor of being nominated is not taken lightly. The members of the Nominating Committee have the responsibility of selecting the physicians who will form the future and the vision of our Academy.

One of the priorities of this committee is to select candidates with insight to prepare us for the evolution of the practice of medicine. These changes are on all fronts. Physicians face challenges in all modes of practice. Our specialty is rapidly advancing in innovations in patient care. We will also conform to the changes required by the Affordable Care Act.

We are an Academy of heterogeneous members from general otolaryngologist to subspecialist, members still in training to seasoned professionals. An ever increasingly diverse group, we join together in one voice. Another imperative/priority of this committee is to select candidates that reflect our members.

I enjoy the opportunity to serve the Academy by being a member of the Board of Governors and Chair of the Diversity Committee, which allows me access to the Board of Directors. Through this involvement I continue to make the acquaintance of our dedicated leaders. I will seek comparable candidates to serve. Thank you for your support.

Shannon P. Pryor, MD

Nominating Committee members must be active in efforts to identify and encourage those individuals with the ability, dedication, and responsiveness to become effective and inspiring leaders of our Academy. We should be following emerging leaders at all levels within our organization to encourage leadership development from the bottom up. We must include both the younger generations who will eventually be most affected by our decisions, and the older generations who are willing to share the wisdom gained from experience. We should strive to achieve diversity within our leadership, not only of race, gender, and age, but also of practice setting, subspecialty, and practice type. More importantly, as practice patterns and physician demographics change, we should be nominating leaders who are not partial to one particular mindset or group, but who will keep open minds and be responsive to the needs of all of our members. We should seek effective communicators who have demonstrated the capacity to work toward consensus within a group while still keeping all points of view and all stakeholders in mind. We should seek those who demonstrate the enthusiasm, flexibility, and vision to do what is best for our Academy, our specialty, and our patients.

Ken Yanagisawa, MD

The current complex climate of medicine highlights the critical role of the Nominating Committee. We face challenges, previously foreign to many of us—increasing regulation of our practice habits, scrutiny of any and all of our interventions and decisions, and total accountability for patient quality outcomes reporting. The committee must select AAO-HNS members who are well versed in medicine, as well as adept with socioeconomic issues, legislative activities, and insurance mandates. Enthusiasm, fairness, and skillful representation of our membership are essential; staying abreast of the ever-changing target of effective healthcare delivery systems is a must.

Experiencing the escalating economic and practical challenges facing practitioners during the past 20 years as an attending otolaryngologist, and understanding how to coordinate and prioritize physicians' goals as Section Chief of Otolaryngology at Yale-New Haven Hospital Saint Raphael campus, as President of the CT ENT Society and President of New England Otolaryngological Society, and serving on the BOG Nominating Committee, I have confidence in identifying exceptional candidates. Excellent communication skills, a firm grasp of our current issues and future directions, and engagement of members—from new graduates to established practitioners—will be my top priorities in selecting our future leaders.

Bills to Watch in the 113th Congress

With the first session of the 113th Congress well underway, the AAO-HNS Government Affairs team is closely monitoring legislation relating to our legislative priorities. Below is a preliminary list of bills to watch that will potentially affect the specialty, your practice, and your patients.

H.R. 351/S. 351, the "Protecting Seniors Access to Medicare Act of 2013"

Introduced by Rep. Phil Roe, MD (R-TN) and Sen. John Cornyn (R-TX), H.R. 351/S. 351 would repeal the provision of the Affordable Care Act (ACA) mandating the creation of an Independent Payment Advisory Board (IPAB) to recommend Medicare policy and payment changes with limited Congressional oversight. The AAO-HNS is a strong supporter of H.R. 351/S. 351 and continues to work with others in the physician community to strengthen the bipartisan cosponsor list for this important legislation.

H.R. 1427, the "Truth in Health Marketing Act of 2013"

Introduced by Rep. Larry Bucshon, MD (R-IN) and Rep. David Scott (D-GA), H.R. 1427 would require all physician and non-physician healthcare professionals to fully disclose their level of training and applicable credentials in all advertising/marketing materials. The AAO-HNS is a key supporter of H.R. 1427 and actively worked with the bill's sponsors to ensure the introduction of legislation in the 113th Congress.

H.R. 1473, the "Standard of Care Protection Act"

Introduced by Rep. Phil Gingrey, MD (R-GA) and Rep. Henry Cuellar (D-TX), H.R. 1473 provides common-sense protections for physicians by preventing certain Federal healthcare laws from establishing healthcare provider "standards of care" in medical liability cases. The AAO-HNS is a strong supporter of H.R. 1473 and continues to educate Members of Congress regarding the importance of ensuring critical medical liability protections.

H.R. 1201/H.R. 1180/S. 577, the "Resident Physician Shortage Reduction Act of 2013"

Introduced by multiple members of the U.S. House of Representatives (Schock, Schwartz) and U.S. Senate (Nelson, Schumer, Reid), H.R. 1201, H.R. 1180, and S. 577 would help to ensure a more robust "physician workforce pipeline" by expanding residency slots in identified physician shortage areas. The AAO-HNS is a strong supporter of legislation that protects and/or expands existing residency slots for specialty physicians.

Pending Legislation: ASHA Proposal

Soon to be introduced by Rep. Gus Bilirakis (R-FL), the proposal being advanced by the American Speech-Language and Hearing Association (ASHA) is intended to better align Medicare coverage of comprehensive audiology services with current billing and reimbursement standards of other non-physician therapeutic services covered by Medicare (PT, OT, SLP). They specifically retain the requirement for a physician referral, as well as physician oversight of the plan of care. The AAO-HNS will take a support position on the bill once introduced.

Outlook for the Remainder of 2013

Audiology Scope Expansion Legislation

The AAO-HNS anticipates the American Academy of Audiology (AAA) and the Academy of Doctors of Audiology (ADA) to pursue legislation that ultimately will threaten patient safety and the provision of quality hearing healthcare. AAA is expected to once again seek introduction of legislation to provide audiologists with direct access to Medicare patients without a physician referral, while ADA intends to seek legislation to amend Title XVIII (18) of the Social Security Act to include audiologists in the definition of "physician." At the time this article was written, no legislation relating to these efforts had been introduced in the U.S. Congress. However, the AAO-HNS will strongly oppose both bills upon their introduction.

Repeal of the Flawed SGR Formula

Since February, the U.S. House Ways and Means and Energy and Commerce committees have been working to develop a framework for legislation to repeal the flawed Sustainable Growth Rate (SGR) formula and replace it with a new Medicare physician payment system. The AAO-HNS and others in the physician community continue to work with Members of the Congress and their staff to examine the pros and cons associated with any new payment model. Committee leaders have identified the Congressional August recess as their target date to have legislation considered on the House floor. However, given the complexity of developing a new payment system, consideration of possible legislation may be pushed until September/October. The AAO-HNS is a long-time advocate of SGR repeal efforts and will continue to work with Congress to advance this necessary reform.

For more information regarding AAO-HNS federal legislative activity in the 113th Congress, visit www.entnet.org/advocacy or email legfederal@entnet.org.

AAO-HNS Mid-Year State Legislative Update

Across the nation, all 50 states and the District of Columbia's legislatures convened for their regular sessions this year. By the end of June, only eight states will remain in regular session as most have already adjourned for the year. As of May 1, 2013, more than 100,000 state-based bills had been introduced in the United States in 2013. The AAO-HNS is monitoring more than 800 bills at the state level, including holdover bills from 2012. Of those, there are 63 state legislative bills that have been identified as being of particular importance to AAO-HNS members, their practices, and their patients. We have provided state otolaryngology leaders with customized tracking reports, notifications, and alerts for these legislative bills of interest.

> As of May 1, 2013, more than 100,000 state-based bills had been introduced in the United States in 2013. The AAO-HNS is monitoring more than 800 bills at the state level, including holdover bills from 2012.

Stay Informed: Follow the Government Affairs Twitter Account

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Follow the Government Affairs Twitter account @ AAOHNSGovtAffrs. By following us, you can learn more about the issues impacting the specialty, including repeal of the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You can also check the Government Affairs webpage for updates at http://www.entnet.org/Advocacy.

Scope of Practice

The AAO-HNS believes it is appropriate for non-physician providers to seek updates to statutes and regulations relating to their defined scope of practice to reflect advances in education and training. However, the AAO-HNS strongly opposes state legislation that would inappropriately expand the scope of practice for non-physician providers beyond their skills. Enabling non-physician providers to independently diagnose, treat, or manage medical disorders could adversely affect the quality of patient care.

This year, the AAO-HNS has advocated to modify and/or defeat several potentially harmful bills that would inappropriately expand the scope of practice of non-physician professionals. In **West Virginia**, the AAO-HNS opposed a bill that inappropriately expanded the current scope-of-practice provisions to allow speech-language pathologists and audiologists to diagnose, manage, and treat medical conditions. In addition, the AAO-HNS, working with the state society, opposed legislation in **Michigan** regarding an inappropriate scope expansion for naturopaths as part of their proposed licensure act. Unfortunately, despite efforts by the Academy, the **Colorado** legislature adopted a scope-of-practice expansion bill for audiologists.

In **New York**, a bill has once again been introduced that seeks to permit non-physician oral and maxillofacial surgeons to perform elective surgeries in the oral and maxillofacial regions if granted hospital privileges. The AAO-HNS is working with other state and national organizations in a coalition to defeat this legislation.

Truth in Advertising

With the emergence of clinical doctorate programs for non-physician providers, which has led to many degree holders referring to themselves as "doctors," there is growing confusion within the patient population about the level of training and education of their healthcare providers. Prior to this year's state legislative sessions, truth-in-advertising legislation has been enacted in Arizona, California, Connecticut, Florida, Illinois, Oklahoma, Oregon, Pennsylvania, Tennessee, and Utah.

In 2013, there have been truth-in-advertising bills—both good and bad—introduced in **Arizona, Arkansas, California, Florida, Iowa, Idaho, Illinois, Massachusetts, Michigan, Nebraska, Nevada, New Jersey, North Dakota, Oklahoma, Vermont, Washington,** and **Wyoming**. **Arizona, Nevada,** and **New Jersey** introduced legislation, which was problematic as it would have excluded certain physicians from advertising their legitimate board certifications. The AAO-HNS, working with other national specialty organizations and the state medical societies, has developed and advanced legislative language to ensure truth and transparency in healthcare advertisements and patient interactions, while ensuring all

AAO-HNS members' board certifications are protected.

Taxes on Medical Procedures

Proposals to tax medical procedures continue to be an issue in the states, and, in light of extensive state budget shortfalls, this year has been no exception. The Stop Medical Taxes Coalition–a coalition of national, state, and local organizations, of which the AAO-HNS is a member–asserts that the taxation of medical procedures is unfair for patients and is a "slippery slope" toward the taxation of other medical services. In **Minnesota and Maine**, the legislatures are considering extending the state sales tax to cosmetic procedures. The AAO-HNS and other Coalition members have submitted written comments to the Minnesota and Maine legislatures in opposition to the proposed taxes.

Hearing Aid Services

The coverage of, sale, and dispensing of hearing aids is an issue considered by several states in various forms each year. In **New York**, the AAO-HNS worked closely with the Patient Access to Hearing Aids (PAHA) Coalition to advocate for a bill that would expand patient access to hearing aid services by striking an archaic law prohibiting physician practices from deriving a profit on hearing aid sales. This year, the PAHA Coalition attained introduction of amended companion bills in both the Senate and Assembly. **Massachusetts** also had legislation seeking to allow otolaryngologists to dispense hearing aids, which the AAO-HNS actively supported.

In addition, several states are considering bills to require insurers to cover the cost of or expand benefits for hearing aids and/or cochlear implants, including **Connecticut, Georgia, Hawaii, Illinois, Maine, Massachusetts, Mississippi, Missouri, New York, South Carolina, Texas, Vermont, Washington,** and **West Virginia**. Several states are also considering bills that would provide a tax credit and/or exemption for hearing aids, including **Arkansas, Hawaii, Massachusetts, Missouri, New Jersey, New York,** and **Oklahoma**.

ENT PAC

ENT PAC, the political action committee of the AAO-HNS, financially supports federal Congressional candidates and incumbents who advance the issues important to otolaryngology–head and neck surgery. ENT PAC is a nonpartisan, issue-driven entity that serves as your collective voice on Capitol Hill to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit our new PAC website at www.entpac.org (log-in with your AAO-HNS ID and password).

Tobacco Use and Smoking Cessation

The AAO-HNS supports legislation and regulations to help reduce the use of tobacco products and exposure to secondhand smoke in order to promote healthy environments and lifestyles for the public. This year, bills have been introduced in 14 states that sought to strengthen existing smoking ban laws, including **Alabama, California, Connecticut, Illinois, Kentucky, Maine, Mississippi, Missouri, New Jersey, Oklahoma, South Carolina, Virginia**, and **Vermont.** A number of states are considering proposals to mandate insurance coverage and/or benefits for tobacco cessation, including **California, Florida, Hawaii, Indiana, Massachusetts, New Jersey, New York, and Virginia**. There are a few states—**Hawaii, Indiana**, and **New Jersey**—that have proposed legislation to exempt certain establishments from a smoking ban if they pay a fee to become licensed as exempt.

A new issue that has arisen this year in the states is the inclusion of regulating alternative nicotine products and electronic cigarettes. **California, Hawaii, Illinois, Missouri,** and **South Carolina** introduced legislation on this issue.

Medical Liability Reform

Thus far in 2013, there are 13 states considering various tort reform measures, including those related to affidavits of merit, alternative reforms, caps on non-economic damages, defensive medicine issues, expert witnesses, health courts, or pre-trial screening panels. In **Connecticut,** there was a proposal to weaken the requirements for current Certificates of Merit. The AAO-HNS, with the state society, advocated against this change. In addition, a number of states, including **Connecticut, Hawaii, Missouri, New Jersey, Oregon, Pennsylvania,** and **Virginia** are considering enacting or modifying caps on non-economic damage awards in medical liability cases. In **Iowa**, the legislature is considering comprehensive medical liability reform.

For more information about AAO-HNS legislative priorities and/or activities, visit the Legislative and Political Affairs website at www.entnet.org/advocacy or contact legstate@entnet.org for state legislation inquiries. If you would like to receive timely updates regarding AAO-HNS legislative efforts, join the ENT Advocacy Network by emailing govtaffairs@entnet.org.

Twitter 'How To'

Twitter Glossary

Twitterverse: The Twitter social networking platform and its users.

Handle: Your twitter name. (e.g., @AAOHNSGovtAffrs or @aao-hns)

Follow: When you "follow" someone, you can see what they have tweeted in real time.

Tag: Mentioning another person by placing an "@" before their Twitter handle.

Feed: There are generally two feeds: one is for tweets you have sent out and the other default feed is the tweets of people you are following.

Tweet: A micro-blog of 140 characters.

Retweet (RT): By retweeting something, it will show up on your feed and will be tweeted to others under your name. It is considered a courtesy to "tag" the author of the tweet in your retweet.

Modified Tweet (MT): A modified tweet is a "retweet" you have edited.

Hashtags (#): Make key terms searchable. When hashtagging, it is common for a phrase or pair of words to become a searchable term. However, this requires removing the space between words. (#SpeakerBoehner)

Trending: Hashtagged terms that are widespread and being used by a large portion of the Twitterverse.

Logging In

1. Go to www.twitter.com.
2. Enter your username (generally your email or twitter handle) and password. If it's your first time, sign up using the box on the screen.

Two Ways to Find Someone on Twitter

1. Enter search terms or names of colleagues in the search bar.
2. Twitter also recommends people you may wish to follow.

How to Tweet

1. There are two areas you may click to compose a tweet.
2. Tweets cannot be more than 140 characters, which includes letters, spaces, links, and punctuation, so make every character count!
3. Tweets are short, so do not get hung up on complex grammar/punctuation rules.
4. Commonly used phrases are often abbreviated and acronyms are often used. For instance, on personal accounts, you may see LOL (laugh out loud), w/o (without), or b/c (because). And, on the AAO-HNS Government Affairs account, you may see SGR (Sustainable Growth Rate), POTUS (President of the United States), or SCOTUS (Supreme Court).
5. If you are linking to an article in your tweet, shorten the link using www.bitly.com. This will help keep within the 140 character limit.
6. Hashtag (#) the key words in your tweet. By hashtagging your key words, your tweet becomes searchable to other people in the twitterverse.
7. If you want to engage an individual on a topic publicly, simply put an "@" in front of their handle. For instance, here is a response by Artur Gevorgyan to our tweet regarding your ears and air travel. By tagging that individual, it gives feedback to the author of the tweet and lets your followers see your comment.

Health Policy By the Numbers: A Snapshot of Early 2013

2013 has proven to be yet another busy year for the Academy's Health Policy team as we continue to work with federal regulatory agencies, private payers, consumer advocate groups, patients, and providers to ensure Academy members receive the best representation and advocacy for our specialty possible. Here is a snapshot, by the numbers, of how the Academy's Health Policy department has advocated on behalf of members thus far in 2013.

3: The number of fact sheets created by the Health Policy and Research and Quality Improvement departments to inform members and aid in their participation in the Physician Quality Reporting System (PQRS), Electronic Health Record (EHR) Meaningful Use (MU) Incentive Program and the Electronic Prescribing (eRx) Incentive Program. These sheets and other information can be found on the Academy's website at www.entnet.org/cmspenalties.

135 (as of May 14): The number of member inquiries the Health Policy department has responded to. Every day, members from across the country contact the Health Policy staff with questions ranging from private payer denials and appeals, questions and requests for resources for Quality Reporting Programs such as PQRS and EHR Incentive Programs http://www.entnet.org/Practice/CMSpenalties.cfm, information on changes to CPT coding requirements or newly developed CPT codes http://www.entnet.org/Practice/CPT-Codes-for-2013.cfm, and tools to aid in the upcoming ICD-10 transition http://www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm. Health Policy staff work to assist members on a wide variety of issues by providing up-to-date resources and expert analysis. We urge members to contact us with any health policy inquiries at healthpolicy@entnet.org.

16: The number of *Bulletin* articles developed by the Physician Payment Policy (3P) Workgroup and Health Policy staff from January2013 - May 2013. Articles included summaries of 2013 physician payment rules, CPT coding guidance, and work the Academy is undertaking on current, and future, payment models and trends in otolaryngology.

7: The number of physician leaders serving on the Academy Ad Hoc Payment Model Workgroup which includes members of the Physician Payment Policy work group (3P) and research and quality leaders. This Ad Hoc group reviews the current and future payment trends in otolaryngology-head and neck surgery with the goal of preparing our leaders to be able to respond to new payment models as they are developed by government and commercial insurers. Members of the Ad Hoc workgroup have recently begun reviewing some potential bundled payment and episode of care models.

2: The number of miniseminars 3P and Health Policy staff will be presenting at the 2013 AAO-HNSF Annual Meeting & Oto Expo in Vancouver, BC, Canada from September 29 to October 2, 2013. Two sessions, titled "Alternative Payment Models & Academy Advocacy" and "Pearls on How to Transition to ICD-10 Coding by 2014" will feature advice from Academy and outside experts on the future of healthcare payment and provider transition to the ICD-10 coding system.

16: The number of Academy Position Statements reviewed in Round 2 by Academy clinical committees. Position Statements serve the following functions: a response to payer policies; a way to publicize our position or support a procedure; for use in advocacy efforts with state and federal regulatory bodies, in response to federal policy or law; or to clarify the Academy's position on certain practices within the specialty. They are reviewed every four years to ensure the statements are up to date and useful for members. The Academy's position statements can be accessed at: http://www.entnet.org/Practice/Position-Statements.cfm

6: The number of CPT codes surveyed by the Academy in 2013 for the January and April AMA Specialty Society Relative Value Scale Update Committee (RUC) meeting. In January, CPT 69210 removal impacted cerumen and new code CPT 6461XX chemodenervation of the larynx were presented to the RUC. In April, the Nasal/Sinus Endoscopy family of codes (31237-31240) were surveyed and data was presented to the RUC during the April, 2013 RUC meeting. Members are encouraged to keep an eye out for future solicitations for participation in RUC surveys, as they are an important tool used to establish Medicare reimbursement for otolaryngology services. To access more information regarding the RUC survey process, visit: http://www.entnet.org/Practice/Applying-for-CPT-codes-and-Obtaining-RVU.cfm.

7: The number of private payer policies the Academy coordinated review of and submitted comments on. These include United HealthCare and Aetna's Septoplasty and Rhinoplasty coverage policies, United HealthGroups: Direct-to-Consumers (DTC) hearing aid sales program, and WellPoint/BCBS Sinus Ostial Balloon Dilation Policy. You can access resources to help you with the Academy's Private Payer Advocacy at http://www.entnet.org/Practice/pmNews.cfm.

2: Number of new or revised CPT for ENT articles distributed and posted on the website for Members. For more information on Academy coding guidance visit: http://www.entnet.org/Practice/cptENT.cfm.

1: Number of in-person meetings the Academy Health Policy and Research, Quality Improvement staff has convened with CMS to discuss clinical quality measures and the need for more specific measures related to our specialty to enable members to meaningfully participate in quality programs such as PQRS and the EHR Incentive program.

Summary of the March 2013 MedPAC Report to Congress

Every spring, the Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency established to advise the U.S. Congress on issues affecting the Medicare program, issues a March report to the Congress. In the March 2013 report, MedPAC focused on several areas, including payment adequacy; payment for hospital inpatient and outpatient services; and payment in Ambulatory Surgical Centers (ASC). Health Policy staff at the Academy regularly track MedPAC reports, and highlight any recommendations that may affect members of the Academy.

Reforming Medicare

In the 2013 report, MedPAC analyzed growth and spending in Medicare and other factors that affect healthcare spending in the U.S. Additionally, it studied the influence spending and growth will have on Medicare and federal healthcare spending. As in previous reports, MedPAC noted that it is essential to reform Medicare to decrease the growth in spending and create incentives for beneficiaries to seek, and for providers to deliver, high quality services at the lowest possible cost.

In October 2011, MedPAC recommended abandoning the Sustainable Growth Rate (SGR) and replacing it with a 10-year path of statutory fee-schedule updates. This path would be composed of a freeze in current payment levels for primary care and for all other services, annual payment reductions followed by a freeze. MedPAC once again reaffirms this recommendation in its March report. The Academy is presently working with members of Congress on a proposal to replace the SGR, and agrees that the current system is broken but does not agree with MedPAC's recommendations and signed on to an AMA letter noting concerns. For more details on the Academy's work to replace the SGR, see the April 2013 issue of the *Bulletin*.

Payment Adequacy Findings and Recommendations

Another aspect of the March report evaluated payment adequacy for care, services, and equipment and decides whether or not to recommend an increase, maintenance, or a decrease to payments provided to Medicare beneficiaries. In previous reports, MedPAC has called for an equalizing of payment rates for office visits provided in outpatient departments and physician offices. This is based on variations in payments between the sites of service, and the Commission's belief that Medicare can achieve savings by equalizing payment rates. In the March 2013 report, MedPAC reiterated this recommendation.

MedPAC also evaluated payment levels and the influences they have on beneficiary care and access. In the 2013 report MedPAC recommends increasing payment rates for inpatient and outpatient services in 2014 by one percent, based on an analysis of these factors. The report stipulates ASC payments and access are adequate for beneficiaries, but growth has slowed. MedPAC therefore recommended eliminating an update to payment rates in 2014 until Congress requires ASCs to begin reporting cost data to CMS.

Health Policy staff will continue to attend and monitor MedPAC meetings regularly for any policies or recommendations that affect Academy members. If you have any questions about MedPAC, or its recommendations, email the Health Policy team at healthpolicy@entnet.org.

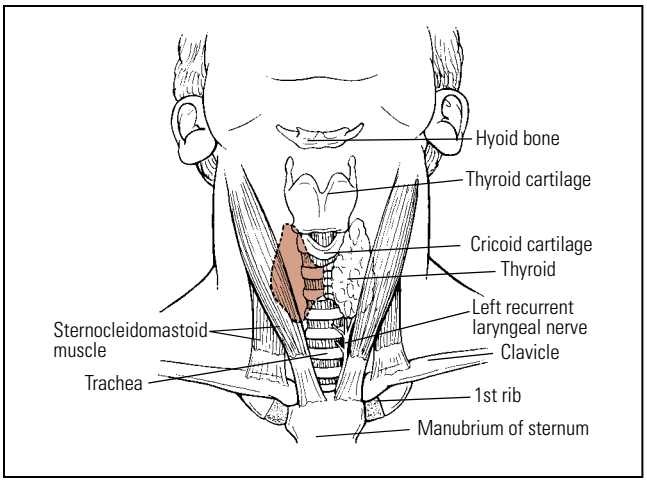
New CPT Assistant: See pages 40-42

As many members know, CPT® Assistant is a product developed by the American Medical Association (AMA) and is a fully-searchable newsletter that includes more than 20 years of historical reference materials approved by the AMA CPT® Editorial Panel. Monthly issues are made available to subscribers that provide clarity on coding issues as well as accurate and reliable coding tips and interpretations. In special circumstances, the AMA grants permission to medical specialty societies, such as the AAO-HNS, to reproduce CPT® Assistant articles that are relevant to a specific specialty, or set of sub-specialties. As such, we are reproducing the following CPT® Assistant article on Thyroidectomy and Parathyroidectomy, printed in the December 2012 CPT® Assistant newsletter, to apprise members of appropriate coding for these services. Members with questions about the article should contact us at: healthpolicy@entnet.org

Thyroidectomy and Parathyroidectomy

Anatomically, the thyroid gland, located in the anterior part of the neck overlying the cricothyroid membrane and thyroid cartilage, is comprised of two halves (lobes) with a butterfly-shape connected by a narrow band of tissue called the isthmus. See Figure 1. The thyroid gland, under the control of the pituitary gland, produces the hormones triiodothyronine (T3) and thyroxine (T4), which play a major role in regulating metabolic functions of most body cells.

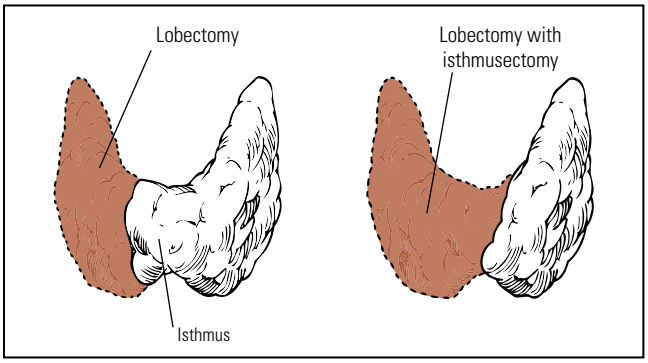
Figure 1. Thyroid Anatomy



Thyroidectomy With or Without Isthmusectomy

Examples of benign thyroid conditions that may require surgery include multinodular (nontoxic), goiter (an enlarged thyroid gland), and thyroid nodules. Surgery may be needed if the gland becomes large enough to compress or displace the trachea or esophagus. See Figure 2.

Figure 2. Thyroidectomy



60210 Partial thyroid lobectomy, unilateral; with or without isthmusectomy

60212 with contralateral subtotal lobectomy, including isthmusectomy

60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy

60225 with contralateral subtotal lobectomy, including isthmusectomy

Thyroid nodules may be solid, fluid filled, or contain both fluid and solid parts (complex nodule). Surgical excision may be required if the nodule is indeterminate or neoplastic on fine needle aspiration (FNA) cytology, or if the nodules are causing airway or other functional problems. Thyroid masses can be benign or malignant and often the distinction can only be made by histologic examination performed on the thyroid tissue containing the nodule(s), which requires at least a partial thyroidectomy. Table 1 provides procedural differentiation of this series of codes.

Table 1. Procedural Differentiation by Codes

CPT Code	Description of Procedure
60210	A portion of one thyroid lobe is removed including the isthmus, if performed.
60212	Portions of both lobes are removed along with the isthmus.
60220	One entire thyroid lobe is removed including the isthmus, if performed.
60225	One entire thyroid lobe is removed including the isthmus and part, but not all, of the opposite thyroid lobe.

Codes 60240-60271

Codes 60240-60271 are generally reported for excision of thyroid tissue because of more complex benign conditions (eg, very large goiter) or malignancy. These conditions may also require neck dissection, a surgical procedure for the evaluation and control of neck lymph node metastasis.

60240 Thyroidectomy, total or complete

(For thyroidectomy, subtotal or partial, use 60271)

60252 Thyroidectomy, total or subtotal for malignancy; with limited neck dissection

60254 with radical neck dissection

60260 Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid

(For bilateral procedure, report 60260 with modifier 50)

60270 Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach

60271 cervical approach

The parenthetical note following code 60260 instructs users to append modifier 50 for a completion thyroidectomy when tissue is resected from both sides of the neck. Technically, if a completion thyroidectomy is performed, it may not be a bilateral lobectomy. For example, in the event a left thyroid lobectomy is performed and two days later a right thyroid lobectomy is performed, code 60260 without modifier 50 appended should be reported, as it represents re-entering an already operated field to remove all remaining residual thyroid tissue following previous removal of a portion of the thyroid gland. When performed on the second side that is undisturbed at the first surgery, the dissection with concern for recurrent laryngeal nerve and parathyroids is the same as with the first surgery, and it would therefore be reported using code 60260. For this specific example, modifier 58, *Staged or Related Procedure or Service by the Same Physician Or Other Qualified Health Care Professional During the Postoperative Period,* should be appended to code 60260. Another example would be when a left partial thyroid lobectomy is performed followed two days later by completion (total) thyroidectomy. In this situation, the removal of the remainder of the left lobe, isthmus, and right lobe would be reported with code 60260 with both modifiers 50 and 58 appended. Please refer to the operative report to determine specific completion thyroidectomy procedure performed.

Review of Lymph Node Regions

The following is excerpted from the August 2010 issue of *CPT Assistant,* which addressed neck dissection reporting.

> In 1991, the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) standardized neck dissection terminology to define the regions of involvement of the cervical lymph node groups. The terminology is as follows:
>
> **Region/Level I:** Submental and submandibular nodes.
>
> **Ia:** Nodes in the submental triangle bound by the anterior bellies of the digastric and the hyoid bone.
>
> **Ib:** Nodes in the submandibular triangle bound by the anterior and posterior bellies of the digastric and body of the mandible.
>
> **Region/Level II:** Upper jugular lymph nodes, including the jugulodigastric nodes.
>
> **IIa:** Nodes in the region anterior to the spinal accessory nerve.
>
> **IIb:** Nodes in the region posterior/superior to the spinal accessory nerve.
>
> **Region/Level III:** Mid-jugular nodes from the carotid bifurcation to the omohyoid muscle.
>
> **Region/Level IV:** Nodes of the lower jugular area that extend from the omohyoid to the clavicle.
>
> **Region/Level V:** All lymph nodes within the posterior triangle of the neck.
>
> **Region/Level VI:** Nodes in the anterior compartment group, between the carotid sheaths, which includes the lymph nodes that surround the midline structures of the neck (trachea and esophagus). (These nodes extend from the hyoid bone superiorly to the suprasternal notch inferiorly.)

Refer to the August 2010 *CPT Assistant* for further discussion of the nodal classifications and the neck dissection classifications. Currently, radical neck dissections are rarely performed for the treatment of thyroid cancer. Code 60240 may be reported when thyroidectomy alone is performed for malignancy. Code 60252 represents a total thyroidectomy with limited lymph node dissection. If a central neck and a lateral level II-IV neck dissection are done, both codes 60252 and 38724, *Cervical lymphadenectomy (modified radical neck dissection),* should be reported.

Code 60260 represents re-entering the central compartment of an already operated field to remove all remaining residual thyroid tissue (benign or malignant) following the previous removal of a portion of the thyroid gland. This is usually performed following a hemithyroidectomy or thyroid lobectomy that returned positive results for cancer.

Codes 60270 and 60271 refer to the removal of the thyroid gland for benign or malignant conditions that extend into the upper chest.

Because the recurrent laryngeal nerve (that provides motor function to the vocal cords) is close to the site of surgery, intraoperative recurrent laryngeal nerve monitoring may be performed. Generally, this is performed using surface electrodes embedded in a special endotracheal tube. In this instance, there is no specific CPT code for recurrent

laryngeal nerve monitoring, and this service is not separately reportable if the surgeon or assistant surgeon does the monitoring.

Parathyroidectomy (60500-60505)

There are four parathyroid glands: one inferior and one superior gland on each side found underneath or rarely within each lobe of the thyroid. Because the parathyroid glands control calcium metabolism in the body, their proper function is essential to the physiology of muscular, cardiac, skeletal, and neural mechanisms.

Parathyroid disease may be limited to a single gland or may be multiglandular. Parathyroidectomy may be indicated for parathyroid tumors as well as hyperparathyroidism (overactivity), which can lead to conditions such as bone demineralization and kidney stones.

A parathyroidectomy may be performed to treat overproduction of the hormone that affects calcium levels or to address malignancy. Parathyroidectomy procedures are represented by codes 60500-60505.

60500 Parathyroidectomy or exploration of parathyroid(s)

60502 re-exploration

60505 with mediastinal exploration, sternal split or transthoracic approach

+60512 Parathyroid autotransplantation (List separately in addition to code for primary procedure)

To avoid hypocalcemia (low serum calcium) when parathyroidectomy is performed (alone or with thyroidectomy), the surgeon may transplant parathyroid tissue to another anatomic site (eg, arm, leg) to retain function. This parathyroid autotransplantation is reported in addition to the appropriate primary parathyroid or thyroid procedure code (60500, 60502, 60505, 60212, 60225, 60240, 60252, 60254, 60260, 60270, 60271) using the add-on code 60512, *Parathyroid autotransplantation (List separately in addition to code for primary procedure)*. However, parathyroid autotransplantation would typically not be necessary with a thyroid lobectomy (60200, 60210, 60220), as the two parathyroid glands associated with the nonexcised lobe or portion of the gland would not be at risk. Therefore, codes 60200, 60210, and 60220 are not in the inclusionary list with add-on code 60512.

Add-on code 60512 may not be reported in addition to the primary procedure, in the event the transplant site is in the neck (eg, sternocleidomastoid muscle) and approached through the same neck incision as the primary procedure into adjacent tissue.

When a thyroidectomy is performed for malignancy, the parathyroid glands may also be removed, and because this would be considered incidental, the parathyroidectomy (60500) would not be separately reported. For example, if a left thyroidectomy was incidental to a left parathyroid biopsy and resection, then the work is considered inclusive of the parathyroid gland removal described by code 60500, as this code refers to all four parathyroid glands and is not reported as a unilateral procedure. Therefore, only code 60500 would be reported. However, if the thyroid lobectomy was performed for an independent diagnosis, then code 60220 would also be reported with modifier 59, *Distinct Procedural Service,* appended.

Definition of Terms

Chronic thyroiditis (Hashimoto's disease). An autoimmune inflammation of the thyroid gland that frequently leads to a decreased function of the thyroid (hypothyroidism).

Hemithyroidectomy. Lobectomy; excision of one entire lobe of the thyroid.

Lymphadenectomy. A surgical procedure to remove lymph nodes.

Multinodular goiter. A nonmalignant enlargement of the thyroid gland, visible as a swelling at the front of the neck. ◆

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Clinical Fundamentals Courses Assist with MOC®

Sukgi S. Choi, MD
Annual Meeting & OTO EXPO℠
Instruction Course Coordinator

AcademyU®, the Foundation's otolaryngology education source, is pleased to offer yet another online learning opportunity. The two Annual Meeting Clinical Fundamentals courses on the treatment of anaphylaxis and evidence-based medicine are now available as online courses and can be accessed through www.entnet.org/clinicalfundamentals. These courses, topics otolaryngologists should know regardless of their practice focus, are designed for practicing otolaryngology head and neck physicians and surgeons, especially those involved in the Maintenance of Certification® process.

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Treatment of Anaphylaxis, presented by **John H. Krouse, MD, PhD**, reviews the clinical fundamentals on anaphylaxis, including recognition, diagnosis, pathophysiology, and treatment in the clinical setting.

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How Many Deaf People in the World Today? Origins of the Global Hearing Loss Prevalence Figures

P.W. Alberti, MBBS, PhD, FRCS
Professor Emeritus, ORL, University of Toronto, and Ex-General Secretary, International Federation of Otolaryngological Societies

IFOS World Congress 2009 miniseminar on "Prevention of hearing loss: a global challenge." l. to r. James E. Saunders, MD; Peter Alberti, PhD, FRCSC, FRCS; Young-Ah Ku, MD; Sujana S. Chandrasekhar, MD; Soha N. Ghossaini, MD.

In 1974, Sir John Wilson, a charismatic blind British activist, founded the World Health Organization (WHO) Global Prevention of Blindness program. A decade later, he challenged otolaryngology and audiology to do the same for hearing loss (HL). WHO had ignored hearing loss but, under the leadership of Baron Jean E. F. Marquet of Antwerp, Belgium, the International Society of Audiology (ISA) and the International Federation of Otolaryngological Societies (IFOS) conducted intense lobbying.

In 1986, this led WHO to commission an internal report on prevalence of HL. Based on a 1971 U.S. public health survey, the report concluded that 42 million people worldwide suffered from moderate to severe HL. WHO initiated a Prevention of Deafness and Hearing Loss program (PDH), but unfortunately because of low prevalence, it was not funded.

However, the figure of 42 million was greeted with incredulity—the landmark UK audiometric prevalence study by Davis, et al., had found a much higher prevalence. In fact, the WHO study probably had a transcription error, perhaps related to differing definitions of zero dB

in the U.S. and ISO standards at that time.

In 1991, PDH was placed in the Prevention of Blindness program under the excellent leadership of its director, Bjorn Thylefors, MD. One of his first actions was to host a weeklong external consultation, at which **James B. Snow Jr., MD**, played a pivotal role, setting the PDH program to the present time. Spurred by the urgent need to update the prevalence figures, Jun-Ichi Suzuki, MD, seconded from Japan to WHO for a year, developed the underpinnings of later national surveys conducted by and with WHO.

In 1994, after surveying literature from the Liverpool School of Tropical Medicine's Kenneth W. Newell collection, I produced a conservative estimate of 150 million worldwide. To avoid exaggeration, the WHO unilaterally cut this figure to 120 million worldwide. When presented to the 1995 WHO General Assembly, this figure led to a resolution urging action on HL, because of the apparent increase in prevalence.

Andrew W. Smith, MSc, MRCP, hired from Liverpool and funded by CBM (Christian Blind Mission), initiated many regional and national surveys. With limited resources, however, these surveys were still too few. The Chinese (PRC) national disability survey of the 1980s showed HL complaints of only 1.7 percent, which dragged down the global figures. Only in the 21st century did the PRC undertake a representative audiometric study that shows prevalence about four percent, similar to the rest of the world.

Meanwhile the aging global population grew by more than one billion. WHO undertook an internal study proposing a HL prevalence of 235 million. The global burden of disease (GBD), initially a WHO initiative, was revised and lowered the threshold for disabling hearing loss to >34 dB. WHO then raised the prevalence, at >34 dB, to 500 million, although not yet accepting the changed definition. Even at that threshold, GBD concluded the prevalence was only 235 million. The discrepancy remains unresolved.

Hearing Loss and the World Health Organization—Call for Action

James E. Saunders, MD
Coordinator-elect for International Affairs

Peter W. Alberti, MD's article outlines the visionary efforts by a group of men and women who fought to bring hearing loss onto the global health stage in the last 20 years. Recognition that worldwide hearing loss is common and can result in social isolation, language delay, poor educational outcomes, and economic hardship led to the creation of many international organizations to address these issues. Among them are Hearing International, Sound Seekers International, World Wide Hearing, the IFOS "Hearing for All" Campaign, and the Coalition for Global Hearing Health.

The recognition gave rise to the World Health Organization (WHO) Office for the Prevention of Deafness and Hearing Impairment. For many years, Andrew W. Smith, MSc, MRCP, who developed many surveys that gave us a more accurate assessment of global hearing loss, staffed this office.

In addition, Dr. Smith created training materials for primary care physicians and healthcare workers around the world that have been translated and adapted in multiple languages. After his mandatory retirement from the WHO, Young-Ah Ku, MD, a Korean otolaryngologist, carried on this work.

Professor Andrew W. Smith, MSc, MRCP, London School of Hygiene and Tropical Medicine, UK

In 2010, after withdrawal of external funding for this WHO office, the post was vacant for two years, despite the rising global estimates of people affected by hearing loss. When the AAO-HNSF and IFOS joined an international consortium to provide temporary support to this key office, the WHO appointed Shelly Khanna Chadha, MD, an Indian otolaryngologist, to direct this program. Dr. Chadha has served admirably in this position, developing an intensive work plan that includes:

- National hearing health programs in multiple countries;
- Promoting Primary Ear and Hearing Care (PEHC) around the globe; and
- Provisions to explore affordable technology to low resources areas.

Unfortunately, support for Dr. Chadha's appointment still relies entirely on external funding and is due to expire December 2013. There is an urgent need to raise awareness within the WHO and its member states about the status of global hearing loss. The WHO General Assembly has not received a hearing loss report since the current WHO Resolution (48.9) was adopted in 1995. Meanwhile, the latest WHO estimates are that 360 million people, five percent of the world population, suffer from disabling hearing loss.

Call to Action

The WHO Executive Board, composed of Health Ministry representatives from 34 member states, determines the WHO General Assembly agenda. We urge colleagues working in these 34 countries (including the U.S.) to contact their Health Ministry representative to the WHO Executive Board, asking for a new progress report on the status of global hearing loss.

For the Executive Board representatives or to learn more, please email James E. Saunders, MD, at James.E.Saunders@Hitchcock.org.

Face the Future Humanitarian Mission to Rwanda

Joseph W. Rohrer, MD
San Antonio Uniformed Services Health Education Consortium

A trip to Rwanda starts with thoughts and images that reflect the country's painful past. Rwanda is marked by the 1994 genocide. This, as we would discover however, is not what defines the country today. Rwandans are redefining themselves and the face we encountered is beautiful, welcoming, clean, safe, and growing.

Our mission in February was the first time the Face the Future Foundation, founded by **Peter A. Adamson, MD**, had gone to Africa. The team leader was Houston otolaryngologist Ife Sofola, MD, a native Nigerian with great passion to help Africa grow, develop, and thrive. This group included a powerful surgical team including Dan S. Alam, MD, from the Cleveland Clinic; **Jose E. Barrera, MD**, from the San Antonio Military Health System; Kofi D. Boahene, MD, from Johns Hopkins; Anthony E. Brissett, MD, from Baylor College of Medicine; **Sydney C. Butts, MD**, from SUNY Downstate; and residents **Joseph W. Rohrer, MD**, San Antonio Uniformed Services Health Education Consortium, and Myriam Loyo, MD, Johns Hopkins. Joseph Kuang, MD, Houston, supported our anesthesia needs.

The team worked out of two sites in Kigali, King Faisal Hospital and the Rwanda Military Hospital, which continues to undergo extensive upgrades. Our team arrived to screen 20 patients that Charles Furaha, MD, the only plastic surgeon in Rwanda, had selected. By the end of the week, 39 patients had been evaluated.

Our first day, we were given tours of the operating theaters and met the staff. Everyone was excited and a bit nervous. Smiles were everywhere and around 9 am we started seeing our patients. Many had been waiting for weeks, months, or years hoping that something could be done. The first day we saw 29 complex patients. They presented with a Tessier 4 cleft, midline cleft with encephalocele, and multiple patients with disfiguring, and painful neurofibromatosis. We saw osteoradionecrosis of the zygoma, congenital aplasia cutis of the scalp, noma, and disfiguring ameloblastoma. We also saw previous trauma patients: with ectropion, auricular avulsion, non-protected dura, and a 15-year-old with the loss of both lips from a grenade explosion. As the day and week progressed, patients continued to present with complex facial defects.

The foundation's mission is to empower the local community to advance their craniofacial management capabilities. Members of the group met with the hospital administrators and the Rwandan Minister of Health to discuss ways to make long-lasting changes. We worked hand-in-hand with the local surgeons and staff. We did revision cases and showed our techniques. They even showed us how to use the non-powered dermatome. Our mission performed a fibula free flap to reconstruct a midface, a radial forearm free flap with bilateral FAMM flaps for an upper lip, and fashioned orbital implants to cover unprotected dura. We did orthognathic surgery, completing molds and model surgery with the local oral maxillofacial surgeons.

Many families presented congenital anomalies. Here they are waiting on the inpatient floor at King Faisal Hospital.

We owe a debt of gratitude to Dr. Furaha, who will continue to see our follow-up patients and send updates. Next year there are plans to give didactic lectures to stimulate academic exchange. Some patients for next year have already been identified and plans are set in motion to bring special supplies. This may have been our team's first mission to Rwanda, but while seeing ourselves on local TV as we boarded the plane for home, I'm confident we made an impact not on just the patients we helped, but also in this country, which is working hard and moving positively towards becoming a jewel of Africa. I speak for the team when I say we have been given so much from this wonderful country and hope to continue this partnership for mutual gain. I would like to thank the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation for their support of resident travel to this mission.

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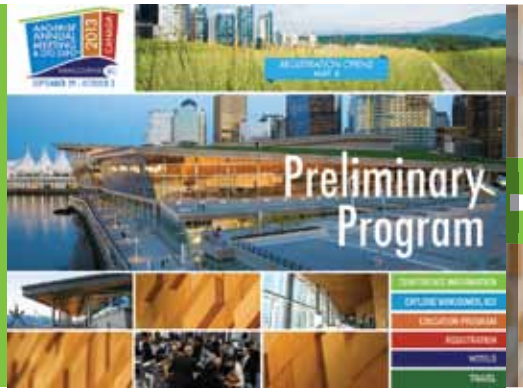

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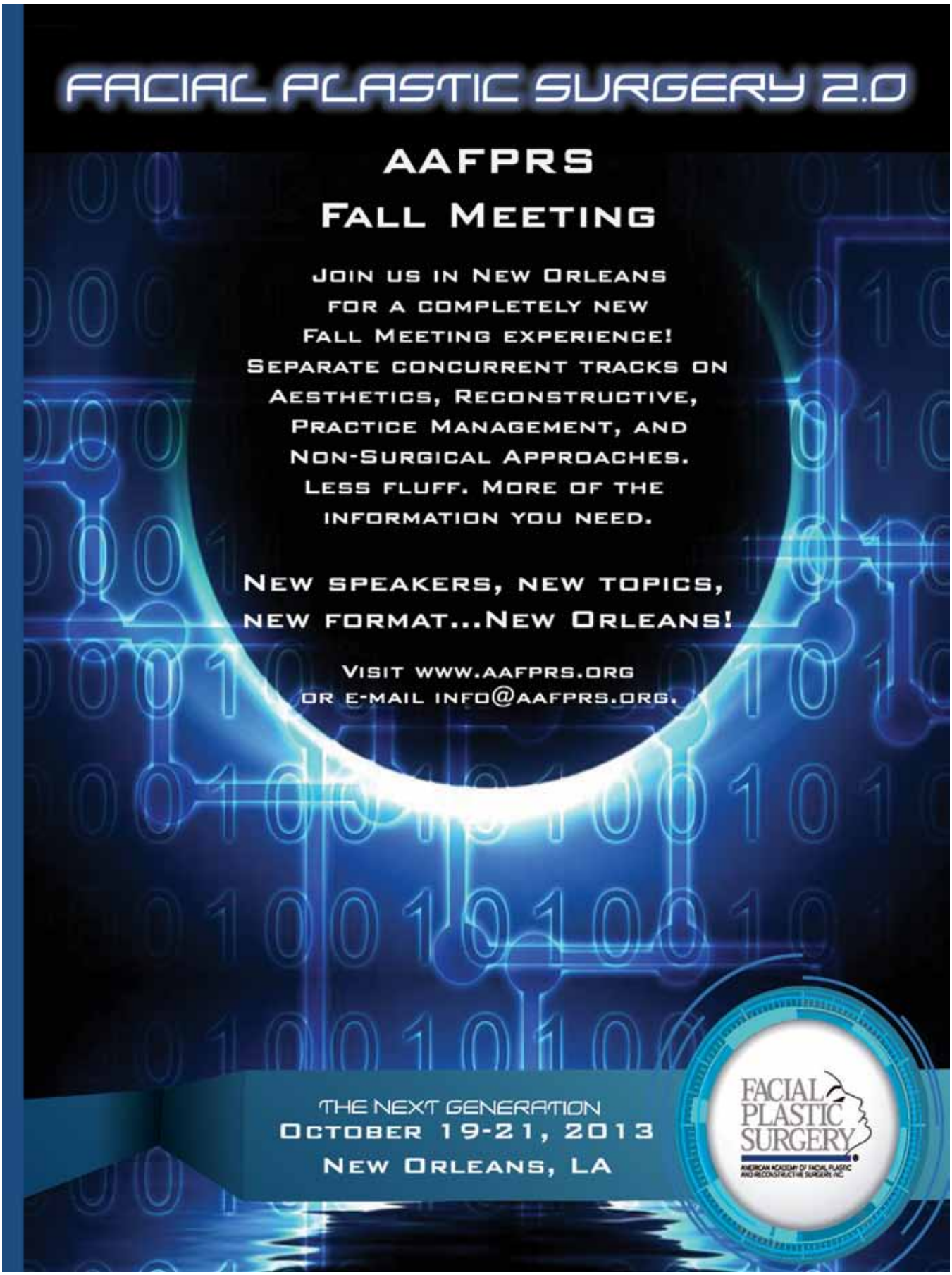
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Central Maine Medical Group (CMMG) seeks a BE/BC otolaryngologist due to community need and pending retirements. Central Maine ENT Head & Neck Surgery is a high volume practice located in the medical building attached to Central Maine Medical Center, a 250 bed hospital and accredited Level II trauma center. Your patients will enjoy the convenience of having their minor procedures performed in your office, and when major surgery is required, Central Maine Medical Center allows you ready OR access through flexible block scheduling. A sophisticated EMR and image retrieval system as well as strong support from a proactive administration make this an opportunity that you do not want to pass up.

Central Maine Medical Group offers top compensation and comprehensive benefits including nose and tail insurance coverage.

Central Maine offers something for everyone in your family: spectacular coastline and lush mountains, progressive schools, affordable housing, and a rich cultural and sports oriented environment.

Qualified candidates and nominees should contact:

Kim DeBlasi
800-678-7858 x64558
kdeblasi@cejkasearch.com

ID#146125AD cejkasearch.com

WestVirginiaUniversity.

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2014 or sooner. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

With a metro area population of over 115,000, Morgantown, WV, is consistently rated as one of the best small cities in the U.S., with affordable housing, excellent schools, a picturesque countryside, many outdoor recreational activities, and close proximity to major cities, such as Pittsburgh, PA, and Washington, DC.

The position will remain opened until filled. For more information please contact:

Laura Blake
Director, Physician Recruitment
blakel@wvuhealthcare.com
Fax: 304.293.0230
http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Northern Dutchess ENT
The Center of Excellence for Sinus, Ear and Throat Care

Special Opportunity
Rhinebeck, New York

We are seeking a general BC/BE otolaryngologist to join our two physician practice. We are located in the beautiful mid- hudson river valley with offices in Rhinebeck and Kingston. The area offers great cultural and recreational opportunities with an excellent school system, New York city is one and a half hour by train.

We provide general ENT services with an in-office ct scanner and special emphasis on rhinology. We have a strong audiology and balance department including hearing aid dispensing. The practice is very successful and financially sound, it is well regarded by both the patients as well as the medical community.

The compensation and benefit package is excellent. The model for partnership is unique and flexible.

We have succeeded over the years in maintaining a healthy and a much needed balance between our personal and professional lives.

Contact:
Nader Kayal, MD, COPM
Managing partner
Northern Dutchess ENT, PLLC
845-518-7780
entdoc53@aol.com

South Florida ENT Associates, P.A.

South Florida ENT Associates, a forty five Otolaryngology group practice in Miami Dade and Broward has immediate openings for full- time ENT Physician's. One location is a busy 2 physician, 2 office practice that is located in Broward County, in the Weston/Pembroke Pines area. Another location is a busy 4 physician, 4 office practice located in Dade County, in Aventura, Coral Gables and Miami. They are both full service ENT practice's with Audiology, Hearing Aid sales and Allergy.
We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.
Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.
This position will include both office and hospital setting.

Requirements:
Must be board certified within 24 months of commencing employment
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills.
ENT Experience a must
F/T - M-F plus call

Contact Information
Contact name: Stacey Citrin, CEO
Phone: (305)558-3724
E-mail: scitrin@southfloridaent.com
Cellular: (954)803-9511

Broward Location:
Jonathan Cooper, MD
(954)389-1414
jcooper@southfloridaent.com
Cellular: (954)816-1087

Dade Location:
Horacio Groisman, MD
Phone: (305)325-0900
horaciogroismanmd@gmail.com

Wayne State University School of Medicine

Faculty Positions

THE DEPARTMENT OF OTOLARYNGOLOGY - HEAD & NECK SURGERY
is currently seeking to hire

ACADEMIC OTOLARYNGOLOGISTS

With training and/or interest in either microlaryngology or pediatric surgery

The successful candidates must demonstrate experience and capability. Academic appointment and compensation commensurate with training and experience. Practice income available to augment negotiated salary.

Send letter of interest and CV to:
Robert H. Mathog, M.D.
Professor and Chair
Department of Otolaryngology
540 E. Canfield, 5E-UHC
Detroit, MI 48201
(313) 577-0804

Wayne State University is an Equal Opportunity/Affirmative Action Employer

North Carolina
General Otolaryngologist
Immediate Opening Available

ENT CAROLINA

Excellent opportunity for a BC/BE otolaryngologist to join a very well-established private, 5 physician otolaryngology practice in Shelby, Gastonia, and Belmont, North Carolina. All aspects of OTO/HNS practiced. Competitive salary, full benefits package, and partnership track available. Exclusive service area of 350,000+ population.

Three well equipped offices offering full allergy, audiology, hearing aid dispensing, vestibular services, and videostroboscopy. Excellent operative facilities with state of the art equipment, supplies and support.

All practice locations located 20 - 45 minutes west of Charlotte, North Carolina. Our physicians enjoy a high quality of life in a family-centered community. You will have the benefits of a low cost of living, easy access to Charlotte, the Carolina coast and the Blue Ridge Mountains. Enjoy the best of both worlds with this excellent opportunity.

Please visit our website at www.entcarolina.com
Please Contact:
Jane Byrum, COPM, Practice Administrator
ENT Carolina, PA
2520 Aberdeen Blvd • Gastonia, NC 28054
P (704) 868-8400 F (704) 868-2344
jane.byrum@entcarolina.com

EMORY HEALTHCARE

THE EMORY CLINIC, INC.
OTOLARYNGOLOGY -
HEAD AND NECK SURGERY

Emory University School of Medicine
Department of Otolaryngology – Head and Neck Surgery

The Division of Head and Neck Surgery in the Department of Otolaryngology – Head and Neck Surgery at Emory University in Atlanta, Georgia seeks to add a fellowship-trained Head and Neck/ Microvascular surgeon, at the rank of Assistant Professor. The ideal candidate would also have experience with trans-oral robotic surgery (TORS). Duties will include resident and fellow level teaching and a clinical practice primarily involving mucosal tumors of the upper aerodigestive tract as well as a healthy free tissue reconstruction component. The position also includes a part-time VA component.

Our current practice features three full-time fellowship trained Head and Neck Surgeons and a new state-of-the-art head and neck clinic on the campus of Emory University Hospital Midtown. The practice also includes two full time nurse practitioners dedicated to the clinic. Multidisciplinary care is a priority with dedicated support in medical oncology and radiation oncology as well as the full complement of ancillary services.

Applicants must be Board Certified or Board Eligible.

Compensation will be commensurate with experience.

Interested applicants should forward letters of inquiry and curriculum vitae to:
Mark W. El-Deiry, MD, FACS
Assistant Professor and Chief of Head and Neck Surgery
Department of Otolaryngology – Head & Neck Surgery
550 Peachtree Street, Medical Office Tower, Suite 1135
Atlanta, Georgia 30308
or fax to (404) 778-2109
Email: meldeir@emory.edu
An Equal Opportunity / Affirmative Action Employer.
Qualified minority and female applicants are encouraged to apply.
EOP # 34944BR

WestVirginiaUniversity.

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2014 or sooner. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Located 80 miles south of Pittsburgh and three hours from Washington, DC, Morgantown has an excellent public school system and offers culturally diverse, large-city amenities in a safe, family setting.

The position will remain opened until filled. Please send a CV with three professional references to:
Laura Blake
Director, Physician Recruitment
Fax: 304-293-0230
blakel@wvuhealthcare.com
http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

St. Vincent's Health Services
CONNECTICUT
ENT SURGEON

St. Vincent's Multi-Specialty Group is seeking a BC/ BE Head and Neck Surgeon to join our well-established group of ENT Providers. We are an academic program and are the official teaching medical center for Quinnipiac University. Academic appointment is commensurate with experience. We are a sub-specialized practice that offers the opportunity for both hospital and private practice work with a reasonable call schedule! We also offer competitive salary and benefits.

Location Matters! Connecticut is a beautiful state, conveniently located in southern New England; only a train ride away from New York City. We work hard and play hard here at St. Vincent's, and playing in and around Fairfield County Connecticut is easy with so many wonderful things to do and so many great places to visit.

With easy access to the shoreline and quality recreational facilities, it won't be hard to find something fun to do at a moment's notice.

Contact Elena Geanuracos, Physician Recruiter at elena.geanuracos@stvincents.org for more information or to forward CV.

ProHealth

THE UNIVERSITY OF TEXAS
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Making Cancer History®

Assistant/Associate Professor, Term Tenure Track
The Department of Head and Neck Surgery

Randal S. Weber, M.D.
Department of Head and Neck Surgery, Unit 1445
The University of Texas
MD Anderson Cancer Center
1400 Pressler Street
Houston, Texas 77030
713-745-0497

The Department of Head and Neck Surgery has an opening for an assistant or associate professor, term tenure track. The selected candidate will be responsible for providing clinical expertise in patient care, engaging in clinical research and teaching fellows, residents and medical students in the clinic and operating room. Key duties include providing surgical care for patients with tumors of the head and neck; participating as a member of the multidisciplinary team; teaching integrated programs in the surgical sciences; conducting clinical trials or other research; and presenting at regional/national/international conferences. Experience with or interest in limited access surgery for the treatment of patients with tumors of the oropharynx and larynx is desirable.

Qualified candidates will have an M.D. degree, will have completed an otolaryngology-head and neck surgery or general surgery residency and have completed advanced training in head and neck surgical oncology. Candidates must be board eligible or board certified.

Interested applicants should send a copy of their curriculum vitae to: cindy.cox@mdanderson.org

MD Anderson is an equal opportunity employer and does not discriminate on the basis of race, color, national origin, gender, sexual orientation, age, religion, disability or veteran status except where such distinction is required by law. All positions at The University of Texas MD Anderson Cancer Center are security sensitive and subject to examination of criminal history record information. Smoke-free and drug-free facility.

South Florida ENT Associates, P.A.

A. Clifford Foster, M.D., F.A.C.S.
Jorge Helo, M.D.
Paul K. Foster, M.D.

Seeking an ambitious Otolaryngologist for a small general ENT practice to replace a retiring member.

- Associated but independent from Mount Sinai Medical Center in Miami Beach, FL., as well as several ambulatory surgical centers.
- Design your own practice, General ENT + whatever focus you like.
- In-Office Balloon Sinuplasty, in office allergy immunotherapy
- Operate with state of the art equipment
- Hospital with da Vinci Robot available.
- Competitive Salary Base plus percentage.
- 4 weeks vacation.
- Malpractice, 401 (k), health insurance.

Must be BC/BE.

Please Contact:
Dr. Paul K. Foster
4302 Alton Rd., Suite 650
Miami Beach, FL 33140
drpkfoster@gmail.com

Ear, Nose & Throat Specialists of Florida

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Alexander J. Lozano, MD, FACS
Howard N. Barrow, MD, FACS
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Vien Phommachanh, MD, FACS
Brian F. McGettigan, MD

Adults & Children • Nasal / Sinus Disorders • Allergy • Snoring & Sleep Apnea Surgery • Facial Skin Cancers • Head & Neck Cancer • Hearing & Balance • Hearing Aid Sales & Repair

ENT Specialists of Florida is the premiere Otolaryngology practice in Fort Myers, Florida. With four offices covering central and south Fort Myers, Cape Coral and Lehigh Acres, the physicians of ENT Specialists of Florida provide state of the art care for all aspects of Otolaryngology.

Currently, 6 physician partners provide care including full audiology with 4 AuD audiologists, hearing aid sales, CT scanner, allergy department and associated surgery center. With the approaching retirement of several senior physicians within the next two years, we anticipate that a new physician will experience rapid growth to a full practice.

Fort Myers offers superior year round weather, beaches, golf, fishing and various other outdoor activities. This is an excellent opportunity for an aggressive, hard working applicant searching for a beautiful city and an excellent growth potential.

The position will include an excellent base salary, chance for production bonuses and full benefits including malpractice insurance, health insurance and a profit sharing retirement plan. A quick transition to full partnership is expected.

Interested applicants should contact:
Kim Parker at 239-936-0939

The Charleston Course
OTOLARYNGOLOGY LITERATURE UPDATE 2013
MEDICAL UNIVERSITY OF SOUTH CAROLINA

at the Beach
July 26 - 28, 2013
Kiawah Island Golf Resort, Kiawah Island, SC

How does a busy clinician stay current in our rapidly expanding specialty?

Our 3rd Annual Literature Update Course is designed to help!

- *Expert critical assessments of over 100 of the past year's most relevant, current evidence-based publications*
- *Lectures and discussions that will evaluate best practices and strategies for how to translate the evidence into practice*

Our faculty members will cover the entire specialty in 15 lectures over 3 half days with emphasis on the "pearls" important to your practice. We hope you will join us in a beautiful location along the South Carolina coast this July.

MUSC MEDICAL UNIVERSITY of SOUTH CAROLINA
Otolaryngology – Head & Neck Surgery
Contact: 843-876-0943 • Email: mansfiee@musc.edu
http://ENT.musc.edu

MEDICAL OTOLARYNGOLOGIST OPPORTUNITY

Geisinger Wyoming Valley (GWV) Medical Center, located in Wilkes-Barre, Pa., is seeking a BC/BE Medical Otolaryngologist.

About the Position

- Join a team led by a specialist in head and neck surgery, thyroid/parathyroid surgery and sinus surgery
- Work with an experienced general otolaryngologist and a nurse practitioner
- Opportunity to develop new programs such as a dedicated allergy program
- State-of-the-art office with new Kay-Pentax videostroboscopy equipment
- One full-time and one part-time audiologist

Geisinger Health System serves nearly 3 million people in Northeastern and Central Pennsylvania and has been nationally recognized for innovative practices and quality care. A mature electronic health record connects a comprehensive network of 4 hospitals, 38 community practice sites and more than 900 Geisinger primary and specialty care physicians.

Geisinger fosters an atmosphere of clinical excellence while offering an excellent quality of life with good schools, safe neighborhoods with affordable housing and a wealth of cultural and recreational activities. The surrounding natural beauty provides opportunities for fishing, skiing, canoeing, hiking and mountain biking. Urban life is easily accessible, with New York, Baltimore, Philadelphia and Washington D.C. just an afternoon's drive away.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit Join-Geisinger.org or send your CV and cover letter to:

Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu

Learn more at Join-Geisinger.org

GEISINGER HEALTH SYSTEM

REDEFINING THE BOUNDARIES OF MEDICINE.

SEEKING BOARD CERTIFIED / ELIGIBLE ASSOCIATE

Small, well-regarded private practice group seeking generalist or sub-specialist associate in Head & Neck, Facial Plastic, or Pediatric ENT that is willing to diversify a bit. Good potential for partnership. Diverse practice includes allergy, audiology, vestibular rehabilitation, facial plastic surgery, neurotology, sinus, speech therapy, laryngology and head & neck cancer surgery. Suburban & tertiary care offices in very desireable Pittsburgh, PA area. Good schools, sports, and cultural amenities available. Although primary emphasis is private practice, some teaching opportunity exists. We offer competitive salary, benefits, and a reasonable on-call schedule.

Please contact Diane Lyda @ 412-749-1611
or send CV to:
Straka & McQuone, Inc.
1099 Ohio River Blvd.,
Sewickley, PA 15143

MedStar Georgetown University Hospital

The Department of Otolaryngology-Head and Neck Surgery at Georgetown University Hospital is seeking a BC/BE physician with fellowship training in Otology/Neurotology to join our program. This position presents a unique opportunity for a full time academic surgeon to focus on the care of hearing and balance disorders as well as clinical/basic science research at two of the premier institutions in the metropolitan DC area: Georgetown University Hospital and Washington DC Veterans Affairs Medical Center. The candidate will be active in resident and medical student education and in clinical research.

Georgetown University Hospital is the largest academic medical center in the DC area and is part of the area's largest health care system, MedStar Health. The Washington DC Veterans Affairs Medical Center is a tertiary care teaching facility offering numerous opportunities for basic, translational and clinical research. For 30 years, the VAMC has been one of the major affiliated hospitals for the Georgetown Otolaryngology Residency Program.

Interested applicants should forward an updated CV to:
Bruce Davidson, M.D.
Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
Georgetown University Hospital
3800 Reservoir Road, NW
1st Floor Gorman Building
Washington, DC 20007
202-444-1351
Email: DAVIDSOB@gunet.georgetown.edu

OTOLARYNGOLOGIST OPPORTUNITY

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Pursue research in your area of interest

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. Geisinger South Wilkes-Barre (GSWB) is GWV's ambulatory campus.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information or to apply for this position, please contact:

Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu

Learn more at Join-Geisinger.org

GEISINGER HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE.

Academic Position – Head and Neck Surgeon
University of Washington
Otolaryngology-Head and Neck Surgery
Seattle, Washington

The University of Washington Department of Otolaryngology–Head and Neck Surgery seeks candidates for a full-time head and neck surgery position as Assistant or Associate Professor without tenure. Fellowship trained candidates for this outstanding opportunity should have interest and experience in head and neck oncology and microvascular head and neck reconstruction. This position will have a high volume of all aspects of head and neck surgical practice. Candidates should have a background and interest in clinical research that focuses on these areas of critical interest to our specialty.

The position is based at University of Washington Medical Center, with activity at the major teaching hospitals in our system. The individual will function in a multi-disciplinary practice environment, which includes fellow, resident, and medical student teaching and clinical or basic science research.

Minimum qualifications include an MD (or equivalent), certified or eligible for certification by the American Board of Otolaryngology, and eligible for a Washington State medical license. In order to be eligible for University sponsorship for an H-1B, graduates of foreign (non-US) medical schools must show successful completion of all three steps of the US Medical Licensing Exam (USMLE), or equivalent as determined by the Secretary of Health and Human Services.

Send letter of interest and CV to:
Neal D. Futran, MD, DMD
University of Washington
Oto-Head & Neck Surgery, Box 356515
Seattle, WA 98195-7923

The University of Washington is building a culturally diverse faculty and strongly encourages applications from female and minority candidates. The University is an equal opportunity/affirmative action employer.

Otolaryngology
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Featured 9th in Money Magazine's "Best Places to Live", Ames, Iowa is recognized as an active, friendly community with plenty to do. A vibrant college town with one of the highest-rated public school systems in the nation, this versatile community provides small-town serenity and charm as well as big-city amenities and culture.

EOE/AA Employer

Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

THE UNIVERSITY OF NEW MEXICO
Department of Surgery, Division of Pediatric Otolaryngology

The Department of Surgery, Division of Otolaryngology, at the University of New Mexico, is seeking applications for a pediatric otolaryngologist trained in all aspects of Pediatric Otolaryngology surgery. This position will be recruited at the Assistant/ Associate Professor level. Research opportunities are available if desired, and clinical research opportunities are readily available. Appointment and salary will be commensurate with level of experience.

The successful candidate will participate in an active Pediatric Otolaryngology practice, as well as provide resident teaching rounds, medical student teaching and participation at local and national conferences. It is an excellent opportunity for a pediatric otolaryngologist interested in academic achievements and good clinical experience. An excellent compensation package is provided.

Minimum Qualifications: Medical doctor who is board certified/eligible in Otolaryngology-Head and Neck Surgery, eligible for licensure in New Mexico, and eligible to work in the U.S.
Preferred Qualifications: Academic/clinical experience and completed fellowship in Pediatric Otolaryngology, or completing a fellowship in the next twelve months.

Interested applicants must apply for this position via UNMJobs website, https://unmjobs.unm.edu/applicants/jsp/shared/frameset/Frameset.jsp?time=1345672123192, Posting # (to be provided). Please attach electronic copies of the CV, letter of interest, and three professional references to your application:

This position will remain open until filled; however, for best consideration, application materials should be received by August 1, 2013. For further information, interested applicants should contact Erica Bennett, M.D., at EBennett@salud.unm.edu.

The UNM School of Medicine is an Equal Opportunity/ Affirmative Action Employer and Educator. This position may be subject to criminal records screening in accordance with New Mexico state law. J1 Visas are not eligible for this opportunity. UNM's confidentiality policy ("Disclosure of Information about Candidates for Employment," UNM Board of Regents' Policy Manual 6.7), which includes information about public disclosure of documents submitted by applicants, is located at http://www.unm.edu/~brpm/r67.htm

University Hospitals

Head and Neck Surgery and Reconstruction Fellowship

The Department of Otolaryngology-Head and Neck Surgery in conjunction with University Hospitals Case Medical Center and the Seidman Cancer Center is proud to announce the establishment of a one-year Head & Neck Surgery and Reconstruction fellowship beginning **July 2014**. The head and neck surgical team includes **Drs. Pierre Lavertu**, **Rod Rezaee** and **Chad Zender**.

This one year fellowship offers advanced training in:
- Microvascular free tissue transfer
  - **Over 120 cases per year**
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
  - Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Fellowship requirements and opportunities include:
- Clinical duties
- Teaching residents and medical students
- 1-11 call
- Clinical or basic science research
- Participation in our resident microvascular course and skull base workshop
- Travel and presentation at national meetings
- Productivity bonus in line with a competitive fellowship salary

Applicant requirements:
- Completion of an ACGME accredited Otolaryngology-Head and Neck surgery residency
- ABO board eligible or certified
- Ohio Medical license eligible

Please visit **http://uhhospitals.org/ENT** to view the position online and to submit CV for consideration.

For more information please contact:
Chad Zender, MD, FACS
Assistant Professor and Fellowship Director
University Hospital-Case Medical Center
Department of Otolaryngology-Head and Neck Surgery
Chad.Zender@UHhospitals.org
216-844-5307

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