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American Academy of Otolaryngology—Head and Neck Surgery

May 2012—Vol.31 No.05

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bulletin

American Academy of Otolaryngology—Head and Neck Surgery

May 2012—Vol.31 No.05

Academy Releases Updated Clinical Indicators

As part of a project designed to deliver the most up-to-date clinical information to our members, the Academy undertook a review of the Clinical Indicator Compendium (CI) listed online.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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

Letters to the Editor Questions, concerns, or comments about *Bulletin* articles and other content may be addressed to the Editor via email at bulletin@entnet.org.

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.

bulletin

May 2012 | Vol.31 No.05

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[1]Athanasiadis T, Beule AG, Robinson BH, et al. Effects of a novel chitosan gel on mucosal wound healing following endoscopic sinus surgery in a sheep modelof chronic rhinosinusitis. Laryngoscope 2008;118:1088–1094; [2]Valentine R, Wormald PJ, Nasal dressings after endoscopic sinus surgery: what and why? Current Opinion in Otolaryngology & Head and Neck Surgery 2010;18:44–48.

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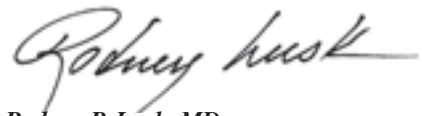
Lessons from Washington's Treatment: We Must Question Current Practices



Rodney P. Lusk, MD
AAO-HNS/F President

In last month's *Bulletin*, I depicted the circumstances of George Washington's death through eyewitness accounts. The diagnosis and treatments have not lacked controversy. Historian Peter R. Henriques indicated that Washington's diagnosis was most consistent with acute epiglottitis (supraglottitis)—rapid onset of symptoms, high fever, an extremely sore throat, drooling, great difficulty swallowing and speaking with progressive airway obstruction (especially when leaning backwards) relieved only by sitting upright, persistent restlessness or agitation, and finally, apparent improvement before death. George Washington slowly and painfully suffocated to death for many hours. In their accounts, Drs. James Craik and Elisha Cullen Dick said, "General Washington was attacked with an inflammatory affection of the upper part of the windpipe, called in technical language, cynanche trachealis." Their accounts reveal symptoms most compatible with acute epiglottitis.

In 1997, White McKenzie Wallenborn, MD, a retired University of Virginia otolaryngology professor, offered an article about Washington's probable diagnosis and the effects of his therapy titled "George Washington's Terminal Illness: A Modern Medical Analysis of the Last Illness and Death of George Washington." He concurred that the most likely diagnosis was acute epiglottitis. Other possible diagnoses were acute diphtheria, quinsy, acute laryngitis, and Ludwig's angina. However, laryngeal diphtheria is unlikely as he was reported to have survived "black canker" as a child and been immune to diphtheria. Quinsy, or peritonsillar abscess, is almost always unilateral and the symptoms would have included trismus and unilateral lymphadenopathy, which was not noted. Acute laryngitis in an adult is not life threatening. Ludwig's angina is a floor of the mouth infection and usually the result of dental or periodontal infection. By the time of his death, Washington had lost all of his teeth and wore poorly fitting dentures; therefore such infection is unlikely to have caused his death.

By all accounts, Drs. Craik, Dick, and Gustavus Brown were well-trained, honest, and caring physicians. They delivered the standard of care for that era. However, Washington would have been treated differently today. In our practices now, we work to deliver not only quality care, but also appropriate, individual care based on evidence and judgment. Unfortunately, these fellows had little else but their own learning and experience to guide them.

While Dr. Dick recommended a tracheal perforation (tracheostomy) and was willing to accept the consequences of a poor outcome, his recommendation was firmly overruled by Drs. Craik and Brown as it was a controversial, new procedure.

But, the most controversial of the treatments was the venesection, or bloodletting. It was common practice and George Washington himself believed in its efficacy. Although not a physician, Washington's overseer, George Rawlins, was experienced with the technique and performed it many times on the general's slaves. He performed the first venesection at Washington's request. Four subsequent bleedings by Drs. Craik and Dick resulted in the depletion of 82 ounces of blood, more than half of his blood volume, in about 13 hours. James Brickell, MD, about eight weeks later, wrote an article objecting to this practice and the judgment of the physicians, concluding that the aggressive bloodletting attributed to Washington's rapid demise. But the article was not published until 100 years later. We should not applaud his clinical prowess, however. His solution was "to have attacked the disease as near its seat as possible [by opening] the vein under the tongue; the tonsils might have been sacrificed; the scarificator and cup might have been applied on or near the thyroid cartilage." Washington would likely not have survived his therapy. Although it is not widely discussed, he was also given several agents, calomel and emetic tartar, causing copious diarrhea that no doubt also contributed to his hypovolemia. His calmness at the time of his demise might well have been secondary to the resulting hypovolemia.

As we now know, a tracheotomy might have prolonged Washington's life. Dr. Dick is reported to have pleaded with Drs. Craik and Brown not to perform additional bleedings, but do a tracheotomy instead. The procedure was well accepted in Europe since 1718 for treatment of respiratory distress associated with diphtheria, but not well known in the United States. Understandably, the two senior physicians were not willing to perform any treatment never before attempted in this country on their famous patient.

Looking back on Washington's care, we can now point to many critical mistakes. Lest we be too critical, with the advent of increasing knowledge of human genetics and treating diseases on the molecular level, our current therapies will be viewed as equally barbaric. Learning of this account renewed my understanding that we must always be willing to question current practices and conventional wisdom. When you come to Washington, DC, for the annual meeting, come early or stay late and enjoy all the opportunities for learning. You may even take the 14-mile trip to Mount Vernon and see the room where the father of our country died.

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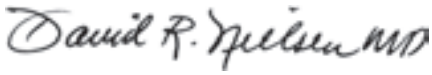
Choosing Wisely



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

As each of us knows, the demand for evidence of quality in practice, measuring performance, and demonstrating improvement has increasingly dominated the practice landscape for the last decade. As quality improvement has become closely linked with physician payment reform, new levels of skepticism are not unexpected. The question frequently asked is, "Is the debate really about making patients better and improving health outcomes, or just another excuse to manipulate payment?"

Our answer: It is up to us to ensure that the focus remains on improving outcomes—on real patient benefits, not just lip-service in the name of payment modification. The Academy and Foundation have developed a robust program with support staff, new committees, and volunteer structures, and increased focus on evidence-based practice designed to "put our money where our mouth is." We not only accept, but champion the challenge of identifying potential gaps in knowledge and care and addressing what we as a specialty and as individual surgeons can do to improve patient outcomes while more effectively managing finite resources. Our Guidelines Development Task Force and its work groups, the Advisory Council on Quality, and our stable of evidence-based guidelines and endorsed performance measures are all demonstrations of our commitment to improve care in meaningful ways. While still small in scope, these efforts are effective and important markers of our leadership in real quality improvement.

But as challenging as it is to identify and prioritize quality topics, develop evidence-based guidelines and measures, and document our involvement, this is still the "easy part." Actual implementation and documentation of real patient improvement with more efficient use of resources remains the greater challenge. Because of that challenge, the Academy has accepted an invitation from the American Board of Internal Medicine (ABIM) Foundation to join in an effort called *Choosing Wisely*™. What does this mean?

To paraphrase the supportive material of the campaign, even after years of investing in quality improvement and cost-cutting measures, the evidence that we are getting a return on our investment in either quality or cost is not strong. This failure emphasizes the fact that implementation is much more difficult than theory; that developing clearly thought-out systems and processes for care that is better managed is essential: that we must be thinking simply about what every otolaryngologist could do to improve care in his or her practice, to reduce waste and duplicated effort. In the office setting this means physicians and patients begin choosing the best care that is appropriate for them and supported by evidence; that the care is not duplicative of tests or procedures already received; that it won't harm them; and that it is truly necessary.

According to the ABIM Foundation, "The Congressional Budget Office estimates that up to 30 percent of care delivered in the United States goes toward unnecessary tests, procedures, doctor visits, hospital stays, and other services that may not improve people's health—and in fact, may actually cause harm. If current trends remain unchanged, the Centers for Medicare and Medicaid Services project U.S. healthcare spending will reach $4.3 trillion and increase from 17.3 percent to 19.3 percent of the nation's gross domestic product by 2019."

We are joining with medical leaders and members of more than a dozen other societies to address what has become an unsustainable healthcare system. Our goal collectively is to improve patient health, and, simultaneously, to identify and reduce waste in the healthcare system. Consumer Reports, the nation's leading independent, nonprofit consumer organization, has also joined the campaign to provide resources for patients (consumers) and physicians to encourage them to have the important conversations leading to commitment to better choices in care. As the ABIM Foundation states, *Choosing Wisely*™ aims to get physicians, patients, and other healthcare stakeholders thinking and talking about the overuse or misuse of medical tests and procedures that provide little benefit, and in some instances harm."

You will note in this issue of the *Bulletin* our updated and revised Clinical Indicators. I urge you to review these to identify areas of your practice that you could address with your office staff and patients where you could more effectively use resources, avoid duplication or waste, and improve care. We will be doing the same on a society basis. As part of *Choosing Wisely*™, each participating specialty society will identify five tests, procedures, or care choices commonly used in its field whose use should be discussed or questioned. Our Patient Safety/Quality Improvement Committee (PSQI), as well as other research and quality and content committees, will discuss the opportunities where we can address and report on to the membership and the public about how we are leading the change to improve healthcare in otolaryngology. This will be an ongoing effort—one in which we will demonstrate the leadership necessary to truly make a difference in healthcare for each individual patient, and for collective and global outcomes.

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'Meaningful Use' of Your Time: The BOG AM Events

Denis C. Lafreniere, MD
BOG, Chair-Elect

The BOG helps members understand the changes coming to healthcare

The Patient Protection and Affordable Care Act (2010), the Health Care and Education Reconciliation Act (2010), and the Health Information Technology for Economic and Clinical Health Act (2009) present us as providers with challenges as we consider the move to the not-yet-fully defined future of medicine. The Board of Govenors (BOG) is working to represent our members and provide information as the issues of healthcare reform come to the fore in our individual states and regions. The BOG has been working this year to update local society representatives on issues, such as the implementation of electronic medical records and achieving meaningful use criteria.

The AAO-HNSF 2012 Annual Meeting & OTO EXPO will take place September 9-12 in Washington, DC, in the midst of election-year excitement. Your BOG is poised to provide you with opportunities to become informed on myriad issues that may influence our professional futures.

The BOG committee meetings begin on **Saturday, September 8**, and will be open to all members. The meetings will address regulatory, legislative, and third party payer issues that will affect all of our practices. The BOG's Socioeconomic & Grassroots Committee is working to improve regional representation nationwide. Regional reports will be presented from society representatives on timely issues, such as maintenance of certification and maintenance of privileges and licensure. The Legislative Representatives Committee will report on legislative and political issues that have an influence on national policy and local legislation that may influence not only the state where the legislation is proposed, but possibly other states, too. BOG member societies can learn from our colleagues in other states. When a particular state deals with a legislative issue, such as scope of practice expansion, they will often share their experience to help resolve another society's local issues.

The BOG General Assembly will meet on **Monday, September 10**, and we encourage all local society governors, legislative representatives, and public relations representatives to attend. The BOG elections will occur during this meeting.

One of the highlights of the annual meeting for the BOG will be the miniseminar on **Tuesday, September 11**. The miniseminar, "Hot Topics," will focus on the changing landscape of the practice of medicine in the era of healthcare reform. The future development of Accountable Care Organizations will have a significant influence on the house of medicine. The relationship between the hospital and physician will undergo a lot of change as new healthcare reform regulations are implemented. Key federal healthcare regulations will be highlighted with specific attention to those federal laws that affect our practice of medicine and to how the AAO-HNS and BOG are working to shape these regulations. **Raymund C. King, MD, JD**, is an otolaryngologist and practicing attorney in Dallas. He has lectured extensively on medicolegal topics and issues related to physician-hospital joint ventures. As portions of the new healthcare law become implemented, hospital-physician joint ventures will be a common trend. Dr. King will present on the legal implications of such alliances. Darlene Burgess is vice president for corporate government affairs in the Henry Ford Health System (HFHS), one of the nation's leading comprehensive, integrated

Denis C. Lafreniere, MD

health systems. In 2010, HFHS had revenues of $4.08 billion with net income of $60.1 million and uncompensated care totaling $200 million. Burgess will discuss how hospitals and physicians can form these joint ventures in ways that are financially feasible for both parties, while providing high-level, quality care to patients.

Healthcare accounts for one-sixth of the U.S. economy. Practicing physicians need to understand transformations in healthcare that are influenced by national policy changes. The political dynamics of deficit reduction can have a significant effect on healthcare economics. **Joy Trimmer, JD**, our Academy's Senior Director of Government Affairs, will update our group on ongoing legislative issues affecting the practice of ENT. **Wendy B. Stern, MD**, chair of the Academy's Media and Public Relations Committee and BOG secretary, will discuss opportunities for our members to participate in shaping the policies to optimize otolaryngologic care in the United States.

This year's annual meeting in Washington, DC, comes appropriately during an election year. The AAO-HNS and your BOG are working to create an educational opportunity that we hope will allow you, our members, to derive "meaningful use" from your time in our nation's capital.

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The journal *Otolaryngology–Head and Neck Surgery* has more digital features than ever before, and the latest member benefit is the new free mobile app for the iPhone, iPad, and iPod Touch. The app is available in the iTunes store and gives users free access to abstracts and each month's table of contents. Our clinical practice guidelines, monthly podcasts, and associated articles, and all annual meeting abstracts will always be free for anyone to access. For the first month, full text articles will be free for all users and always available to members.

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Dates to Remember

May Is Better Hearing and Speech Month.

May 6-8 BOG Spring Meeting and OTO Advocacy Summit.

Mid-May The AAO-HNS Presidents Forum & Follow Up Online.

May 7 General Registration opens for 2012 AAO-HNSF Annual Meeting & OTO EXPO.

May 31 Humanitarian Resident Travel Grants application deadline: humanitarian@entnet.org.

June 1 Proposed 2012-2013 Combined Budget presented in the *Bulletin* as well as the Official Canidates' Statements.

June 1 Monthly mini PR and media outreach tools available for members.

June 1 G-I-N Scholorship Applications Due.

June 1 International Visiting Scholars application deadline: international@entnet.org.

June 1 Otolaryngology Historical Society Call for Papers closes: museum@entnet.org.

June 22 Early registration discount deadline to save for the 2012 AAO-HNSF Annual Meeting & OTO EXPO.

July 1 Bulletin features a Research and Quality Update .

May 2012

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Presidential Citations

Presidential Citations acknowledge individuals who have given much to otolaryngology in a variety of ways and uniquely within the life of the standing president. The following well deserving recipients have been influential to the specialty and particularly to our president, **Rodney P. Lusk, MD**.

Thomas J. Balkany, MD

Thomas J. Balkany, MD, is the Hotchkiss Endowed Professor and director, University of Miami Ear Institute, and chair emeritus of its department of otolaryngology.

He is also professor of otolaryngology, neurological surgery, and pediatrics for the University of Miami Miller School of Medicine. Dr. Balkany is a pioneer in the field of cochlear implantation and known for his work on the ethics of cochlear implantation in deaf infants. Dr. Balkany has published more than 250 scientific articles and three books and served on the editorial boards of numerous medical journals. He holds 14 U.S. and international patents, including 13 on cochlear implants.

His service to the American Academy of Otolaryngology—Head and Neck Surgery exemplifies a lifetime commitment to the specialty, serving in positions on the Board of Directors, Audit Committee, Nominating Committee, and chairing three hearing-related committees. Dr. Balkany also has received an AAO-HNS Honor Award and Distinguished Service Award, and now this Presidential Citation. His activities have influenced the global practice of otolaryngology, earning him the Bárány Society Hallpike-Nylen Prize for Clinical Research (Uppsala, Sweden); the League for the Hard of Hearing Fowler Award (a national award); the Graham Fraser Medal and Lecturer, (Royal College of Surgeons, London, England); and the Prof. Y. N. Mehra Medal and Oration (Institute of Medical Education and Research, Chandigarh, India).

Dr. Balkany is widely respected within our specialty and by the deaf and hard of hearing community. Among other honors, he holds the President's Honor Award of the American Neurotology Society and the Otological Society President's Award. He has served as senior examiner of the American Board of Otolaryngology and vice president of the Otological, Rhinological, and Laryngological Society (Triological).

Charles D. Bluestone, MD, received his bachelor's (Magna Cum Laude) and medical degrees (Alpha Omega Alpha) at the University of Pittsburgh (UP), was the first UP Eberly Professor of Pediatric Otolaryngology, and was recently promoted to distinguished professor of otolaryngology. Dr. Bluestone and his division have trained more than 60 fellows in pediatric otolaryngology—most of whom are now in academic medicine. He founded the NIH-funded Pittsburgh Otitis Media Research Center and is a recipient of the UP Philip S. Hench Distinguished Medical Alumnus Award, the Albany Medical College Theobald Smith Award, and has been the guest of honor at several national and international meetings.

In 2004, the president of the Triological Society designated him a "near giant" in otolaryngology. He is a pioneer of pediatric otolaryngology, particularly for his contributions as founding chair of the American Academy of Pediatrics' Pediatric Otolaryngology Section, and as a charter member and past president of the American Society of Pediatric Otolaryngology. Dr. Bluestone's activities beyond the specialty include membership on the NIH National Advisory Neurological and Communicative Disorders and Stroke Council and presidency of the UP

Charles D. Bluestone, MD

Medical Alumni. He has authored or co-authored more than 500 publications; 250 of which are peer-reviewed articles and almost 40 of which are textbooks or similar publications. In 1975, he, **David Lim, MD**, and **Ben Senturia, MD**, organized the first of 10 quadrennial international symposia on advances in otitis media.

David W. Kennedy, MD, is best known nationally and internationally for pioneering endoscopic sinus surgery and minimally invasive endoscopic skull base surgery. He has served as chair of the department of otorhinolaryngology–head and neck surgery and vice dean at the University of Pennsylvania, where he also continues clinical practice as a rhinology professor. He is past president of the American Academy of Otolaryngology—Head and Neck Surgery, the American Rhinologic Society, the International Rhinologic Society, and the International Symposium on Infection and Allergy of the Nose.

He helped to establish the subspecialty of rhinology by developing its first

David W. Kennedy, MD

fellowship and holding the first courses in endoscopic sinus surgery internationally. His research interests are the pathogenesis of chronic rhinosinusitis and continued development of minimally invasive skull base surgery. Dr. Kennedy has been elected to the Institute of Medicine of the National Academy of Sciences. He is a prior recipient of the Board of Governors Practitioner Excellence Award and was awarded the 2010 National Physician of the Year for Clinical Excellence from Castle Connolly, publishers of *America's Top Doctors*. He is editor-in-chief of the International Forum of Allergy and Rhinology and serves on the editorial boards of numerous other journals. Dr. Kennedy has published nearly 200 articles and chapters and received a number of international awards.

Harlan R. Muntz, MD, was trained in otolaryngology at the Washington University School of Medicine under **Joseph Ogura, MD**. He became the acting director of pediatric otolaryngology at St. Louis Children's Hospital, recruiting current AAO-HNS/F President Rodney P. Lusk, MD, as the director. He remained at St. Louis Children's for 18 years focusing on team building and multidisciplinary care of children as the otolaryngologist for the cleft palate team and starting the trach-speech-airway team and the speech physiology team. In 2000 he moved to direct the pediatric otolaryngology program at the University of Utah, helping to develop subspecialty pediatric ENT and multidisciplinary programs in aerodigestive, swallowing, and trach-vent. Dr. Muntz has traveled Latin America extensively during the last 20 years, primarily educating in airway and sinus disease, including animal courses on airway foreign body and airway reconstruction.

Harlan R. Muntz, MD

He trained two surgeons at Mercy Hospital in Kolkata, India, in cleft surgery, allowing it to become the first Smile Train-accredited hospital in northeastern India. The hospital now performs more than 500 cleft cases each year. Dr. Muntz is currently a part of Operation Restore Hope, caring for cleft palate children in Cebu, Philippines. Though his clinical focus is diverse, he has a passion for global surgery and the influence that timely and well done surgical care may have on the lives and communities of those in developing countries. Dr. Muntz has remained active in the AAO-HNS in committees and in research-focused groups.

2012 G-I-N Conference Scholars, G-I-N North America Conference

The AAO-HNSF is pleased to announce it will sponsor four members ($1,500 each) to attend the annual Guidelines International Network (G-I-N) North America (NA) Conference, December 10-11, in New York, NY. G-I-N aims to encourage partnerships and foster work in the guidelines community, thus supporting evidence-based healthcare and improved health outcomes throughout the world. The theme of the 2012 G-I-N NA Conference is "Evidence Based Guidelines Affecting Policy, Practice, and Stakeholders: Promoting Constructive Dialogue in Guideline Development, Dissemination, and Implementation."

In addition to plenary sessions, conference attendees will have access to workshops and breakout sessions, providing additional skills and knowledge to deepen understanding of guideline development, adaptation, and implementation. Key themes for the G-I-N NA conference include:

- From bench to trench: how evidence and guidelines shape healthcare policy
- What makes a clinical practice guideline trustworthy?
- Managing the message: advocates, the media, and guideline dissemination
- Making it happen: adapting, implementing, and tracking
- Application and requirements

In exchange for receiving a G-I-N travel grant, recipients must agree to serve on an upcoming AAO-HNS clinical practice guideline panel. Recipients may serve as either a panel member or as assistant chair if he or she has prior guideline experience. Recipients are also expected to submit a commentary to *Otolaryngology–Head and Neck Surgery* on any aspect of the guideline (e.g., development, dissemination, adaptation, implementation, etc.) within three months of publication of the clinical practice guideline.

Please note that residents are not eligible, and applicants must be members of the Academy. To access the G-I-N Conference Scholars application, visit http://www.entnet.org/Community/G-I-N_Scholars.cfm.

The deadline for applications is June 1. For questions about becoming an AAO-HNSF G-I-N Scholar, please contact Stephanie Jones at sljones@entnet.org or 1-703-535-3747.

Academy Mourns Loss of Past President Loring W. Pratt, MD (1918-2012)

Loring Withee Pratt, MD, died March 13, 2012. He was president (1981-1982) and a 63-year member of the American Academy of Otolaryngology—Head and Neck Surgery. Dr. Pratt's guidance to the Academy came at a pivotal time in its organizational development. In 1981 as president-elect of the former American Council of Otolaryngology-Head and Neck Surgery, he extended an assured sense of balance and integrity that helped merge the Council organization with the then American Academy of Otolaryngology—Head and Neck Surgery into the AAO-HNS of today.

Dr. Pratt graduated with an AB from Middlebury College, VT, in 1940 and three years later earned his medical degree from the Johns Hopkins School of Medicine. He completed his residency in otolaryngology at Johns Hopkins Hospital and served in the U.S. Air Force before entering private practice. He was well-loved by his family, local community, and the community of medicine as an exciting and engaging teacher and mentor.

After serving in the Air Force, Dr. Pratt settled with his wife, Jennie, in Waterville, ME, as a community otolaryngologist. There he reached beyond the office setting, serving as assistant director of the F.T. Hill Seminar at Colby College in Waterville, ME; chief of staff at Thayer Hospital in Waterville from 1979 to 1981; and chief of the department of otolaryngology-head and neck surgery from 1977 to 1979 at Thayer Hospital. Dr. Pratt also spent a great deal of time working with TB patients at the Central Maine Sanatorium in Fairfield. He was active as a consulting physician for many area hospitals, including the VA facility in Togus. He worked in that community until 1985, and so loved medicine that he continued working in his retirement for the Mayo Clinic in Scottsdale, AZ, and Johns Hopkins Medical Center.

His community spirit was also exhibited in other ways. Early in his career, he became a Freemason and continued that association all his life; his family will receive his 60-year certificate from the Waterville Lodge this month. Dr. Pratt's active and varied interests included the Fairfield Historical Society, for which he served as president from 2003 to 2010. His interest in historical preservation benefited the AAO-HNSF museum through donations from his personal collection and in his volunteer work within its collections committees.

Dr. Pratt and Mrs. Pratt

Beyond community activity, Dr. Pratt engaged on a national level in the field of medicine. He was an active leader in the American College of Surgeons, the Triological Society, and the American Medical Association until his death and served as president of the American Laryngological Association, the American Broncho-Esophagological Association, and the American Society for Head and Neck Surgery. Dr. Pratt contributed to the field by publishing many papers. One of his specialties was treating chainsaw injuries to the head and neck, and his lectures on the topic were widely disseminated.

Dr. Pratt's passions did not end with healthcare or community. He loved the natural world—"*all creatures, great and small.*" He loved geology and photography and combined these loves to form many intact collections of note. In his late 80s, he became a Master Gardener. He could state the genus and species of many plants and animals found in the wild. The gardens around his home were glorious throughout the growing seasons. It was not uncommon for Dr. Pratt's car to be seen stopped by the side of a road while he rooted up a sample of some wild under-identified species.

Dr. Pratt is survived by his nine children and their families. His legacy of excellence, balance, commitment, and engagement will survive as well.

Disaster and Mass Casualty Response for Physicians

Anna M. Pou, MD, chair-elect
Mark E. Boston, MD, member
AAO-HNS Trauma Committee

Anna M. Pou, MD

You are finishing a late-afternoon consult at your community hospital when a security guard rushes to the nurses' station demanding that everyone take cover because a tornado is expected to hit near the hospital. What do you do? Are you prepared? Is your family prepared for such a disaster? Within minutes the hospital is slammed by a powerful tornado that tears off the roof, shatters the windows, knocks out the electricity, destroys the generators, rips open gas and water lines, and cuts off all communication, including cell phones. Seconds later the tornado has passed leaving the hospital dark, the floors covered by debris and two inches of water, a strong smell of gas in the air, and the shouts and cries of the injured and dying all around you. What do you do? Where do you go? What is your role in the hospital disaster plan? While this is something most of us will fortunately never have to endure, this is the exact scenario the physicians, employees, patients, and visitors of St. John's Mercy Hospital in Joplin, MO, faced on May 22, 2011.[1]

The past year has seen devastating tornadoes in Joplin and Tuscaloosa, AL; an earthquake in New Zealand; an earthquake and tsunami in Japan; and floods in Thailand and Australia. And who can forget the 2010 earthquake in Haiti, Hurricane Katrina in 2005, or the terrorist attacks of 9/11? No person or place on earth is invulnerable to the consequences of natural or manmade disasters, but we are all capable of being prepared to face the chaos that follows the catastrophe. Furthermore, as physicians, we have a critical responsibility in the planning and implementation of medical response plans for disasters and mass casualty situations.

The past decade has seen great improvements in U.S. disaster preparedness policy and investment. The federal government has increased resources and focused attention on state and local governments, community volunteers have become more involved in local disaster planning, and more medical professionals have engaged as partners in disaster preparedness planning and response.[2] In addition, an increasing emphasis has been placed on individual and family readiness. This is imperative for first responders and medical professionals who will have community response obligations during any local disaster. Knowing your family is prepared is essential to your being able to respond to the needs of others. Excellent resources for individual and family readiness planning can be found at www.ready.gov.

Disaster preparedness and management training programs for physicians and other healthcare professionals have also been developed during the past few years. In 2003, the American Medical Association (AMA), in conjunction with other medical groups, established the National Disaster Life Support (NDLS) program to train physicians and other healthcare professionals to safely and successfully respond to disasters. The NDLS program offers instructor-led and online disaster life support courses that introduce all-hazards disaster management and mass-casualty response concepts (www.ndls.org). The NDLS has also developed a curriculum for medical students and residents. The American College of Surgeons (ACS) offers the one-day Disaster Management and Emergency Preparedness course (www.facs.org.trauma/disaster) to better train surgeons to be able to properly respond during disasters and mass casualty events. Both the AMA and ACS courses provide a solid introduction to the language, fundamentals, and essential principles of disaster response and mass-casualty management. However, in order for the training to be meaningful, disaster drills specific to the most likely event that a population could face should be done at least annually. The benefit of drills cannot be underestimated.

The most difficult challenge for most healthcare providers is the allocation of resources. Mass casualty protocols address this issue; that is, there are algorithms to follow to help decide who will get treatment and who will not at any given time depending on the resources. For example, in the

The DISASTER Paradigm

Detect—know how to identify unique and common medical problems in various disaster scenarios.

Incident command—who has responsibility for command and control at the disaster location?

Scene security and safety—keep yourself and others safe.

Assess hazards—know the most typical hazards associated with various disaster situations.

Support—who is available to help and what are your available resources?

Triage and treatment—categorize and prioritize patient care.

Evacuation—the orderly flow of patients from the scene to community hospitals.

Recovery—for the affected area, the populace, and you (resiliency).

Source: National Disaster Life Support Foundation

pandemic flu protocols there are objective criteria that are to be followed indicating who will be placed on a ventilator, who will receive palliative care, and who will be removed from a ventilator if the condition deteriorates or does not improve. When preparing for mass casualty events, healthcare providers should discuss these ethical issues frankly and be prepared to handle them as they will occur.

Everyone needs to be emotionally ready to deal with these situations. A national consensus regarding ethical guidelines should also be established to help those caring for patients during disasters. **Richard G. Holt, MD, MSE, MPH**, wrote on this subject in 2008.[3] In addition, we should do a better job of educating the public regarding this issue, as many people do not fully realize that there may not be treatment for all during a mass casualty event or overwhelming public health emergency.

Everyone reading this article is highly encouraged to develop individual and family disaster response plans, and to take one of the above-mentioned disaster and emergency response training courses to acquire a fundamental knowledge of the topics. Furthermore, it is important that all physicians understand and be ready to perform their disaster response duties within their local communities and hospitals. No one knows where he or she will be at the time of a disaster, so it is important for all to be knowledgeable regarding hospital disaster protocols and to be ready to perform any job assigned to them even if it is outside of their area of expertise. The successful evacuation of patients within 90 minutes at St. John's Mercy Hospital was largely due to the advanced planning and disaster drills.

Serious consideration should be given to the requirement of disaster education to medical students and residents around the country. It should be mandatory to healthcare workers in order to be credentialed at various hospitals. Civilian physicians have much to learn about triage from military colleagues and should not overlook this important resource. The knowledge, training, and skills you acquire by working with your local hospital or community emergency response agencies will prepare you not only to respond in your community, but also to provide emergency relief to other communities or other countries. In addition, knowledge and preparedness is likely to improve provider resilience in response to a disaster or mass casualty event.

U.S. Air Force and Ecuadorian military medics establishing an outdoor clinic in Cotalo, Ecuador, following the eruption of the Tungurahua volcano in 2006. The town lost electricity, water, and sewage services as a result of the eruption. The devastation of natural disasters is greater in areas and countries with limited resources, and disaster response teams must be prepared for difficult or unusual working conditions.

References

1. Kikta, K. 45 Seconds: Memoirs of an ER Doctor from May 22, 2011. Accessed at http://www.mercy.net/joplin/stories-of-mercy/45-seconds.
2. Inglesby, TV. Progress in disaster planning and preparedness since 2001. JAMA. 2011;306:1372-3.
3. Holt, R. Making difficult ethical decisions in patient care during natural disasters and other mass casualty events. Otolaryngol Head Neck Surg. 2008;139:181-186.

Life Lessons from Leaders: A Talk with the Women Chairs of Otolaryngology

Erika A. Woodson, MD
Cleveland Clinic Foundation
for the Women in Otolaryngology Section

Although women are entering residency in increasing numbers, there are still few women otolaryngologists with high rank within academic medicine. I interviewed the current U.S. women chairs in otolaryngology to highlight them and to make their accomplishments seem accessible and desirable to young women in our specialty. I am grateful for their candor and the support they have for each other and for all women in otolaryngology.

All of you have multiple children. How did you balance everything when the children were young?

Cherie-Ann O. Nathan, MD, Louisiana State University-Shreveport: Time management, organization, help, and a wonderful husband are keys to balancing work and motherhood.

Gayle E. Woodson, MD, University of Southern Illinois: Until our youngest was in junior high, we always tried to have at least two helpers—one living in, an au pair or nanny, plus a housekeeper/cook.

Carol R. Bradford, MD, University of Michigan: I made it to most of the kids' activities by scheduling these events on my calendar. I am still a gymnastics mom to my daughter, a 16-year-old level 9 gymnast. We travel many weekends to gymnastics meets.

Do you feel that you put your career advancements or national involvement "on the back burner" when your children were young?

Marion E. Couch, MD, PhD, University of Vermont: I do feel that my career did not advance as fast as my male colleagues did while the children were young. As they became older, I returned to my academic career in a big way. Having children made me a "late bloomer" in my career, but my perspective and experience are invaluable to me now.

Kathleen L. Yaremchuk, MD, Henry Ford Medical System: My daughter thought MD stood for Mommy Doctor. I think for a period of time I was on the "mommy track" because otolaryngology, as a specialty, was not very welcoming to women, especially women with children. I made it a point to bring my family to conferences and meetings and would bring my mother or husband to help with the kids.

At what point do you think a young woman in otolaryngology should get involved at the national level?

Almost everyone suggested starting now. Dr. Nathan further recommended that a clinician-scientist prioritize establishing her lab and securing grant funding before getting too involved politically.

Do you have a suggestion as to how she should get started?

Dr. Yaremchuk: The AAO-HNS WIO is filled with people who have great ideas and showing up is the first step.

Dr. Woodson: Volunteer or have someone nominate you for AAO-HNS committees and the Task Force to write questions for the Boards and In-Service. Present as much as possible at national meetings. Identify a niche that you can master as an expert.

Dr. Bradford: Network at meetings. Say yes to most opportunities offered.

Did you benefit from any mentor, female or male, as you built your career? Can you share with us any important lessons you learned from them?

Dr. Nathan: Dr. Jon Glass was a wonderful mentor for my research.

Dr. Woodson: Bobby Alford, MD, was a role model that I could emulate in seeing how he interacted with people.

Dr. Couch: Drs. Charlie Cummings, Richard Holt, John Saunders, and Janice Clements. Be professional, available, and ethical.

Erika Woodson, MD

Dr. Bradford: A colleague in my department was one of my research mentors throughout my career. There is no limit to what you can accomplish as long as you do not worry about who gets the credit.

How do you feel the field of otolaryngology has changed, good or bad, for young women entering it today or choosing it as a career versus when you were entering your training?

Dr. Couch: There is still a glass ceiling. There are not enough women in senior leadership. Not enough professors.

Dr. Yaremchuk: The increase in number of women in AAO-HNS has been the single biggest help for recruiting medical students and residents to our specialty. [The establishment of] the AAO-HNS Women In Otolaryngology section has been the single biggest event to bring women together and develop processes for the further development of women in otolaryngology.

Dr. Woodson: There are many more opportunities and role models now.

What do you think about the growing number of young otolaryngologists, particularly women, who may want to work part-time?

Dr. Bradford: I believe the new generation places a higher priority on balance, which I think is terrific. I am a strong advocate for professionals to adapt their work environment to meet their personal and professional goals.

Dr. Couch: Whatever works for them is the right answer.

Better Hearing and Speech Month

May is Better Hearing and Speech Month. This annual event provides opportunities to raise awareness about communication disorders and to promote treatment that can improve the quality of life for those who experience problems with speaking, understanding, or hearing. You may want to offer the following short article, tips, and AAO-HNS resources to your patients during this month.

Speech and language disorders can take many forms and can limit academic achievement, social adjustment, and career advancement. An individual may be born with a speech or language disorder, or it may develop due to an injury or illness.

The National Institute on Deafness and Other Communication Disorders reports that nearly 43 million people in the United States suffer from a speech, voice, language, or hearing impairment. Almost 28 million people suffer from a hearing loss. About 10 percent of children have moderate to severe communication impairments, including speech production/articulation, stuttering, and language-learning difficulties. Children with speech and language impairments are four to five times more likely than their peers to experience other language-learning disabilities, including significant reading problems. About 1 million people in the United States have aphasia—a language disorder resulting from brain damage caused by a stroke.

Now is a good time to take stock of your own hearing and seek help if you think you may have a problem. You may have hearing loss if you experience the following:

- Frequently ask people to repeat themselves
- Often turn your ear toward a sound to hear it better
- Understand people better when you wear your glasses or look directly at their faces
- Lose your place in group conversations
- Keep the volume on your radio or TV at a level that others say is too loud
- Have pain or ringing in your ears

Find out more about hearing and speech health by visiting http://www.entnet.org/AboutUs/publicCampaigns.cfm. Watch for an online interview with **James E. Saunders, MD,** later this month.

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Electronic Medical Record, Social Media Malpractice Risks

David B. Troxel, MD
Medical Director, The Doctors Company

Electronic Medical Record: Malpractice Risks

The Doctors Company supports the integration of the electronic medical record (EMR) into medical practices and believes it has great potential to advance both the practice of good medicine and patient safety. However, there are unanticipated consequences when new technologies are adopted, and the EMR is no exception. Real and potential liability risks are beginning to be recognized, and it is important for doctors to become familiar with them.

Doctors are responsible for information to which they have reasonable access, and there may be e-health data from outside the practice that enter the practice EMR or website, or that is accessed from the practice EMR or website, such as hospital charts, consultants' reports, lab results and radiology reports, community medication histories, etc. If patient injury results from a failure to access or make use of available patient information, the doctor may be held liable.

E-prescribing is being rapidly adopted, driven by federal financial incentives, and is currently used by about 25 percent of office practices. Potential capabilities and benefits include the following:

- Most electronic prescriptions are transmitted via a Surescripts network (which has data on 200 million insureds) to all chain pharmacies, 60 percent of independent pharmacies, and most insurance formularies.
  - Most electronic health records (EHRs) have an e-prescribing module, which is a required capability under the federal financial incentives for "meaningful use" of EHRs.
  - Stand-alone e-prescribing software is also available at no cost from Allscripts and the National ePrescribing Patient Safety Initiative (NEPSI).
  - Most programs also check for drug interactions, dosage errors, medication allergies, and patient-specific medication factors.
  - Office prescription renewal requests can be synchronized with most e-prescribing systems and with some personal health records.
  - E-prescribing encourages patients to fill prescriptions (currently 20 percent do not) because their prescription is sent to the pharmacy electronically and is ready to be picked up when they arrive.
  - Costs are lowered by flagging generic and "on-formulary" drugs.
- However, practices are exposed to community medication histories through e-prescribing. For example, Dr. A renews a medication and his e-prescribing program sends an alert advising him that the medication could interact with another drug the patient is taking. He has not prescribed that drug, so his office staff will have to contact the patient to identify who has prescribed it, and then Dr. A will have to contact Dr. X to "negotiate" which drug will be discontinued or changed. If failure to take action results in patient injury from a drug interaction, the doctor may be liable.
- Because of "alert fatigue," there is a danger that doctors may ignore, override, or disable alerts, warnings, reminders, and embedded practice guidelines. If it can be shown that following an alert or a guideline would have prevented an adverse patient event, the doctor may be found liable for failing to follow it.
- Doctors may copy information from a prior note or visit and paste it into a new note or visit (known as "cloning"), making changes where appropriate or documenting by exception. This may result in irrelevant over-documentation, and the patient may appear to have more or fewer complex problems since the prior encounter. By substituting a word processor for the doctor's thoughtful review and analysis, the narrative documentation of daily events and the patient's progress may be lost, thereby compromising the record of the patient's course. The quality of notes and documentation may be further compromised by the use of templates.
- The computer may become a barrier between the doctor and the patient. When the doctor fills in a computer template, it may divert attention from the patient, limit interactive conversation, and restrict creative thinking. This may depersonalize and weaken the doctor-patient relationship. The computer's location in the office is an important ergonomic consideration; i.e., the location of electrical outlets shouldn't force you to sit with your back to the patient.
- Many EMRs autopopulate the history and physical fields (H&P) from data derived from data fields in a prior H&P, and in procedure notes from personalized or packaged templates. While over-documentation may facilitate billing, entering erroneous or outdated information may increase liability. For example, an internist was deposed, and his EMR was the medical record. Some of the autopopulated fields contained obviously wrong information. At deposition, the plaintiff's attorney asked these questions:
  - "So is the information in this record accurate or not?"
  - "Do you bother looking at your records?"
  - "If these 'autopopulated' fields are incorrect, can we trust anything in this record?"
  - "Do you deliver the same level of care as you do in record keeping?"

"Meaningful use" requires online patient connectivity. Some EMRs have patient questionnaires that use an algorithm to interview the patient. These questionnaires often address—and memorialize in the record—issues that many doctors are simply not prepared to pursue (depression, substance abuse, etc.). Lack of or incomplete follow-up can create potential

liability and provide a clear record for the plaintiff's attorney to follow.

Vendor contracts may attempt to shift medical liability risks resulting from faulty software design or decision support data onto the doctor. They may also provide that the vendor has rights to utilize patient or provider data. Read all contracts carefully.

Electronic discovery: Lawyers may request not only printed copies of the EMR, but also the raw e-data for metadata analysis. This includes logon and logoff times, what was reviewed and for how long, what changes or additions were made, and when the changes were made. Smart phone and email records are also discoverable. Doctors need to know that all of their interactions with the EMR are time-tracked and discoverable.

Templates with drop down menus facilitate data entry. However, drop down menus are usually integrated with other automated features. An entry error may be perpetuated elsewhere in the EMR—and it may be overlooked, resulting in a new potential for error. Erroneous information, once entered into the EMR, is easily perpetuated and disseminated.

Many EMRs provide e-prescribing drug information and clinical decision support, and the government's "meaningful use" requirements mandate minimum functionalities in both of these areas. Clinicians should know the source of drug and clinical decision support information in their EMRs because they may be held accountable to the clinical standards of care for their specialty and for the information in FDA-approved drug labels or drug alerts.

Social Media: Malpractice Risks

Social media (YouTube, Twitter, Facebook, MySpace, blogs, etc.) can be used by doctors for doctor-to-doctor networking. However, these types of media are not appropriate for doctor-patient communications because they are too informal and lack an atmosphere of professionalism—making it easy to lapse into casual conversation and inadvertently cross the boundary between personal and professional relationships. The following recommendations are made regarding the use of social media:

1. Do not discuss individual patients, dispense medical advice, respond to clinical questions from patients, or otherwise practice medicine on these sites. These types of media do not use HIPAA-compliant secure networks, and inadvertently disclosing a patient's health information will violate HIPAA.
2. Presume that anything you say or post is in the public domain, and remember that anything typed or emailed creates a permanent record that is subject to discovery.
3. Doctor office practices should have written confidentiality and communication policies with employees that clearly forbid online disclosure or discussion of patient health information.

Content contibued by *The Doctors Company*. For more information on diagnostic errors, visit the Knowledge Center at www.thedoctors.com.

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Academy Releases Updated Clinical Indicators

As part of a project designed to deliver the most up-to-date clinical information to our members, the Academy undertook a review of the Clinical Indicator Compendium (CI) listed online. We are proud to announce that the first round of Clinical Indicators is now available to members at http://www.entnet.org/Practice/clinicalIndicators.cfm. Newly updated indicators include: Endoscopic Sinus Surgery, Nasal Endoscopy, and Canalith Repositioning, Tonsillectomy, Adenoidectomy, and Adentonsillectomy, Septoplasty, Adenoidectomy, Laryngoscope/Nasopharyngoscopy, and Endoscopic Sinus Surgery: Pediatric.

The Academy's Patient Safety and Quality Improvement (PSQI) Committee oversaw the development of the Clinical Indicators for Otolaryngology–Head and Neck Surgery in 1988. These indicators were sent to AAO-HNS/F committees to ensure they had the most up-to-date clinical information. The Physician Payment Policy Workgroup (3P) had final approval of all clinical indicators. The primary target audiences for the Academy's Clinical Indicators include otolaryngologist–head and neck surgeons, practice managers, practicing non-physician providers who work with otolaryngologists, and other providers. Payers, attorneys, and quality assurance staff also utilize the Academy's Clinical Indicators.

In 2000, during the first revision of the CI, the PSQI included a logical argument in each CI to justify the diagnosis. By doing so, there was greater importance associated with the quality of the history, physical examination and diagnostic tests. The PSQI also expanded each CI to include procedure-specific post-operative observations, outcome issues suggested for use by institutions and surgeons and a patient information section that physicians could use during surgical counseling. In 2006, the Academy established the Guideline Development Task Force and a process to develop clinical practice guidelines that would be more comprehensive and include documentation of opinions from scientific literature.

In 2010, 3P and the Academy undertook a second review of the CI to examine which indicators needed to be updated. These indicators were sent to AAO-HNS/F committees to ensure they had the most up-to-date clinical information. The Academy would like to thank the following chairs and committees that participated in the review of these indicators: **David E. Tunkel, MD,** and the Pediatric Otolaryngology Committee; **Pell Ann Wardrop, MD**, and the Sleep Committee; **Scott P. Stringer, MD,** and the Rhinology and Paranasal Committee; **Daniel G. Deschler, MD**, and the Head and Neck Surgery & Oncology Committee; **Robert K. Jackler, MD**, and the Hearing Committee; **Donna J. Millay, MD**, and the Plastic & Reconstructive Surgery Committee; and **Milan R. Amin, MD**, and the Airway and Swallowing Committee. Without their hard work, dedication, and expertise, the Academy would not be able to provide these resources to its members and others who utilize the CI.

If you have any questions about the Clinical Indicator Compendium or the revision process, email the Health Policy team at healthpolicy@entnet.org.

Richard W. Waguespack, MD, Discusses Revised Clinical Indicators

In the dozen years since the last Clinical Indicators (CIs) for Otolaryngology–Head and Neck Surgery were released, there has been change throughout the practice of medicine. Not the least is the high-speed communication enabled by the Internet. While the 1988 CIs, originated by the Patient Safety and Quality Improvement Committee, might have been written in stone, the current ones reflect instant information. As a result, the Physician Payment Policy (3P) Workgroup, which provides oversight of the CIs, has kept a sharp eye on the accuracy of the list, and has, in fact, pulled some off the website to update them. The new CIs reflect the best-known procedures for the range of medical practices included in otolaryngology–head and neck surgery. The *Bulletin* spoke with **Richard W. Waguespack, MD,** AAO-HNS Socioeconomic Affairs coordinator and co-chair of 3P, which oversaw the revisions. It was a long process, he noted, to combine "the art of medicine with hardcore evidence," collecting input from many sources. He emphasized that the clinical indicators are not laws, but are meant to help ease the doctor and payer relationship and secure the best treatment of every individual patient.

Richard W. Waguespack, MD

Simply, what are clinical indicators?

Dr. Waguespack:
Basically, the clinical indicators define a basis of medical necessity for a range of procedures. The [CIs] initially were generated around 1988 by quality improvement processes at many levels. Their intent is to help practitioners engage in the best practices, reduce errors, and improve value received as much as humanly possible.

The clinical indicators are not meant to be cookbooks, but general procedural guides. It becomes a slippery slope defining how exactly one should adhere to the clinical indicators or how precise to make them, but most doctors would adhere closely and base any variance on patient-specific factors.

For example, there is a CI for putting tubes in ears, which would outline the amount of therapy and examination findings that would justify placing tubes. But if one had a patient who was intolerant of antibiotics, whose speech was being delayed because of fluid, or had other factors that might make it inappropriate to wait or fulfill all listed criteria, then the doctor would be justified in considering intervening sooner than the CI might suggest.

The CIs are not so specific as to lock people into specific management because there are often multiple ways to treat problems and differences between patients.

How are CIs developed?

Due to the significant socioeconomic implications inherent with publishing CIs, the Academy uses 3P as the steering committee that oversees the process, making sure they reflect

> It becomes a slippery slope defining how exactly one should adhere to the clinical indicators or how precise to make them, but most doctors would adhere closely and base any variance on patient-specific factors.

current practice. In turn, 3P seeks recommendations from our committees and other interested parties for revisions or new CIs. Our committees provide the medical expertise that underpins the indicators. Occasionally, more than one committee looks at a subject and there is often a need for coordination between specialties and subspecialty societies.

While this is the first major revision in 10 or 11 years, we had taken several CIs off our website because there was dated information there. In this major revision, we took the old indicators and prioritized those that were most in need of revision. For example, the Caldwell-Luc indicator was deleted, the determination being that so few of these are done anymore. Although Caldwell-Luc is still a valid procedure for a very small number of people, because of the evolution of endoscopic sinus surgery, it was not reasonable to invest time and resources to update at this time.

Fundamentally, we work a great deal by email and with a rigorous back and forth until a good consensus is reached.

There is a patient information section at the end of each clinical indicator. How is this information intended to be used?

Much of this section's information would come to the patient during their face-to-face physician encounter or consultation. It's not a script to follow, but it will act as a guide and reference for pertinent information. It's also reasonable for a primary care practitioner to be aware of the procedures and use the CI to explain to a patient what he or she might expect when referred to a specialist. Or, if the clinical indicator says it's reasonable to treat medically, then the doctor can see that he or she may consider treating this patient up to a point, before referring.

What are some examples of what turned up or changes that were made?

One example is a procedure that helps people with BPPV (benign paroxysmal positional vertigo). The Epley maneuver, or canalith repositioning, was not in the old CIs, but seemed a helpful addition since it now has its own CPT code and is a mainstream treatment modality.

How are clinical indicators different from the Academy's policy statements and clinical guidelines/consensus statements?

Policy statements are documents that express the Academy's position on any of a number of issues, ranging from general statements (such as support of a patient's right to choose their own physician, primary care or specialist) to specific ones (such as defining the number of times sinus surgery patients should be debrided postoperatively). Clinical guidelines are in-depth, evidence-based documents on a specific topic that define how a clinical condition might be evaluated and treated. Their development is based on a comprehensive and generally cross-specialty literature review and is intended to represent state-of-the-art management of that condition. Authors are drawn from a broad base of clinicians. Examples include otitis externa, hoarseness, and sudden idiopathic sensorineural deafness. Consensus statements are similar, but are based more on expert opinion. In contrast, CIs are briefer and are intended to outline the clinical context and rationale for performing certain procedures or services. Associated diagnoses and ICD-9 codes are included, as is a brief description intended for patient education.

How do insurers use clinical indicators? Can you give an example of how the clinical indicators have been used by private payers/Medicare to benefit otolaryngologists?

I think the overall intent of everyone involved is to engage in the best practices and the majority of insurance carriers are truly trying to do what they perceive is the right thing to serve their clients. But there are inevitably controversies between the doctors' and others' perspectives of optimal care. The devil is in the details.

If an insurance carrier wants to change its indicators it can, and when they are reasonable, there's nothing too much to be said. But oftentimes we need to act. In one case, we learned from our members about a major carrier that had changed its indicators on septal surgery. We engaged our subspecialty societies and the plastic surgery society to work on this. This is where the art of medicine is balanced with hardcore evidence. This gets down into the weeds, defining practical medical management. We engaged in a written and phone dialogue to make their requirements to pre-certify the surgery more clinically relevant and medically logical. This was by no means simple and took many

> If an insurance carrier wants to change its indicators it can, and when they are reasonable, there's nothing too much to be said. But oftentimes we need to act.

weeks to finalize. We then needed to monitor via our membership that the policy was properly implemented. We did not sense this carrier used our then-existing CI for their policy development and we remained mindful of this interaction as the septoplasty CI was revised.

Another example relates to sinus surgery wherein a carrier created a precertification policy requiring the patient to have maximum medical therapy before surgery would be approved. The carrier understandably wished to have the doctor treat medically until the point that non-surgical treatment had failed or the patient was having significant disease progression requiring surgical intervention. The definition of maximal medical therapy was a major source of contention and varies from patient to patient, depending on their specific clinical condition. This carrier cited an old, outdated CI to define maximal medical care, so a discussion ensued to update indications. These updates are now incorporated into our revised CI.

Is there a way physicians can provide input into the development of future clinical indicators?

Doctors can make relevant individual committees aware of the need for new, or revisions to, CIs or directly contact the Academy. Most likely this would be driven by a need encountered in their practice, say to help deal with payers. The committee or 3P would then start the formal process of development.

How can a physician use clinical indicators in their everyday practice?

Making primary care physicians aware of the CIs should aid their making more appropriate referrals and help their patients begin to understand what to expect and the rationale for recommending these procedures. Otolaryngologists might well consider sending CIs to their referring physicians in this educational manner.

What other resources does the Academy have that can help otolaryngologists and head and neck surgeons improve quality?

The Academy and the American Board of Otolaryngology are interested in seeing that all practicing otolaryngologists are engaged in lifelong learning. For those of us working on health policies, instruction, and writing articles, it is an obligation both to keep our quality standards high and communicate and disseminate this to our colleagues. Personally, I feel the profession has given a lot to me, and our ongoing job is mentoring younger physicians to assume our positions.

Physician Payment Policy (3P) Workgroup Update: Current Technological Incentive Programs and Upcoming Penalties

Richard W. Waguespack, MD, coordinator for Socioeconomic Affairs and Michael Setzen, MD, coordinator for Practice Affairs, Co-chairs of 3P Health Policy staff: Jean Brereton, senior director, Research, Quality, and Health Policy; Jenna Kappel, director, Health Policy; Jenna Minton, senior manager, Health Policy; Joe Cody, Health Policy analyst; Harrison Peery, Health Policy analyst

The Physician Payment Policy Workgroup (3P), co-chaired by **Richard W. Waguespack, MD**, and **Michael Setzen, MD**, is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding or reimbursement, and practice services or management. 3P and the Health Policy staff have been busy in 2012 with a continued high level of activity, constant emails, and monthly calls, working diligently and tirelessly on behalf of all members.

Below, we want to draw your attention to the fact that, in the next few years, there will be numerous opportunities through incentives and potential minefields by way of penalties that will affect your practice as technological advances change the way we practice medicine (see Table 1). These include the Electronic Prescribing (eRx) Incentive Program, Medicare and Medicaid's Electronic Health Records (EHR) Incentive Program, the Physician Quality Reporting System (PQRS), and the upcoming transition to ICD-10. This article will give a brief description of each of these programs and provide you with the information you need to take advantage of available incentives and avoid penalties by becoming compliant.

Electronic Prescribing (eRx) Incentive Program

The eRx Incentive program is designed to facilitate the transition to electronic prescribing software through incentive payments and penalties. E-prescribing can be achieved through standalone software or through Electronic Health Records that have an e-prescribing capability. The first year of the program that features both incentive payments and payment adjustments (penalties) is 2012. Eligible professionals who successfully reported eRx measures in 2011 received a 1 percent bonus payment from Medicare in 2012.

In 2012, physicians must report the eRx measure for at least 25 unique electronic prescribing events in which the measure is reportable by the eligible professionals during 2012 in order to be eligible for the 1 percent incentive payment. Physicians who fail to report at least 25 prescribing events or report the G8553 code via claims for at least 10 unique denominator-eligible eRx events for services provided January 1, 2011, through June 30, 2011, will be subject to a 1 percent payment penalty for all Medicare payments in 2012. There is also a group practice reporting option (GRPO) that allows groups to earn a 1 percent incentive payment. Eligible professionals may be exempt from the application of the payment penalty if CMS determines that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship. Applications for a hardship exemption are due by June 30, 2012.

It is important to note that for each year physicians do not meet the criteria for successful electronic prescribing, payment penalties increase. In 2013, physicians may be subject to a 1.5-percent penalty, and in 2014 this increases to a 2-percent payment penalty.

For more information on the eRx Incentive Program, see the Academy's information page at http://www.entnet.org/Practice/MedicareERxFactSheet.cfm.

YEAR	INCENTIVE (+)	PENALTY (-)
2012	eRx +1% PQRS +0.5%	eRx -1%
2013	PQRS +0.5%	eRx -1.5% ICD-10 Implementation (likely delayed)
2014	PQRS +0.5%	eRx -2%
2015	None	EHR -1% PQRS -1.5%
2016	None	PQRS -2%
2020	None	EHR -5%

Table 1. Timeline of Incentives and Penalties/Payment Adjustments

Medicare and Medicaid's Electronic Health Records (EHR) Incentive Program

The Electronic Health Records Incentive Program is an initiative from CMS designed to facilitate the use of EHRs in clinical settings. Eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of EHRs are eligible for incentive payments. Incentive payments can accumulate to up to $44,000 by 2015 if eligible professionals begin to successfully participate in 2012.

The EHR Incentive Program is structured in three stages, with a possible fourth stage starting in 2018. In order to successfully demonstrate meaningful

use in Stage 1, which began in 2011, eligible professionals must meet 20 objectives out of 25 possible choices. There are 15 required core objectives, while the remaining five objectives may be chosen from the list of 10 menu set objectives. Eligible professionals must report on six total clinical quality measures: three required core measures (substituting alternate core measures where necessary) and three additional measures (selected from 38 clinical quality measures). The meaningful use criteria for Stage 2, which is scheduled to begin in 2014, were proposed by CMS in early March and are expected to be finalized sometime in the summer of 2012. The Academy will provide timely updates on the development of Stage 2 meaningful use criteria.

Just like the eRx program, there are coming penalties for professionals who do not begin participating in the EHR Incentive Program. Starting in 2015, eligible professionals, hospitals, and critical access hospitals that do not successfully demonstrate meaningful use of EHRs will be subject to a 1 percent penalty that increases annually up to 5 percent by 2020.

For more information on the EHR Incentive Program, visit the Academy's information page at http://www.entnet.org/Practice/ONC.cfm.

Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System is currently a voluntary reporting program that provides an incentive payment to physicians or groups that report data on quality measures. In 2012, physicians who successfully report data on quality measures are eligible for .5 percent bonus payment on all Medicare claims. Individual eligible professionals may choose to report information on individual physician quality reporting quality measures or measures groups to CMS on their Medicare Part B claims, to a qualified Physician Quality Reporting registry, or to CMS via a qualified EHR product, or to a qualified Physician Quality Reporting data submission vendor.

The Academy currently offers an online tool named PQRI*wizard* to help collect and report quality measure data for the PQRS program in 2012. PQRI*wizard* offers automatic data validation, minimized data entry time, and retrospective or prospective data submission. Information for PQRI*wizard* can be found at http://www.entnet.org/Practice/PQRS.cfm.

Beginning in 2015, CMS will adopt a payment penalty as part of the PQRS program like the eRx and EHR programs. Eligible professionals who do not satisfactorily submit PQRS quality measure data face a 1.5 percent payment penalty. This penalty rises to 2 percent in 2016. To avoid the 2015 payment penalty, an eligible professional must satisfactorily report PQRS quality measure data during the 2013 reporting period (January 1, 2013, to December 21, 2013).

For more information on PQRS, visit the Academy's information page at http://www.entnet.org/Practice/cmsPQRIBonus.cfm.

"Beginning in 2015, CMS will adopt a payment penalty as part of the PQRS program like the eRx and EHR programs. Eligible professionals who do not satisfactorily submit PQRS quality measure data face a 1.5 percent payment penalty."

The Transition to International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)

As the enforcement deadline for the transition to the Health Insurance Portability and Accountability Act

of 1996 (HIPAA) Version 5010 approaches, providers and billers must take heed of the fact that penalties for non-compliance could be severe. On April 1 the Office of E-Standards and Services began enforcement of any complaints it receives for non-compliance. Notably, providers can be penalized up to $1.5 million annually for uncorrected, repeated, willful neglect of compliance with new HIPAA standards. Although it may be unlikely that the Department of Health and Human Services (HHS) will exercise such extreme enforcement capabilities, the possibility exists. While HHS has announced intent to delay the ICD-10 compliance deadline of October 1, 2013, it did not delay the 5010 enforcement deadline. Further, providers should understand that part of the Electronic Health Record (EHR) Incentive Payment Program for 2012 consists of submitting all electronic claims under 5010.

Even with the potential ICD-10 delay, your practice should work to become compliant with ICD-10 by October 1, 2013, (or by the time of implementation) to avoid delayed payments from Medicare and private payers. Although CMS has not created a specific penalty structure for non-compliance with ICD-10, providers will still fall under the same HIPAA umbrella of regulations and again may be fined up to $1.5 million for uncorrected willful neglect with a maximum of $50,000 per violation. The Academy originally opposed the ICD-10 transition and advocated for a delay in the compliance deadline in previous efforts, to help our members during the transition.

For any questions or information about these programs, email the Health Policy unit at healthpolicy@entnet.org or visit the Regulatory and Socioeconomic Affairs site at http://www.entnet.org/Practice/regulatorySocioAdvocacy.cfm.

Incentives, Penalties Related to Technology: What You Should Be Aware Of, How the Academy Is Helping Members

Note from the AAO-HNS/F President Rodney P. Lusk, MD

Those of you who don't think the incentive is worth the time and expense to adopt these new technologies, you need to beware that for many of the technology incentive programs mentioned in the 3P article by Richard W. Waguespack, MD, and Michael Setzen, MD, there will soon be penalties that can total as much as 10 percent from all Medicare payments for your practice. This adds up and may really affect you as the reimbursement for Medicare procedures continues to decline.

The Academy takes every opportunity to meet with CMS and submit comments related to these various programs, their overlapping time frames, and potential for future penalties. In March, the Academy participated in an AMA sign-on letter that expressed concerns to CMS about the various quality program payment penalties, which are rapidly approaching and will affect providers all within a very narrow time frame.

The Academy is diligently working on your behalf to help you with information about participating in these programs. There is a lot of helpful information on the Academy website and the Meaningful Use, EHR, and eRX pages have recently been updated. Take note of the important highlights below about the Physician Quality Reporting System (PQRS).

PQRS: The Academy currently offers an online tool named the PQRI*wizard* to help collect and report quality measure data for the PQRS program. PQRI*wizard* was first made available for the 2011 reporting period and the tool is currently being revised for 2012. The PQRI*wizard* tool calculates your PQRS quality measures and includes a built-in progress monitor to validate your report. Unlike 2011, the 2012 edition of PQRI*wizard* will include a selection of individual measures specific to otolaryngology. The importance of participation in PQRS continues to grow as CMS will adopt a payment adjustment (penalty) in 2015 for physicians who do not satisfactorily submit PQRS quality measure data. To avoid the 2015 payment adjustment, physicians must satisfactorily report PQRS data during the 2013 reporting period. Information for the PQRIwizard can be found on the website at http://www.entnet.org/Practice/PQRS.cfm.

"The Academy is diligently working on your behalf to help you with information about participating in these programs. There is a lot of helpful information on the Academy website and the Meaningful Use, EHR, and eRX pages have recently been updated."

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As of February 9, 2012

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

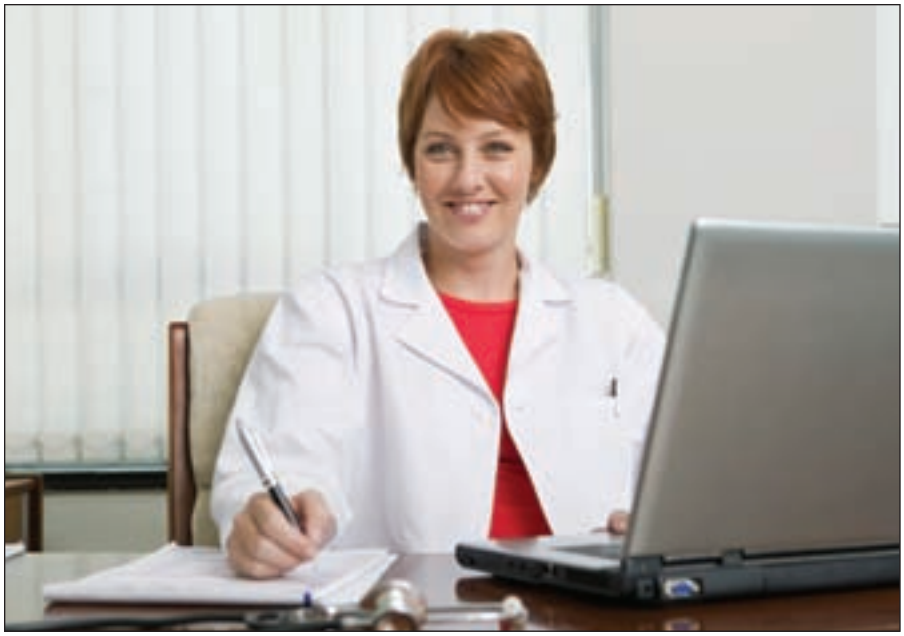
ICD-10 HIPAA and the HIPAA Version 5010 Transitions

While the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 and D.0 electronic transaction standards and ICD-10 code transition continues to pose a significant financial burden for providers, the Department of Health and Human Services (HHS) has been responsive to providers' preparation needs and continues to delay deadlines to give providers, Medicare Administrative Contractors (MACs), and private payers more time to appropriately prepare. Despite this, providers should move toward full compliance as soon as possible to experience an optimum return on investing in the transition.

The Office of E-Health Standards and Services (OESS) announced on March 15 that the enforcement deadline for compliance with HIPAA Version 5010 and D.0 standards will be delayed until June 30 of this year. As the delayed enforcement deadline for the transition approaches, several providers continue to experience delayed payments from MACs. Both MACs and providers alike have experienced problems with the transition, resulting in delayed payments and miscommunications between providers and MACs. Further, several providers have reported to the AAO-HNS Health Policy staff that some MACs have been unresponsive due to understaffed call centers. Moving forward, it will be important for providers, private payers, and MACs to fix any further clerical issues quickly in order to minimize financial difficulties.

Providers must understand that, as of right now, the office responsible for enforcing compliance—the Office of E-Health Services and Standards (OESS)—has not established specific penalties for non-compliance with version 5010 standards. As a result, providers who are non-compliant may be exposed to HIPAA tiered penalties that may result in up to $1.5 million for repeated willful non-compliance. While it is highly unlikely that the OESS will pursue such penalties, non-compliant providers will not be paid by Medicare and/or several private payers, resulting in significant financial hardship. Although Version 5010 supports both the ICD-9 and the ICD-10 code set structures, it is not possible to create or transmit electronic claims using ICD-10 codes without transitioning to Version 5010 HIPAA transaction standards. Version 4010/4010A1 does not support ICD-10 codes.

The ICD-10 transition will expand the current ICD-9 codes from roughly 17,000 codes under ICD-9 to roughly 140,000 total codes for ICD-10 (70,000 ICD-10-CM and 70,000 ICD-10-PCS). Notably, the expansion is expected to increase practice expenses dramatically for physicians making the transition. HHS shares the sentiment that implementation of ICD-10 code sets may cause serious cash flow problems for providers, but argues that these could be addressed through mechanisms, such as periodic interim payments. Given its recent announcement of its "intent" to delay ICD-10 implementation, HHS has begun to listen carefully to the physicians, vendors, and payers who will be affected by changes in the code set standards. In addition, the fact that the OESS has delayed the enforcement date for compliance with 5010 standards further demonstrates that HHS understands the hardship many providers face with the transition. Despite the anticipated delay in the deadline for full compliance with ICD-10, HHS advocates that ICD-10, in the long run, is anticipated to support operational and strategic planning, and improve clinical, financial, and administrative performance. As such, it lies in providers' best interests to gravitate toward ICD-10 and Version 5010 compliance as soon as possible.



Becoming familiar with the new code sets, providing training to preview the structure and conventions of ICD-10, educating staff regarding the difficulties of translating clinical documentation into appropriate codes, and utilizing innovative technology as mapping tools are just a few of many strategies providers should take to realize the benefits of ICD-10 sooner.

For Academy Resources on the ICD-9 to ICD-10 transition, visit http://www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm. If you or your staff are interested in additional educational materials on ICD-10, email the Academy's Health Policy team at healthpolicy@entnet.org.

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.

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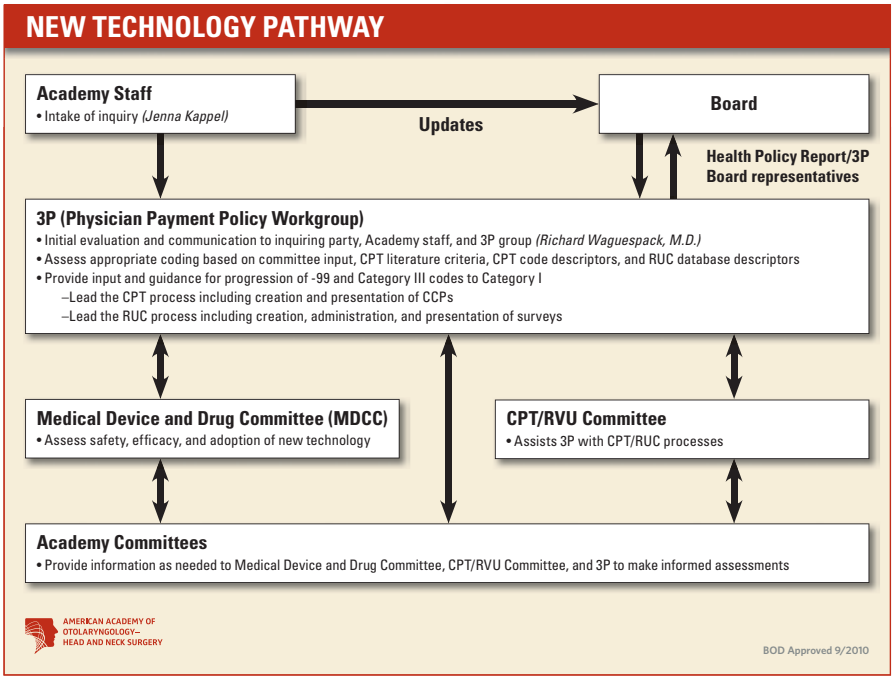
What You Should Know about Requesting New or Revised CPT Codes, Guidance on How to Code for New Technology

The Physician Payment Policy Workgroup (3P), co-chaired by **Richard W. Waguespack MD**, coordinator for Socioeconomic Affairs and **Michael Setzen, MD**, coordinator for Practice Affairs, is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding/reimbursement, and practice services/management.

The 3P group works tirelessly to evaluate inquiries for new technology coding and requests for new Current Procedural Terminology (CPT) codes or revisions to existing CPT codes. Members of 3P, including Dr. Waguespack, **Bradley M. Marple, MD**, and **Brendan M. Stack, MD**, represent otolaryngology interests on the AMA CPT Advisory Committee. Our CPT representatives advocate for otolaryngology by presenting new and revised CPT codes to the CPT Editorial Panel for inclusion in the code set used for physician billing.

When it comes to valuing CPT codes, 3P serves as the expert consensus panel to analyze surveys completed by Academy members and make recommendations for appropriate Relative Value Units (RVUs) to the AMA/Specialty Society Relative Value Update Committee (RUC) for otolaryngology-related codes. Some of these members (**Wayne M. Koch, MD; John Lanza, MD; Charles F. Koopmann, MD, MHSA; Bill Moran, MD**; and **Jane Dillon, MD**) also represent the Academy at the RUC meetings. The RUC makes recommendations on the RVUs of new and revised physician services to the Centers for Medicare and Medicaid Services (CMS).

The RUC also performs broad reviews of the Resource Based Relative Value System every five years and rolling reviews of many codes based on screens, such as high utilization, frequency of codes used together, and codes not surveyed since the beginning of the RUC process more than 20 years ago.



To provide a more streamlined process consistent with approaches adopted by other specialty societies, 3P initiated development of the New Technology Pathway. The process was approved by the Board in September 2010 and the Academy adopted and now requires it be used for any requests for guidance on how to code for a new technology, new CPT codes for services or procedures, or revisions or revaluations of existing codes.

The newly formalized process includes coordination between 3P and experts from other applicable AAO-HNS committees (e.g., Medical Devices and Drugs Committee, CPT and Relative Value Committee, etc.) as a way to incorporate all of the Academy's resources in the interest of its members. Since the New Technology Pathway process has been formalized, we have been able to be confident in addressing such requests in a manner that is clearly defined, is consistent with AMA CPT and RUC guidelines, accounts for the interests and perspectives of all stakeholders while protecting against undue influence of any group or individual, encourages the collection of reliable data, and promotes efficient, fair reimbursement for our members and appropriate access to new procedures and services for our patients.

The New Technology Pathway starts by completing the New or Revised CPT Code Application, an internal Academy document, elements of which are illustrated below. Inquiring parties, including physicians and industry representatives, should email the completed package to the Academy's staff at JKappel@entnet.org. Applications are available at http://www.entnet.org/Practice/Applying-for-CPT-codes-and-Obtaining-RVU.cfm.

Elements from the New or Revised CPT Code Application

AAO-HNS
Physician Payment Policy Group (3P)

1. Name of applying party.
2. Name and brief description of service/procedure.
3. Reason for application/background information.
4. Is this a revision of an existing code, request for revaluation of an existing code, request for a new code, or inquiry regarding proper coding for new technology?
5. Is the service/procedure FDA-approved for the specific use of applicable devices or drugs?
6. Is the service/procedure performed by many physicians/practitioners across the United States? If not widely practiced, provide names of individuals/centers providing this service.
7. Is the service/procedure currently being reported by one or more existing codes? If so, which codes are being used?
8. If a new code request, is this for Category I or III?
9. For Category III code requests, please attach the following:
   - A protocol of the study or procedures being performed. Please attach, along with descriptions of current U.S. trials outlining efficacy of the procedure.
   - Support from the specialty societies who would use this procedure.
   - Availability of U.S. peer-reviewed literature for examination by the CPT Editorial Panel. Please supply electronic copies of any available references and fill in reference grid below, assigning levels of evidence using the table provided.
   - Descriptions of current U.S. trials outlining the efficacy of the procedure.
10. For Category I code requests (new or revised), is the clinical efficacy of the service/procedure well-established and documented in U.S. peer-reviewed literature? If so, please supply electronic copies of references and fill in the reference grid below. Optimally, five references should be submitted, of which at least three report the procedure/service in U.S. patient populations. At least two articles should report different patient populations or have different, non-overlapping authors. Foreign references are acceptable if published in English and relevant or applicable to U.S. populations. Please assign level of evidence for each reference from the table below. Note that, for codes describing new procedures, at least one publication should meet or exceed the criteria for level III.
11. Are there subspecialty societies within our specialty that are supporting this application? If so, please list, including contact information.
12. Are there subspecialty committees within AAO-HNS that are supporting this application? If so, please list, including contact information.
13. Are there members of other specialties that may also perform this procedure/service? If so, please list.

After the Health Policy department receives an application, it is reviewed to ensure completeness. Next, the application is routed to 3P, which will evaluate the request and take appropriate action, with input from Academy committees that relate to the specific procedure or service. The Medical Devices and Drugs Committee will assess the safety, efficacy, and adoption of any new technology. During the process, the applicant will receive communications from Health Policy and 3P representatives. The Academy Board will also receive regular updates from these sources. If you are interested in submitting a code change proposal to the CPT Editorial Panel, you must follow this process in order for the Academy to support the proposal. Make sure to submit the New or Revised CPT Code Application to the Academy at least six to eight weeks before the code change proposal submission date to the American Medical Association so there is time for thorough review and approval.

For more information, visit (http://www.entnet.org/Practice/Applying-for-CPT-codes-and-Obtaining-RVU.cfm) or email Jenna Kappel, director of Health Policy, at JKappel@entnet.org.

Level	Type of evidence (based on AHCPR 1992)
Ia	Evidence obtained from meta-analysis of randomized controlled trials
Ib	Evidence obtained from at least one randomized controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomization
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
V	Evidence obtained from case reports or case series

References	Level of Evidence Based on LOE Table	U.S. or Foreign Peer Reviewed	U.S. or Foreign Population Studied	Prospective Study	Total Patients Studied
Article (Author, Title, Journal, Year, Volume, and Pages)	Insert level #	U.S. Foreign	U.S. Foreign Both	Yes No	Insert #
Provide brief description regarding relevance to the CPT process.					

* For each article cited, please provide a brief description of why the specific literature reference is relevant (e.g. "this is the hallmark double-blinded controlled study establishing the value of the procedure/service," "this is a case report describing the procedure/service in detail," or "this is an opinion statement from a respected authority in the field").

Do I Need a Coach?

Rahul K. Shah, MD
George Washington University School of Medicine, Children's National Medical Center, Washington, DC

I was at my daughter's tennis lesson this past weekend when something caught my eye. A ninth grader came to the coach and said, "Last week, I was off. I could not hit the backhand accurately." The coach took him on the court and in four minutes the stroke was corrected. They practiced the shot repeatedly for the remaining 56 minutes. That is a great coach.

I have often wondered how useful the cadre of coaches that surround professional athletes really are—there is a swing coach, a physical trainer, a caddie, a sports psychologist, etc. However, watching this four-minute transition in this young competitive tennis player sealed the deal for me.

After witnessing that moment, I immediately recalled the astute, introspective article by Atul Gawande, MD,[1] a frequent contributor to *The New Yorker*. In the article he makes the case for surgical coaching and describes the experience of having a senior surgeon shadow him in the operating room, making suggestions to improve his surgical performance. It is an interesting concept; however, it is somewhat limited in that the model suggested by Dr. Gawande assumes there are senior surgeons who want to step back from the busy surgical lifestyle to coach or mentor other surgeons. I am sure we all have personal senior mentors who would be thrilled to help us on a one-off basis to improve our surgical skills. However excited I was by reading the article, I was somewhat skeptical that such individuals exist in sheer quantity to coach all of the surgeons who would want such coaching. Indeed, I wondered what makes a great coach. As noted earlier, unless a surgeon has a strong personal relationship with such an individual, the availability and trust would be difficult to find.

If we extrapolate from other high-performing industries that depend on individual performance, such as sports, themes emerge. For example, the best coaches are not necessarily the ones who have won all the championships or awards, such as the most valuable player. One can think of almost any sport and understand this.

"I wondered what makes a great coach. As noted earlier, unless a surgeon has a strong personal relationship with such an individual, the availability and trust would be difficult to find."

Hence, perhaps surgery, and specifically otolaryngology, needs to consider what the attributes of a superb coach are and consider ways to train or recruit people to provide similar services.

Like many hospitals, our organization is constantly trying to improve physician-patient relationships, and a metric we use is our patient satisfaction score. I received mine a couple of months ago and felt great—my patient satisfaction score was in the low 80 percent. Once my arrogance subsided, I reviewed the scores for all the physicians in the hospital and found three surgeons who were two standard deviations away from the mean—with scores better than 95 percent. I wondered if I could score higher after shadowing them.

You can imagine the fleeting awkwardness when I, as an associate professor, shadowed my friends (also mid-level surgeons) in general surgery, neurosurgery, and orthopedics. I tried to put away my medical interest in the pathology of the patient and the treatment decisions being made and focused on the surgeon's interactions with the patient. After a while, a few commonalities surfaced: there were no distractions during the office sessions (they did not check emails or their cell-phones): the only priority was the patient and his or her issues; they maintained complete eye-contact during the entire visit (even with me hovering around them); and they took no notes (they scribbled their thoughts later after the visit and dictated during breaks, lunch, or after the office session finished). Certainly, that morning was a great use of my time, and the question remains: "Will it pay off in terms of improving my ability to deliver care?"

I am excited about the concept of surgical coaching and what that holds for our patients and our specialty in the coming years and will begin writing about this topic more frequently.

Reference

Reference

1. Gawande, A. What Makes Top Performers Better? http://www.TheNewYorker.com/reporting/2011/10/03/111003fa_fact_gawande.

We encourage members to write us with any topic of interest, and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

Registration is Now Open!

AAO-HNSF Annual Meeting & OTO EXPO 2012 September 9-12 WASHINGTON, DC

Register early to save up to 50%
(early registration ends June 22)

Make your free time count while you're in town for the annual meeting, by visiting top attractions in Washington, D.C.!

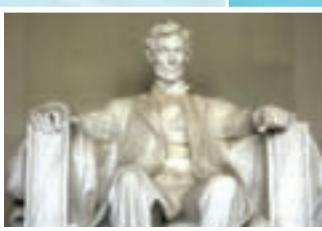
1. Visit the Smithsonian Museums and the National Gallery of Art.
2. Tour the Monuments and Memorials on the National Mall.
3. Tour the three houses of government.
4. Tour the Library of Congress.
5. Catch a show at the Kennedy Center, Ford's Theatre, Warner Theatre, National Theatre, or the Verizon Center.

★ We look forward to seeing you in Washington, D.C., at the 2012 AAO-HNSF Annual Meeting & OTO EXPO, September 9-12.

Visit www.entnet.org/annual_meeting to learn more!







AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care

1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.

Hearing Aid Dispensing in New York: Advocating for Patient Access

Under current law in New York state, few physicians offer hearing aid services within their practices, as it is not economically feasible to do so. Because they are unable to charge for reasonable and necessary expenses and can recover only the wholesale price of the hearing aid, physicians cannot afford to offer hearing aids, despite hearing aid dispensing being within the scope of practice of otolaryngologist–head and neck surgeons and the audiologists who work with them. This results in limited patient choice and reduced access to quality hearing healthcare for patients. Independent audiologists and hearing aid dispensers, with limited treatment solutions for hearing loss, can and do profit from the sale of hearing instruments.

Earlier this year, Assemblyman Jeffrey Dinowitz and Senator Betty Little amended and reintroduced A. 1739A/S.5164A. If adopted, these bills would expand patient access to treatment services by enabling physician offices to dispense hearing aids for a profit.

The Patient Access to Hearing Aids (PAHA) coalition, comprised of state and national medical and specialty organizations, was formed to educate New York legislators, patients, and otolaryngologists about an archaic law in New York prohibiting physicians from dispensing hearing aids for a profit and to advocate for change. Building on our momentum from 2011, we are at a critical juncture to change this outdated law and make a difference in New York. The PAHA Coalition includes the AAO-HNS and the New York State Society of Otolaryngology-Head and Neck Surgery (NYSSO), along with the Medical Society of the State of New York (MSSNY), the American Medical Association (AMA), the American Osteopathic Association, the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery, the American Otological Society, and others.

The NYSSO will conduct its annual State Lobby Day in conjunction with the New York Coalition of Specialty Care Physicians on Tuesday, May 15, in Albany. **A good turnout is critical to effectively advocate for patients and the profession, so all New York otolaryngologists are urged to participate May 15 in Albany**. For additional details and a registration form, contact the NYSSO office at 1-518-439-2020 or nyssohns@aol.com.

For more information on the PAHA Coalition and its legislative efforts, visit the PAHA Coalition website at http://www.entnet.org/Practice/members/PAHA.cfm (AAO-HNS member log-in required). Email questions to the AAO-HNS Government Affairs team at legstate@entnet.org.

One Strong Voice!

ENT PAC, the political action committee of the AAO-HNS, is only as strong as you, its members. Help ensure the strength of our collective voice on Capitol Hill by becoming an ENT PAC Investor today. With the 2012 election season already upon us, now is the time to make sure ENT PAC is poised to support incumbent Members of Congress and candidates who will champion the issues important to the specialty. To make a contribution, visit the ENT PAC webpage at www.entnet.org/entpac (U.S. AAO-HNS member log-in required) or send a personal check payable to "ENT PAC" to 1650 Diagonal Road, Alexandria, VA 22314.

Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the American Academy of Otolaryngology—Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year.

Stay Informed

Bookmark the AAO-HNS Legislative and Political Affairs Webpage

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Bookmark the Legislative and Political Affairs webpage today! By visiting the webpage, you can learn more about the issues affecting the specialty, such as the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy.

Wanted: Physician in the State Capitol

The AAO-HNS, in collaboration with state medical societies, wishes to encourage members to consider participating in a Physician in the Capitol program in their state. This program gives physicians an opportunity to learn more about their state's political process and to advocate on issues of importance to their practices and their patients.

Physician in the Capitol is organized with a state's legislative staff as an advocacy event during the state's legislative session, wherein a different physician is available each day during business hours to provide medical services to the members. The AAO-HNS, in collaboration with state medical and specialty societies, will schedule member physicians to be available at the state capitol for a designated day to render basic healthcare services. The bonus for this unique opportunity is that members can learn more about the legislative process and have the chance to personally hear legislative debate from lawmakers and private citizens.

Please consider making a difference in your state and experience first-hand the legislative process. A number of programs are already established nationwide. If you are interested in participating, please email legstate@entnet.org. We will work with you and your schedule to facilitate your participation in an existing program or work to implement a new program in your state.

AcademyU® Learning Station at Annual Meeting & OTO EXPO

Cathy Conley
Senior Manager, Online Learning

There is more to learn at the 2012 Annual Meeting & OTO EXPO in Washington, DC, than what you will find in the instruction courses and miniseminars. In addition to the live education activities, the Foundation will showcase all education products available to members and nonmembers alike at the AcademyU® Learning Station. As described in the 2012 Education Opportunities, received with the February *Bulletin*, the complete array of education activities will be available for hands-on review.

> "Excellent presentation and overview of topics in every Foundation education activity."

The AcademyU® Learning Station will showcase the breadth of learning opportunities available for physicians, residents, students, and allied health professionals. These include our online education (AcademyU® courses, the Online Lecture Series, and Clinical Otolaryngology OnLine (COOL)), our subscription-based activities (Home Study Course and Patient Management Perspectives in Otolaryngology (PMP)), live activities (Coding and Reimbursement Workshops), and our library of e-books. Samples of the products will be available to pique your interest and for you to learn how each one uniquely provides education for a variety of audiences. Most of the products offer AMA PRA Category 1 Credit.™

"The AcademyU® Learning Station offers Annual Meeting & OTO EXPO attendees a unique opportunity to review and interact with all the education activities provided by the Foundation. Each year, new products and modules are developed to meet the needs of every otolaryngology learner group," said **Sonya Malekzadeh, MD**, coordinator for education with the Foundation.

Also featured at the annual meeting will be demonstrations of the Foundation's online products. These include the 25 courses, 125 online lectures, and 30 COOL modules. The demonstrations will assist you with navigating the courses and finding the content that is important to you. Also on display will be the significant upgrades to the site, making access and use of this content easier and more meaningful.

COOL modules are designed for the non-otolaryngologist. PAs especially enjoy these activities as AAPA credit can be earned upon completion. In addition, many medical schools and residency programs use them to teach basic otolaryngology-head and neck surgery concepts.

Another online demonstration will be the newly renamed and refocused Patient Management Perspectives in Otolaryngology (PMP). While this product remains available as a print piece, this demonstration will show the enhanced features of the online version through the use of multimedia. Registration for these fantastic products will be available onsite at the Learning Station.

While attending the annual meeting you will have a final opportunity to register for the 2012-2013 Home Study Course. Next year's topics include rhinology and allergic disorders, voice disorders, inflammatory diseases of the head and neck, and otology. Sample past publications will be available for your review and your registration can be completed onsite.

Residents and residency program directors will want to visit the Learning Station and view the completely updated and enhanced Comprehensive Otolaryngologic Curriculum Learning through Interactive Approach (COCLIA). Test-drive the new COCLIA website and learn how to use it to start your own resident discussion groups. All discussion questions have been updated and digital media has been added to enrich the experience.

New this year is the ENT Exam instructional video, which will be available to the public on YouTube and entnet.org. The video covers how to perform a thorough ENT exam complete with images of normal anatomy, normal variances, and common abnormalities. There are four modules covering the ear, oral cavity and neck, face and nose, and nasopharynx and larynx. See how this video can help you train medical students, first year residents, PAs, NPs, and allied health professionals.

Lastly, learn about the variety of e-books the Foundation has available. These are easily accessed on the Foundation website and can be downloaded for free. Visit the Learning Station to learn how to find our four e-books ("Primary Care Otolaryngology (3rd Edition)," "Geriatric Care Otolaryngology," "Antimicrobial Therapy in Otolaryngology," and "TMN Staging for Head and Neck Cancer").

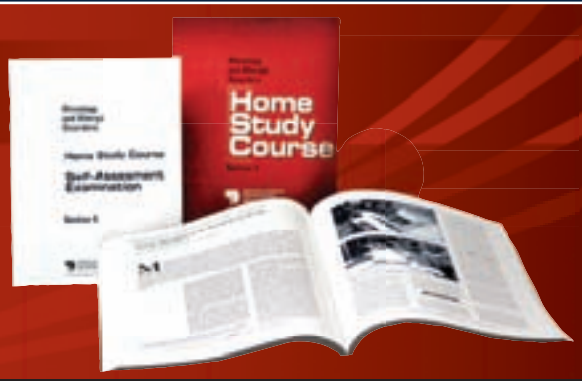
> "The patients presented in these courses are just like my patients."

"We take educating our members very seriously at the Foundation," said Mary Pat Cornett, CMP, CAE, AAO-HNSF senior director of Education and Meetings. "The AcademyU® Learning Station is a great way to experience the engaging and relevant education products members need to enhance their knowledge, competence, and practice in the field of otolaryngology-head and neck surgery."

Register online @ www.entnet.org/hsc

2012 Home Study Course registration deadline September 3, 2012

Sign up before August 3 to SAVE



For more Home Study Course information: www.entnet.org/hsc

Early registration savings up to 20% available until August 3, 2012

Registration fee is based on AAO-HNS membership status at the time form is received.

Payment must be received by September 3, 2012, to receive 2012–2013 courses. First packet begins mailing in late August.

PRACTICING PHYSICIANS & ALLIED HEALTH PROFESSIONALS					
Order 2 YEARS and SAVE!	Member Early (By Aug.3)	Member Regular	Nonmember Early (By Aug.3)	Nonmember Regular	Total
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			TOTAL		$

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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Address Information

❑ New address for ALL Academy correspondence ❑ New address for HSC ONLY
Your Home Study Course (HSC) and all other AAO-HNS/F publications will be mailed to the same address.

First Name _____ Family/Last Name _____ Degree (MD, DO, PhD) _____

AAO-HNS ID# (Please note that an AAO-HNS ID# does not automatically signify membership.) _____

Address _____

Address (No P. O. boxes, please) _____ Suite/Room _____

City _____ State/Province _____

ZIP+4/Postal Code _____ Country _____

Phone/Extension _____ Fax _____ Email _____

Exam Options (Choose One)

❑ Paper version ❑ Online: (email required) _____

Present Position

❑ Resident in Otolaryngology–HNS
(Copies of your examination profiles will be sent to your program director)

Institution _____ Program Year _____ Program Director _____

❑ Practicing Otolaryngologist ❑ Other (specify) _____

Payment

Enclose your check or write credit card information below. Checks must be in U.S. dollars drawn on a U.S. bank. Credit card orders only can be faxed to 1-703-519-1570.

❑ Check ❑ VISA ❑ MasterCard ❑ American Express

Account #: _____ Exp. Date: _____

Authorized Signature: _____

To receive the first section on time, registration must be RECEIVED with payment by August 3, 2012. Registration closes September 3, 2012. A $200 late registration penalty will be applied to all registrations **RECEIVED** after September 3, 2012.

Instruction Courses for the 2012 Annual Meeting

This begins a *Bulletin* series of instruction courses samplers each month from the myriad options to be offered at the 2012 AAO-HNSF Annual Meeting & OTO EXPO in September. One notable course in each of the nine categories will be listed with an excerpt from its objective each month. To read the full course description and to get your first choice of courses, sign up early. The series is based on selections made by Eduardo M. Diaz, Jr., MD, coordinator for instruction courses. Make sure to take advantage of the scheduler to review the full listing of courses and to enable you to find those of special interest to you.

Eduardo M. Diaz, Jr., MD, coordinator for instruction courses.

Business of Medicine/Practice Management

2729-2 **Business of Medicine for Residents and Fellows**
Interactive
Lee D. Eisenberg, MD, MPH
3:00 pm-5:00 pm, September 10

Residents and fellows often do not give adequate consideration to where they wish to practice: family considerations, lifestyle, and community. In addition, the interview process and contract issues are frequently neglected. A discussion of the CPT process, how new codes are added and valued, and E&M coding documentation, modifiers and their appropriate usage will complete the course.

Facial Plastic and Reconstructive Surgery

3524-1 **Botox and Fillers for Facial Lines and Wrinkles**
Andrew Blitzer, MD
12:30 pm-1:30 pm, September 11

This course will focus on minimally invasive techniques for facial rejuvenation. All of the available autologous, heterologous, and alloplastic materials will be reviewed. The mechanisms of action, indications, and contraindications of botulinum toxin use for facial lines will be reviewed. The technique of botulinum toxin injections for upper face, midface, and lower face and neck, and the complications will be reviewed. The combination use of injectable fillers, botulinum toxin, and/or laser resurfacing will also be reviewed.

General Otolaryngology

3723-2 **Histology, Histopathology, and Radiology of the Ear**
Sujana S. Chandrasekhar, MD
3:00 pm-5:00 pm, September 11

By correlating CT imaging of the temporal bone with its histologic anatomy, and then correlating diseases of the ear with the attendant histopathology, this course will enable the student to have a more thorough understanding of the complex anatomy and physiology, and leave him/her with an increased ability to perform otologic diagnosis and surgery with enhanced patient safety.

Head and Neck Surgery

4716-1 **The HPV Epidemic and Oropharyngeal Cancer**
James William Rocco, MD
2:30 pm-3:30 pm, September 9

Head and neck cancer in the United States and the Western world is undergoing a major shift in epidemiology. A dramatic increase in oropharyngeal cancer due to an ongoing epidemic of HPV infection is occurring in a large cohort of patients without the traditional risk factors of tobacco and alcohol abuse. This course will review the clinical implications of this HPV oropharyngeal epidemic for the general otolaryngologist.

Laryngology/ Broncho-Esophagology

3620-1 **Building a Busy Laryngology Practice**
Albert L. Merati, MD
1:45 pm-2:45 pm, September 11

Laryngology continues to be a major growth area within Otolaryngology. Two clinicians with a combined 25 years of clinical laryngology practice at several varied locations will present both pearls and pitfalls in program and practice building in Laryngology. Beginning with the selection and purchase of clinic and operating room equipment, the development of partnerships with Speech-Language Pathology and medical subspecialties, and finally to the critical areas of laryngology coding and billing, the presenters will review key steps and measures to enhance the laryngology component of the participant practice and business.

Otology/Neurotology

3718-1 **Modern Mastoid Surgery: New Techniques**
Bruce J. Gantz, MD
3:00 pm-4:00 pm, September 11

Management of cholesteatoma requires clear understanding of its natural behavior and pathogenesis before considering treatment. Open cavity mastoid surgery remains a vital operation that is an important part of both adult and pediatric practice. Creating a stable safe ear with useful hearing following open cavity surgery remains difficult for many practitioners. This course will review the pathophysiology of cholesteatoma and demonstrate two different techniques of open cavity mastoidectomy with reconstruction. A stepwise illustration of the techniques will be presented.

Pediatric Otolaryngology

2716-1 **Evidence-Based Otitis Media 2012**
Richard M. Rosenfeld, MD, MPH
3:00 pm-4:00 pm, September 10

Rational treatment of otitis media begins with an evidence-based approach that separates myth from fact. This course will summarize 40 years of published evidence about otitis media, emphasizing randomized trials, prospective studies, and epidemiologic reports. The focus will be on acute otitis media (AOM), recurrent AOM, and otitis media with effusion, not on rare complications or sequelae. In addition to debunking common myths, this course will arm clinicians with insights necessary for superior treatment results.

Rhinology/Allergy

3507-2 **CT Imaging and Rhinology: Safety, Technology, and Interpretation**
Interactive
Donald C. Lanza, MD
12:30 pm-2:30 pm, September 11

Point of service imaging has re-emerged in otolaryngology with the availability of in-office CT scanning as an important tool to facilitate and improve patient care. However, there are escalating concerns of over-utilization for all forms of CT imaging as it relates to radiation exposure and to healthcare costs. This program is intended to address radiation safety, advances in imaging technology, and proper imaging interpretation as it applies to the paranasal sinuses and skull base. Audience response system will be used to enrich the educational experience.

Sleep Medicine

3506-1 **Office Management of Snoring in 2012**
Interactive
Scott E. Brietzke, MD
12:30 pm-1:30 pm, September 11

Snoring continues to be a significant public health problem affecting millions of American couples and families. The treatment of palatal snoring is diverse and controversial. Multiple procedures are available, but with conflicting opinions and results regarding the "best" treatment technique. However, there clearly is a strong interest in moving away from painful, invasive procedures requiring a prolonged recovery to an office-based management with minimal pain and a rapid return to daily activities. The basis of comparison will consist of clinical experience and an evidence-based review of the literature in regard to subjective efficacy, available objective data, and the recognition and management of potential complications.

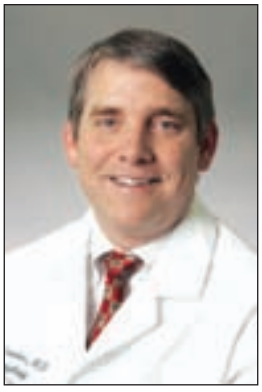
Global Campaign against Hearing Loss Gains New WHO Champion, New Worldwide Observance

James E. Saunders, MD
Co-chair, Coalition for Global Hearing Health

The hearing impaired people of the world have a new champion in Geneva, Switzerland. This January, the World Health Organization (WHO) appointed **Shelly K. Chadha, MD**, as the new medical officer for the Prevention of Deafness and Hearing Impairment (PDHI).

More than 285 million people worldwide have debilitating hearing loss (a pure-tone average greater than 40 decibels), accounting for more than 4 percent of the world's population. In addition, the majority of these people live in developing countries where services are scarce or nonexistent. Despite these staggering statistics, the WHO PDHI position—vacant for almost two years—was in jeopardy of being permanently eliminated.

In response to this crisis, a consortium of organizations interested in hearing loss gathered to salvage this office. Thanks to a generous donation from Cochlear Co, the AAO-HNSF joined the consortium and contributed funds to reinstate the WHO Office for Deafness. Other consortium members include the International Society of Audiology, the International Federation of Oto-Rhino-Laryngological Societies (IFOS), the Christian Blind Mission, IMPACT, and the Hearing Conservation Council.


James E. Saunders, MD

The consortium not only helped raise funds to support the WHO office for its first two years, but also worked with the WHO as an advisory group to define the job description and goals of the office. The consortium unanimously decided that the WHO PDHI office is critical to addressing hearing loss as a global health issue and the highest priority for hearing loss prevention worldwide is to educate and train primary care providers in identifying, managing, and preventing hearing loss.

The consortium enthusiastically endorsed Dr. Chadha for this position and for good reason. An otolaryngologist from India, Dr. Chadha has been active in developing public health programs for hearing loss in India and Southeast Asia. She was a key resource in developing and implementing the National Program for Prevention and Control of Deafness in India and contributed to the development of SOUND HEARING 2030 for the region.

In addition to multiple publications and presentations, she developed training materials in primary ear and hearing care and hearing loss awareness and infant hearing screening in India and Asia. Thanks to grant support from AAO-HNSF Humanitarian Fund, Dr. Chadha was the guest of honor at the 2011 meeting of the Coalition for Global Hearing Health (CGHH), a new multidisciplinary group committed to hearing loss issues in developing countries.

The CGHH meeting took place at the House Research Institute in Los Angeles, immediately prior to the Academy meeting. In her inspiring keynote address, Dr. Chadha emphasized the need for creative and collaborative solutions to this daunting problem and encouraged professionals to work together on grassroots efforts and to advocate for improved public policy.

Upon her arrival in Geneva, Dr. Chadha went to shape these priority goals into a specific work plan. As a result, the WHO will roll out a major campaign to train primary providers in primary ear and hearing care during the next two years.

Training manuals for this project were developed in multiple languages through the combined efforts of the two previous WHO hearing loss officers, Professor Andrew Smith, MD, and Young-Ah Ku, MD, and other contributors. The current program will take this effort to the next level by partnering with NGOs and governments to implement


International Ear and Hearing Day observance in Bangladesh, March 3, 2012.

comprehensive training programs in a few pilot countries.

This work will focus on otitis media, congenital and childhood hearing loss, presbycusis, noise-induced hearing loss, and ototoxicity. The consortium will serve in an advisory/supportive role in these efforts, working to gain support from member states and raise funds to maintain the WHO office beyond the first two years.

One of Dr. Chadha's initial activities was to promote International Ear and Hearing Day on March 3, through the use of social media. The observance began in Asia and spread around the world. When the WHO social media team publicized this day through a tweeted message, it received a tremendous response. This type of grassroots awareness campaign through social media is a great example of how we can use today's technology to get the message out. Other activities in observance of International Ear and Hearing Day have raised awareness in Asia and elsewhere in the world.

These are exciting times for efforts to reduce the global burden of hearing loss and otolaryngologists like Dr. Chadha are vital to this work. Along with multispecialty groups like the consortium to support the WHO Prevention of Deafness Office and the CGHH, otolaryngologists are working with other professionals to address this crucial problem. And we are beginning to see signs of progress.

If you would like to become involved with this movement or want to learn more about programs to reduce the global burden of hearing loss, visit the WHO website at http://www.who.int/

Shelly K. Chadha, MD

Call for Applications for the Position of Coordinator-Elect for International Affairs

The Foundation coordinator-elect for International Affairs serves for one year, starting September 2012 and works with the coordinator in a learning capacity before becoming coordinator for a four-year term starting in September 2013.

The coordinator is responsible for enhancing international awareness of the Foundation's educational and research programs, especially the International Outreach program; for helping to recruit and retain international members; and for attracting international attendance at AAO-HNSF meetings. The coordinator also is the physician ombudsperson for the international members and the International Corresponding Societies to the Foundation Board of Directors, advocating for international issues and support.

The coordinator chairs the International Steering Committee and has oversight of three international committees: International Otolaryngology, Panamerican, and Humanitarian Efforts. The coordinator also has oversight of the International Visiting Scholars and the international and humanitarian travel grants.

Term of Office and Voting

The coordinator-elect serves for one year followed by four years as coordinator. The coordinator is a non-voting member of the Foundation Board of Directors.

Qualifications and Stipend

Qualifications should include an interest in, and prior involvement with, the specialty in different regions of the world; availability to travel outside North America; and a local staff to assist the Foundation staff in development and conduct of the International Outreach program. The Foundation provides a stipend for the coordinator.

Application Process

Academy members interested in this position should send a letter in PDF format outlining their qualifications, experience in international affairs, and a narrative on how the applicant would enhance international efforts within the Foundation to clincoln@entnet.org.

Applications must be submitted by May 15.

International Caucuses at Annual Meeting

Coordinator for International Affairs **Gregory W. Randolph, MD**, cordially invites Academy members with ties to, or interest in, Africa and the Middle East to meet visiting delegates from those regions at the Africa and Middle East Caucuses. **James W. Netterville, MD**, and **James E. Saunders, MD**, regional advisors for Africa, will host the Africa Caucus, now in its third year. **G. Richard Holt, MD, MPH, MSE**, regional advisor for the Middle East, will host the Middle East Caucus. Watch the program announcements for room, date, and time. If you wish to add your name to the invitation list, email international@entnet.org.

If you are an International Member and wish to take part in the second International Member Caucus, hosted by past-president **Eugene N. Myers, MD**, please email international@entnet.org to be invited to this invitation-only event. Room, date, and time will follow.

12TH ANNUAL
Charleston Magnolia Conference
JUNE 1 - 2, 2012

– GUEST SPEAKERS –

John W. House, MD
President,
House Research Insititute
Los Angeles, CA

Heinrich Iro, MD
Professor & Chair
Otorhinolaryngology
Head & Neck Surgery
University of Erlangen
Nurnberg, Germany

John S. Rhee, MD, MPH
John C. Koss
Professor and Chair
Otolaryngology &
Communication Sciences
Medical College of Wisconsin,
Milwaukee, WI

James D. Sidman, MD
Chief, Otolaryngology
Children's Hospital
Minneapolis, MN

– TOPICS –

• Endoscopic Sinus Surgery • Pediatric Sleep Apnea
• Endoscopic and Robotic Head and Neck Cancer Surgery
• Management of Cholesteatoma
• Management of Salivary Gland Disease
• Facial Reconstructive Surgery • Endocrine Surgery
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Opal Reynolds
Clinical Support Specialist
opal.reynolds@emoryhealthcare.org
Tel: 404-686-8184 Fax: 404-686-3782

2012
New York Advanced Rhinology and Sinus Surgery Course
SAVE THE DATE

Presented by NYU, Montefiore, and Weill Cornell Medical Centers

Course Co-Directors
Vijay K. Anand, MD
Michael G. Stewart, MD, MPH
Richard A. Lebowitz, MD
Alexis H. Jackman, MD

Featured Guest
Brent Senior, MD

NYU School of Medicine

Montefiore

EINSTEIN

Weill Cornell Medical College

November 9-10, 2012 • New York City

Description
This two day course provides practicing otolaryngologists and residents in training with in-depth information on advanced medical and surgical management of patients with rhinosinusitis. The format includes didactic presentations, panel discussions, and interactive laboratory dissection sessions.

Course Objectives
Participants will: understand the anatomy, pathology and radiology of the paranasal cavities; understand the diagnosis and management of inflammatory and infectious upper respiratory disease; understand diagnosis and management of complications of sinus surgery including CSF leaks; improve endoscopic surgical skills including advanced surgical techniques.

Information & Registration
Heather Crosby, Program Coordinator
Department of Otolaryngology - Head and Neck Surgery
Weill Cornell Medical College
1305 York Avenue, 5th Floor, New York, NY 10021
Tel: 646.962.4712 • Fax 646.962.0125 • Email: hec3001@med.cornell.edu

18th Annual

UTAH OTOLARYNGOLOGY UPDATE

JUNE 22 & 23, 2012 - Salt Lake City

GUEST SPEAKERS:

- Patrick J. Antonelli, MD
  James Parkin Lecturer
  University of Florida
- Shan R. Baker, MD
  David Dolowitz Memorial Lecturer
  University of Michigan
- David R. White, MD
  Steven Gray Memorial Lecturer
  Medical University of South Carolina

For further info please contact:
Halley Langford, 801-581-7515
halley.langford@hsc.utah.edu

Sponsored by University of Utah Otolaryngology - Head and Neck Surgery and by University of Utah School of Medicine

The University of Utah School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AUGUSTA ENT

a large Ear, Nose & Throat practice in Augusta, Georgia, is seeking a hardworking General Otolaryngologist to join our team serving a growing suburban area.

The practice has 2 offices as well an ASC, a large Allergy Center, an Audiology / Vestibular Department, CT scanners, Speech Therapists and a Sleep Lab.

Excellent compensation plan, partnership track, and benefits package.

If interested please send email & CV to emily@augustaent.com.

PHYSICIAN OPENING!

2012 ARS SUMMER SINUS SYMPOSIUM

American Rhinologic Society

JULY 13-14 • CHICAGO, IL • WESTIN MICHIGAN AVENUE

Registration and Housing Now Open for Attendees and Exhibitors

To Register or View the Exhibit Opportunities Please Visit www.american-rhinologic.org

Course Directors
Rakesh Chandra, MD
Kevin C. Welch, MD

Program Committee
Michael Setzen, MD
Brent Senior, MD
Todd Kingdom, MD
Timothy Smith, MD
Joseph Jacobs, MD
Peter Hwang, MD
James Palmer, MD
Joseph Han, MD
Raj Sindwani, MD

Featuring National Leaders in Rhinology and Sinus Surgery

- Keynote Lecture by Dr. Brent Senior
- A Live Sinus Dissection with Dr. David Kennedy
- A Live Cadaver Demonstration by Dr. James Stankiewicz
- Karen Zupko On Maximizing Practice Efficiency

Accreditation Statement
The American Rhinologic Society (ARS) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement
ARS designates this live activity for a maximum of 7.75 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CHARLOTTE EYE EAR NOSE AND THROAT
MONROE, NC
COMPREHENSIVE OTOLARYNGOLOGIST

Charlotte Eye Ear Nose and Throat Associates, PA, (headquartered in Charlotte, North Carolina) a physician-owned and operated dual specialty practice is seeking a BC/BE full time comprehensive otolaryngologist to practice all aspects of the field for 2013 in our Monroe facility located 20 miles from Charlotte. The largest provider of eye and ENT services in the Charlotte area, CEENTA offers a full range of services including general otolaryngology, pediatric otolaryngology, neurotology, laryngology subspecialty representation, voice center with 2 SLP, sleep medicine and facial plastic surgery.

The group, consisting of forty-seven ENT providers and sixteen locations has state of the art equipped offices including complete audiology services, allergy clinics, a CT scanner, an ambulatory surgery center, sleep lab and an in-house contract research organization.

Charlotte, NC is two hours east of the Appalachian Mountains and 3 ½ hours west of the Atlantic Ocean. It is nationally recognized for combining academic rigor with rich opportunities in the arts and humanities as well as professional and collegiate athletics. It is also recognized as one of the leading cultural capitals of the south and spectators can cheer their home favorite in just about any sport.

Excellent salary with partnership anticipated, 401(k), professional liability insurance, health insurance, long term disability and life insurance.

Annette Potts, Director-Human Resources
Charlotte Eye Ear Nose and Throat Associates, PA
6035 Fairview Road Charlotte, North Carolina 28210
Email: apotts@ceenta.com
Fax: 704.295.3415
EOE

Amazing Otolaryngology Opportunity
Get to know New York like never before!

Samaritan Medical Center, a 287 bed, not-for-profit hospital in Northern NY, is offering an excellent employed opportunity for an Otolaryngologist.

- **$350,000 Salary Guarantee with WRVU incentive program, $35,000 Signing Bonus, $10,000 Relocation & $10,000 Annual Educational Loan Repayment, Full Medical Liability Coverage.**
- **CME Annual allowance, Call is 1:3, Paid Immigration Assistance.**
- **Join highly respected providers in an unopposed practice with a catchment population of 250,000.**

Explore the beauty of NNY, from the shores of Lake Ontario to the magical St. Lawrence River, home of the 1000 Islands, to the foothills of the Adirondack Mountains. Small Town Feeling with Big City Amenities. Excellent school systems.

Contact: **Jennifer Haley Saiff - 315-779-5184** or **jsaiff@shsny.com -www.samaritanhealth.com**
830 Washington Street, Watertown, NY 13601

OTOLARYNGOLOGY OPPORTUNITY

Southern Maryland

Civista Health, the newest member hospital of the University of Maryland Medical System, (UMMS), is undergoing an expansion of physician services in our local community. Plans include employing ENT surgeons and establishing a hospital based practice. Physician office space will be located in immediate proximity to Civista Medical Center in La Plata, MD. Coverage will be for this single facility. Qualified candidates are invited to join the Civista medical community where there is great demand for your services and incredible potential for growth. As a Civista employed physician, you will enjoy practicing your specialty while we manage the business for you. Our surgeons will have access to state of the art treatment rooms, endoscopy suite, four opening rooms and two rooms for minor procedures. Successful candidates will receive competitive compensation and benefits package. BE/BC, Maryland licensure required.

Civista Health System is a regional, not-for-profit, integrated health system serving Charles County and the surrounding areas of southern Maryland. In 2008, Civista completed expansion of the medical center, doubling the size of the facility and vastly increasing services and capacity. Constantly reinvesting resources into the community with innovative technology, Civista offers community health education whose mission is to provide excellent care and foster a healthier community by providing service and open access to quality healthcare. One of the fastest-growing counties in Maryland, Charles County is a charming community steeped in culture and history. And Civista Medical Center has been in the heart of it all. A school system ranking in Maryland's top five...a convenient commute to the metro D.C. area...the history of a "true" community hospital...and the ideal place to live, work and raise a family combine to make life in Charles County truly satisfying.

Working for Civista also gives you the opportunity to enjoy all Maryland has to offer including sandy beaches, Appalachian hiking trails, professional and college sports teams and easy access to Washington, D.C.

Come see why Civista is the place for physicians to practice.

University of Maryland Medical System

Civista Medical Center

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

Beth Briggs
ebriggs@cejkasearch.com
800-678-7858 x64454

ID#143158AD

cejkasearch.com

COASTAL NORTH CAROLINA PRACTICE OPPORTUNITY

Well established regional Otolaryngology practice is seeking a BC/BE Otolaryngologist. In its fourth decade, this four physician group has three office locations serving Eastern North Carolina.

Practice includes full audiology and allergy services with CT scanner, EMR, and operating/laser suite. Three audiologists and a strong support staff are in place to support further practice growth. All aspects of Otolaryngology are practiced and specialty interests in laryngology, head & neck oncology or facial plastics can be easily integrated into existing practice.

Coastal Eastern North Carolina is a beautiful region rich in history and offering abundant access to local rivers and sounds as well as various beach communities along North Carolina´s Outer Banks.

Interested applicants should contact:
T. Oma Hester, MD, FACS
Coastal Ear, Nose & Throat Associates, PLLC
3110 Wellons Blvd.
New Bern, NC 28562
252-638-2515
ohester@coastalent.com

Northern New Jersey Practice Opportunity

Well-established busy ENT group in Northern NJ is seeking an additional BC/BE otolaryngologist to join our expanding practice. We are in our fourth decade of practice and have a very strong referral base. Our office is fully equipped including EMR, Allergy and Audiology services. We work out of a community hospital with modern operating rooms and reasonable ER call responsibilities.

Conveniently located within 30 minutes of New York City. We are offering a competitive starting salary benefits with a path to partnership. Interested parties should send their CV to:

njentjob@gmail.com

Children's Mercy HOSPITALS & CLINICS | Kansas City

Children's Mercy Hospitals and Clinics – Kansas City is seeking a fellowship trained Pediatric Otolaryngologist to join our professional staff at the assistant or associate professor level. The position would entail clinical care, research, and teaching of medical students, and pediatric and otolaryngology residents. In addition, our ACGME-accredited pediatric otolaryngology fellowship will be welcoming our 4th fellow starting this July, 2012.

Our active Pediatric Otolaryngology Section provides comprehensive tertiary patient care in a family-centered environment. There are currently 8 pediatric otolaryngologists on staff, as well as 3 neurotologists. Children's Mercy Hospitals & Clinics is a large pediatric health care system that is affiliated with the University of Missouri-Kansas City School of Medicine. The main hospital is growing to nearly 400 beds this year with plans to expand to 41 PICU beds and 80 NICU beds. Salary and academic range are commensurate with experience. EOE/AAP

Robert A. Weatherly, MD
Section Chief, Ear, Nose, and Throat
rweatherly@cmh.edu
For consideration submit CV via email to physicianjobs@cmh.edu
www.childrensmercy.org

Head and Neck SURGERY ASSOCIATES, PSC

Greater Cincinnati/Northern Kentucky
Ten Doctor, Single Specialty, General ENT Practice
Seeking BC/BE Otolaryngologist to replace retiring physician

- Busy, Successful, Established 34-year-old growing practice
- Competitive compensation and vacation package
- Two-year partnership potential
- Four-day work week for all doctors (including future associate)
- Private ambulatory surgery center with two operating rooms, AAAHC certified, Medicaid/Medicare approved and state licensed
- Large Allergy Department
- Busy Hearing Aid business with five audiologists
- Electronic Medical Records
- In-office CT Scanner
- Three upscale offices owned by the Practice
- Greater Cincinnati/Northern Kentucky living area offers cosmopolitan/urban, suburban or country lifestyles as well as award winning school systems

For consideration, send your cover letter and CV to:
Sarah Gosney, Administrative Services,
Head and Neck Surgery Associates, P.S.C.
40 N. Grand Avenue, Suite 103, Fort Thomas, KY 41075
Phone: (859) 572-3046, Fax: (859) 572-3045, Email: sarahg@nkyent.com

BC/BE OTOLARYNGOLOGIST

Geisinger Medical Center (GMC) in Danville, PA is seeking a BC/BE fellowship-trained Head & Neck Otolaryngologist with special interest in Endocrine Surgery

Bring your expertise to an established, growing practice at Geisinger Medical Center – Danville, PA. This practice opportunity is pre-built with a broad-range of referrals coming from community-based primary care physicians. Take part in the growth of this dynamic department, teach residents and pursue research in your area of interest.

For more information or to apply for this position, please contact **Autum Ellis, Professional Staff Recruiter, at 1-800-845-7112, email amellis1@geisinger.edu or learn more at Join-Geisinger.org**

GEISINGER
HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE

Join the health system whose innovations are influencing the future of healthcare. Learn more at **Join-Geisinger.org**

The Steven & Alexandra Cohen Children's Medical Center of New York

Department of Otolaryngology, North Shore-Long Island Jewish Health System

Pediatric Otolaryngologist

The Division of Pediatric Otolaryngology at the Steven & Alexandra Cohen Children's Medical Center of NY is seeking a board certified, fellowship trained Pediatric Otolaryngologist to join our full-time academic faculty. The Children's Medical Center system is the largest provider of pediatric services in New York State.

This position will offer extensive clinical opportunities in all areas of Pediatric Otolaryngology. Responsibilities include patient care, teaching, and opportunities for clinical and basic science research. Competitive salary and benefits will be offered.

Interested candidates should email or send letter of interest and CV to:

Lee P. Smith, MD
Chief, Division Pediatric Otolaryngology
Cohen Children's Medical Center of New York
North Shore Long Island Jewish Health System
430 Lakeville Road
New Hyde Park, NY 11042
Phone: 717-470-7982
Email: LSmith8@nshs.edu

North Shore LIJ

General Otolaryngologist

POSITION NUMBER: M0202609

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a General Otolaryngologist to join a faculty of 15 physicians. The successful candidate will develop a practice at The Kansas University Medical Center and affiliated hospital sites and teach residents & medical students.

Head and Neck Surgeon

POSITION NUMBER: J0010781

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a BC/BE Head and Neck Surgeon for a full-time academic position. Fellowship training with expertise in microvascular surgery and an interest in oncologic research preferred.

Responsibilities include continued development of a strong clinical practice with three other members of the Head and Neck Team, resident and medical student education, and clinical or basic science research.

Head and Neck Fellow

POSITION NUMBER: J0020146

CLINICAL FOCUS

Head and Neck Surgical Oncology, Skull Base Surgery (anterior and lateral), Minimally Invasive Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery

Responsibilities will include clinical activities, clinical/basic science research, and resident and medical student teaching. Additional educational opportunities include a graduate level Clinical Research Training series, access to a microvascular laboratory, a craniomaxillofacial plating course and clinical research support personnel.

APPLICANT REQUIREMENTS

Successful completion of an ACGME-accredited Otolaryngology-Head and Neck Surgery Residency training program, ABO board certified/eligible and Kansas and Missouri license eligible.

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

To view position online:
http://jobs.kumc.edu
(Search by Position Number)

For job information or to apply, contact:

Douglas Girod, MD, FACS
Professor and Chairman

The University of Kansas
School of Medicine
Department of Otolaryngology-
Head & Neck Surgery
3901 Rainbow Blvd. MS 3010
Kansas City, KS 66160

Phone: 913-588-6719
Email: dgirod@kumc.edu

The University of Kansas School of Medicine is an Equal Opportunity/ Affirmative Action employer.

Academic Head and Neck Otolaryngologist
Eastern Virginia Medical School
Norfolk, Virginia

The Department of Otolaryngology/Head and Neck Surgery/Eastern Virginia Medical School is recruiting a third fellowship-trained Head and Neck Surgeon to complement our practice. Experience in Head and Neck Oncologic Research is strongly desired. This position provides up to 0.5 FTE protected research time as part of our new multidisciplinary Cancer Research Center. The successful applicant will join a very busy Head and Neck division, providing extensive experience in head and neck cancer, endocrine, and microvascular reconstruction. Salary and benefits are outstanding, along with graduated administrative responsibilities.

CONTACT:

Barry Strasnick, MD, FACS
Professor and Chairman
Department of Otolaryngology/Head and Neck Surgery
Sentara Norfolk General Hospital/River Pavilion
600 Gresham Drive, Suite 1100
Norfolk, Virginia 23507
757-388-6280
strasnb@evms.edu

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

ACADEMIC GENERAL OTOLARYNGOLOGY IN NEW YORK CITY

Join the full time faculty of the Department of
Otolaryngology-Head and Neck Surgery
at Weill Cornell Medical College

Opportunities include:

- *Outpatient practice in brand new Manhattan location multispecialty Weill Cornell office on the Upper West Side*
- *Inpatient and OR at NewYork-Presbyterian Hospital/Weill Cornell Medical Center on the Upper East Side*
- *State of the art facilities*
- *Ivy League medical school*
- *Top 10 rated academic hospital*
- *Faculty housing available*

If interested, please contact Amy Noltz at amn2004@med.cornell.edu.

EOE M/F/D/V

Division Chief, Pediatric Otolaryngology - Head and Neck Surgery

Nemours Children's Clinic, Jacksonville, FL

We are seeking candidates for this full-time position who possess strong leadership and interpersonal skills and who demonstrate collaborative communication. The candidate should have a strong record in pediatric clinical care and education, as well as the ability to shape annual divisional objectives and plans and to manage the support of these goals. The division currently consists of 6 full-time fellowship-trained physicians, 5 audiologists, 4 speech pathologists and 1 Ph.D. researcher within a 70+ physician pediatric subspecialty practice. Complete ancillary services are available on-site. The practice is 100% pediatric case mix and serves children from Southeast Georgia and Northeast Florida. An opportunity for an academic appointment to the Mayo Clinic College of Medicine is available. Nemours offers a competitive salary and a full array of benefits.

Jacksonville is on the northeast coast of Florida. It is bordered by the Atlantic Ocean, and the St. Johns River travels through the city, offering wonderful water views. We have wonderful weather all year-round, allowing outdoor activities and water sports to be enjoyed during personal time.

For further information, please contact: **Gary D. Josephson, M.D., Office: 904-390-3690, Cell: 904-226-1231 or gjosephs@nemours.org. Nemours Children's Clinic, 807 Children's Way, Jacksonville, FL 32207**

Nemours, an Equal Opportunity Employer, is one of the nation's largest pediatric subspecialty practices operating the Nemours Children's Clinics throughout Florida and Delaware and the Alfred I. duPont Hospital for Children in Wilmington, DE.

Nemours®

NORTHWEST HOUSTON OTOLARYNGOLOGIST

Busy, stable general otolaryngology private practice in NW Houston seeks a board certified or board eligible Otolaryngologist to join our group. All facets of otolaryngology are covered at this facility, including an allergy lab, hearing aid lab, VNG and sleep lab. Practice consists of three otolaryngologists (two full time board certified with one subspecialty board certified in sleep medicine & one part-time) and two audiologists. Practice has two locations in medical professional buildings. Demographic base of more than two hundred thousand patients in vicinity of nearby hospital and half a million patients in general NW Houston area.

Interested physicians should contact

Don Unfried at **281-732-9770**

or email at **donunfried@hcstexas.com**

MAYO CLINIC

Otolaryngology Surgeon

Heal the sick, advance the science, share the knowledge.

The Department of Otolaryngology Head-Neck Surgery at Mayo Clinic in Jacksonville, Florida, is seeking a board-certified otolaryngologist with fellowship training. The ideal candidate will have the skill set needed to support and further develop a rapidly expanding head and neck practice. Experience in laser surgery is required and robotic surgery is preferred. This position also requires an individual with a demonstrated commitment to education and research, as it carries an academic appointment to the Mayo Medical School.

Mayo Clinic's state-of-the-art, regional referral hospital opened in April 2008, integrating our inpatient and outpatient practice on a single 400-acre campus. Mayo Clinic in Jacksonville is a 300+ physician practice with a national and international referral base. Northeast Florida's coastal location offers a pleasant climate and many outdoor recreational activities. To learn more about Mayo Clinic in Jacksonville, Florida, please visit **http://www.mayoclinic.org/physician-jobs**

A comprehensive and competitive salary and benefits package is being offered. Interested individuals should submit a letter of interest and curriculum vitae to:

John Casler, M.D.
Chairman, Department of Otorhinolaryngology
Mayo Clinic
4500 San Pablo Road • Jacksonville, FL 32224
E-mail: casler.john@mayo.edu
Phone: 904-953-2217 • Fax: 904-953-2489

Mayo Foundation is an affirmative action and equal opportunity employer and educator. Post-offer/pre-employment drug screening is required.

ACADEMIC HEAD & NECK SURGEON

West Virginia University

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to expand our well established head and neck oncology service. Expertise with both ablative and microvascular reconstructive procedures is desired. 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 scientists.

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. Morgantown is located 80 miles south of Pittsburgh and three hours from Washington, DC. The position will become available in October 2011 and will remain open until filled. The WVU Health Sciences Center is a smoke free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Contact:
Hassan Ramadan, MD
Department of Otolaryngology
R.C. Byrd Health Sciences Center
Morgantown, WV 26506-9200
Telephone: (304) 293-3233; Fax: (304) 293-2902
e-mail: hramadan@hsc.wvu.edu
West Virginia University is an EOE/AA employer.

SOUTH FLORIDA PRIVATE PRACTICE OPPORTUNITY

Busy three physicians ENT practice in Miami, part of a large single specialty group, South Florida ENT Associates, looking for a Board Certified/Board Eligible physician Otolaryngologist.

Subspecialist will be considered. Position offers competitive financial package, excellent benefits with partnership track, Spanish desirable.

Affiliated with the University of Miami Hospital, Aventura Hospital & Medical Center and Miami Children's Hospital.

Please direct your letter of interest and CV to:
Stella Litke
slitke@southfloridaent.com

ear, nose & throat specialists

Southern New Hampshire Otolaryngology Group Seeks Fourth Physician

Three established physicians who appreciate hard work, enthusiasm and the highest quality of medical care are looking for a BC/BE Otolaryngologist who shares the same values.

Manchester, New Hampshire is conveniently located one hour from Boston, the seacoast and the White Mountains. New Hampshire is known for its excellent skiing, hiking, biking and fishing. Its beautiful lakes broaden the appeal to those who enjoy an active outdoor lifestyle set in a temperate four-season climate.

Money magazine has named Manchester, NH as the top small city in the Northeast. It boasts low unemployment, low crime rate and is a wonderful city to raise a family. New Hampshire is unique for having no sales or income tax and has the highest qualities of living in the nation!

Southern New Hampshire continues to grow at a rapid pace, therefore affording us the opportunity to expand. Our physicians have worked hard to earn the respect of the community and are held in the utmost regard.

We offer a 2 year partnership tract, competitive salary with incentive bonus and a very generous benefit package including 401K and profit sharing.

To learn more about our group, please visit our website: www.entspecialistsnh.com or contact Heather Rice, Hrice@entspec.org

Ear Nose & Throat Specialists of Southern New Hampshire, PA
30 Canton Street, Suite Two
Manchester, NH 03103 • (603)656-2100

THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE
CLINICAL FACULTY
FULL-TIME FACULTY POSITION

OTOLARYNGOLOGY/HEAD AND NECK SURGEON- The Department of Otolaryngology/Head and Neck Surgery, University of North Carolina at Chapel Hill School of Medicine is seeking a board-certified or eligible Otolaryngologist for a full time position of Assistant Professor Level on the Clinical Track. The successful candidate should have an interest in developing a strong clinical program in otolaryngology with a special expertise in Head and Neck Oncology and have demonstrated the potential for teaching, patient care and clinical research. Fellowship training in Head and Neck Oncology is preferred. Projected start date is fall of 2012.

Apply online at http://jobs.unc.edu/2502579.

Address cover letter to:
Harold C. Pillsbury, MD
Professor and Chair
Otolaryngology/Head and Neck Surgery
170 Manning Drive, Physician Office Building, CB# 7070
University of North Carolina School of Medicine
Chapel Hill, NC 27599-7070
(919) 966-3342
Fax (919) 966-7941

The University of North Carolina at Chapel Hill is an equal opportunity/ADA employer.

Northern California ENT and Otology Opportunities

Sutter Health is one of the nation's leading non-for-profit networks whose health care providers join resources and expertise to deliver care to patients in over 100 Northern California communities.

Current opportunities include: Auburn - Establish a practice with Sutter Medical Group (SMG) or Sutter Independent Physicians (SIP) affiliated with Sutter Auburn Faith Hospital (SAFH). SAFH is an 80-bed community based hospital with a service area of 95,000. **Vacaville** - Join Sutter Medical Group (SMG), affiliated with Sutter Solano Medical Center (SSMC) and Sutter Davis Hospital (SDH). SSMC has 102 licensed beds, is among the top hospital in the region according to independent quality rating organizations. SDH is a 48-bed acute care hospital that provides convenient, quality care. **Sacramento** – Join SMF affiliated with Sutter Medical Center, Sacramento (SMCS). SMCS has more than 400 licensed beds at three facilities: Sutter General Hospital, Sutter Memorial Hospital and Sutter Cancer Center for Psychiatry.

SMG is a multi-specialty, 600+ physician group in the Placer, Sacramento, Solano, and Yolo Counties, recognized as a Top Performing group by the Integrated Healthcare Association. **SIP** is an independent practice association comprised of 500+ physicians throughout the Placer, Sacramento, Solano and Yolo counties.

No matter where you decide to practice within Sutter Health, you'll enjoy:
- *Generous compensation and benefits with relocation assistance*
- *Exceptional Integrated Referral Base*
- *Personal/professional balance with reasonable call and coverage during time off*
- *Enterprise-wide PACS, voice recognition system and EMR*

Contact: Sutter Health Sacramento Sierra Region Physician Recruitment
800-650-0625 ▪ develops@sutterhealth.org
www.checksutterfirst.org

Sutter Health
Sacramento Sierra Region
With You. For Life.

OTOLOGIST / NEUROTOLOGIST

Seeking an experienced, fellowship-trained otologist/neurotologist to replace a retiring senior partner at the world-renowned Shea Ear Clinic in Memphis, TN. The **Shea Ear Clinic** was founded in 1926 and is a tertiary referral otologic clinic that specializes in the treatment of all diseases of the hearing and balance system, including chronic otitis media, stapedectomy, cochlear implantation, and inner ear perfusion. We are an extremely successful and innovative four-physician private practice with our own outpatient surgery center and hearing aid center. We currently have three otologists and one general otolaryngologist. Our state of the art audiology department has three Aud's and one audiology tech. Clinical appointments are available at the University of Tennessee Department of Otolaryngology – Head and Neck Surgery and teaching of residents is encouraged. Major procedures such as acoustic neuromas are performed at one of several large local hospitals.

Extremely competitive salary and benefits plus fast track to partnership, generous signing bonus, and relocation package. Memphis is a major regional medical center that serves patients from the mid-south and beyond. Memphis offers a laid-back lifestyle with a low cost of living and small town southern hospitality, but big-city amenities, professional sports, good schools, and many cultural attractions.

Please reply ASAP to

john.emmett@sheaclinic.com

UNIVERSITY OF Cincinnati

COLLEGE OF MEDICINE
Department of Otolaryngology - Head & Neck Surgery

The Department of Otolaryngology – Head & Neck Surgery and Myles L. Pensak, MD, FACS, H.B. Broidy Professor and Chairman, are expanding their clinical/academic programs and recruiting a full-time, board certified **Otolaryngologist with a background and experience in adult and pediatric otologic patient care including cochlear implantation.**

This position requires a strong interest and commitment to the education of residents, fellows and medical students. Academic appointment will be commensurate with experience/qualifications. MD degree and the obtainment of a permanent Ohio medical licensure required.

Interested candidates should send a letter of interest, CV and a list of three references to:

www.jobsatuc.com

--The University of Cincinnati is an equal opportunity and affirmative action employer--

UKHealthCare

The Department of Otolaryngology – Head & Neck Surgery at the University of Kentucky in Lexington, KY seeks an Assistant Professor with an interest in developing a translational or clinical research program in addition to teaching and clinical responsibilities. The successful applicant will provide clinical services as an attending physician on the Otolaryngology – Head & Neck Surgery Service, develop the existing Head and Neck Oncology program, and establish clinical research protocols and participate in the research activities of the Department of Otolaryngology – Head & Neck Surgery.

Position requires an M.D., D.O., or foreign equivalent; eligibility for state medical license; completion of Otolaryngology residency and Head and Neck Oncology fellowship or foreign equivalents.

Interested applications should email CV to bjsmit@uky.edu

The University of Kentucky is an equal opportunity employer. Employment is contingent upon passing a pre-employment drug screen.

To learn more about the University of Kentucky, please visit ukhealthcare.uky.edu.

University of Missouri

Department of Otolaryngology—
Head and Neck Surgery

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. A Faculty opportunity at all academic levels (Assistant/Associate Professor or Professor or Clinical Assistant/ Associate Professor or Clinical Professor) is available in **Head and Neck Surgical Oncology**. Title, track, and salary are commensurate with experience.

- Competitive production incentive
- Research interests encouraged and supported
- New outpatient clinic with state-of-the-art equipment and ancillary services
- Well established and expanding hospital system
- Live and work in Columbia, ranked by *Money* magazine and *Outside* magazine as one of the best cities in the U.S.

For additional information about the position, please contact:
Robert P. Zitsch, III, M.D.
William E. Davis Professor and Chair
Department of Otolaryngology—Head and Neck Surgery
University of Missouri—School of Medicine
One Hospital Dr, MA314, DC027.00
Columbia, MO 65212
zitschr@health.missouri.edu

To apply for this position, please visit the MU web site at
hrs.missouri.edu/find-a-job/academic/

The University of Missouri is an Equal Opportunity/Affirmative Action Employer and complies with the guidelines of the Americans with Disabilities Act of 1990. To request ADA accommodations, please contact (573) 884-7282 (V/TTY).

Full Time Faculty Opportunities
University of Rochester Medical Center

Laryngologist
BC/BE, fellowship trained or equivalent experience laryngologist at any rank is sought to help build a nationally prominent laryngology and voice practice. Applicants should have a strong interest in clinical care and academic teaching. Protected research time and resources are available if candidate seeks a career as a clinician-scientist.

Pediatric Otolaryngologist
BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the Golisano Children's Hospital. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

General Otolaryngology
BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support. Protected research time and resources are available for clinician-scientists.

Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial Hospital. The clinical office is located in a new facility opened in 2004. These are excellent opportunities to practice with an established group of academic faculty who already have practices in all Otolaryngology subspecialty areas, in a growing academic department.

The University of Rochester is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

Interested candidates should send their curriculum vitae and letter of interest to:

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.
Professor and Chair
Department of Otolaryngology
Strong Memorial Hospital
601 Elmwood Avenue
Box 629
Rochester, NY 14642
(585) 758-5700
shawn_newlands@urmc.rochester.edu

AMERICAN HEARING RESEARCH FOUNDATION

The American Hearing Research Foundation is now accepting research proposals in hearing and balance disorders related to the inner ear for our 2013 funding cycle. Grants are $20,000 for one year of research. Only researchers in the United States holding PhD and/or MD degrees may apply. Priority is given to new investigators and researchers early in their careers.

Proposals are due by Wednesday, August 1, 2012 at noon (CST) to Sharon Parmet as either a PDF or Word doc at sparmet@american-hearing.org.

You may view the application guidelines at www.american-hearing.org. For further information contact: Sharon Parmet, Executive Director, at (312) 726-9670.

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Department of Otolaryngology Head & Neck Surgery

ASSISTANT OR ASSOCIATE PROFESSOR

The Department of Otolaryngology - Head and Neck Surgery at the University of Virginia seeks candidates for an Assistant or Associate Professor position in the area of laryngology. This tenure eligible position will be responsible for teaching medical students and residents, participating in laryngologic and swallowing disorders research, and providing clinical services in both outpatient and OR settings. This position will also take a lead role in the development of a multi-disciplinary swallowing center. Rank will be dependent on qualifications and experience. Candidates must have an MD and be board-eligible or board-certified in Otolaryngology, as well as have completed a fellowship in laryngology.

To apply, visit **https://jobs.virginia.edu** and search on **Posting Number 0609465.** Complete a Candidate Profile online, attach a cover letter, curriculum vitae and contact information for three references. Please also attach a copy of your surgical case log from residency, fellowship or last three years of practice. The position will remain open until filled.

For further information regarding the application process, please contact: Jennifer Oliver, via e-mail, **jmo8n@virginia.edu** or telephone, **434-243-3697**.

The University of Virginia is an Equal Opportunity/Affirmative Action Employer strongly committed to achieving excellence through cultural diversity. The University actively encourages applications and nominations from women, minorities, veterans and persons with disabilities.

Academic Head and Neck Surgeon
Virginia Commonwealth University

The Department of Otolaryngology-Head and Neck Surgery at Virginia Commonwealth University seeks a BE/BC fellowship trained head and neck surgeon to join an established and growing head and neck surgery division. Microvascular free flap reconstruction, transoral robotic surgery, and endocrine surgery programs are in place and skills in these areas are desired.

Applicants should have a strong interest in clinical care, teaching, and research. Applicants must have demonstrated experience working in and fostering a diverse faculty, staff, and student environment or commitment to do so as a faculty member at VCU. Salary and academic appointment will be competitive and commensurate with experience.

VCU is an urban, research/ intensive institution with a richly diverse university community and commitment to multicultural opportunities. VCU is an EEO/AA employer. Women, minorities and persons with disabilities are encouraged to apply.

Please send curriculum vitae and three references to:
Laurence J. DiNardo, M.D., F.A.C.S.
Peter N. and Julia R. Pastore Professor and Chair
Department of Otolaryngology-Head and Neck Surgery
Virginia Commonwealth University Health System
PO Box 980146
Richmond, VA 23298-0146
FAX: (804) 828-5779
e-mail: ent@vcu.edu

OTOLARYNGOLOGIST

Geisinger Health System is seeking a BC/BE Otolaryngologist

Bring your expertise to a well-established program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA. Take part in the growth of this dynamic department, teach residents and pursue research in your area of interest.

Visit **Join-Geisinger.org/266/OtoGWV** to learn more about this position or contact Autum Ellis, Physician Recruiter, at 1-800-845-7112 or amellis1@geisinger.edu.

GEISINGER
HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE

Join the health system whose innovations are influencing the future of healthcare. Learn more at **geisinger.org/national.**

Vanderbilt University seeks full time General Otolaryngologists for 2013

The Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences seeks qualified candidates for two full time positions in General Otolaryngology at the rank of Assistant Professor on the clinician educator track. The principal practice location is a suburb of the Nashville medical campus in beautiful Williamson County, Tennessee and offers a busy community based practice with both adult and pediatric patients.

We are seeking not only skilled clinicians, but also innovative contributors to become valued participants in one of the top otolaryngology departments in the nation. Opportunities to participate in clinical research and teaching already are modeled. The successful candidates must be board certified or board eligible in otolaryngology by the American Board of Otolaryngology and eligible for an unrestricted Tennessee license. We encourage current PGY 4 level residents to consider this opportunity.

Please submit a CV and letter of interest to: Molly.breen@vanderbilt.edu or Molly Breen, c/o office of Roland D. Eavey, MD, SM, Director, Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences, Chair, Department of Otolaryngology, Medical Center East, Suite 6310, 1215 21st Ave South, Nashville TN 37232-8605

Vanderbilt University is an equal opportunity employer.

SCHOOL OF MEDICINE
VANDERBILT UNIVERSITY

The Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences inhabits a comprehensive, state-of-the art facility in Nashville, Tennessee, along with several other clinics throughout the area. Over 300+ full-time professionals serve the world of human communication. The Center educates approximately 160 graduate students, residents and fellows annually in highly competitive training programs. The Departments of Hearing & Speech and Otolaryngology consistently receive top national rankings; Audiology is ranked #1 by US News and World Report. The Bill Wilkerson research and education enterprise consists of nearly 50 grants totaling more than $10 million dollars annually. The Center's efforts are aided by five endowed chairs.

Registration is Now Open!

AAO-HNSF Annual Meeting & OTO EXPO 2012 September 9-12 WASHINGTON, DC

Register early to save up to 50%
(early registration ends June 22)

Make your free time count while you're in town for the annual meeting, by visiting top attractions in Washington, D.C.!

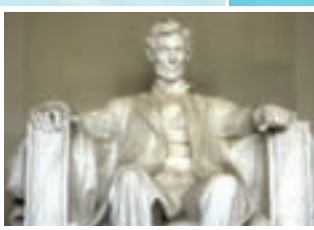
1. Visit the Smithsonian Museums and the National Gallery of Art.
2. Tour the Monuments and Memorials on the National Mall.
3. Tour the three houses of government.
4. Tour the Library of Congress.
5. Catch a show at the Kennedy Center, Ford's Theatre, Warner Theatre, National Theatre, or the Verizon Center.

★ We look forward to seeing you in Washington, D.C., at the 2012 AAO-HNSF Annual Meeting & OTO EXPO, September 9-12.

Visit www.entnet.org/annual_meeting to learn more!







AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care

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