bulletin

American Academy of Otolaryngology—Head and Neck Surgery October 2012—Vol.31 No.10

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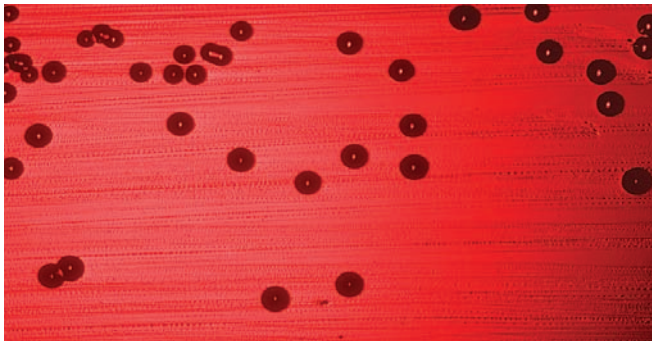
Compounded medications. Prescribing made easy.

Infecting Organism:

Haemophilus influenzae

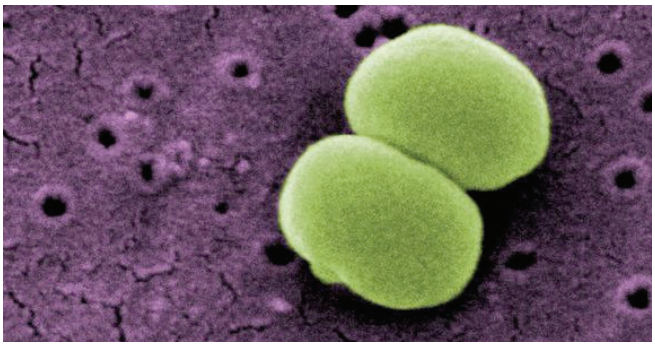
Gram Negative Bacteria



Infecting Organism:

Staphylococcus epidermidis

Gram Positive Bacteria



Medications that may be prescribed depending on culture and sensitivity reports:

Levofloxacin	Ceftriaxone

Vancomycin	Levofloxacin
Mupirocin	

Many ENT surgeons have prescribed combinations to treat polymicrobial infections that may include an antibiotic, corticosteroid and anti-fungal.

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Ceftriaxone + Mometasone + Itraconazole

Vancomycin + Betamethasone + Tobramycin
Mupirocin + Budesonide + Tobramycin
Levofloxacin + Mometasone + Itraconazole

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Triological Society Research Grants

The Triological Society
UPHOLDING THE NOBLE LEGACY

The Triological Society continues to promote research into the causes of and treatments for otolaryngic diseases by providing financial support for the research efforts of young otolaryngologists. Since 1974, the Society has awarded more than $3 million to otolaryngologists-head and neck surgeons in support of clinical and basic research. The Society's two competitive research grant programs are described here.

Triological Society Research Career Development Awards

Research Career Development Awards are available to otolaryngologists who hold full-time, part-time and contributed service medical school faculty appointments. These awards provide support for the research career development of otolaryngologists-head and neck surgeons who have made a commitment to focus their research endeavors on patient-oriented research such as clinical trials, translational research, outcomes research and health services research. Five awards are available for up to $40,000 each to be expended over a one or two year period.

Letters of intent are due December 17, 2012 (midnight ET) and applications are due January 15, 2013 (midnight ET) through the CORE grant program.

Guidelines and additional information are available at http://www.triological.org/researchgrants.htm. Questions may be referred to Gail Binderup at info@triological.org or 402-346-5500.

Triological Society/American College of Surgeons Clinical Scientist Development Award

This award provides supplemental funding to otolaryngologists-head and neck surgeons who receive a new NIH Mentored Clinical Scientist Development Award (K08/K23) in 2011/2012 or have an existing award with a minimum of 3 years remaining in the funding period as of June 1, 2013. This award is being offered as a means to facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal prior to the conclusion of the K award. This award will provide financial support in the amount of $80,000 per year for up to five years, or for the remainder of the term of existing grants, to supplement the K08/K23 award. Funding is dependent upon receipt of meritorious applications.

The application deadline is May 5, 2013.

Details are available at http://www.triological.org/researchgrants.htm. Questions may be referred to Gail Binderup at info@triological.org or 402-346-5500.

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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 model of 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.

For detailed information regarding indications for use, contraindications, warnings and precautions, see Instructions for Use.

2012-01 REV AC

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American Academy of Otolaryngology—Head and Neck Surgery October 2012—Vol.31 No.10

Membership Aids Individuals and Profession

16

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.

Ad Index

bulletin

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Your Strategic Partner

We didn't go to medical school so we could be politicians.

We didn't take the Hippocratic Oath in order to spend hours on coding.

We didn't pass the boards so we could parcel out cures according to the insights of insurance actuaries.

Yet, here we are in 2012, battling disease and bureaucracies.

As Vanderbilt University Medical Center's director of the Division of Head and Neck Surgical Oncology, I have worked in medical and educational environments worldwide and felt confident in that work at home and abroad. But building and maintaining a professional career in our own healthcare delivery environment now requires more than staying abreast of the best patient care. We all must be ready to work with regulatory agencies and governing bodies. Practicing medicine has never been more demanding or unpredictable.

Fortunately, early in my career my mentors encouraged my membership in the AAO-HNS. Our Academy has been a mainstay for many in the specialty as it monitors these socioeconomic and policy activities on every front. This has allowed us to keep medicine as our primary focus.

When I had the honor last year of being named your AAO-HNS/F President-Elect, I was eager to gain a deeper understanding of these challenges. With the benefit of data from the latest member survey, I now understand more fully what your main concerns are, and how the Academy has prepared—through attention to its long-term strategic plan—to focus its strategy and address your concerns.

As I begin my presidential year, I am happy to say the AAO-HNS/F is in an excellent position to advance these long-term strategies with a deeper intentionality. Our past years' diligence in solidifying our infrastructure and strategic position has paid off. We are ready to push forward from positions of strength for bigger strategic gains. So, in preparation for the AAO-HNS/F leaders' annual strategic planning events in December, this is a great time for me to remind you of the broad strategic areas of our activity to date. They are grouped by areas of identified concerns:

Broad Strategy: Advocacy and Health Policy

- Enhance our legislative outreach efforts to policymakers and patients to increase the general awareness of the specialty by the public.
- Enhance our grassroots activities to recognize and incentivize member involvement in our legislative and political programs.
- Integrate health policy-specific priorities, using input from the Physician Payment Policy (3P) Workgroup, to maintain our visibility and credibility on socioeconomic and federal regulatory issues.
- Advocate for appropriate reimbursement and fair policies with Medicare and private payers, providing members with information and guidance on reimbursement issues encountered at the state and local level.

Broad Strategy: Research and Quality

- Create a continuum of research and quality activities that are aligned with education and lifelong learning needs.
- Build a sustainable infrastructure to test, pilot, and promote adoption of research and quality products such as guidelines, measures, lifelong learning projects, and evidence-based medicine.
- Demonstrate the value of strong research and quality education and granting programs to the specialty.

Broad Strategy: Education and Knowledge

- Consolidate and enhance the otolaryngology practice gap analysis and needs assessment process.
- Develop the next generation of otolaryngology education and knowledge resources through continuous assessment and redesign.
- Provide resources for board certification preparation, business of medicine, trauma, robotic surgery, surgical simulation, and resident education.
- Increase member engagement in generation and usage of education and knowledge resources to improve care and outcomes.

Broad Strategy: Membership Strength and Unity

- Improve the member experience by providing meaningful engagement opportunities and encourage participation in Academy activities to increase the overall relevance.
- Enhance and articulate the member value for all member segments.
- Support physician's ability to meet requirements of healthcare reform, third-party payers, credentialing, certification, and licensure.

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

- Facilitate collaboration and communication among the specialty societies to enhance and strengthen the specialty.

Broad Strategy: Sustainability

- Provide exceptional stewardship of AAO-HNS/F assets.
- Enhance the value of the AAO-HNS/F brand.
- Leverage non-dues revenue streams.
- Support a culture of philanthropy.
- Review and update governance documents.
- Enhance the AAO-HNS/F website.

Through benchmarked milestones and set measurable goals, each of these strategic areas has received considerable attention during the past three years. You will find the latest accomplishments in the Annual Report in next month's *Bulletin*. In fact, quoting from the Treasurer's Report of the Academy Secretary/Treasurer and the Chief Operating Officer: **John W. House, MD**, and Brenda Hargett, CPA, CAE, in the most recent Board of Directors report, "…the increasing stabilization of financial management, budgeting, and reporting better positions AAO-HNS/F to take advantage of opportunities and challenges in the upcoming year."

So, my presidential year's challenge will be to ensure that the work of the past three can be used to bring into focus those paramount activities that will be most needed and sustaining for the immediate years to come. I look forward to your support and to the challenge.

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1. Manes RP, Tong L, Batra PS.: "Prospective evaluation of aerosol delivery by a powered nasal nebulizer in the cadaver model" *Int Forum Allergy Rhinol*, 2011; 1:366–371
2. Yuri M. Gelfand, MD; Samer Fakhri, MD; Amber Luong, MD, PhD; Seth J. Isaacs, MD & Martin J. Citardi, MD: "A Comparative Study of the Distribution of Normal Saline Delivered by Large Particle Nebulizer vs. Large Volume/Low Pressure Squeeze Bottle" 56th Annual Meeting of the American Rhinologic Society, September 25, 2010, page 38

A Tradition of Effective Leadership

It is my honor and privilege each year to work with a new set of elected leaders. We congratulate **Rodney P. Lusk, MD,** for his stellar year and the achievements we have made under his leadership. Several of these were the direct result of his personal interest in, and aptitude for, elements of our strategic plan, including more effective use of technology accelerators to advance both clinical science and member services. While Dr. Lusk is stepping down as president, he remains on our Boards of Directors as immediate past president, and will also preside over the Nominating Committee, as do all past presidents, whose work is arguably the most critical and influential of any Academy committee.

While we thank Dr. Lusk for his outstanding service, we welcome our new president, **James L. Netterville, MD**, who assumed the reins for 2012-2013 at the conclusion of our annual meeting last month. Dr. Netterville has done an outstanding job as president-elect in reviewing all Academy and Foundation committees and hundreds of committee applications and assuring that positions are optimally filled. He has already exhibited his presidential leadership in our Executive Committees and Boards of Directors. His engaging leadership style and his exceptional people skills provide additional reasons for confidence in our success in the coming year.

> "Each new president and elected board leader brings personal skills and interests that can accelerate and advance the Academy's long-term strategic objectives."

One of the more useful and practical improvements of this year is the Academy's updated website. Dubbed the "Website Content Relevancy Project" (WCR), this initiative has led to the review of every page of the Academy's site, revising, updating, or eliminating content as needed. Most Academy content committees reviewed thousands of pages of content. Your Academy staff also worked hard to include this additional assignment in their daily workflow. This was a much needed "house cleaning" and reorganization, and I encourage every member to use and benefit from this cleaner and more useful website.

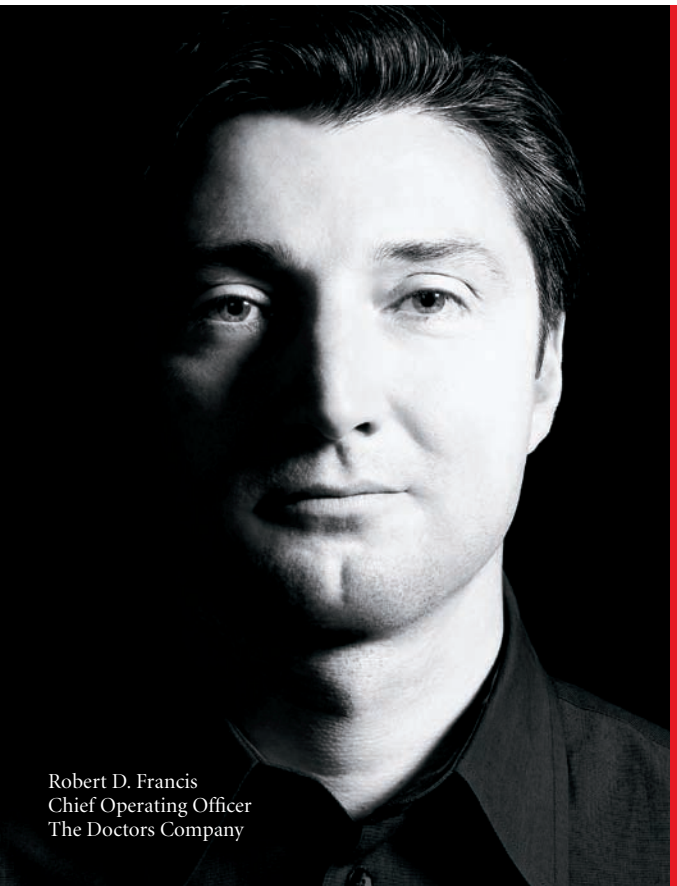
Of particular interest and use to all of us is the upgraded and more effective search capacity of the website. Most proprietary websites have a "search" field, usually allowing the visitor to enter a search term and receive a list of pages from the site related to those key words. We go much further. In addition to the more relevant pages, we have asked for, and obtained permission from, many other related medical association websites to "crawl" their sites and search their relevant pages. Since we are the first medical society to do this, we anticipate the ability to add all primary medical association sites in time, greatly adding to the value of searching through AAO-HNS' website. We have also added a direct link to PubMed, giving us a highly effective method for obtaining relevant content ranging from clinical science, health policy and advocacy, to member services and interests. You can even select a specific tab to confine your search to a single source, such as publications only, or a specific society, or our own site.

While the elected presidents lead and speak for the Boards of Directors, they certainly do not act alone in their leadership and sacrifices on behalf of all otolaryngologists. Each year, dedicated men and women rotate off the board and are replaced by newly elected or appointed members. We extend our heartfelt thanks to **J. Regan Thomas, MD; John W. House, MD; Michael D. Seidman, MD; Debara L. Tucci, MD; Stephen J. Chadwick, MD; Samuel H. Selesnick, MD; Eduardo M. Diaz, Jr., MD,** and **John H. Krouse, MD, PhD**, who have given exceptional service and honorably and faithfully completed their board terms.

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

Each new president and elected board leader brings personal skills and interests that can accelerate and advance the Academy's long-term strategic objectives. Because our strategic plan covers many years, and our work is too complex for each president to have a separate agenda, or to initiate new short-term focus on their "watch," each president with whom I have served has had to apply a higher level of inclusive and legislative leadership. The positive results of such leadership often extend for many years beyond the individual's presidency. I salute the sacrifice, hard work, and patience exhibited by these men and women who have selflessly devoted so much of their life to giving back to the profession. I invite all of you to extend your personal thanks when you can, and your continued support to your elected leaders who sacrifice so much of their personal life, professional income, and family time to provide volunteer leadership to the Academy and Foundation.

We fight frivolous claims. We smash shady litigants. We over-prepare, and our lawyers do, too. We defend your good name. We face every claim like it's the heavyweight championship. We don't give up. We are not just your insurer. We are your legal defense army. We are The Doctors Company.



Robert D. Francis
Chief Operating Officer
The Doctors Company

The Doctors Company built its reputation on the aggressive defense of our member physicians' good names and livelihoods. And we do it well: Over 82 percent of all malpractice cases against our members are won without a settlement or trial, and we win 87 percent of the cases that do go to court. So what do you get for your money? More than a fighting chance, for starters. The American Academy of Otolaryngology—Head and Neck Surgery has sponsored our medical professional liability program since 2003. To learn more about our program for AAO-HNS members, call (800) 352-0320 or visit us at www.thedoctors.com.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

THE DOCTORS COMPANY

Advocacy Promotes Better Patient Care

Getting involved in the AAO-HNS advocacy opportunities: a bit of time. Ensuring a system of outstanding patient care: priceless.

The current status of our healthcare system in the United States is one of uncertainty and the topic of much debate. Medicare, with the unsustainable Sustainable Growth Rate (SGR) formula, is one such example of a system that affects our ability to practice and, ultimately, the health of our patients. The upcoming elections both locally and nationally will provide us one vehicle to participate in the healthcare discussion. However, your potential to influence this system can be amplified by participating in the AAO-HNS-related committees available to all of our members. This participation can occur on both the local and national levels and can have a measurable effect on the politics that shape our system of healthcare.

Your Academy's primary grassroots vehicle for member advocacy is the Board of Governors (BOG). The BOG has representation from nearly all state and local societies across the United States. Each local society has three representatives on the BOG, a governor (often, but not necessarily, the president of the local society), a legislative rep, and a public relations rep. These representatives will meet with their counterparts from other state societies twice a year at the BOG Meeting in Washington, DC, and the AAO-HNSF's annual meeting in the fall. Members will serve on committees of the BOG including the Socioeconomic and Grassroots (SEGR) and Legislative Representatives. These committees take on the issues that affect our ability to practice. Regularly scheduled conference calls and legislative alerts from our Academy office keep members apprised of issues as they arise and provide our state societies with information gleaned from other states' experiences. This information is powerful and practical and can have an extraordinary impact.

The BOG has been working to reorganize and improve the state societies' relationship with the BOG, attempting to create a regional system of societies that can better serve their respective members. This would mimic, to some degree, the CMS regional organization. Being involved in your local society and developing a system to communicate issues can help provide our patients with the care they need. An example of this occurred recently in Connecticut when the CMS regional interpretation on the use of Botox for spasmodic dysphonia adversely affected our Medicare population and would have resulted in these patients, many on fixed incomes, having to pay hundreds of dollars out of pocket for their laryngeal Botox treatments. The Connecticut ENT Society, working with our national AAO-HNS office and the 3P work group, was able to quickly work through our Connecticut Society's CAC representative, Raymond Winicki, MD, to reverse the decision in about three weeks. Our patients were extremely grateful and ultimately well cared for. This was all made possible by a system where clinicians in a local society got involved and were able to help fellow members open the appropriate lines of communication to resolve the issue.

"Being involved in your local society and developing a system to communicate issues can help provide our patients with the care they need."

Besides the BOG, there are many other varied groups that members can participate in, all of which can provide the opportunity to advocate for our practices and our patients. The Women in Otolaryngology Section (WIO), for example, provides a forum specifically advocating for our women providers. The Section for Residents and Fellows-in-Training (SRF) is an excellent initiation for our members still in training. This section helps to introduce the ongoing issues to our future providers and helps to deliver to the Academy the issues affecting our trainees. The importance of embedding the concept of advocacy as a core competency in our young physicians' training is essential if we intend to continue to hold a position of strength in the healthcare debate.

The opportunities to participate within the Academy are vast. Research and clinical committees provide a vital link to updated content for our members and will continue to help with requirements, such as Maintenance of Certification. Clinical guidelines development continues and needs dedicated participants to accomplish this necessary work. The time and effort required to participate in these Academy committees are varied, but ultimately provide a vital service for our members. The constant need for our members' participation in our local and national advocacy efforts will continue as long as we have political opinions as to how the healthcare issues should be handled in our country. This election year highlights our need to be involved. The effort needed may be a slight burden on our time; the outcome for our patients could be priceless.

Denis C. Lafreniere, MD,
Chair, BOG
Division Chief, Otolaryngology-Head and Neck Surgery, University of Connecticut Health Center

New

DYMISTA™ for rapid and

(azelastine hydrochloride and fluticasone propionate) Nasal Spray 137 mcg/50 mcg per Spray

Indication

Dymista Nasal Spray, containing an H_1-receptor antagonist and a corticosteroid, is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

Important Risk Information

- Patients may experience somnolence. Caution patients against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery
- Patients should avoid concurrent use of alcohol or other central nervous system (CNS) depressants because additional reductions in alertness and additional impairment of CNS performance may occur
- Because of the inhibitory effect of corticosteroids on wound healing, avoid use in patients with recent nasal ulcers, nasal surgery, or nasal trauma until healed
- Glaucoma, cataracts, and increased intraocular pressure may be associated with nasal corticosteroid use; therefore, close monitoring is warranted in patients with a change in vision and/or with a history of increased intraocular pressure, glaucoma, and/or cataracts
- Patients using corticosteroids may be susceptible to infections and may experience a more serious or even fatal course of chicken pox or measles. Dymista should be used with caution in patients with active or quiescent tuberculosis; fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex
- Systemic corticosteroid effects, such as hypercorticism and adrenal suppression, may occur with very high dosages or at the regular dosage in susceptible individuals. If such changes occur, discontinue Dymista gradually, under medical supervision
- Potent inhibitors of cytochrome P450 (CYP) 3A4 may increase blood levels of fluticasone propionate
- Ritonavir: coadministration is not recommended
- Other potent CYP3A4 inhibitors, such as ketoconazole: use caution with coadministration
- Intranasal corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista
- In clinical trials, the most common adverse reactions that occurred with Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone nasal spray, and vehicle placebo groups, respectively, were dysgeusia (4%, 5%, 1%, <1%), epistaxis (2% for each group), and headache (2%, 2%, 2%, and 1%)
- Pregnancy Category C: based on animal data; may cause fetal harm

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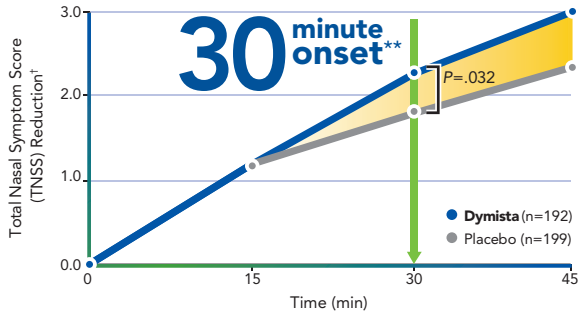
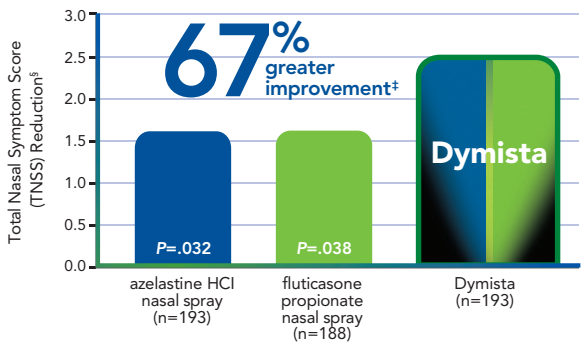
Nasal Symptom Reduction: Statistically Superior at 30 Minutes*[1,2]



Magnitude of Nasal Symptom Relief Relative to azelastine HCl and to fluticasone propionate*[1,2]



Data shown are from study MP 4004. Across the 3 pivotal clinical trials, the improvement with Dymista ranged from 40% to 67% greater relative to the improvement achieved with either comparator.[1,2]

*As listed in the Full Prescribing Information, in 3 pivotal trials, symptom relief was measured by change from baseline in Total Nasal Symptom Score (TNSS) averaged over the 14-day study period. Dymista provided a statistically significant improvement in TNSS compared with both azelastine hydrochloride (HCl) and fluticasone propionate. The azelastine HCl and fluticasone propionate comparators used the same device and vehicle as Dymista and are not commercially marketed. Additionally, Dymista provided a statistically significant, rapid improvement in TNSS as early as 30 minutes after administration when compared with placebo.[1]

**Data shown are from study MP 4004. Onset of action was defined as the first timepoint at which Dymista was statistically superior to placebo in the mean change from baseline in instantaneous TNSS and was sustained thereafter.[1]

†Change from baseline in instantaneous TNSS following administration.[2]

‡Percent difference represents the improvement in TNSS with Dymista relative to azelastine HCl or fluticasone propionate comparator.[2]

§Change from baseline in the placebo-subtracted mean TNSS for each day (maximum score 24), averaged over the 14-day study period.[2]

References: 1. Dymista [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; 2012.
2. Data on File. Meda Pharmaceuticals Inc.

Please see Brief Summary of Full Prescribing Information on the following pages.

DYMISTA™
(azelastine hydrochloride and fluticasone propionate) Nasal Spray
137 mcg/50 mcg per Spray

www.Dymista.com

DYMISTA (AZELASTINE HYDROCHLORIDE 137 MCG / FLUTICASONE PROPIONATE 50 MCG) NASAL SPRAY

Brief Summary (for Full Prescribing Information, see package insert)

1 INDICATIONS AND USAGE

Dymista Nasal Spray is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

5 WARNINGS AND PRECAUTIONS

5.1 Somnolence

In clinical trials, the occurrence of somnolence has been reported in some patients (6 of 853 patients) taking Dymista Nasal Spray [*see Adverse Reactions (6.1)*]. Patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and motor coordination such as operating machinery or driving a motor vehicle after administration of Dymista Nasal Spray. Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because additional reductions in alertness and additional impairment of central nervous system performance may occur [*see Drug Interactions (7.1)*].

5.2 Local Nasal Effects

In clinical trials of 2 to 52 weeks' duration, epistaxis was observed more frequently in patients 38 treated with Dymista Nasal Spray than those who received placebo [*see Adverse Reactions (6)*].

Instances of nasal ulceration and nasal septal perforation have been reported in patients following the intranasal application of corticosteroids. There were no instances of nasal ulceration or nasal septal perforation observed in clinical trials with Dymista Nasal Spray. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal ulcers, nasal surgery, or nasal trauma should not use Dymista Nasal Spray until healing has occurred. In clinical trials with fluticasone propionate administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has occurred. When such an infection develops, it may require treatment with appropriate local therapy and discontinuation of treatment with Dymista Nasal Spray. Patients using Dymista Nasal Spray over several months or longer should be examined periodically for evidence of *Candida* infection or other signs of adverse effects on the nasal mucosa.

5.3 Glaucoma and Cataracts

Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Therefore, close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma, and/or cataracts.

Glaucoma and cataract formation were evaluated with intraocular pressure measurements and slit 56 lamp examinations in a controlled 12-month study in 612 adolescent and adult patients aged 12 years and older with perennial allergic or vasomotor rhinitis (VMR). Of the 612 patients enrolled in the study, 405 were randomized to receive Dymista Nasal Spray (1 spray per nostril twice daily) and 207 were randomized to receive fluticasone propionate nasal spray (2 sprays per nostril once daily). In the Dymista Nasal Spray group, one patient had increased intraocular pressure at month 6. In addition, three patients had evidence of posterior subcapsular cataract at month 6 and one at month 12 (end of treatment). In the fluticasone propionate group, three patients had evidence of posterior subcapsular cataract at month 12 (end of treatment).

5.4 Immunosuppression

Persons who are using drugs, such as corticosteroids, that suppress the immune system are more susceptible to infections than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in susceptible children or adults using corticosteroids. In children or adults who have not had these diseases or been properly immunized, particular care should be taken to avoid exposure. How the dose, route, and duration of corticosteroid administration affect the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chickenpox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin 74 (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chickenpox develops, treatment with antiviral agents may be considered.

Corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract; untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex because of the potential for worsening of these infections.

5.5 Hypothalamic-Pituitary-Adrenal (HPA) Axis Effects

When intranasal steroids are used at higher than recommended dosages or in susceptible individuals at recommended dosages, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, the dosage of Dymista Nasal Spray should be discontinued slowly, consistent with accepted procedures for discontinuing oral corticosteroid therapy. The concomitant use of intranasal corticosteroids with other inhaled corticosteroids could increase the risk of signs or symptoms of hypercorticism and/or suppression of the HPA axis. The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency, and in addition some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude, and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

5.6 Use of Cytochrome P450 3A4 Inhibitors

Ritonavir and other strong cytochrome P450 3A4 (CYP3A4) inhibitors can significantly increase plasma fluticasone propionate exposure, resulting in significantly reduced serum cortisol concentrations [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of Dymista Nasal Spray and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Use caution with the coadministration of Dymista Nasal Spray and other potent CYP3A4 inhibitors, such as ketoconazole [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*].

5.7 Effect on Growth

Corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista Nasal Spray [*see Use in Specific Populations (8.4)*].

6 ADVERSE REACTIONS

Systemic and local corticosteroid use may result in the following:

- Somnolence [*see Warnings and Precautions (5.1)*]
- Local nasal effects, including epistaxis, nasal ulceration, nasal septal perforation, impaired wound healing, and *Candida albicans* infection [*see Warnings and Precautions (5.2)*]
- Cataracts and glaucoma [*see Warnings and Precautions (5.3)*]
- Immunosuppression [*see Warnings and Precautions (5.4)*]
- Hypothalamic-pituitary-adrenal (HPA) axis effects, including growth reduction [*see Warnings and Precautions (5.5 and 5.7), Use in Specific Populations (8.4)*]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect rates observed in practice. The safety data described below reflect exposure to Dymista Nasal Spray in 853 patients (12 years of age and older; 36% male and 64% female) with seasonal allergic rhinitis in 3 doubleblind, placebo-controlled clinical trials of 2-week duration. The racial distribution for the 3 clinical trials was 80% white, 16% black, 2% Asian, and 1% other. In the 12-month open-label, active-controlled clinical trial, 404 Asian patients (240 males and 164 females) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray, 1 spray per nostril twice daily.

Adults and Adolescents 12 Years of Age and Older

In the 3 placebo-controlled clinical trials of 2-week duration, 3411 patients with seasonal allergic rhinitis were treated with 1 spray per nostril of Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone propionate nasal spray, or placebo, twice daily. The azelastine hydrochloride and fluticasone propionate comparators use the same vehicle and device as Dymista Nasal Spray and are not commercially marketed. Overall, adverse reactions were 16% in the Dymista Nasal Spray treatment groups, 15% in the azelastine hydrochloride nasal spray groups, 13% in the fluticasone propionate nasal spray groups, and 12% in the placebo groups. Overall, 1% of patients in both the Dymista Nasal Spray and placebo groups discontinued due to adverse reactions.

Table 1 contains adverse reactions reported with frequencies greater than or equal to 2% and more frequently than placebo in patients treated with Dymista Nasal Spray in the seasonal allergic rhinitis controlled clinical trials.

Table 1. Adverse Reactions with ≥2% Incidence and More Frequently than Placebo in Placebo-Controlled Trials of 2 Weeks Duration with Dymista Nasal Spray in Adult and Adolescent Patients With Seasonal Allergic Rhinitis

	1 spray per nostril twice daily			
	Dymista Nasal Spray (N=853)*	**Azelastine Hydrochloride Nasal Spray†** (N=851)	**Fluticasone Propionate Nasal Spray†** (N=846)	**Vehicle Placebo** (N=861)
Dysgeusia	30 (4%)	44 (5%)	4 (1%)	2 (<1%)
Headache	18 (2%)	20 (2%)	20 (2%)	10 (1%)
Epistaxis	16 (2%)	14 (2%)	14 (2%)	15 (2%)

*Safety population N=853, intent-to-treat population N=848

† Not commercially marketed

In the above trials, somnolence was reported in <1% of patients treated with Dymista Nasal Spray (6 of 853) or vehicle placebo (1 of 861) [*see Warnings and Precautions (5.1)*].

Long-Term (12-Month) Safety Trial:

In the 12-month, open-label, active-controlled, long-term safety trial, 404 patients (12 years of age and older) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray 1 spray per nostril twice daily and 207 patients were treated with fluticasone propionate nasal spray, 2 sprays per nostril once daily. Overall, adverse reactions were 47% in the Dymista Nasal Spray treatment group and 44% in the fluticasone propionate nasal spray group. The most frequently reported adverse reactions (≥ 2%) with Dymista Nasal Spray were headache, pyrexia, cough, nasal congestion, rhinitis, dysgeusia, viral infection, upper respiratory tract infection, pharyngitis, pain, diarrhea, and epistaxis. In the Dymista Nasal Spray treatment

group, 7 patients (2%) had mild epistaxis and 1 patient (<1%) had moderate epistaxis. In the fluticasone propionate nasal spray treatment group 1 patient (<1%) had mild epistaxis. No patients had reports of severe epistaxis. Focused nasal examinations were performed and no nasal ulcerations or septal perforations were observed. Eleven of 404 patients (3%) treated with Dymista Nasal Spray and 6 of 207 patients (3%) treated with fluticasone propionate nasal spray discontinued from the trial due to adverse events.

7 DRUG INTERACTIONS

No formal drug interaction studies have been performed with Dymista Nasal Spray. The drug interactions of the combination are expected to reflect those of the individual components.

7.1 Central Nervous System Depressants

Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because somnolence and impairment of central nervous system performance may occur [*see Warnings and Precautions (5.1)*].

7.2 Cytochrome P450 3A4

Ritonavir (a strong CYP3A4 inhibitor) significantly increased plasma fluticasone propionate exposure following administration of fluticasone propionate aqueous nasal spray, resulting in significantly reduced serum cortisol concentrations [*see Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of fluticasone propionate and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Ketoconazole (also a strong CYP3A4 inhibitor), administered in multiple 200 mg doses to steady-state, increased plasma exposure of fluticasone propionate, reduced plasma cortisol AUC, but had no effect on urinary excretion of cortisol, following administration of a single 1000 mcg dose of fluticasone propionate by oral inhalation route.

Caution should be exercised when Dymista Nasal Spray is coadministered with ketoconazole and other known strong CYP3A4 inhibitors.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Dymista Nasal Spray: Teratogenic Effects: Pregnancy Category C:

There are no adequate and well-controlled clinical trials of Dymista Nasal Spray, azelastine hydrochloride only, or fluticasone propionate only in pregnant women. Animal reproductive studies of azelastine hydrochloride and fluticasone propionate in mice, rats, and/or rabbits revealed evidence of teratogenicity as well as other developmental toxic effects. Because animal reproduction studies are not always predictive of human response, Dymista Nasal Spray should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Azelastine hydrochloride: Teratogenic Effects: In mice, azelastine hydrochloride caused embryo-fetal death, malformations (cleft palate; short or absent tail; fused, absent or branched ribs), delayed ossification, and decreased fetal weight at an oral dose approximately 610 times the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m2 basis at a maternal dose of 68.6 mg/kg). This dose also caused maternal toxicity as evidenced by decreased body weight. Neither fetal nor maternal effects occurred at a dose that was approximately 26 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rats, azelastine hydrochloride caused malformations (oligo- and brachydactylia), delayed ossification and skeletal variations, in the absence of maternal toxicity, at an oral dose approximately 530 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg). At a dose approximately 1200 times the MRHDID (on a mg/m2 basis at a maternal dose of 68.6 mg/kg), azelastine hydrochloride also caused embryo-fetal death and decreased fetal weight; however, this dose caused severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rabbits, azelastine hydrochloride caused abortion, delayed ossification, and decreased fetal weight at oral doses approximately 1100 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg); however, these doses also resulted in severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 11 times the MRHDID (on a mg/m2 basis at a maternal dose of 0.3 mg/kg).

Fluticasone propionate: Teratogenic Effects: Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Subcutaneous studies in the mouse and rat at doses approximately equivalent to and 4 times, respectively, the MRHDID in adults (on a mcg/m2 basis at maternal doses of 45 and 100 mcg/kg respectively), revealed fetal toxicity characteristic of potent corticosteroid compounds, including embryonic growth retardation, omphalocele, cleft palate, and retarded cranial ossification.

In the rabbit, fetal weight reduction and cleft palate were observed at a subcutaneous dose less than the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 4 mcg/kg). However, no teratogenic effects were reported at oral doses up to approximately 25 times the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 300 mcg/kg) of fluticasone propionate to the rabbit. No fluticasone propionate was detected in the plasma in this study, consistent with the established low bioavailability following oral administration [*see Clinical Pharmacology (12.3)*].

Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in corticosteroid production during pregnancy, most women will require a lower exogenous corticosteroid dose and many will not need corticosteroid treatment during pregnancy.

Nonteratogenic Effects: Fluticasone propionate crossed the placenta following oral administration of approximately 4 and 25 times the MRHDID in adults (on a mcg/m2 basis at maternal doses of 100 mcg/kg and 300 mcg/kg to rats and rabbits, respectively).

8.3 Nursing Mothers

Dymista Nasal Spray: It is not known whether Dymista Nasal Spray is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when Dymista Nasal Spray is administered to a nursing woman. Since there are no data from well-controlled human studies on the use of Dymista Nasal Spray by nursing mothers, based on data from the individual components, a decision should be made whether to discontinue nursing or to discontinue Dymista Nasal Spray, taking into account the importance of Dymista Nasal Spray to the mother.

Azelastine hydrochloride: It is not known if azelastine hydrochloride is excreted in human milk.

Fluticasone propionate: It is not known if fluticasone propionate is excreted in human milk. However, other corticosteroids are excreted in human milk. Subcutaneous administration to lactating rats of 10 mcg/kg of tritiated fluticasone propionate (less than the maximum recommended daily intranasal dose in adults on a mcg/m2 basis) resulted in measurable radioactivity in the milk.

8.4 Pediatric Use

Safety and effectiveness of Dymista Nasal Spray in pediatric patients below the age of 12 years have not been established.

Controlled clinical studies have shown that intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of HPA axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The long-term effects of this reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch-up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied. The growth of pediatric patients receiving intranasal corticosteroids, including Dymista Nasal Spray, should be monitored routinely (e.g., via stadiometry). The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment alternatives.

8.5 Geriatric Use

Clinical trials of Dymista Nasal Spray did not include sufficient numbers of patients 65 years of age and older to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Dymista Nasal Spray: Dymista Nasal Spray contains both azelastine hydrochloride and fluticasone propionate; therefore, the risks associated with overdosage for the individual components described below apply to Dymista Nasal Spray.

Azelastine hydrochloride: There have been no reported overdosages with azelastine hydrochloride. Acute azelastine hydrochloride overdosage by adults with this dosage form is unlikely to result in clinically significant adverse events, other than increased somnolence, since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 23 mg of azelastine hydrochloride. Clinical trials in adults with single doses of the oral formulation of azelastine hydrochloride (up to 16 mg) have not resulted in increased incidence of serious adverse events. General supportive measures should be employed if overdosage occurs. There is no known antidote to Dymista Nasal Spray. Oral ingestion of antihistamines has the potential to cause serious adverse effects in children. Accordingly, Dymista Nasal Spray should be kept out of the reach of children.

Fluticasone propionate: Chronic fluticasone propionate overdosage may result in signs/symptoms of hypercorticism [*see Warnings and Precautions (5.2)*]. Intranasal administration of 2 mg (10 times the recommended dose) of fluticasone propionate twice daily for 7 days to healthy human volunteers was well tolerated. Single oral fluticasone propionate doses up to 16 mg have been studied in human volunteers with no acute toxic effects reported. Repeat oral doses up to 80 mg daily for 10 days in volunteers and repeat oral doses up to 10 mg daily for 14 days in patients were well tolerated. Adverse reactions were of mild or moderate severity, and incidences were similar in active and placebo treatment groups. Acute overdosage with this dosage form is unlikely since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 8.5 mg of fluticasone propionate.

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Sujana S. Chandrasekhar, MD, Former Chair, Board of Governors

***"You cannot hope to build a better world without improving the individuals. To that end each of us must work for his own improvement, and at the same time, share a general responsibility for all humanity, our particular duty being to aid those to whom we think we can be most useful."* – Marie Curie**

"Each of us must work for his [or her] own improvement."

Providing the tools needed for otolaryngologist-head and neck surgeons to deliver the best patient care through education, research, and advocacy is the cornerstone of the AAO-HNS/F's mission. We, as Academy members, know this. It's why we belong to this organization. It's the second part of this great quote that I want to call your attention to.

"Share a general responsibility…" for the whole.

Who is responsible for our specialty? For innovation? For quality care? For fair representation? Who is better to play this role than those who are uniquely trained, experienced, and in the best position to serve it? We all share this responsibility and we all can lend a hand. You may know about the professional development tools offered by the Academy, but did you know that our colleagues create those tools? Each of the products and services offered by the Academy and Foundation trace their roots back to members who accepted the task to develop content, lend their expertise, volunteer their time and leadership, advocate for fair and equitable practices, and/or contribute financially. You might say that each otolaryngologist-head and neck surgeon is the curator of the specialty, and the Academy is a vehicle for production and distribution.

If not you, then who?

In today's culture, time is scarce. There are so many demands on us professionally and personally, that taking on even just one more thing seems impossible. What I suggest in response, however, is: If we don't, then who will? Who will take over this role of curator? Can we leave it up to the government agencies, commercial industry, or non-specialized physician groups to figure out what's best for our patients? All of these groups play a part in the healthcare system, of course, but none of them are poised to know how to deliver the best otolaryngologic patient care. Our Academy is positioned, through the participation of its members, to protect, sustain, and advance the specialty of otolaryngology-head and neck surgery. This is why continuing your membership and participating in Academy activities are so important.

How can you help?

The AAO-HNS/F has created opportunities for you to not only continue improving as a physician leader, but also to further your role as curator of the specialty. These opportunities are designed to fit any level of participation, from face-to-face networking opportunities to activities that require only your computer. Each of these activities plays an important role in the specialty, whether it is creating content to educate the next generation of physicians, participating in research activities that improve quality of care, lending your voice to educate legislative and regulatory bodies on issues affecting our practices, or contributing to our body of knowledge through journal articles. Participation is based on your schedule and interests, and input from all types of otolaryngology practice experiences—academic, private practice, military, governmental, rural, suburban, urban, etc.—makes our entire specialty stronger. I encourage you to maximize your membership and explore the opportunities that have been created to allow all otolaryngologist-head and neck surgeons to curate our specialty. Visit www.entnet.org/getinvovolved.

Special Recognition of a 2012 Distinguished Service Award Winner: Eiji Yanagisawa, MD

The AAO-HNS extends a special honor to Eiji Yanagisawa, MD, a 2012 Distinguished Service Award recipient. Like all of this year's renowned recipients, Dr. Yanagisawa has a long-standing, dedicated history of loyalty and support to the Academy and its mission. He has dedicated his time and expertise to serve on many Academy and Foundation committees, participated in countless annual meetings, and been extremely generous in his philanthropic pledges to the Foundation over the course of his entire membership. Of particular note is his donation of his personal collection of ENT-related images, which have been built to become the ENT ImageViewer and Collections. The application was initially conceived of and developed specifically to house Dr. Yanagisawa's extensive library of ear, nose, and throat images. The purpose of this library is to provide Academy members with digital images of common and uncommon diseases of the ear, the nose and paranasal sinuses, and the larynx, so that Academy members can utilize these images for teaching purposes.

Wisdom from Our Three-Time DSA Winners

In the history of our Academy, three members have won the Distinguished Service Award (DSA) three times. Each describes what membership means to him below:

Andrew Blitzer, MD, DDS

I have been attending AAO-HNSF annual meetings since 1976, when I first went as a resident. The annual meeting is like a three-ring circus, where just about everything in our specialty is reviewed through lectures, posters, exhibits, and courses. I had the opportunity to sit and listen to the masters in our field review their new science or technical expertise. Under one roof, I was able to learn a wide variety of new thinking relevant to my practice, from the very best. As the years went by, I became more involved in Academy activities and committees. I served on a number of educational committees, chaired the SIPac (Self Instructional Packages) committee for six years and served on the Instruction Course Advisory Committee for 15 years, including six years as coordinator. Aside from the joy of being able to give back to a specialty that I feel so privileged to be a member of, I was able to meet otolaryngologists from across the United States, and around the world and share discussions about topics and research we have in common. I also served on the Foundation Board of Directors, and witnessed how the Academy serves the needs of all otolaryngologists. No other organization provides for education, practice administration advice, political action, and research opportunities in otolaryngology. I have spent half of my career in full-time academic medicine, and the other half in private practice, and still find the Academy the most complete resource available for the otolaryngologist. I am still thrilled to be a part of my specialty—to teach, to provide patient care, to participate in clinical research, and to learn from others. The AAO-HNS still represents the best otolaryngology resource for me.

Richard M. Rosenfeld, MD, MPH

William Osler proposed that "The very first step toward success in any occupation is to become interested in it," and what better way than through the AAO-HNS? I have attended 20 consecutive annual meetings, along the way advocating with colleagues on Capitol Hill, presenting countless courses and miniseminars, chairing numerous research and quality committees, and serving as editor-in-chief of the Academy journal. The personal growth and satisfaction gained through these endeavors is dwarfed by the joy of working with colleagues and hyper-talented Academy staff to make a real and lasting difference in patient care, on a national and international stage. Osler also wrote that a medical society "... keeps the mind open and receptive, and counteracts that tendency to premature senility, which is apt to overtake someone who lives in a routine." Unless you crave premature senility it's time to get out of your routine and get

involved with the AAO-HNS. Success will inevitably follow.

Mark K. Wax, MD

I first participated in the Academy as a resident. I was amazed that I was able to listen to, and learn from, those who were leaders in the field. Following my training, I realized that nowhere else could I encounter such a diverse offering of otolaryngologic expertise, and for so little. The annual meeting was a fantastic venue to learn from the leaders in the field, get expert opinions in a flash, visit the exhibit hall to learn about new technology, and visit friends. As my career progressed, I wanted to pay back and contribute to the field. No other venue allowed me to contribute in so many ways. The AAO-HNS was always receptive to any type of volunteer activity. They were open-minded and continued to foster learning, no matter what level. The Academy is active in so many aspects that influence otolaryngologists. No matter what your area of interest or expertise, there is a spot for you.

AAO-HNS Honor and Distinguished Service Awards

The AAO-HNS has two programs that recognize member voluntary contributions to otolaryngology, the AAO-HNS, and their community. The Honor Award is the first award a member can obtain for participation in specific AAO-HNS activities. The Distinguished Service Award is recognition of volunteer service beyond the level of an Honor Award. Members receive honor points for participation in a variety of activities and leadership roles. Nonmembers can receive honor points, but are not eligible for Honor Awards or Distinguished Service Awards. However, points earned as a nonmember convey if the individual becomes an AAO-HNS member.

The Honor Award is the first award a member can obtain for participation in certain activities. A member can earn only one Honor Award in a lifetime. To receive an Honor Award, a member must earn 10 volunteer service points during a minimum of five years. The Honor Award point system is constructed to promote recognition not only for the quantity of service, but also for the variety and longevity of service. A maximum of two points, each of which must come from a different category of service, can be accrued each year.

The DSA is a recognition of volunteer service beyond the level of an Honor Award. Members who attain 50 honor points, including the 10 points received for an Honor Award, receive the Distinguished Service Award. There is no limit on the number of Distinguished Service Awards a member may receive. All honor points, regardless of quantity earned in each category in a year, are credited toward the DSA.

As of 2012, the AAO-HNS has bestowed 1,627 Honor Awards and 291 Distinguished Service Awards.

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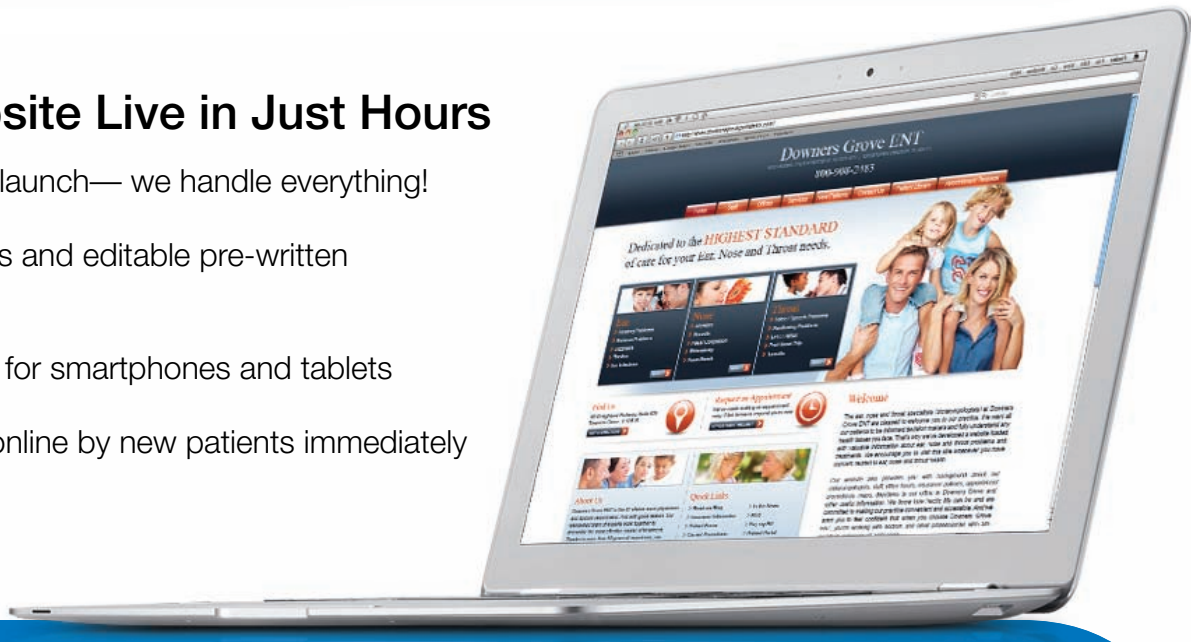

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The following are the committees of the Academy and Foundation, grouped by clusters. These are all members, unless otherwise noted, who were appointed to terms October 1, 2012, as well as continuing their service. The number following each name indicates end of their term. If you'd like to serve on a committee, submit your application at www.entnet.org/Community/.

Review the committee rosters online for the most up-to-date lisitng at www.entnet.org/Community/committeeRoster.cfm.

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We Asked, You Told Us, and Here's What We Heard

This summer, many of you told us what you thought by filling out the member satisfaction and needs assessment survey, the Voice of the Member Survey. This comprehensive, biannual survey was sent to all members and covered topics such as overall satisfaction with the organization and satisfaction with individual programs and services. We have validated, compiled, and analyzed the results. We learned why you belong and how satisfied you are with the Academy and its ability to represent and advance the specialty.

What we heard was an overall sense of satisfaction from members. More than half of you (51%) indicated you were "very satisfied" with the Academy. This is up 4 percentage points from the 2010 results. You also told us that your confidence is strong in the Academy's ability to represent (up 6% points from 2010) and advance (up 4% from 2010) the specialty of otolaryngology-head and neck surgery.

- Why You Belong
- In 2012, the Top 5 characteristics ranked No. 1 in importance to members are the following:
- Relevance of articles and features (publications): (ranked No. 2 in 2010)
- Educational products to support lifelong learning: (ranked No. 1 in 2010)
- Relevance of subject matter/sessions (annual meeting): (ranked No. 3 in 2010)
- Usefulness in facilitating professional growth: (new to Top 5: ranked No. 7 in 2010)
- Overall value of member benefits: (new to the Top 5: ranked No. 6 in 2010)

Thank you to those who filled out the survey. The Board of Directors and the staff at the Academy headquarters heard your answers and comments. While credit is due all across the organization for this increase, including you—the individual contributions of each member—special recognition should be made to our volunteer leaders for developing and implementing a solid strategic plan for the organization. This strategic plan has set the course for the organization and these satisfaction numbers indicate that we are on the right track to serving your needs and representing the specialty.

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Why Women Don't Run for Office (and How We Can Change That!)

Jennifer L. Lawless, PhD, MA
Associate Professor of Government
Director, Women & Politics Institute
American University for the Women in Otolaryngology Section

As of the 1970s, women occupied almost no major elective political positions in the United States. Ella Grasso, a Democrat from Connecticut, and Dixie Lee Ray, a Democrat from Washington, served as the only two women elected governor during the decade. Not until 1978 did Kansas Republican Nancy Kassebaum become the first woman elected to the U.S. Senate in her own right. By 1979, women comprised fewer than five percent of the seats in the U.S. House of Representatives, and only about 10 percent of state legislative positions.

Today, if we glance at the television screen, peruse the newspaper, listen to the radio, or scan the Internet, we might be tempted to conclude that women have made remarkable gains. Nancy Pelosi currently serves as the minority leader in the U.S. House of Representatives. Secretary of State (and former U.S. Senator) Hillary Clinton not only received 18 million votes when she sought the Democratic nomination for president—she also has the highest favorability ratings of any member of the Obama administration. And in 2011, polls repeatedly placed former vice presidential candidate Sarah Palin in the top tier of potential candidates for the Republican presidential nomination.

But these famous faces obscure the dearth of women who hold elective office in the United States. When the 112th Congress convened in January 2011, 84 percent of its members were men. Large gender disparities are also evident at the state and local levels, where more than three-quarters of statewide elected officials and state legislators are men. Further, men occupy the governor's mansion in 44 of the 50 states, and men run city hall in 92 of the 100 largest cities across the country.

Why are so few women in politics, especially in light of the fact that women fare as well as men in terms of vote totals and fundraising receipts?

During the past decade, Richard L. Fox, PhD, MA, and I have surveyed and interviewed more than 7,500 "eligible candidates"—highly successful individuals who occupy the professions most likely to precede a career in politics. Although about 50 percent of the people we spoke to had considered running for office, women were more than one-third less likely than men to have considered a candidacy. And they were only half as likely as men to have taken any of the actions that usually precede a campaign—like investigating how to place their name on the ballot, or discussing running with potential donors, party or community leaders, or even mentioning the idea to family members or friends. If we focus only on the 50 percent of people who *had* thought about running, women were one-third less likely than men to throw their hats into the ring and enter actual races. The good news is that women were just as likely as men to win their races. The bad news is that—because of this winnowing process—they were far less likely than men to make it to Election Day.

Jennifer L. Lawless

Because we cannot really begin to determine how to minimize the gender gap in political ambition if we do not understand its roots, I'd like to begin a conversation about political ambition, why men have it, and why women don't.

Impediment 1: Perceptions of Qualifications

Despite comparable resumes, the men we surveyed and interviewed are nearly 60 percent more likely than women to assess themselves as "very qualified" to run for office. Women are more than twice as likely as men to rate themselves as "not at all qualified." Importantly, the gender gap in perceptions of qualifications to run for office does not stem from gender differences in direct political experiences or exposure to, and familiarity with, the political arena (the women and men are similarly situated on these dimensions).

Women's self-doubts are particularly important because they play a much larger role than do men's in depressing the likelihood of considering a candidacy. More specifically, among women who self-assess as "not at all qualified" to run for office, only 39 percent have considered throwing their hats into the ring. Among men who do not think they are qualified to run for office, 55 percent have given the notion of a candidacy some thought.

Impediment 2: Recruitment

Women are less likely than men to have received the suggestion to run for office—from anyone. This gender gap in political recruitment exists at all levels of office. From local, to state, to federal positions, party leaders, elected officials, political activists, colleagues, family members, and friends, encourage far more men than women to enter the electoral arena.

The lack of recruitment is a powerful explanation for why women are less likely than men to consider a candidacy. Sixty-seven percent of respondents who have been encouraged to run by a party leader, elected official, or political activist, for example, have considered running, compared to 33 percent of respondents who report no such recruitment. The same pattern holds for non-political actors. Importantly, women are just as likely as men to respond favorably

to the suggestion of a candidacy. They are just less likely than men to receive it.

Impediment 3: Family Roles

Women working in the top tier of professional accomplishment still tend to exhibit traditional gender role orientations. In families where both adults are working (generally in high-level careers), women are roughly six times more likely than men to bear responsibility for the majority of household tasks, and they are about 10 times more likely to be the primary childcare provider. Notably, these differences in family responsibilities are not merely a matter of gendered perceptions. Both sexes fully recognize this organization of labor. More than 50 percent of men acknowledge that their spouses are responsible for a majority of household tasks and childcare, while only seven percent of women make the same claim. This division of labor is consistent across political party lines. For many women, even considering a candidacy might seem like a "third job."

What Can We Do to Bring about Change?

Given the persistent gender gap in political ambition, we are a long way from a political reality in which women and men are equally likely to aspire to attain high-level elective office. The 2012 elections, which are already being heralded as another great year for female candidates, are likely to result in only incremental changes to the number of women serving in the U.S. Congress. Both parties have proudly announced that they are running more women in the 2012 cycle than in any previous election. But this record number still means that women—should they win their primary contests—will compete in less than one-third of the Senate races in 2012. Thus, even if 2012 turns out to be a "banner year" for female candidates, and even if the majority of these women win their races, their victories will amount to, at most, a one-to-two percentage point increase in the seats held by women in the U.S. Congress.

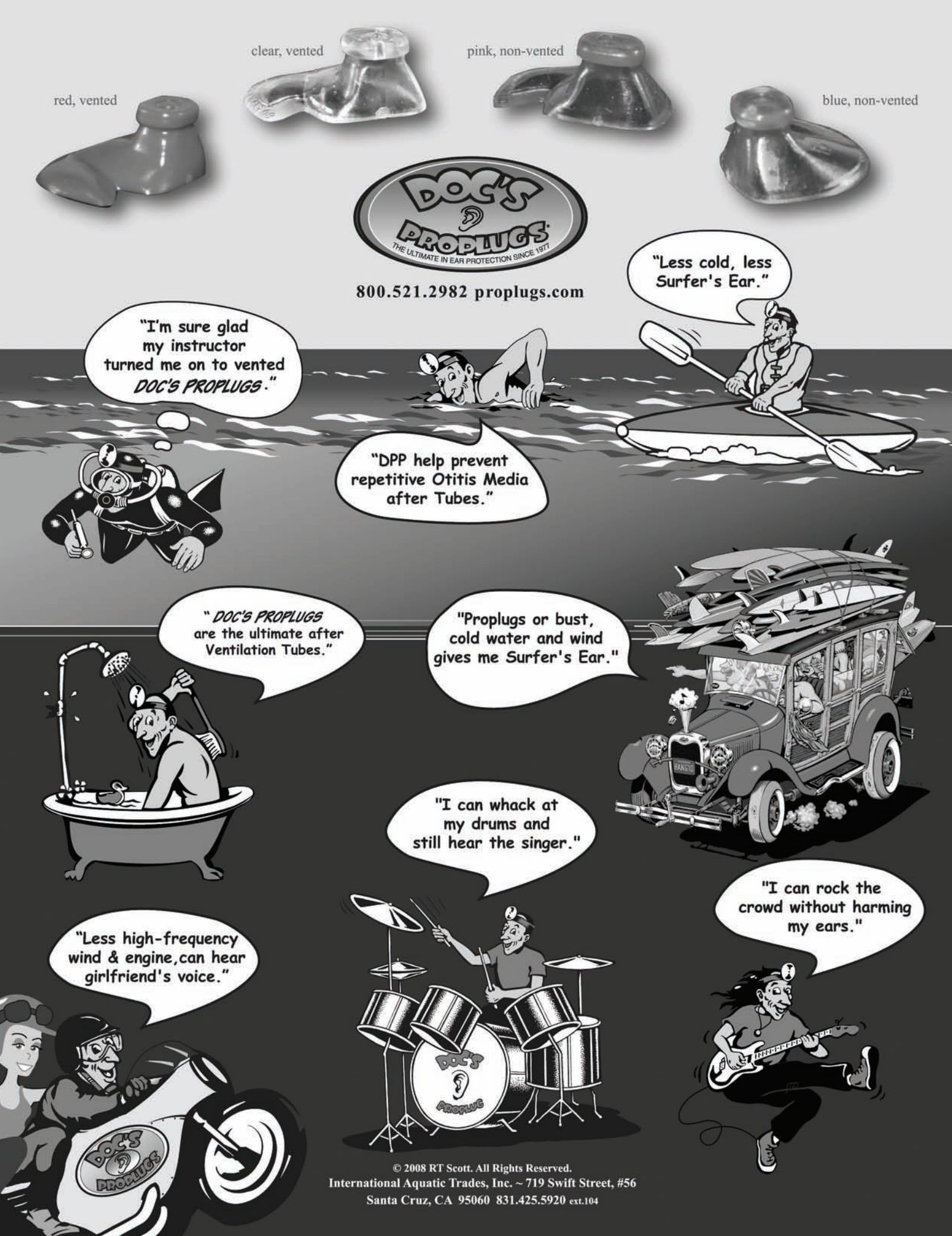
The problems that underlay women's numeric under-representation are more fundamental than the occasional attention that political parties and the media pay to women's candidate emergence might suggest. Our findings highlight the importance of deepening our understanding of the manner in which women and men in contemporary society are socialized about politics, the acquisition of political power, and the characteristics that qualify individuals to seek it.

Susan Cordes, MD, spoke about leadership at the BOG Leadership Training luncheon in September.

At a practical level, though, our findings offer some direction for people interested in increasing the numbers of women serving in office:

- First, although women are less likely than men ever to have considered running for office, they are just as likely as men to respond positively to political recruitment. Recruiting early and recruiting often are vital ingredients for closing the gender gap in political ambition. Indeed, we need to go to high schools and colleges and encourage girls and women to engage in politics. Every time any of us runs across a woman who seems to fit the bill, we need to tell her—and we should tell her more than once—that she should consider running for office.
- Second, a substantial barrier for many female potential candidates is the perception of a biased and competitive electoral atmosphere in which women have to be twice as good to deem themselves "qualified." Yet this perception is not consistent with the reality that women are just as likely as men to succeed in the electoral arena. Spreading the word about women's electoral success and fund-raising prowess can work to change perceptions of a biased electoral arena.
- Third, the gendered division of labor we uncovered demonstrates that women and men who are similarly situated professionally are not similarly situated at home. Any move toward a more family-friendly work environment and campaign arena would likely confer disproportional benefits to women.

The large gender gap in political ambition, coupled with the stagnation in the number of women serving in elected offices in the last decade, makes the road ahead look quite daunting. Many barriers to women's interest in running for office can be overcome only with major cultural and political changes. But in the meantime, recruiting female candidates and disseminating information about the electoral environment and women's successes can help narrow the gender gap and increase women's numeric representation. The challenges in front of us are to continue to raise awareness about the barriers women face, and to continue to advocate for a more inclusive electoral process.



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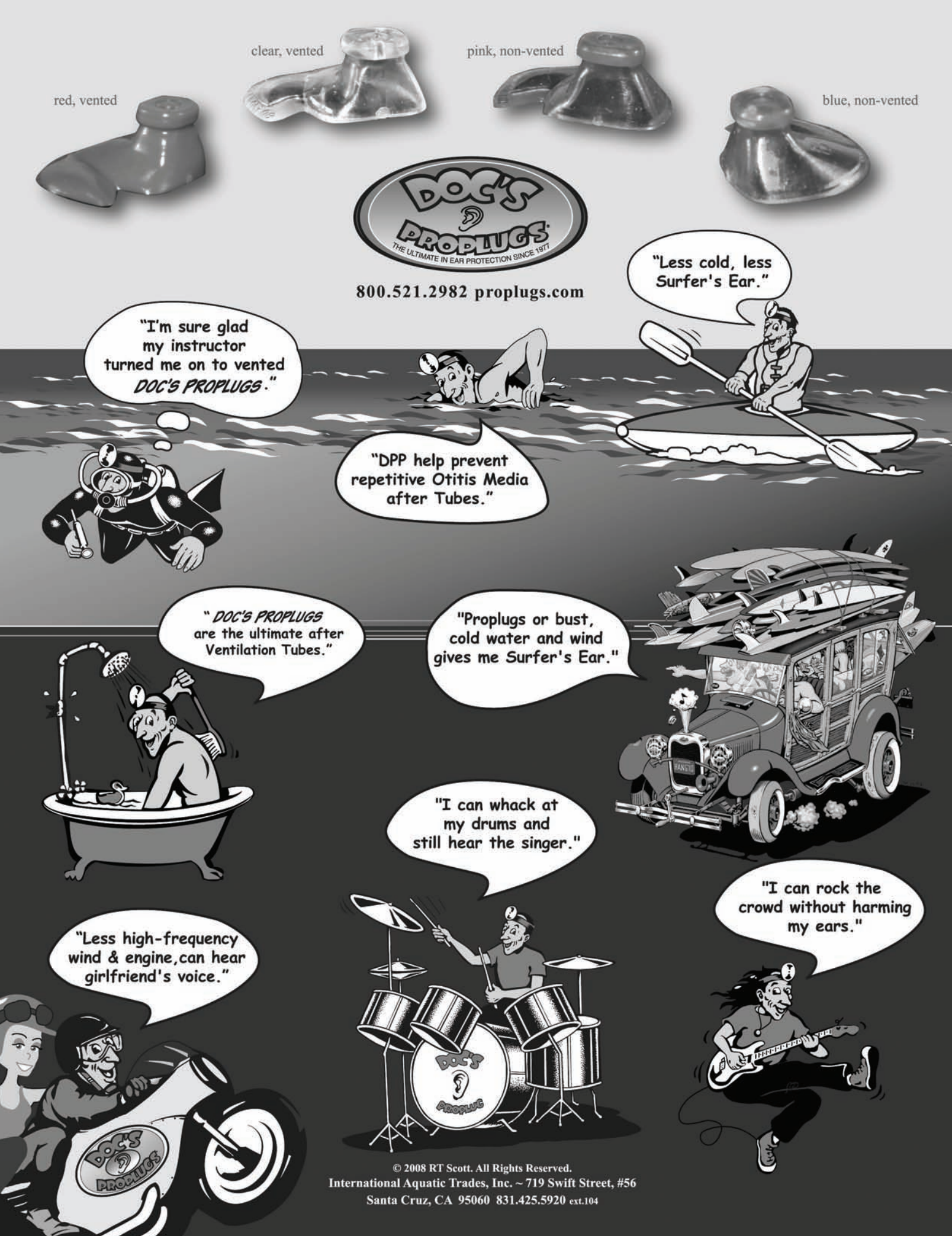

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The Supreme Court Has Ruled: Now What?

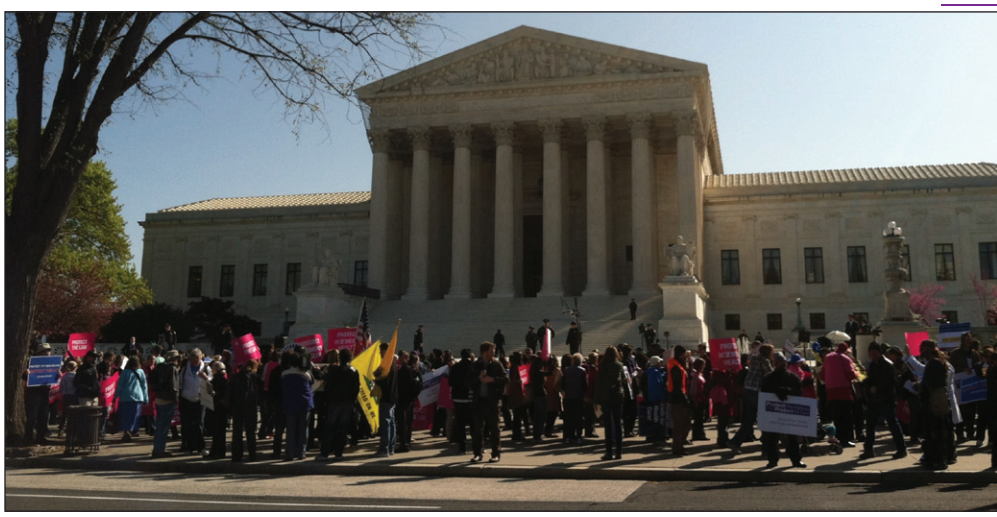
On June 28, the U.S. Supreme Court released a landmark decision regarding the constitutional challenges to the Patient Protection and Affordable Care Act (ACA). The main issues under consideration by the Court were the constitutionality of the "individual mandate" section of the law, requiring all Americans to be insured by 2014, and the Medicaid expansion provisions. The Court's 5-4 decision largely affirmed the constitutionality of the ACA, while limiting the impact of the Medicaid expansion provisions.

In a majority opinion written by Chief Justice John Roberts, the individual mandate was upheld under Congress' authority to levy taxes. There was not a majority of the Justices to uphold the individual mandate under the Commerce Clause or the Necessary and Proper Clause, which were the two primary arguments the government presented during its oral arguments. Private and state plaintiffs had argued that Congress did not have the power to enact a law that would require all citizens to purchase health insurance or pay a penalty.

With this decision, the majority of Americans must purchase "minimum essential" health insurance coverage by 2014. If they opt to not purchase the coverage, they must pay a penalty to the IRS together with their taxes. Since the Court upheld the individual mandate, the Court did not have to decide whether the individual mandate would be severable from the law.

When the Court addressed the Medicaid expansion provisions, it limited, but did not invalidate, the provision that sought to cover all adults younger than 65 with household incomes below the poverty level. The Court held that Congress cannot threaten the states with the loss of all federal Medicaid funding if the states declined to expand Medicaid coverage as mandated by the ACA. However, if a state decides to accept the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. If a state chooses not to participate in the expansion, it is limited to the loss of Medicaid expansion funds, and cannot lose all of its funds under the current Medicaid program. The states thus have a financial incentive to comply, but they must choose to accept or reject the new requirements without consequences to existing programs.

Since the release of the Court's decision, states have felt the pressure to move forward with complying with the majority of the ACA's provisions. The states' actions leading up to the Court's decision will now influence their progress in implementing healthcare reform. As of September, 16 states and the District of Columbia had already established exchanges and other states have made substantial steps toward creating exchanges. In addition, a number of states have indicated they will not participate in the Medicaid expansion program.



Although the AAO-HNS did not support the final version of the healthcare reform law when it was enacted in March 2010 due to reasons unrelated to the individual mandate and Medicaid provisions, the Academy recognizes the need for, and supports substantive reforms to, the nation's healthcare delivery system. With the Court's decision, the AAO-HNS expects the next few months to be challenging as the next chapter of the healthcare reform debate is written, and the national elections approach.

The Academy's Government Affairs team will continue to actively monitor Congressional and Administrative responses to the Court's ruling and their effect on Academy members and their patients. Immediately following the Court's decision, the Republican-controlled U.S. House of Representatives passed legislation to repeal the ACA. As expected, the proposal stalled in the U.S. Senate. Repeated efforts to repeal all or some of the provisions are expected to continue into 2013.

As this debate continues, please help us ensure the specialty's voice is heard on Capitol Hill to protect the interests of both physicians and their patients. To receive timely updates on legislative and political issues and access to legislative action alerts, join the ENT Advocacy Network today—a free AAO-HNS member benefit. If you have questions regarding the Supreme Court's decision, implementation of the ACA, or the Academy's legislative priorities, please email the Government Affairs team at govtaffairs@entnet.org.

United We Stand!

During the AAO-HNSF 2012 Annual Meeting & OTO EXPO in Washington, DC, nearly 250 otolaryngologist–head and neck surgeons signed a "Declaration of Independence from the Sustainable Growth Rate Formula" petition. The petition, which will be delivered to every member of the U.S. Congress, helps our organization send a clear message to Capitol Hill regarding our resolve to band together in an effort to advocate on a critical aspect of ongoing healthcare reform. This initiative is a good reminder that there is strength in numbers—a lesson that can be equally applied to other facets of AAO-HNS advocacy efforts.

Tell Congress to support Medicare choice

Urge your lawmakers to support the Medicare Patient Empowerment Act (H.R. 1700/S.1042). This legislation would allow patients to use their Medicare coverage to help cover the cost of seeing any physician, even those who do not accept Medicare.

Take action

- Visit **ama-assn.org/go/privatecontracting** to access resources for physicians and patients, and to get involved in grassroots activities.
- Sign our online petition at **MyMedicare-MyChoice.org**.

AMA AMERICAN MEDICAL ASSOCIATION | AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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 site, you can learn more about the issues affecting the specialty, including the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy.

Highlights from the 2012 Leadership Program in Health Policy and Management

Michael J. Brenner, MD
2012 ACS/AAO-HNS Health Policy Scholar

There has never been a greater need for healthcare policy leadership in otolaryngology–head and neck surgery. Greater engagement of surgeons is a critical step in cultivating future leaders. The American Academy of Otolaryngology—Head and Neck Surgery and the American College of Surgeons have therefore partnered to offer a scholarship in health policy and leadership. This unique program represents one of the many ways the Academy grows future leaders in our specialty.

This year's Leadership Program in Health Policy occurred May 20-26 at Brandeis University's Heller School. Nearly 40 surgeons, representing the full range of surgical specialties, participated in the weeklong course critically evaluating health policy. The program afforded a broad perspective on the international healthcare landscape and addressed the unique challenges and opportunities facing us as healthcare providers in the United States. Participants left the session empowered with this knowledge, impassioned and prepared to contribute to leadership in a wide variety of health policy areas nationally.

The opening program provided a historical backdrop that outlined how we arrived at the current, precarious position in healthcare in the United States. Presenters addressed the challenges posed by rising costs and proliferating technology. Surgeons often feel disenfranchised by major political movements, many of which have led to changes in practice structure, reimbursement, and diminished autonomy. The health policy leadership program empowered participants to drive positive change on behalf of patients and fellow colleagues.

Payment, Care Delivery Models

Several sessions addressed various models in payment and care delivery, such as episode-based bundling—an approach to clustering healthcare services that appeared repeatedly this year in the *New England Journal of Medicine*. Another session addressed Accountable Care Organizations, detailing the rationale for these organizations and their unintended consequences. Data Envelopment Analysis, a quantitative model for assessing value and quality, also was evaluated. It became readily apparent that surgeons require a working knowledge of these areas to have an influential voice in national dialogues on health policy. Such policy can profoundly influence how we practice medicine.

> "Greater engagement of surgeons is a critical step in cultivating future leaders."

The leadership program used interactive, data-intensive breakout sessions to teach participants how to execute strategic planning. A detailed vignette on race car engine failure provided a compelling model for examining larger questions of risk tolerance and safety. Common cognitive errors were considered and strategic thinking was emphasized. An exercise on effecting change showed pathways to cultivating relationships and capitalizing on resources. The program struck a balance between high-level thinking and data-driven critical analysis.

The unrivaled complexity of the U.S. healthcare system underscores the need for such strategic thinking and surgical leadership in healthcare policy. Even if we are stalwart advocates for our individual patients, our efforts will fall short if we allow policy makers to promulgate policies that fail to serve our patients' best interests. Surgeons who understand patient care, national issues in healthcare, and the financial underpinnings of proposed policies are in an ideal position to promote positive change.

Policy Makes—or Breaks—Practice

One might be tempted to ask whether we can afford the precious time necessary to engage in these leadership and health policy activities. The answer, borne out time and again by history, is that we cannot afford not to serve in this role. Engagement in health policy is an opportunity to grow and to reinvent ourselves.

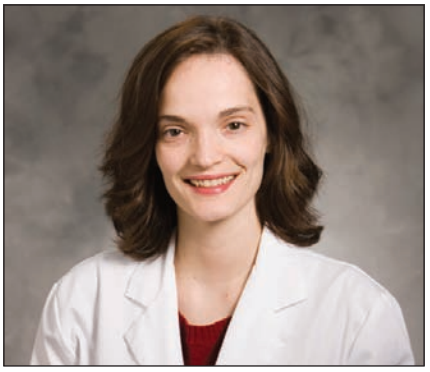
In my own experience, involvement in healthcare policy and committee efforts has opened doors that I would never have anticipated. In the few short months since that conference, I have seen an influence in the hospitals where I work and traveled as far as Glasgow, Scotland, for an international collaborative. As with so many things in life, doors open unexpectedly. What one gets out of an effort is inextricably linked to what one puts into it. Participating in the health policy leadership program allowed me to build professional friendships that will undoubtedly last for many years to come.

In the future, we will need to work together to develop a unified voice in health policy. We are fortunate to have tremendous leadership from within our Academy, and it is imperative that we each find a way to make a contribution. Otolaryngology-head and neck surgery has a pivotal role to play in national healthcare reform. This role has bearing on our ability to ensure safe, effective, and high quality care. Through engagement in health policy and providing leadership in our national organizations, we can shape national discourse, and thereby ensure a bright future for our specialty.

Delegation Report: AMA Annual Meeting 2012

Liana Puscas, MD
Chair, AAO-HNS Delegation to the AMA

In June, the American Medical Association (AMA) conducted its Annual House of Delegates meeting in Chicago. **Liana Puscas, MD,** delegation chair, and delegates **Michael S. Goldrich, MD, Robert Puchalski, MD,** and **Shannon P. Pryor, MD,** represented the Academy. Joy Trimmer, JD, senior director for AAO-HNS Government Affairs, and Jenna Kappel, MPH, MA, director for AAO-HNS Health Policy, served as our staff liaisons. Several AAO-HNS members were elected to leadership positions during the meeting. The delegation congratulates Dr. Puscas, who was elected chair of the Otolaryngology Section Council; Dr. Goldrich, who was elected secretary of the Otolaryngology Section Council; and Dr. Pryor, who was elected as an at-large member of the Women Physicians Congress Governing Council.



Liana Puscas, MD

A number of issues are always discussed and/or considered by the House of Delegates. However, this year there were several topics that pertain to otolaryngology, including:

Electronic prescribing of controlled substances. Currently, many electronic health record (EHR) vendors and pharmacies do not permit electronic prescriptions for narcotics. The AMA voted to advocate for removal of legal barriers to electronic prescribing of controlled substances, and in the interim, to work with the Centers for Medicare and Medicaid Services to eliminate from any program the requirement for electronic prescription of controlled substances until such time as the necessary protocols are in place to allow pharmacies and electronic prescribing software to process such prescriptions.

Drug shortages. Various drug shortages have affected the practice of otolaryngology–head and neck surgery (OHNS) in recent years. The AMA House of Delegates supported measures to require drug companies to give notice of impending shortages and for the Food and Drug Administration (FDA) to allow other companies to step in and manufacture needed drugs in the face of looming shortages.

Sign language interpretation. This is germane to many OHNS practices, but is often overlooked in the larger discussion of reimbursement for translation services. The AMA voted to seek legislation and/or regulation to require health insurers to fully reimburse providers for the cost of providing sign language interpreters for hearing impaired patients.

Tobacco use. The consequences of tobacco use often present to an otolaryngologist's office manifesting as head and neck cancer or as a contributing factor to allergic rhinitis and sinusitis. Although the Board of Trustees had originally proposed that the AMA no longer needed its annual report on tobacco use and the ongoing efforts to curb that use, the House of Delegates voted to continue the report. The report contains information on the demographics of tobacco use and actions taken by government and health agencies to address its social, economic, and health effects.

Support for private practice. In an era when traditional private practice is at risk, the AMA voted to strongly continue its support of private practice because patients and physicians benefit from keeping this as a viable option for healthcare delivery.

Medicare Financing Options. The AMA's Council on Medical Service has been charged with taking an in-depth look at transitioning Medicare from its current model to one in which beneficiaries would receive a defined contribution from the federal government. This would allow greater flexibility for Medicare recipients to choose either traditional Medicare or a private health insurance plan.

For more information, email govtaffairs@entnet.org. The AMA House of Delegates will next meet for its interim meeting November 10–13 in Honolulu, HI.

AAO-HNSF ANNUAL MEETING & OTO EXPO

CALL FOR PAPERS 2013 DEADLINES:

Instruction Course
Submission Open: November 5, 2012
Submission Closes: December 3, 2012
Notifications Sent: Late March 2013

Miniseminar
Submission Open: November 5, 2012
Submission Closes: December 3, 2012
Notifications Sent: Late March 2013

Scientific (Oral & Poster)
Submission Open: January 21, 2013
Submission Closes: February 18, 2013
Notifications Sent: Late April 2013

VISIT
WWW.ENTNET.ORG/ANNUAL_MEETING
TO SUBMIT YOUR ABSTRACT.

AAO-HNSF ANNUAL MEETING & OTO EXPO 2013 CANADA
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Academy Committees Impact Payment Coverage for Otolaryngology

Richard W. Waguespack, MD
Coordinator for Socioeconomic Affairs
Michael Setzen, MD
Coordinator for Practice Affairs,
and Co-chairs of 3P

The Physician Payment Policy (3P) Workgroup, 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.

On behalf of the AAO-HNS and 3P, we would like to thank Academy committees for the work they have done in the past in response to requests for expert review and input on payer/insurer (i.e., United Healthcare, Wellpoint, Aetna, Medicare, Medicaid, etc.) payment policies. We anticipate a higher volume of requests for review of payer/insurer payment policies in the future.

As you know, payers give the Academy limited time to provide comments on the payment policies, and as a result we will continue to need to draw on committee members' expertise in reviewing these policies.

Background on Need for Committee Input on Payment Policy Requests from Payers

The Academy has excellent relationships with many payers and as they perform periodic review of payment policies related to specific otolaryngology-head and neck surgery services, they reach out to the Academy for input prior to publishing the finalized version. This often provides the Academy an excellent opportunity to proactively advocate for its members and our patients. While payers do not always accept our recommendations, we do well on balance. Membership sometimes alerts 3P about payer policies that are already implemented and are restrictive to the specialty. In these cases, in order to advocate on behalf of members for appropriate coverage and payment of services, committee input is needed to provide comments. Occasionally, Academy input is needed for issues not directly relating to payment, but other elements of health policy.

Urgency and Importance of Payer Payment Policy Review

The urgency of these requests to review the payer payment policies is determined by the payer's time frame and the fact that the payers typically only review policies annually. Therefore, it is critical for the Academy committees to provide comments in a timely manner to ensure they are included in the payer's policy meetings where decisions are made. The review of payer payment policies affects coverage and payment of services you provide to your patients.

Process for Receiving Committee Input

Currently, once a payer receives a request for review, the Health Policy staff sends it to 3P for review and they determine which committees have the expertise needed to review and provide comments on the policy. Health Policy staff then forwards to the committee chair, and copies the staff liaison, requesting the committee's review. Committee input on payer payment policies is essential to ensuring that our clinical experts have the opportunity to provide their expertise and input to shape future payment policy for their services.

Exemplary Committee Input Resulting in Positive Progress with Payer Payment Policy

In a recent example, the Implantable Hearing Devices Committee (IHDC) has reviewed and provided comments on United Healthcare's Policy for reimbursement of Implantable/Non-Implantable Hearing Aids and Bone Anchored Hearing Aids (BAHA) during the past four to five years. In 2010, the committee provided comments on UHC's policy, arguing for expanded inclusion in UHC's descriptions of various covered devices. After the committee's 2012 review of the policy, it mostly concurred with UHC's reimbursement policy for devices and clinical procedures associated with this policy. In addition, the IHDC determined United Healthcare has integrated many of the Academy's past comments and has modified its policy integrating past Academy recommendations. As such, our members should have confidence that the Academy can amicably work with insurers to change reimbursement policies and achieve progress that will benefit membership as a whole. In some cases, it may take time to develop substantive peer-reviewed literature sources to support various procedures and devices, but every bit of support helps. The Academy would like to extend its sincere gratitude to **Jeffery J. Kuhn, MD**, chair of the IHDC, and all of the members of the committee who diligently worked on this effort, which resulted in positive change for all Academy members providing these services to patients.

> While payers do not always accept our recommendations, we do well on balance.

For more information on recent changes to private payer payment policies, visit http://www.entnet.org/Practice/News-and-Updates-from-Private-Payers.cfm.

Summary: Proposed CY 2013 Medicare Physician Fee Schedule

On July 6, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for the Medicare physician fee schedule (MPFS) for calendar year (CY) 2013. The Academy submitted comments to CMS on the proposed rule, which can be viewed on the Academy's website at http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm#CL. Some key provisions from the proposed rule included:

Medicare Sustainable Growth Rate (SGR)

The overall estimated influence of the policy changes within the proposed rule for CY 2013 MPFS on otolaryngology is zero percent. (Note: This amount does not include the possible 27 percent reduction to the conversion factor (CF) that could result if Congress does not take action to prevent the annual cuts from the SGR [if the cuts were to take effect, the CF would go from $34.0376 in 2012 to potentially $24.7124 for CY 2013].) While the 27 percent is due to projected SGR cuts, the reduced CF is partially due to CMS' proposal to add new G-codes to the Medicare system, which due to budget neutrality requirements, causes a reduction to all other services in the fee schedule in order to pay for the existence of the new code's expected utilization.

Improving Valuation of the Global Surgical Package

Since 1992, different methodologies have been used in valuing global surgical services through the American Medical Association Relative Value Scale Update Committee (AMA RUC) process. Studies by the United States Government Accountability Office (GAO) have shown that codes reviewed more recently tend to have fewer evaluation and management (E/M) visits in their global periods while codes reviewed less recently did not appear to have the full work RVUs of each E/M service in the global surgical package. This resulted in inconsistent numbers of E/M visits during the postoperative period across families of procedures. CMS acknowledges that under current policy surgeons are not required to document in the medical record what level of E/M visit they are providing, making it difficult to determine whether the number and type of visits provided in association with a surgical procedure is appropriate. As a result, CMS states it is interested in a "claims-based data collection approach" to track E/M visits provided during the global surgery period, and the Agency requested comments on this and other methods of obtaining data.

Validating RVUs of Services

Under the ACA, the Secretary of Health and Human Services (HHS) is directed to validate a sampling of RVUs for services. In the proposed rule, CMS states it intends to "enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, for both new and existing services." It states it will discuss this model in future rulemaking.

Expanding the Multiple Procedure Payment Reduction Policy (MPPR)

CMS proposes to expand the MPPR to the Professional Component (PC) of certain advanced diagnostic imaging services (CT, MRI, and ultrasound) when two or more physicians in the same group practice furnish services to the same patient, in the same session, on the same day.

G-Code for Care Coordination

CMS proposes the creation of a HCPCS G-code, valued at 1.28 RVUs, to describe the work involved with care management and coordination (including non-face-to-face care management services). Specifically, the transition of a beneficiary from care furnished by a treating physician during a hospital stay (inpatient, outpatient observation services, or outpatient partial hospitalization) and other facilities to care furnished by the beneficiary's primary care physician within 30 calendar days following the date of discharge.

CMS clarifies that the new G-code is not billable by a physician or non-physician billing for a procedure with a 10- or 90-day global period because it considers such management "included in the postoperative portions of the global period." However, some otolaryngology-head and neck surgeons may be able to use this code, e.g., those who receive patients from a hospital and provide E/M services through referrals, those treating trauma cases, and those treating cancer patients.

Physician Quality Reporting System (PQRS)

CMS proposes many overarching changes to the PQRS system, with highlights of those potentially affecting otolaryngology following here:

Changes to Group Reporting: CMS proposes to change the definition of a "group practice" from 25 or more eligible professionals to two or more eligible professionals.

Modification of Reporting Periods: CMS proposes the continuation of a six-month reporting period (July 1-December 31) for reporting measures groups via registry in 2013 and 2014 only.

Satisfactorily reporting for the 2015 and 2016 payment adjustment: CMS proposes to allow individuals and group practices to report only one PQRS individual measure or one measure groups to avoid the 2015 and 2016 penalty adjustment. The penalty adjustment will be -1.5 percent in 2015 and -2 percent in 2016 and subsequent years.

Adult Sinusitis Measures: CMS proposes the addition of 13 new measures for reporting individual quality measures in 2013 and proposes the addition of 45 new individual measures for 2014. However, the newly approved "Adult Sinusitis" measures were not included in any of their proposals.

Physician Compare Website

CMS plans to publish additional information to the Physician Compare website, including whether a professional is accepting new Medicare patients, board certification information, whether or not a professional participates in the electronic health record (EHR) Incentive Program, names of professionals satisfactorily participating in PQRS, as well as foreign language and hospital affiliation data. CMS also proposes adding patient experience survey measures such as Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for groups participating in the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) and Accountable Care Organization (ACO) programs.

Electronic Prescribing (eRx) Incentive Program

CMS proposes reducing the minimum group practice size for participation in the eRx incentive program from 25 to two eligible professionals (EPs) for 2013. Groups of two to 24 would have to report the eRx numerator code during a denominator-eligible encounter at least 225 times within the designated reporting periods. CMS also proposes adding two new hardship exemptions to the 2013 and 2014 eRx payment penalties. Finally, CMS proposes extending the PQRS-Medicare EHR Incentive Pilot for 2013.

Value-Based Payment Modifier and Physician Feedback Reporting Program

Beginning January 1, 2015, the ACA requires the Secretary to establish a value-based payment modifier (incentive or penalty) to specific physicians and groups of physicians. The incentive or penalty is based on measuring quality of care furnished as compared to cost of that care for Medicare beneficiaries with certain chronic conditions. The Agency is proposing to begin a three-year phase-in of the program that would apply the incentive or penalty (up to potential -1 percent) in 2015 based on 2013 performance for groups of 25 or more providers. CMS proposes that incentives or penalties in 2016 will be based on 2014 performance for groups of 25 or more providers. The program is voluntary the first two years, but not later than 2017, the value-based payment modifier will apply to all physicians, regardless of group size.

As part of this program, the Secretary is required to provide Physician Feedback reports to providers that measure the resources used in providing care to beneficiaries and the quality of care. To achieve this, CMS has included information reported in the PQRS program in the 2010 Physician Feedback reports that were provided to groups of physicians in 2011 and individual physicians in early 2012, which some otolaryngologists received.

For a more detailed summary on the proposed requirements for the programs highlighted above, visit the Academy's CMS Regulations and Comment letter page at http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm#CL or email Academy staff at HealthPolicy@entnet.org.

Evidence-Based Guidelines Affecting Policy, Practice, and Stakeholders (E-GAPPS) Conference

The E-GAPPS Conference is a two-day meeting co-sponsored by the Guidelines International Network North America (G-I-N NA) and the Section on Evidence Based Health Care (SEBHC) of the New York Academy of Medicine. The E-GAPPS mission focuses on constructive dialogue and collaboration; best practices in guideline development, dissemination, and implementation; and perspectives, processes, values, and principles that affect healthcare policy.

To register or learn more about the confirmed plenary speakers, conference themes, or breakout sessions, visit http://www.nyam.org/events/2012/evidence-based-guidelines-conference.html.

2012 E-GAPPS Conference
New York, NY
Monday, December 10 to Tuesday, December 11

You Chose Wisely!

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

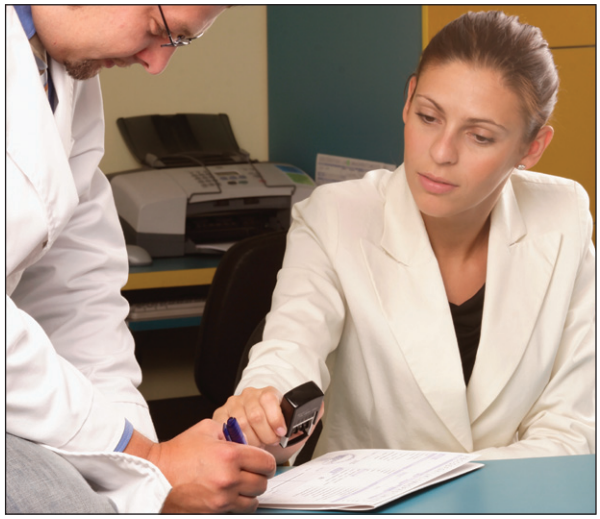
There has been tremendous media attention in the past year discussing the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely® campaign. We have discussed this campaign in prior *Bulletin* articles along with the Foundation's intended participation and, as such, we wanted to update you on this initiative.

The Choosing Wisely campaign is based on the fact that overuse exists in our healthcare system. Who best to curb such overuse than the healthcare providers themselves? This, of course, resonates with physician organizations such as our Foundation, as we would like to have a vested interest in looking at our own practices. Essentially, the campaign is asking healthcare professionals and their organizations to look at the tests and procedures physicians recommend and how they affect patients.

As we have previously discussed, the Choosing Wisely campaign is moving into its second phase. Our Foundation is part of this phase and our Board has identified five specific procedures, tests, or treatments to be submitted to the ABIM Foundation's Choosing Wisely campaign. The goal of submitting five such instances to the campaign is to draw attention to these procedures, tests, and treatments. With all medical specialties looking at these conditions in aggregate, we as a healthcare team can reduce overuse.

In the first phase of the campaign, 45 tests and procedures were identified by nine medical specialties as potentially being overused. The initial nine specialties that participated in the Choosing Wisely campaign were the American Academy of Allergy, Asthma & Immunology, American Academy of Family Physicians, American College of Cardiology, American College of Physicians, American College of Radiology, American Gastroenterological Association, American Society of Clinical Oncology, American Society of Nephrology, and the American Society of Nuclear Cardiology.

For the second phase of the campaign, our Foundation was the first surgical society to have joined and agreed to develop a list of five items whose necessity should be questioned and discussed. Herein lies the rub. For a surgical specialty with a tremendous amount of outpatient care, such as ours, and with such disparate technical procedures under our umbrellas—pediatric airway, microvascular reconstruction, cosmetic plastic surgery, robotic surgery, allergy evaluations and treatment, etc.—one can begin to be lost with the prospect of trying to identify five items.



The final list that our Board will decide upon will be released soon. However, this article is meant to highlight our Foundation's leadership by participating in the Choosing Wisely campaign and also to explain how we arrived at the measures that were presented to the Board for voting/approval. Per the Academy, this project was assigned to the Patient Safety and Quality Improvement (PSQI) Committee to spearhead the effort. From here, the PSQI committee solicited the input of members of the Specialty Society Advisory Council (SSAC), the Guidelines Development Task Force (GDTF), and members of each of the AAO-HNS/F committees. The final five items selected were based on the support of the above groups and available supporting evidence, such as AAO-HNSF clinical practice guidelines.

When the Board votes and approves the final list of topics that our Foundation submits to the Choosing Wisely campaign, we want our membership to be absolutely confident that all stakeholders within the AAO-HNSF and the associated societies have had an opportunity to submit topics and have helped in the overall process of choosing items submitted to the ABIM Foundation. Personally, I could not be more pleased at the ability of an organization with practices as diverse as ours to be able to reach consensus on a list of topics examining our practice patterns in only a couple of months. It is our membership's ability to introspectively examine our own practices for the ultimate benefit of our patients that is most impressive to me and to other organizations nationally.

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. Email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

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Education Committees Working Hard for Foundation

Sonya Malekzadeh, MD
AAO-HNSF Coordinator for Education

The Foundation's extensive education opportunities stem from the efforts and dedication of the AAO-HNS Education Committees. Each committee contributes countless hours to the development of courses, publications, and workshops. The Foundation acknowledges and recognizes the committee chairs and members for their commitment to its professional development mission.

The eight Education Committees represent the specialty areas within otolaryngology-head and neck surgery. Charged with identifying practice gaps and underlying education needs, they propose, develop, implement, and evaluate education activities that are designed to affect patient care and outcomes. During my first year as Coordinator for Education, I am amazed at the level of engagement and by the enormous contributions of the committee members who voluntarily devote time and resources. As we move into a new education year, I would like to express my sincere gratitude to the retiring members and to warmly welcome new members.

Each year the Education Committees generate four Home Study Course (HSC) sections, eight Patient Management Perspectives in Otolaryngology (PMP) issues, and numerous online courses through Clinical Otolaryngology OnLine (COOL) and AcademyU®. In 2012, the Education Committees tackled a number of exciting new projects. AcademyQ: Otolaryngology Knowledge Assessment Tool is a mobile app comprised of 400 multiple-choice questions intended for self-assessment or test preparation. The website content relevancy initiative aimed to review and update the Academy website and to improve the search functionality. The revised Comprehensive Otolaryngologic Curriculum, Learning through Interactive Approach (COCLIA) offers residents an upgraded platform with interactive media and references. The Education Committees continue the process of updating the *Maintenance Manual for Lifelong Learning* (MMLL). This publication provides an overview of more than 100 otolaryngology topics and addresses issues of practical importance for otolaryngologists.


Karen T. Pitman, MD


Sukgi S. Choi, MD


Dennis H. Kraus, MD

At last month's Annual Meeting & OTO EXPO in Washington, DC, three Education Committees were granted the Model Committee Award: the General Otolaryngology Education Committee (GOEC), under the direction of chair **Karen T. Pitman, MD**, the Head and Neck Surgery Education Committee (HNSEC), led by chair **Dennis H. Kraus, MD,** and the Pediatric Otolaryngology Education Committee (POEC), under the guidance of chair **Sukgi S. Choi, MD**. Selected by the Academy president, this award recognizes committees that contribute to the success of our mission through strong leadership and active membership. During the last two years, GOEC developed 15 online courses, produced five PMP issues, issued one HSC volume, led two successful ENT for the PA-C conferences, (Physician Assistant CME) and published the third edition of *Primary Care Otolaryngology*. In that same time period, HNSEC developed 33 online courses, printed eight PMP issues, and distributed one HSC volume. Lastly, POEC generated 22 online courses, circulated nine PMP issues, and issued one HSC volume.

Each of these committees sponsored and supported numerous Annual Meeting & OTO EXPO instruction courses and miniseminars, which were well attended and highly regarded. These chairs and their respective committees are to be congratulated on producing outstanding materials that support the Foundation's education goals.

I have had the privilege of working with eight extraordinary committee chairs on the Education Steering Committee (ESC). Each chair a leader in their respective field, they have supported the ESC work plan and effectively guided their committees to providing outstanding education materials for our learners. This month marks the end of service for **Richard W. Waguespack, MD**, chair of the Core Otolaryngology and Practice Management Education Committee (COPMEC); Dr. Kraus, chair of the HNSEC; Dr. Choi, chair of the POEC; and **James A. Hadley, MD**, chair of the Rhinology and Allergy Education Committee (RAEC). We are indebted to them for their guidance and dedication.

Continuing professional development remains a core mission of the AAO-HNS/F. Our Education Committees strive to deliver the most effective, relevant, and highest quality products. By incorporating new knowledge and skills, otolaryngologists will improve the quality of care for patients and their communities. The Education Committees continually seek individuals interested in developing innovative education resources. Committee applications will soon be available and are due February 2013. Consider joining an Education Committee and contributing to the education efforts of the Foundation.

CRISP Mission to Mazatenango, Guatemala

Melynda A. Barnes, MD
Resident, Stanford University Hospital and Clinics

From February 19-26, I traveled to Mazatenango, Guatemala, as part of the Children's Rehabilitation Institute and Surgical Program (CRISP) Foundation, with founder **Ronald Strahan, MD; Jesse E. Smith, MD; Jeffrey Hall, MD;** and **Robert Kang, MD**. Our mission was to provide free surgical repair of cleft lip and palate to all children in need. We also performed several reconstructive and cosmetic surgeries.

I was fortunate to accompany the group, which travels to Guatemala every August and February, by receiving one of the AAO-HNSF Humanitarian Efforts Committee Travel Grants.

An indigenous woman waits while one of her children has his cleft palate repaired.

The CRISP Foundation has traveled to Guatemala since the organization was established in 1997, and currently partners with Hospital Privado Shalom. With the help of local physicians who work at the hospital, missionaries, and local advertising, children come from all over with unrepaired cleft lip and palate, scar division, and other surgical needs.

When we arrived on Monday morning, there were at least 60 people in the waiting room. We didn't have translators that day, so my Spanish came in handy. We saw patients until 4:00 pm and then operated until 11:00 pm. Our team consisted of three fellowship-trained facial plastic surgeons, two general plastic surgeons, a nurse anesthetist, a facial plastics fellow, two volunteers (scrub techs and OR circulator) and myself, a fourth-year OHNS resident.

With one large operating room consisting of three OR tables and two anesthesia machines, cleft lip, palate, and reconstructive surgeries were performed under general anesthetic. Mole removal, scar revision, blepharoplasty, and other minor procedures were performed on the third table under local anesthesia. About 15 cases were performed each day, with more than half being cleft palate repair.

The February 2012 team enjoying a nice dinner at the end of the week.

Other cases included sinus surgery on a young girl with severe polyps (without endoscopes and navigation) and a paramedian forehead flap on a young woman who needed nasal ala and tip reconstruction. We brought anesthetic agents and surgical trays and instruments, and suitcases full of sutures, needles, syringes, gauze, tape, skin adhesives, and pain medication. Since the patients and their families were from remote villages, many of them camped out in the hospital during the week.

This trip was amazing and I highly recommend participation in a surgical mission trip. My passion for medicine was re-energized and I look forward to incorporating annual surgical missions into my career.

VIII Balkan Congress of Otorhinolaryngology–Head and Neck Surgery

Eugene N. Myers, MD, FRCS, Edin (Hon)

With 362 participants from more than 40 countries, the VIII Balkan Congress of Otorhinolaryngology–Head and Neck Surgery took place June 10-12, at the President Hotel, Tirgu Mures, Romania. Professor Gheorghe Muhlfay, MD, University of Medicine and Pharmacy, organized and presided over the meeting. An elegant opening ceremony took place on Sunday, June 10, in the Culture Palace's Great Chamber with a delightful organ concert, offered by Ms. Molnar Tunde, followed by a cocktail party and the President's Faculty Dinner. As the Congress' Honorary President, I gave an invited lecture.

The well-organized program featured outstanding guest faculty from the Balkans, other European countries, and the United States. The program content was broad enough to appeal to everyone in otolaryngology with lectures on hearing loss, balance disorders, rhinology, and cancer of the head and neck. Featured panels on cochlear implants included one with Piotr Henryk Skarzynski, MD, and audiologists Margaret Price and T. J. George, and an excellent companion piece, the MED-EL Symposium. Other scientific sessions covered obstructive sleep apnea, laryngeal neoplasia, cancer of the head and neck, and rhinology, cervical endocrine, and plastic facial surgery. There was also a poster session.

The Gala Dinner at the President Hotel featured an outstanding group of young Romanian dancers in costumes typical of the ethnicities in Transylvania. The day after the closing ceremony on June 12, the guests took a trip to the Cheile Turzii salt mines followed by dinner at Sighisoara's medieval castle. Overall, the meeting was outstanding, enjoyable, and was done at a very high level.

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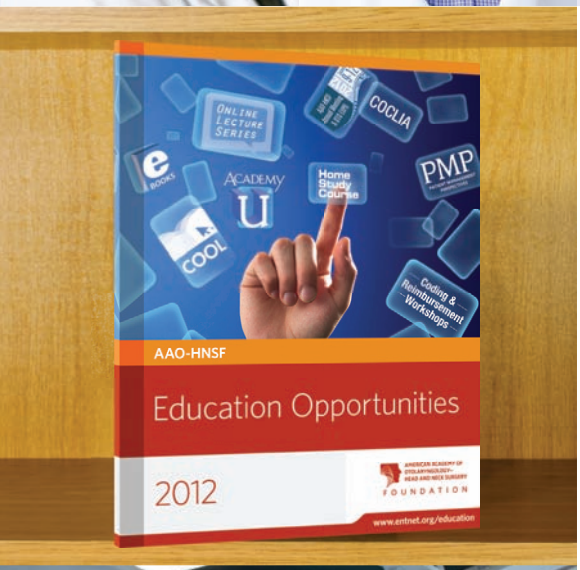

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Nationwide Children's Hospital Pediatric Otolaryngology Outreach to Managua, Nicaragua

Melissa A. Scholes, MD

On January 23, **Meredith N. Merz, MD**, led a humanitarian mission from Nationwide Children's Hospital to Managua, Nicaragua, sponsored by Assemblies of God. I accompanied Dr. Merz as the pediatric otolaryngology fellow, joined by pediatric anesthesiologist Iwona Bielaska, MD, and family physician Brian D. Williams, MD.

Our team, "La Brigada," volunteered at Managua's Hospital Lenin Fonseca, a public hospital and training center for otolaryngology residents. Our focus was to perform otologic surgeries in children, as there are no pediatric otolaryngologists in Nicaragua and few otolaryngologists who perform any type of ear surgery. Nicaragua is the poorest country in Central America and second poorest in the Western Hemisphere. Supplies were tight, but the doctors at Lenin Fonseca do an amazing job with what they have. Nothing goes to waste, and what we consider disposable is reused for as long as possible.

Our first day was spent meeting potential surgical candidates in the clinic.

Dr. Scholes and Dr. Merz (in scrubs) interacting with attendings and residents in clinic.

We worked among the attendings and residents where there was a whirlwind of teaching and pathology. Noemi Callazo, the missionary for Assemblies of God in Nicaragua, was helpful in translating and facilitating communication. She has a working relationship with the doctors at the hospital, and helps facilitate care for those with the greatest need. The residents screen patients throughout the year for visiting teams and they did an excellent job performing pre-operative work-up.

Our next three days were spent in the operating room. As with most equipment, there is a desperate need for operating microscopes in Nicaragua. We brought a microscope head and light source to attach to an existing stand and ear instruments and supplies that were generously donated through Medtronic. The majority of surgeries were otologic. The residents enjoyed learning more detail about ear anatomy and surgery. An urgent tracheostomy was performed on a newborn and a bronchoscopy on a child with a strangulation injury. Dr. Bielaska also had the opportunity to teach the anesthesiology residents about pediatric anesthesia. Dr. Williams saw patients and served as a liaison for the Nationwide Children's Hospital team and the doctors from Lenin Fonseca.

This was the first humanitarian trip for Dr. Merz, Dr. Bielaska, and me. It is difficult to express the total of our experience—we were challenged, humbled, and stimulated at every turn. Thank you to the AAO-HNSF Humanitarian Efforts Committee and Alcon Foundation for their support.

Dr. Scholes at microscope while Dr. Merz explains a tympanomastoidectomy to the residents. Dr. Bielaska is in the background teaching an anesthesia resident.

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Aspen at Night Photo, Hal Williams

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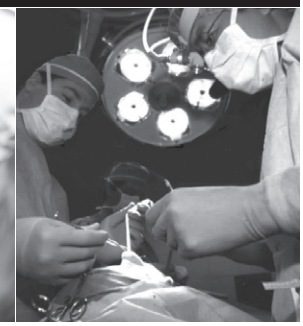

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MaineGeneral Medical Center in Augusta, Maine is seeking a BC/BE ENT/Otolaryngologist. You will join an established practice with a strong referral base with opportunity to specialize. This state-of-the-art office space has been completely renovated and is located beside our Allergy and Audiology departments. We offer excellent benefits including three pension plans, relocation assistance, loan forgiveness, and competitive salary. We are located in scenic central Maine, just a short drive away from ski resorts, lakes and rivers, award-winning golf courses, abundant hiking trails, and the beautiful Maine coast. We are just an hour north of Portland, Maine's largest city, and three hours from Boston. MaineGeneral is currently building a new, state-of-the-art, 192-bed regional hospital to open in late 2013 that will consolidate inpatient hospital services in Augusta. Visit ournewhospital.org for details!

Please send CV to Lisa Nutter, Physician Recruiter at lisa.nutter@mainegeneral.org, call 1-800-344-6662, or visit mainegeneral.org for more information.

McLeod Health
Florence, South Carolina

A two doctor private practice in Florence, South Carolina is recruiting a Board Certified/Eligible ENT physician. Call will be 1/5. This highly reputable, busy practice is well-equipped with microscopes in each exam room, fiber optic laryngoscopes and sinus scopes, and audiology services. EMR has been implemented in the practice, including radiology and e-prescribing.

The population of Florence and its surrounding area is approximately 200,000 people. In the 12 county referral area the population is nearly 1,000,000 people. The geographic location is such that you can reach our capital city, Columbia, in an hour, historic Charleston in about 2 hours and the beaches in 1 hour. The mild climate allows us to utilize the excellent recreational opportunities on nearly a year-round basis.

For more information, contact:
Tiffany Ellington
843-777-5169
tellington@mcleodhealth.org.
Please visit our website: www.mcleodhealth.org and www.farrellmckayent.com.

The University of Kansas Department of Otolaryngology-Head & Neck Surgery is seeking a laryngologist, a head and neck surgeon, and a rhinologist/skull base surgeon who are interested in full-time academic positions.

The successful candidate will have fellowship training with expertise in their specialty and is BC/BE. The candidate will join as an Assistant or Associate Professor and will be involved with resident and medical student education while developing a strong clinical practice and research interests.

Laryngologist
Position Number M0204650
Join a busy voice and swallow team with a state-of-the-art laryngeal lab and experienced speech pathology support.

Head and Neck Surgeon
Position Number M0203642
Join a division of four head and neck surgeons. Fellowship in microvascular surgery, surgical oncology and an interest in oncologic research preferred.

Veterans Affair Clinician/Scientist
The Department is looking for a full-time VA position with potential for VA research funding. Ideally this position will allow 50% protected time for research.

Head and Neck Fellowship
Clinical Focus: Head and Neck Surgical Oncology, Skull Base Surgery, Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery and Robotic Surgery.

Applications are accepted through the American Head and Neck Society: **www.ahns.info**.

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

To view position online, go to http://jobs.kumc.edu
(Search by position number.)

Letters of inquiry and CV may be mailed to:
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

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

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Three-person highly regarded and well-established otolaryngology group seeks a General or Subspecialty-trained Otolaryngologist to join their busy practice. Large referral base. Their new office is just minutes from the hospital. Traditional practice: office visits, hospital consults, and surgery for adults and children. Call 1 in 4. Competitive salary, bonus opportunity, full benefits, and paid malpractice are offered. Short partnership track and surgery center investment opportunity.

The New Jersey suburbs of Philadelphia offer outstanding schools, beautiful homes, fantastic shopping, and many recreational and social amenities without the Philadelphia wage tax. The local towns are highly desired by young professionals. All are less than 20 minutes to Center City restaurants, stadiums, theaters and nightlife. Be at the Jersey shore in less than an hour and in NYC or Baltimore/Washington in 90 minutes!

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For more information, please contact:

Ken Sammut
888.372.9415 • ksammut@cejkasearch.com

ID#143194AD cejkasearch.com

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**

Mid-Kansas Ear Nose & Throat
Division of Wichita Surgical Specialists, P.A.

Mid-Kansas Ear Nose & Throat is looking to replace a retiring physician with a full time board certified or board eligible Otolaryngologist.

Our practice includes 6 physicians and 2 mid-levels, Allergy, CT, Speech and Voice, Audiology and Hearing Aid services. Two practice locations in Wichita, Kansas with a strong referral base. Seeking highly motivated professional associate to join our team.

Competitive financial and benefit package and future partnership shareholder opportunity. Low overhead and an income potential greater than the 95th percentile make this an excellent practice to join. (No Facial Trauma coverage required)

As the largest city in the state of Kansas, Wichita is a thriving community. Excellent schools, a diverse range of cultural, sports and recreational opportunities combined with low cost of living are just a few of the many things Wichita has to offer.

Please submit resume or contact:
Mid-Kansas Ear Nose & Throat
310 S Hillside Wichita, KS 67211
316-928-4973 Fax 316-684-3326
Email: jstephens@midkansasent.com

UMDNJ NJNJ Neurological Institute of New Jersey

Faculty Position
Dept of Otolaryngology-Head and Neck Surgery

The University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Department of Otolaryngology-Head and Neck Surgery is recruiting a fellowship-trained Head and Neck Surgeon to join our expanding faculty. Experience in head and neck oncologic clinical or basic research is desirable. The successful applicant will join a busy Head and Neck Division, working in a multidisciplinary tertiary care academic setting. Fellowship training in Head and Neck Surgery is required.

Applicants for this position must be able to perform at a high level both clinically and academically. Salary will be commensurate with ability, training, experience and demonstrated prior performance, and is designed to attract an outstanding surgeon.

Submit inquiries and current Curriculum Vitae to:

Soly Baredes, M.D.
Professor and Chairman

Aaron Hajart, MS, ATC
Sr. Director of Administration

UMDNJ-New Jersey Medical School
Department of Otolaryngology-Head and Neck Surgery
90 Bergen Street, Suite 8100
Newark, NJ 07103
(973) 972-2341
hajartaf@umdnj.edu

Pediatric Otolaryngologist Faculty Advertisement

The Department of Otolaryngology - Head and Neck Surgery at Saint Louis University, a Catholic, Jesuit institution dedicated to student learning, research, health care and service is seeking applications for a Fellowship Trained Pediatric Otolaryngologist beginning summer 2013. The position is based at the Sisters of St. Mary Cardinal Glennon Children's Medical Center. Appointment in Pediatric Otolaryngology is available at the level of Assistant/ Associate Professor. Candidates must be Board Certified in Otolaryngology - Head and Neck Surgery.

SSM Cardinal Glennon Children's Medical Center is a 160-bed free-standing hospital located in midtown Saint Louis, adjacent to Saint Louis University and Saint Louis University Hospital. The Hospital serves a diverse population from the inner city, the metropolitan area and a 200-mile referral radius. St. Louis is an urban center with a population of 2½ million and ample cultural, sports and entertainment opportunities.

Interested candidates must submit a cover letter, application and current curriculum vitae to: https://jobs.slu.edu. Review of applications begins immediately and continues until the position is filled.

For further information contact:
Mark A Varvares, M.D., Chairman
Department of Otolaryngology – Head and Neck Surgery
Saint Louis University School of Medicine
3635 Vista at Grand Boulevard
6th fl, FDT
St. Louis, MO 63110-0360
varvares@slu.edu

Saint Louis University is an affirmative action, equal opportunity employer and encourages nominations and applications of women and minorities.

THE UNIVERSITY OF UTAH

Head and Neck Oncology Surgeon/Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks BC/BE faculty with fellowship training in head and neck oncology. This is a full-time tenure track position. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/16564
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: clough.shelton@hsc.utah.edu

Dedicated to physicians who are dedicated to children.

Join our Pediatric Otolaryngology team in Jacksonville, FL.

As part of one of the premier pediatric health care systems in the nation, the Nemours Children's Clinic, Jacksonville is an 80+ physician pediatric subspecialty practice. Currently, we're looking for a full-time Pediatric Otolaryngologist to join our established 6-physician division with complete speech and audiology services. Ancillary services are available on site. Candidates must be fellowship-trained in Pediatric Otolaryngology, be BC/BE in Otolaryngology, and have a strong interest in clinical care, education and research.

Our opening for Pediatric Otolaryngologists offers:

- A 100% pediatric case mix
- Excellent benefits and relocation packages
- Opportunity for academic appointment to the Mayo Medical School
- A beautiful Florida lifestyle – urban, suburban or coastal

For information, contact:
Brian Richardson, Nemours Physician Recruiter
407-650-7670 or brichard@nemours.org

Learn more at Nemours.org.

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UF UNIVERSITY of FLORIDA
College of Medicine
Jacksonville

University of Florida College of Medicine–Jacksonville Seeks Otolaryngologist

The University of Florida College of Medicine–Jacksonville, Department of Surgery, Division of Otolaryngology, seeks a full-time faculty member at the tenure or non-tenure accruing level of Assistant/Associate Full-time Professor.

This is an opportunity for expanding a fast-growing academic practice. It offers a diverse clinical population allowing any specialty area of focus. No trauma call. Satellite clinic; Outpatient surgical center. Major responsibilities include teaching, patient care, administration and research. Responsibilities may also include serving as the Division Chief based upon experience and interest. MD, DO and Board Certified or Board Eligible in Otolaryngology. Competitive salary and excellent benefits.

Application deadline is open until position is filled. **Send CV and three letters of recommendation to:** Search Chair, Iman Naseri, M.D. Position number 00017206, Department of Surgery, 653 West 8th Street, Jacksonville, FL 32209 or e-mail iman.naseri@jax.ufl.edu or fax to (904) 244-7730.

The University of Florida is an equal opportunity institution dedicated to building a broadly diverse and inclusive faculty and staff.

THE UNIVERSITY OF NORTH CAROLINA
SCHOOL OF MEDICINE

PEDIATRIC OTOLARYNGOLOGY FELLOWSHIP
July 1, 2014 – June 30, 2015

The Department of Otolaryngology – Head & Neck Surgery is currently seeking candidates for the one-year clinical fellowship position in Pediatric Otolaryngology. The University is home to the North Carolina Children's Hospital – ranked in the top 10 by U.S. News & World Report for the care of children with respiratory disorders. Multi-disciplinary centers at UNC include the N.C. Children's Airway Center, the UNC Craniofacial Center and the UNC Pediatric Cochlear Implant Team. Fellows also benefit from a significant experience in cleft lip and palate care through the Division of Plastic and Reconstructive Surgery. Call responsibilities are flexible and for pediatric ENT patients only.

A letter of interest, curriculum vitae and two letters of recommendation should be sent to:
Austin S. Rose, MD
Director, Pediatric Otolaryngology Fellowship Program
Department of Otolaryngology – Head & Neck Surgery, CB #7070
University of North Carolina School of Medicine
Chapel Hill, NC 27599-7070
(919) 966-3342

Candidates must also register with the
San Francisco Matching Program - www.sfmatch.org
The University of North Carolina at Chapel Hill
is an equal opportunity/ADA employer.

PRESBYTERIAN HEALTHCARE SERVICES
Albuquerque, NM

Presbyterian Medical Group is seeking two BC/BE otolaryngologists to join our outstanding, well-established group of ENT providers. Have a satisfying full-spectrum ENT practice with a large built-in referral base while at the same time enjoying a great quality of life in the beautiful Southwest. ER call 4 days/month. Practice call shared equally among group. Our medical group employs more than 600 primary care and specialty providers and is the fastest growing employed physician group in New Mexico.

In addition to a competitive guaranteed base salary, plus productivity bonus, we offer a generous sign-on bonus, quality bonus, malpractice, relocation, house hunting trip, health, dental, vision, life ins, 403(b) w/contribution and match from employer, 457(b), short & long term disability, CME allowance, etc.

Albuquerque thrives as New Mexico's largest metropolitan center and has been listed as one of the best places to live in the United States by several major publications. A truly diverse and multicultural city, Albuquerque offers you and your family a wide variety of experiences, outdoor activities and entertainment. It is also home to the University of New Mexico, a world renowned institution.

Contact Michael Criddle, MD at mcriddle@phs.org or Kay Kernaghan, Physician Recruiter, kkernagh@phs.org or 505-823-8770 for more information or to forward CV. Please visit our website at www.phs.org

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Dynamic, energetic ENT group offers you the opportunity like no other to practice and live in beautiful suburban Philadelphia. This multi office practice requires minimum on call schedule and offers predominantly outpatient ENT care with high earnings, top of the line benefits and partnership. Enjoy your daily practice, be home with your family for dinner and reap the benefits of your hard work.

For a unique lifestyle opportunity...

Call Deborah Bovee for further details
610-279-1414 x104

University of Maryland Otorhinolaryngology

The Department of Otorhinolaryngology — Head and Neck Surgery is seeking a board certified or board eligible, full-time, academic Pediatric Otolaryngologist to join the faculty. The candidate should be fellowship trained in Pediatric Otolaryngology. Responsibilities include teaching of medical students and residents, patient care and clinical/basic science research.

Faculty rank, tenure status and salary will be commensurate with the level of experience.

Qualified applicants should submit their Curriculum Vitae and the names of three references to:

Kevin D. Pereira, M.D., M.S. (ORL)
Director of Pediatric Otolaryngology
Dept of Otorhinolaryngology — Head & Neck Surgery
University of Maryland
16 South Eutaw St., Suite 500
Baltimore, MD 21201-1619

The University of Maryland encourages women and minorities to apply and is an AA/EEO/ADA employer.

UCSF

FACIAL PLASTICS/AESTHETICS DEPARTMENT OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

UCSF Department of Otolaryngology-Head and Neck Surgery seeks a facial plastic and reconstructive surgeon to focus on reconstructive head/neck surgery and microvascular surgery. Individual should seek an academic career, with strong interest in resident and fellow education, as well as clinical research. The selected candidate will work as part of a busy Head and Neck Oncologic surgery practice within an NCI-designated Comprehensive Cancer Center. There is significant growth potential, with a new dedicated adult cancer hospital opening in 2015. Must demonstrate superior patient care skills, and ability to work as part of a multi-disciplinary surgical team.

Candidates must be MD/ or MD/PhD and completion of an accredited residency in otolaryngology/head and neck surgery. Must be BE/BC. Demonstrated experience in microvascular surgical technique preferred.

Please forward a letter of inquiry and C.V. to:

P. Daniel Knott, MD
Chairman, UCSF Search Committee
Associate Professor
Director, Division of Facial Plastic and Reconstructive Surgery
Department of Otolaryngology - Head and Neck Surgery
University of California, San Francisco
2233 Post Street, 3rd Floor, Box 1225
San Francisco, CA 94115
Telephone (415) 502-0498
Fax (415) 885-7546
pdknott@ohns.ucsf.edu

Search number # M-3581

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Affirmative Action/Equal Opportunity Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for person with disabilities, and for covered veterans.

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).

Pediatric Otolaryngology - Academic Position

The Department of Otorhinolaryngology is recruiting a third Pediatric Otolaryngologist to join a busy, tertiary Pediatric Otolaryngology practice. This is a unique opportunity to join a rapidly growing Department at a major University Children's Hospital with a large Level III NICU and a Level I Trauma Center. Excellent compensation and benefits. Academic appointment commensurate with experience. Strong interest in resident and medical student teaching and research is encouraged.

Applicants should forward a CV and statement of interest to:
Soham Roy, MD, FACS, FAAP
Director of Pediatric Otolaryngology
The University of Texas Medical School at Houston
Department of Otorhinolaryngology-Head & Neck Surgery
713-383-3727 (fax)
Soham.Roy@uth.tmc.edu
http://www.ut-ent.org

UTHealth™
The University of Texas Health Science Center at Houston
Medical School

UTMSH is an equal opportunity employer.

THE UNIVERSITY OF UTAH

Head and Neck Oncology Surgeon/Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks BC/BE faculty with fellowship training in head and neck oncology. This is a full-time tenure track position. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/16564
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: clough.shelton@hsc.utah.edu

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

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

Children's Hospital LOS ANGELES
DIVISION OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

Division of Otolaryngology-Head and Neck Surgery
Children's Hospital Los Angeles

Department of Otolaryngology
Keck School of Medicine
University of Southern California

Full-Time Pediatric Otolaryngologist at the Assistant/Associate Professor level.

The candidate must be fellowship trained and either board eligible or certified. Specialty interest and/or training in otology or laryngology would be preferred. The candidate must obtain a California medical license.

CHLA is one of the largest tertiary care centers for children in Southern California. Our new "state-of-the-art" 317 bed hospital building with 85% private rooms opened July 2011. Our group has a nice mix of academic and private practice. Both clinical and basic science research opportunities are available and supported.

Excellent benefits available through USC.
USC values diversity and is committed to equal opportunity in employment. Women and men, and members of all racial and ethnic groups are encouraged to apply.

Please forward a current CV and three letters of recommendation to:
Jeffrey Koempel, MD, MBA
Chief, Division of Otolaryngology - Head and Neck Surgery
Children's Hospital Los Angeles
4650 Sunset Boulevard MS# 58
Los Angeles, CA 90027

jkoempel@chla.usc.edu
(323) 361-5959

UNIVERSITY OF CONNECTICUT HEALTH CENTER

The Department of Otolaryngology at the University of Connecticut School of Medicine has an immediate openings for a fellowship trained **Rhinologist** and a **Neurotologist** on our faculty.

The positions are available for a recent fellowship trained or an experienced Practitioner. Candidates must be board eligible and actively working toward certification. The positions require a majority of clinical work and will have some protected time for research and teaching purposes. UConn has an active Otolaryngology residency training program consisting of 10 residents. Call is filtered by the residents.

The University of Connecticut pays a highly competitive salary and productivity based compensation package. A benefits package includes health and dental benefits, life and disability insurances, tax-deferred retirement compensation plans with paid vacation and opportunities for continuing medical education.

Please send your CV in confidence to
recruiting@uconnmedicalrecruiting.com.
UConn is an equal opportunity Employer

PEDIATRIC OTOLARYNGOLOGIST DEPARTMENT OF OTOLARYNGOLOGY - HEAD & NECK SURGERY UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

UCSF Department of Otolaryngology-Head and Neck Surgery seeks a pediatric otolaryngologist for a very busy pediatric outpatient clinic and potential work as a pediatric hospitalist. Individual should seek an academic career, with strong interest in resident and fellow education, as well as clinical research. The selected candidate will work as part of a practice with outpatient clinics in outlying geographic areas (Marin, Contra Costa County). There is significant growth potential, with a new dedicated pediatric hospital opening in 2015 (Benioff Children's Hospital). Must demonstrate superior patient care skills, and ability to work as part of a multi-disciplinary surgical team.

Candidate must be MD or MD/PhD and completion of an accredited residency in otolaryngology/ head and neck surgery, as well as Fellowship training in Pediatric Otolaryngology. Must be BE/BC and hold or be eligible for a CA medical license.

Please forward a letter of inquiry and C.V. to:
Kristina Rosbe, MD
Professor, Chair, UCSF Search Committee
Department of Otolaryngology-Head & Neck Surgery
University of California, San Francisco
2233 Post Street, 3rd Floor, Box 1225
San Francisco, CA 94115
Telephone (415) 514-6540
Fax (415) 885-7546
krosbe@ohns.ucsf.edu

Search number # M-3582

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Affirmative Action/Equal Opportunity Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for person with disabilities, and for covered veterans.

Children's Mercy HOSPITALS & CLINICS | Kansas City

Children's Mercy Hospitals and Clinics – Kansas City is seeking fellowship trained Pediatric Otolaryngologists 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.

Our active Pediatric Otolaryngology Section provides comprehensive tertiary patient care in a family-centered environment. There are currently 7 pediatric otolaryngologists on staff, as well as 3 neurotologists. In addition, our ACGME-accredited pediatric otolaryngology fellowship welcomed our 4th fellow this July, 2012. 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.

Kansas City is a bi-state community with close to 2 million residents who enjoy an excellent quality of life. There is a robust offering of arts and entertainment, with a number of new venues having just opened within the past few years. The Kansas City metroplex contains a wide selection of highly rated public and private schools. We are also the regional home to several major colleges and universities. Salary and academic range are commensurate with experience. EOE/AAP

Robert A. Weatherly, MD
Section Chief, Ear, Nose, and Throat
rweatherly@cmh.edu
Phone: 866-CMH-IN-KC/866-264-4652
www.childrensmercy.org

PEDIATRIC OTOLARYNGOLOGY FELLOWSHIP

July 1, 2014 – June 30, 2015
(with optional second year)
BOSTON CHILDREN'S HOSPITAL
HARVARD MEDICAL SCHOOL
Boston, Massachusetts

Address inquiries to:
Reza Rahbar, DMD, M.D.
Associate Chief in Otolaryngology
Director of Education – Fellowship Program
Department of Otolaryngology & Communication Enhancement
Boston Children's Hospital
300 Longwood Avenue, LO-367
Boston, MA 02115
617.355.5064 (Phone)
617.730.0611 (Fax)

email inquiries to: Alanna.boyson@childrens.harvard.edu

Participants in the San Francisco Matching Program (www.sfmatch.org)

THE UNIVERSITY OF UTAH

Rhinologist

University of Utah Otolaryngology–Head & Neck Surgery seeks a BC/BE fellowship-trained Rhinologist at the Assistant or Associate Professor level for a full-time faculty tenure track position. Responsibilities will include patient care, medical student and resident education, and research. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/16550
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: clough.shelton@hsc.utah.edu

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

Tremendous ENT Practice Near Boston
NOW INTERVIEWING

Heywood Hospital

Come to the scenic area of North-central Massachusetts and experience an exquisite blend of a busy private practice and fulfilling personal lifestyle. Heywood Hospital and Health Alliance Hospital, located just a short drive from Boston, are collaborating in an effort to bring an additional ENT physician to join an existing practice within their service area. The combination of a manageable call arrangement and definitive need for additional general otolaryngology care for the area communities makes this a wonderful career choice for anyone seeking a practice opportunity in New England. No concern for sufficient patient volumes exists here!

This established practice, located between Gardner and Leominster, MA, has been in existence for over 10 years and is poised and prepared for growth. Recent renovation and expansion of office space will accommodate this new ENT physician in a very comfortable layout. Both hospitals offer state-of-the-art OR suites, with Heywood Hospital unveiling a brand-new OR platform in 2014. This provides all surgeons on staff with the opportunity to provide input into final details of this new surgical facility.

A very competitive starting income and benefits package awaits you, as does an opportunity for an exceedingly successful practice, both financially and personally. If this is what you have been seeking as it relates to the future of your medical career, this opportunity in Massachusetts will not disappoint.

Central Massachusetts, located in the Heart of New England is a hidden gem of culture, arts, special events and wonder waiting to be discovered. New England is a dynamic area rich in culture and natural beauty. Central Massachusetts in particular, including the communities of Gardner and Leominster, is an area that fully exhibits the character of New England. Rolling hills and deep woodlands create a landscape that has been the centerpiece of countless works of art. Country towns with smiling locals and rising metropolitan areas come together to form the heart of New England. Few areas in the Northeast offer so much so close!

For more information, please contact:
Michelle Kraft
800-678-7858 x64457 | mkraft@cejkasearch.com

ID#145978AD

cejkasearch.com

UCSF

HEAD & NECK ENDOCRINE SURGEON
DEPARTMENT OF OTOLARYNGOLOGY - HEAD & NECK SURGERY
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Full-time academic position for a clinician or clinician-scientist with expertise in Head and Neck Surgery with an emphasis on Thyroid and Parathyroid Surgery. Academic rank depends upon qualifications. Candidates must be board certified or eligible, and eligible for a California medical license. Candidates will be expected to participate in clinical training and research programs for medical students and residents.

Please forward a letter of inquiry and C.V. to:

Lisa Orloff, MD, FACS
Chair, UCSF Search Committee
Department of Otolaryngology-Head and Neck Surgery
University of California, San Francisco
2233 Post Street, 3rd Floor, Box 1225
San Francisco, CA 94115
Telephone (415) 885-7528
Fax (415) 885-7711
lorloff@ohns.ucsf.edu

Search number # M-3329

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Affirmative Action/Equal Opportunity Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for person with disabilities, and for covered veterans.

THE UNIVERSITY OF UTAH

Sleep Apnea Surgeon

University of Utah Otolaryngology–Head & Neck Surgery seeks a BC/BE Fellowship trained Sleep Apnea Surgeon at the Assistant or Associate Professor level for a full-time faculty tenure track position. A dental background is desirable but not required. Responsibilities will include patient care, medical student and resident education, and clinically oriented research. Position available July 2013.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/16535
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: clough.shelton@hsc.utah.edu

WestVirginiaUniversity.

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2013. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

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

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

The position will remain opened until filled. Please send a CV with three professional references to:

Laura Blake
Director, Physician Recruitment
Fax: 304-293-0230
blakel@wvuhealthcare.com
http://www.hsc.wvu.edu/som/otolaryngology/

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

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We have state of the art offices offering allergy, comprehensive audiology services, FEESST/Stroboscopy, and in office CT scanners.

Office locations on Long Island, and in the New York City Boroughs.

Contact Carlos Lopez at
cell # 516-220-6448
or email to nyents@optonline.net

***** Onsite interviews will be available at the AAO-HNS annual meeting in Washington, D.C. *****

University Hospitals Case Medical Center

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

Academic Otolaryngology Opportunities

University Hospitals Medical Group (UHMG), the unified faculty practice plan of University Hospitals of Cleveland (UH), is comprised of several practices representing medical and surgical specialties located within University Hospitals Case Medical Center and throughout Northeastern Ohio. As part of our historic primary affiliation, UHMG physicians serve on the faculty of Case Western Reserve University School of Medicine. UHMG strives to champion the success of the physician practices and UH in fulfilling our mission: To Heal. To Teach. To Discover.

Due to increased patient demand and institutional support for expansion, the Department of Otolaryngology - Head and Neck Surgery at University Hospitals Case Medical Center in Cleveland, Ohio is seeking to add the following full time academic faculty positions:

- Rhinologist- Allergy Surgeon (fellowship trained)
- Otologist/Neurotologist (fellowship trained)
- Pediatric Otolaryngologist (fellowship trained)
- Head and Neck Surgeon Scientist with a focus on squamous cell carcinoma research
- General Otolaryngology with an interest or additional training in sleep medicine
- Laryngologist trained in tracheotomy care, voice surgery and cartilage research (fellowship trained)

We offer a comprehensive compensation package and excellent benefits including CME funding, paid vacation and educational time, medical, dental and vision coverage and more. University Hospitals is proud to be an equal opportunity employer.

Candidates may forward a current CV to: Stacy.Porter@UHhospitals.org or mail to:

Cliff A. Megerian, MD
Chair, Department of Otolaryngology-Head and Neck Surgery
Director, Ear, Nose and Throat Institute
c/o Stacy M. Porter, Manager of Institute and Department Practices
11100 Euclid Avenue
Mailstop LKS 5045

University Hospitals

Head and Neck Surgery and Reconstruction Fellowship

The Department of Otolaryngology-Head and Neck Surgery in conjunction with University Hospitals Case Medical Center and the Seidman Cancer Center is proud to announce the establishment of a one-year Head & Neck Surgery and Reconstruction fellowship beginning **July 2013**. The head and neck surgical team includes **Drs**. **Pierre Lavertu**, **Rod Rezaee** and **Chad Zender**.

This one year fellowship offers advanced training in:

- Microvascular free tissue transfer
  - **Over 120 cases per year**
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
  - Transoral laser a nd transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Fellowship requirements and opportunities include:

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

Applicant requirements:

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

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

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

2013 CORE GRANT FUNDING OPPORTUNITIES

| www.entnet.org/CORE

CORE

CENTRALIZED OTOLARYNGOLOGY RESEARCH EFFORTS

Submission Deadlines

Letter of Intent (LOI) to be submitted electronically by **December 17, 2012 midnight ET**
Application to be submitted electronically by **January 15, 2013 midnight ET**

THE ALCON FOUNDATION

The Alcon Foundation/AAO-HNSF Resident Research Grant $10,000, non-renewable, one year to complete project. One available annually.

AMERICAN ACADEMY OF OTOLARYNGIC ALLERGY (AAOA) FOUNDATION

AAOA Foundation Research Grant $45,000, non-renewable, one to two years to complete project. One available in 2013.

AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY (AAO-HNSF)

AAO-HNSF Resident Research Award $10,000, non-renewable, one year to complete project. Up to eight available annually.

AAO-HNSF Maureen Hannley Research Grant $50,000, renewable, one to two years to complete project. One available annually.

AAO-HNSF Percy Memorial Research Award $25,000, non-renewable, one year to complete project. One available annually.

AAO-HNSF Health Services Research Grant $10,000, non-renewable, one year to complete project. Up to two available annually.

NEARLY $750,000 AWARDED BY THE CORE SPECIALTY SOCIETIES, FOUNDATIONS AND INDUSTRY SUPPORTERS IN 2012!

AMERICAN HEAD AND NECK SOCIETY (AHNS)

AHNS Pilot Grant $10,000, non-renewable, one year to complete project. One available annually.

AHNS Alando J. Ballantyne Resident Research Pilot Grant $10,000, non-renewable, one year to complete project. One available annually.

AHNS/AAO-HNSF Young Investigator Combined Award $40,000 ($20,000 per year), non-renewable, two years to complete project. One available annually.

AHNS/AAO-HNSF Translational Innovator Combined Award $80,000 ($40,000 per year), non-renewable, two years to complete project. One available annually.

AMERICAN HEARING RESEARCH FOUNDATION (AHRF)

AHRF Wiley H. Harrison, MD Grant $25,000, non-renewable, one year to complete project. One available annually.

AMERICAN LARYNGOLOGICAL ASSOCIATION (ALA)

ALA Award, $10,000, non-renewable, one year to complete project. One available annually.

THE AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, INC., AKA THE TRIOLOGICAL SOCIETY

The Triological Career Development Award $40,000, non-renewable, one to two years to complete project. Five awarded annually.

AMERICAN RHINOLOGIC SOCIETY (ARS)

ARS New Investigator Award $25,000 ($12,500 per year), non-renewable, two years to complete project. One available annually.

ARS Resident Research Grant $8,000, non-renewable, one year to complete project. Two available annually.

AMERICAN SOCIETY OF PEDIATRIC OTOLARYNGOLOGY (ASPO)

ASPO Research Grant $20,000, non-renewable, one year to complete project. Two available annually.

COOK MEDICAL

Cook Medical/AAO-HNSF Resident Research Grant $10,000, non-renewable, one year to complete project. One available annually.

THE DOCTORS COMPANY FOUNDATION

The Doctors Company Foundation/AAO-HNSF Resident Research Grant $10,000, non-renewable, one year to complete project. One available annually.

THE EDUCATIONAL AND RESEARCH FOUNDATION FOR THE AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY (AAFPRS)

AAFPRS Leslie Bernstein Grant $25,000, non-renewable, up to three years in which to complete project. One available annually.

AAFPRS Leslie Bernstein Resident Research Grant $5,000, non-renewable, up to two years to complete project. Two available annually.

AAFPRS Leslie Bernstein Investigator Development Grant $15,000, non-renewable, up to three years to complete project. One available annually.

HEARING HEALTH FOUNDATION (HHF)

Hearing Health Foundation Centurion Clinical Research Award $7,500, non-renewable, one year to complete project. One available annually.

KNOWLES HEARING CENTER AT NORTHWESTERN UNIVERSITY

Knowles Center Collaborative Grant $30,000, non-renewable, one year to complete project. One available annually.

THE OTICON FOUNDATION

The Oticon Foundation/AAO-HNSF Resident Research Grant $10,000, non-renewable, one year to complete project. One available annually.

THE PLASTIC SURGERY FOUNDATION (PSF)

PSF/AAO-HNSF Combined Grant $20,000, non-renewable, one year to complete project. One available in odd numbered years.

For more information about these grants and the application process visit: www.entnet.org/CORE.
Questions? Contact Stephanie L. Jones sljones@entnet.org or Sarah O'Connor soconnor@entnet.org

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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* Independent research completed 11/08 by Kelton Research