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The official Member magazine of the American Academy of Otolaryngology—Head and Neck Surgery

APRIL 2016



Get to know the candidates for AAO-HNS president-elect, audit committee, director at large, and nominating committee before the election e-ballot goes live in May.

Toning down noise-induced hearing loss 24

Antimicrobial stewardship in otolaryngology **28**



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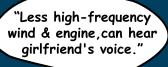
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inside this issue

bulletin

Volume 35, No. 3

The Bulletin (ISSN 0731-8359) is published 11 times per year (with a combined December/January issue) by the American Academy of Otolaryngology—Head and Neck Surgery 1650 Diagonal Road Alexandria, VA 22314-2857 . 1-703-836-4444

The Bulletin publishes news and opinion articles from contributing authors as a the *Bulletin* in no way constitutes approval or endorsement by AAO-HNS of products or services advertised unless indicated as such.

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INQUIRIES AND SUBMISSIONS

Postmaster: Send address changes Otolaryngology—Head and Neck Surgery, 1650 Diagonal Road, Alexandria, VA 22314-2857

Return undeliverable Canadian addresses to PO Box 503, RPO West Beaver Creek, Richmond Hill, Ontario, Canada L4B 4R6 Publications Mail Agreement NO. 40721518

Otolaryngology—Head and Neck Surgery

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Informing your vote

The e-ballot for the AAO-HNS candidate election goes live in May





Toning down noise-induced hearing loss



Antimicrobial stewardship **4**8

READ MORE ONLINE

Longer articles available: Restoring hearing in American Samoa

10

Better Hearing and Speech Month: Toning down noise-induced hearing loss 24

departments

The leading edge

Great slate of candidates 3 by Sujana S. Chandrasekhar, MD

Opportunities abound by James C. Denneny III, MD

At the forefront

5

2016 federal legislative priorities for AAO-HNS . What to expect from Congress . On the road . Counting down to the Annual Meeting - CPT Assistant: drug-eluting sinus implant (CPT 0406T, 0407T) Web portal puts Members' humanitarian activity on the map Restoring hearing in American Samoa .. Correctly coding CPT 69209 .. Board of Governors: Our presidential election ...



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Great slate of candidates

n this issue of the Bulletin, our future leaders get the chance to tell us about themselves. Each candidate is competing against colleagues and friends. Many have worked together on Academy projects. I remember agonizing about what to write for my statement. Do I throw all humility to the wind and crow on about how incredibly awesome I am? Or do I speak in my real voice and say that I want to serve, and you should think about voting for me, but the other candidates are fantastic too? The Nominating Committee reviewed a large number of terrific applications and held thoughtful, confidential discussions about who would be able to carry our mission forward. The ensuing slate of nominations reflects the serious nature of those deliberations, and presents our membership with several great choices. When Jennifer Derebery, MD, and Nancy L. Snyderman, MD, ran for president, they famously said that they wished it could have been a co-presidency, so that both could serve.

The first time I lost an Academy election, I was struck by the comforting tone of that phone call from the past president, urging me to keep at it. Although it's nice to win (really, it is!), it is really nice that those who do not win this time continue to contribute time, energy, and knowledge to the Academy/Foundation and continue to participate at all levels. Please read the statements knowing that each nominee's experience reflects a portfolio of service, accomplishment, and dedication. And then don't forget to vote when the balloting opens on May 6. The election cycle was shortened in order to encourage more Members to vote and allows the new president elect a few months of ramp-up time before the Annual Meeting. Voting will close on June 8. Don't miss the opportunity to let your voice be heard.

At the AAO-HNS/F Leadership Forum & BOG Spring Meeting in Alexandria, VA, in March, we had a jam-packed weekend of activities highlighting specialty unity, the socioeconomic and grassroots work of our Members in the Board of Governors, presentations by the candidates for president-elect, and events pertaining to the Section for Residents and Fellows, the Young Physicians Section, and the Women in Otolaryngology Section. I encourage you to sign up for the e-newsletters from these important components of our Academy, and/or to join ongoing conversations on ENTConnect. It is the fastest way to keep up with changes in MOC, PQRS, MU, GME, and all of the rest of the alphabet soup that affects our lives. And

keep checking the Academy's website for updates on our very own clinical data registry (CDR), RegentSM.

Specialty Unity. What does that mean? The Academy serves all otolaryngologist-head and neck surgeons, both generalists and specialists. It provides educational resources for primary and continuing medical education and materials for us to share with non-otolaryngologists: referring physicians, allied health professionals, our patients, their families, and the public. The Academy provides our collective voice to legislators and regulators, participates in salient coalitions to advance healthcare topics, and is the go-to ENT authority for the media. It is the only group that can develop and manage a specialty-wide clinical data registry, including all areas within the scope of otolaryngology practice, so that we working docs can participate in the new healthcare delivery system. The specialty societies' missions are to advance and share specialty knowledge. They participate at the Academy via the Specialty Society Advisory Council (SSAC), which has members from the Academy, the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), the American Academy of Otolaryngic Allergy (AAOA), the American Broncho-Esophagological Association (ABEA), the American Head and Neck Society (AHNS), the American Laryngological Association (ALA), the American Neurotology Society (ANS), the American Otological Society (AOS), the American Rhinologic Society (ARS), the American Society of Pediatric Otolaryngology (ASPO), and The Triological Society. The productive Specialty Summit in March served to strategize ways that the Academy and specialty societies can work together to improve otolaryngology overall.

April has some interesting days of note, starting with April Fool's day on the first, Major League Baseball Opening Day on the fourth, and Earth Day on the 22nd. As otolaryngologists, we commemorate Oral, Head and Neck Cancer Awareness Week (OHAN-CAW) April 10-16, and World Voice Day on April 16.

The entire month of May, Better Hearing and Speech Month, "speaks" volumes to many of us and our patients. What a great way to highlight otolaryngology's team approach to hearing and language.

For all these special awareness days, there are materials to help you educate your patients and colleagues on these important public health ENT issues, both here in this edition of the *Bulletin* and on the website at www.entnet.org. Enjoy!



Sujana S. Chandrasekhar, MD AAO-HNS/F President



Read the statements
knowing that each
nominee's experience
reflects a portfolio of
service, accomplishment,
and dedication.







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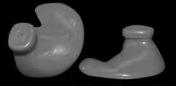


blue, non-vented* * don't use for scuba-diving





clear, vented -(safe for scuba)



red, vented -(safe for scuba)

Opportunities abound

he recently concluded AAO-HNS/F
Leadership Forum & BOG Spring Meeting,
hosted in Alexandria, VA, was one of
the most comprehensive gatherings I've
attended in some time. The meeting was
highlighted by the Specialty Unity Summit,
the Boards of Directors planning meeting, the Board of
Governors assembly, and the unveiling of the recently
renovated Otolaryngology-Head and Neck Surgery
History exhibit at Academy headquarters. The Program
Advisory Committee, the Specialty Society Advisory
Committee (SSAC), and Section leaders (SRF, YPS,
WIO) all met. The weekend concluded with Capitol Hill
visits by our leaders on Monday.

The Specialty Unity Summit featured a review of collaborative initiatives undertaken since last year's inaugural meeting including common advocacy issues, CPT/RUC matters, shared educational materials, resident work hour regulations, USP 797 concerns, Maintenance of Certification, and registry implementation. Further conversations occurred in the subsequent SSAC meeting that followed. It is quite clear that intentional efforts to work together benefits the members and patients of all involved organizations.

Kudos to David R. Edelstein, MD, chair of the Board of Governors, the Board of Governors Executive Committee, and our staff for planning an exceptional series of topics germane to the ever evolving changes in healthcare. The Board of Governors also hosted the "Candidates Forum," where the president-elect candidates James A. Hadley, MD, and Gavin Setzen, MD, fielded numerous questions from Members. Last year on the recommendation of the Election Review Task Force, chaired by Richard W. Waguespack, MD, we moved the election to spring. This turned out to be very successful and has allowed earlier integration of incoming leaders into their new positions. Please review the candidates' statements in this month's Bulletin and the video of the candidates' presentations at www.entnet.org/content/annual-election and then exercise your right to vote for your leaders!

I would like to thank the Boards of Directors, led by President **Sujana S. Chandrasekhar, MD**, for their participation in a highly productive and educational board meeting in which they reviewed and prioritized our current Strategic Plan prior to the adoption of a final budget. As the Academy navigates the waters of change currently flowing through society, particularly healthcare, it is mandatory that leadership and staff adopt the "duty of foresight" to thrive in the conditions that will emerge over the next three to five years. This societal transformation will end up affecting our specialty, association, and stakeholders including Members and patients. We will need to continue to "strategically learn" about transforming factors, particularly those we may be unfamiliar with. How well we do may well be the differentiating factor in success for our Members.

We must have the courage to pursue opportunities created by the massive disruption that the healthcare industry is experiencing. A tangible example of acting on opportunity is the decision and commitment of our Board of Directors to proceed with RegentSM, our clinical data registry, which is now well under way in its pilot phase. Once fully operational this fall we anticipate it will allow you, our Members, to meaningfully and successfully participate in the quality-based patient care world.

Another sea change that will affect you and your patients involves the delivery of hearing healthcare. The Institute of Medicine (IOM) and the President's Council of Advisors on Science and Technology (PCAST) along with the public have expressed great interest in improving access to hearing healthcare services, particularly rehabilitation services and adjunctive hearing devices. The Academy has been working with the American Neurotology Society and the American Otological Society to comment constructively on proposed changes that maintain the principle of medical evaluation for hearing problems, while expanding access and controlling costs so that a greater percentage of patients in need of both services and devices are able to get the help they need. This month I will be testifying on this subject before the FDA panel on Personal Sound Amplification Products (PSAPs).

Additionally, the International Task Force presented a comprehensive report after almost a year of study that identifies a number of opportunities to increase international involvement in collaboration with the global otolaryngology community. The 2016 AAO-HNSF Annual Meeting & OTO EXPOSM in San Diego, September 18-21, will feature our inaugural International Symposium, which will consist of outstanding international scientific presentations. We have the highest confidence that this will represent an excellent opportunity for our domestic and international attendees to expand their knowledge base.

I encourage any Members with insight into transformative disruption that affects our specialty to contact me directly so we can work on this together.



James C. Denneny III, MD AAO-HNS/F EVP/CEO



We must have the courage to pursue opportunities created by the massive disruption that the healthcare industry is experiencing.



2016 federal legislative

he American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) is committed to the enactment of legislation that will strengthen the delivery of, and access to, quality healthcare. To that end, the AAO-HNS urges Congress to take the following actions in 2016:

Protect patient safety within the Medicare program

The AAO-HNS strongly believes a physician-led hearing healthcare team, with coordination of services, is the best approach for providing the highest quality care to patients. In past years, some in the audiology community have pursued unlimited direct access to Medicare patients without a physician referral, and the AAO-HNS has repeatedly opposed

such legislative efforts due to significant patient safety concerns. In addition, some members of the audiology community now seek to amend Title XVIII of the Social Security Act to achieve "limited license physician" status within the Medicare program. Hearing and balance disorders are medical conditions that require a full patient history and physical examination by a medical doctor (MD) or doctor of osteopathic medicine (DO). While audiologists play a critical role in providing quality hearing healthcare, their desire to independently diagnose hearing disorders transcends their level of training and expertise. To ensure patient safety is preserved, Members of Congress are urged to take the following actions regarding audiology-related legislation:

■ OPPOSE H.R. 2519, a bill that would provide

audiologists with unlimited "direct access" to Medicare patients without a physician referral, and inappropriately include audiologists in Medicare's definition of "physician."

■ SUPPORT/COSPONSOR H.R. 1116, a bill that appropriately strengthens the structure for hearing healthcare services in the United States by better aligning Medicare coverage of comprehensive audiology services with current billing and reimbursement standards of other non-physician therapeutic services covered by Medicare (PT, OT, SLP).

Reauthorize funding for Early Hearing Detection and Intervention (EHDI) program

The Early Hearing Detection and Intervention (EHDI) program helps to establish

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priorities for AAO-HNS

statewide plans that identify children with hearing loss, directing them to early intervention services. This vital program includes initial screening of infants for hearing loss, audiological diagnostic evaluations to confirm hearing loss, and early intervention. At the first signs of hearing loss, it is imperative that children receive medical services, access to early intervention programs, and family support. This early intervention enhances language, communication, cognitive and social skill development. The U.S. House of Representatives passed its reauthorization bill, H.R. 1344, in September 2015. To ensure continued funding for this critical program, the AAO-HNS urges members of the U.S. Senate to cosponsor, and support passage of, the Early Hearing Detection and Intervention Act (H.R. 1344/S. 2424).

Support clarity and transparency in healthcare advertisements

Currently, there is little "transparency" associated with the most fundamental and important component of healthcare delivery—the many health professionals who interact with patients every day. Recent studies confirm America's patients prefer a physician-led approach to healthcare and are often confused about the level of training and education of their healthcare providers. Because of this uncertainty, patient autonomy and decision-making have been compromised. America's patients deserve to be fully informed and able to easily identify in healthcare advertisements

and interactions their providers' credentials, licenses, and training when seeking treatment. Members of Congress are urged to cosponsor H.R. 1741, the Truth in Healthcare Marketing Act.

Enact comprehensive medical liability reforms

The nation's current medical liability system places patients in jeopardy of losing their access to vital healthcare services. With affordable and adequate medical liability insurance becoming difficult to find, physicians are retiring early, limiting their practices, or moving to states with less costly premiums. This disturbing trend is leaving entire communities without access to critical healthcare services. As a specialty, in an effort to reduce and learn from instances of medical error, the AAO-HNS has committed substantial resources to and engaged our Members in proactive quality improvement initiatives. However, further statutory changes are necessary to address flaws in our current tort system and enact proven reforms to reduce frivolous lawsuits. Members of Congress are urged to explore innovative solutions to alleviate the burdens associated with the current medical liability system.

Protect funding for Graduate Medical Education (GME)

While the AAO-HNS recognizes the stark fiscal reality now present in the United States, it is critical that support and funding for the nation's graduate medical education (GME) programs not be jeopardized as a means to achieve savings within the healthcare system. Reductions in GME funding will only cripple the nation's already dwindling physician pipeline and leave Americans with an inadequate supply of physicians, including specialists. Tackling the deficit is important, but cutting physician training at a time when our nation faces a critical shortage of physicians would threaten the health of all Americans. The AAO-HNS urges Members of Congress to refrain from reducing and/ or redistributing critical GME program funding and support legislation designed to strengthen the overall structure for GME in the United States.

Join the Congressional Hearing Health Caucus

Hearing health is a growing concern in the United States, especially as the population of Baby Boomers continues to age and our nation's servicemen and women return home from active tours of duty. As a result, it is critically important that robust programs and research are available to mitigate the challenges associated with prolonged and acute hearing loss. The Congressional Hearing Health Caucus (CHHC) is a bipartisan caucus of members from the House and Senate committed to supporting the needs of those who are deaf or hard of hearing. The CHHC strives to increase public and Congressional awareness of the issues of critical importance to those with hearing loss through periodic briefing and correspondence. Members of Congress are urged to help promote effective hearing healthcare by joining the **Congressional Hearing Health Caucus.** Contact the offices of Reps. David McKinley (R-WV) and Mike Thompson (D-CA) to join.

For more information on AAO-HNS federal legislative priorities, contact the Legislative Advocacy team at legfederal@entnet.org. ■



The American Academy of Otolaryngology—Head and Neck Surgery is committed to the enactment of legislation that will strengthen the delivery of, and access to, quality healthcare



What to expect from Congress

ith lawmakers having convened the second session of the 114th Congress in early January, questions remain regarding what's in store for a potentially unpredictable 2016. While it may be too soon to determine who will win the White House, and if Republicans will retain their slim majority in the U.S. Senate, a few things are certain. Read on to learn more about what we know, what we don't, and ways AAO-HNS Members can stay informed and get involved.

Things we know

- Because it is a presidential election year, federal lawmakers will return to their districts for more frequent, and longer, in-district work periods. As such, the 2016 legislative workday calendar is extremely light.
- Earlier this year, Speaker of the U.S. House
 of Representatives Paul Ryan (R-WI) told the
 physician community his focus for the second
 session is creating a strong Republican agenda, with particular emphasis on "big" policy
 items. Therefore, smaller "ancillary" issues
 may not receive much attention.
- 3. The U.S. Senate has indicated its intent to focus on funding-related legislation.
- President Obama has stated he plans to pursue "audacious" executive action during his final year in office.

Things we don't know

- 1. Will the "honeymoon" between the new Speaker and the ultra-conservative faction of his caucus end? The Speaker's unconventional ascent to leadership came with a condition of support from the entire House Republican Conference—an agreement that has (thus far) remained intact. However, as Speaker Ryan moves forward with an "updated" agenda, it remains uncertain whether the ultra-conservatives will remain supportive.
- 2. How focused will Republicans remain this year on efforts to repeal the Affordable Care Act (ACA)? With the first-ever full ACA repeal bill already having been



Lawmakers will be in their home districts more often this year. Consider scheduling an In-district Grassroots Outreach (I-GO) meeting with your U.S. Representative and/or U.S. Senator(s).

delivered to, and vetoed by, the President, it's hard to tell whether the ACA repeal will remain a central theme in Congress this year, or whether they will hold off on subsequent efforts until after the elections. GOP lawmakers have indicated they will begin work on an ACA "replacement" package.

Stay informed, get involved

- Given the compressed Capitol Hill work schedule, lawmakers will be in their home districts more often this year. Consider scheduling an In-district Grassroots Outreach (I-GO) meeting with your U.S. Representative and/or U.S. Senator(s). For more information, or assistance in scheduling a meeting, contact govtaffairs@entnet.org.
- 2. A heightened election season offers the perfect opportunity to amplify our voice on Capitol Hill via ENT PAC, the political action committee of the AAO-HNS. ENT PAC supports Congressional incumbents and candidates who champion issues important to our specialty. Growing ENT PAC strengthens our visibility with policymakers. For more information, visit www.entpac.org.*
- 3. Volunteer for PROJECT 535, a BOG-sponsored initiative designed to recruit a "key

- contact" for each U.S. Senate and House Congressional seat to help improve our outreach to federal legislators when the specialty's issues are debated on Capitol Hill.
- 4. Although 2016 may not be a legislative "rich" year, it's still important to remain informed. AAO-HNS Members can learn more about legislative, political, and grassroots news by joining the ENT Advocacy Network. Or, consider following the AAO-HNS Legislative Advocacy Twitter account @AAOHNSGovtAffrs. Your participation is vital to the success of the specialty.

For more information about the 114th Congress and specific AAO-HNS legislative priorities, email govtaffairs@entnet.org or visit www.entnet.org/advocacy.

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On the road

■ James E. Saunders, MD, AAO-HNSF Coordinator for International Affairs. This is an occasional series from the International Coordinator, reporting on global topics and travels.

hether inspired by Willie Nelson,
Jack Kerouac, or Bob Hope and
Bing Crosby, sometimes we are
just called to go "on the road" for parts unknown. Perhaps it is the cold New England
weather or just my nature, but this time of
year always makes me long for faraway (and
warmer) places. The international relationships of our Academy provide unique ways
to explore the world of otolaryngology.

We maintain relationships with more than 50 partner otolaryngology societies around the world, forming the International Corresponding Societies (ICS) network. The ICS holds meetings throughout the year, which constitute wonderful opportunities to exchange ideas with otolaryngologists from other countries, experience other cultures, explore collaborative ways to address mutual problems, and gain from the wealth of expertise that lies outside U.S. borders. Each meeting has its own charm and value and I encourage AAO-HNS Members to attend these meetings and discover that you have many friends beyond our borders.

This summer, the Balkans Society of Otorhinolaryngology will host a meeting in Tirana, the colorful and vibrant capital of Albania. You also might consider joining the AAO-HNSF delegation in Havana, Cuba, for the Pan-American Congress of Otorhinolaryngology in June. This will be a once-in-a-lifetime chance to interface with Latin American partners in a country relatively unknown to most Americans. These meetings also offer great travel opportunities for

Academy Members.

try partners in a given country or region. Over the past few years, the Academy has es as Victoria Falls, Cartagena, Paraguay, Prague, the Bahamas, Singapore, Taiwan, experiences in these far-flung corners of the meetings occur in the first half of the year Emirates Rhinology and Otology Congress United Arab Emirates, where they encounis the All African Ear Nose and Throat and Audiology Congress in June, where region will descend on Kigali, Rwanda, for the Events Calendar at www.entnet.org for more details. But be sure you leave room in Diego, CA, September 18-21, 2016. This meeting will be one of the best ever, with lots of new international offerings—more

jointly organize a meeting with in-coun-

But the best thing about these meetings and experiences is that we get to share them with a whole network of new friends. I am always astounded by the hospitality of our overseas colleagues at these meetings. When visiting colleagues in their home countries, one really does feel part of a much larger, global community of otolaryngology. For me one of the greatest benefits of the Academy has always been the friendships with people who share a common cause and common attitude. To share this with people from all over the world is a wonderful thing. To paraphrase Willie Nelson, "The life I

on that in a later edition of this column.

my friends, and I
can't wait to get
on the road
again."■



Counting down to the Annual Meeting

Building on the success of last fall's AAO-HNSF 2015 Annual Meeting & OTO EXPOSM in Dallas, TX, the 2016 Annual Meeting & OTO EXPOSM scheduled for September 18-21 in San Diego, CA, will be bigger, bolder, and feature more of the latest technology to enrich our attendees' experience. In Dallas we broke the mold when we premiered

all-inclusive registration pricing giving conference goers access to the full array of educational offerings without any additional fees.



Attendance at the Miniseminar and Instruction Course sessions surpassed all records with attendees applauding this innovative programming change.

We promise not to let you down this year as we have plans to introduce several new captivating educational and networking opportunities. These changes will enhance your experience and better meet your professional needs. You'll experience even more of what you've come to expect at the world's premier event for otolaryngologist-head and neck surgeons.

What to expect at this year's Annual Meeting:

- **NEW** surgical techniques
- **NEW** treatment protocols
- High-level learning in enticing learning environments
- International Symposium
- Inventive networking events

Be sure to check the May *Bulletin* for a complete overview of this year's meeting.

■ at the forefront

CPT Assistant: drug-eluting sinus implant (CPT

or 2016, Current Procedural Terminology (CPT®) codes **0406T** Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; and **0407T** with biopsy, polypectomy or debridement were created. In order to help otolaryngologist-head and neck surgeons correctly code, the Academy's CPT team helped the American Medical Association (AMA) draft a *CPT Assistant* article on the placement of a drug-eluting implant into the ethmoid sinus.

The following AMA *CPT Assistant* article, "Drug-Eluting Sinus Implant (Codes **0406T**, **0407T**)," which can be found on page 10 of the February 2016 *CPT Assistant*, is re-published with permission from the AMA.

Codes **0406T** and **0407T** describe the placement of drug-eluting implant into the ethmoid sinus by a physician or other qualified healthcare professional. The implant is intended to remain in place for days to weeks and slowly elute a drug into the ethmoid sinus cavity mucosa while disintegrating. These codes apply

only to manufactured drug-eluting implants (medication is integral to and embedded within the device), and are not for the placement of packing or other material (e.g., sponge, dressing, gel or foam), which has been soaked in, or mixed with, steroid or another medication.

Code **0406T** is reported when the procedure is performed as a stand-alone service, whereas code 0407T is reported when the procedure is performed at the same session as a biopsy, polypectomy, or debridement (typically, the latter) involving the ethmoid sinus. Both codes describe procedures performed only within the ethmoid sinuses, which are located between the eyes and nasal cavity behind the bridge of the nose. It would not be appropriate to report code **0406T** in conjunction with 0407T, if the procedure were performed on the same side during the same session. A new parenthetical reference note has been added following code 0407T to instruct users that both codes should not be reported together for the same ethmoid side/site during the same session.

All nasal endoscopy codes include the work of performing the endoscopy, as well as any packing that is used at the conclusion of surgery. These codes also encompass the placement of a stent or implant that is used to maintain the patency of the cavity, achieve hemostasis, or elute a medication. Therefore, codes **0406T** and **0407T** should not be reported in addition to open or endoscopic ethmoid sinus surgery on the same side because the placement of any packing or stent, including a drug eluting implant, is considered inherent to those procedures.

A new parenthetical reference note was added to instruct users that codes 0406T and 0407T should not be reported in conjunction with code 31200 (ethmoidectomy, anterior); 31201 (ethmoidectomy, intranasal); 31205 (ethmoidectomy, extranasal); 31231 (nasal endoscopy, diagnostic); 31237 (nasal endoscopy surgical, with biopsy, polypectomy or debridement); 31240 (concha bullosa resection); 31254 (endoscopic ethmoidectomy, partial); 31255 (endoscopic

Restoring hearing in

Web portal puts Members' humanitarian activity on the map

■ Peter G. Volsky, MD

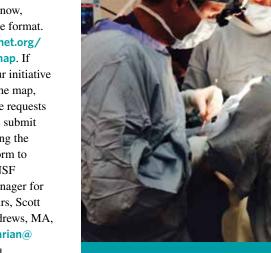
ith great fanfare online as well as on Academy social media channels, the Humanitarian Efforts Committee and the Membership and IT Business Unit have launched a Humanitarian Efforts Map now ready for viewing on our website. The map is a user-friendly graphical interface for otolaryngol-

ogy-related humanitarian efforts around the globe. It allows rapid identification of ongoing projects that are geographically or clinically similar, for the purpose of enhancing collaboration among otolaryngologist Members and non-members.

This web project has been years in the making.

The Academy's Humanitarian Efforts
Committee has long kept a list of otolaryngology-related healthcare delivery projects and collaborations in resource-limited areas and developing nations, but, until now, never in an easily accessible online format.
The site is accessible at www.entnet.org/content/humanitarian-efforts-map. If you are interested in featuring your initiative

or project on the map,
the Committee requests
that Members submit
all details using the
designated form to
the AAO-HNSF
Program Manager for
Global Affairs, Scott
Vincent Andrews, MA,
at humanitarian@
entnet.org.



0406T, 0407T)

ethmoidectomy, total); **31288** (endoscopic sphenoidotomy with removal of tissue); or **31290** (endoscopic repair of cerebrospinal fluid leak, ethmoid), when performed on the same side.

In the event that the endoscopic placement of a drug-eluting implant is performed during the same session but on the opposite side as a primary ethmoidectomy, it would be appropriate to report the code for the endoscopic procedure along with code 0406T or 0407T. Modifier 59 should be appended to the additional code to indicate that a distinct procedural service was performed. Placement of a drug-eluting implant into any sinus other than the ethmoid should be reported with unlisted code 31299. Third-party payers may have different reporting guidelines; therefore, check with your individual third-party payers regarding their specific reporting guidelines.

The full article is available to Academy Members at www.entnet.org/content/ama-cpt-assistant-drug-eluting-sinus-implant-cpt-0406t-0407t (login required).

American Samoa



■ **Robert M. Brody, MD**, University of Pennsylvania, Humanitarian Travel Grant Awardee

Matthew Pierce, MD, Robert M. Brody, MD, and Richard Wagner, MD, operate at LBJ Tropical Medical Center, Pago Pago, American Samoa, during a Global ENT Outreach (GEO) trip August 2015. With a high incidence of hearing loss and a high prevalence of diabetes, 6 percent to 10 percent of American Samoa's population suffers from some form of otologic disorder. The group performed 20 otologic cases including tympanomastoidectomy for cholesteatoma, stapedectomy and ossicular chain reconstruction, and tympanoplasty for persistent tympanic membrane perforations with

hearing loss.

Correctly coding CPT 69209

or 2016, Current Procedural Terminology (CPT®) code 69209 Removal impacted cerumen using irrigation/ lavage, unilateral was created. In order to help otolaryngologist-head and neck surgeons correctly code, the Academy helped the American Medical Association (AMA) draft a CPT Assistant article on the removal of impacted cerumen. In addition to the CPT Assistant article, the Academy's CPT team has updated the CPT for ENT: Cerumen Removal to further clarify billing 69209 and 69210 Removal impacted cerumen requiring instrumentation, unilateral. The CPT for ENT article can be found at www.entnet.org/node/258.

The following are excerpts from the AMA *CPT Assistant* article "Removal of Impacted Cerumen," which can be found on page 7 of the January 2016 *CPT Assistant*, and are reprinted with permission from the AMA:

In the CPT 2016 code set, code **69209** was added to the Auditory System subsection to report the removal of impacted cerumen (earwax) using irrigation or lavage. Impacted cerumen was defined in *CPT Assistant* October 2013, page 14, as having any of the following:

- Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
- Inflammatory considerations: Associated

with foul odor, infection, or dermatitis.

Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

69209 is reported when irrigation and/or lavage is used to remove impacted cerumen. This method uses a continuous flow of liquid (e.g., saline, water) to loosen impacted cerumen and flush it out with or without the use of a cerumen softening agent. Although direct physician work is not required, the removal of cerumen by irrigation or lavage usually takes longer to perform and may require additional staff time and equipment.

Only one code (69209 or 69210) may be reported for the primary service provided on the same day on the same ear. Modifier 50, Bilateral Procedure, should be appended if either one of the cerumen removal procedures is performed on both ears.

Codes **69209** and **69210** should not be reported together when both services are provided on the same day on the same ear.

The appropriate evaluation and management (E/M) code based upon category and site of service (e.g., office or other outpatient, hospital care, nursing facility services) should be reported when non-impacted cerumen is removed.

An E/M code may be reported if there is a separate and distinct service performed at the same session.

The full article is available to Academy Members at www.entnet.org/content/ama-cpt-assistant-removal-impacted-cerumen-69209 (login required).

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69209 is reported when irrigation and/or lavage is used to remove impacted cerumen.

77

■ at the forefront

BOARD OF GOVERNORS

Our presidential election

■ Wendy B. Stern, MD, BOG Immediate Past Chair

he Democratic and Republican National Conven-



tions are just a couple of months away, and many of us have been riveted by the campaigns, debates, caucuses, and primary elections as the candidates declare who they are and what they can do for us and our country. We all understand not only the big picture and significance that lies in the outcome of this presidential election, but also recognize the impact that it will have on healthcare.

I know most of our Members are committed to understanding the candidates, and will participate by voting in the upcoming national elections. I hope that everyone recognizes the parallel importance of our upcoming Academy elections. Like our national elections, whom we elect can make a difference.

The Board of Governors (BOG) serves as your grassroots voice. We represent your interests to our elected leadership through your BOG governors and representatives

from your local, state, regional, and specialty societies. Our Academy oversees, influences, institutes, and regulates many behind-thescenes efforts that impact your everyday ability to provide otolaryngological care. Whether it is the development of guidelines, responding to carrier or scope-of-practice issues, weighing in on the now-repealed SGR physician payment formula, addressing practice management issues, education, or mentoring residents and interns, the mission and strategic goals of our Academy affect us all. All of us have the opportunity to help shape our Academy by participating in the election of our Academy leaders, in addition to the many other volunteer opportunities.

I was privileged to recently serve on the Election Review Task Force, and I learned many interesting facts along the way. Our Academy is one of the most democratically organized national medical societies. Our Academy president, directors-at-large, and Members of the Nominating Committee and Audit Committee are voted into office by you. We have a well-defined system of campaigning to make the elections fair. We have a well-publicized election and easy access to voting. What was discouraging was learning

how few of our Members actually vote (typically under 15 percent). Our participation rate is not very different from many other societies, but I know we can do better!

Why wouldn't you want to help shape the single most important institution to your practice of otolaryngology? In order to do that, start by learning about our current candidates. The BOG traditionally hosts the AAO-HNS president-elect candidates during our spring General Assembly & Candidates Forum (open to the general membership) which is now an important part of the AAO-HNS/F Leadership Forum & BOG Spring Meeting. This past March, many of us gathered in Alexandria, VA, to listen to and meet the candidates. If you didn't join us this year, come next year! I encourage everyone to read all of our candidates' statements in this issue of the Bulletin and on our website.

Also, join in the Candidate Forum on ENTConnect! It's an opportunity to ask the candidates how they would further the strategic goals and mission of the organization, or anything else that's on your mind. Visit the annual election webpage for details on how you can submit your questions, www.entnet.org/content/annual-election.



Our Academy is one of the most democratically organized national medical societies. Our Academy president, directors-at-large, and Members of the Nominating Committee and Audit Committee are voted into office by you. We have a well-defined system of campaigning to make the elections fair. We have a well-publicized election and easy access to voting.

Wendy B. Stern, MD BOG immediate past chair



JOIN US IN SAN DIEGO, CALIFORNIA, FOR OUR AAO-HNSF 2016 ANNUAL MEETING & OTO EXPOSM



This invigorating, thought-provoking, and inspirational event showcases the latest advances in the specialty and exposes you to new research findings, approaches, and treatment options to help you deliver excellent patient care. In its 120th year, the AAO-HNSF Annual Meeting & OTO EXPO™ features all day cutting-edge education programming, dynamic evening events, and draws more than 5,500 otolaryngology, medical experts, and professionals from around the world.

As healthcare providers and otolaryngologist—head and neck surgeons, you owe it to yourself and to your patients to participate in the otolaryngology event of the year.

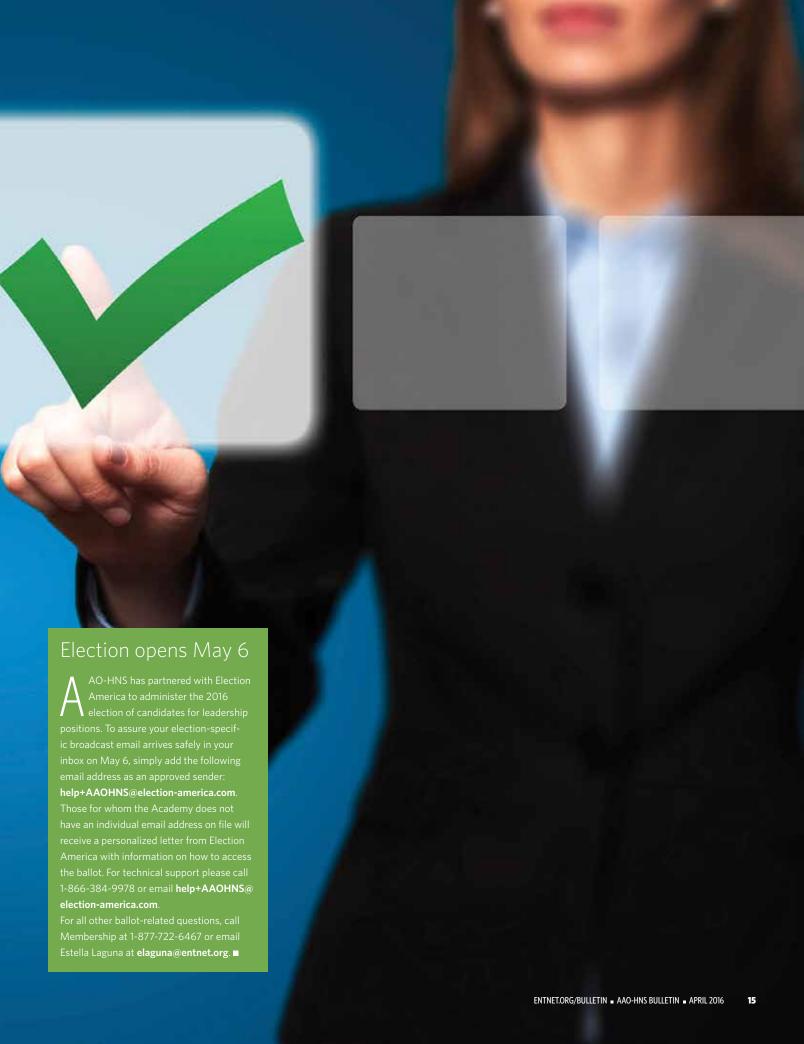
Visit www.entnet.org/annual_meeting



INFORMING YOUR Contact the second se

Statements from your candidates for president-elect, audit committee, director at large, and nominating committee

t's a big election year nationally, with a presidential contest that has captured well-warranted attention. In midst of the sound bites and partisan rhetoric, we ask you to take a moment from politics to focus your attention on the important election season for the American Academy of Otolaryngology— Head and Neck Surgery. While we don't have debates, caucuses, or primaries to spread candidates' views, you can learn what you need to know right here about the hard-working volunteers who are running to serve you. We've asked each candidate questions pertinent to the office they're seeking. They have replied with straightforward statements on topics including engaging Members in outcomes research, strengthening grassroots advocacy efforts, and selecting our leaders.



candidate statements president-elect



What life lessons in your career would you use to identify and strengthen portions of our strategic plan to improve our membership's future? How can we engage membership to be involved in outcomes research, specifically the RegentSM clinical data registry?



t is truly a distinct honor to be nominated as a candidate for President-Elect of our

James A. Hadley, MD

esteemed Academy. I am grateful for the previous opportunities in this profession that have offered me the opportunity to share in the advancement of education that is one of the tenets of our Academy.

I would like to continue this passion and follow in the footsteps of my father and other valued otolaryngologists to passionately assist in the support of the Academy's strategic goal initiatives.

Professionalism in our specialty is something that I endorse and will employ to stimulate Members and students. One of the mottos of my previous institution at the University of Rochester Medical Center is "Medicine of the Highest Order" and I have always tried to encourage colleagues and students to this ideology.

Life's lessons: Beginning my career in an ENT group private practice associated with a residency training program established a solid foundation on which many of my life's lessons began. I was one of the first ENT physicians in our area to fight the general allergy establishment involved with insurance reimbursement to garner the ability to manage those patients for ENT allergy care.

This early lesson gave me the fortitude and strength to advocate for quality care and local endorsement of our profession. The lessons learned from this endeavor provided me with tools to engage in future leadership positions on the Boards of the AAOA, the ARS, and the AAO-HNS as well as the American Board of Otolaryngology. Throughout my career, I have been blessed with the ability to share this lesson with other physicians with whom I have enjoyed the passion of our specialty.

We have all witnessed government intrusion into our practices including a change to ICD-10 and mandatory use of EHR programs to collect our clinical data for accountability.

RegentSM is the clinical registry and method for members to invest in their future to assist in accurate reporting of quality data.

We are in an interesting time with the upcoming presidential elections and we will witness a potential change in the political climate. In contrast to the politics, the leadership of the Academy is primed to educate its Members for the changes under the new regulations from CMS and the adoption of MACRA. With the changes to payment models proposed under these new guidelines, we need leadership to present better models for physicians to endorse and participate in anticipation of degradation of reimbursement from the changes.

RegentSM is a mechanism for academy membership to invest in the future of quality care. Our Academy needs to develop specialty specific otolaryngology care metrics, and RegentSM can assist our members. I will assist in the engagement of our members to participate in APM development. As it is in the best interest of our membership, a commitment to the RegentSM program will be a primary focus of my leadership.

Having been involved in multiple clinical trials and in the "Sinus and Allergy Health Partnership" I have invested time and effort for these educational endeavors. My investiture on the ABOto has also given me the comprehension of certification maintenance and a witness to its inception. I will apply my experience from this service to engage our colleagues and to foster membership participation.

The leaders of the AAO-HNS need to balance the current resources. I plan to work diligently with the CEO/EVP and the Board of the Academy and Foundation to link the current programs of Education, Advocacy, Research, and Outreach. I will advocate aggressively for professionalism in our specialty to secure and improve patient quality care and enhance the "BestENT" practices for our membership.



I was one of the first ENT physicians in our area to fight the general allergy establishment involved with insurance reimbursement to garner the ability to manage those patients for ENT allergy care.







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I have a strong commitment to supporting our residents, fellows, young physicians, and researchers—the future of otolaryngology.



Gavin Setzen, MD

ince immigrating to the United
States from South Africa 25 years
ago, I have experienced numerous
life lessons in my career, through my
training, education, medical practice,
patients, and varied leadership
experiences within the Academy, other medical
organizations, and community service roles.
These have provided me intellectual, business,
governance, management, negotiating, and
emotional skills to deal with a wide range of
circumstances, individuals, and problems, and
have allowed me to make rational and thoughtful decisions under difficult circumstances.

As president of a single-specialty group (eight MDs and five PAs), with an academic faculty appointment (involved in resident training for ENT, Family Practice, and Physician Assistant programs), I have learned and understand the complexities and challenges facing otolaryngologists in varied practice settings.

In addition, I have learned the true meaning and value of mentorship, friendship, and collegiality in our field, and as such, I have a strong commitment to supporting our residents, fellows, young physicians, and researchers—the future of otolaryngology.

Diverse committee and governance participation since residency has provided broad-based exposure to every aspect of administrative and membership-related functions throughout the Academy. I recently completed my seven-year term on the Board of Directors and served as secretary-treasurer elect and secretary-treasurer (four years) while on the BOD Executive Committee. This AAO-HNS executive leadership experience has provided the highest level of continuity and oversight in decision-making capability related to overall Academy strategic plan function/operation/implementation, impacting every level of the organization and the entire membership.

The Academy mission, Members, colleagues, and patients, call for a specific skill set and philosophy in achieving the strategic plan objectives and I have harnessed my experiences and career lessons to focus on providing inspiring leadership, consistent with the Guiding Principles of the Academy—prioritizing high-quality programs, improving process and organizational performance, leveraging internal/external relationships, and ensuring stable funding—to propel our organization and profession to new heights!

It is imperative to clearly demonstrate the **value proposition** that a clinical data registry (CDR)—RegentSM—brings to EVERY otolaryngologist in EVERY practice setting, in EVERY corner of the United States.

RegentSM is the great "leveler"—now every otolaryngologist will be able to more easily comply with regulatory burdens and reporting requirements (PQRS, MU, etc.), providing ease of data capture, processing, and retrieval across the care continuum in all practice settings.

In addition, it must be emphasized that in an era of ongoing payment reform with the MAC-RA (Medicare Access and CHIP Reauthorization Act) legislation recently passed, quality measurement and patient outcomes reporting will be integral to continued payment reform with Alternative Payment Models (APMs) blended with fee-for-service payments in the future.

Otolaryngologists can now drive/control the outcomes research that will in turn drive quality reporting and ultimately "value" payment for our services.

It should be made clear that this is a major priority for AAO-HNS and is a key Strategic Plan objective with extensive board-approved funding to ensure success.

Academy leadership and RegentSM pilot program participants will be important ambassadors for this program. ■

■ candidate statements ■ **director at large: academic**



How would you strengthen our grassroots activities to protect our specialty from legislation that would undermine our mission? How would you engage all Members to be more active in the Academy?



Denis C. Lafreniere, MD

he current era of healthcare reform with its ever changing demands on our practices makes the need for grassroots participation all the more important as we deal with reaction on both the state and national levels. If elected, I would aim to continue the work that I had the privilege to help initiate while I was the Chairman of the Board of Governors. Effective advocacy for our patients and our colleagues can only occur when useful information flows easily from the local state societies to the Academy and vice versa. The Regional State Society network that I helped to develop is an

excellent vehicle to encourage real grassroots participation, which has and will continue to produce measureable benefit to our Members and their patients.

Increasing the participation of our membership is a vital goal, which will contribute to the Academy's success. That goal is tied directly to our ability to define and improve the value of membership in the Academy. We've made great strides in improving the educational and advocacy services the Academy offers. The more we can enhance our Members' ability to care for their patients the more essential the Academy becomes to their successful vocations.



Sonya Malekzadeh, MD

ffective legislation demands a strong and unified voice. Although the Academy boasts a solid grassroots foundation, increasing Member support is critical to ongoing successful advocacy.

The residents, fellows, and young physicians offer perhaps the greatest untapped opportunity to improve awareness and engagement. By actively involving and nurturing the next generation of otolaryngologists, we can demonstrate their voices will be heard, their opinions are valued, and they can transform the organization. A determined and systematic outreach approach targeting our valuable colleagues will enhance buy-in and strengthen commitment to the Academy. Similarly, it is essential to invigorate the current member-

ship. Building on the success of ENTConnect and growing social media presence, we can communicate regular updates with relevant information and share policies shaping our profession. A well-informed membership will realize the value of our organization, resulting in greater involvement and investment in the present and future of otolaryngology.

As AAO-HNS/F Education Coordinator and Chair of WIO, I gained valuable insight into opportunities and challenges facing our specialty, while forming excellent working relationships with colleagues both within and outside of the organization. With these experiences in hand, I will strive to represent the interests of all otolaryngologists, engage Members, and foster continued growth of the specialty toward shared goals.





Peter J. Abramson, MD

here is power in the grassroots organization. During my tenure as Chair of the Board of Governors, the grassroots arm of the Academy, we worked diligently with our societies developing the regional plan so that any socioeconomic and legislative challenges could be quickly identified and addressed. We need to continue strengthening innovative programs such as I-Go, state legislative trackers and Project535 (matching Academy Members with members of Congress) in order to fight challenges like scope of practice issues, restrictive hospital practices, and legislative attempts to limit physician reimbursement.

You can't make someone be engaged, they have to want to be engaged. Members need to feel that there is extreme value and true advantage to their involvement. The Academy needs to offer high quality products, support, advocacy, and education that help its membership on a daily basis. We have a responsibility to foster the potential of our greatest resource our Members, particularly focusing on our residents, fellows, and young physicians. It is imperative to engage the subspecialists and subspecialty societies so that we all can move forward together. The ultimate cornerstone of Member engagement is the commitment to a culture of inclusiveness and diversity. Every Member has a voice. ■



Pell Ann Wardrop, MD

multi-pronged approach with further enhancement of Member services and expanded stable revenue is vital to successfully addressing the current threats to otolaryngology and increasing Member engagement. Academy support for young physicians entering our specialty is essential as they are our future. Programs providing employment assistance and practice management expertise may be a source of support for them and revenue for the Academy.

We have an amazingly talented staff with extensive experience in health policy advocacy. We empower them through stable fiscal support. In addition to current innovative Academy revenue initiatives, other options include expanded industry collaboration, additional changes to the Annual Meeting, restructuring of Foundation donations, and extended Member services in payer issues. The Academy should be the repository of third-party payer appeals allowing Members access to Academy and Member activity in this important area.

Advocacy in the governmental, regulatory, and private payer arena is absolutely key to our future and we will prevail only if we proceed as a united specialty. We can emphasize the exceptional skills in otolaryngologic care that we all possess while still recognizing subspecialty expertise. As Ben Franklin and, recently, Sujana Chandrasekhar said: "We must all hang together, or assuredly..."

candidate statements audit committee



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



Jerome W. Thompson, MD, MBA

he experience that I bring to the Audit Committee is that I have served on the committee for a total of four years. I have participated in IRS audits of medical societies and learned from these experiences. I have an MBA in finance and have a very good understanding of the business of the Academy, and the risks that it

faces. I work well with the accounting firm that conducts our annual audit, and with the Academy financial staff. As associate dean of Graduate Medical Education I managed a \$60 million budget, and have gone through many audits successfully. I believe in the mission of the Academy and will strive to serve it well and protect it. Thank you for this opportunity.





nominating committee: academic a candidate statements a

What do you see as the priorities of the Nominating Committee in selecting the future leaders of our Academy? What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?



Christine B. Franzese, MD

ontinued progress forward is critical to our Academy's success, the impetus of which comes from our leadership. Our leadership must have the experience and courage to enact difficult decisions, the flexibility and creativity to develop original solutions, and the willingness and humility to build on past achievements. Our leaders should not reinvent the wheel, but instead seek to perfect, adapt it, and harness it for the Academy's benefit. With the implementation of the clinical data registry, changes in the socioeconomics of medicine, and volatility in the political landscape, our leaders must ensure our Academy continues to be poised for future success and positioned to take advantage of new opportunities.

Currently serving as Treasurer of the AAOA and Immediate Past Chair of the AAO-HNS Section for Women in Otolaryngology (WIO), I have previously served as Chair of the AAOA Nominating Committee and first Chair of the SUO-Otolaryngology Program Directors Organization. With my experience within the Academy and other organizations, I feel I can capably serve our membership by selecting leadership candidates with creative foresight, with experience to handle adversity by fully utilizing the Academy's resources, and with courage to determine the continuance of prior endeavors and the strategic launch of new ones.



Earl H. Harley, MD

unning for the nominating committee is a serious undertaking as the ongoing viability and strength of our organization rests with those we elect to lead us. Our leaders must be visionary and transformative individuals with bold ideas who are willing to push the envelope and think outside the box.

As a retired military otolaryngologist and now in academics for over 20 years, I feel that I am especially equipped and uniquely qualified to be on the nominating committee. I will be able to draw on my long association with the Academy and broad experience in the military. The experiences I call on include my past position as chair of the Infectious Disease Committee, co-chair of the Home Study, a member on the Task Force on New Material, and I was a representative on the Board of Governors. Also, I have been a guest examiner for the American Board of Otolaryngology. Additionally, I have served as the former Interim Chair of Otolaryngology Head and Neck Surgery at Georgetown University and Vice-Chair at the Naval Medical Center San Diego.

In summary, I will draw on all of my experiences in helping to select potential candidates to lead us through these challenging times.



Cherie-Ann O. Nathan, MD

hile all our Members have the desired qualities of leadership such as integrity, courage, humility, and fairness, the major prerequisite for the incoming Academy leaders will be the ability to adapt successfully to the upheavals currently occurring in healthcare.

There is a looming mandate to control costs. Therefore the Academy faces the herculean task of helping our membership (both general otolaryngologists and subspecialists) through collaborative leadership, Member support, clinical protocols, pay-for-performance strategies and technology.

I have been fortunate to know, up close, many of our dynamic leaders through my involvement with the Academy committees and our sister societies. My experience working with these exemplary visionaries will help me serve my fellow Members to choose those leaders best qualified to guide us through the unchartered healthcare landscape ahead.

It is imperative that these leaders are resourceful and adept at navigating these challenges that disrupt patient care and medical education, while preserving our original mission that is healing our patients.

In short, we need leaders from diverse practice settings and backgrounds who've seen it all, can do it all, unfazed by anything, and ready for everything! The nominating committee will find our future visionaries who will stand up for our specialty.



Mark E. Zafereo, Jr., MD

he Academy should continue to expect leaders with commitment to service within and beyond the specialty: diverse servant leaders of varying age, gender, ethnicity, practice setting, subspecialty, and geography who embody common qualities of both servant and leader: integrity, humility, vision, grace, and strength of character.

I have been given opportunities to serve in numerous leadership, task force, and committee roles spanning a wide breadth of the AAO-HNS, benefiting greatly from the wisdom and example of past and current Academy leaders who have advanced the specialty in patient care, public education, and health policy advocacy.

The strength of the Academy is its membership, both the talent of its individual Members and the broad representation of the specialty. Some have particular gifts to understand the economics of health policy and payment reform; others to mobilize grassroots efforts to influence legislation; some to push the frontiers of research; others to improve evidence-based clinical care guidelines. While any one person cannot possess all, effective servant leaders of the Academy will harness and inspire the wealth of gifts and diversity within Academy membership, so that the Academy will continue to be true to its mission: to empower otolaryngologists to deliver the best patient care.

■ candidate statements ■ nominating committee: private practice



What do you see as the priorities of the Nominating Committee in selecting the future leaders of our Academy? What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?



Seilesh Babu, MD

ur leaders must exemplify in-depth knowledge and passion for issues that impact our Academy's mission and possess empathy, accountability, and insurmountable energy. They must be able to identify and articulate salient issues that impact our daily professional lives and prepare the organization for future challenges. It is critical that these individuals engage and unite Members on key issues in clinical practice and cutting edge research while attracting future Members. Each should have demonstrated success in evaluating complex situations and outlining important next steps in a direct and tactical method to achieve strategic goals in a timely manner.

As a leader within our hospital, private practice, and as Past President of our Otolaryngology Society, I have extensive experience in assembling diverse, strong, balanced, and result-oriented teams. I have worked with outstanding individuals to prioritize critical success metrics and correlate this with the strengths of those around me-leading to the consistent attainment of desired outcomes. Communication skills, strategic thinking, empathy, and integrity are key strengths that I bring to any endeavor. I would be honored to share this with our Academy and assist in selecting our future leaders.



Catherine R. Lintzenich, MD

am honored to be considered for the Nominating Committee, which shapes the future of the Academy of Otolaryngology Head—Neck Surgery. The nominating committee is responsible for selecting and vetting candidates for leadership positions within the AAO-HNS. These future leaders should represent all facets of otolaryngology care, and should be eager to stand up for the rights of patients and physicians. In particular, it is important for the leadership to understand the changing education landscape and support advancement of new digital and mobile technologies to meet education needs. The Academy leaders must continue strong efforts to become the primary educational resource for otolaryngologists and their patients. The goal should be to support clinical and academic otolaryngologists as well as APPs, residents, and medical students.

I have spent years dedicated to Academy education and leadership. I am the current chair of the Laryngology/Bronchoesophagology Education Committee as well as an active member of the Education Steering Committee and the Instruction Course Advisory Committee. I have held numerous leadership roles outside the Academy, including past-president of the North Carolina Society of Otolaryngology and Head and Neck Surgery. I am enthusiastic about transitioning to this new role in service to the AAO-HNS.



Brian J. McKinnon, MD, MBA

ur Academy shapes the arguments that advocate for our patients and our profession. This advocacy requires a leadership that is varied in background and experience, has an interest in listening to different perspectives, can weave together the common elements to build support for our patients and colleagues, and then can effectively persuade those in the public and private sectors to join in our Academy's efforts for our patients and profession.

I have been in practice in the military, academics, and now currently private practice. I pursed and completed an MBA, and am currently pursuing an MPH. My service to our Academy on the Program Advisory Committee, Implantable Hearing Devices Committee, Geriatrics Committee, Socioeconomics and Grassroots Committee, and Legislative Grassroots Taskforce has been critical to my understanding of what leadership qualities and abilities our Academy will benefit from. If provided the opportunity to serve our Academy on the Nominating Committee, I will use that understanding to seek out and support candidates who will be best able to advocate for our patients and profession.



Daniel L. Wohl, MD

e are in a transformational time in medicine where the need to promote the strengths of our subspecialty through the ongoing development of educational tools while still promoting a balanced political advocacy profile has become an increasingly challenging process. The Nominating Committee has the important responsibility to identify leaders with both the critical thinking skills and clear vision to help guide us through this uncertain time. I believe our Academy continues to evolve and understands the benefits from balanced leadership positions reflecting our membership diversity. In over 20 years of practice, the first half in academic medicine and the current half in private practice, I have learned much about the diverse needs of our Academy membership. My long term Academy committee and Board of Governors responsibilities have afforded me the opportunity to maintain access to a diverse, highly skilled and committed tier of our otolaryngology colleagues. There is clinical scholarship throughout our subspecialty and our Nominating Committee benefits all of us by selecting Academy leadership candidates who recognize that our collective goals are strengthened by encouraging and incorporating the views of our entire membership.

Academy Bylaws: Proposed amendments

he proposed amendments to the Nominating Committee are to extend the term of service from two years to three years for all elected Nominating Committee Members, and to add four more elected members (two each Academic and Private Practice) to allow for staggered terms and easier transition of new Members as each learns how to become a productive member of the committee (i.e. four roll off each year); this would increase the number of elected Members from eight to 12.

Note: Former text to be removed is shown as struck. New language is shown as underscored.

Article VI Committees and Coordinators

Section 6.03. Nominating Committee There shall be a Nominating Committee consisting of the Immediate Past President, who shall be Chair, the Chair of the Board of Governors, and eight twelve (12) Voting Fellows or Members of the Academy who are not members of the Board of Directors. Four of the latter eight twelve (12) members of this committee shall be elected from eight voting Fellows or Members nominated by the Nominating Committee annually, and shall serve a two three (3) year term. Four of the eight nominees shall be primarily in private practice and shall run against each other for the two positions reserved for private practice designees and the other four nominees shall be academicians who shall run against each other for the two positions reserved for academicians. In this manner, two seats on the Nominating Committee shall be filled by private practitioners and two seats will be filled by academicians each year. Elected members of the Nominating Committee shall be ineligible for a second term until three years have elapsed following the close of their first term. Voting for the election of Nominating Committee members shall not be cumulative. Additionally, the Chair of the Ethics Committee shall serve as an ex-officio member of the Nominating Committee without vote. The Nominating Committee shall determine what offices, positions on the Board of Directors, and positions on any committees (including positions on the Nominating Committee) shall become vacant to be filled by election

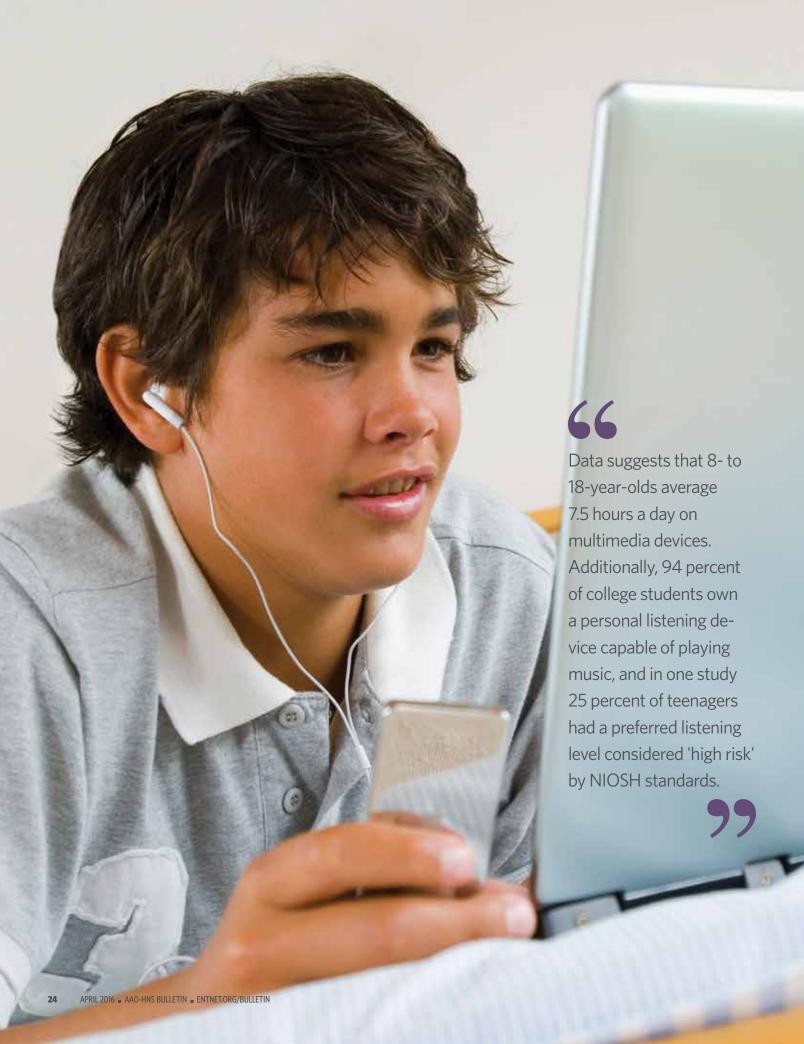
of the membership and shall publicize that information. The Committee shall have the power to nominate individuals for those positions and shall accept other nominations submitted by petition(s) signed by at least one percent of the voting Fellows and Members, which percentage shall be certified by the Secretary-Treasurer based on the prior year's membership records. The Nominating Committee shall assure that there are at least two nominees for each position which shall become vacant, provided, however, that the Nominating Committee need not assure that there are at least two nominees for a position where an incumbent is being nominated to serve an additional term. In odd years, the Nominating Committee shall select two nominees for President-elect who are academicians, and in even numbered years, the Committee shall select two nominees for President-elect who are private practitioners. In no instance shall any member of the Nominating Committee be nominated for any Academy position while he or she serves on the Nominating Committee. In any solicitation of the voting Fellows and Members, all nominees shall be listed in alphabetical order with notation of the source of nomination.

The proposed language change to Section 2.07. Life Fellow/Life Members of the AAO-HNS Bylaws will serve to more clearly define what constitutes a "life member." The current language defines a life member as any physician who has been a Fellow or Member of the Academy for 35

years. The new proposed language defines a life member as any physician who has held continuous membership with the Academy for a minimum of 35 years, and is fully retired from the practice of medicine. All current life fellow/life members would be grandfathered in and not be impacted by this change. In addition, should a physician who is fully retired and is doing humanitarian work by seeing patients, the physician is still considered "fully retired" for the purposes of the definition.

Article II Membership

Section 2.07. Life Fellow/Life Member A Life Fellow/Life Member is any Any physician who has held continuous membership with the Academy as been a Fellow or Member for a minimum of 35 years, and fully retired from the practice of medicine. The member must provide written notification to the Executive Vice President/CEO requesting this status change and include a copy of his/her medical malpractice tail insurance coverage or acknowledgement of retirement from his/her medical licensing board for this class of membership to be considered for final approval by the AAO-HNS Board. of the Academy, or its predecessors-in-interest ingood standing for thirty-five (35) years shallautomatically become a Life Fellow or Life Member; provided, however, that years as a Member of the Academy prior to becominga Fellow shall be counted in determiningwhether one qualifies as a Life Fellow. A Life Fellow or Life Member need not have an active license to practice medicine.



BETTER HEARING AND SPEECH MONTH

Toning down noise-induced hearing loss

New research challenges the misconception that brief exposure to loud noise is reversible and without sequelae

By **Michael S. Harris, MD**, neurotology fellow, The Ohio State University and **Cameron C. Wick, MD**, neurotology fellow, University of Texas Southwestern, for the AAO-HNS Hearing Committee



he American Academy of Otolaryngology—Head and Neck Surgery
(AAO-HNS) Hearing Committee
works together with its Members
and allied organizations to raise
awareness, promote public policy,
and advocate for hearing health in the U.S. May
is the Better Hearing and Speech Month and
as part of that campaign the AAO-HNS would
like to draw attention to the important issue of
noise-induced hearing loss (NIHL).

NIHL is a growing problem with broad public health implications. An estimated 22 million workers are exposed to potentially dangerous levels of noise each year and 10 million Americans are affected by irreversible NIHL. Potentially harmful noise levels have been recognized and regulated in occupational

settings since the 1974 passage of the Occupational Noise Exposure Standard.² Today, this standard limits the level and duration of noise exposure that workers can be exposed to, mandates provision of hearing protection, and enforces minimum safety standards (Table 1). More stringent standards have subsequently been proposed by the National Institute for Occupational Safety and Health (NIOSH).³

While noise exposure standards exist for the workplace, no such protections are in place for recreational noise exposure. Public awareness of NIHL caused by high sound levels from personal listening devices (PLDs), concerts, sporting events, or other leisure activities remains low (Figure 1). Environmental noise in recreational settings can be significant, for instance, in 2014 the Kansas City Chiefs

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of the National Football League recorded a record-setting crowd noise of 142.2 dB. The National Institute on Deafness and Other Communication Disorders (NIDCD) has specifically highlighted NIHL as an area in need of greater awareness and made it the target of their national public education campaign: *It's a Noisy Planet. Protect Their Hearing*.

New research is challenging a misconception that brief exposure to loud noise is reversible and without sequelae. Evidence now exists in mice and guinea pigs that a single loud-noise exposure that causes a reversible hearing threshold shift can cause both immediate and long-term structural damage within in the cochlea. A similar injury profile has been found in human temporal bone specimens. This new insight into inner ear pathology has

been termed "hidden hearing loss" because standard hearing tests often miss the underlying damage. With repeated noise trauma there is potential for cumulative inner ear damage that may accelerate age-related hearing loss and contribute to poor speech discrimination.

Teenagers and young adults are key targets for Better Hearing and Speech Month. This demographic, in whom awareness of NIHL and hearing protection remains particularly low, is the major consumer of digital music delivered through PLDs. In light of the aforementioned research, this youth demographic may benefit the most from conscientious noise protection. Data suggests that 8- to 18-year-olds average 7.5 hours a day on multimedia devices.7 Additionally, 94 percent of college students own a PLD capable of playing music, and in one study 25 percent of teenagers had a preferred listening level considered "high risk" by NIOSH standards.89 Conventional hearing assessment protocols may have underestimated the potential harm of PLDs. New research with extended high frequency audiometry (9-16 kHz) suggests that a preferred listening level of greater

than 85 dB is associated with high-frequency hearing decline in young adults.10

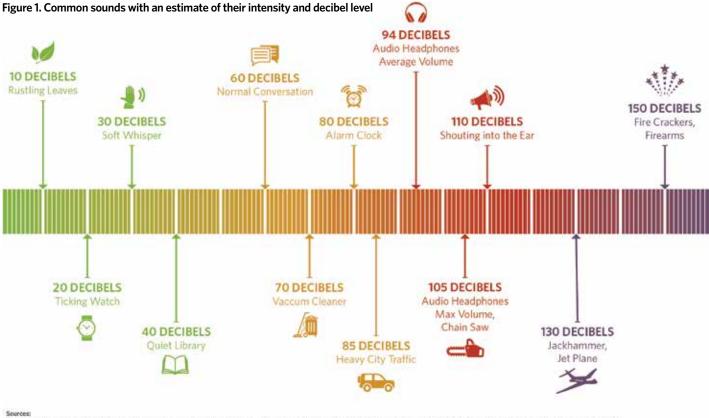
One challenge of educating the youth on NIHL is the incorrect assumption that sensorineural hearing loss is an affliction only associated with aging. Data suggests that more young people are showing evidence of sensorineural hearing loss. According to the National Health and Nutrition Examination Survey, the prevalence of hearing loss among United States adolescents aged 12 to 19 years old was 14.9 percent from 1988 to 1994, but rose to 19.5 percent in the period between 2005 and 2006.1 The role of NIHL and PLDs on this increase remains unknown.

Numerous organizations, including the AAO-HNSF, are dedicated to increasing public awareness on NIHL and healthy listening practices. One award-winning program developed by the American Speech-Language-Hearing Association (ASHA) is called "Listen to Your Buds." This campaign educates children, parents, and educators on NIHL and healthy listening habits when using PLD (www.asha.org/buds), A more comprehensive list of partnership organizations working on NIHL prevention can be found on the NIOSH website (www.cdc.gov/niosh/).

In general, healthcare providers can reinforce three basics tenets of NIHL prevention: decrease exposure time, increase distance from the noise source, and buffer the noise when possible. Hearing protection devices are recommended whenever a noise is above 85 dB. A variety of hearing protection devices are available ranging from disposable foam inserts to earmuffs to customizable musician plugs. New inexpensive smartphone apps also make testing environmental noise easier than ever.

The Hearing Committee continues to track this and other critical issues in order to provide the AAO-HNS with expert input for its role in consumer advocacy and public policy making by governmental agencies. Please join us this May, during Better Hearing and Speech Month, to raise awareness about NIHL.

See full reference list at www.entnet. org/bulletin.



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The role of antimicrobial stewardship is to help find the balance between the immediate needs of a patient and the future needs of that patient and everyone else

By **Nicholas Bennett MA, MBChir, PhD**, and **Tulio A. Valdez, MD, Msc**, Connecticut Children's Medical Center and University of Connecticut Health Center, for the AAO-HNS Infectious Disease Committee

t is an oft-touted statistic that about half of all antibiotics are used inappropriately—a statistic garnered from inpatient and outpatient surveys of antibiotic usage rates, compared against specific diagnosis codes, and in some instances with a degree of "expert opinion" thrown in for good measure. What, after all, should be considered inappropriate usage?

Certainly the use of antibiotics to treat symptoms due to viruses, or noninfectious conditions, would be inappropriate. We are fortunate perhaps in that the diagnosis of viral versus bacterial upper respiratory tract infections is so easy to make. (We jest.) Is it more appropriate to withhold antibiotics on the assumption that most viral infections are self-limited, or prescribe antibiotics just in case of a primary or secondary bacterial

infection? In the context of headlines on worsening antibiotic resistance should the empiric use of antibiotics include the use of broader-spectrum agents than we have used previously? In order to avoid surgical site infections, is widespread empiric perioperative antibiotic usage necessary? These are all legitimate questions to ask, and worthy of asking because the answers aren't obvious. While antibiotics have led to dramatic improvements in health, inappropriate antibiotic usage has been shown to lead to increased adverse drug reactions, antibiotic resistance, Clostridium difficile infections, and unnecessary cost.

The role of antimicrobial stewardship

Antimicrobial stewardship



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Surgical specialties have as much of a role to play in antimicrobial stewardship as any other medical field—and in fact have so much more to lose. If we lose the battle with the microorganisms, we lose the ability to keep our patients safe from invasive procedures, and what is now routine could become too risky to perform unless under exceptional circumstances.

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is to help physicians, surgeons, residents, and advanced practitioners find the balance between the immediate needs of a patient and the future needs of that patient and everyone else. There are several well-studied, evidence-based approaches to the dilemmas of antibiotic use¹ but how to apply them in practice is often more difficult than one might think. There are certain core concepts though: In general, one should use only as broad an antibiotic as one needs to treat an infection, at the correct dose, for the correct duration. So how does one come to that information, and what can we do to ensure it happens routinely in practice?

In the hospital-based setting formal antimicrobial stewardship programs have gone from being a nice idea to inclusion in Presidential Executive Orders. There is wide variation in practice between institutions, and where there is variation there is the need for standardization.

With specific regard to otolaryngology, Valdez, et al.,² reported on perioperative antibiotic use among 442 surgeons, with wide variation is usage rates, from 91.1 percent for laryngectomy to 11.2 percent for microlaryngoscopy. Interestingly, for many surgeons who routinely used antibiotics perioperatively, around half of them felt there was "not enough evidence" to use antibiotics in that way. Antonelli's recent review³ of the literature regarding the use of perioperative antibiotics in otolaryngology would support

this view, with antibiotics either showing no benefit in reducing surgical site infection rates for clean procedures, whereas there was data to support the use of antibiotics in neurotologic craniotomies. At least a few studies (covered in Antonelli's review) have addressed the impact of anti-staphylococcal and anti-pseudomonal antibiotics as perioperative coverage for tympanoplasty with or without mastoidectomy, where post-surgical infection rates can be higher than 10 percent. Results have been mixed, and may depend as much on patient-specific factors such as the pre-operative microbial flora as the type of surgery and antibiotic used—a situation that makes both the development and implementation of broad, consensus guidelines difficult, but also identifies an area of research need.

Perhaps duration of prophylaxis is an area of need to be addressed; most surgical procedures probably need no more than enough antibiotics to cover the procedure itself, with no additional benefit seen in extended post-operative therapy for 24 or 48 hours.⁴

Evidence-based guidelines, adapted for local needs and concerns, can make significant improvements in antibiotic usage without any increase in adverse patient outcomes—in fact more typically with improvements in the risks associated with antibiotic usage. There are guidelines with direct application to otolaryngology that could readily be adopted and adapted using the concepts of antimicrobial stewardship. The American Academy of

Otolaryngology Foundation—Head and Neck Surgery has practice guidelines on adult sinusitis5 for example, and the most recent update now recommends watchful waiting without antibiotics for all cases of uncomplicated disease, rather than just those with mild symptoms. The guidelines also recommend the use of amoxicillin with or without clavulanate as initial therapy, and the use of a "wait and see prescription" as part of the initial management in some cases. For some clinicians these may be significant changes in practice, but ones which have proven positive effects on overall antibiotic utilization, and which could be relatively easy to implement as an individual or group effort. Aside from improved clinical care, reduced healthcare costs, and lower risks of future antibiotic resistance, such quality-improvement efforts can be used toward Part IV Maintenance of Certification credit.

Surgical specialties have as much of a role to play in antimicrobial stewardship as any other medical field—and in fact have so much more to lose. The modern antibiotic age has allowed surgical procedures to be performed that would have been fatal without the availability of relatively safe and effective antimicrobials. If we lose the battle with the microorganisms, we lose the ability to keep our patients safe from invasive procedures, and what is now routine could become too risky to perform unless under exceptional circumstances. We owe it to our future selves and colleagues, and our patients, to do the best we can to use antibiotics judiciously.

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Andrew F. Inglis, MD Steven Gray Memorial Lecturer University of Washington School of Medicine

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Otolaryngology - Inpatient Hospitalist

The Department of Otolaryngology - Head & Neck Surgery at Emory University School of Medicine, Atlanta, GA seeks to add an Otolaryngologist at the rank of Assistant or Associate Professor with primary duties as Inpatient Hospitalist at Emory University Hospital. Duties will include Inpatient and Emergency Department consultation and continuing care during the normal scheduled work week. Opportunities for resident and fellow teaching and academic productivity are also available. A broad Otolaryngology base is required in order to handle urgent airway issues, invasive fungal disease and general consultation on complex and critically ill patients. Applicants must be Board Certified or Board Eligible and will have a University appointment. The practice currently consists of two part-time physicians covering all standard work days. Opportunity for additional outpatient practice can be arranged depending upon mutual interest.

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• A General Otolaryngologist to expand our general otolaryngology & allergy services. The candidate would be expected to work in our main office as well as in one of our satellite offices. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

• A board-certified Otolaryngologist Program Director of the residency training program with 30% protected time, & the rest will be devoted for clinical services at the main campus. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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Successful candidates must also have an MD, MD/PhD or DO degree (the employer accepts foreign educational equivalent) and be eligible to obtain an unrestricted West Virginia medical license. Candidates must be board certified/eligible by the American Board of Otolaryngology. Faculty rank and salary will be commensurate with credentials.

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For additional information, contact **Dr. Hassan Ramadan**, Professor and Chair, Department of Otolaryngology at hramadan@hsc.wvu.edu / 304-293-3233. WVU is an AA/EO employer - Minority/Female/Disability/Veteran - and is the recipient of an NSF ADVANCE award for gender equity.

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The current practice features one full-time Rhinologist, one part time Laryngologist, and one part time Otologist. Two residents supported by an Advanced Practice Practitioner and a Patient Care Coordinator. Operating rooms are well equipped.

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Interested applicants should forward letters of inquiry and curriculum vitae to:

Douglas E. Mattox, MD

William Chester Warren, Jr. MD, Professor and Chair Department of Otolaryngology – Head & Neck Surgery 550 Peachtree Street, Medical Office Tower, Suite 1135

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Featured 8th in Money Magazine's "Best Places to Live," Ames, lowa is recognized as an active, friendly community with plenty to do. Ames is a vibrant university town with one of the highest-rated public school systems in the nation. Having close access to several major metropolitan cities means that this versatile community provides small-town serenity and charm plus big-city amenities and culture.

EEO/AA Employer/Protected Vet/Disabled

Contact Doug Kenner 866.670.0334 or dkenner@mountainmed.net

Head and Neck Surgery Fellowship

The Head and Neck Fellowship is a comprehensive one-year fellowship, encompassing a full spectrum of Head and Neck Oncology, Multidisciplinary management of head and neck cancer patients, with clinical research involvement.

Clinical Focus: Head and Neck Oncologic Surgery, Microvascular Reconstructive Surgery, Skull Base Surgery, Minimally Invasive Endocrine Surgery, Transoral Laser Surgery, Transoral Da Vinci Robotic Surgery, and management of skin cancers, including melanoma, and sentinel lymph node biopsy.

Admission to the fellowship is contingent upon completion of one of the ACGME-accredited residency programs in Otolaryngology, Plastic Surgery or General Surgery and eligibility to sit for board examination in applicant's respective specialty. Applicants must be eligibile for a medical license in the state of Kansas.

All interested candidates should apply via the American Head and Neck Society Match.

www.ahns.info/residentfellow



DEPARTMENT OF OTOLARYNGOLOGY -HEAD AND NECK SURGERY

> Contact: Samantha Hall Senior Coordinator at 913-588-6739 or shall7@kumc.edu www.kuent.info

Rhinology and Skull Base Surgery Fellowship

The Department of Otolaryngology-Head & Neck Surgery at the University of Kansas Medical Center has added a new Rhinology and Skull Base Surgery Fellowship and is currently accepting applications for the 2017-2018 academic year.

Under the mentorship of Drs. Alexander Chiu and David Beahm, this one-year fellowship will facilitate exposure to a large volume of sinus and skull base procedures. The fellow will also be afforded tremendous opportunities for clinical and/or translational research within the department's research program. The fellow will learn medical management of sinonasal disease and otolaryngic allergy practice via experience in outpatient clinics.

Eligibile applicants must have successfully completed an ACGME-accredited Otolaryngology residency training program, are expected to be American Board certified/eligible and must be able to obtain a Kansas and Missouri medical license.

All interested candidates should apply via the SFMatch.

www.SFMatch.org

Chester County Otolaryngology & Allergy Associates

SCENIC PHILADELPHIA SUBURBS

- Flourishing four physician Otolaryngology practice seeking an additional BC/BE physician.
- Located in beautiful Chester County, Pennsylvania's fastest growing county, with easy access to Philadelphia, New York City, Washington DC, mountains, and shoreline.
- Current services include audiology with hearing aid dispensing and balance testing, sinus surgery and allergy testing/immunotherapy, endocrine surgery, head and neck oncologic surgery, reconstruction of malignant cutaneous defects, and general pediatric and adult otolaryngology.
- Competitive salary, early partnership, health/dental insurance, 401k/Profit Sharing, paid CME and vacation.

Interested candidates please forward letter of interest and curriculum vitae to Alice via email at ccofps@comcast.net.

Head and Neck Surgical Oncologist/ Microvascular Reconstructive Surgeon

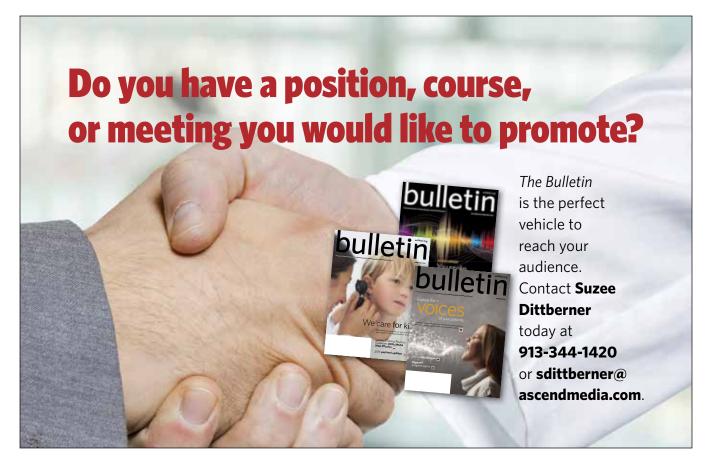
FULL-TIME BE/BC FACULTY FELLPSHIP TRAINED FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for a full-time position. This job entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country. Clinical research is encouraged but not mandatory.

Please direct your Letter of Interest and CV to:
Vicente Resto, MD, PhD, FACS
Chair, Department of Otolaryngology, UTMB Health
301 University Boulevard, Galveston, TX 77555-0521
Email: varesto@utmb.edu Phone: 409-772-2701



UTMB is an equal opportunity, affirmative action institution which proudly values diversity Candidates of all backgrounds are encouraged to apply.





Otolaryngology

Bassett Healthcare Network, a progressive health care network in central New York and major teaching affiliate of Columbia University, is seeking a hospital-employed, full-time BC/BE Otolaryngologist to join as Chief of a busy expanding OHNS practice.

The Division of Otolaryngology-Head & Neck Surgery offers a full range of services including otology, laryngology, facial plastic surgery, sinus surgery, head and neck surgery, research and teaching opportunities. Training in surgical oncology is encouraged but not a requirement.

Bassett Healthcare Network is an integrated health care system that provides care and services to people living in an eight county region covering 5,600 square miles in upstate New York. The organization includes six corporately affiliated hospitals, as well as skilled nursing facilities, community and school-based health centers, and health partners in related fields.

Nestled in the foothills of the Adirondack and Catskill Mountains, Bassett Medical Center is located in Cooperstown, New York, a beautiful resort village on Otsego Lake.

For confidential consideration, please contact:

Debra Ferrari

Bassett Medical Center
One Atwell Road, Cooperstown, NY, 13326
phone: 607-547-6982 • fax: 607-547-3651
email: debra.ferrari@bassett.org
or visit our website: www.bassettopportunities.org

EEO Employer







Otologist/Neurotologist Massachusetts Eye and Ear

The Department of Otolaryngology at the Harvard Medical School is seeking an Otologist/Neurotologist with special interest in the vestibular system for a clinical and research faculty position at the Massachusetts Eye and Ear. An appointment at the level of Instructor, Assistant Professor or Associate Professor is anticipated, depending upon the level of the candidate's qualifications. The successful candidate must have completed fellowship training in the area of Otology/Neurotology or equivalent expertise, a track record of effective teaching, and is expected to be engaged in clinical, translational, and/or basic research in dizziness, balance or the vestibular system.

Please send inquiries, CV and letters of interest to:

Steven D. Rauch, M.D.

Professor and Search Committee Chair Department of Otolaryngology Massachusetts Eye and Ear Harvard Medical School 243 Charles Street, Boston, MA 02114 Steven_Rauch@meei.harvard.edu

The Massachusetts Eye and Ear and Harvard Medical School are Equal Opportunity/Affirmative Action Employers.

Women and minorities are encouraged to apply.

Incredible Otolaryngology Opportunity in

SOUTHWEST ARIZONA

Seize this opportunity to establish and build an extremely successful practice in a growing community of 200k residents, with another 100k residents who join our community to play during our mild winters... and YES - in our 70 degree temperatures in February!

Flexible practice models exist, including a hospital employed position, a solo practice option, as well as the opportunity to join an existing practice already established in our community-completely your choice.

Yuma, Arizona sits on the edge of the Colorado River/Martinez Lake and the borders of California and Arizona and is located just under a 3-hour drive from San Diego, CA to the west and the same distance from Phoenix, AZ to the east.

Abundant recreational activities can be enjoyed all year in Yuma; boating, water skiing, kayaking, fishing, hiking, biking, hunting or camping to name a few.

Yuma Regional Medical Center (YRMC), a 406 bed top-intechnology facility, is the only acute care hospital of its size within a 170 mile radius and provides almost all modalities of



care. We boast a medical staff of over 400 physicians and allied health professionals across the majority of specialties, with more than 94% holding board certification.

Take advantage of this chance to earn EXCEPTIONAL income while enjoying a balanced and fulfilling personal life, all in a wonderful collegial environment—you will not be sorry you did!

Contact me to learn more:

Pam Orendorff

Director of Physician Relations & Recruitment Phone: (928) 336-3032

Email: porendorff@yumaregional.org



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UMass Memorial Medical Center is situated in Worcester, MA, a community rich in history. Worcester is the second largest city in Massachusetts and New England, and has a very large patient referral base. Worcester and the surrounding area have a strong and diverse economic base with family oriented communities and excellent school systems. Boston and Providence are only forty miles away, and beaches, lakes, and mountains are all easily accessible.

For consideration and/or additional details, please submit your CV and Letter of Introduction to:

Daniel Kim MD

Department Otolaryngology - Head and Neck Surgery UMass Memorial Medical Center

c/o Melissa Miller, Physician Recruiter

Email: melissa.miller3@umassmemorial.org

Phone: 774-443-2980

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

Otologist/Neurotologist FULL-TIME BE/BC FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for a full-time position. This job entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. Additionally, the department operates a state of the art clinical vestibular laboratory established in collaboration with NASA. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country. Clinical research is encouraged but not mandatory.

Please direct your Letter of Interest and CV to:

Vicente Resto, MD, PhD, FACS

Chair, Department of Otolaryngology, UTMB Health 301 University Boulevard, Galveston, TX 77555-0521 Email: varesto@utmb.edu Phone: 409-772-2701





UTMB is an equal opportunity, affirmative action institution which proudly values diversity Candidates of all backgrounds are encouraged to apply.



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 continue its competitive one-year Head & Neck Surgery and Reconstruction fellowship beginning **July 2017**. The head and neck surgical team includes **Drs. Pierre Lavertu, Rod Rezaee, Nicole Fowler** and **Chad Zender**.

This one year fellowship offers advanced training in:

- Microvascular free tissue transfer
- Over 150 cases per year
- · Endoscopic and open skull base surgery
- · Minimally invasive head and neck surgery
- · Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Applicant requirements:

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

Fellowship requirements and opportunities include:

- Clinical duties
- Teaching residents and medical students
- 1-12 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

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

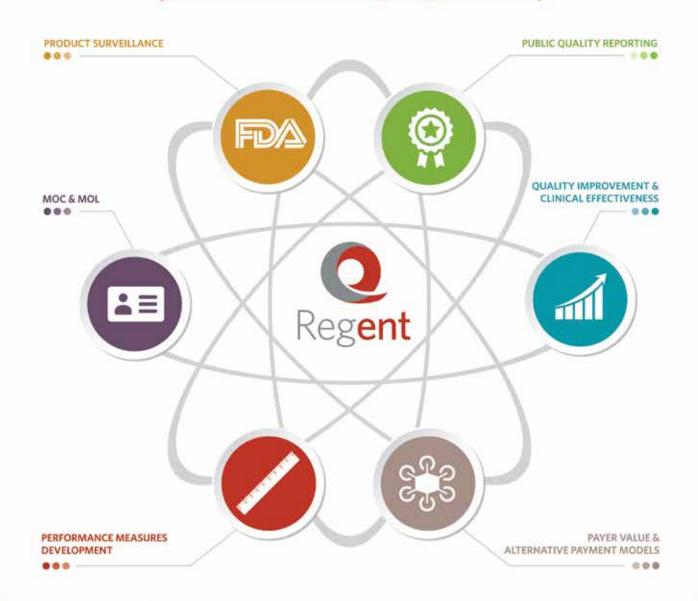
Associate Professor • Director of Head and Neck Fellowship • Vice Chair of Clinical Affairs and Translational Research
University Hospital-Case Medical Center • Department of Otolaryngology-Head and Neck Surgery
Chad.Zender@UHhospitals.org • 216-844-5307

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