bulletin

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

NOVEMBER 2016

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*See Holstein N. Ginkgo special extract EGb 761 in tinnitus therapy: An overview of results of completed clinical trials. *Fortschr Med* 2001 Jan 11; 118(4): 157-64. Also: Von Boetticher A. Ginkgo biloba extract in the treatment of tinnitus: a systematic review. *Neuropsychiatr Dis Treat* 2011; 7:441-447.

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**Rhodus, N.L.: The Effectiveness of Artificial Salivas in Relieving Xerostomia as Assessed by Mucoprotective Relativity., J Dent Res 70:407, 1991. Abstract 1133.*

Pride and privilege

Surgeons must be very careful
When they take the knife!
Underneath their fine incisions
Stirs the Culprit—Life!
—Emily Dickinson, 1859

We have an unusual privilege. To meet and quickly enter the lives of our patients in their time of need. To interact humanely and to understand their pain and fear and guide them to a better place. I was always interested in biology, but my thoughts did not turn to medicine until my father's health downturn late in life.

We each find our path to this human calling. Most days after clinic as I drive home I realize I have entered into the lives of multiple people. For many of these individuals and families our interaction is of lifelong significance. This meaning, this significance, is more important than money and time. We do this work because it celebrates both hand and mind. We do this to move toward the perfect surgical offering realizing we can never get there. We do this because it honors our patients. We do this to be the best we can be.

The distractions and the Academy

The pride in doing something as perfectly as one can is the daily conduct of the surgeon. There are difficulties: inadequate staffing, time constraints, burdensome paperwork, excessive regulation and legislation, an evolving army of surrogate "patient advocates," and inadequate and uninformed reimbursement. These issues must not be allowed to alter the importance of our work in the care of our fellow humans. For these other distractions, let the American Academy of Otolaryngology—Head and Neck Surgery help. This is why the Academy exists. Here are just three ways you can benefit:

- Network with the vast resources of our membership through **ENTConnect** (entconnect.entnet.org/home).
- Collaborate with your colleagues through Academy **committee** work.
- Share data and advance the field through AAO-HNSF's **Regent**[SM] registry (www.entnet.org/content/regent-ent-clinical-data-registry).

Complications and Regent

When we operate, we will from time to time have complications and "less than optimal outcomes." I have explained to my residents and fellows that if you are human and treating humans, you will have complications. The commitment to the patient is to learn from this complication. This is not just our surgical foundation, but how we understand ourselves as human beings and as partners with our patients. A Spanish proverb reads: "There is no better surgeon than a man with many scars."

Our commitment is to do better the next day, to improve. Regent makes this possible in very real terms. Regent allows us to gather data to define our performance and to endeavor to improve the surgical care we offer each day—to exactly determine the outcome of what we do and to do so within our community of otolaryngology. With Regent we can all learn together. Regent will help us to educate ourselves to be better the next time in the OR!

Leadership

Surgeons are leaders and can provide insight into disease processes. James Berry, an early surgeon anatomist, said in 1887 of the structure subsequently named after him, the ligament of Berry: "I have noticed in operations of this kind, which I've seen performed by others upon the living and in a number of excisions which I have myself performed on the dead body that most of the difficulty in the separation of the tumor has occurred in the region of these ligaments … This difficulty I believe to be a very frequent source of that accident which so commonly occurs in the removal of goiter, I mean division of the recurrent laryngeal nerve."

In 1938, Frank Lahey, an early American thyroid surgeon, said of the recurrent laryngeal nerve, which was previously felt to be too fragile for surgical dissection and therefore should not be dissected, "careful dissection would not increase but definitely decrease the number of injuries to the recurrent laryngeal nerves." He wrote further that "I am convinced that the best management of RLN injuries is of the preventative character."

Join me in our Academy work, collaboratively with one unified otolaryngology voice, strengthened and focused through its mission and service. The turbulence ahead provides an opportunity to defend our right to improve the quality of our care, to come together reaching beyond the familiar, and to open ourselves to new understandings. We were not second to the moon—this is our time! ■

Gregory W. Randolph, MD
AAO-HNS/F President

> "For many of our patients our interaction is of lifelong significance. This meaning, this significance, is more important than money and time."

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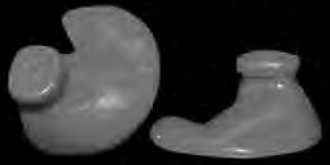

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Private practice will thrive

We have highlighted the diverse nature of otolaryngology practices across the United States in the "Practice Profile" feature in the *Bulletin*. In this issue we spotlight **Jerrold Polterock, MD**, a semi-retired otolaryngologist practicing in California who has found a very satisfying way to remain active in a field he loves. There are many veteran Members of our Academy who have taken advantage of opportunities such as this or are looking for similar ways to continue practicing. Challenges inherent in this type of practice are materially different than those faced by physicians practicing in larger groups or academic centers, particularly in the availability and depth of supporting resources.

I was recently privileged to attend and speak at the Large Group Executive Forum (LGEF), a component group of the Association of Otolaryngology Administrators (AOA), and experienced firsthand the cutting-edge strategies and allocation of resources that allow otolaryngologists to best serve their patients. The willingness to share "best practices" regarding such crucial issues as scheduling, compliance, reporting, and services provided gave me great confidence that the private practice of otolaryngology will not only survive but thrive in the future.

One of the driving forces behind the creation of our clinical data registry, Regent[SM], was the realization that otolaryngologists, irrespective of their clinical situation and access to resources, will need to demonstrate and report on quality-based practice going forward. Regent will allow them to do that as well as allow the specialty to help define standards of clinical care rather than relying on other agencies to do so. The initial participation in the registry has been well beyond our expectations and is continuing to grow.

Single-use devices

One of the feature articles in this month's *Bulletin* concerns FDA deemed "single-use devices." I would like to compliment and thank the group led by **C. W. David Chang, MD**, for this informative educational piece on a topic that cuts across multiple areas of our specialty. This document includes contributions from the diverse clinical areas and societies of otolaryngology that potentially would deal with this issue along with the Ethics, Patient Safety and Quality Improvement, and Medical Devices and Drugs committees, the 3P Advisory Group, and the FDA. This article informs our Members of the current landscape regarding these devices and how they are regulated.

Payers scrutinize common procedures

There seems to be a resurgence in the scrutiny applied to some of our more common procedures by payers across the country. Our Health Policy team has been working with the 3P Advisory Committee to provide cogent comments on potential policy changes by various insurers affecting some of our most common procedures such as fiberoptic flexible laryngoscopy, nasal and sinus endoscopy, functional endoscopic sinus surgery (FESS), balloon sinus ostial dilation (BSOD), and vocal fold injection for paralysis and glottic insufficiency. These proposals range from change in indications to change in pre-certification requirements and all the way to reclassification of long-standing, successfully performed procedures such as FESS and vocal injection for paralysis and glottic incompetency to "investigational." There is an accelerating concern by payers related to BSOD, particularly ones performed in the office setting. As part of a collaborative effort with the American Academy of Otolaryngic Allergy and the American Rhinologic Society, **Joseph Han, MD**, led a special project to revise our Position Statement on BSOD, which was approved at the September Board of Directors meeting and is posted on our website. As part of a longer-term strategy, a Consensus Statement will also be considered. Recently, in Pennsylvania and Delaware there have been requests for refunds from our Members of up to three years for in-office BSOD. It is clear that the specialty must take the lead in establishing reasonable indications based on evidence for this procedure or others will do it for us.

Perhaps the most concerning of all of these above-mentioned issues was the proposed reclassification of FESS as investigational after more than 30 years of use. Several senior rhinologists worked with our Health Policy staff to produce an evidence-laden reply documenting multiple studies validating the utility and value of the procedure. We will use the same model with senior laryngologists to respond to a similar change proposed for vocal injection for paralysis.

It is critical that we receive input from our Members across the country when changes are recognized relating to insurer policies so we can be on board early. With your help, we will continue to work aggressively to protect our patients and the ability to perform procedures that give them benefit. ■

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

> "The willingness to share 'best practices' regarding such crucial issues as scheduling, compliance, reporting, and services provided gave me great confidence that the private practice of otolaryngology will not only survive but thrive in the future."

BOARD OF GOVERNORS

The Academy is you

Spencer C. Payne, MD,
BOG Governance & Society Engagement chair

This month, we celebrate and thank the Members of the various AAO-HNS/F committees who have faithfully served over the past year. Originally defined as "the one to whom something has been entrusted," the idea and implementation of "a committee" has evolved to comprise more than just the individual, but a larger group working as one. Though a search of the internet is replete with any number of less flattering definitions of the word, I can assure you that none of them would be an accurate portrayal of the pooled abilities of our Academy Members. And for this, I thank all the volunteer leaders who have worked tirelessly to advocate, educate, and administrate on our behalf.

This is not, however, just a time to appreciate, but a time to encourage and exhort. As we thank those who have served, we also open the doors for Academy Members who have not yet held positions to find their passions and *commit* to a cause! I have run across a number of more senior Members, young physicians, and residents who do not know how to get involved or are discouraged if not selected. The fact is that committee meetings are open to all and decisions are made by those who show up. By getting involved early, everyone benefits and grows through the comingling of different perspectives and visions. Whether it's hearing health, rhinology education, medical devices, or even otolaryngologic history, there is a committee that can use you and that you can use to strengthen the Academy.

As the committee applications open up this month, I encourage you to also consider involvement with the Board of Governors (BOG) and its three committees: Governance & Society Engagement, Socioeconomic & Grassroots, and Legislative Affairs. As the grassroots organization within the Academy, the BOG is often tasked with interfacing on many of the issues that affect us as physicians and not just as otolaryngologists. Issues ranging from alternative payment models, to changes in insurance carrier policies, to scope of practice concerns, need to be addressed, and the BOG provides a home for this. If not through a committee, even serving as a local advocate (PROJECT 535) or a BOG Socioeconomic Grassroots regional representative can ensure the numbers needed to effect change.

Whether it is through networking, developing friendships and mentoring relationships, or strengthening the educational and research endeavors of the Academy, it is hard not to come away from any involvement on a committee without a serious sense of accomplishment. Additionally, the personal growth that comes from appreciating and working with other points of view to create more widely encompassing solutions is another of the many reasons I have been and continue to remain active in Academy committees.

I know from ENTConnect that many of you have found your voice, and many have asked "what is the Academy doing about this?" The answer is "the Academy is you!" Our BOG and AAO-HNS/F committees await your enthusiasm and engagement to help solve these many issues, and I look forward to seeing your names on the committe roster. ■

FDA issues fluoroquinolone black-box warning

On July 8, the Food and Drug Administration notified the manufacturers of fluoroquinolone antimicrobials that black-box warnings must be added to the drugs' labels to warn of risk for possibly permanent nerve damage from antibacterial fluoroquinolone drugs taken by mouth or by injection.

The *Otolaryngology–Head and Neck Surgery* journal's Clinical Practice Guideline: Adult Sinusitis includes the following paragraph as part of key action statement five related to "choice of antibiotic for acute bacterial rhinosinusitis" (page S17).

Penicillin-allergic patients

For penicillin-allergic patients, either doxycycline or a respiratory fluoroquinolone (levofloxacin or moxifloxacin) is recommended as an alternative agent for empiric antimicrobial therapy. Fluoroquinolones, however, are not recommended for first-line therapy of ABRS in patients without penicillin allergy because outcomes are comparable to amoxicillin- clavulanate, and adverse events are higher in some trials.[126] Combination therapy with clindamycin plus a third-generation oral cephalosporin (cefixime or cefpodoxime) is recommended in adults with a history of non–type I hypersensitivity to penicillin. ■

Congratulations Regent℠ leadership and staff

Individual sign-up for participation in Regent℠ topped 1,000 academicians and private practitioners prior to the close of its initial introductory period, September 30.

This is a dynamic beginning for the AAO-HNSF registry.

Regent is an otolaryngology-specific clinical data registry that will become the foundation for quality reporting, measures development, quality improvement, clinical and product research, and support for maintenance of certification and licensure. With Regent, AAO-HNSF is investing in our Members' future, a future that will increasingly involve payment based on quality of care and performance measurement.

Learn more about how Regent can help you and your practice prepare for MIPS reporting. Sign up today and be ready for the transition to new reporting at **www.entnet.org/content/regent-benefits**. ■

Legislative Advocacy highlights from the Annual Meeting

Once again, Annual Meeting attendees had the opportunity to learn more about the Academy's federal legislative priorities, grassroots initiatives, and political programs by visiting one, or both, of the Legislative Advocacy booths. Highlights of our Legislative Advocacy successes during Annual Meeting follow.

PROJECT 535

The Board of Governors and Legislative Advocacy staff are happy to report that the ranks of PROJECT 535 grew by 23 individuals thanks to new volunteers from this year's Annual Meeting. As a reminder, the goal of PROJECT 535 is to build relationships with federal legislators in every U.S. Congressional seat —435 in the House and 100 in the Senate. PROJECT 535 will help establish key "grasstop" contacts, *voting* physicians with access to national leaders in *every district*. As of October 11, 54 percent of districts were "covered" by AAO-HNS Members. Send an email to govtaffairs@entnet.org to sign-up and represent your district/state.

ENT PAC success at Annual Meeting

Thanks to the generous support of its Investors, ENT PAC, the Academy's political action committee, raised more than $20,000 during the AAO-HNSF 2016 Annual Meeting & OTO EXPO℠.*

Lunch among Advocacy leaders

On September 19, the ENT PAC Board of Advisors hosted the annual Advocacy Leadership Luncheon. Attendees included 2016 ENT PAC Chairman's Club donors, representatives from the various AAO-HNS Sections and the Board of Governors, as well as other key advocacy leaders. During the event, attendees discussed critical healthcare issues with **special guest speaker, U.S. Representative Raul Ruiz, MD (D-CA)**. For more information about the ENT PAC Leadership Clubs, email entpac@entnet.org.

ENT PAC Thank You Reception

On September 19, ENT PAC Investors were invited to attend the annual PAC Thank You Reception. This year's event took place at The Shout! House in San Diego's popular Gaslamp District. Attendees enjoyed a night of music and camaraderie during a private "dueling pianos" show. The ENT PAC Board of Advisors and staff thank all our 2016 PAC Investors!

To receive the latest legislative and political news year round, join us via social media. **"Follow" us on Twitter @AAOHNSGovtAffrs, "Like" us on Facebook, and "Connect" to us on LinkedIn!** ■

*Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all Members of the American Academy of Otolaryngology-Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year. ENT PAC is a program of the AAO-HNS which is exempt from federal income tax under section 501 (c) (6) of the Internal Revenue Code.

2017 AAO-HNS/F committee application cycle is open

The 2017 application cycle opened November 1 and closes on January 1, 2017. Committee applicants must be in good standing and either a voting fellow, Member, resident Member, scientific fellow, international fellow, or international Member to be eligible. All current committee members and committee applicants must pay 2017 Academy dues no later than January 15, 2017. Committee applicants will not be considered unless payment has been received by that date. For more information and for the application, please visit our website at **www.entnet.org/content/committees**. ■

Call for 2017 AAO-HNS election candidates

The Nominating Committee of the Academy is calling for recommendations of individuals to be considered for an AAO-HNS elective office. Academy Member(s) must be in good standing, have proven leadership qualities, be active in the Academy, be familiar with the strategic direction of the Academy, and be able to dedicate the necessary time to serve. Please complete the application packet of materials and submit to any Member of the Nominating Committee requesting he or she support your nomination for elected office. For more information and the application packet, please visit our website at **www.entnet.org/content/call-election-nominees**.

Application deadline is December 7, 2016 (no extensions permitted). ■

PRACTICE PROFILE

A life of service

Longtime Academy Member **Jerrold Polterock, MD**'s 'retirement' practice provides majority of head and neck care in rural California county

When he was around age 70, **Jerrold Polterock, MD**, considered hanging up his otoscope.

"That was 2008. I was thinking about retirement but that only lasted a few days," quips Dr. Polterock. "So then I thought, 'Okay, I'll go out and do locum tenens.' Once you do that though, your name is out there for recruiters."

One thing led to another and eventually Dr. Polterock, who spent the majority of his career in San Bernardino, Los Angeles, and San Diego (with a brief stint in South Carolina), landed in Stanislaus County, CA, where he continues to practice.

"I work four mornings a week in what is considered a rural health clinic," he explains. The clinic is subsidized by the state of California. "I see mostly Medicaid patients there. I also have what is basically a small private practice in those same four afternoons."

The average afternoon for Dr. Polterock is seeing three to five patients. He also operates one day each week, averaging six to eight cases.

Dr. Polterock is on staff at a 25-bed hospital where he helps with the emergency room, though he rarely receives calls and if so, it's usually for a consult.

"I say that I've discovered a way to retire and get paid for it. I'm out in a semi-rural community, at a hospital that doesn't do trauma. You could do this falling off a log," he says in jest. If he has any really big cases that come in, he sends them to UC Davis or UC San Francisco.

"I still do surgery, though I wouldn't do a stapedectomy," Dr. Polterock says with a pause, "Then again, I haven't done a stapedectomy since 1974."

That he is pleased to be serving right where he is was evident during a phone interview. "There are no extraordinary demands placed on me, and I'm doing a service for the community," he says. "Where I'm at is not a huge county though Modesto is in it. I could guarantee you that I do 90 percent of all head and neck work in the county, maybe even more." Some patients travel four hours to see him. "That may be great for your ego, but then you stop and think about it and realize there is nobody taking a Medicaid patient between you and four hours away."

Asked about reimbursement frustrations or other business concerns, Dr. Polterock responds, "I haven't looked at reimbursement, honestly speaking, since probably 1996. The reality is there's nothing you can do about it. There's no way you can fight with an insurance company. Any physician that's out there and is going to war about reimbursement is knocking his own head against a wall. The only time I think you have an argument is if an insurer approves something and then later down the road denies it." He finishes his point, "You gotta get the work done anyway."

It's clear. Dr. Polterock is in this for the patients.

He selected otolaryngology because he would get to see both sexes, all ages, and because it was fun. "And it has continued to be fun," he interjects.

When he first started out and his own kids were little, he says that he preferred not to treat children. But now, if he could only see kids, he'd be elated. "They're just the best," he says.

Another draw for otolaryngology is that most patients get better. "Except for the occasional cancer case that you could never get ahead of, almost everybody gets better because it all boils down to you making the correct diagnosis and treating it. If I have someone come in, treat them and in a week or two, they're not better. I change my diagnosis."

He also has a deep respect for surgical relationships. "The only decision you have to make in medicine is whether you're going to cut somebody or you're not, and that just depends on your personality that was laid down when you were a little kid. You're either aggressive enough to do that—and you know, it's an extremely aggressive act, even if you're doing it for therapeutic purposes—to cut somebody. So when you operate on somebody and they get better—that feedback—you've solved a problem for them for the rest of their life," says Dr. Polterock. "You develop very personal relationships with the people that you've operated on. Even if you get somebody better medically, it's just not the same connection as when you get somebody better surgically."

Dr. Polterock feels fortunate to have seen and heard from otolaryngology pioneers. "For the people that trained at the same time as I did, the giants were still around, not only in otology, but in head and neck and in plastics. I think my generation was the last to benefit from that. I'm talking about the people that laid the ground for otolaryngology."

In 1965, as a resident in Chicago, Dr. Polterock began a habit of taking in our Annual Meetings, which were held there at that time. He now claims to have attended more than 50 since then.

He recalls shortly after he first started practicing and doing outpatient surgeries, running into his former chief and telling him about outpatient tonsillectomies. "Chief thought that was just unbelievably outrageous. He just couldn't imagine and now, that's standard of care," chuckles Dr. Polterock. He has always felt that outpatient procedures were a significant move forward in medicine.

Asked for wisdom to impart, Polterock remarks, "If residents love what they're doing now, they can love it for the rest of their career. I play tennis, and I always tell the people that I play with: my ego gets fed first by my family, second by my profession, and tennis is a really poor third." ■

2017 CORE GRANT FUNDING OPPORTUNITIES

www.entnet.org/CORE

CENTRALIZED OTOLARYNGOLOGY RESEARCH EFFORTS

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Application to be submitted electronically by **January 17, 2017 midnight ET**

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

AAO-HNSF Bobby R. Alford Endowed Research Grant
$30,000, non-renewable, one year to complete project. One available.

AMERICAN HEAD AND NECK SOCIETY (AHNS)

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

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$40,000 ($20,000 per year), non-renewable, two years to complete project. One available annually.

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

AMERICAN RHINOLOGIC SOCIETY (ARS)

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

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

AMERICAN SOCIETY OF PEDIATRIC OTOLARYNGOLOGY (ASPO)

ASPO Research Career Development
$40,000, non-renewable, one to two years to complete project. One available annually.

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

ASSOCIATION OF MIGRAINE DISORDERS (AMD)

AMD Resident Research Grant
$10,000, non-renewable, one year to complete project. One available annually.

COOK MEDICAL

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Responsible

Reuse of single-use devices may become a part of managing healthcare costs and operating sustainably

By **C. W. David Chang, MD**, Patient Safety and Quality Improvement Committee chair

Every surgeon has experienced first-hand the amount of medical waste that is generated with every surgical procedure. Countless numbers of paper drapes, gowns, gloves, tubing, gauze linens, and surgical instruments are thrown out at the conclusion of each surgery. Multiply that by the number of other disposable supplies utilized throughout other parts of the hospital and pretty soon you have a voluminous and expensive trash problem. Medical waste costs five to 10 times more to properly dispose of than regular solid waste because of increased handling requirements, impacting the cost of care delivery. As physicians, hospitals, and payers look to manage healthcare costs—and operate in a green-conscious manner—responsible recycling of single use devices (SUD) may become part of the strategy.

History

Reprocessing of medical equipment is a common practice. Historically, most medical equipment was constructed and designed to be reused. Durable medical equipment approved for multiple use undergoes carefully validated disinfection and sterilization before its next patient encounter. However, the American medical industry has evolved toward increasing reliance on disposable items. First, disposable items, which are traditionally discarded, can save hospital labor costs by reducing reprocessing needs. Second, in the past, disposable costs could be passed on to third-party payers as hospitals would item bill for supplies used. Third, with increasing concerns and scrutiny of infectious disease issues, utilizing disposable items more easily assuaged fears of disease transmission. In this context, Original Equipment Manufacturers (OEMs) produced SUDs to cater to the disposable demand. However, utilization of disposable equipment creates a recurring expense for medical entities.

OEMs determine whether to pursue labeling of devices as single-use or reusable. For devices

recycling

Currently, all risk classifications for devices are eligible for reprocessing, but class I and class II devices (such as harmonic scalpels, shown at left) are the most commonly reprocessed devices.

labeled as reusable, OEMs must demonstrate that the product can be properly cleaned, be durable enough to withstand the disinfection or sterilization process, and packaged with appropriate instructions informing the user of proper reprocessing methods. In contrast, OEMs do not have to demonstrate such for SUDs, reducing development and production costs. Therefore, an OEM may label a device as single-use because the OEM believes that it cannot or should not be reused, or that available studies are inadequate to demonstrate reusability.

With mounting economic pressures, hospitals began reprocessing SUDs initially on their own. As the complexity of equipment design increased and construction materials such as plastics became more common, device cleaning disinfection and sterilization became a more complicated task. Cottage industries arose to relieve hospitals of the task and responsibility for reprocessing equipment. Concerned stakeholders questioned the appropriateness of unregulated reprocessing SUDs in terms of ensuring safety and efficacy of the equipment.

FDA regulation

In 2000, the Food and Drug Administration (FDA) issued guidance that formally defined requirements that hospitals and third-party reprocessors have to follow if they wish to reuse SUDs.[1] The Medical Device User Fee and Modernization Act of 2002 (MDUFMA) further tightened regulatory requirements of companies wishing to market SUDs. Under the current process, the FDA essentially considers SUD reprocessors to be device manufacturers and therefore must comply with all of the FDA statutory and regulatory requirements.

Currently, all risk classifications for devices are eligible for reprocessing, but class I and class II devices are the most commonly reprocessed devices. Class I is the lowest device risk category and includes items such as blood pressure cuffs and nasal cannulas. Class II is comprised of moderate risk devices, including many otolaryngology surgical devices such sinus microdebriders, harmonic scalpels, blades, bits, burs, and some laser fibers. Class III is the high risk category and includes devices such as heart valves and coronary stents.

To reprocess class I and II devices, third-party reprocessors must submit a pre-market notification, also known as a 510(k) marketing application, which includes the submission of validation data attesting to the cleaning, sterilization, and performance of the device. Reprocessors are required to closely monitor and check their cleaning procedures. Reprocessing personnel must be provided with appropriate and continuing education. Upon completion of the reprocessing, the device must remain substantially equivalent to the original device after the maximum number of times the device is intended to be reprocessed. In addition to these regulations, reprocessors are also subject to standard guidelines required of OEMs, such as device registration, quality reporting, and labeling. Class III devices require additional pre-market reporting to achieve approval. To date, no class III devices have completed requirements for reprocessing.

FDA oversight provides some rigor in the regulation of reprocessing SUDs. Daniel Schultz, former FDA Director of the Center for Devices and Radiological Health, in his 2006 statement to the U.S. House Committee on Government Reform, testified, the "FDA has carefully evaluated and conducted research to develop the scientific basis for addressing SUD reprocessing. We have inspected third-party reprocessors, evaluated and investigated reports of patient injuries, and reviewed numerous pre-market submissions. Taken together, the Agency believes that these efforts have provided, and will continue to provide, reasonable assurance of safety and effectiveness of reprocessed SUDs for patients."[2]

Are reprocessed SUDs safe?

To ensure patient safety, the FDA has implemented not only pre-market oversight (as described above), but also has engaged in post-market surveillance. Such surveillance includes inspection of reprocessing facilities as well as evaluation of event reporting databases. The FDA's Medical Device Reporting system requires end users (hospitals and practitioners) as well as manufacturers (including third-party reprocessors) to report deaths and serious injuries resulting from a device. Healthcare professionals can also voluntarily report incidences to the FDA through the MedWatch reporting system (**https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home**).

In 2008, the General Accounting Office provided a report to Congress titled "Reprocessed Single-Use Medical Devices: FDA Oversight Has Increased, and Available Information Does Not Indicate That Use Presents an Elevated Health Risk," in which they detail the current state of the SUD reprocessing industry.[3] The FDA did admit that the available data lacked rigor for definitive comparisons: no adequate head-to-head trials had been performed and event reported data likely is an underrepresentation of reality. Nonetheless,

“If we are going to use reprocessed devices in our practices, we should be informed about the OEM recommendations, FDA guidance on reprocessing, and ensure that any reprocessing is performed using qualified and FDA-compliant methods.”

from 2000 to 2006, only 65 reports involving reprocessed SUD had been filed, compared to 320,000 reports filed in 2006 alone for all other devices. In addition, the types of adverse events reported on reprocessed SUDs were found to be similar to those filed on original devices. Because the denominator (number of total number or reprocessed devices used per year) is not exactly known, incidence cannot be compared. Despite these limitations, the FDA concluded that the data “does not indicate that reprocessed SUDs currently in use pose an increased safety threat.”

Peer-reviewed published research on the efficacy and cleanliness of reprocessed SUDs is variable.[4-11] Some studies show concerns of contamination and loss of efficacy while other studies show the opposite. At this time, it is difficult to fully make conclusions from these studies. Variability may be in part due to differing degrees of instrument design complexity as well as differing time frames in which FDA regulations were in place. Some of these publications study experimentally measured outcome variables; some report more real world variables.

“It is important that we, as practitioners, be educated about the devices that we use,” said **Anand K. Devaiah, MD**, AAO-HNS Medical Device and Drug Committee chair. “If we are going to use reprocessed devices in our practices, we should be informed about the OEM recommendations, FDA guidance on reprocessing, and ensure that any reprocessing is performed using qualified and FDA-compliant methods.” Physicians and hospitals will make decisions on the use of devices based on a multiplicity of factors, including patient safety, treatment efficacy, systems complexity, and purchasing contracts. It is critical to recognize not only the importance of disinfection and sterility, but also the preservation of structural integrity to ensure delivery of the originally intended therapeutic result with no additional risk to the patient. This is an important concept even when using a SUD on the same patient. In order for physicians to provide optimal patient care, end-user transparency of reprocessed SUDs is needed.

What to tell patients

Commonly, physicians and practitioners wonder if there is an obligation to inform the patient of reprocessed SUDs. Typically, informed consent doesn’t require discussing the type or brand of instruments used for a surgical procedure. In consenting to medical care, patients need to be made aware of appropriate reasonable risks, benefits, and alternatives to make a decision. Devices reprocessed using FDA regulated methodology may not subject patients to significantly higher risks. When reprocessed accordingly, the devices are “substantially equivalent” to original devices. If reasonably equivalent, the surgeon may decide, without obligation of disclosure, the type of instrument he or she uses in a procedure for the benefit of the patient.

Reusing a SUD from an FDA-approved third-party reprocessor is not considered “off label.” The reprocessed device has passed all FDA statutory and regulatory requirements as a medical device and the reprocessor is now considered the manufacturer of the device itself. Specifically informing patients of the use of reprocessed SUDs may create the implication of compromised medical care and significant increased risk. Framed as thus, such knowledge may lead to decisions based on fear or prejudice.

In addition to medical judgment, transparency and fairness are key to the delivery and acceptance of any medical treatment. The direct benefit of incorporating reprocessed SUDs in healthcare is largely enjoyed by medical institutions, with less immediate direct benefit to the patient. Depending upon contracts, cost of materials used in the operating room may or may not be passed on to patients or third-party payers. Increasingly, procedures are reimbursed at a set fee regardless of disposable costs. Thus the cost reduction of using reprocessed SUDs is an immediate benefit to the facility. While reduction of medical costs has indirect benefits to the global cost of delivering medical care, the benefit may not be realized as tangible by the patient.

“The ethical issues related to the reuse of SUDs are complex and interrelated,” said **Susan McCammon, MD**, chair of the AAO-HNSF Ethics Committee. “Patient safety and autonomy are often privileged over more utilitarian considerations of benefit, waste, and social justice. The transparency and translation of cost savings will be critical to the validation and acceptance of safe reprocessing of medical equipment.”

Reprocessing of SUDs has evolved from a practice carried out by individual hospitals and operating facilities to a practice that is now regulated and overseen by the FDA, with the aim of ensuring public safety carried out by individuals, hospitals, and outpatient operating facilities.

Billing/reimbursement

FDA-regulated third-party reprocessed devices are reimbursed by Centers for Medicare and Medicaid Services (CMS) like any other FDA cleared “single-use” device. According to Pub 100-04 Medicare Claims Processing, “Hospitals may bill for transitional pass-through payments only for those devices that are ‘single use.’ Reprocessed devices may be considered ‘single use’ if they are reprocessed in compliance with enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.”[12] Conversely, devices reprocessed in a manner not compliant with FDA regulations may not be eligible for pass-through payments.

For surgical procedures, CMS does not generally reimburse operating room facilities for the use of individual devices. Rather, CMS reimburses hospitals for entire procedures, which subsumes the cost of equipment used. Although facility payments by commercial carriers vary, it is typical for most of them to reimburse by procedure also. Procedures performed in the non-facility or office setting have device costs factored into

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> Our current healthcare environment demands that we advocate for the best quality care delivered in a safe and cost-effective manner to our patients.

the practice expense portion of the Relative Value Units (RVUs) assigned to that service. Reprocessed SUDs meeting FDA regulations are eligible for reimbursement by payers.

'Green' savings: cost and environment

Third-party reprocessed SUDs on average cost 50 percent less to purchase than their new counterparts. This savings could add up. According to the Association of Medical Device Reprocessors (AMDR), a trade association of medical device reprocessors, a typical 200 bed hospital taking advantage of a reprocessor's full product line can save between $600,000 and $1 million a year, and divert between 5,000 and 15,000 pounds of waste from landfills.[13] Real world cost savings certainly vary from one institution to the next depending upon facility volume and extent of reprocessing. In 2007, Banner Health, a large Phoenix-based healthcare organization comprised at that time of 21 acute care centers and eight outpatient surgery centers, reported nearly $1.5 million in savings.[14] This does not include savings from medical waste disposal. Smaller entities such as surgery centers can capitalize on savings as well. Madison Surgery Center in Wisconsin reported nearly $60,000 in savings after the first year of implementation.[15] However, real world savings calculations should also include additional labor costs to collect and store items and operative costs should reprocessed devices fail or not be adequate, potentially resulting in additional material and time costs. These variables were not reflected in the calculations above.

SUD reprocessing has the capability of increasing competition. Reprocessed SUDs on the market put price pressure on the original product line for OEMs to remain competitive. AMDR cites that in some circumstances OEMs have dropped their prices by as much as 50 percent to win contracts.[13] The market for reprocessing SUDs has also attracted OEMs to enter the business as well. Stryker, a medical technology company, acquired Ascent Healthcare Solutions, a reprocessing company, in November 2009 for $525 million.[16]

Conclusion

Our current healthcare environment demands that we advocate for the best quality care delivered in a safe and cost-effective manner to our patients. As such, the AAO-HNS:

- Supports FDA guidelines regarding the reprocessing of SUDs.
- Encourages continued research and surveillance of reprocessed SUDs.
- Promotes physicians and medical organizations to incorporate individualized patient care and clinical judgment in the consideration of using FDA-compliant reprocessed SUDs. ■

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A medical journey with Lewis and

Mosquitoes, boils, frostbite, dysentery and venereal disease test the mettle of explorers and their caretakers

By **M. Eugene Tardy, Jr., MD**, Professor Emeritus, University of Illinois School of Medicine at Chicago, and the first Legends of Otolaryngology honoree

One rainy afternoon in May 1804, nearly four dozen carefully selected young men, their two captains, and a dog pushed off in a keelboat and two pirogues up the Missouri River from St. Louis in pursuit of President Thomas Jefferson's quest to explore the heretofore unknown western regions of the American continent. Facing unknown territory, bitter weather, unpredictable Indian tribes, wild animals, and geographical challenges, the Corps of Discovery endured continuous and vexing medical challenges.

And, in an arduous journey of more than 8,000 miles and 28 months, *only one man died*.

In the end, the Lewis and Clark expedition failed to find an all-water passage to the Pacific Ocean, but they realized an incredible outcome: the men documented knowledge of the West, the Native Americans, and plant and animal species; invigorated the western fur trade; established the United States' claim to the western territories; and unveiled the mysteries of the West to stimulate unprecedented westward migration.

Of all the many challenges the explorers faced, a wide variety of medical problems taxed their ingenuity, limiting their capabilities and challenging their primitive but dedicated medical skills.

Constantly and pervasively, hordes of "mosquiters" tormented the men and their animals, creating repetitive skin eruptions and infection. The descriptive journals religiously kept by the explorers document well the torment they endured.

Whether the presence of a physician during the expedition would have better protected the health of the men is open to question. The captains ministered most professionally to the men, the Indians, and each other, employing common sense and the traditional remedies available to them.

President Jefferson arranged for Meriwether Lewis to receive instruction from Dr. Benjamin Rush of Philadelphia, the leading physician of his time. As the prevailing sense of medical care in the early 19th century, the use of "bleed, blister, and purge" characterized the limited armamentarium of most physicians. Dr. Rush counseled the value of the following "medications" to be included with the explosive purgative of chlorine, mercury, and jalap; opium; laudanum; mercury ointment; emetics (ipecac); diaphoretics (camphor); barks (quinine-containing cinchona); various herbs; and saltpeter.

In his surgical kit, Lewis selected scalpels, suturing tools, probing forceps (for musket balls and arrowheads), tooth extractors, enema and penis syringes, lancets, and tourniquets.

As the Corps pulled, paddled, and pushed their heavily loaded boats up the Missouri River, within the first month illness magnified the hardships of the journey. The captains wrote: "the party is much afflicted with Boils and several have Decissentary, which I attribute to the river water. Two thirds with ulsers or Boils, some with 8 or 10 of those Tumors." In addition, sore feet, chafed thighs, insect bites, bloating, fatigue, diarrhea from contaminated water, and a poor diet plagued the men. And yet, without complaint, "We Proceeded On."

On July 4, 1804, a rattlesnake bit Private Joseph Fields on the ankle. After treatment with a poultice of Peruvian bark (quinine) he painfully resumed his duties. Lewis "opened the Tumer of a man on the left breast, which discharged half a pint." Repeatedly, the journals record the phrase "Mosquiters excessively troublesum."

The first indication of a serious medical problem surfaced on July 30. According to William Clark: "Sergt Floyd very unwell a bad cold and chills." On August 30: "Serjeant Floyd taken very bad all at once with a Biliose Chorlick.

Clark

Inset photos

Top: Throughout the journey, 375 elk provided much of the protein required by the expedition's participants.

Bottom: Hordes of mosquitoes plagued the men incessantly.

Far right: When they encountered the immense Great Falls of the Missouri, expedition participants were forced to carry canoes and equipment 18 ½ miles in one month.

Please consider making a donation to the AAO-HNS Foundation's Annual Fund in honor of Dr. Tardy. Your donation, in any amount, can be made by going to **www.entnet.org/donate** and selecting "Legends of Otolaryngology." All donor names will be listed on Dr. Tardy's web page at **www.entnet.org/content/annual-fund-legends-otolaryngology**.

We attempt to relieve him without success as yet, he gets worse and we are much allarmed." After tending to Floyd all night, Clark wrote: "Sergeant Floyd much weaker and no better … as bad as he can be, no pulse and nothing will stay a moment on his Stomach or bowels."

Floyd's violent diarrhea and vomiting with symptoms of shock suggest to most authorities the diagnosis of ruptured appendix with peritonitis. Doubtless no surgeon, under these severe circumstances, could have saved the life of Sgt. Floyd, who "died with A great deal of composure."

In October Clark wrote: "last night at 1 oClock I was violently and Suddenly attacked with rhumetism in the neck which was

“Cervical muscle spasm due to severe muscular effort and possible nerve root impingement marked the first of several otolaryngological ailments the Corps encountered.”

so violent I could not move. … Capt. Lewis applied a hot stone raped in flannel which gave me some temporay ease.” Cervical muscle spasm due to severe muscular effort and possible nerve root impingement marked the first of several otolaryngological ailments the Corps encountered.

The group of explorers built a fort and camped over the bitter winter near the Mandan Indian villages. Clark recorded: “last night was excessively cold … the Murckery this morning stood at 40 degrees below zero.” Under such extreme conditions, it is not surprising that cold injury surfaced in both men of the Corps and the Indians as well. On December 8 during a bitterly cold buffalo hunt, York, Clark’s African-American slave, suffered frostbite of his penis, from which he apparently completely recovered. The journals reveal “a boy about 13 years of age Came to the fort with his feet frosed.” “4 men of ours who had been hunting returned, one frost’d.” “Capt. Lewis took off the toes of one Foot of the Indian boy who got frost bit Some time ago.”

In early October, Clark lyrically recorded: “a curious custom with the Sioux and well as the Ricarees is to give handsom squars to those whome they wish to show some acknowledgements to.” Venereal disease thus was introduced as one of the many medical ailments of the men of the expedition, as most of the Indian tribes were accustomed to bartering wives and daughters as sexual partners to visitors.

Clark noted on November 4, 1804: “a French man by Name Chabonah [Toussaint Charbonneau, a French Canadian] … visit us, he wished to hire and informed us his 2 squars were Snake Indians.” Charbonneau, who proved to be a bungler and coward, was hired as interpreter and chose to bring along his 15-year-old Indian wife, who was six months pregnant. Thus Sacagawea, who proved invaluable to the success of the expedition, entered the scene. In February, Lewis assisted in the delivery of her child, Jean Baptist.

On November 29, 1804, a journal recording reads: “Sergeant Pryor in taking down the mast put his Sholder out of Place, we made four trials before we replaced it.”

The Corps spent the bitter winter with the Mandans, and proceeded up the Missouri once again when the ice melted in March 1805.

Encountering the immense Great Falls of the Missouri, they were forced to portage their canoes and equipment 18 ½ miles over one month, suffering cut feet, cactus thorns, heat exhaustion, and massive exhaustion.

Finally encountering the Shoshone Indians, Sacagawea’s original tribe, with horses they crossed the massive Continental Divide and Bitterroot mountains despite deep snowdrifts, bitterly cold weather, and absent trails. Hunger and constant dysentery plagued the men, and the Nez Perce Indians they encountered schemed to kill them for their weapons, but were dissuaded by an Indian woman who had earlier been well treated by white men.

Finally reaching the Columbia River estuary in crudely dug out canoes, the Corps passed a miserable winter of 1805-1806 in a constant wet, flea- and mosquito-infested and food-deprived state. Elk sustained them, but rotted quickly in the extreme weather. With clothes rotting off their bodies, they joyously began their easterly homeward voyage on March 22, 1806.

Encountering the Walla Walla and Nez Perce tribes once again, Clark used his medical skills to soothe the Indians’ severe conjunctival irritations (probably gonorrheal conjunctivitis) and a variety of other complaints. His medical skills proved to be valuable commodities in exchange for food and horses.

Sacagawea’s son developed neck swelling, perhaps cervical abscess, tonsillitis, mastoiditis, or parapharyngeal abscess, and was treated with cream of tartar and a poultice of boiled onions—with complete recovery.

After two attempts, the men were finally able to cross the cold and snow-covered mountains and commence their homeward journey eastward. Their arrival on September 23, 1806, in St. Louis after 28 months and a journey of 8,000 miles was nothing short of miraculous.

This fascinating, captivating story begs the questions:

1. Would the expedition have fared better with a physician along?
2. Why did Sacagawea abandon her Shoshone tribe and continue with the expedition to the Pacific?
3. What was life like for York, Clark’s slave, during the journey?
4. Where are the lost journals of Captain Lewis documenting the early part of the journey?
5. How different would the narrative of the expedition be if told from the perspective of the Native Americans?
6. Was Lewis actually bipolar, and perhaps an alcoholic?

In the end, President Jefferson characterized the Lewis and Clark Expedition as “having all the success which could have expected.” The mysterious West was opened for further exploration and migrant expansion. The fur trade was opened, and the American claim to the western territories was secured. Clark mapped the continent.

I personally am firmly of the conviction that every American school child should be taught the critical lessons of the men and woman of the Corps of Discovery: courage, discipline, teamwork, perseverance, improvisation, negotiation, and, not least, devotion to country.

And all admirably accomplished despite the maddening, inescapable, recurring and plaintive record of: “Mosquiters very troublesome.” ■

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PROPOSED CY 2017 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

What you need

On July 8, the Centers for Medicare & Medicaid Services (CMS) posted the proposed Medicare physician fee schedule (MPFS) for calendar year (CY) 2017. The Academy submitted comments to CMS on the proposed rule on September 6, and has also developed a Member summary, which details the important proposed requirements. You may access them at **www.entnet.org/content/regulatory-advocacy**. Some key provisions of the proposed rule that Members should be aware of include:

Practice expense

CMS noted that during routine reviews of direct practice expense input recommendations, they have regularly found unexplained inconsistencies involving the use of scopes and the video systems associated with them. Some of the scopes include video systems bundled into the equipment item, some of them include scope accessories as part of their price, and some of them are stand-alone scopes with no other equipment included. To promote appropriate relativity among the services and facilitate the transparency of their review process, CMS developed a structure that separates the scope and the associated video system as distinct equipment items for each code. Under this approach, CMS proposes stand-alone prices for each scope, and separate prices for the video systems used with scopes. CMS also proposed standardizing refinements to the way scopes have been defined in the direct PE input database.

These proposed changes applied to the codes in the Flexible Laryngoscopy family (CPT codes 31575, 31576, 31577, 31578, 315X1, 315X2, 315X3, 31579) and the Laryngoplasty family (CPT codes 31580, 31584, 31587, 315Y1, 315Y2, 315Y3, 315Y4, 315Y5, 315Y6) along with updated prices for the equipment items related to scopes utilized by these services. In response to the CMS proposals, the Academy strongly urged CMS to consider the single item prices used in the invoices submitted following the January 2016 AMA/Specialty Society Relative Value Scale Update Committee (RUC) meeting for the standard endoscope equipment. Additionally, in the event CMS wishes to create endoscopic packages in the future, we urged them to create the packages through the AMA RUC Practice Expense Subcommittee process and to include all impacted specialties to ensure accuracy and comprehensive input.

Global surgical data collection requirements

Within the 2015 proposed fee schedule, CMS proposed a major change to reporting global surgical procedures by suggesting a two-year transition of all 010 and 090 global services to a 000 global designation. CMS finalized this proposal within the final 2015 MPFS rule. However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibited the Secretary from implementing this policy. Instead, the MACRA required CMS to develop a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017.

In the proposed rule, CMS proposes a three-pronged approach to collect timely and accurate

to know

Academy addresses CMS proposed rule for 2017

data on the frequency of, and input involved in furnishing, global services. This includes:

1. The creation of a new G-code, reported in 10-minute increments, for comprehensive claims-based reporting about the number and level of pre- and post-operative visits furnished for all 010 and 090 global services by all clinicians,
2. A survey of a representative sample of practitioners about the activities involved in and the resources used in providing, a number of pre- and post-operative visits during a specified recent period of time, such as two weeks, and
3. A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

In comments submitted to CMS, the Academy strongly disagreed with CMS' proposal, instead requesting CMS honor congressional intent and create a representative sample of surgical services using the following criteria: Medicare volume of at least 10,000; and/or $10 million in allowed charges; and at least 100 separate physicians performed the procedure. In comments, we also put forth the recommendation to use CPT code 99024 *Post-operative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* once per visit to identify the number of postoperative visits associated with a surgical procedure.

Appropriate Use Criteria (AUC) for advanced diagnostic imaging requirements

In the proposed rule, CMS provides details on requirements and processes for specification of qualified clinical decision support mechanisms (CDSMs) under the Medicare AUC program; the initial list of priority clinical areas; and exceptions to the requirement that ordering professionals consult specified applicable AUC, when ordering applicable imaging services.

CMS notes that for this program, AUC are a set of individual appropriate use criteria and each individual criterion is an evidence-based guideline for a particular clinical scenario. CDSMs are the access point for ordering professionals to consult AUC to assist during patient workup, treatment and follow-up. CDSMs could both ensure integration of patient-specific data from electronic health records (EHRs), and allow clinicians to optimize the time spent using the tool. Imaging would be included in the clinical management decision tree and the ordering clinician would receive immediate feedback on the appropriateness of one or more imaging services.

In comments submitted to CMS, the Academy urged CMS to require EHR vendors to incorporate a CDSM for AUC into individual vendor EHRs as most physician practices do not have the resources or relevant experience to meet these requirements on their own. Additionally, we called for the development of a testing framework for CDSMs that includes mandated interoperability to ensure that AUC are incorporated across CDSMs and that physicians have access to the AUC. Finally, the Academy is concerned that the implementation of the Medicare AUC program is moving too quickly to satisfy the reporting requirement and agree with CMS' sentiment expressed in the proposed rule that the accelerated timeframe could inadvertently result in technical and operational problems that could cause delays in payments.

Updates to the Value-based Modifier (VM) and physician feedback programs

In the proposed rule, CMS states if a third-party vendor or CMS made an error in EP or a group's Value-based Payment Modifier (VM) calculation, the TIN would be classified as "average quality," or if time allows, would have the score recalculated. CMS states recalculating the quality composite score is not always practical or possible. The Academy expressed serious reservations about CMS' ability to ensure VM calculations and the subsequent payment modifications are correct with a high degree of certainty. Until CMS can ensure correct calculations, the Academy asked CMS to work to refine the VM calculation process to ensure costly VM calculation errors are limited, rather than placing the onus on clinicians to determine if an error has been made on their VM calculation and file for an informal review.

Finally, starting in 2019, CMS will roll the VM into the composite performance score (CPS) as part of the Merit-based Incentive Payment System (MIPS). CMS' admission of continued issues calculating performance scores through the VM underscores comments the Academy submitted to CMS for the MIPS and Alternative Payment Model (APM) proposed rule, where we stated "we are concerned that the issues experienced with the VM program will be rolled over to the new Resource Use Performance Category without clarification prior to implementation and we urge CMS to fully address the previously raised issues within the final rule." The Academy continues to remain concerned that components of the VM program will roll into the calculation for clinicians' CPS and could adversely affect reimbursement. ■

Annual Meeting features 'firsts' in San Diego

For the 8,600 registrants, the 120th AAO-HNSF Annual Meeting & OTO EXPO℠ featured many "firsts:" the International Symposium, OTO Experience, International Advisory Board, Legends in Otolaryngology Lecture, community outreach, and fitness events.

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Keynote speaker Mae C. Jemison, MD, a former astronaut who flew aboard the Space Shuttle Endeavour STS-47, encouraged the Opening Ceremony crowd to reach for the extraordinary.

AAO-HNS/F President **Sujana S. Chandrasekhar, MD**, welcomed the International Guests of Honor from Brazil, India, Nicaragua, and Singapore in their native languages.

Keynote speaker and former astronaut Mae C. Jemison, MD

On the final day of the meeting, **Gregory W. Randolph, MD**, took the reins as president. ➲

In an Opening Ceremony moment, AAO-HNS/F President Sujana Chandrasekhar, MD, (left) received a Past President's gavel and pin from new President Gregory Randolph, MD.

Annual Meeting activities extend into the community

On the Saturday before the AAO-HNSF 2016 Annual Meeting & OTO EXPO℠, otolaryngologists **Anthony E. Magit, MD, MPH**, and **Wen Jiang, MD**, three audiologists, and six audiology doctoral students participated in a hearing screening for children at the San Diego Neighborhood House Association's (NHA) Webster Head Start location in San Diego. The AAO-HNSF and NHA also provided activity booths for face painting and bubbles, free haircuts, and breakfast. This community outreach project was the first of what is expected to become an annual event for the community in the Annual Meeting host city. ➲

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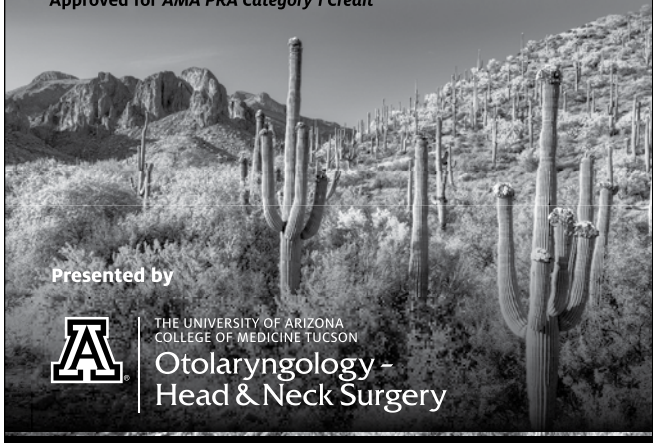

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December 6, 2016, 8 pm, EST
Presented by: Robert Ferris, MD, PhD
Professor, UPMC Department of Otolaryngology

Evaluation of Noisy Breathing in Infants and Children

January 10, 2017, 8 pm, EST
Presented by: Jeffrey Simons, MD
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*NOTE: **Bob Glazer** will be at this year's AAO-HNS Annual Meeting in San Diego, CA, and would be delighted to meet with you and answer any questions you might have. If you plan on attending as well, please email him at **rglazer@entandallergy.com**.*

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Rhinologic Surgeon (PIN 23036)

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M. Boyd Gillespie, MD, MSc.
Department of Otolaryngology-HNS
U.T. Health Science Center
910 Madison Avenue, Suite 408
Memphis, TN 38163

Or email: jkeys@uthsc.edu

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Candidates should email CV, letter of interest and arrange 3 letters of reference to be sent to:

Lucian Sulica, MD
Director, Sean Parker Institute for the Voice
1305 York Avenue, 5th Floor
New York, NY 10021
lus2005@med.cornell.edu

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Chair, Department of Otolaryngology UTMB Health
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Email: varesto@utmb.edu
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Weill Cornell Medicine Otolaryngology Head & Neck Surgery

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Admission to fellowship is contingent upon completion of residency in Otolaryngology, and eligibility for a medical license in New York state. All interested candidates should apply through the American Laryngological Association match.

Preliminary interviews are available by appointment at The Fall Voice Conference, Scottsdale, Oct. 13-15

Candidates should email CV, letter of interest and arrange 3 letters of reference to be sent to:

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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

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THE UNIVERSITY OF KANSAS
DEPARTMENT OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

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

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All interested candidates should apply via the SFMatch.

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CLINICAL FELLOWSHIP IN LARYNGEAL SURGERY AND VOICE DISORDERS

Massachusetts General Hospital

The Division of Laryngeal Surgery is seeking applicants for clinical fellowship positions. The fellowship training covers all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences, including phonomicrosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia.

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Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.

Direct inquiries to:

Steven M. Zeitels, MD, FACS
Eugene B. Casey Professor of Laryngeal Surgery, Harvard Medical School
Director: Center for Laryngeal Surgery & Voice Rehabilitation
Massachusetts General Hospital
One Bowdoin Square, 11th Floor
Boston, MA 02114
Telephone: (617) 726-0210 Fax: (617) 726-0222
zeitels.steven@mgh.harvard.edu

Otolaryngology

Call This "Top 10" Community Home

McFarland Clinic PC

Seeking a BE/BC Otolaryngologist to join our collegial, collaborative team. Practice medicine in a vibrant, Big 12 university city and enjoy a family friendly, Midwestern lifestyle where your patients are your friends and neighbors.

- daVinci Robot and the Olympus Video System
- In-office laryngeal biopsies
- New state-of-the-art minor procedure room
- Epic EMR System
- Weekly cancer case conference
- Established, collegial team and support staff
- Physician owned and governed
- Large, established referral network
- One of the least litigious states in the country

Featured 8th in Money Magazine's "Best Places to Live," Ames, Iowa is recognized as an active, friendly community with plenty to do. Rated 5th "Most Beautiful College Campuses in the World" (Buzzfeed), ISU is located in this vibrant college 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

The Ear, Nose, Throat & Plastic Surgery Associates

- General Otolaryngologist
- Neurotologist
- Head and Neck Surgeon

The largest otolaryngology group in Central Florida, which offers a full array of subspecialty care including emphasis in general otolaryngology, neurotology and head and neck surgery, is seeking several partners. We offer the best of private practice with opportunities for academic pursuits. Integrity, quality and camaraderie are our core values.

We offer an excellent salary, benefits, partnership and the opportunity to teach residents and medical students, if desired. Orlando is a world destination offering a variety of large city amenities and is a short drive to both the East and West Coasts of sunny Florida.

For more information, visit us online at www.entorlando.com

Interested candidates should send CV to or may contact:
Debbie Byron, Practice Administrator
Phone: Cellular: 407-342-2033
E-Mail: dbyron@entorlando.com

UNC HEALTH CARE

Otolaryngologist Opportunity in Beautiful Eastern North Carolina

BC/BE Otolaryngologists wanted to join thriving small practice in Eastern North Carolina. Easy driving distance to Raleigh, Lake Gaston, the beach and the mountains. Modern practice on hospital campuses involving all aspects of adult and pediatric ENT.

Full range of services including:

- Audiology/Hearing aids
- Balance testing
- Allergy/Immunotherapy
- Videostroboscopy

Other Specifics:

State of the art minor procedure room. Able to easily integrate cosmetic services, sleep medicine, transoral robotic surgery, office balloon sinuplasty, and/or your specific practice interest. Competitive salary and benefits with production bonus and equitable call schedule. Affiliated with UNC Physicians Network. Enjoy temperate climate, busy, fulfilling practice without the traffic!

Contact: Amber Canzater or Jerry Boylan at
PhysicianRecruitment@unchealth.unc.edu or by phone at **984.215.4127/4128**

Surgeon • Otolaryngology • Plattsburgh, NY

The Department of Surgery at the University of Vermont College of Medicine is seeking a Clinical Practice Physician in the Division of Otolaryngology to join the Champlain Valley Physicians Hospital (CVPH) in Plattsburgh, New York. CVPH is a progressive medical center with nine state-of-the-art ORs and an Ambulatory Surgery Center. The position entails providing Otolaryngology services to the patient population served by CVPH, a community medical center which is a regional referral hospital partnered with the University of Vermont Medical Center. This position offers the unique opportunity to work in a community setting while having an active affiliation with Vermont's only Academic Medical Center; the only ACS verified Level 1 trauma center in the state providing tertiary care to patients from Vermont and Northern NY.

Applicants must be board certified or board eligible and eligible for medical licensure in the state of New York. This is a full-time, 12 month, salaried position.

Plattsburgh is located on the shores of Lake Champlain, near the Adirondack Mountains, Olympic-Lake Placid region, Montreal and Burlington, VT.

The University is especially interested in candidates who can contribute to the diversity and excellence of the academic community through their research, teaching, and/or service. Applicants are requested to include in their cover letter information about how they will further this goal. The University of Vermont is an Affirmative Action/Equal Opportunity Employer. Applications from women, veterans, individuals with disabilities, and people of diverse racial, ethnic and cultural backgrounds are encouraged. Applications will be accepted until the position is filled.

Interested individuals should submit their curriculum vitae with a cover letter and contact information for four references electronically to Division Chief, William Brundage, MD c/o Emily Nuse at Emily.Nuse@uvmhealth.org or apply online at https://www.uvmjobs.com.

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital

WAYNE STATE

School of Medicine

Academic Faculty Positions

The Department of Otolaryngology
is currently seeking to hire two

ACADEMIC OTOLARYNGOLOGISTS

with training and/or interest in Sinus Surgery
or General Otolaryngology

The ideal candidates must have strong interest in academic career, a commitment to resident education and basic/clinical research as well as a desire to build a busy clinical practice. Academic appointment and compensation commensurate with training and experience. Candidates must be BC/BE in Otolaryngology.

Qualified and interested candidates should apply through WSU Online Hiring System at https://jobs.wayne.edu for

Posting # 041998

Please also send letter of interest and CV to:

Ho-Sheng Lin, M.D., Professor and Chairman
Department of Otolaryngology
4201 St. Antoine, 5E-UHC, Detroit, MI 48201
hlin@med.wayne.edu

WSU is an Equal Opportunity/Affirmative Action Employer

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Neurotology Fellowship

The Otology Division at the Medical University of South Carolina is seeking applicants for a 2-year clinical fellowship position in Neurotology. Fellowship training includes all aspects of Neurotological and Otological surgery. The program provides a wide variety of clinical and surgical opportunities including lateral skullbase surgery for removal of acoustic neuromas and other skullbase tumors, CSF leak repair, SCCD management, surgeries for malignancies involving the temporal bone, and other neurotological procedures. The fellow should be proficient with tympanoplasty, OCR and stapedectomy, and mastoidectomy and have a good working knowledge of cochlear implantation. The fellow is expected to assist in the supervision of some resident training in otologic procedures. In addition, the fellow covers attending Neurotology clinics. There is one fellow at a time for each 2-year period.

Four clinical faculty make up the Otology Division, Drs. Paul R. Lambert, Ted R. McRackan, Ted A. Meyer, and Habib G. Rizk. In addition, the division also boasts a tremendous research team under the direction of Judy R. Dubno, Ph.D.. Numerous clinical and basic science research opportunities exist, and a significant research effort is expected. In addition to MUSC, fellows have patient care opportunity at the Ralph H. Johnson VAMC.

To date, we have graduated two fellows. Dr. Rizk, our second fellow, remained at MUSC to direct the Vestibular Program.

We have been approved by MUSC to apply for ACGME accreditation for the Neurotology Fellowship, and we are currently in the submission process. If ACGME approval is obtained next year, the 2017-2019 fellow would sit for the Neurotology Board.

Direct inquiries to:

Ted A. Meyer, MD, PhD
Neurotology Fellowship Program Director
Medical University of South Carolina
Department of Otolaryngology - HNS
135 Rutledge Avenue, MSC 550

WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER®
SAN ANTONIO

FULL-TIME FACULTY POSITIONS

The Department of Otolaryngology-School of Medicine at UT Health Science Center San Antonio is actively recruiting for qualified candidates for full-time academic positions. We are seeking faculty with interests in Head & Neck Surgery and General Otolaryngology/Otology for non-tenure track positions. Competitive Salary will be commensurate with academic rank.

Qualifications include board certification, Texas licensure and a commitment to pursue resident education, patient care and research. Research experience and/or fellowship training are highly desirable.

Interested applicants should send inquiries, CV and 3 to 5 references to

Frank Miller, M.D., Professor and Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Texas Health Science Center
7703 Floyd Curl Drive, MS 7777
San Antonio, TX 78229
Email: cowartk@uthscsa.edu

Applications will be accepted until the position is filled. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer including protected veterans and persons with disabilities. All faculty appointments are designated as security sensitive positions.

Geisinger

Academic Pediatric Otolaryngology Opportunities

Join our team and discover for yourself how Geisinger's award-winning, physician-led system focuses on patient care through innovative care models, compassionate providers and robust, integrated technology.

Geisinger Medical Center's Department of Otolaryngology has an immediate opening for a fellowship-trained pediatric otolaryngologist.

- Join nine otolaryngologists, including two fellowship-trained in pediatrics, providing all aspects of subspecialty care.
- Candidates should be BC/BE by the American Board of Otolaryngology, licensed or eligible to practice in Pennsylvania and have a commitment to academic otolaryngology, resident education and clinical research.

Janet Weis Children's Hospital (JWCH), located on GMC's campus in Danville, is the region's only dedicated 5-floor, 89-bed children's hospital with a full-service hospitalist program. JWCH's team of medical and surgical specialists provide care in over 30 pediatric specialties, including high-level care with a Level IV NICU and Level I PICU.

Geisinger Health System is an integrated health services organization widely recognized for its innovative use of the electronic health record and the development of innovative care delivery models such as ProvenHealth Navigator® and ProvenCare®. As one of the nation's largest health service organizations, Geisinger serves more than 3 million residents throughout 45 counties in central, south-central and northeast Pennsylvania, and also in southern New Jersey. The physician-led system is comprised of approximately 30,000 employees, including nearly 1,600 employed physicians, 12 hospital campuses, two research centers and a 510,000-member health plan.

A competitive compensation and benefits package is offered for this position. Interested applicants should send a cover letter and CV to:

Edward Wood, MD
Director, Pediatric Otolaryngology
wewood@geisinger.edu

cc: Sarah Lipka, Talent Management Consultant
slipka1@geisinger.edu
570-271-5406

Caring

Washington University in St. Louis
SCHOOL OF MEDICINE

Full Time Academic Faculty Positions Available

OTOLOGIST/NEUROTOLOGIST

The Department of Otolaryngology at Washington University School of Medicine in St. Louis, Missouri is seeking candidates for a full-time faculty position at the Assistant or Associate Professor level on the Clinician/Educator track. Fellowship training in Otology/Neurotology is required. Candidates must be board certified or eligible for certification. Expected responsibilities will include both inpatient and outpatient medical and surgical care within the Department of Otolaryngology, resident and medical student education, and interdisciplinary collaborations in a very supportive and stimulating academic department. For candidates with a research background, there are opportunities to develop an independent or mentored research program if desired. Candidates must be able to obtain a Missouri State license and must be board certified or eligible for certification. Interested applicants are invited to submit their CV on the WUSM website at **https://facultyopportunities.wustl.edu.**

RHINOLOGIST

The Department of Otolaryngology at Washington University School of Medicine in St. Louis, Missouri is seeking candidates for a full-time faculty position at the Assistant or Associate Professor level on the Clinician/Educator track. Fellowship training in Rhinology is required. Candidates must be board certified or eligible for certification. Expected responsibilities will include both inpatient and outpatient medical and surgical care within the Department of Otolaryngology, resident and medical student education, and interdisciplinary collaborations in a very supportive and stimulating academic department. For candidates with a research background, there are opportunities to develop an independent or mentored research program if desired. Candidates must be able to obtain a Missouri State license and must be board certified or eligible for certification. Interested applicants are invited to submit their CV on the WUSM website at **https://facultyopportunities.wustl.edu.**

Washington University in St. Louis is committed to the principles and practices of equal employment opportunity and affirmative action. It is the university's policy to recruit, hire, train, and promote persons in all job titles without regard to race, color, age, religion, gender, sexual orientation, gender identity or expression, national origin, veteran status, disability, or genetic information.

HEAD AND NECK ONCOLOGIC AND RECONSTRUCTIVE SURGERY

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine invites applications for a full-time faculty position at the Assistant or Associate Professor level in the Division of Head & Neck Surgical Oncology. Fellowship training or extensive experience in ablative surgery, reconstructive microsurgery and multidisciplinary management of head & neck cancer patients is required. For candidates with a research background, there are opportunities to develop an independent or mentored research program if desired. This position will include patient care responsibilities at Barnes-Jewish Hospital & the Siteman Cancer Center, a NCI Comprehensive Cancer Center & member of the National Comprehensive Cancer Network (NCCN). Candidates must be able to obtain a Missouri State license and must be board certified or eligible for certification. Interested applicants are invited to submit their CV to on the WUSM website at **https://facultyopportunities.wustl.edu.**

Craig A. Buchman, MD, FACS
Lindburg Professor and Head, Department of Otolaryngology-Head & Neck Surgery
Washington University School of Medicine

BARNES JEWISH Hospital BJC HealthCare

Washington University in St. Louis Physicians

Children's HOSPITAL OF ST. LOUIS

Otolaryngologist

Southeastern Massachusetts

ENT Specialists, Inc. seeks a Board Certified / Board Eligible Otolaryngologist to join our 8 physician private practice located just south of Boston, serving the communities of Brockton, Norwood, Plainville, and Taunton. We offer comprehensive services that include audiology, vestibular testing, videostroboscopy, voice therapy, as well as allergy testing and immunotherapy. In office procedural capabilities include thyroid ultrasound, and balloon catheter sinus dilation. Our practice is integrated with the Tufts Medical Center Otolaryngology Residency Program, with a full time resident rotation allowing for opportunities to teach both in the office and in the OR. We offer competitive salary with productivity bonus structure, full benefits package including health, life and disability insurance, stipend for CME, and partnership tract. Call is 1 in 8 allowing for a great lifestyle, with close proximity to the city of Boston, as well as Cape Cod and the Islands, or even the mountains of New Hampshire and Vermont.

If you are interested in learning more about our opportunity, please contact:

Douglas O'Brien, MD
dobrien@entspecialists.com

The Ohio State University
Department of Otolaryngology – Head and Neck Surgery

The Ohio State University Department of Otolaryngology is accepting applications for the following faculty positions:

BC/BE Allergy Clinician

BC/BE Vestibular Clinician

Vestibular Research Scientist (PhD)

Applicants must demonstrate excellence in patient care, research, teaching, and clinical leadership. This is an outstanding opportunity to join one of the top ranked programs in the country. Located in the heart of Ohio, Columbus offers a population of over 1.5 million people and excellent cultural, sporting, and family activities.

Send letter of interest and CV to:

Ted Teknos, MD
Professor and Chair
The Ohio State University
Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212
E-mail: mark.inman@osumc.edu
Department Administrator
Or fax to: 614-293-7292
Phone: 614-293-3470

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Otolaryngologist

Maine Medical Partners Otolaryngology is seeking a Board Certified/Board Eligible Otolaryngologist to join their well-established practice in Portland, Maine.

Maine Medical Partners Otolaryngology is a team of 5 Board certified physicians, 4 audiologists, medical assistants, an advanced practice provider and excellent administrative staff all working together to deliver high quality care in five locations throughout the state of Maine, specializing in the treatment of ear, nose and throat conditions in adults and children. Services include sinus surgery, ear surgery, head and neck surgery, treatment for skin cancers, pediatric ENT, hearing and hearing aids, and snoring.

Physicians work in an office with modern examination rooms and equipment, including videostroboscopy, a surgical suite for office procedures, full audiological services and a new hospital surgery center. Head and Neck Oncology and Pediatrics are subspecialties of need presently.

Maine Medical Center has 637 licensed beds and is the state's leading tertiary hospital and Level One Trauma Center, with a full complement of residencies and fellowships and is an integral part of the Tufts University Medical School. The position involves teaching and mentoring residents and medical students from the Maine Medical Center-Tufts University School of Medicine Program, and the successful candidate would have an academic appointment at Tufts University School of Medicine.

The successful candidate will be employed by Maine Medical Partners (MMP), a subsidiary of Maine Medical Center and Maine's largest multi-specialty group. MMP serves the health care needs of patients throughout Maine and Northern New England. This high quality team of more than 500 physicians and 200 advanced practice professionals provides a wide range of hospital based, primary, specialty, and sub-specialty adult and pediatric care delivered throughout a network of 30 locations across the State and acts as a regional referral network.

Situated on the Maine coast, Portland offers the best of urban sophistication combined with small-town friendliness. The area provides four season recreational opportunities, such as skiing, hiking, sailing, and miles of beautiful beaches. Just two hours north of Boston, this is an exceptionally diverse and vibrant community.

For more information, please contact Alison C. Nathanson, Director, MaineHealth Physician Recruitment Center at (207) 661-7383 or nathaa@mainehealth.org.

MaineHealth
Physician
Recruitment Center

The Ohio State University

Department of Otolaryngology – Head and Neck Surgery

General Otolaryngologists to work in Community Practices

OSU currently has multiple positions available within the Central Ohio region. Positions combine the ability to practice in a community setting while being affiliated with Ohio State University. Applicants must demonstrate excellence in patient care, research, teaching, and clinical leadership. This is an outstanding opportunity to join one of the top ranked programs in the country. Located in the heart of Ohio, Columbus offers a population of over 1.5 million people and excellent cultural, sporting, and family activities.

Send letter of interest and CV to:

Ted Teknos, MD
Professor and Chair
The Ohio State University
Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212
E-mail: mark.inman@osumc.edu
Department Administrator
Or fax to: 614-293-7292
Phone: 614-293-3470

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University is an Equal Opportunity Affirmative Action Employer. Women, minorities, Vietnam-era veterans, and individuals with disabilities are encouraged to apply

Penn Medicine

Pediatric Otologist/Neurotologist

The Children's Hospital of Philadelphia and the Department of Otorhinolaryngology: Head and Neck Surgery at the Perelman School of Medicine at the University of Pennsylvania seek candidates for an Associate or Full Professor position in the non-tenure clinician-educator track. The successful applicant will be accomplished in the area of Pediatric Otology/Neurotology focusing on vestibular disorders in children.

Expertise in the specific area of Pediatric Otolaryngology and Otology/Neurotology is required. Applicants must have an M.D or M.D./Ph.D. degree and have demonstrated excellent qualifications in education, research, and clinical care. Candidates must be fellowship trained in Pediatric Otolaryngology and Otology/Neurotology or Otology/Neurotology fellowship trained with an extensive Pediatric Otolaryngology experience. All candidates must be board certified in Otolaryngology.

We seek candidates who embrace and reflect diversity in the broadest sense.

The University of Pennsylvania and The Children's Hospital of Philadelphia are EOEs. Minorities/Women/Individuals with disabilities/Protected Veterans are encouraged to apply.

Apply for this position online at: https://www.med.upenn.edu/apps/faculty_ad/index.php/g329/d4367

SOUTH FLORIDA ENT ASSOCIATES

South Florida ENT Associates, a fifty-five physician group practice operating in Miami-Dade, Broward and Palm Beach Counties, has immediate openings for full-time ENT Physicians. South Florida ENT Associates is the second largest ENT group in the country and the largest in the state of Florida. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics and CT services.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.

Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.

This position will include both office and hospital settings.

Requirements:

Board Certified or Eligible preferred
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills
F/T - M-F plus call
For more information about us, please visit www.sfenta.com.

Contact Information:

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

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology/ Head & Neck Surgery

NEUROTOLOGIST/OTOLOGIST

- Rank commensurate with experience
- Excellent resources are available in this rapidly expanding program
- Fellowship training required

To apply and receive additional information about the support associated with this opportunity, please contact:

Stil Kountakis, MD, PhD, Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
1120 Fifteenth Street, BP-4109, Augusta, Georgia 30912-4060

Or email skountakis@augusta.edu

AUGUSTA UNIVERSITY

Augusta University is an Equal Opportunity, Affirmative Action and Equal Access employer.

Excellent Otolaryngology Opportunity in the Midwest - Toledo, Ohio

ProMedica Physicians Ear, Nose & Throat, Toledo's premier ENT practice is seeking highly motivated, personable BC/BE Otolaryngologists to join their progressive and expanding practice. The practice consists of 5 ENT physicians, of which 3 are fellowship trained, offering patients the full spectrum of ENT services. The services include: allergy testing and treatment, and complete audiology and vestibular services including VNG, rotary chair, posturography, and cochlear implantation and mapping. In addition, a full time speech pathologist that offers videostroboscopy & voice analysis with speech therapy, dysphagia evaluation and treatment.

ENT Practice located in ProMedica Health and Wellness Center, a three-story, 230,000-square-foot center that brings a full-spectrum of care under one roof housing primary care and specialty physician offices; medical imaging, laboratory, behavioral health and wellness services; an endoscopy center; ProMedica Optical; ProMedica Pharmacy Counter; ProMedica Urgent Care; and a food pharmacy.

We are seeking candidates who excel at general ENT with advanced subspecialty interest and fellowship trained in:
• Neurotology / Otology • Head and Neck Surgical Oncology • Laryngology

Highlights:

- Opportunity to join a collegial, dynamic team of 5 Otolaryngologists
- "Built in" referral base and high volume
- Call shared equally among all members (currently 1:5)
- Trauma call is optional and paid separately
- Opportunity for teaching residents and medical students
- All members participate in weekly board meetings
- Full employment with ProMedica Physicians
- CME allowance plus vacation, holiday and sick time
- Perfect balance of work and lifestyle

For more information, contact:

Deanna Stocker
Physician Recruiter
deanna.stocker@promedica.org
419-824-7456

Employment with ProMedica Physicians includes:

- Competitive compensation and generous benefit package to include medical, dental, vision, life insurance, long & short-term disability, deferred retirement options and malpractice insurance
- Relocation paid up to $10K
- Being part of a diverse provider network that focuses on high-quality and patient-centered care.

ProMedica Physicians is a multi-specialty physician network of more than 900 physicians and midlevel providers throughout northwest Ohio and southeast Michigan. The ProMedica Physician professional team handles every aspect of practice management including billing, coding, compliance, human resources, legal issues and marketing to name a few. For more information, please visit www.promedica.org/doctors.

PROMEDICA | Your health. Our mission.

Excellent Neurotologist Opportunity in the Midwest - Toledo, Ohio

ProMedica Physicians Ear, Nose and Throat is seeking a full time BE / BC Neurotology fellowship-trained individual to join a five-physician ENT group based in Toledo, Ohio. Three partners within the group are fellowship-trained subspecialists.

Highlights:

- Oversee an existing, comprehensive "turn-key" neurotology practice
- Complete audiology and vestibular services including VNG, rotary chair, posturography cochlear implantation and mapping
- Collaborative, multidisciplinary culture
- ProMedica ensures you have the means to deliver exceptional personalized care to your patients
- Mix of general ENT and neurotology
- Group meets weekly for board meeting
- Strong referral base from within group and the surrounding community
- Employment with ProMedica Physicians Includes:
- Competitive compensation and generous benefit package to include medical, dental, vision, life insurance, long & short term disability, deferred retirement options and malpractice insurance
- Relocation paid up to 10k
- Teaching and research opportunities
- Being a part of diverse provider network that focuses on high-quality and patient-centered care
- Toledo, population 300,000, is the 4th largest city in Ohio offering attributes of a large city while maintaining the atmosphere and charm of a small town. The Toledo Zoo is #1 in the US. The area offers an extensive Metro park system, Museum of Art, and excellent institutions of higher education. Toledo is home to a minor league baseball team, and hockey team. Located within 1 hour access of other professional sports teams.

For more information, contact:

Deanna Stocker
Physician Recruiter
deanna.stocker@promedica.org
419-824-7456

PROMEDICA | Your health. Our mission.

LOMA LINDA UNIVERSITY
Faculty Medical Group

Retina Division Chief Opportunity in Southern California

Loma Linda University Faculty Medical Group, Department of Ophthalmology, is seeking a BC Ophthalmologist fellowship trained in Vitreoretinal Surgery to join our full time group of ophthalmic subspecialties and generalists as Chief of the Retina Division. Ideal candidates will currently be at the academic rank of Associate Professor or eligible for promotion to Associate Professor level. Responsibilities include patient care, resident teaching and supervision, medical student teaching, coverage and call for subspecialty members, service level meetings, recruitment strategy and other service items.

We have a very busy group practice with satellite locations in Riverside, Banning, and San Bernardino in addition to our main location in Loma Linda. Our group provides professional services at the Riverside County clinic/hospital as well, where we have an active Resident training program. We are currently building out additional dedicated retina clinical space at our Loma Linda location to facilitate optimal patient service/flow. Our facilities are equipped with the most up to date equipment needed for diagnostic purposes and we have several retinal clinical trials underway. In the last 12 month period, as a group we had close to 50,000 billed visits.

This position will include competitive salary based on academic rank and a comprehensive benefit package, including medical, dental, CME, relocation assistance and paid malpractice insurance.

Loma Linda University is located East of Los Angeles, known as the Inland Empire. The beached of Newport, Laguna, and Malibu are only 60-90 minutes to the West, with superb swimming, sunbathing, surfing, and sailing. Also 60 minutes to the West is downtown Los Angeles, with its top-quality restaurants, world-renowned museums, opera, and other cultural opportunities. The Big Bear Mountain Ski resort is about an hour drive from LLU. The golf courses, shopping, and spas of Palm Springs are an hour drive to the East and the World-class Mammoth Mountain resort is a 6 hour drive to the North.

Interested candidates, please send your CV to:

Mike Unterseher
Director of Physician Recruitment
recruitmd@llu.edu
800-328-1163

Ear, Nose & Throat Associates of New York, P.C.
Hear Better, Breathe Better, Feel Better
www.nyents.com

BE PART OF NEW YORK'S PREMIER ENT PRACTICE

One of the largest and most established private practices in the Greater New York area. Specializing in all facets of General Otolaryngology, Facial Cosmetic Surgery, Laryngology, and Otology.

Offices conveniently located in Queens, Long Island, Brooklyn and The Bronx.

For more information contact Carlos Lopez at (516) 220-6448 or nyents@optonline.net

Henry Ford Medical Group

Henry Ford Health System, one of the nation's largest group practices, is actively recruiting Board certified/Board eligible academic Otoloaryngologists in the following areas:

- Head and Neck Surgical Oncology
- Laryngology
- Sleep Medicine
- Rhinology
- Neurotology/Otology
- General Otolaryngology

The Department has fellowship trained specialists in the areas of laryngology, neurootology, head and neck cancer, head and neck endocrine, rhinology, pediatric otolaryngology, facial plastic and reconstructive surgery and sleep medicine. The department supports a very competitive otolaryngology residency program with an outstanding national reputation for clinical educational and research programs.

We offer a competitive salary with an incentive opportunity and a full benefit package including health, dental, moving costs, licensure reimbursement, four retirement savings plans, paid vacation and CME time and allowance. Clinical faculty academic appointments are available through Wayne State University School of Medicine.

Contact: Current Curriculum Vitae (CV) should be sent to:

Kathleen Yaremchuk, MD, MSA, Chair,
Department of Otolaryngology
Head and Neck Surgery
c/o
Jennifer Feddersen
jfedder1@hfhs.org or fax (313) 874-7989

Henry Ford Health System

American Rhinologic Society

JOIN US

COSM 2017
April 27-28, 2017

Manchester Grand Hyatt,
San Diego, California

6TH Annual

Summer Sinus Symposium

The Best Sinus Course in the World:
Improving Rhinology from Office to OR

July 14-16, 2017

Omni Shoreham Hotel
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ARS 63rd Annual Meeting
September 8-9, 2017

Renaissance Chicago
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Chicago, Illinois

Questions: Contact Wendi Perez, Executive Administrator, ARS, PO Box 495, Warwick, NY 10990
Tel: 845-988-1631 | Fax: 845-986-1527 | wendi@amrhso.com

www.american-rhinologic.org