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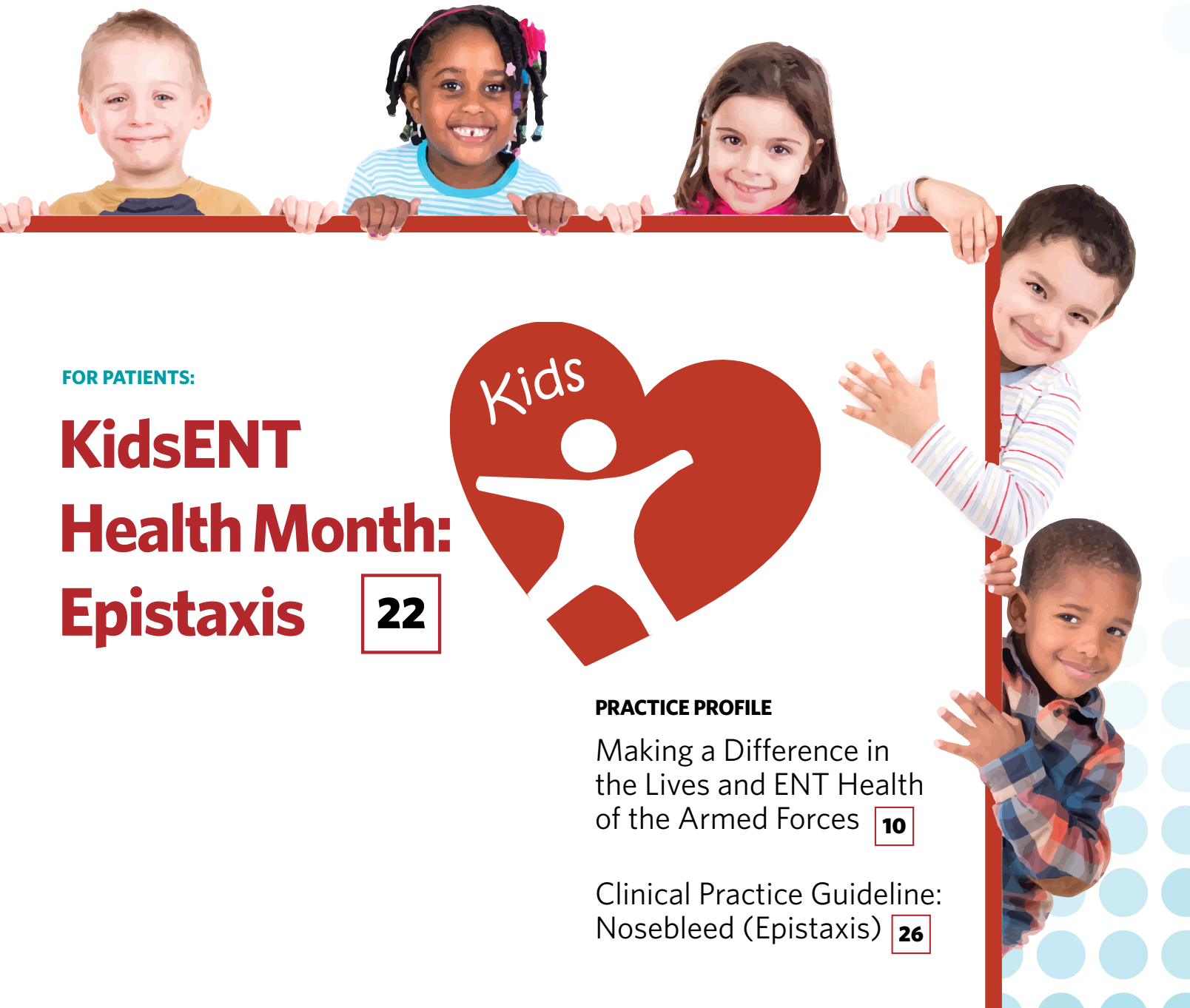
The official member magazine of the **American Academy of Otolaryngology–Head and Neck Surgery**
FEBRUARY 2020



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Are Your Pediatric Patients Part of the "Team?"

Because February is our Academy's Kids ENT Health month, we all have the opportunity to shine the spotlight on certain Kids ENT health issues and direct patients and parents to accurate information that affect this younger segment of our patient population (**ENTHealth.org**). This month, we also have a chance to pause and reflect on the way we communicate with, care for, and influence our pediatric patients along with their parents.

Every interaction I have with a child has been viewed through a different lens based on experiences (including being a parent). My pediatrics hospital rotation in medical school was my initial exposure to working with sick children, and I remember it vividly. My first patient was a 12-year-old boy (call him Andy) who suffered from a rare congenital cardiomyopathy. Andy had frequent hospital admissions, and the staff were quite familiar with him and his condition. Andy's twin had passed away from the same condition just a few months prior to my starting the rotation, and his life expectancy was not anticipated to be much longer without a transplant.

This initial experience (as a soon-to-be doctor) required me to understand the perspective and experiences of this young patient and his parents as they struggled through this ritual of hospitalizations with an ominous prognosis. The lessons and insights I learned from following and listening to this young person and watching how the experienced team interacted with both him and his parents would lay the foundation for my relationships with many pediatric patients and their parents throughout my training and career.

Andy knew the possibility of an early demise was real, yet he stayed positive. He yearned for support through hope with every interaction and appreciated the human touch as well as the measured realities that were presented to him daily by his doctors and the rest of the healthcare team. Such wisdom and courage I had never witnessed in someone this young, but I appreciated it. I realized the value of making kids (along with their parents) part of the "team" from the beginning was as important as the information, knowledge, and compassion given to the parents.

My second most memorable early experience with a pediatric population was a month-long medical mission to South America during my senior year of medical school. This was one of the many life-changing experiences that truly shaped me as a person and reaffirmed my commitment to be a physician. I was selected to join a team of doctors, nurses, medical students, and other volunteers from North America as a part of an ophthalmology medical mission traveling to a small town in Ecuador. We worked in a makeshift clinic housed in a church that saw hundreds of patients (most of whom were children of all ages brought in by their parents) who waited patiently in line after trekking for miles to be seen by our team.

Those patients needing surgery were scheduled and had procedures in a tiny OR in a nearby hospital. Although supplies were shipped in, the resources and facilities were limited. The need to triage patients by severity of condition, availability for follow-up visits, and compliance had to be discerned with an interpreter by members of the team quickly.

I admired the parents who brought their children dressed in their "Sunday best" for medical care in spite of the challenges of poverty they faced back home. I tried my best to meet and greet each with the dignity they deserved for this effort.

Each of us on the front lines heard personal perspectives from each child (who could give it) and their parent or grandparent regarding their problem and followed with an engaging dialogue and treatment plan. The gratitude and appreciation shown by these parents/relatives and children was heartfelt, and the growth I experienced (in this case in another culture) was priceless and immeasurable.

In both of these early experiences, communication, understanding, building trust, being nonjudgmental, and inclusion in team decisions proved to be equally important and critical to building my foundation for the many youth/parent encounters that would follow. As the composer John Powell said, "Communication works for those who work at it." So, let's not forget this applies to the kids you see and their parents. I encourage you all to explore and review how you and your staff might enhance interactions with your pediatric patients this month. ■

Duane J. Taylor, MD
AAO-HNS/F President

“I realized the value of making kids (along with their parents) part of the "team" from the beginning was as important as the information, knowledge, and compassion given to the parents.”

AAO-HNSF ANNUAL MEETING & OTO EXPERIENCE 2020

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CALL FOR APPLICANTS:

AAO-HNSF Coordinator for International Affairs

The Foundation Board of Directors is seeking applicants to serve as Board Coordinator for International Affairs.

- The appointment is for a four-year term.
- Candidates must be an otolaryngologist and full U.S. Fellow member of the AAO-HNS.
- The Coordinator for International Affairs oversees implementation of the high-profile, important portfolio of AAO-HNSF's global outreach and programs and ensures alignment with the strategic plan.

Interested applicants are invited to submit a letter summarizing their qualifications, a curriculum vitae, and letters of recommendation to Rebecca Dobbins, AAO-HNSF Director, Global Affairs, at **rdobbins@entnet.org** **no later than 11:59 pm (ET), March 1.**

To learn more, visit **www.entnet.org/CoordinatorIA** to review the qualifications, specific duties, and general expectations before applying.

New Year, New Committees

The current volatility we have witnessed over the last six months in Washington, DC, will likely accelerate as we move closer to the 2020 elections. Healthcare reform will likely be one of the most widely debated topics throughout the process, extending for years to come. The need to balance access, quality, and cost will continue to be addressed from distinctly different points of reference. The healthcare industry and provision of these services to the public is inherent both philosophically and economically to American society. Crafting a solution that meets the needs of increasingly diverse stakeholders will be challenging. Specialty society input will be critical as we work to ensure appropriate access to the highest quality of care for American citizens. The best solutions will come by incorporating the ideas and experiences of all constituents and establishing evidence-based principles that cannot be compromised in the final product as well as innovative implementation strategies that can move the needle.

This month's *Bulletin* highlights a potpourri of activities requiring collaborative effort and innovation to achieve desired goals. They have a commonality in initiatives that will benefit our patients and can be driven by real evidence. Our Guidelines Task Force, which consists of stakeholders representing broad interests across our specialty—including representatives of all of our subspecialty societies and the public—continues a long history of exemplary expansion of quality in our specialty through Clinical Practice Guidelines (CPG) and Clinical Consensus Statements (CCS). The newly released CPG on epistaxis is no exception.

Thanks to the foresight of your presidential leaders, **Drs. Merati, Taylor,** and **Bradford,** and interested Academy members, we will have three new committees operating in 2020. In recent years, it has become apparent that the increasing number of awards and honors has resulted in difficulty in identifying an appropriate pool of qualified candidates. Dr. Merati has formed the Awards Task Force that will now be charged with promoting each award, recognizing deserving individuals, and selecting the awardees. This will begin for the 2020 cycle. Drs. Bradford and Taylor recognized the rapid progression and the future integration of telehealth and telemedicine as essential tools and remedies for current and future access and care optimization in otolaryngology and, through the Executive Committee, they have resumed the Telehealth and Telemedicine Committee that was sunsetted 12 years ago.

Finally, members interested in salivary gland disease based on recent advances in management options have followed the prescribed mechanism for committee formation and completed all requirements. The Executive Committee approved their application, and the committee will be populated in the near future.

We are also highlighting the successful international program in this month's issue. We now have 72 International Corresponding Societies and have had a steady progression of bidirectional joint meeting programs around the world as well as significant international attendance at and substantial expansion of our Annual Meeting global programming. The leadership of our Coordinator for International Affairs, **J. Pablo Stolovitzky, MD;** the International Advisory Board, chaired by **Sady Selaimen da Costa, MD, MSc, PhD;** and the International Steering Committee has spearheaded the escalating global collaboration and education that can lead to individual and systemic progress for all.

Our practice profile this month features one of our newest at-large Board of Directors members, **Colonel LaKeisha R. Henry, MD.** Dr. Henry's long-term commitment to military service and progression to the rank of colonel is inspirational and brings to light the significant contributions that military clinical medicine and research have made both in general trauma and otolaryngic trauma care. Future *Bulletin* articles will feature a comprehensive look at the history of otolaryngology in the military and the numerous advances made possible through that experience.

The Executive Director of the American Board of Otolaryngology - Head and Neck Surgery (ABOHNS), **Brian Nussenbaum, MD,** has given us a comprehensive update on the many activities that the ABOHNS has pursued on behalf of our members/diplomates and the entire specialty of otolaryngology, much of which is done in association with the Academy and Foundation.

The next several months will see some interesting and unpredictable activity specific to otolaryngology embedded in federal and state legislation that will potentially come to vote this year involving audiology and hearing issues as well as healthcare system changes. We will be sending out timely communications asking for your help in contacting your representatives as these issues arise and would appreciate your participation. ■

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

> Specialty society input will be critical as we work to ensure appropriate access to the highest quality of care for American citizens.

at the forefront

Information, resources, and updates in this section

Nominate Your Colleagues for a Prestigious Academy Award

Humanitarian Travel Grant Recipient Teams Up with Kenya Relief Mission

WIO2.0 Initiatives Campaign: Investing in the Next Decade

University of Kansas Team Treats Goiters, Neck Masses in Philippines

OTOSource Pediatrics

Don't Miss the Latest Podcasts

READ MORE ONLINE

Humanitarian Travel Grant Recipient Teams Up with Kenya Relief Mission

University of Kansas Team Treats Goiters, Neck Masses in Philippines

Nominate Your Colleagues for a Prestigious Academy Award

By Albert L. Merati, MD, AAO-HNS/F Immediate Past President and Chair of the Board of Directors Awards Task Force

We are surrounded by amazing AAO-HNS colleagues with remarkable accomplishments and vision for local, national, and international outreach. Our mentors, friends, and trainees are the embodiment of our Academy's vision of optimizing quality ear, nose, and throat patient care and deserve recognition as such. These folks don't always work in the limelight but rather pursue their passion without recognition. Let us speak up for these champions as well.

Nominations are now open for outstanding individuals to receive the Academy's highly prestigious awards for their achievements and notable contributions to the profession and to the communities they serve. Nominating your colleague for an award is an awesome way to express gratitude to someone in your life who has devoted themself to sustained and selfless service, earn the respect of their peers, and become a role model. It is important that we pause on occasion and celebrate our colleagues and their contributions to otolaryngology; speak up for those who have made a difference.

The Academy has many prestigious awards, ranging from the Jerome C. Goldstein, MD Public Service Award to the Helen F. Krause, MD Trailblazer Award. All the awardees will receive special recognition in the *Bulletin,* online, and at the AAO-HNSF 2020 Annual Meeting & OTO Experience in Boston, MA.

We streamlined the application and submission process to make it easier to use. Learn more at www.entnet.org/awards. The submission site will remain open through March 13. ■

HUMANITARIAN TRAVEL GRANT

Humanitarian Travel Grant Recipient Teams Up with Kenya Relief Mission

Jaxon W. Jordan, MD, traveled to Migori, Kenya, as part of a surgical team that included **Lana L. Jackson, MD, Gina D. Jefferson, MD,** Tammara L. Watts, MD, and Gil Jackson, MD, to remove head and neck masses from patients who couldn't afford healthcare.

Over the course of the trip, 66 operations as well as numerous other clinical procedures were performed and the group treated more than 100 additional patients at the Brase Clinic and Vision Centre. The mission was about providing more than just physical care.

"The spiritual impact of our surgeries went far deeper than we could have expected, as many patients had been told that their tumors were a sign that their lives had been cursed," said Dr. Jordan. "The gratitude we received was unparalleled, and it will have a lasting impact on everyone who was involved with the mission." ■

WIO2.0 Initiatives Campaign: Investing in the Next Decade

The WIO2.0 Initiatives Campaign is a yearlong celebration of both the 10th anniversary of the WIO Endowment that was established in Boston, MA, at the AAO-HNSF 2010 Annual Meeting and a yearlong fundraising campaign to raise $800,000—double what was raised in four days in 2010. Since the launch of the campaign at the AAO-HNSF 2019 Annual Meeting & OTO Experience, $121,400 has been raised. We are 15 percent of the way there. We will need everyone's support to get to the finish line by the AAO-HNSF 2020 Annual Meeting & OTO Experience in Boston, back where it all began. To learn more and invest in the next decade of Women in Otolaryngology, please donate at **entnet.org/give2wio.** ■

> "There's no better avenue for cultivating female leaders than through the WIO Endowment: Financial support is the key to longevity, progress, and success."
>
> Angela M. Powell, MD, WIO Chair

OTOSOURCE
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February: Pediatrics

Explore the difference in care between pediatric and adult patients in the OTOSource Pediatric Otolaryngology unit. Multiple modules and surgical videos cover topics from general care to specific conditions, such as anesthesia techniques, hearing loss, GERD, and OSA, among others. Access these free resources at **www.otosource.org.** ■

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HUMANITARIAN TRAVEL GRANT

University of Kansas Team Treats Goiters, Neck Masses in Philippines

G. Nina Lu, MD, traveled to Calapan City on Mindoro, an island of the Philippines, to join the World Outreach Foundation of Kansas City on its annual mission to serve the Calapan Provincial Hospital Major Surgery and Clinic. During their week-long stay, the University of Kansas otolaryngology team, along with local surgeons, focused efforts on endemic thyroid goiters and congenital neck masses.

Dr. Lu remembered one patient in particular.

"Boobie was a 7-year-old kid presenting to us with a midline neck mass," she said. "It had been previously infected, and the parents were very concerned about another infection. We performed a Sistrunk procedure for removal of the thyroglossal duct cyst, and his parents were so grateful for our help. Taking care of patients such as Boobie really energizes my interest in global health and inspires me to continue to figure out what role otolaryngologists can play in establishing sustainable trips across the world." ■

➲ READ MORE ONLINE
Longer article available

REGISTRATION IS NOW OPEN

Don't Miss the Keynote Speaker for #BOGMTG20

Martin Makary, MD, MPH
AAO-HNS/F 2020 Leadership Forum & BOG Spring Meeting General Session Keynote Speaker

Martin Makary, MD, MPH, will be the general session keynote speaker at the AAO-HNS/F 2020 Leadership Forum & BOG Spring Meeting. Dr. Makary is a healthcare futurist, Johns Hopkins surgeon, and professor of health policy. He is a frequent medical commentator on NBC and FOX News and a leading voice for physicians, writing for *The Wall Street Journal* and *USA Today.* He advises policy leaders at the highest levels of government on healthcare and leads an advocacy effort to rebuild the public trust in hospitals around the United States

Dr. Makary is a champion of lifestyle medicine and the redesign of how people interface with the healthcare system. As a gastrointestinal surgeon, he is a strong proponent of healthy foods and the impact of the microbiome on health. Dr. Makary advises several businesses on how to find quality care and use a holistic approach to healthy living.

His book *The Price We Pay* discusses rebuilding the public trust in the medical profession. He advocates for the new movement of relationship-based clinics that spend time with patients to address the social, economic, and lifestyle determinants of health. His previous bestselling book, *Unaccountable*, was adapted for television into the hit medical series "The Resident."

Dr. Makary has been elected to the National Academy of Medicine. He speaks frequently on health policy and how everyday Americans and business leaders can get a better deal on their healthcare. His current research focuses on the appropriateness of medical care, drug prices, and the impact of the healthcare cost crisis on low-income populations. Using a nonpartisan approach, Dr. Makary explains the current billing-throughput system of medical care and describes the disruptors who are revolutionizing the way we get care.

Dr. Makary's lecture will take place at 2:00 pm (ET), Saturday, May 2, at the Westin Old Town Hotel in Alexandria, VA. ■

AAO-HNS/F LEADERSHIP FORUM & BOG SPRING MEETING
MAY 1-3, 2020 | ALEXANDRIA, VA

Join your colleagues for a weekend of leadership discussions, Board of Governors (BOG) meetings, informative speakers, advocacy updates, and mentoring/networking opportunities. This meeting is one of many AAO-HNS benefits that give Academy members the opportunity to network and engage in peer-to-peer interaction with eminent leaders.

WHEN: May 1 – May 3, 2020 (Meetings at Capitol Hill are scheduled on May 4; invitation only)

WHERE: Westin Alexandria Old Town Hotel, 400 Courthouse Square, Alexandria, VA 22314

Preliminary programming information (program is subject to updating), online registration, and online hotel reservations are now available. For more information on the AAO-HNS/F 2020 Leadership Forum & BOG Spring Meeting, visit **https://www.entnet.org/leadershipforumregistration.** We look forward to welcoming you to Old Town Alexandria for this outstanding event.

Questions concerning the BOG Spring Meeting? Contact **BOG@entnet.org**.

BOG

CONNECT AND SHARE: #BOGENT

Kids, Family, and the BOG

Spencer C. Payne, MD
Chair, BOG

I cannot help but think about my kids and my family as I write this article for Kids ENT Health Month. I have four little people who rely on me for love, shelter, and nourishment (mind, body, and soul). I think about them every time I leave for my job in the morning, travel for work on weekends, or participate in AAO-HNS/F activities, whether they be across the country or closer to my home in Virginia where the Academy has its headquarters. Each moment I spend away, I must reflect on the opportunity cost and the value added. In the end, these experiences must provide value in order to compete with the time lost with friends, family, and loved ones.

As Chair of the Board of Governors, I have the honor of organizing the AAO-HNS/F 2020 Leadership Forum & BOG Spring Meeting. Every bit of it has been crafted to be value-added since I, like you, will spend two to three days away from the people who matter most, and we want to make the most of it for you. This year's program brings a twist to the Fourth Annual State OTO Society Roundtable. With an invited lecturer who will describe the best practices for forming and maintaining a local/regional society, attendees are certain to go home with new and great ideas. Although it is intended for presidents and administrators of the BOG Member Societies, anyone is welcome to attend. We are also reorganizing Saturday's programming to make it easier for governors or their alternates to attend the general assembly, which is being moved to the afternoon. Our keynote speaker is Martin Makary, MD, MPH, an internationally renowned surgeon who has had innumerable experiences in quality and cost and will be addressing his ideas on our "broken" healthcare system. Read more about him on page 8. Our closing speaker on Sunday is Allison Linney, MBA, who has a fantastic talk prepared on navigating difficult conversations, which will guide attendees through both delivering and receiving less than stellar feedback. Additionally, the "in between" is stocked with panels organized by some of our Academy's brightest leaders on allyship, bullying, social media, and the controversies surrounding the assessment of surgical competency. Also, come see what our BOG committees have been up to as they tackle issues ranging from society member engagement, protecting your online identity, and optimizing payer relations.

Although I am sure that all of these informative sessions should be enough to attract you to Alexandria, VA, May 1-3, the intangibles must be boldly stated as well. Reconnect with friends, leverage the networking opportunities, enjoy the local nightlife (and regular karaoke outing), and bask in the knowledge that when we come together as a specialty, we stand united for our profession, our patients, our families, and our children.

I look forward to seeing you in May in Alexandria. As always, attendance is free for AAO-HNS members, so please register and sign up for housing at **www.entnet.org/LeadershipForumRegistration.** Member login required. ■

> “Bask in the knowledge that when we come together as a specialty, we stand united for our profession, our patients, our families, and our children.”

Making a Difference in the Lives and ENT Health of Our Armed Forces

LaKeisha R. Henry, MD, Colonel, USAF, MC, FS

LaKeisha R. Henry, MD, holds the rank of Colonel in the U.S. Air Force (USAF) and currently serves as Division Chief at the Department of Defense Hearing Center of Excellence (HCE), located in the Wilford Hall Ambulatory Surgery Center at Joint Base San Antonio-Lackland, Texas. HCE is part of the Defense Health Agency and is a collaborative effort with the Department of Veterans Affairs. HCE facilitates auditory and vestibular research and develops best practices that enhance the prevention, diagnosis, mitigation, treatment, and rehabilitation of patients with associated disorders.

Dr. Henry is an assistant professor in the Department of Surgery at the Uniformed Services University of the Health Sciences (USUHS) and an Advanced Trauma Life Support instructor. She was Otolaryngology Consultant to the Air Force Surgeon General for several years, which allowed her to mentor residents and other otolaryngologists. She served as the 59th Medical Group's Otolaryngology Master Clinician and has held the position of Squadron Commander in addition to other leadership roles during clinical assignments both in the United States and overseas.

"I knew that I enjoyed helping people, and I was looking for a long-term career where I could make a difference in the military beyond my initial commission. I thought I might become a pediatrician, but with a bachelor's degree in Engineering Management, I like to tinker with my hands, so I considered surgery," she said.

Dr. Henry is a cross-service graduate, which means that after graduating from the U.S. Military Academy at West Point, she took a commission into the USAF instead of the Army. Along the way, two of her West Point classmates encouraged her to attend medical

school and a mentor inspired her to consider otolaryngology as a career path.

"I became interested in providing service for all genders, all age groups, and after being exposed to a number of surgical specialties, I learned more about otolaryngology and began to appreciate the complex anatomy of the specialty, the people, the personalities, the family, and community concept of ENT surgeons, and the ability to mix aspects of the whole patient, whether they need surgery or not. I really liked the provider-patient relationship of other medical specialties, so ENT appealed to me."

During the time between graduating from medical school from USUHS and completing a residency in otolaryngology at the San Antonio Uniformed Services Health Education Consortium, Dr. Henry became a flight surgeon. Trained in aerospace medicine and disorders that can occur at or are associated with altitude, a flight surgeon is the primary care provider for an aviation unit's members and their families.

> "I knew that I enjoyed helping people, and I was looking for a long-term career where I could make a difference in the military beyond my initial commission. I thought I might become a pediatrician, but with a bachelor's degree in Engineering Management, I like to tinker with my hands, so I considered surgery."

Upon completing her residency, Dr. Henry was based mostly in community-sized hospitals, which meant moving every three to four years while enjoying a comradery with other clinicians and a true team approach to patient care. She was assigned to Royal Air Force Lakenheath Hospital in Suffolk, England, before being transferred to Landstuhl Regional Medical Center in Germany. She returned to the U.S. when she was assigned to Mike O'Callaghan Military Medical Center at Nellis AFB, Nevada. After being selected as a Squadron Commander, she began assuming more leadership responsibilities in the Washington, DC, area before arriving at Joint Base San Antonio-Lackland.

"My practice would be based on the population of the military installation I was assigned to, including beneficiaries such as active-duty personnel, retirees, and their family members, as well as reservists and VA patients," she explained. "Sometimes, that also included

Dr. LaKeisha R. Henry performs surgery with resident **John W. Lally, MD**

patients who had been evacuated from deployed or austere environments.

"Prior to being assigned in Germany, I deployed to Afghanistan. I don't think there was another ENT in theater, but we had a head and neck team that included a neurosurgeon, myself, our technician, and a colleague who was a reservist dentist. It was a comprehensive practice that included treating trauma and battlefield-type exposures…and during my tour, we took care of U.S. forces, NATO and coalition forces, the host nation [Afghan] army, and civilian [local national] patients who were injured.

"There were opportunities to provide humanitarian care while I was deployed. Deployment is one of the highlights of my career because it was rewarding and challenging in many ways. You're not looking for someone to give you gratitude but having the opportunity to make a difference in the lives of our forces and others was something very special. I was grateful to have had that opportunity."

Dr. Henry describes her typical practice as general in nature, treating conditions similar to other otolaryngologists, but there are specific requirements for ensuring that someone is fit for active military duty. Trauma-related conditions and noise-induced hearing loss are of particular interest to the military because there are certain aspects of military service that make hearing a critical sense. Service members need to maintain situational awareness, be able to localize within their surroundings, and communicate clearly and effectively with their unit.

Because military otolaryngologists move to various assignments more often than their civilian counterparts, being able to take advantage of and secure funding for continuing education courses can be a challenge. As a member of the AAO-HNS since she was a resident, Dr. Henry explains that military members often do not receive permission to attend the AAO-HNSF Annual Meeting & OTO Experience, for example, until right before it begins. That can make logistical planning and registering for pre-meeting courses—valuable opportunities for residents and staff surgeons—difficult.

Even so, she feels that military members are encouraged to participate in and become involved with AAO-HNS committees, and she sees opportunities for certification and continuing education growing, such as online learning options and being able to view Annual Meeting session presentations back home (non-attendees can purchase the Annual Meeting Webcasts with all 338 recorded sessions through AcademyU). "The Academy is constantly looking for ways to add value for its members."

Dr. LaKeisha R. Henry welcomes speakers and attendees to the Society of Military Otolaryngologists Trauma Symposium prior to the start of the AAO-HNSF 2018 Annual Meeting & OTO Experience in Atlanta, GA

Dr. Henry serves as Chair of the AAO-HNS Trauma Committee. In conjunction with the Society of Military Otolaryngologists (SMO), the committee hosts a Trauma Symposium on the Saturday before the start of the Annual Meeting, which is another forum for military otolaryngologists to network and share lessons learned that may not be solely unique to military situations, but cross over the breadth of the specialty. The Trauma Symposium welcomes Annual Meeting and local participants and offers CME credit.

Dr. Henry feels that the specialty has grown in diversity and maintains the highest standards of care and expectations from the AAO-HNS community. She feels that it's important to continue encouraging diversity in all forms, particularly for women and fulfillment and balance in surgical specialties, as well as developing leadership and mentoring opportunities.

"Our specialty encourages broad competencies for generalists as well as subspecialists and I would like to see that continue," she explained. "I've noticed in specialties outside of otolaryngology there seems to be more and more restrictions placed on generalists and the types of procedures they can perform. Especially within the military, we are expected to practice appropriately within our capabilities, but we must maintain comprehensive and broad skills sets given varying practice environments. This is also important when caring for deployed patients in theater hospitals.

"We're also able to collaborate and consult with colleagues who may have more specialized training or experience in a certain area, and I hope we continue to maintain that level of comradery within our specialty in order to provide the best possible care for our patients. I appreciate the opportunity to practice alongside a community of talented ENT specialists while leading the HCE and guiding enthusiastic new residents." ■

The views expressed are those of the author and do not necessarily reflect the official policy of the DoD Hearing Center of Excellence, Defense Health Agency, or Department of Defense. This information is provided for education purposes only. Reference to any commercial product or service does not imply endorsement by the Department of Defense or DoD Hearing Center of Excellence.

Weaving the World of Otolaryngology: Your Academy Around the World

Report from the AAO-HNSF International Steering Committee

"Weaving the World" aptly describes the growth of the AAO-HNSF global outreach and some remarkable gains.

It is appropriate that we acknowledge the legends in our specialty. **Eugene N. Myers, MD, FRCS (Edin),** and **KJ Lee, MD,** continue to lead, educate, and inspire future generations. At each Annual Meeting, we celebrate the emerging leaders in the specialty at the International Young Physicians Forum and at the International Women's Caucus. On behalf of the International Steering Committee, we are pleased to share recent highlights of our global program, often referred to as "Your Academy Around the World."

- International Membership: The Academy saw a 17 percent increase in global membership.
- Joint Meetings: Academy members and leadership as well as volunteer faculty presented at more than 15 global joint meetings in 2019. In addition, AAO-HNS/F leadership served as guests of honor and presenters at the Chinese Society of ORL-HNS's Annual Meeting in Shenyang, China.
- Global Partnerships: The AAO-HNSF collaborates with the world's 73 International Corresponding Societies to unite nations and regions. This AAO-HNSF-led effort works to enhance the education and experiences of otolaryngologists worldwide, under the auspices of the International Advisory Board, which serves as the voice of the global otolaryngology community.
- International Symposium: The International Symposium at the AAO-HNSF 2019 Annual Meeting & OTO Experience featured worldwide thought leaders composing more than 50 interactive, in-depth, state-of-the-art presentations.
- International Visiting Scholarships (IVS): Increased funding for these scholarships provided more opportunities for junior academics from developing countries to attend the 2019 Annual Meeting and participate in observerships at U.S. otolaryngology programs and institutions. Read about the experiences of a few of the past IVS recipients in recent issues of the *Bulletin.* ■

Society Spotlight:

Pressing Issues in Academic Practice and

Otolaryngology Program Directors Organization (OPDO)

Sonya M. Malekzadeh, MD, OPDO Chair

Residency training requirements are continuously evolving. Recently, the Accreditation Council for Graduate Medical Education instituted significant changes to the otolaryngology program requirements. First, the PG-1 year must now include six months of otolaryngology and six months of structured education on nonotolaryngology rotations. The proposed revision reduces education that is not in alignment with otolaryngology education goals and shifts the responsibility of basic surgical skills training to the otolaryngology faculty. The alternative specialty rotations must focus on the development of specific patient care skills essential for practicing otolaryngologists. This greater emphasis on earlier surgical and nonsurgical basic skills achievement during PGY-1 will allow for a higher level of proficiency in higher skills throughout the remaining residency years. The second change centered on the fact that more than 50 percent of otolaryngology residents pursue subspecialty fellowships. By initiating otolaryngology training earlier, residents would achieve milestones earlier and hence, senior residents would have the flexibility in the design of the final two years of residency to allow a subspecialty focus in the PG-5 year. This change may be beneficial to those hiring residents as well as to the residents themselves. The effectiveness of this shift in education emphasis is unknown and feedback from the otolaryngology community about new graduates' readiness for practice will be very important.

This year, a task force explored the development of a comprehensive PGY-1 curriculum to assist residents and program directors with a standardized set of education modules. A needs assessment survey of program directors and residents identified unique topics that covered specific otolaryngology and nonotolaryngology knowledge, skills, and behaviors critical to the PG-1 year. The task force piloted goals and objectives for 10 otolaryngology topics with plans to develop education methods and strategies to accomplish these objectives. ■

Society for University Otolaryngologists (SUO)

Anand K. Devaiah, MD, SUO Past President

The Society for University Otolaryngologists (SUO) initiated and advanced numerous programs this year to address the needs of academic otolaryngologists, and we appreciate the opportunity to apprise you of some of them. SUO recognizes the value of simulation-based boot camps as a means of providing novice trainees with experiences to improve their technical and nontechnical skills. SUO took the recommendations of our Boot Camp Task Force, examining the feasibility and need for boot camps, built a partnership with the American Academy of Otolaryngology–Head and Neck Surgery Foundation and the American Board of Otolaryngology - Head and Neck Surgery, and moved this initiative forward. A Boot Camp Grant was also created to help support a coordinated network of regional simulation-based boot camps with structured curricula.

The Education Innovation Grant was established, supporting research congruent with SUO's mission, such as education methods, professional development, future workforce needs, gender equality, diversity, and other areas. A Task Force for Medical Student Education was also established to explore the ways SUO can educate and attract medical students, working in coordination with other societies. To embrace the ways SUO can grow by taking a more global perspective, we created a new international category of membership to welcome academic otolaryngologists from around the world.

A very productive year for SUO was capped by a record-setting annual meeting in November. We explored the different paradigm shifts facing academic otolaryngologists and how we will both contribute and adapt to them. We were delighted to hear from our colleagues and our keynote speaker, Jonathan Woodson, MD, an internationally recognized leader in healthcare innovation from Boston University. ■

SUO | AADO | OPDO | SOCIETY OF UNIVERSITY OTOLARYNGOLOGISTS HEAD & NECK SURGEONS

Organizational Initiatives

Association of Academic Departments of Otolaryngology Head & Neck Surgery

Jeffrey M. Bumpous, MD, AADO President

The Association of Academic Departments of Otolaryngology-Head & Neck Surgery (AADO) represents the Academic Departments of Otolaryngology-Head and Neck Surgery in the United States and Canada. We have Spring and Planning Meetings at COSM, and our Annual Meeting is part of the SUO-AADO-OPDO meeting. Like most organizations in healthcare and education, we continue to evolve. We work hard to prepare department chairs and departments for optimization in complex healthcare and education environments. We focus on helping chairs and departments to understand and have valuable tools in structuring sound financial models for now and the future. One example is our Annual Productivity Survey that looks at clinical productivity (wRVU) data in academic departments. We also work with ASCENT, the otolaryngology-head and neck surgery administrator group, to conduct, analyze, and distribute this survey.

AADO has also concentrated on departmental leadership development. We have sponsored an annual leadership panel at our fall meeting concentrating on aspects of leadership formation and development. During the November 2019 meeting, the panel concentrated on perspectives and skills in negotiation in academic otolaryngology, in which we were fortunate to be challenged by Linda Kaboolian, PhD, from Harvard University, a nationally respected authority on negotiation skills. We promote a healthy leadership pipeline for academic units for the future by this commitment to development. Furthermore, we have a new chairs group that meets with our Chair Development Committee led by **Paul W. Flint, MD,** to help mentor new chairs in otolaryngology-head and neck surgery. We additionally continue to monitor the pipeline of trainees and faculty into otolaryngology-head and neck surgery (including the otolaryngology National Resident Matching Program), emphasizing ways to increase diversity, promote excellence, integrate optimal systems and technology, and collaborate with our sister organizations in otolaryngology-head and neck surgery to maintain the vitality and excellence of this important specialty. ■

What Matters in the End: Care at

Andrew J. Redmann, MD, Roger D. Cole, MD, Susan D. McCammon, MD, and Andrew G. Shuman, MD

Presented at the AAO-HNSF 2019 Annual Meeting & OTO Experience in New Orleans, LA

Often otolaryngologists do not discuss dying with their patients, as their traditional role is to prolong and improve life. Over the past few decades, there has been an explosion of interest in popular culture about end-of-life care. In particular, Paul Kalanithi's 2016 posthumous autobiography, "When Breath Becomes Air," about completing a neurosurgical residency after a diagnosis of terminal lung cancer, hit number one on *The New York Times* bestseller list, illustrating a cultural interest in what a "good death" looks like.

Understanding palliative care, contextualizing goals, and mastering how to treat incurable disease is highly relevant but understudied in almost every subspecialty in otolaryngology. It is thus clear that a structure is necessary from which to approach difficult patients in a compassionate and ethical manner.

Beauchamp and Childress have extolled principlism, the most common method of reasoning in contemporary clinical ethics. In particular, as surgeons offering interventions to patients, we consider beneficence (Will the intervention benefit the patient?), autonomy (What does the patient want?), nonmaleficence (Will the intervention cause harm?), and justice (Is the intervention a good use of limited resources?). Of course, complicated cases involve overlapping and conflicting principles.

Consider the following case. A 69-year-old man with locoregionally advanced oropharyngeal cancer was treated with chemoradiation and presents to your clinic for post treatment follow-up. He did not tolerate treatment well and missed a number of treatments due to poor social support/financial issues. Your examination is concerning for persistent disease. Subsequent imaging shows widely metastatic, unresectable disease. Upon telling him this information, the patient tearfully looks you in the eye and asks, "Doc, am I going to die?"

Very few of us would feel comfortable in this situation. But there are some general principles that will help guide the discussion. First, it is important to understand if patients are asking an emotional question or a knowledge question. If a patient is asking an emotional question, the correct answer is not to answer without addressing the real question the patient is asking. Rather, open-ended questions about what the patient's individual goals are can be helpful: What are you most worried about? What are you hoping for? What is most important to you? What are you thinking about right now? Patients often have difficulty describing what is really important until they are explicitly asked. Commonly described goals are to prolong life, minimize pain, and maintain independence, but clarifying what this means to the patient will clarify the decision-making process. In addition, not every decision needs to be made in real-time, and giving patients/families time to think about their goals is often necessary. This can be difficult for surgeons who are trained to quickly identify and provide a fix to problems, but giving this additional time may lead to a better long-term outcome over the illness trajectory.

Occasionally even after a clarifying conversation, patients, such as the one described in the vignette, may nonetheless ask you to attempt surgery. But we must be clear about what surgery can and cannot accomplish. Palliative surgery may include tracheostomy for airway obstruction or gastrostomy for nutrition access and offering these as options is part of best care practices to address discrete goals. Major surgery in the context of incurable disease, however, may have disproportionate risk. Surgeons must also be clear that choosing not to operate does not mean that they are abandoning the patient, or that there are no adjunctive or alternative treatment options. It is incumbent for surgeons to continue to care for patients even if surgery is not warranted, wanted, or feasible.

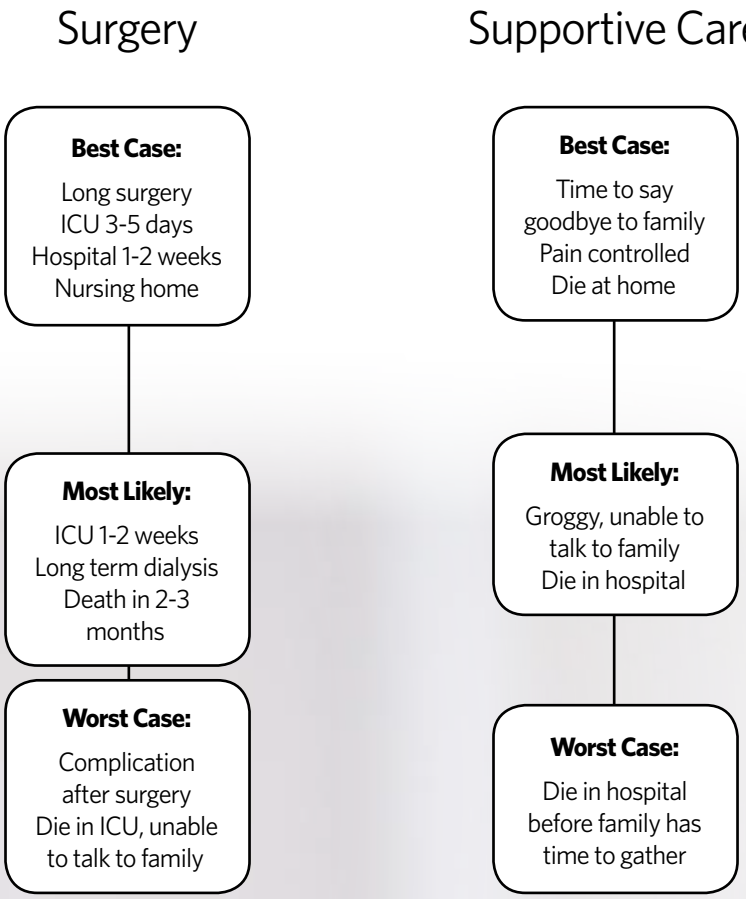
For patients with advanced head and neck malignancy or other incurable disease, palliative care consultation is recommended by the American Society of Clinical Oncology, as significant evidence exists that there is increased survival and quality of life with upstreaming palliative care. Palliative care is defined as supportive care designed to improve quality of life and treat symptoms. This can be as simple as giving an ibuprofen for pain, or as complex as targeted radiation therapy. Palliative care does not preclude patients from receiving treatment for their underlying disease, and it should be clear that it is not "giving up," but often improves both quality and quantity life. For example, in one study in patients with inoperable lung cancer, patients randomized to early palliative care consultation had improved survival and quality of life compared to patients randomized to standard of care chemotherapy without palliative care consultation.[1] As Atul Gawande writes, "If palliative care were a cancer drug, if it were a pill, it would be a blockbuster

the End of Life in Otolaryngology

company, and we'd all want stock in it." Understanding what palliative care entails is thus something that all otolaryngologists should understand and be able to explain.

Despite evidence that palliative care is highly beneficial to patients nearing the end of life, barriers to access are significant. These include economic barriers such as a lack of gas money to make it to appointments, loss of work, and comparatively low reimbursement for palliative services. Other barriers include a lack of support systems and a persistent misunderstanding by many physicians that palliative care consultation is tantamount to "giving up." Training for otolaryngology residents and fellows to provide end-of-life care is also limited, though there are efforts to improve training paradigms. The American Society for Head and Neck Surgery recently included palliative care as a core competency for fellowship, and the American College of Surgeons has introduced a resident's guide for palliative care. But widespread dissemination of this information remains aspirational.

Having a systematic way to approach difficult conversations may be a way to improve care at the end of life. If physicians have a well-trodden path, they will feel more comfortable bringing up these topics, which is a service to our patients and their families. Thus, a decision tool such as the one shown is quite helpful when discussing treatment options in patients with poor prognosis.[2] When discussing two alternative options, each option should have the "best case, worst case, and what the physician feels is the most likely case" discussed, and this should be drawn on a sheet so patients can easily visualize their decisions in a head to head manner. This allows frank, realistic discussions about expectations, is expedient, and allows patients to have something to hold onto after the physician leaves.



To close, a quote from Atul Gawande's "Being Mortal" sums up how we should think about palliative care as otolaryngologists. "We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive." ■

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OUT OF COMMITTEE: DIVERSITY AND INCLUSION

Why Pronouns Matter

Jeffrey Teixeira, MD

All providers aim to build rapport with patients, and that process begins with the first greeting. For transgender patients, an important part of that rapport includes getting their preferred name and pronoun correct. The easiest way to achieve this is by just asking the patient. The proper use of pronouns ensures that the patient is respected and allows for more open, bidirectional communication and the development of a true partnership between patient and provider.

Any provider who has direct patient clinical care should be aware of basic terminology within the transgender community. For example, it is important to understand that the term "sex" refers to the assignment of male, female, or intersex that occurs at birth, while "gender" is a social construct to classify between a man, woman, or other identity. In transgender individuals, there is a gender incongruency between self-identified gender and sex assigned at birth. Gender plays a significant role in our daily lives and directly influences our norms and relations. When providers misgender transgender individuals, they contribute to the negative social and health outcomes associated with gender dysphoria. While many individuals who identify as male or female may prefer the pronouns "he/him/his" or "she/her/hers," there are others who may not, since some individuals identify as nonbinary. Nonbinary individuals do not ascribe to male or female classification and may identify as both or neither genders. These individuals may instead prefer the pronouns "they/them/theirs."

Establishing proper pronouns and preferred names is further complicated by current limitations in healthcare electronic medical records. These systems are programmed to record a patient's legal name and sex, which allows opportunities for misgendering of patients. **It is therefore recommended that providers approach all patients, whether transgender or not, by asking how they prefer to be addressed.** Such an approach reduces the risk of misgendering patients and ensures that we provide the inclusive healthcare we all aim to deliver. ■

Tech Talk

Protecting Data against Equipment Failure

Mike Robey, MS, AAO-HNS/F Senior Director, Information Technology

Technology and cyberthreats are ever changing. In this new series for the *Bulletin,* I will share best practices for you to consider in maintaining the security of your data and how technology can best be implemented to work for you. The following highlight some standard operations you may want to consider employing related to the protection of on-premise servers against equipment failure. These are based on two axioms that work for me: 1) all systems will eventually fail, and 2) single points of failure should be eliminated.

Uninterruptible Power Supply (UPS)

Servers should be protected by UPS systems such as an APC Smart-UPS. Surge protectors with no battery backup are not enough. If you have a UPS, check the batteries. Battery life is between three to five years. If you cannot recall when the batteries were last replaced, replace them now. Another must-have feature is a software agent. Most UPSs come with a software agent that gets installed on the server. When the building electricity goes out, the UPS will signal the sever to gracefully shutdown before the battery run-time runs out.

Server lifetime

To mitigate hardware failure, servers should be replaced every five years. Servers should also have redundant power supplies. If one goes out, the server is still up. Equally important is making sure the software is patched on a regular basis. Outdated software is more vulnerable to cyberattacks.

Regular review of system logs

A system administrator needs to be checking the system's event logs and database logs on a regular basis. Although cryptic, these logs contain valuable information about the health of the system and database. Regular review may prevent a major disaster from occurring.

Disk storage

Redundant array of independent disks (RAID) configurations are a must. RAID enables individual hard drives to work together as an integrated subsystem. If one drive fails, you don't lose everything. The storage subsystem continues without data loss until the failed drive is replaced. Make sure the hard drives are not swappable, and you may want to have a spare drive (or two) on-site for faster recovery. Also, make sure the RAID controller is dual-paired.

Back up your data

Two big advantages to third-party, cloud-based backups, which are highly recommended: 1) the backups are offsite providing disaster recovery protection, and 2) you don't have to worry about ensuring you have adequate backup media on hand. (Backup media ages, too, and should be replaced on a regular basis.)

Probably the most overlooked aspect of backups is testing.

- When was the last time your backup solution was tested by doing a database restore? This critical point is true for any backup solution, cloud-based or premise-based.
- Another important aspect of backups is how far back can you recover? Two weeks? Six months? One year?

The effects of a ransomware attack or virus can be equally devastating. In my next article I will be talking about building a security foundation to protect your infrastructure and staff against cyberattacks. ■

Reg-ent℠
ENT CLINICAL DATA REGISTRY

How to Champion the Reg-ent Registry in Your Institution

Need help getting your colleagues and/or leadership team on board with joining the Reg-ent registry? Here are a few key steps to help you get your organization signed up and started with Reg-ent.

Gather support, spread the message, and get approval

1 Identify and involve decision-makers. In most cases, your department chair is the key decision-maker and is the first person to approach. Schedule time with your department chair to review and discuss the benefits of Reg-ent to your department and institution, your patients, and to the otolaryngology specialty. Your department chair will likely have questions that you aren't able to answer; we ask that you please direct your department chair to the Reg-ent team at **reg-ent@entnet.org** and the Reg-ent website **(www.entnet.org/reg-ent_toolkit)** to address questions they have about Reg-ent, the integration process, and associated fees. Specific content that your department chair may find especially useful can be found at **www.entnet.org/reg-ent_for_institutions.**
Note: *If you are the department chair and are interested in moving forward with the Reg-ent registry, please contact the Reg-ent staff at* **reg-ent@entnet.org.**

2 Reach out to your peers in other departments to see if their specialty has a FIGmd registry already up and running in your institution. If there are other specialty registries in place, this will facilitate contract review, IT review, security audit, and integration processes.

3 Collaborate and involve other decision-makers in the process under the guidance of your department chair. The individuals we recommend reaching out to include staff leadership from IT, informatics, legal/contracts, finance, data security, quality, compliance, and any others who will be involved in the review, approval, integration, and/or oversight processes.

4 Let Reg-ent staff know if you need to give a presentation to the administration or your department. The Reg-ent team is available to speak with you and assist you in your preparations. Email: **reg-ent@entnet.org.**

5 Schedule time for Reg-ent registry staff to connect with your organization to discuss the registry and integration processes. Email: **reg-ent@entnet.org.**

The contracting and payment processes

6 Once it is confirmed that your organization intends to proceed with Reg-ent, please designate primary points of contact from each of the following departments: IT, legal/contracts, finance, data security, quality, compliance, and "other." The Reg-ent team will then work with your legal/contracts department(s) to complete execution of the Reg-ent contract ("Participation Agreement").

7 With assistance from your department administrator, complete the required Appendix A ("Participant's List of Clinicians Participating in the Registry") to the contract. Clinician details including name, NPI, AAO-HNS ID, and email address are required to add clinicians to your account, generate an invoice for payment, and, most importantly, enable Reg-ent to secure data for your department members.

8 Once the contract is signed, it is recommended that both a clinical and operations project manager is assigned to assure success.

Congratulations! Your contract is signed, and your payment is made—now what?

9 After signing up, registry staff will contact you and the other identified individuals, including those from IT, to begin technical integration and preparation of your Reg-ent registry dashboard.

10 Once your Reg-ent registry dashboard is available, data validity and mapping will take place with designated staff from your department to assure accurate data in your Reg-ent registry dashboard.

American Board of Otolaryngology-Head and Neck Surgery Updates

Brian Nussenbaum, MD, MHCM
Executive Director, American Board of Otolaryngology - Head and Neck Surgery

On behalf of the Board of Directors of the American Board of Otolaryngology-Head and Neck Surgery (ABOHNS), I wanted to provide this timely communication with a few important updates. The first being related to the CertLink pilot, which entered the second year of the planned two-year pilot in January 2020. As a reminder, CertLink is an alternative to the traditional, single point-in-time every 10-year exam; one in which the assessment can be done at the diplomate's convenience on his/her computer using an online platform. In addition to the convenience, this new assessment is formative, meaning that one learns as the assessment is being done. The diplomate receives immediate feedback on whether his/her answer choice was correct, what the correct answer is, the key learning point of the question, a brief explanation about all answer choices being correct or incorrect, and links to appropriate references. For questions answered incorrectly, spaced repetition is used such that the diplomate receives a similar question, called a clone, later that year. If answered correctly the second time—demonstrating learning—full credit is given for answering the initial question correctly. Given that this activity incorporates a significant self-assessment component, part 2 self-assessment credit is additionally obtained for each year of participation.

The first year of the pilot went well, with survey results from the participants meeting or exceeding expectations in all aspects questioned about the content and platform. We were especially impressed that 75 percent of our diplomates responded Strongly Agree or Agree to "the program helps me provide better patient care." Several changes were made for the second year of the pilot. These changes include: (1) eight practice area options to select for the assessment instead of three, (2) approval for awarding up to 10 AMA PRA category 1 CME credits for each year of participation, with the AAO-HNSF being the CME provider for the activity, (3) reference links to additionally include AcademyU® activities and the online comprehensive OTOSource curriculum, and (4) single-sign-on access to the CertLink platform through the diplomate's login on the ABOHNS website. There were 1,140 participants in the first year of the pilot and 3,301 participants registered for the second year. Plans beyond the second year of the pilot are still being made and will be communicated as details become available.

Another update for 2020 is a policy change for the ABOHNS to recognize successful completion of otolaryngology-head and neck surgery residency training in programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPS(C)) as fulfilling training requirements for eligibility for primary board certification in otolaryngology-head and neck surgery. In 2015, the ABOHNS was approached by the RCPS(C) to consider this policy change. Information was gathered between 2015 and 2018 by the ABOHNS. A Task Force was convened in 2018 to review the information obtained, gather additional information, and conduct further discussions with otolaryngology-head and neck surgery leadership at the RCPS(C). At the conclusion of this thorough evaluation, the Task Force recommended to move forward with recognizing training in RCPS(C)-accredited programs. This was approved by the ABOHNS Board of Directors and the newly created policy was later approved by the American Board of Medical Specialties (ABMS). The policy has some complexity due to: (1) aligning the new policy with our current policies for graduates from ACGME-accredited residency programs, and (2) needing to be consistent with prior policy decisions on this matter. For those that are interested, the policy can be found on the ABOHNS website (www.aboto.org). The ABOHNS wants to recognize **D. Bradley Welling, MD, PhD, Ramon M. Esclamado, MD, MS,** Wayne Matthews, MD, and Brian Westerberg, MD, for their leadership roles with this change.


Brian Nussenbaum, MD, MHCM

The ABOHNS will be proceeding in 2020 to determine if updates are needed to the exam blueprints for primary certification. This important activity is periodically performed by certifying organizations to ensure that the certification exams still validly represent and include the relevant knowledge and skills required for safe and effective practice. When doing this, an essential activity is performing a Job Task Analysis (JTA) following a rigorous, psychometrically valid process. The analysis of the job (being an otolaryngologist-head and neck surgeon) subsequently informs the content of the certification exams and if changes to the current exam blueprints are needed. With the help of our Sponsoring Societies, including the AAO-HNS/F, the ABOHNS has assembled an exceptional, diverse group of Subject Matter Expert (SME) otolaryngologist-head and neck surgeons representing all practice areas on our primary certification exams. These SMEs will delineate the knowledge and skills tasks required for the contemporary practice of otolaryngology-head and neck surgery that will subsequently be incorporated into a survey sent to all ABOHNS diplomates for critically needed feedback. Please be on the lookout for a request from the ABOHNS to complete this survey later this year. Your help with this effort will be greatly appreciated.

Constructive feedback is always a valuable commodity. The ABOHNS encourages current and future diplomates who want to talk to reach out directly through the "Office Hours with the Executive Director" program (www.aboto.org). I hope this early 2020 update has been informative, and I look forward to hearing from you. ■

FOR PATIENTS:

KidsENT Month:

Ryan H. Belcher, MD; James M. Ruda, MD; Michael E. McCormick, MD; Margo McKenna Benoit, MD, of the Pediatric Otolaryngology Committee

"Epistaxis" is another word for nosebleed, which can commonly occur in children. About 64 percent of children aged 11 to 15 years have had at least one episode of epistaxis. The most common cause is a ruptured blood vessel on the nasal septum, the part that divides the nose into the right and left nostrils. Though pediatric epistaxis is common, it has been shown to induce significant amounts of stress for both parents and children.

The vast majority of pediatric nosebleeds originate from the anterior portion of the nose, with very few coming from the posterior portion. Two of the more common causes of epistaxis in children involve digital trauma (i.e., picking their nose) or chronic irritation of the lining of the nose due to colds or allergies. These are often spontaneous and rarely severe enough to require a trip to the emergency department or hospital, so a lot of emphasis is put on measures to prevent the nosebleeds. Suggestions for prevention include humidifying the air in the home by using a cool mist humidifier in your child's bedroom, using nasal saline sprays several times a day, or local application of Vaseline or other ointments (Aquaphor, polysporin, etc.) in the nostrils at bedtime.

Epistaxis

What to do if nosebleeds don't stop or keep recurring?

If your child's nosebleeds continue to recur despite these preventive measures, then a clinic appointment with an ENT may be appropriate to help determine the underlying cause. It will be important to let your physician know any family history of bleeding disorders (if known), nasal trauma, recent sinusitis, and all medications, such as nasal steroid sprays (Flonase, Nasonex, etc.), that your child is taking. While at the otolaryngologist's office, they will be able to look in your child's nose and potentially visualize a source of the bleeding. These sources include fragile blood vessels or even foreign bodies that the child may have placed in their nose. When looking in the nose, otolaryngologists often use a small camera called an endoscope to visualize past the front of the nose. During this appointment, the otolaryngologist can also perform cauterization to the anterior part of the nose if a bleeding source is identified while in the office setting. This is typically done with numbing solution, so the patient doesn't feel it.

If your child's nosebleed does not stop after 20-30 minutes despite attempts at direct pressure and over the counter oxymetazoline, then you should strongly consider taking them to the emergency department (ED). To get the bleeding to stop, dissolvable nasal packing may be placed in order to apply direct pressure to the bleeding. As in the clinic setting, cautery may also be performed in the ED to get the bleeding to stop. Very rarely do children have to be admitted to the hospital or taken to the operating room due to epistaxis, as this usually happens only with the most severe bleeding episodes. If you have questions or would like more information on this topic, please see **www.ENThealth.org** ■

Follow these steps to stop a nosebleed:

1. Stay calm, or help a young child stay calm. A person who is agitated may bleed more profusely than someone who feels reassured and supported.
2. Sit up and keep the head higher than the level of the heart.
3. Lean forward slightly so the blood doesn't drain into the back of the throat.
4. *Gently* blow any clotted blood out of the nose. Spray the nose with a nasal decongestant; oxymetazoline is the active ingredient in most over-the-counter sprays.
5. Using the thumb and index finger, pinch all the soft parts of the nose.
6. Hold the position for five minutes. If it's still bleeding, hold it again for an additional 10 minutes.

For more information about nosebleeds, such as causes, treatments, and tips to prevent them, go to **ENThealth.org.**

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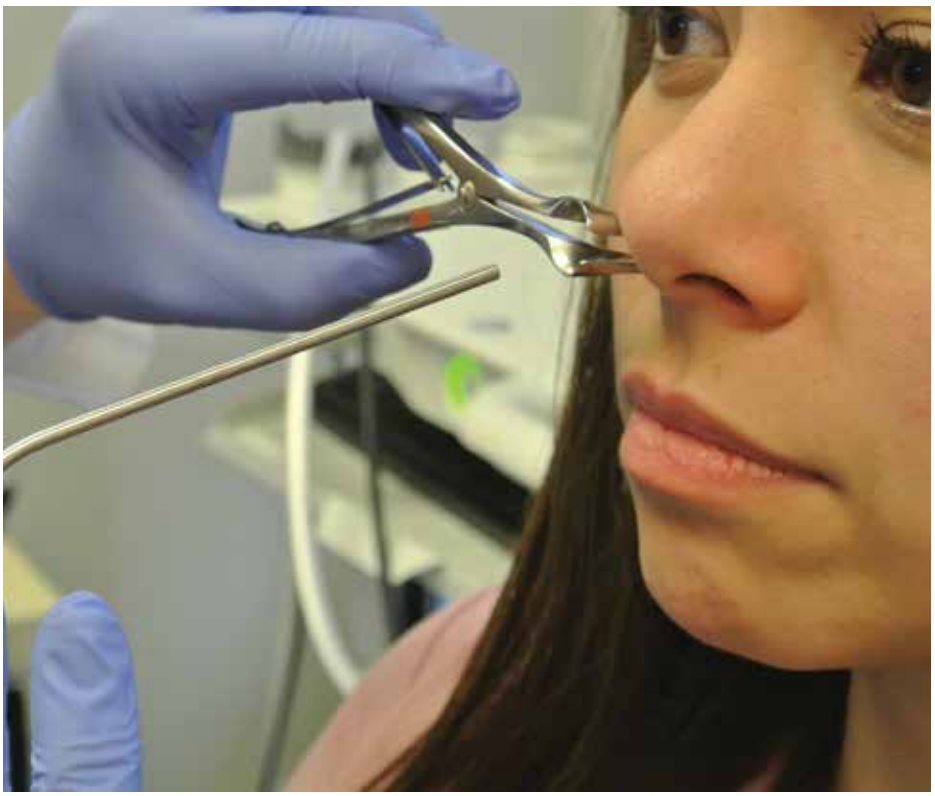
Epistaxis Clinical Treatment

Anterior rhinoscopy may augment the physician examination and guide treatment.

The following two photos are published with permission from the American Academy of Otolaryngology–Head and Neck Surgery Foundation Tunkel DE, Anne S, Payne SC, et al. Clinical Practice Guidelines: Nosebleed (Epistaxis). *Otolaryngol Head Neck Surg.* 2020;162(1_Suppl):S1-S38.



CPG

Clinical Practice Guidelines

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- Tonsillectomy in Children (Update)
- Hoarseness (Dysphonia)
- Earwax (Cerumen Impaction)
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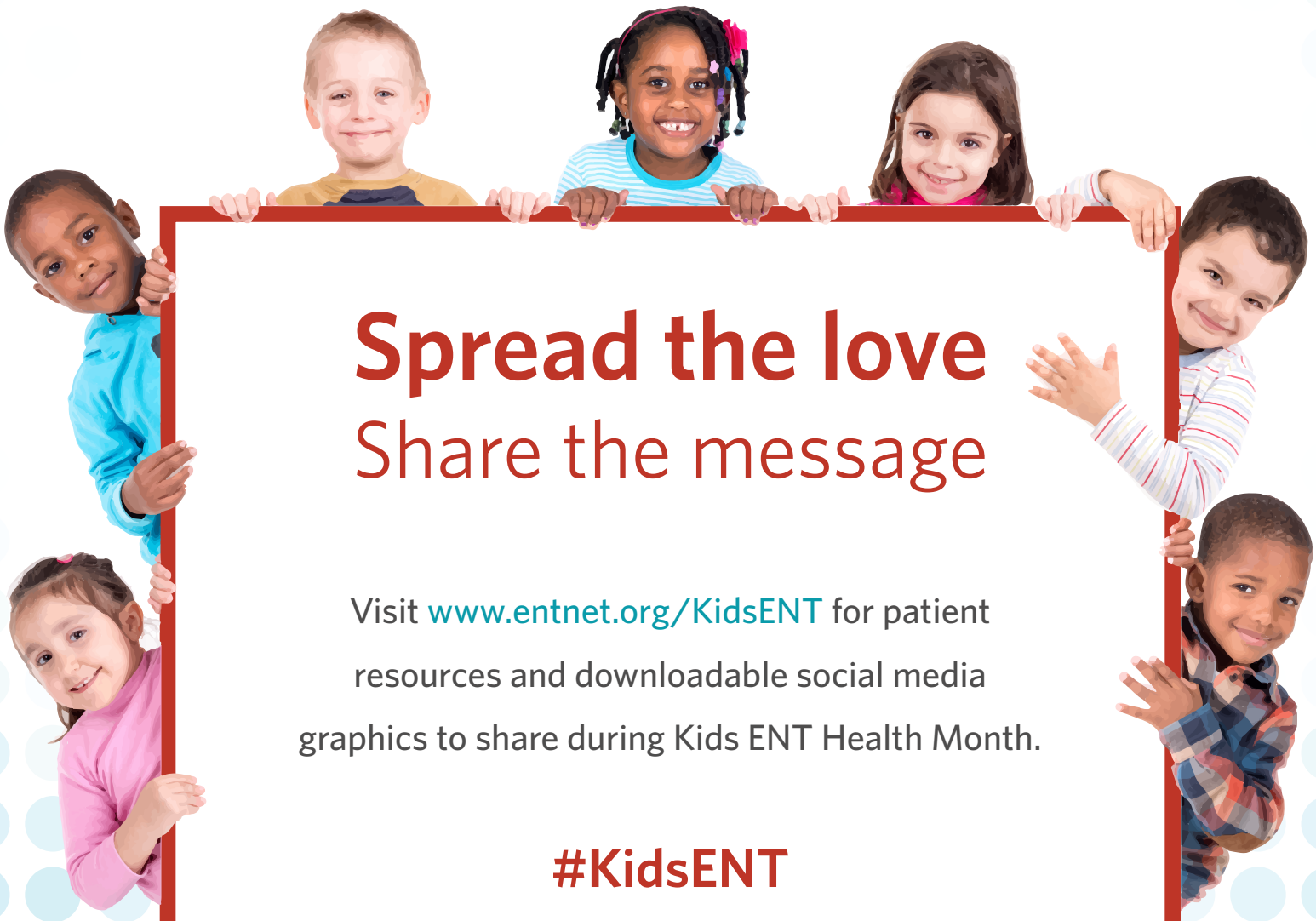
- Allergic Rhinitis
- Acute Otitis Externa
- Bell's Palsy
- Tympanostomy Tubes in Children

Go to **www.entnet.org/CPG** for more.

ENThealth

Tunkel DE, Anne S, Payne SC, et al. Clinical Practice Guidelines: Nosebleed (Epistaxis). *Otolaryngol Head Neck Surg.* 2020;162(1_Suppl):S1-S38.

February is Kids ENT Health Month



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Visit www.entnet.org/KidsENT for patient resources and downloadable social media graphics to share during Kids ENT Health Month.

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CLINICAL PRACTICE GUIDELINE

Nosebleed (Epistaxis)

Adapted from the 2020 Supplement to *Otolaryngology–Head and Neck Surgery.* Read the guideline at **otojournal.org.**

"A nosebleed is a common occurrence, happening at some point in about six out of 10 people in the United States. Although it is common, methods of diagnosis and treatment for nosebleed have not been uniformly used across clinicians and settings. To address that and to help reduce variations in care, this guideline provides evidence-based recommendations to improve quality of care," said **David E. Tunkel, MD,** Chair of the guideline development group (GDG). **Samantha Anne, MD, MS,** and **Spencer C. Payne, MD,** served as assistant chairs, and **Stacey L. Ishman, MD, MPH,** and **Richard M. Rosenfeld, MD, MPH, MBA,** served as methodologists.

The overarching aim of this multidisciplinary guideline is to identify quality improvement opportunities in the management of nosebleed and to create clear, actionable recommendations for clinical practice.

This guideline is intended to promote best practices, reduce unjustified variations in care of patients with nosebleed, improve health outcomes, and minimize the potential harms of nosebleed and/or interventions to treat nosebleed.

"This is the first multidisciplinary, evidence-based guideline on nosebleed developed in the United States," said Dr. Tunkel. "It informs clinicians about the current level of evidence and includes areas of improvement of practice—such as providing patient instructions for nasal packing care—that were developed by the guideline panel after a review of all the literature."

This guideline discusses first-line treatments, such as nasal compression, application of vasoconstrictors, nasal packing, and nasal cautery. It also addresses more complex epistaxis management, which includes the use of endoscopic arterial ligation and interventional radiology procedures. Because the GDG recognized an opportunity for improved care, management options for two special groups of patients—patients with hereditary hemorrhagic telangiectasia (HHT) and patients taking medications that inhibit coagulation and/or platelet functions—are included.

This guideline does not apply to patients who have a previously diagnosed bleeding disorder, tumors of the nose or nasopharynx, vascular malformations of the head and neck, a history of recent facial trauma, or have undergone nasal and/or sinus surgery in the past 30 days.

Guideline Key Action Statements (KAS)

KAS1: Prompt management (recommendation)

At the time of initial contact, the clinician should distinguish the nosebleed patient who requires prompt management from the patient who does not.

KAS2: Nasal compression (recommendation)

The clinician should treat active bleeding for patients in need of prompt management with firm, sustained compression to the lower third of the nose, with or without the assistance of the patient or caregiver, for five minutes or longer.

KAS3a: Nasal packing (recommendation)

For patients in whom bleeding precludes identification of a bleeding site despite nasal compression, the clinician should treat ongoing active bleeding with nasal packing.

KAS3b: Nasal packing in patients with suspected increased bleeding risk (recommendation)

The clinician should use resorbable packing for patients with a suspected bleeding disorder or for patients who are using anticoagulation or antiplatelet medications.

KAS4: Nasal packing education (recommendation)

The clinician should educate the patient who undergoes nasal packing about the type of packing placed, timing of and plan for removal of packing (if not resorbable), post-procedure care, and any signs or symptoms that would warrant prompt reassessment.

KAS5: Risk factors (recommendation)

The clinician should document factors that increase the frequency or severity of bleeding for any patient with a nosebleed, including personal or family history of bleeding disorders, use of anticoagulant or antiplatelet medications, or intranasal drug use.

KAS6: Anterior rhinoscopy to identify location of bleeding (recommendation)

The clinician should perform anterior rhinoscopy to identify a source of bleeding after removal of any blood clot (if present) for patients with nosebleeds.

KAS7a: Examination using nasal endoscopy (recommendation)

The clinician should perform, or should refer to a clinician who can perform, nasal endoscopy to identify the site of bleeding and guide further management in patients with recurrent nasal bleeding, despite prior treatment with packing or cautery, or with recurrent unilateral nasal bleeding.

KAS7b: Examination of nasal cavity and nasopharynx using nasal endoscopy (option)

The clinician may perform, or may refer to a clinician who can perform, nasal endoscopy to examine the nasal cavity and nasopharynx in patients with epistaxis that is difficult to control or when there is concern for unrecognized pathology contributing to epistaxis.

KAS8: Appropriate interventions for identified bleeding site (recommendation)

The clinician should treat patients with an identified site of bleeding with an appropriate intervention, which may include one or more of the following: topical vasoconstrictors, nasal cautery, and moisturizing or lubricating agents.

KAS9: Nasal cautery (recommendation)

When nasal cautery is chosen for treatment, the clinician should anesthetize the bleeding site and restrict application of cautery only to the active or suspected site(s) of bleeding.

KAS10: Ligation and/or embolization for persistent nosebleeds (recommendation)

The clinician should evaluate, or refer to a clinician who can evaluate, candidacy for surgical arterial ligation or endovascular embolization for patients with persistent or recurrent bleeding not controlled by packing or nasal cauterization.

KAS11: Management of patients using anticoagulation and antiplatelet medications (recommendation)

In the absence of life-threatening bleeding, the clinician should initiate first-line treatments prior to transfusion, reversal of anticoagulation, or withdrawal of anticoagulation/antiplatelet medications for patients using these medications.

KAS12: HHT identification (recommendation)

The clinician should assess, or refer to a specialist who can assess, the presence of nasal telangiectasias and/or oral mucosal telangiectasias in patients who have a history of recurrent bilateral nosebleeds or a family history of recurrent nosebleeds to diagnose hereditary hemorrhagic telangiectasia syndrome (HHT).

KAS13: Patient education and prevention (recommendation)

The clinician should educate patients with nosebleeds and their caregivers about preventive measures for nosebleeds, home treatment for nosebleeds, and indications to seek additional medical care.

KAS14: Nosebleed outcomes (recommendation)

The clinician or designee should document the outcome of intervention within 30 days or document transition of care in patients who had a nosebleed treated with non-resorbable packing, surgery, or arterial ligation/ embolization.

The GDG included representatives from the fields of nursing, family medicine, emergency medicine, otolaryngology-head and neck surgery, pediatrics, rhinology, radiology, internal medicine, and hematology. The GDG also included a consumer/patient representative.

This guideline is intended for clinicians who evaluate and treat patients with nosebleed. This includes primary care providers such as family medicine physicians, internists, physician assistants, nurse practitioners, and pediatricians. It also includes specialists such as emergency medicine providers, otolaryngologists, interventional radiologists/neuroradiologists and neurointerventionalists, hematologists, and cardiologists. The target patient for the guideline is any individual aged three years and older with a nosebleed or history of nosebleed.

The nosebleed guideline was created using the methods listed in the AAO-HNSF "Clinical Practice Guideline Development Manual, Third Edition." (https://journals.sagepub.com/doi/full/10.1177/0194599812467004)

The full guideline and other resources are available at www.entnet.org/CPGNosebleed and in *Otolaryngology–Head and Neck Surgery* as published at otojournal.org.

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Endorsements:
The guideline is endorsed by the American College of Emergency Physicians (ACEP), American College of Radiology (ACR), American Rhinologic Society (ARS), American Society of Hematology (ASH), American Society of Pediatric Otolaryngology (ASPO), Cure Hereditary Hemorrhagic Telangiectasia (Cure HHT), Society of Interventional Radiology (SIR), Society of Neurointerventional Surgery (SNIS), Society of Otorhinolaryngology and Head-Neck Nurses (SOHN), and The Triological Society.

Affirmation of Value:
"The American Geriatrics Society (AGS) affirms the value of this document. Affirmation of value means that AGS supports the general principles in this document and believes it is of general benefit to its membership."

Disclaimer:
This guideline is intended to focus on evidence-based quality improvement opportunities judged most important by the working group. It is not intended to be a comprehensive, general guide for managing patients with nosebleed. In this context, the purpose is to define useful actions for clinicians, generalists, and specialists from a variety of disciplines to improve quality of care. Conversely, the statements in this guideline are not intended to limit or restrict care provided by clinicians based upon their experience and assessment of individual patients.

CPG
Clinical Practice Guidelines

Accompanying Resources:

- Plain Language Summary
- Executive Summary
- Slide deck
- Podcasts
- Patient handouts (in both English and Spanish)
- Official quick-reference pocket guide and app

Access all these resources and more at www.entnet.org/CPGNosebleed

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

NOSEBLEED FAQS

HOW CAN I PREVENT A NOSEBLEED?	Nosebleeds can be prevented by avoiding nose-picking or blowing the nose too hard. Keeping your nose clean and moist with nasal saline (salt water) and gels can also help. Additionally, using a humidifier to keep the air moist will help keep your nose moist, which can prevent a nosebleed.
I HAVE AN ACTIVE NOSEBLEED. WHAT CAN I DO?	A nosebleed can be stressful. Keeping calm and knowing how to stop a nosebleed ahead of time can help. Once a nosebleed starts, lean forward and pinch the soft part of the nose for at least 5 minutes. If the nosebleed slows, keep holding for a full 15 minutes.
CAN I USE ANY OVER THE COUNTER MEDICATIONS TO HELP IF MY NOSE IS BLEEDING?	Nasal saline (salt water) gel or spray can help moisturize the inside of the nose. Oxymetazoline (pronounced ok-see-muh-taz-uh-leen) or phenylephrine (pronounced fen-l-ef-reen) are nasal sprays which can help slow nosebleeds. Blow the nose to clear any clots and then spray two sprays in the bleeding nostril and keep holding the soft part of the nose for 5 minutes. You may repeat this once.
MY NOSEBLEED WON'T STOP! WHAT SHOULD I DO?	If your nosebleed does not stop even after you tried the above methods, you should call a medical professional. If the bleeding is heavy, long-lasting, or you feel weak or lightheaded then seek immediate care at an emergency room department or call 911.
I SAW MY ENT AND MY NOSE WAS CAUTERIZED. DO I HAVE ANY RESTRICTIONS?	You have to treat your nose with care to allow the area to heal. Avoid nose blowing, tiring activity, heavy lifting, or placing any cotton or tissues in the nose for at least a week. You may use saline (salt water) gel or spray to help wet the nose one to three times a day.
I AM ON A BLOOD THINNER MEDICATION AND MY NOSE OFTEN BLEEDS. SHOULD I STOP TAKING THIS MEDICATION?	You should quickly check with the health care provider who prescribed the blood thinning medication, since these medications are usually given to treat or prevent serious medical problems. If your nosebleed is heavy, do not take additional doses of blood thinner until you are checked up by a health care provider and you should not delay the checkup.

SOURCE: Tunkel DE, Anne S, Payne SC, et al. Clinical Practice Guideline: Nosebleed (Epistaxis). *Otolaryngol Head Neck Surg*. 2020;162(1_Suppl):S1-S38.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION®

www.entnet.org

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The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) represents approximately 12,000 specialists worldwide who treat the ear, nose, throat, and related structures of the head and neck. The AAO-HNS Foundation works to advance the art, science, and ethical practice of otolaryngology–head and neck surgery through education, research, and lifelong learning.

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

NASAL PACKING: FAQS FOR NOSEBLEED PATIENTS

HOW LONG WILL THE PACKING STAY IN?	Your packing will stay in place for a time agreed upon with your health care provider. Typically, it should be in place for no longer than 5 days. Other things that may determine how long the packing will stay in include how heavy the nosebleed is, where the nosebleed is, certain underlying medical conditions, and your comfort. If your packing is resorbable, it may not need removal and it will go away with time and the use of nasal saline (salt water) sprays.
WILL I BE UNCOMFORTABLE WITH PACKING?	Nasal packing takes up space in your nose and lessens the airflow into your nose, making it harder to breathe through your nose. It can also block your sinuses from draining and block the flow of your tears into the nose. You may feel like you have a cold while the packing is in place. You may have a stuffy nose, decreased ability to smell, pressure around your face, headaches, runny nose, and tearing from the eyes.
CAN I STILL HAVE A NOSEBLEED WITH THE PACKING IN?	Yes, if pressure from the packing is not able to reach the area of bleeding in the nose, bleeding can happen. If this happens, pinch the soft part of the nose. If bleeding continues or becomes heavier, call your health care provider, or go to the emergency department.
SHOULDN'T WE LEAVE THE PACKING IN LONGER?	If you are given non-resorbable packing (packing that does not dissolve), leaving the packing in past the time recommended by your health care provider can cause possible complications. It is important to stick to the exact follow-up directions from your health care provider.
WHAT COMPLICATIONS CAN RESULT FROM PACKING?	Packing is a foreign object that can allow the growth of bacteria in the nose. There is a low risk of infection spreading to the nose and sinuses or, in extremely rare cases, throughout the body. The packing also provides pressure inside the nose. This may lower blood flow to areas of the nose and result in injury. Septal perforations (hole in the partition dividing the right and left nasal cavity) and scarring in the nasal cavity can form after the packing is removed. If the packing is held with clips at the nasal opening, pressure sores of the outside skin can form over time and result in scarring. Packing blocks airflow into the nose, making it harder to breathe through your nose, and can interrupt sleep at night, which can contribute to or worsen obstructive sleep apnea.

SOURCE: Tunkel DE, Anne S, Payne SC, et al. Clinical Practice Guideline: Nosebleed (Epistaxis). *Otolaryngol Head Neck Surg*. 2020;162(1_Suppl):S1-S38.

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CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

NASAL PACKING: FAQS FOR NOSEBLEED PATIENTS

HOW CAN I REDUCE THE CHANCE OF COMPLICATIONS ASSOCIATED WITH PACKING?	In some cases, your health care provider will prescribe oral antibiotics if the risk for infection is high. Antibiotics, while generally safe, do have some risks, including allergic reactions and gastrointestinal (stomach) problems. You should discuss the risks and benefits of antibiotics with your health care provider. Keeping the nose and packing moist with nasal saline (salt water) sprays throughout the day can reduce dry crusting and help resorbable packing melt away. There should be fewer chances of complications if you follow the exact follow-up instructions from your health care provider.
WHAT TYPES OF RESTRICTIONS SHOULD I FOLLOW?	To avoid increased blood flow to the nose and risk of further bleeding, you should avoid straining, lifting over 10 pounds, bending over, and exercising. Sleeping with the head slightly higher may also help. Walking and other light activity is allowed. Unless otherwise told by your health care provider, avoid over-the-counter pain medicine that may increase bleeding, including aspirin and ibuprofen. Acetaminophen (Tylenol) does not increase bleeding and can be used. In general, you should not try to blow your nose if you have packing in place. If you feel the need to sneeze, sneeze with your mouth open.
WHAT TYPES OF SYMPTOMS SHOULD I BE CONCERNED WITH?	You should call your health care provider with any of the following: return of blood from the nose or mouth, fever over 101 degrees Fahrenheit, increasing pain, vision changes, shortness of breath or difficulty breathing, loss of color around the skin of the nose, swelling of the face, or a diffuse (spreading) skin rash.
WHO WILL REMOVE THE PACKING AND WHERE WILL THIS HAPPEN?	You should talk about this with your health care provider at the time the packing is placed.
WHAT HAPPENS AFTER THE PACKING IS REMOVED?	You may at first have some small amount of bleeding from the raw areas inside your nose. Keeping the nose moist with saline (salt water) spray and moisturizing agents (like petroleum jelly and antibiotic ointments) will prevent dry crusts and help with healing. In some cases, nosebleeds may happen again and additional treatment may be needed. If this happens, pinch the soft part of the nose and consider the use of nasal sprays like oxymetazoline (pronounced ok-see-muh-taz-uh-leen) or phenylephrine (pronounced fen-l-ef-reen), which can help slow nosebleeds. If bleeding continues, call your health care provider or go to the emergency department.

SOURCE: Tunkel DE, Anne S, Payne SC, et al. Clinical Practice Guideline: Nosebleed (Epistaxis). *Otolaryngol Head Neck Surg*. 2020;162(1_Suppl):S1-S38.

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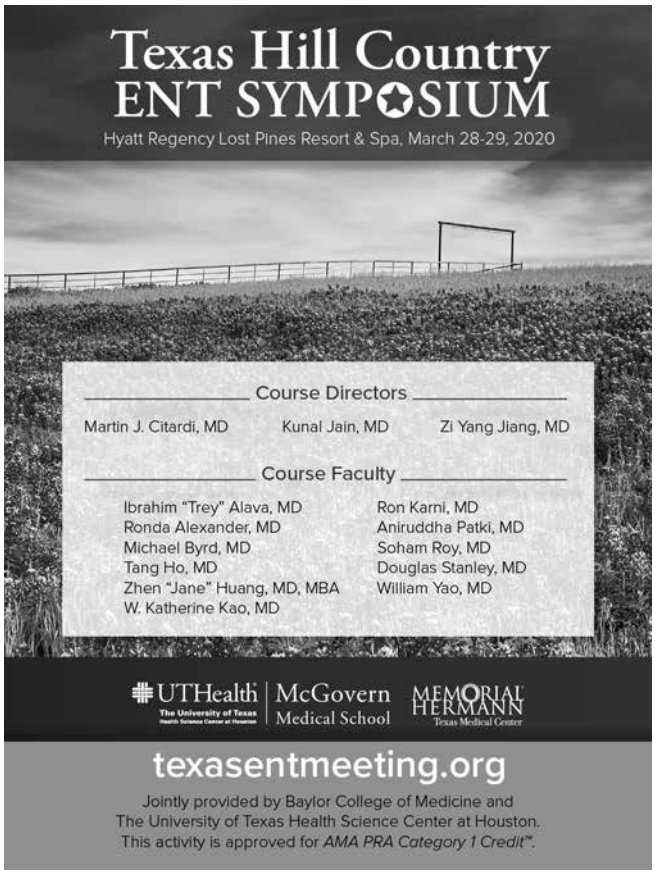

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Our continued growth, coupled with upcoming physician retirements, means opportunity for you!

For more information, contact our President, **Robert Green, MD** (Rgreen@entandallergy.com) or our Chief Executive Officer, **Robert Glazer** (Rglazer@entandallergy.com or call 914-490-8880).

Otolaryngology

Call This "Top 10" Community Home

McFarland Clinic is seeking a BE/BC Otolaryngologist to join our extraordinary team and provide exceptional care within Iowa's largest multidisciplinary clinic. Consistently ranked in the top 10 "Best Places to Live" by Money Magazine and CNNMoney.com, this thriving town has been ranked in the top 3 cities in the country for job growth.

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- 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
- "#1 Best State to Practice Medicine" -*WalletHub*

Ames, Iowa is a family friendly town that offers top-quality education with the best school district in the state. This Big 12 city has been voted the "Best College Town" by Livability.com. Our proud community boasts the cultural, recreational and entertainment amenities of a big city while maintaining the charm that you would expect from small-town living. Welcome to Ames, a place that will quickly become your hometown.

EEO/AA Employer/Protected Vet/Disabled

Contact Doug Kenner

866.670.0334 or dkenner@mountainmed.net

McFarland Clinic

Extraordinary Care, Every Day

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South Florida ENT Associates, a fifty plus physician group practice operating in Miami-Dade, Broward and Palm Beach Counties, has immediate openings for full-time ENT Physicians. Established since 2001, South Florida ENT Associates has been a market leader in ENT services in a dynamic, multicultural community. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics, CT services and more.

We offer an excellent salary and bonus structure, 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

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Contact Information:

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

Pediatric Otolaryngologist

Hershey, Pennsylvania

PennState Health

Join a growing team of clinical providers with the resources of one of the leading academic medical centers in the nation.

The Department of Otolaryngology – Head & Neck Surgery at Penn State Health Milton S. Hershey Medical Center, Penn State Children's Hospital and Penn State College of Medicine is seeking an additional full-time Pediatric Otolaryngologist.

Appointment will be at the Assistant/Associate/Professor level. Qualified candidates must have completed an approved Otolaryngology – Head & Neck Surgery residency program, be board certified or board eligible, and be fellowship trained to provide clinical and hospital-based Pediatric Otolaryngological care for our patients. You will have the opportunity to build an airway practice.

The Children's Hospital building was opened in 2013 and is already undergoing expansion due to exponential growth. It sits on the campus of the Hershey Medical Center, a 548-bed Level I regional trauma center. As central Pennsylvania's only academic medical center and home to the College of Medicine, we are sought out as a resource for the most complex adult and pediatric cases. We were recognized as one of *U.S. News & World Report's* Best Hospitals for Ear, Nose and Throat Care in 2016. The Children's Hospital has been recognized for eight consecutive years among the best children's hospitals in multiple specialties. Additionally, it is one of only eight hospitals in the nation to be named a Level 1 Children's Surgery Center by the American College of Surgeons Children's Surgery Verification Program.

The successful applicant will join a growing team of collaborative, clinical providers with the resources of one of the leading academic medical centers in the nation. We offer a competitive salary and benefits.

FOR MORE INFORMATION, PLEASE CONTACT:

David Goldenberg, MD, FACS, Chair, Department of Otolaryngology – Head and Neck Surgery c/o Ashley Nippert, Physician Recruiter
anippert@pennstatehealth.psu.edu or to apply online **http://tinyurl.com/hkmrwlc**

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce.
Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled

Facial Plastic and Reconstructive – Microvascular Surgeon
Department of Otolaryngology – Head and Neck Surgery

The Department of Otolaryngology – Head and Neck Surgery at Penn State Health Milton S. Hershey Medical Center is seeking a full-time board eligible/certified Facial Plastic and Reconstructive Surgeon. Appointment will be at the Assistant/Associate Professor level. Qualified candidates must have completed an approved residency program and be fellowship trained. Experience in a wide spectrum of aesthetic and reconstructive facial plastic surgery including training in microvascular reconstruction is desired. A strong commitment to patient care, resident education and research is required.

Penn State Health is multi-hospital health system serving patients and communities across central Pennsylvania. The system includes Penn State St. Joseph Medical Center in Reading, Penn State Health Milton S. Hershey Medical Center, Penn State Children's Hospital, Penn State Cancer Institute, and Penn State Health Rehabilitation Hospital (jointly owned with Select Medical) based in Hershey, as well as more than 1,300 physicians and direct care providers at 78 medical office locations.

Hershey is a suburban community in a metropolitan area and is one of the fastest growing regions in the state with excellent schools and a safe friendly environment. Hershey is approximately 12 miles from Harrisburg, the state capital, and within a short train ride or drive to New York City, Philadelphia, Washington, DC, and Baltimore.

PennState Health

FOR MORE INFORMATION, PLEASE CONTACT:
David Goldenberg, MD, FACS, Chair, Department of Otolaryngology – Head and Neck Surgery c/o Ashley Nippert, Physician Recruiter
anippert@pennstatehealth.psu.edu.

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled

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Located in the Green Mountains of Vermont near Killington Ski Resort, Rutland is a safe, family-oriented community with a four-season climate. Our location offers world-class skiing, good schools, reasonable cost of living and proximity to Boston, Montreal and New York.

If you're interested in becoming part of our community, please contact:
Rebecca Banco, CMSR, DASPR, Physician Recruiter
802.747.3844 or **bbanco@rrmc.org**

Rutland Regional Medical Center
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- **Head & Neck Surgery**
- **Pediatric Otolaryngology**
- **General Otolaryngology & Sleep**

Fellowship training or experience in health services research is preferred.

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Interested candidates, please reach out to **Ken Altman, MD, PhD, Chair, Department of Otolaryngology – Head & Neck Surgery, and Professor – Geisinger Commonwealth School of Medicine, 100 N. Academy Avenue, Danville, PA 17822** at **kaltman@geisinger.edu** or apply at **geisinger.org/careers.**

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HEALTH
UNIVERSITY OF UTAH

The University of Utah Otolaryngology is seeking BC/BE Pediatric Otolaryngologists at the Assistant or Associate Professor level. Fellowship training is required.

These new faculty will staff the Primary Children's Hospital in Lehi, Utah, and will also have privileges at the main campus in Salt Lake City. This is a full-time academic position at the University of Utah. We have an existing pediatric group of 8 providers.

The successful candidates must demonstrate excellence in resident education, clinical research and patient care. Primary Children's Hospital is the only freestanding pediatric center for the state of Utah, and it has a large referral base comprising the surrounding states. For more information contact:

Albert Park, MD, Professor
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
(801) 585-3186
susan.harrison@hsc.utah.edu

Applicants should send an updated CV and a list of three references to the above address.

Interested applicants must apply online at:
http://utah.peopleadmin.com/postings/100106

The University of Utah Health (U of U Health) is a patient focused center distinguished by collaboration, excellence, leadership, and respect. The U of U Health values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to our mission.

Equal Employment Opportunity
University of Utah is an Affirmative Action/Equal Opportunity employer and does not discriminate based upon race, national origin, color, religion, sex, age, sexual orientation, gender identity/expression, status as a person with a disability, genetic information, or Protected Veteran status. Individuals from historically underrepresented groups, such as minorities, women, qualified persons with disabilities and protected veterans are encouraged to apply. Veterans' preference is extended to qualified applicants, upon request and consistent with University policy and Utah state law. Upon request, reasonable accommodations in the application process will be provided to individuals with disabilities. To inquire about the University's nondiscrimination or affirmative action policies or to request disability accommodation, please contact: Director, Office of Equal Opportunity and Affirmative Action, 201 Presidents Circle, 135, (801)581-8365.

The University of Utah values candidates who have experience working in settings with students from diverse backgrounds, and possess a strong commitment to improving access to higher education for historically underrepresented students.

utmb Health
Otolaryngology

Facial Plastic/ Reconstructive Surgeon

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

Laryngologist

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

Surgeon/Scientist

with interest in comparative effectiveness outcomes research

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

Rhinologist

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

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

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for four full-time positions.

These positions entail opportunities to participate in all aspects of clinical practice, as well as resident and medical student education. Candidates interested in pursuing comparative effectiveness clinical outcomes research are of particular interest.

In response to the rapid growth in our communities, the department has grown to now include 12 practitioners delivering care through all subspecialty areas of otolaryngology, a division of audiology, and a division of speech language pathology.

As a system, UTMB Health has similarly grown as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country.

Please direct your Letter of Interest and CV to:

Vicente Resto, MD, PhD, FACS
Associate Chief Physician Executive
Vice President for Physician Integration and Strategic Alignment
Chair, Department of Otolaryngology UTMB Health
301 University Boulevard, Galveston, TX 77555-0521

Email: varesto@utmb.edu
Phone: 409-772-2701

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