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The official member magazine of the **American Academy of Otolaryngology-Head and Neck Surgery**

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Recognizing Your Dedication and Skills During This Critical Time

Duane J. Taylor, MD, AAO-HNS/F President, and James C. Denny III, MD, AAO-HNS/F Executive Vice President and Chief Executive Officer

Note: This piece reflects the current COVID-19 situation as of March 23, 2020. The fast-changing pace of information related to this pandemic may not all be reflected in this column due to the Bulletin's publication schedule.

We recognize the significant impact the COVID-19 pandemic has already had and will continue to have on your day-to-day lives, particularly relating to your ability to practice otolaryngology. First of all, we thank you for the dedication and skills that you each bring to the critical services you and your staff provide to a very anxious and fearful population.

The Academy continually monitors the progress of the COVID-19 pandemic and rapidly accumulating scientific information related to the virus. There continues to be an evolving understanding of the particular risks for otolaryngologists that must be included in the decision-making process for delivering patient care. In particular, a high rate of transmission of COVID-19 to otolaryngologists has been reported from China, Italy, and Iran, providing even further evidence that otolaryngologists are among the highest risk group when performing upper airway surgeries and examinations.

The difficulty in identifying those with the disease without readily available, formal testing and adequate supplies of personal protective equipment has added significant stress to already strained healthcare resources, particularly for otolaryngologists. The restrictions on elective surgical procedures and decreased patient volume due to limiting care only to time-sensitive, urgent, and emergent medical conditions, will be challenging financially for the next several months, especially with likely staff and personal fatigue.

There will be significant heterogeneity in potential exposure based on practice type and location as well as differing levels of support for you and your patients. Shortages of personal protective equipment and other supplies for both hospital and office-based care will necessitate careful stewardship to successfully get through this.

There may well be varying recommendations and government mandated restrictions for different parts of the United States based on relative risk and actual documented disease penetration. It will be important for each physician to be familiar with the relative risk in their area as well as the resources available to them.

The Academy continues to monitor the

evolving situation and keep you informed in a timely fashion. You may have noted the increase in emails and ENTConnect posts on this topic. We are also utilizing social media and *OTO News*. While we try not to oversaturate your inboxes in normal situations, we are employing all efforts to get you this critical information across platforms for your easy access, such as our statements on Otolaryngologists and the *COVID-19 Pandemic, New Recommendations Regarding Urgent and Nonurgent Patient Care*, and *Academy Supports CMS, Offers Specific Nasal Policy* found on the Academy's Coronavirus Disease 2019: Resources webpage (<https://www.entnet.org/content/coronavirus-disease-2019-resources>).

We realize that other recurring practice needs and concerns related to financial relief from COVID-19 impact private payer payment policies, particularly preauthorization and denials will continue to demand attention and we will continue to aggressively advocate for you, your practice, and your patients in these matters. We will also continue to follow federal and state regulatory activities that threaten the underpinnings of your practices that are advancing in the face of pandemic response. As always, you, your staff, and your patients are our foremost priority. Please be safe! ■



CORONAVIRUS DISEASE 2019 Resources for Members

The Academy is continuously monitoring the public health situation related to coronavirus disease 2019 (COVID-19) to provide information and resources for you, your practice, and your patients. Browse the "Guidance for Your Practice" section at <https://www.entnet.org/content/coronavirus-disease-2019-resources> for select information, including telehealth, elective surgeries and procedures, financial relief assistance, patient triage, practice preparedness, personal protective equipment, and more.

DIVERSITY AND INCLUSION

Celebrating 10 Years Since Inception

Harry Barnes, MD Endowment Leadership Grant and the Diversity Endowment

For the Diversity and Inclusion Committee:
Cristina Cabrera-Muffly, MD, Chair

2020 marks the 10th anniversary of the Diversity and Inclusion Committee, the Harry Barnes, MD Endowment Leadership Grant, and the Diversity Endowment. The Harry Barnes, MD Endowment Leadership Grant provides travel grants for otolaryngology residents of African descent from the United States, the Caribbean, or Canada to attend the Annual Meeting or the Spring Leadership Forum.

Since its inception, 20 residents have received these grants that have helped foster networking, education, and leadership development for underrepresented members of our Academy. In addition, the Diversity and Inclusion Endowment provides grants for fourth-year underrepresented medical students applying to otolaryngology. Two grants are awarded each year to defray costs associated with doing an away rotation. Twenty students have received the away rotation grants, with the intent to further strengthen their match potential to our field.

The endowments that allow for funding of these grants were spearheaded by our current Academy President, **Duane J. Taylor, MD**. Through these endowments, Dr. Taylor and several other generous donors made a commitment to increase the number and support the development of underrepresented populations in otolaryngology. Our field, similar to other surgical subspecialties, has lagged behind in including racially and ethnically diverse individuals among its ranks. This is important to our patients who appreciate being able to see providers who look like them and understand their

cultural backgrounds. The 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial/Ethnic Disparities in Healthcare* states, “Racial and ethnic disparities in healthcare exist and, because they are associated with differences in health outcomes, are unacceptable.”¹

The Sullivan Commission report in 2004, *Missing Persons: Minorities in the Health Professions*, identified that “today’s physicians, nurses, and dentists have too little resemblance to the diverse populations they serve.”² In the 16 years since the Sullivan report, our population has continued to diversify, while our medical professionals have not. In “Impact of a Mentored Student Clerkship on Underrepresented Minority Diversity in Otolaryngology–Head and Neck Surgery,” Nellis et. al. reported that within otolaryngology, “African American representation is declining by 2.3% per year, Native American representation remains low with growth of only 1.5% per year, and Hispanic representation is growing at 17.3% per year, half the rate of growth in the general population.”³ Diversity and inclusion are clearly important to our trainees and fellow providers who, like our patients, want mentors who look like them and understand their backgrounds.

While we have made progress in the past 10 years, much work remains in otolaryngology to address diversity and inclusion not only with respect to race and ethnicity, but also gender, sexual orientation, and gender identity, all of which are critical to the continued success of our



William Harry Barnes, MD (1887-1945)

specialty. My hope is that continued endowment funding and volunteer efforts will further our development of a more diverse and inclusive otolaryngology community for our patients, our trainees, and ourselves. ■

References

1. Institute of Medicine. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press; 2003.
2. Sullivan Commission on Diversity in the Healthcare Workforce. *Missing persons: minorities in the health professions*. Washington, DC: Sullivan Commission; 2004.
3. Nellis JC, Eisele DW, Francis HW, Hillel AT, Lin SY. Impact of a mentored student clerkship on underrepresented minority diversity in otolaryngology-head and neck surgery. *Laryngoscope*. 2016;126(12):2684-2688.

The Value of a Mentor

Tell me and I forget, Teach me
and I may remember, Involve me
and I learn.

— Benjamin Franklin

Over the last several months, I have had the opportunity to speak to many individuals, including students, residents, and colleagues, about my journey in our specialty—all leading up to my current role as President of our Academy. The recollections have forced me to reflect on the value and importance of many individuals who served as mentors in my life and those who cared enough to reach out and offer me advice at just the right time. I saw the opportunities to mentor others at an early age and felt compelled to do so from the example set by my parents, who always unselfishly shared their guidance and advice with youth outside of our family. Although there were times as a medical student and resident (with limited life and professional experiences) when advice to those behind me might have been viewed as the blind leading the blind, the intentions were good and, overall, taken well and appreciated.

How do I choose a specialty? Where should I apply for residency? Should I do a fellowship, and if so, in what? What type of practice type do I want? How do I maintain the right work-life balance? Why is involvement in our Academy important?

All of these were questions that I found

the answers to with the assistance of someone who helped me put things in perspective. Never underestimate the impact you can have on someone else who needs another perspective from someone with your professional and life experience. Sometimes sharing bumps in the road and challenges along the way that you have faced will encourage those who aspire to follow your path with a newfound knowledge and have a ripple effect that grows exponentially. I have found these types of interactions leave both myself and the individual with whom I have talked a sense of enlightenment, growth, and knowledge at the end of the day. This dynamic interaction/relationship that quenches the thirst for knowledge and information on one side and sustains the appreciation and willingness to give back and nurture someone else's growth on the other side keeps us all connected in a positive way.

Whether you serve as a faculty attending, chief resident, or leader in our Academy, work with medical students, or have the chance to speak to undergraduate students pondering a future in medicine, take the time to share those lessons learned and experiences from your journey. We all have someone in our lives who helped us along the way. In spite of some of the daily frustrations that we may face with our current healthcare environment, recall those things about your practice and our specialty that still put a smile on your face or give you a sense of enjoyment and fulfillment, and share them with those who look to you as mentors. ■



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

“
Never underestimate the
impact you can have on
someone else who needs
another perspective
from someone with your
professional and life
experience.”

Whether it's in your business, your school, your community, or your family, if you want to make a difference in the lives of the people you lead, you must be willing to walk alongside them, to lift and encourage them, to share moments of understanding with them, and to spend time with them, not just shout down at them from on high. Mentors build mentors. Leaders build leaders. When you look at it closely, it's really one and the same thing.

— Tony Dungy,

The Mentor Leader: Secrets to Building People
& Teams That Win Consistently



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We Must Do Better: Zeroing Out Preventable Errors

Since the release of the 1999 Institute of Medicine (IOM) report on medical errors, *To Err Is Human: Building a Safer Health System*, over 20 years ago, there have been considerable effort and resources applied attempting to identify preventable causes of these errors and limit their occurrence through system improvement and education. Most individuals who work within the United States healthcare system have seen or experienced at least one medical error during their careers but seem surprised at the nationwide statistics reflecting the prevalence of the problem.

When *To Err Is Human* was released, it was estimated that 2-4 percent of deaths, or roughly 98,000 deaths per year, were related to medical errors. Most recent figures range from 250,000 deaths yearly up to 440,000 deaths yearly in the U.S. Using the lower figure, that is the equivalent of three jet airliners full of passengers crashing every day. This places medical errors as the third leading cause of death in America. Whether that indicates that our system is getting less safe or that we are better at identifying these causes is irrelevant. We must do better!

When this information first became available and early research suggested systemic improvements could offer protections against such events, particularly in the operating room, there was considerable resistance to initial suggestions and process alterations by those who denied the problem or thought it could never happen to them. Even when effective policies were put in place, many times they were not followed. While attending a recent Triological Society meeting, I had the great fortune to hear CAPT Ryan Carron (U.S. Navy) deliver an emotional and outstanding lecture titled, "Patient Safety: How to Avoid Medical Errors." He is a career naval officer specializing in safety for a variety of naval operations as well as quality control and problem investigation. He related a personal event where both systemic and personal failure in a medical situation resulted in an unspeakable tragedy for him and his wife.

He subsequently reviewed the event through the eyes of a quality-control and safety expert in another field and identified areas for improvement in collaboration with the hospital system and has helped implement these locally.

Medical errors will typically fall within these **general categories**: adverse drug reactions, medication errors, laboratory errors, surgical errors, patient-controlled analgesia, falls, and healthcare-associated infections. In general, medication errors are the most commonly occurring medical error resulting

in death. The Agency for Healthcare Research and Quality (AHRQ) attributes most medical errors to eight **common root causes**, including communication problems, inadequate information flow, human problems, patient-related issues, organizational transfer of knowledge, staffing patterns and workflow, technical failures, and inadequate policies. The agency considers communication problems by far the most important of the group. Review of both the general categories of medical errors and the root causes of errors within these categories would suggest significant potential for meaningful improvement in all these areas.

The AAO-HNS has had an active Patient Safety Quality Improvement (PSQI) Committee for many years. The committee has been instrumental in the creation of the Patient Safety Event Reporting Tool that allows members to report adverse events in otolaryngology. This database contains de-identified patient data for study in a secure environment. This web link follows AHRQ guidelines and helps identify areas of focus for future research. The committee also was instrumental in a comprehensive study of tracheotomies using a combination of national survey data and multi-institutional data to develop a series of manuscripts regarding the outcome for patients with tracheotomies, including actionable items with the potential to materially decrease adverse events and improve outcomes. It also recently completed a study on post-tonsillectomy admission practices, looking at the likelihood of accidental death and postoperative delayed bleeding complications to help physicians make rational decisions about postoperative admission practices that emphasize safety. This month's *Bulletin* gives us a first look at their most recent project involving "Intraoperative Sentinel Events."

Following the completion of his talk, CAPT Carron asked the audience a survey question that was thought-provoking. He asked the audience if they would rather have a grade "A" participant in a grade "B" system or a "B" participant in an "A" system. The audience was split almost evenly on their answers. CAPT Carron favored the grade "A" system. I feel to really move the needle in the right direction we shouldn't settle for anything other than an "A" for both. Defining our goal and training participants to work in a culture that demands high quality and safety will be critical to addressing this unacceptable problem. The Academy will continue to identify and promote improvement activities that will move us toward the goal of no preventable errors. ■



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

“The Academy will continue to identify and promote improvement activities that will move us toward the goal of no preventable errors.”

”

■ at the forefront

Information, resources, and updates in this section

May Is Better Hearing & Speech
Month

Humanitarian Travel Grant
Awardees

Celebrating WIO Day:
March 8, 2020

Recognize Better Hearing & Speech
Month With AAO-HNSF Quality
Resources

Humanitarian Travel Grant Recipient
Travels to Philippines

New in AcademyU®: New Technology
for Hearing Loss

OTOSource: Hearing and Speech

FrequENTcy App Now Available

➔ READ MORE ONLINE

Humanitarian Travel Grant
Awardees

Humanitarian Travel Grant Recipient
Travels to Philippines

May Is Better Hearing & Speech Month

ENThealth.org offers information for your patients

Your Ear Gear and Hearing Health shares the facts about noise-induced hearing loss and tips for preserving hearing.

https://www.enthealth.org/be_ent_smart/your-ear-gear-and-hearing-health/

How Can I Lessen the Impact of Tinnitus? offers tips for reducing the impact of Tinnitus and answers some frequently asked questions.

https://www.enthealth.org/be_ent_smart/how-can-i-lessen-the-impact-of-tinnitus/

Speech and Language Development is gleaned from the AAO-HNSF Clinical Practice Guideline (update): Otitis Media with Effusion (OME) offering patient-friendly information for caregivers when OME affects speech and language development.

https://www.enthealth.org/be_ent_smart/speech-and-language-development/



For more patient information, search [ENThealth.org](https://www.enthealth.org) content under Conditions and Treatments and Be ENT Smart articles by using keywords "hearing" and "speech."

[ENThealth.org](https://www.enthealth.org) is dedicated to helping patients. The content is developed from a team of AAO-HNS members, and information is delivered via peer-reviewed articles, interactive features, and video content featuring physicians. Learn more about the site and our contributors at <https://www.enthealth.org/about-us/>. ■

Humanitarian Travel Grant Awardees

Congratulations to the residents who each received a \$1,000 travel grant for medical missions taking place during the first six months of the year (January-June 2020). The list of awardees is online.

The application deadline for missions taking place July 1 through December 31, 2020, is May 31, 2020. Visit www.entnet.org/humanitarian or contact humanitarian@entnet.org for more information. Applications, including support letters, must be submitted as a PDF to humanitarian@entnet.org. ■

➔ READ MORE ONLINE
Longer article available

Celebrating WIO Day: March 8, 2020



Colleagues at The Ohio State University Department of Otolaryngology - Head and Neck Surgery gathered on March 8 in recognition of both International Women's Day and Women in Otolaryngology (WIO) Day and to celebrate women in the specialty—sharing thoughts about their lives, challenges, and highlights of their careers. Photo provided by WIO member **Leslie R. Kim, MD**



Recognize Better Hearing & Speech Month in May with AAO-HNSF Quality Resources

Clinical Practice Guidelines that provide physician- and patient-related resources on hearing related topics:

- Ménière's Disease (see page 28 for more information)
- Sudden Hearing Loss (Update)
- Earwax (Cerumen Impaction) (Update)
- Otitis Media with Effusion (Update)
- Tinnitus
- Acute Otitis Externa (Update)
- Tympanostomy Tubes in Children

2020 Qualified Clinical Data Registry (QCDR) measures available exclusively through the Reg-entSM registry:

- AAO16 – Age-related Hearing Loss: Audiometric Evaluation

- AAO17 – Age-related Hearing Loss: Advanced Diagnostic Imaging of Bilateral Presbycusis or Symmetric SNHL
- AAO21 – Otitis Media With Effusion: Hearing Test for Chronic OME > 3 Months
- AAO31 – Otitis Media With Effusion: Avoidance of Inappropriate Use of Medications
- AAO12 – Tympanostomy Tubes: Topical Ear Drop Monotherapy Acute Otorrhea
- AAO20 – Tympanostomy Tubes: Hearing Test
- AAO36 – Tympanostomy Tubes: Resolution of Otitis Media With Effusion in Adults and Children

To learn more, visit www.entnet.org/CPG and www.entnet.org/2020-measures. ■



New in AcademyU: Technology for Hearing Loss

Keep up with the latest technologies being utilized for hearing loss. Due to the varied nature of these technologies, the course is divided into three main device categories: cochlear implants, osseointegrated devices, and middle ear implants. This course was authored by **Marc L. Bennett, MD, Richard K. Gurgel, MD, Jim V. Crawford, MD, and David H. Chi, MD**, of the AAO-HNSF Otolaryngology and Neurotology Education Committee.

<http://academyu.entnet.org/diweb/catalog/item/id/4965256> ■



Hearing and Speech

Through the free online study guides and surgical videos, medical professionals can learn and review an array of topics, from the anatomy of the temporal bone to the most common symptoms of vestibular schwannoma. Visit the Otolaryngology/Audiology unit in OTOSource for your learning needs at www.otosource.org. ■

HUMANITARIAN TRAVEL GRANT

Grant Recipient Travels to Philippines

Arvind K. Badhey, MD, traveled with nonprofit organization Sustainable Surgery on a skull base team mission to Manila, the capital of the Philippines.

"An established history of combined approaches with neurosurgery and otolaryngology is something not regularly practiced at such institutions in the Philippines," Dr. Badhey said. "Our goal was to act as a bridge to foster such collaborative and long-lasting relationships between these departments. With the help of an educational symposium involving interdisciplinary cases and discussion, we were able to demonstrate this collaborative model in action."

Dr. Badhey was the first resident to join the mission, an experience which provided for an added layer of education.



➔ READ MORE ONLINE
Longer article available

"I have an interest in global health as part of my academic career and being able to watch a mission start from the ground up was full of new lessons." ■

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Culture and Engagement in Your Practice

Scenario

A busy and productive otolaryngology practice struggles to manage personnel issues effectively while keeping up the pace and delivering the quality of patient care that the practice is accustomed to providing. This is not an unusual situation, and how it is managed can affect the entire practice.

Practice statistics

5 physicians, 1 administrator, 3 APPs, 3 audiologists, 2 RNs, 3 CMAs, and 35 additional support personnel with numerous ancillaries.

Situation

With 52 people working in a busy environment, there are bound to be personnel issues, and who has time to deal with all of them? It seems as if there is barely a day without a fire to put out; staff morale is low, with those in charge not sure which way to turn. Additionally, employees feel that no one is listening and that they, too, have nowhere to turn.

Does this sound familiar?

You are not alone. Let's hear from a few of the people involved and see if we can help them.



Physician

As a lead physician and one of the two partners, I have worked hard to build a solid practice. However, I feel like I am one of a few who are genuinely invested in both the practice and our patients. I struggle with unengaged staff members who do not seem to care. I do not want to see my life's work erode. Something must change.



Administrator

I see different groups evolve within the practice. They fight with one another and are constantly running to the physicians for "special attention," which hinders my ability to enforce policies and procedures across the practice.



Junior physician

I am just trying to get into a groove that allows me to build my practice. I try to work as a collaborative team member, but I simply do not have time to get involved in any staff drama.



CMA

No one appreciates me, and I was just offered \$3 more per hour to work as a CMA in a practice down the street from my house. Why should I stay?



Additional personnel grumblings

No one values my contributions. I used to like my job, but all I hear is that I am not working hard enough. I have a great idea that would improve our patient flow, but no one has listened when I have tried to offer suggestions. This is just a job until I can get out of here. I am being bullied by one of my coworkers, so who can I talk to about it?

What would you do? The following are all responses from ASCENT Administrators.

Respondent 1: It is up to the leadership team to create an environment that is healthy for everyone. I would get together with the managing physicians and discuss the issues at hand. I would be open and direct about what has been said and suggest pulling together to get everyone engaged. I would stress that it's important for us to listen to each person and to provide feedback for their suggestions and ideas.

Respondent 2: After meeting with the physicians, I would have an all-staff meeting to address the concerns. I would discuss the vision of the practice and why each of us is there: to make a difference. I would announce how we will move forward and that the hierarchy for issues, solutions, and concerns is through me or an anonymous vehicle, such as a suggestion box. My responsibility is to then address or solve the issues, discuss with the physicians, and take the outcomes to the staff through a means of communication that works, whether via short newsletters, huddles, or staff meetings. I also try to overcommunicate. If there is a question in your mind, then you should discuss with everyone.

Respondent 3: I would work on developing the supervisors. It has been said many times that employees don't quit the organization but quit the supervisor. Courteous interactions, direct communication, and a show of compassion for real-life issues go a long way to keep employees engaged. If you just ask staff how they are doing, you might be surprised at the responses. Supervisors should also know how to coach their direct reports to improve current skill levels and develop new ones.

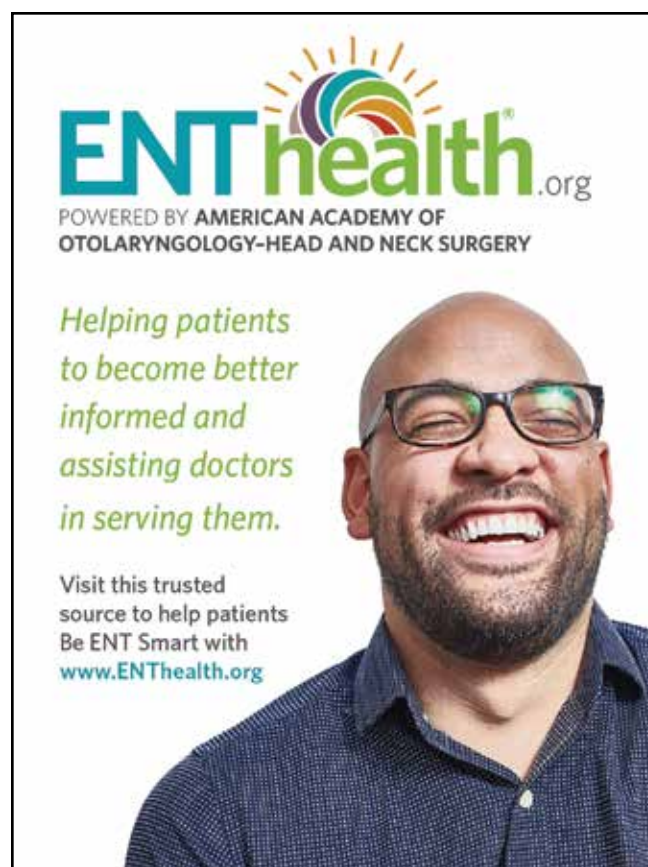
Respondent 4: From this scenario, I wonder about two things: (1) Are you hiring the correct people? (2) Is there a strong onboarding process in place? A positive culture is dependent on hiring people with the right personalities and backgrounds. It's important for the practice to identify the culture and to be consistent in ensuring the culture remains intact. If you are just trying to hire people because you are short-staffed, it doesn't usually work well. You need people who are both competent in work and willing to further the vision you have for the practice. There are some behavioral questions to ask in an interview to find out if potential hires are toxic to the work environment. For example: What would you change about your previous job? What do you like best about your current job? What values of your employer most align with yours?

Once your hiring decision is made, make sure the onboarding process is completed. It is easy to short-change onboarding because you are short-staffed. If necessary, onboard in shorter periods over a longer time period. Make sure all the bases are covered and that the new hires understand they are valued team members from day one.

Make sure they understand the commitment being made, what will spell success, and what the expectations are for both of you.

Respondent 5: I would also spend time on building culture. Make sure staff members understand their importance and the importance of their contribution to enhancing patient care in your community. Find ways to consistently recognize people for jobs well done, going above and beyond, and growing in their positions. Also, don't forget to celebrate successes and have fun in the workplace. Find ways to make work a place where employees want to come, want to work hard, and want to stay. That is the culture and engagement for which you are looking.

Need a culture or engagement adjustment? Ask your administrator to join the Administrator Support Community for ENT (ASCENT), which—in addition to resources and education—provides a network to help you work through common practice issues. Check us out at www.askASCENT.org. ■



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Four Projects Receive WIO Endowment Grants

The Women in Otolaryngology (WIO) Section has been productive in the last year. The WIO Endowment grants, totaling \$19,000, were awarded to four standout projects:

- **Implicit Bias in Evaluation of Surgical Residents**, a research study. Grant recipient: **Heather M. Weinreich, MD**.
- **Negotiation Skills for Women in Otolaryngology**, to be offered in workshops/seminars, webinars, and on-demand events. Grant recipients: **Megan L. Durr, MD**, **Miriam N. Lango, MD**, and **Selena E. Briggs, MD, MBA, PhD**. The first workshop was presented at the AAO-HNSF 2019 Annual Meeting & OTO Experience. Plans are underway for development of an updated workshop in 2020.
- **Gender Disparities in Assessments of Surgical Training**, a one-year multicenter study of gender disparities in assessments during surgical residency. Grant recipients: **Jenny X. Chen, MD**, **Stacey T. Gray, MD**, and **Elliott D. Kozin, MD**.
- **History of Women in Otolaryngology Video Archive Project**, a historical documentary of women in otolaryngology. Grant recipients: **Minka L. Schofield, MD**, **Angela M. Powell, MD**, and **Evelyn Kalyoussef, MD**. The video—celebrating the 10th anniversary of the WIO Section's formation—is in production, to be presented at the 2020 Annual Meeting in Boston.



Panelists (L-R) **Natasha Mirza, MD**, **Erica R. Thaler, MD**, and **Marta T. Becker, MD**, speak at an event at Thomas Jefferson University on January 29, 2020. The event was open to all women in otolaryngology in the Philadelphia, PA, region, including residents and fellows.

These projects are certain to provide much-needed data to help in eliminating gender disparity in otolaryngology.

The women otolaryngologists in Philadelphia kicked off WIO Day by hosting a panel discussion on January 29 on germane issues such as negotiation, mentorship, and identifying role models. Panel members included moderator **Mindy Rabinowitz, MD**, with panelists **Marta T. Becker, MD**, **Natasha Mirza, MD**, **Erica R. Thaler, MD**, and **Elina M. Toskala, MD, PhD, MBA**. The event was well attended, with representation from both academic and private practice arenas, and may provide inspiration for events in your area.

Please look for future *Bulletin* articles covering AAO-HNSF 2020 Annual Meeting & OTO Experience programming. ■

Do you have WIO events, news, and photos?

Share them on social media by using these hashtags:

#IAMOTO
#WomeninOTO
#WIO
#WomeninMedicine
#otolaryngology
#otolaryngologist
#entsurgeon
#headandneck
#headandnecksurgery
#womeninotolaryngology



CAST YOUR VOTE

Election opens May 4, 2020

Previewing the Proposed Bylaw Changes

There are several clarifications to the bylaws that will be on the ballot as part of the upcoming election opening May 4. Take a moment to review these proposed clarifications before casting your vote.

[https://www.entnet.org/
content/2020-proposed-
bylaw-amendments](https://www.entnet.org/content/2020-proposed-bylaw-amendments)

How to Cast Your Vote

AAO-HNS has partnered with Election America to administer the 2020 election of candidates for leadership positions. To ensure your election-specific broadcast email arrives safely in your inbox on May 4, simply add the following email address as an approved sender: **help+AAOHNS@election-america.com**. Those who have not provided an individual email address to the Academy will receive a personalized letter from Election America with information on how to access the ballot. For technical support, please call 1-866-384-9978, or email **help+AAOHNS@election-america.com**. For ballot-related questions, call Membership at (703) 836-4444, or email Lisa Holman at **elections@entnet.org**.

Q ■ What are the strengths of the Academy that will lead us forward in our specialty, and how will you capitalize on those strengths? What do you think is the most important item in the Academy's Strategic Plan?



J. Pablo Stolovitzky, MD

We must always remember our Academy's core value: to position member otolaryngologists for success in today's unsettled healthcare environment, whether in independent private practice, academics, or employed. In challenging times, this is our guiding principle, one that as President I will pursue as I seek to enhance our core mission of education, advocacy, and research.

Our goal must be the restoration of otolaryngologists' ability to direct the destiny of patients' care and our own practices.

Our Academy is second to none in the advocacy and regulatory arenas. We must rely on our strengths to continue standing up with conviction for our patients and profession against government and private payers' overreach. I will continue to find common ground among our profession's differing interests. I'll implement unifying strategies that I have successfully utilized as International Coordinator to foster synergistic partnerships with otolaryngology societies worldwide.

The leaders of tomorrow must be afforded ways to contribute today. Such opportunities add lasting value to their careers. I will foster a culture of inclusiveness and engagement by working with our profession's constituent groups to ensure our diversity is treasured. I commit to transforming early-career professionals from observers to contributors through mentoring and guidance; let's engage them earlier in our creative process.

I've been a leader in the Academy for over 30 years, including 10 on the Board of Directors. I wield broad business expertise as a healthcare executive and entrepreneur in a large otolaryngology practice. I've made

significant academic faculty contributions. I'm uniquely prepared to serve in this role with the knowledge and confidence to succeed.

When I look at the evolving healthcare landscape, I see enormous opportunity for our profession in our clinical data registry Reg-entSM. It's the most important element of the Academy's Strategic Plan. With Reg-ent, we are prepared for changing patient populations and payers' policies that link quality and value to payment.

Physicians should define quality, not policymakers and politicians. In time, the Reg-ent registry will allow us to do so, putting us in the driver's seat through relevant, specialty-developed measures that actually benefit our patients without hindering our practice.

Think of what the Reg-ent registry means to us. Registries improve clinical outcomes through real-time feedback. They produce large data sets that can shape how we care for our patients. Across medicine, clinical data registries are saving physicians millions in MIPS penalties.

What can we do with this powerful tool, this nexus of quality, physician payment, and real-world evidence? If nurtured correctly, our registry will allow us to control our own destiny in Medicare payment and help preserve fair value for our services.

The accomplishments on which we stand are the result of visionary leaders who served before us. It is our responsibility to honor their legacies by creating our own. As your President, I will devote my energy, talent, and commitment to you, my colleagues. Together, we will get the job done of empowering otolaryngologists to succeed. It will be a great honor to serve as your President. ■

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Our goal must be the restoration of otolaryngologists' ability to direct the destiny of patients' care and our own practices.

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Ken Yanagisawa, MD

Our Academy's two primary strengths are vision and unification. It is my distinct honor and privilege to contribute to the advancement of these missions.

Our Academy's visionary leadership has strategically anticipated issues and challenges that could impact our members and our practices. Reg-entSM has proactively created opportunities for practices to meet MIPS reporting requirements, has shaped relevant measures on our terms to grade our patient care, and is accruing and shepherding vital research data. AcademyU[®] has evolved to offer podcasts, to webcasts, to printed material to provide lifelong learning techniques appropriate for every generation.

Otolaryngology is a small yet wonderfully diverse specialty. We must remain united with energy and priorities aligned under the larger otolaryngology/Academy banner. I have had the privilege of contributing to and understanding many facets of our Academy, from service on the Executive Committee of the Board of Directors and Board of Governors; as Board of Governors Chair, Secretary, and SEGR Chair; Development and Nominating Committee member; ENT PAC Chairman's Club member; CPG and Regent Clinical Advisory Committee member; lifetime Millenium and Hal Foster Society member; and founder of the Eiji Yanagisawa International Visiting Scholarship travel grant. Through all of these interactions, it is clear that with cooperation we have untold strength and direction. I will utilize my abilities to hear and listen to the concerns of all constituents to create meaningful, thoughtful, and fair resolutions and directives.

Practicing physicians are continually juggling patient expectations, practice management challenges, and human resource/

provider-staffing dilemmas. I will seek diverse viewpoints for these and other issues through grassroots voices via the BOG, WIO, YPS, SRF, and DIC, practitioner voices from every practice type, and global voices via our ever-growing international community network. I will advocate for our Academy to study, share, and promote successful strategies and solutions for our most key concerns, thus improving our practice workflow and our personal wellness.

Communication is the universal determinant of success and failure. I will foster the Academy's bidirectional member communication to amplify awareness and provide timely updates in the plethora of Academy activities and actions being undertaken on our behalf.

The critical theme underlying our Strategic Plan is membership value. Our 2018 Strategic Plan contains important short-, mid-, and long-term goals in Quality, Patient Education, Future Workforce, Wellness, Advocacy, and Global Outreach. Today's provider stressors originate from financial, physical, mental, and even employment/practice ownership demands. The Academy must demonstrate the value it provides to keep it at the top of all otolaryngologists' to-do list. By keeping my finger on the pulse of ever-evolving member concerns and expectations, I will promote integration of the most pertinent elements to keep the next version of the Strategic Plan member-relevant.

Our Academy is the body that best understands each of our joys, our struggles, and our issues, and best represents all otolaryngologists. I hope that every member can join me in taking great pride and satisfaction in being an Academy member, and through participation and engagement, contribute to our continued growth and success. ■

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We must remain united with energy and priorities aligned under the larger otolaryngology/Academy banner.

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Q: What are your priorities for fiscal responsibility in the present economy? What non-dues revenue stream, current or proposed, do you plan to optimize to help improve the financial status of the Academy?



Steven W. Cheung, MD, MBA

I am deeply honored to be a candidate for election as Secretary/Treasurer-Elect of the Academy. The incumbent serves as Chair of the Finance Investment Subcommittee and discharges three major duties: (1) oversees the annual budgeting process, (2) monitors budgetary variances and operational activities of the Academy and the Foundation, and (3) reports to the Executive Committee and the Board of Directors. Those responsibilities require active stewardship of financial sustainability and promotion of accounting transparency.

I had the privilege to serve as a member and Chair of the Academy Audit Committee from 2012 to 2018. In that role, I helped to analyze financial statements, strengthen internal control procedures, and adopt best practices. I have been impressed with the Academy's consultative culture to ensure a highly disciplined approach for decision-making on budgetary, investment, and debt service matters. I was extremely pleased that the Academy acted to retire an expensive interest rate swap contract arising from permanent headquarters acquisition in 2008. Leadership chose a predictable fixed rate debt instrument that took advantage of the current permissive Federal Reserve monetary policy. So long as inflation stays in check, I would, as your Secretary/Treasurer, prioritize maintaining membership dues and meeting

fees at their current levels.

I hope to work with the Academy to reduce dependency on publication revenue as a critical driver of net income accrual. Momentum toward open access publishing has accelerated. There is a strong likelihood of major disruption to the traditional funds flow model, where society-sponsored journals make material payments to professional organizations. I believe Academy leadership should address this issue soon. I would catalyze discussions among stakeholders to develop a consensus strategy. I would aspire to deliver a solution that provides unfettered public access to scholarly contributions and advances patient care, research, and education. I am confident we will be able to navigate this incipient change in revenue stream successfully.

I would seek to assist EVP/CEO Dr. Denny and the Reg-entSM team to undertake a comprehensive review of this initiative. I would prune unpromising paths, rebalance resources to promising areas, and identify payors and payment models to grow revenue. I would devote considerable time and energy to ensure the Academy remains financially robust to meet its obligations and realize its ambitions. I would be extremely pleased to serve as your Secretary/Treasurer-Elect to move our common interests forward. ■

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I would aspire to deliver a solution that provides unfettered public access to scholarly contributions and advances patient care, research, and education.

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Ken Kazahaya, MD, MBA

Fiscal responsibility is important for operational efficiency to ensure long-term sustainability, viability, and growth of the AAO-HNS/F (Academy). In recent years, the Academy has annual net gains in assets. We must strive to continue to grow revenue from current and new sources. It is important to be conscious of expenditures and returns on those expenditures while continuing to build value the Academy provides to the membership. In addition to developing realistic balanced annual budgets, we must maintain adequate cash flows to ensure payment of existing obligations. Growth of dues and non-dues revenue and assets will reduce reliance upon investment income and asset reserves and allow them to grow for future projects. Strong financial health is important if we wish to be able to pursue the Academy's Strategic Plan.

Non-dues revenue comprised about 61% of the annual budget. The largest non-dues revenue for the AAO-HNS is the Annual Meeting (AM) & OTO Experience. The 2019 AM accounted for about 38% of the FY20 budget (62% of non-dues revenue). While the majority of the revenue is from domestic attendees, international attendees comprise about 5% of AM revenue. Boston, Los Angeles, Philadelphia, Nashville, and Miami constitute the next five AM locations—it is essential to provide an enticing program and capitalize on the attraction of the host city for both domestic and international attendees. Formulating concepts to expand the benefits for meeting attendees and encourage the involvement of resident and young providers as well as otolaryngology affiliates would expectantly continue to increase attendance. Other efforts should encourage former attendees who have not attended a recent AM to return. Increasing

meeting attendance should translate into increased revenue by enticing more robust exhibitor participation and corporate support.

Miscellaneous revenue sources include publications, product sales, corporate support, donations, and investment income. Education products such as the Home Study Course and digital education products (Members+ and the AM webcasts provided the most revenue) provide membership with valuable information. Perhaps new content could be directed at satisfying the ever-growing CME requirements that many states are instituting (opioid prescribing/crisis, child abuse, domestic violence, etc.). A bright star on the horizon is the Reg-entSM registry. Reg-ent's design shall provide meaningful benefit to our membership, and when fully realized, the Academy will develop significant revenue streams from Reg-ent. It will also be important for Reg-ent to have tangible benefits for and relationships with otolaryngologist employers. Additionally, development activities need to cultivate donor support for the Academy and the ENT-PAC and will need to find means to monetize advocacy efforts.

The Academy's portfolio has continued to grow. The current economy has seen significant investment growth. I believe that it is important to stay well informed in this potentially volatile time and maintain a conservative stance while not being afraid to make calculated aggressive moves when appropriate. I would strive to maintain a balanced and well-diversified investment policy, work to maximize our investment income while not putting our portfolio at unnecessary risk, and monitor our investment portfolio performance against standardized metrics. ■

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A bright star on the horizon is the Reg-entSM registry. Reg-ent's design shall provide meaningful benefit to our membership, and when fully realized, the Academy will develop significant revenue streams from Reg-ent.

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Q: What do you see as the essential task of the Directors, and in what ways are you well suited to that role?
What do you think is the most important item in the Academy's Strategic Plan?



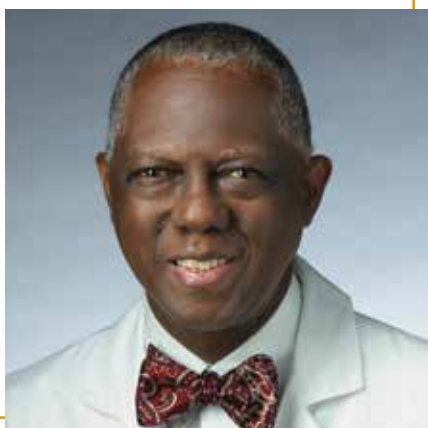
Ellen S. Deutsch, MD, MS

My vision is to accomplish our mission in a strategic and fiscally responsible manner. The most essential task of At-Large Directors is to probe our strategic approach with good and timely questions and provide thoughtful solutions. The Boards' overall purposes are to ensure adequate planning and resources, manage resources appropriately,

determine and monitor programs and services, and enhance the Academy's public image. I have served as President of the ABEA and Medical Director of the Pennsylvania Patient Safety Authority, with a successful track record of leadership in nonprofit and educational organizations. I will apply knowledge gained from these experiences to help the Academy accomplish its vision and mission, including advocating for our members and the public.

The Academy's Strategic Plan provides a balanced portfolio designed to promote quality, enhance the Academy's outreach and impact, and cultivate future otolaryngologists. As an At-Large Director, I will tirelessly support all of the Academy's goals and objectives. Right now, the most important item in the Academy's Strategic Plan is enhancing our future workforce. As my career has evolved, I have experienced

the Academy's beneficial influence on my professional growth, innovation, and change in how we deliver patient care and training. I have contributed to and benefited from deep involvement in developing and implementing creative methods to enhance the knowledge and skills of trainees, colleagues, and other members of healthcare delivery teams, improve the systems in which we provide healthcare, and enhance provider and patient satisfaction. My experience analyzing data from the Pennsylvania Patient Safety Reporting System, containing more than three million patient safety event reports, can help the Academy optimize insights derived from the Reg-entSM database. In summary, my broad range of professional experiences and interests provide insight and perspective that will allow me to champion each item in the Academy's Strategic Plan. ■



Earl H. Harley, MD

Also, my three-year tenure as interim chair of Otolaryngology Head and Neck Surgery at Georgetown University further qualifies me to be a director.

An organization requires an engaged board of directors. The essential role of a director is to ensure the organization's viability and long-term success. This includes devising and implementing policies and procedures that ensure the organization remains strong.

To remain strong, there must be adequate oversight. The main areas of oversight must be in the following categories: financial, membership engagement, and strategic planning. Financial stability includes proper stewardship of our resources with wise decision-making and budgetary restraints. Membership engagement involves reaching all segments of our specialty, including trainees, practicing otolaryngologists, and

emeritus members. But it also involves inclusion and diversity that encompasses religion, gender, ethnicity, and sexual orientation, not only in the rank and file but at all levels of the leadership. Additionally, fostering a strong bond between the Board of Directors and the Board of Governors is imperative.

The Academy's Strategic Plan as promulgated in 2018 included five goals. I believe the most important goal is the first that seeks to identify environmental conditions having the greatest impact on our future direction. This is because knowing the landscape prepares an organization in a way that is flexible enough to adjust to changes and transitions that can be swift and unpredictable. Without knowing the current environment, an organization may find itself unable to survive. ■

I am pleased to be nominated for this position, and I feel that I am well suited to be an At-Large Director because of my broad background as a retired Navy physician with leadership experience in both naval medical centers as well as fleet commands, including my assignment as a Flight Surgeon with the Second Marine Airwing in operation Desert Shield/Desert Storm.

- Q ■ What do you see as the essential task of the Directors, and in what ways are you well suited to that role?
■ What do you think is the most important item in the Academy's Strategic Plan?



Eugene G. Brown III, MD

As a private practice otolaryngologist in Charleston, SC, it is an honor for me to receive a nomination for Director At-Large Private Practice. A seat on the Board comes with it a duty to lead Academy initiatives and to oversee operations. For me, the position also offers a larger platform from which I can focus on my

passion to increase physician participation and leadership in Academy initiatives. The charge is to identify and to encourage next generation leaders. We need to embrace mentorship and take an active role in the direction of our practices, our field, and the house of medicine overall. If physicians don't lead, then we will be led and probably in unpopular directions.

We took a leadership position in our region when we chose a different strategy to combat burnout, narrowing profit margins and physician employment. We launched OASIS (Otolaryngology and Allergy Specialists – Integrated Solutions), a grassroots organization whose mission is to promote collaboration among otolaryngologists. In five years, we have created value for members, and we have promoted physician leadership. Our annual

conference attracts a national audience and creates a platform from which we consider challenges and opportunities. Our simple message is “together we are stronger.”

I was identified as a stakeholder and participated in the creation of the new Strategic Plan. The plan highlights a need for membership growth globally. A corollary challenge in times of increasing subspecialization is to keep the Academy centered as the organization for all otolaryngologists so that our interests are not splintered. From my perspective, the most important items in the plan involve future practice needs and workforce challenges. Predicting what our specialty will be and what we will need in the future is difficult but paramount in positioning otolaryngology for long-term success.

Thank you for this opportunity. ■



G. Lee Bryant, Jr., MD

energy as my son is now attending medical school. Our Academy has played a large role in my professional satisfaction. My desire is to help the Academy to continue inclusivity and to support the wide variety of environments in which our members practice otolaryngology. As an At-Large Director from the private practice sector, I understand the importance for advancement of initiatives that may impact private practice most while also supporting the overall objectives of the Academy.

With regard to our Academy's Strategic Plan, obviously the most important goal relates to our core purpose, which is essentially to be patient-centric and to strive for excellence in patient care. I feel that advocacy is a need for the future

success of all practicing physicians, both in the United States and globally. My goals have always been patient-centric, and my skill set includes being President of a single specialty group for the past 20 years, in which we have had a vibrant general otolaryngology practice and busy allergy practice following the AAOA guidelines. Our practice has incorporated Advanced Practice Practitioners over the past 15 years; and in conjunction with ASCENT, I have given instructional courses at our Annual Meeting on this topic. Lastly, I have a passion for cutting-edge in-office procedures and have trained hundreds of peers over the past few years. I look forward to the opportunity to advance the initiatives of our Academy. ■

It is an exciting time to practice otolaryngology-head and neck surgery. After 21 years of private practice, I am as professionally satisfied as ever. I have a genuine passion and excitement for our field, and even my own family has felt that

Q: How will you select candidates for Academy leadership that best represent our diverse membership?
What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?



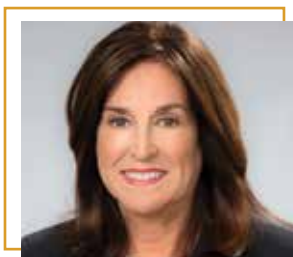
Samantha Anne, MD, MS



C.W. David Chang, MD



Alexander Hillel, MD



Anna M. Pou, MD

Candidates for Academy leadership need to have innovative vision and advocate for our membership. To truly capture the needs of our heterogeneous membership, I believe that leaders need to represent the diversity, including practice settings, race, gender, and other aspects. Most importantly, I believe our leaders must conduct themselves with integrity and civility. I will seek these characteristics in recruiting prospective leaders of our Academy.

I have had the opportunity to serve the American Academy of Otolaryngology–Head and Neck Surgery in various ways, including on the Board of Directors (as Young Physician Section Chair) and on the Board of Governors (as Secretary and current Vice Chair of the Governance and Society Engagement Committee). In addition, I have previously served as Chair of the Women in Otolaryngology Section’s Nominating Committee and on the American Society of Pediatric Otolaryngology’s Nominating Committee.

This service afforded me the chance to observe leaders and the qualities that elevate them as successful advocates for our profession. This insight, along with my motivation to identify talented, diverse, and innovative leaders, will guide me if I am given the incredible honor to serve on the Nominating Committee. ■

Leadership selection for such a large eclectic organization should be focused on seeking those with visionary outlook, with the ability to bridge and connect among our diverse membership, and who advocate equitably and ethically on behalf of providers and patients. Embracing diversity means valuing the multiplicity of perspectives within our membership. However, professional identities are too often simplified into labels of gender, race, sexual orientation, ethnicity, social economic status, education/training pedigree, geography, subspecialty, and practice organization. While it remains important to appreciate shared experiences within such groups, compartmentalization can also lend to assumptions that downplay the complexity of influences.

As a residency program director, the resident selection mirrors the task of the Nominating Committee. I believe that quantifying characteristics into neat boxes and algorithms fails to faithfully and holistically evaluate candidates. I strive to keep this in mind in all leadership roles I have served, ranging from president of my state society to co-chairing the PSQI Committee. Through my work with the Academy—as BOG Region 7 Representative, member of committees, and associate editor for the Academy’s journals—I continue to meet differently talented individuals within our society, reminding me that our unity does not require uniformity. ■

To better serve the evolving needs of our communities, it is incumbent upon our leaders to represent diverse backgrounds and experiences. I recognized this need and pioneered a specialized clerkship focused on providing students who are underrepresented in medicine an opportunity for mentorship with otolaryngology faculty who themselves came from diverse backgrounds. Those students have since gone onto myriad residency programs throughout the country and are now primed to shape the next generation of otolaryngologists. In a similar spirit, I will emphasize the selection of candidates for Academy leadership who will champion our values of equity and excellence; anticipating their diverse perspectives will drive richer discussions amongst our leadership and better serve all Academy members.

Through my leadership as residency program director, service on multiple hospital committees, and as a member of otolaryngology and surgical societies I have extensive firsthand experience working with all types of leaders. These roles helped me recognize that great leaders clearly communicate their vision and rationale, hold themselves and others accountable, and understand that leadership is grounded in service. Identifying future leaders who demonstrate these qualities will ensure the Academy continues to advance our mission and enrich the experience for all our members. ■

I will look for leaders who themselves represent a diverse group and who can unite the members of the AAO-HNS moving our Academy forward. Through my experiences on multiple committees and mentoring young physicians, I have met such a diverse group of clinicians who are forward-thinking, insightful, and open-minded; it would be a privilege to nominate such individuals for Academy leadership. By also involving young members with leadership potential, we can better understand their challenges regarding parenting, family, and career, so that we can work together toward continued progress and excellence in these changing times.

Over the years, I served on multiple AAO-HNS and AHNS committees, serving as AHNS Program Chair in 2017 and Chair of the Trauma Committee. These experiences provided me with the opportunity to work with many members, including our military colleagues, forming lasting relationships and providing a better understanding of the needs of our membership.

As Program Director following Hurricane Katrina, I networked with many program directors and leadership in the RRC to rebuild our residency program. I served on many SUO committees, furthering my relationships.

I have numerous, diverse contacts nationally through extensive lecturing on disaster medicine. ■

nominating committee: private practice ■ candidate statements ■

Q ■ How will you select candidates for Academy leadership that best represent our diverse membership? What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?



Eli R. Groppo, MD

As a member of the Nominating Committee, my No. 1 goal will be to protect and nurture the amazing diversity of our Academy, ensuring that our members are fairly represented at all levels of leadership. While we all get up each day with the goal of taking the best care of our patients, the nature of our practice environment plays a huge role in how we accomplish this. The struggles of taking care of patients in private practice, academic, military, and employed practice environments can be very different. Having leaders who bring perspective from each of these practice environments is paramount.

To accomplish this goal, I will rely on my experience as a leader in a large private practice otolaryngology group and a large network of similar physician leaders from around the country. I am honored to have served on several Academy committees as well as serving on our Board of Governors. This service has provided me insight on how our Academy interfaces with government, hospitals and administrators, other physician organizations, and most importantly, our patients. I will use this insight to help identify and recruit physician leaders who will carry on our mission. I humbly ask for your support. ■



Darius Kohan, MD

During my 30-year career in private practice and academics, I have had the privilege of collaborating with colleagues from all aspects of otolaryngology throughout the United States. I have been involved in numerous BOG and AAO-HNS committees and gotten to know, and appreciate, the outstanding dedication and leadership quality demonstrated by our members. In private practice, I am familiar with all the challenges facing us and the opportunities available for improving the welfare of our patients and the well-being of the otolaryngologists attempting to optimize patient care. Participating in regional and national efforts to promote Academy goals, educate the next generation of otolaryngologists, and improve patient care, while collaborating with our peers in all fields of medicine, allowed me to personally become familiar with the large pool of talent available to the Academy. Their work ethic and dedication to the welfare of our patients and achieving Academy goals was amply demonstrated. I intend to nominate the most deserving otolaryngologists to leadership positions based upon merit and ability to represent our ever-more diverse membership. Leadership must reflect the needs of both private practitioners and academicians, the geography and demographics of our country, and the vision of the Academy for a brighter future. ■



Seth R. Schwartz, MD, MPH

Our Academy is diverse in location, practice setting, specialization, ethnicity, age, gender, religion, sexual orientation, and interests. Having a leadership team that is representative and understanding of these differences is critical to our success as an organization. As well as leveraging my connections through the AAO-HNS, my regional society, my subspecialty society, and my many colleagues and former residents, I plan to work with groups such as WIO, SRF, the subspecialties, and regional societies to find future leaders who represent and embrace our diverse membership and are interested and willing to work with Academy.

I just finished a term on the Board of Directors and Executive Committee of the AAO-HNSF and previously was involved in guiding the direction of the Academy as Chair of the Guideline Task Force, an invited guest of the Board, and a member of the last two strategic planning sessions. Through this involvement, I have seen different leadership styles and gotten to know current and former leaders of our Academy. I have seen our strengths, but also opportunities for new perspectives in leadership to make sure that our Academy stays relevant in this rapidly changing healthcare environment. ■



Daniel L. Wohl, MD

The strength of our relatively small but impactful specialty comes from understanding and connecting the interests of our diverse membership, whether from urban or rural communities, whether in private, academic, or a hybrid practice model, remaining fully respectful of all academic and social backgrounds. If elected, I would listen to returning members of the Nominating Committee and bring my career experience into the conversation, having started out in academic medicine and now in private practice for over 15 years.

My career arc has afforded me the opportunity to continuously interact with an ever-evolving spectrum of highly motivated, skilled, and involved tier of colleagues who help define our specialty. My 10 years of Board of Governors responsibilities, including the past three years on the Executive Committee, have enabled me to hear both grassroots and state society concerns. I have served three full terms on Academy committees and remain an active member in two subspecialty societies. I would use this experience to identify colleagues who understand the value of our specialty's interconnectivity, who will represent all of us well, and who will be passionately proactive and supportive of both the current and future generations of otolaryngologist-head and neck surgeons. ■

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



Oswaldo A. Henriquez-Ajami, MD

I currently serve as the President of the Metro Atlanta Educational Society of Otolaryngology, a nonprofit society with parallel goals to our Academy. Having served in various roles, including the principal financial officer, has given me unique insight into the importance of reliable financial reporting while reducing risk to foster and maintain membership confidence.

Our current socioeconomic environment has elevated the importance for institutions such as our Academy to form effective Audit Committees in order to assist our governing board in achieving our mission objectives while ensuring transparency.

For our Academy to serve as a nonprofit institution aimed at advancing our field, it is crucial to offer the utmost transparency in its governance. The Audit Committee plays a pivotal role in this, and that is the main reason I am running to be one of its members. If elected, I will commit myself to being an engaging, active member of the Audit Committee and helping our Academy to reach its missions and goals.

Thank you for considering my candidacy. ■



Susan D. McCammon, MD

I will be an effective member of the Audit Committee because I provide institutional memory and broad understanding of the strategic goals of the Academy. I am honored to be the immediate past chair of the AAO-HNS/F Ethics Committee. Thus, I have been a member of the Boards of Directors, ex officio, for six years. This has given me broad exposure to the issues of risk management, conflict and coincidence of interest, and accountability that face our members. I have been an invited participant in the Academy long-range strategic planning sessions, and I have prior experience serving on the Audit Committee of the Head and Neck Cancer Alliance. A critical role of the Audit Committee is to help the Academy match stable funding to its mission and Strategic Plan. Diligent, detail-oriented oversight of the annual books and records of the Academy will be balanced by prudent understanding of the priorities of the Academy membership. I have been a head and neck surgeon for 15 years and have practiced in a university setting and in underserved communities. My clinical practice has evolved over the years to include clinical ethics and conflict mediation, medical humanities, and palliative and supportive care. ■



Let Your Voice Be Heard: Voting Opens May 4

Thank you for reviewing the thoughtful statements of the 18 candidates for elected office of the Academy. That is just the first step. It is critical that you follow through and cast your ballot for the candidate of your choice when elections open on May 4. The process is streamlined and should take no more than a few minutes to complete. Your Nominating Committee, chaired by Past-President **Albert L. Merati, MD**, has done a fabulous job in identifying and selecting these outstanding candidates who will help lead us through the evolving transition to our healthcare system. This is your chance to have your voice heard. Please finish the job and cast your ballot during the 2020 election cycle.

Intraoperative Sentinel Events: Righting Wrongs or Ticking Boxes?

John D. Cramer, MD, Karthik Balakrishnan, MD, Michael J. Brenner, MD, and Soham Roy, MD

Time-out protocols and checklists are now widely used in efforts to deter sentinel events in the operating room. Academy members were queried about their experiences, affording insights into what is happening in otolaryngology-head and neck surgery. In the survey, 543 Academy members shared their experiences relating to sentinel events that continue to occur in the modern operating room. The survey asked about wrong site, wrong patient, and wrong procedure errors; surgical fires; inadvertent administration of wrong medication; and retained surgical items. The full quantitative analysis of the survey will be described in an upcoming publication; however, several broad themes emerged from dozens of free text responses and these are shared in this article.

Checklist Use

Surgical safety checklists have been adopted nearly universally, although components vary across institutions. Widely used components include the following:

- Preoperative marking of surgical site
- “All Stop” to direct attention to the checklist
- Time-out to confirm correct patient identification, correct procedure site, and correct procedure
- Discussion of any special medication or equipment requirements
- A debrief including discussion of instrument, sponge, and needle counts after completion of procedure

The majority of respondents believed preoperative time-outs have helped to prevent serious events. The success of such routine requires the surgeon to champion and lead the practice. One otolaryngologist commented, “[There should be] involvement of the surgeon to ensure that any process used is important, valued, and utilized regularly. Everyone in the room needs to be empowered to help keep the case safe.”

Other respondents reported frustration about the burden of checklists. The performance of checklists become dulled when the simple is made too complicated. One respondent commented, “The checklists are becoming too long and too many people are losing focus on the key elements in favor of the paperwork.” Another respondent lamented, “I feel they do more harm than good by directing attention and discussion away from pertinent things.” Rote checklists are not a substitution for relevant and timely communication.

Sentinel Intraoperative Events

Ten years after widespread adoption of safe surgery checklists, sentinel events continue to occur. Among otolaryngologists surveyed, these events include wrong site surgery, operating room fires, incorrect medication administration, and retained surgical items.

Errors of procedure or person varied in severity from wrong side tympanostomy tube placement to wrong side skull base surgery. Especially prevalent were errors involving high-volume cases that may be performed with slight variability from one patient to another. This includes wrong side tympanostomy tube placement, wrong side hemithyroidectomy, and wrong cutaneous or oral lesion removed. Other instances involved performing incorrect combination of procedures on a patient—inadvertently performing a tonsillectomy on a patient that needed only an adenoidectomy.

The most common examples of **operating room fires** were self-limited incidents that did not reach the patient, but the survey also revealed more disquieting reports of fires that resulted in permanent harm or mortality. Unsurprisingly, the devastating consequences of operating room fires resulted in a higher incidence of financial repercussions. Operating room fires frequently related to poor communication about oxygen during laser airway surgery and facial surgery. Fiberoptic light sources were also reported as frequent ignition sources. One respondent

reported a case where a “light box ignited as a fan had stopped working,” further igniting the anesthesia machine.

Inadvertent administration of medication most commonly involved injection of concentrated epinephrine, injection of oxymetazoline, or administration of a medication to which the patient had a known allergy. Several instances of concentrated epinephrine injection involved miscommunication that occurred when medications were drawn up during breaks and shift changes. For example, one otolaryngologist noted that after a scrub change, two medications in clear glass cups were left on the field. What turned out to be 1:1,000 epinephrine was drawn up and injected. “Patient became tachycardic and hypertensive causing us to abort procedure.”

Retained surgical items most commonly involved materials not routinely included in surgical counts. Among the most frequently reported items were throat packs and other temporary splints or packing material.

Conclusions

What can the practicing otolaryngologist take away? First, clear communication is essential. While surgical safety checklists standardize communication, a culture of safety that includes teamwork is required. Furthermore, checklists can create fatigue and foster indifference. As leaders of the surgical team, otolaryngologists should strive to develop effective, structured time-outs that focus attention on salient and relevant risks of the procedure. Surgeons can foster environments where all team members can effectively communicate.

The Patient Safety and Quality Improvement Committee wishes to thank Academy members for participating in this survey and sharing their stories and Taskin Monjur and Jean Brereton for support in preparing this survey. A formal publication detailing quantitative data and findings of this survey is forthcoming later in 2020. ■

Incorporating Advanced Practice Providers Into Your Practice

Part II: Why Work With an APP?

Wendy B. Stern, MD

In 2020, AAO-HNS members find themselves challenged by our commitment to quality care for our patients, meeting regulatory and financial demands, and maintaining our own wellness. The 2017 AAO-HNS Socioeconomic Survey¹ determined that 51 percent of members have unmet demand for access, and 40 percent of members have inadequate time with patients despite our reporting that 56 percent of us work more than 51 hours a week and 86 percent of us take no more than six weeks of vacation. And fewer of us are considering retirement than in 2014 or 2011. **James C. Denny III, MD**, addressed physician wellness in his *Bulletin* article, “Speaking Up for Physician Well-being” (March 2017, vol. 36, no. 2)², and AcademyU[®] has several offerings³ on physician wellness and how to prevent burnout.

In Part II of our series examining the physician/advanced practice provider (APP) team approach, I have invited two of my colleagues to explain some of the benefits of working with APPs. First is **Ilana Feinerman, MD**, chief of the otolaryngology division at Southcoast Hospital Group in North Dartmouth, MA, who is also a former senior partner of a single specialty ENT group and now employed by a large multispecialty group. Second is **Denis C. Lafreniere, MD**, professor of surgery, chief of the Division of Otolaryngology, medical director of UConn Medical Group, and associate dean of clinical affairs at UConn Health.

How has the APP team approach improved access to care?

Dr. Feinerman: Our APPs write prescription renewals, perform H&Ps [history and physical evaluations], and hand out patient education



Wendy B. Stern, MD

materials in addition to handling phone calls from patients, pre-op counseling, and post-op care. They see selected new patients, initiate the work-ups, and facilitate our urgent visits. This has expanded access by freeing me to see more new patients.

In what ways have you experienced improved patient satisfaction and quality outcomes?

Dr. Lafreniere: One of the biggest advantages to working with an APP in an academic program is the ability to maintain a responsive clinical presence even when academic duties may pull you off the floors and out of the clinic. Many practitioners in academia may not be in clinic more than a few days a week. An APP can easily fill those gaps and improve response time for patient care. This leads to improved satisfaction scores such as the CGCAHPS. In our pediatric hospital, the APPs cover daytime floor calls two days a week, allowing uninterrupted OR time for the residents, which improves their educational experience and wellness.

How did the team approach improve the practice's financial profile?

Dr. Feinerman: The bottom line is that the team approach leads to higher volumes and codes with lower overhead, resulting in an improved financial profile.



Ilana Feinerman, MD



Denis C. Lafreniere, MD

Has the team approach allowed for an expansion of ENT services?

Dr. Lafreniere: Having an APP has allowed us to continue our Taste and Smell specialty clinic as the APP performs the smell test protocol on our patients. The APP also sees new nonsurgical patients, freeing the subspecialist to provide specialty care and surgery.

How has the team approach benefited your personal and professional lifestyles?

Dr. Feinerman: My quality of life is significantly better due to the help I have in the office. APPs truly extend me. We execute high-quality care in a timely fashion. I leave the office satisfied and ready to spend time with my family.

Dr. Lafreniere: The APP can reduce many of the small stressors that can invade any practitioner's workday. In the academic setting where educational, research, and administrative duties can often demand a large part of your week, having an APP helps to ensure a consistent level of patient care. This improves wellness all around. ■

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1. <https://www.entnet.org/content/socioeconomic-data>
2. <https://bulletin.entnet.org/article/speaking-up-for-physician-well-being/>
3. <http://academyu.entnet.org/diweb/catalog>

Study Explores Ibuprofen Versus Opioid Therapy for Outpatient Post-Op Pain Control



In this *Bulletin* segment, our committee shares highlights from recent key publications in otolaryngology-head and neck surgery. We offer concise summaries of significant findings that may alter current surgical practice. The following original research is the focus for this issue.

Uchechukwu Megwalu, MD, MPH, Joshua Bedwell, MD, Nikhila Raol, MD, MPH, and Vikas Mehta, MD, for Outcomes Research and Evidence-Based Medicine Committee

Prescription drug abuse is an epidemic in the United States, leading to over 60,000 deaths annually. Surgeons commonly prescribe opioid medications postoperatively for pain control. Diversion of unused prescribed opioid medications has been identified as a major contributor to the opioid epidemic. Furthermore, overprescribing of opioid medications can lead to chronic opioid dependence. In 2016, the Centers for Disease Control and Prevention issued guidelines for primary care physicians treating chronic pain with opioids. Unfortunately, there is a paucity of opioid-prescribing guidelines for postoperative pain control. Consequently, there is a wide variety of opioid-prescribing practices among surgeons. Nonopioid analgesics represent a possible alternative to opioid medications. However, it is unclear if they are as effective in controlling postoperative pain in patients undergoing otolaryngologic surgery. This single-blind randomized control study examined the efficacy of primary analgesic therapy with ibuprofen versus opioid medication in patients undergoing outpatient otolaryngologic surgery.

The study participants included adult patients undergoing outpatient otolaryngology surgery at a tertiary care academic hospital. The surgical procedures included thyroidectomy, parathyroidectomy, functional endoscopic sinus surgery (FESS), septoplasty, septorhinoplasty, tympanoplasty, and endolaryngeal procedures requiring general anesthesia

and microsuspension direct laryngoscopy. Tonsillectomy was excluded. All patients received a prescription for hydrocodone/acetaminophen (APAP) (5 mg / 325 mg) and ibuprofen (600 mg) to be used every six hours as needed for pain. Primary analgesic therapy was defined as the first medication that patients were assigned to take for pain control, and secondary therapy was defined as the backup medication to be used when primary therapy provided inadequate analgesia. Patients were randomly assigned to take either the opioid medication (opioid group) or ibuprofen (ibuprofen group) as the primary analgesic therapy. The attending surgeon was blinded to the patient's assigned treatment group, but patients were not blinded. The primary outcome measure was opioid consumption, and the secondary outcome measure was the patient-reported pain score.

A total of 185 patients were randomized, 97 patients in the opioid arm, and 88 patients in the ibuprofen arm. Of these, 108 (58 percent) completed the study: 56 patients in the opioid arm and 52 patients in the ibuprofen arm. Patient characteristics were similar between groups. The opioid consumption rate was higher in the opioid group compared with the ibuprofen group. The mean number of opioid pills taken was 4.9 (95% Confidence intervals [CI] 3.6 to 6.1) for the opioid group versus 2.0 (95% CI 0.9 to 3.1) for the ibuprofen group. Those in the opioid group also required more doses of their secondary medication. There was no difference in reported pain scores between the treatment groups. No major complications were noted in either group. No patient reported hematoma or bleeding that required intervention.

The findings of this study suggest that the use of ibuprofen as primary analgesic therapy

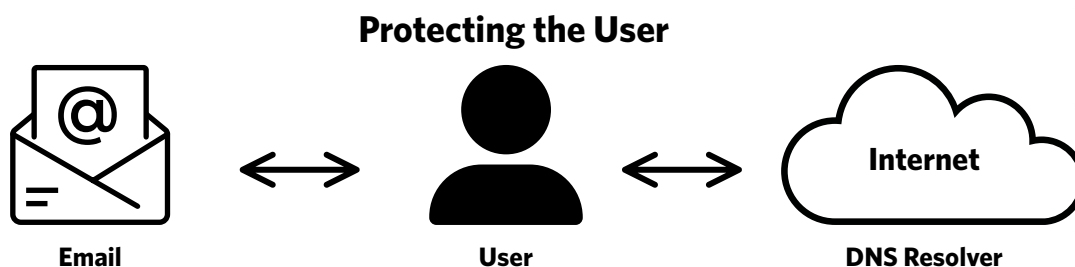
provides equally effective pain control as hydrocodone/APAP in patients undergoing a wide variety of outpatient otolaryngology surgical procedures. Furthermore, this strategy decreases overall opioid requirement. The authors also noted that many more patients assigned to the opioid group took their secondary medication than patients in the ibuprofen group, suggesting with this self-crossover design that ibuprofen may be superior in controlling postoperative pain. Finally, and of particular interest given the concerns about diversion, the patients were prescribed 20-30 pills of opioids in each treatment arm and the vast majority used very few of these pills regardless of the primary pain regimen and surgical procedure.

This study was limited by significant loss of participants to follow up. Additionally, while the power analysis indicates adequate sample size to detect differences in pain scores between groups when all surgical procedures were combined, it is unclear if the sample size was adequate for analyses by procedure. Finally, the authors did not control for medications used in the perioperative setting. Thus, the findings need to be interpreted in light of these limitations. Overall, the results of the study highlight that opioids are often overprescribed after routine otolaryngology procedures and that the use of ibuprofen as a primary means of controlling pain is a safe and potentially more effective method than opioids. ■

Nguyen KK, Liu YF, Chang C, Park JJ, Kim CH, Hondorp B, Vuong C, Xu H, Crawley BK, Simental AA, Church CA, Inman JC. A randomized single-blinded trial of ibuprofen-versus opioid-based primary analgesic therapy in outpatient otolaryngology surgery. *Otolaryngology Head Neck Surg.* 2019 May;160(5):839-846.

Tech Talk

User-centric Cybersecurity Foundation



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

Cybersecurity is one of the most important and broadest topics in the technology management space. The defense in-depth approach has always been key.

Regular software patches, firewalls, intrusion detection, network monitoring, and antivirus protection are some of the many landscape components to keep the bad guys out and sensitive information in. These preventive technology elements are vital, but full protection to prevent data breaches requires a concentration on the end-user experience.

The focus of this article is on a user-centric cybersecurity foundation. This is critical because most breaches begin when someone is tricked into clicking on a malicious link delivered via email. As the figure suggests, there are three areas to discuss: email protection, protection against fake links, and user awareness training.

Why do the bad guys spend so much energy crafting malicious emails? Getting someone to open an email is the easiest way to bypass a network's defenses. Think of surfing the web as a communications dialogue. Most firewalls are set up to block unsolicited inbound traffic. However, if the conversation initiates inside your firewall then two-way traffic is allowed through. This is the reason the bad guys craft socially engineered messages to entice or trick the recipient to click on a link. When a user clicks on a malicious link, the communications begin inside your network,

bypassing firewall safeguards. Email protection is vital to prevent these unwanted emails from getting through in the first place.

What happens if a malicious email does make it through? You need "bad link" protection. This is where a domain name system (DNS) resolver comes in. To better understand, let me explain what DNS is. When you type in the name of a site in your browser, you typically enter something that looks like English. As an example, www.entnet.org. For you to get to this site something must translate the name to a series of numbers so that you can be routed to where you want to go. DNS is essentially the phone book for the internet. It automatically translates the entered English to the associated number.

Your internet service provider typically provides the address of a nameserver for you. These default DNS nameservers typically don't provide a whole lot of protection. You need a third-party DNS resolver that blocks malicious and suspicious domains. With a DNS resolver, when a user clicks on a suspicious link, the DNS resolver looks it up in its blocked list. If the site is found, the resolver prevents the user from going to it. (Adult sites and other inappropriate content are often included in the blocked list.)

So far, I've talked about the two end points shown in the figure. Email protection blocks suspicious emails from coming in. And a DNS resolver prevents a user who clicks on a malicious link from getting to the bad or

inappropriate site. Now let's talk about the most critical piece: cybersecurity awareness training.

We can deploy a lot of technology to prevent bad things from happening. But it only takes one malicious email with a bad link to make it through and infect your entire organization. Users are the first line of defense. Do they know what a phishing email looks like? Do they know how to report a suspicious email? At the risk of oversimplifying cybersecurity awareness, here are three golden rules:

1. Never click on any link. Instead, hover your mouse over the link. This will tell you where the link is pointed to.
2. Never click on an attachment until you've verified that the email is legitimate.
3. Slow down and read your emails. It's not a race. By slowing down, you can identify the tell-tale signs of a fake email.

In-depth awareness training is necessary to fully understand each of these golden rules.

Cybersecurity is a big topic. The three elements presented here—email protection, DNS resolver, and awareness training—are foundational. Because most infections and data breaches originate from a malformed email, these steps and regular software patching will help keep a network safe. I would be remiss if I did not suggest that you consider having a security consultant do a vulnerability assessment to identify your risks so that you develop your own action plan to combat the bad guys. ■

Transition to In-office Treatments: Ménière's Disease

Varun V. Varadarajan, MD, and Oliver F. Adunka, MD, Chair of the AAO-HNS Hearing Committee

Given the benefits of improved healthcare access, decreased cost, avoidance of anesthetic risk, and improved patient safety, many procedural specialties have embraced the trend of transitioning operating room-based treatments to in-office procedures. In contrast to some other otolaryngology subspecialties, the evolution of in-office procedures for the otologist has advanced more slowly. More specifically, many modern in-office otologic procedures are similar to those performed in the early days of the specialty; common procedures include myringotomy, tympanostomy tube placement, cerumen disimpaction, mastoid debridement, myringoplasty, minor otoendoscopic procedures, and transtympanic injections. Peripheral vestibular disorders, such as benign paroxysmal position vertigo, superior semicircular canal dehiscence, and Ménière's disease, are typically managed conservatively until medically refractory disease necessitates procedural intervention. The treatment of Ménière's disease, however, has a unique history and evolved over time from early surgical intervention to predominantly outpatient and in-office management.

Ménière's disease is a clinical condition defined by spontaneous vertigo attacks (each lasting 20 minutes to 12 hours) with documented low- to mid-frequency sensorineural hearing loss (SNHL) in the affected ear before, during, or after one of the episodes of vertigo. It also presents with fluctuating aural symptoms (hearing loss, tinnitus, or ear fullness) in the affected ear.¹ The evaluation and management contribute to the significant economic burden of Ménière's disease. This is due to diagnostic testing (e.g., imaging, vestibular testing, electrocochleography), procedural

interventions, frequent office visits, and auditory rehabilitation.² Treatments aim to reduce the frequency and severity of attacks as well as restore hearing in late-stage disease; patients are counseled on both ablative and non-ablative procedures with regard to hearing preservation. In the mid-20th century, vestibular nerve sectioning, labyrinthectomy, and endolymphatic sac procedures were commonly performed, as techniques improved in safety with the availability of the operating microscope. In the late 20th and 21st centuries, the management of Ménière's disease experienced a transition from invasive surgical interventions to largely outpatient and in-office treatments. This shift in practice is attributable to a large armamentarium of conservative interventions such as lifestyle modification (trigger identification, stress reduction), dietary modification (e.g., sodium, caffeine, alcohol restriction), and pharmacologic therapy (e.g., diuretics, betahistine). The increasing evidence of an immunomodulatory link between allergies and Ménière's disease has encouraged control of allergen exposure and potentially utilizing immunotherapy as an avenue for trigger management. Most significantly, the widespread use of transtympanic injections has allowed patients to undergo a relatively low-risk, short-duration in-office procedure before considering surgical interventions requiring general anesthesia or inpatient hospitalization.

Transtympanic steroid and gentamicin injections were recently reported to be the most common procedure performed for Ménière's disease in the United States.³ Transtympanic steroid injections serve as a non-ablative option for attempting to control vertigo episodes as well as to treat SNHL. Chemical labyrinthectomy

using titrated transtympanic gentamicin injections provides a gradual, outpatient ablative therapy in contrast to surgical procedures such as labyrinthectomy or vestibular nerve sectioning, which result in immediate vestibular deafferentation. Given gentamicin's preferential ablation of the vestibular end organs, patients who retain serviceable hearing may also remain candidates for non-ablative surgical therapy, such as endolymphatic sac decompression or vestibular nerve section.

Clinicians must continue to critically interpret the literature when considering the numerous therapeutic options for Ménière's disease, as the levels of evidence and reported success rates vary. An improved understanding of the distinctions between Ménière's disease and vestibular migraine or atypical presentations of other peripheral vestibular disorders have likely reduced the incidence of erroneous diagnoses. The recently published AAO-HNSF Clinical Practice Guideline: Ménière's Disease reviews the best existing literature, improves the awareness of our community to the efficacy of the available therapies, and provides consensus recommendations for this challenging disorder. (See page 28 for the article on the Clinical Practice Guideline: Ménière's Disease) ■

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CLINICAL PRACTICE GUIDELINE

Ménière's Disease

Adapted from the April 2020 Supplement to
Otolaryngology–Head and Neck Surgery.

Read the guideline at otojournal.org.

Ménière's disease is a clinical condition defined by spontaneous vertigo attacks, each lasting 20 minutes to 12 hours, with documented low- to mid- frequency sensorineural hearing loss in the affected ear before, during, or after one of the episodes of vertigo. Prevalence estimates as low as 3.5 in 100,000 and as high as 513 in 100,000 have been reported from Ménière's disease studies worldwide.

“Ménière's disease has a lot of factors and can be mimicked by other illnesses. To add to that, it is an episodic disease that can take months, or even years, to diagnose,” said **Gregory J. Basura, MD, PhD**, Chair of the Guideline Development Group (GDG). **Meredith E. Adams, MD**, and **Ashkan Monfared, MD**, served as Assistant Chairs, and **Seth R. Schwartz, MD, MPH**, served as Methodologist.

To improve the diagnostic workup and treatment outcomes for Ménière's disease, this clinical practice guideline (CPG) used the best available published scientific and/or clinical evidence to enhance diagnostic accuracy and appropriate therapeutic interventions (medical and surgical), while reducing unindicated diagnostic testing and/or imaging.

“The guideline aims to reduce the subjectivity of diagnosis and treatment for Ménière's disease and to provide some objective standards based on the literature available today,” said Dr. Basura. “This new CPG gives providers some optimal tools with which to make their clinical decisions.”

The guideline discusses the background on possible causes of Ménière's disease, disorders that present similarly to it, and the ways in which the disease can progress. Due to the variability in clinical presentation in patients with definite

and probable Ménière's disease, it is important to note that it may take many months to make a full and accurate diagnosis of the disease.

Ménière's disease is almost exclusively reported in adults, with less than three percent of cases estimated to occur in children younger than 18 years. The disease is most prevalent between ages 40 to 60 years, with peak onset in the 40s and 50s. In many patients, the most detrimental decline in hearing and balance function occurs within the first decade of diagnosis, yet patients continue to have long-standing deficits that make Ménière's disease a chronic disease.

Guideline Key Action Statements (KAS)

KAS1: Diagnosis of Ménière's Disease (recommendation)

Clinicians should diagnose definite or probable Ménière's disease in patients presenting with two or more episodes of vertigo lasting 20 minutes to 12 hours (definite) or up to 24 hours (probable) and fluctuating or non-fluctuating sensorineural hearing loss, tinnitus, or pressure in the affected ear, when these symptoms are not better accounted for by another disorder.

KAS2: Assessing for Vestibular Migraine (recommendation)

Clinicians should determine if patients meet diagnostic criteria for vestibular migraine when assessing for Ménière's disease.

KAS3: Audiometric Testing (strong recommendation)

Clinicians should obtain an audiogram when assessing a patient for the diagnosis of Ménière's disease.

KAS4: Utility of Imaging (option)

Clinicians may offer magnetic resonance imaging (MRI) of the internal auditory canal (IAC) and posterior fossa in patients with possible Ménière's disease and audiometrically verified asymmetric sensorineural hearing loss.

KAS5: Vestibular or Electrophysiologic Testing (recommendation against)

Clinicians should not routinely order vestibular function testing or electrocochleography to establish the diagnosis of Ménière's disease.

KAS6: Patient Education (recommendation)

Clinicians should educate patients with Ménière's disease about the natural history, measures for symptom control, treatment options, and outcomes.

KAS7: Symptomatic Management of Vertigo (recommendation)

Clinicians should offer a limited course of vestibular suppressants to patients with Ménière's disease for management of vertigo only during Ménière's disease attacks.

KAS8: Symptom Reduction and Prevention (recommendation)

Clinicians should educate patients with Ménière's disease on dietary and lifestyle modifications that may reduce or prevent symptoms.

KAS9: Oral Pharmacotherapy for Maintenance (option)

Clinicians may offer diuretics and/or betahistine for maintenance therapy to reduce symptoms or prevent Ménière's disease attacks.

KAS10: Positive Pressure Therapy (recommendation against)

Clinicians should not prescribe positive pressure therapy for patients with Ménière's disease.

KAS11: Intratympanic Steroid Therapy (option)

Clinicians may offer, or refer to a clinician who can offer, intratympanic (IT) steroids to patients with active Ménière's disease not responsive to noninvasive treatment.

KAS12: Intratympanic Gentamicin Therapy (recommendation)

Clinicians should offer, or refer to a clinician who can offer, intratympanic (IT) gentamicin to patients with active Ménière's disease not responsive to non-ablative therapy.

KAS13: Surgical Ablative Therapy (recommendation)

Clinicians may offer, or refer to a clinician who may offer, labyrinthectomy in patients with active Ménière's disease who have failed less definitive therapy and have non-usable hearing.

KAS14a: Role of Vestibular Therapy for Chronic Imbalance (recommendation)

Clinicians should offer vestibular rehabilitation/physical therapy for Ménière's disease patients with chronic imbalance.

KAS14b: Role of Vestibular Therapy for Acute Vertigo (recommendation against)

Clinicians should not recommend vestibular rehabilitation/physical therapy for managing acute vertigo attacks in patients with Ménière's disease.

KAS15: Counseling for Amplification and Hearing Assistive Technology (recommendation)

Clinicians should counsel patients, or refer to a clinician who can counsel patients, with Ménière's disease and hearing loss on the use of amplification and hearing assistive technology.

KAS16: Patient Outcomes (recommendation)

Clinicians should document resolution, improvement, or worsening of vertigo, tinnitus, and hearing loss and any change in quality of life in patients with Ménière's disease after treatment.

The GDG consisted of 21 members who represented experts in advanced practice nursing, audiology, consumer advocacy, emergency medicine, family medicine, otolaryngology, otology and neurotology, otolaryngic allergy, neuroradiology, and neurology.

The CPG is intended for all healthcare providers in any setting who are likely to encounter, diagnose, treat, and/or monitor patients with suspected Ménière's disease. This includes emergency medicine, primary care, otolaryngology, neurology, audiology, and physical/vestibular therapy. The target patient for the guideline is anyone 18 years of age or older who has a suspected diagnosis of definite or probable Ménière's disease.

The Ménière's disease CPG was created using the methods listed in Rosenfeld RM, Shiffman RN, and Robertson P. Clinical Practice Guideline Development Manual, Third Edition: A Quality-Driven Approach for Translating Evidence Into Action. *Otolaryngol Head Neck Surg*. 2013;148(1S):S1-S55. doi:10.1177/0194599812467004 (<https://journals.sagepub.com/doi/full/10.1177/0194599812467004>)

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

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Society (ANS), American Otological Society (AOS), American Speech-Language Hearing Association (ASHA), Society of Interventional Radiology (SIR), Society of Otorhinolaryngology Head-Neck Nurses (SOHN), The Triological Society, Vestibular Disorders Association (VeDA)

Affirmation of Value:

American Academy of Neurology (AAN)

Disclaimer:

This clinical practice guideline is not intended as an exhaustive source of guidance for managing patients with Ménière's disease. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands, and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates. These do not and should not purport to be a legal standard of care. The responsible physician, based on all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.



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/MDCPG

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

FREQUENTLY ASKED QUESTIONS (FAQS) ABOUT MÉNIÈRE'S DISEASE TRIGGERS

WHAT TRIGGERS WILL MAKE MY SYMPTOMS WORSE OR BRING ON A VERTIGO ATTACK?	Ménière's disease (MD) triggers are different from patient to patient. It is possible that you have one trigger, or you may have many. You may want to keep a food and activity diary. This can help you find what your triggers are.
IF I KNOW THAT SODIUM (SALT) IS A TRIGGER FOR ME, HOW MUCH CAN I CONSUME DAILY?	While there is no sodium (salt) recommendation specifically for patients with MD, the American Heart Association recommends an "ideal" limitation of 1500 mg and having no more than 2300 mg. [†]
I HAVE A HIGH STRESS JOB/LIFE AND IT MAKES MY SYMPTOMS WORSE. HOW CAN I AVOID STRESS?	<p>Stress can play a role in making MD symptoms worse. It is hard to live a stress-free life; however, there are many things you can do to manage stress. A few things you can do are:</p> <ul style="list-style-type: none">● get adequate sleep and exercise● meditate● join support groups● avoid natural depressants like alcohol and drugs
IS THERE A SPECIAL DIET I SHOULD FOLLOW TO AVOID AN ATTACK?	<p>Diet may not affect everyone the same way. However, having too much sodium (salt) in your diet can increase fluid in the inner ear. Reading food labels can help you keep track and avoid having too much sodium. Foods that are naturally low in sodium include:</p> <ul style="list-style-type: none">● fresh fruits and vegetables● whole food (not processed)● fresh beef, poultry, and fish <p>Also, having too much caffeine has been known in some people to trigger an attack. However, caffeine does not affect everyone.</p>

[†] Cogswell ME, Zhang Z, Carriquiry AL, et al. Sodium and potassium intakes among US adults: NHANES 2003-2008. *Am J Clin Nutr*. 2012;96(3):647-657.

SOURCE: Basura GJ, Adams ME, Monfared A, et al. Clinical practice guideline: ménière's disease. *Otolaryngol Head Neck Surg*. 2020;162(2_Suppl):S1-S55.

ABOUT THE AAO-HNS/F

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

FREQUENTLY ASKED QUESTIONS (FAQS) ABOUT MÉNIÈRE'S DISEASE TRIGGERS

WHAT LIFESTYLE CHANGES CAN I MAKE TO HELP PREVENT SYMPTOMS?

Living a healthy lifestyle and developing coping methods is a great practice to maintain good health. It may also help to control symptoms of MD. Examples of lifestyle changes are:

- Limit salt in your diet
- Avoid too much caffeine, alcohol, and nicotine
- Eat well-balanced meals throughout the day
- Drink plenty of water throughout the day, avoiding drinks with lots of sugar
- Manage stress appropriately
 - get plenty of exercise
 - get enough sleep
 - join a support group
 - journal
 - practice breathing exercises
- Identify and manage any allergies
- Get tested for sleep apnea if you have increased attacks of vertigo

SOURCE: Basura GJ, Adams ME, Monfared A, et al. Clinical practice guideline: ménière's disease. *Otolaryngol Head Neck Surg.* 2020;162(2_Suppl):S1-S55.



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ABOUT THE AAO-HNS/F

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.

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Stil Kountakis, MD, PhD
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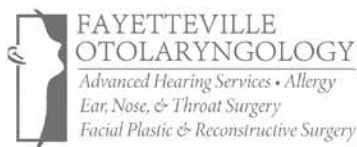
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Icahn School of Medicine at Mount Sinai
Department of Otolaryngology – Head and Neck Surgery

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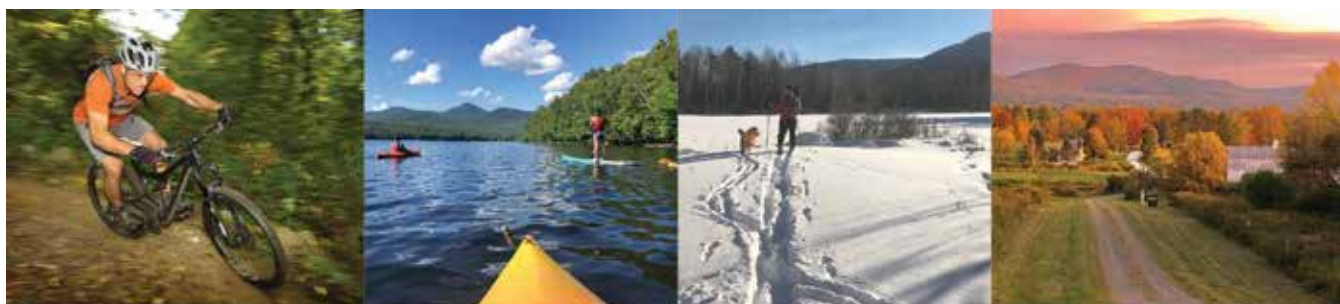
PLEASE SEND INQUIRIES AND CURRICULUM VITAE TO:

Eric M. Genden, MD

Professor and Chair,
Icahn School of Medicine at Mount Sinai
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David Goldenberg, MD, FACS, Chair, Department of Otolaryngology – Head and Neck Surgery c/o Ashley Nippert, Physician Recruiter
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David Goldenberg, MD, FACS, Chair, Department of Otolaryngology – Head and Neck Surgery c/o Ashley Nippert, Physician Recruiter
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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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The successful candidate will provide leadership and expertise in developing and advancing collaborative relationships among the medical team, will promote alignment, and shared accountability between physicians, the Hospital, and the overall system for the benefit of patients, providers, and the community. The successful candidate will serve as a liaison and advocate building long-term collaborations and relationships will also have a significant role in partnering with the members of the executive leadership team. In addition, the successful candidate will have an academic appointment at the Zucker School of Medicine at Hofstra/Northwell.

Lenox Hill Hospital is a 450-bed, acute care hospital located on Manhattan's Upper East Side. Relocation to the Greater New York City area is required for this role.

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It is the policy of Northwell Health to provide equal employment opportunity and treat all employees equally regardless of age, race, creed/religion, color, national origin, alienage or citizenship status, sexual orientation, military or veteran status, sex/gender, gender identity, gender expression, disability, generic information or genetic predisposition or carrier status, marital status, partnership status, victim of domestic violence, or other characteristics protected by applicable law. Northwell Health leaders, including the CEO, are committed to the principles of Equal Employment Opportunity and Affirmative Action.

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