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

FEBRUARY 2021

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bulletin

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CALL FOR PAPERS:

NOW OPEN

Otolaryngology–Head and Neck Surgery is Seeking Papers Relevant to

DIVERSITY, EQUITY, AND INCLUSION IN OTOLARYNGOLOGY-HEAD AND NECK SURGERY

for a Themed Issue to be Published in Summer 2022

Relevant topics for consideration include:

- Social Determinants of Health
- Diversity, Equity, and Inclusion in Medical Education
- Health Disparities in Vulnerable Populations
- Development of a Diverse Workforce in Otolaryngology-Head and Neck Surgery
- Health Policy and Inequality
- Promoting and Facilitating Diversity in Leadership
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- Economic Drivers of Healthcare and Their Implications
- Ethical Implications of Inequity in Health and Society

Submit papers for the themed issue at

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If you have any questions, please contact the Editorial Office at **otomanager@entnet.org**.

AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY FOUNDATION®

Diversity, Equity, and Inclusion in Otolaryngology: Our Pathway to the Future

"In diversity there is beauty and there is strength."

– Maya Angelou
Poet, author, and civil rights activist

I am a fierce advocate of diversity, equity, and inclusion. I believe that every individual should have an opportunity to feel valued and to thrive. In addition, I believe that all should have access to high-quality, safe, and compassionate ear, nose, and throat care.

Similarly, the American Academy of Otolaryngology–Head and Neck Surgery strives to serve as a positive example of inclusive excellence, where all our members have the opportunity to thrive. We strive for a workforce that has parallel diversity to the communities we serve. We aspire to overcome healthcare disparities such that we can provide high-quality, equitable care to all. These are our aspirational goals.

We know that significant health disparities exist. Many scholarly articles have been written about the benefit of a diverse healthcare workforce to reduce healthcare disparities. The Ohio State Diversity, Equity, and Inclusion web page sums it up very nicely: "A diversity of cultures and life experiences strengthens our mission to provide evidence-based health care. It gives us a greater understanding and appreciation for each patient's unique genetic makeup, behavior, experiences and beliefs."

We know that the work ahead of us matters, and this work will require us to devote our talents, resources, and creativity to make a meaningful difference. I encourage you to explore the opportunities to make a difference by contributing to 125th anniversary fundraising initiative, 125 Strong Campaign. I am very grateful for our dedicated volunteers who worked to develop worthy projects. All of these initiatives are very worthy of your investment and all will make a huge impact on the future of our Academy. *(See page 7 for more detailed information about the specific projects of the 125 Strong Campaign.)*

I do want to highlight the initiatives put forward by the work group led by **Dr. Angela Powell** on Diversity, Equity, and Inclusion. These projects will deploy travel grants to address the pipeline and the Core Grant mechanism to do high-quality research on health equity outcomes in otolaryngology.

As we reflect upon the importance of diversity, equity, and inclusion to our Academy and the communities we serve, I encourage you to take a few moments to commemorate the legacy of Martin Luther King, Jr., and his "I Have a Dream" speech. We are still pursuing the dream that he described so beautifully and eloquently on August 28, 1963. Let us work together to make this dream a reality. ■

Carol R. Bradford, MD, MS
AAO-HNS/F President

> We strive for a workforce that has parallel diversity to the communities we serve. We aspire to overcome healthcare disparities such that we can provide high-quality, equitable care to all. These are our aspirational goals.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION®

CALL FOR APPLICANTS

AAO-HNS/F Seeks:

Chair of Ethics Committee

The incoming Chair of the Ethics Committee would serve from October 1, 2022, for four years with a possible two-year extension at the discretion of the Executive Committee. Prior to assuming the role of Chair, they would serve one year as Chair-elect.

The Ethics Committee Chair serves as an ex-officio non-voting member of the Board of Directors (BOD) and the Nominating Committee.

The Ethics Committee assists the BOD in its oversight responsibilities with respect to:

- development and enforcement of the Code for Interactions with Companies and the Code of Ethics;
- the management of potential conflicts of interest;
- the oversight of policy recommendations regarding ethical issues to the BOD for its action; and
- upholding the procedural guidelines for the AAO-HNS disciplinary proceedings.

For more information about the position, visit www.entnet.org/applicants.

Interested candidates should submit a CV and cover letter to Kathy Lewis, Ethics Committee staff liaison, at klewis@entnet.org by March 1, 2021, 5:00 pm (ET).

AAO-HNSF Seeks:

Coordinator for Research and Quality

The incoming Coordinator for Research and Quality would serve from October 1, 2022, for four years. Prior to assuming the role of Coordinator, they would serve one year as Coordinator-elect.

This position coordinates the research and quality efforts of the Foundation with particular attention to oversight of research and evidence-based activities that improve care, including the development and maintenance of Reg-ent[SM]; quality measure development; treatment effectiveness and outcomes efficiency; patient safety; and activities that provide members with education and opportunities to improve performance in practice and translate research.

Specific duties include facilitating Foundation research and quality/patient safety efforts through input from the Reg-ent Executive Committee and relevant content committees. This includes oversight of Reg-ent; clinical practice guideline and quality measure development; surveys; clinical and outcomes research; CORE grant program; and more.

For more information about the position, visit www.entnet.org/applicants.

Interested candidates should submit a CV and cover letter to Jean Brereton at jbrereton@entnet.org by March 1, 2021, 5:00 pm (ET).

AAO-HNSF Seeks:

Editor in Chief for *Otolaryngology–Head and Neck Surgery* and *OTO Open*

The Editor in Chief of the Foundation's scientific publications would serve from October 1, 2022, for four years. Prior to assuming the role of Editor in Chief, they would serve one year shadowing the current Editor in Chief.

The incoming Editor in Chief is responsible for the scientific content of the journals, maintaining and enhancing the journals' high standards for authoritative, innovative, and top-quality research. In addition, they monitor and ensure the fairness, timeliness, and thoroughness of the peer-review editorial process; implement practices and assess manuscripts for conflict of interest, in accordance with Federal standards and with policies of the Committee on Publication Ethics and the International Committee of Medical Journal Editors; identify emerging areas of importance; set strategic editorial goals in consultation with the publisher and the AAO-HNSF Board, and more.

For more information about the position, visit www.entnet.org/applicants.

Interested candidates should submit a CV and cover letter to Tina Maggio at tmaggio@entnet.org by March 1, 2021, 5:00 pm (ET).

APPLICATIONS ARE DUE MARCH 1, 2021, 5:00 PM (ET)

For more information, please visit: www.entnet.org/applicants

Strategic Priorities and Planning to Benefit Members and Your Patients

As we emerge from the pandemic and vaccination becomes widespread, otolaryngologists along with the entire medical community look forward to being able to provide the full spectrum of care they are used to furnishing. There are a number of indications that 2021 will be a very active year in terms of healthcare delivery overall as well as individual segments of the healthcare system that will have long-term impact on otolaryngologists in all types and locations of practice. The Academy will be ready to make meaningful contributions in all areas as opportunities arise. We are in the process of identifying matters of the greatest importance that will provide the most benefit for our members and their patients through the strategic planning and budgeting process. We have received considerable input from both internal and external stakeholders representing the full spectrum of the otolaryngology community, which included over 100 participants. The strategic plan and budget will be finalized at the Board of Directors meeting in April.

Simultaneously with the strategic planning process, extensive work was done to prepare the 125th anniversary fundraising initiative, 125 Strong Campaign. President **Carol R. Bradford, MD, MS,** chose, and the Executive Committee approved, four areas of focus for this campaign, each with a dedicated committee. These include Diversity, Equity, and Inclusion; Education; Leadership Development and Mentorship; and Wellness. The chair from each of these respective committees submitted their recommendations for specific projects within their area to the Executive Committee. Following extensive discussion on these recommended projects, the Executive Committee prioritized the projects for funding donations. Members and other friends of the organization will be able to donate specifically to the projects they support. All contributions will be spent as designated on these projects and not used to fund reserves. The selected projects will not be funded through the budget but will be dependent on philanthropic support. For complete details of the campaign, please see the article on page 7 of this month's *Bulletin.*

After months of discussion and negotiation, an additional COVID-19 relief package was recently passed by Congress and signed by the president. This included a "Surprise Billing" component that did include Independent Dispute Resolution (IDR) and several other beneficial components—although there are still some areas of concern. It apparently will take a year for the final rules related to the IDR process to be put into place. Additionally, concerns of cutting Medicare reimbursement to any portion of the medical community that had responded heroically during the COVID-19 pandemic led Congress through a series of maneuvers that mitigated most of the negative update related to the large increases given to E/M values. While Congress did not waive the "budget neutrality" attached to the Medicare budget, it did infuse $3.75 billion additional funding and put the CPT code G2211 into a three-year moratorium and waived sequestration through March 2021. This offset roughly two-thirds of the cuts that were planned. This is a one-year fix, and nothing was done to address the continuing devaluation of surgical procedures. There is also a provision in this bill for another round of Paycheck Protection Program loans that will be available for both 501(c)3 and 501(c)6 organizations. This will allow the AAO-HNS/F to apply for loans based on both Academy and Foundation expenses. This bill also included a wider range of costs that can be used to calculate the loan amount including practice expenses related to COVID-19 personal protective equipment costs. These loans should be accessible to most of our practitioners not employed by a large entity.

The Academy, in collaboration with the Society of University Otolaryngologists Head & Neck Surgeons (SUO), the Otolaryngology Program Directors Organization (OPDO), and multiple medical associations, will be studying the effects of virtual interviews on the residency and fellowship selection process from the candidate's and program's perspective through a survey process that will involve both surgical and medical-based specialties. Data will be gathered from both groups about the selection process and followed up after the candidates have joined their respective residency and fellowship programs to evaluate the reality of their expectations after the interview process. This data will help direct the future utilization of virtual strategies in this process.

I want to congratulate **Duane J. Taylor, MD,** on presiding over our first virtual Nominating Committee meeting and the members of the committee for recruiting an excellent group of candidates to choose from. I also want to thank and applaud those members willing to serve in leadership positions at a time so critical in medical history. I encourage all members to become familiar with each candidate and vote in our election, which will open in May. ■

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

> The Academy will be ready to make meaningful contributions in all areas as opportunities arise. We are in the process of identifying matters of the greatest importance that will provide the most benefit for our members and their patients through the strategic planning and budgeting process.

In Memoriam: **Reginald F. Baugh, MD**

Reginald F. Baugh, MD, dedicated his life's work to advancing the field of otolaryngology. His reach was far and wide as a physician, mentor, published author, colleague, collaborator, and more. His undoubtable passion and tireless pursuit for quality, patient care, and education was contagious and will have a long-lasting impact on the countless lives who crossed his path throughout his remarkable career.

"Reggie embodied dedication, leadership, brilliance, and determination throughout his life. He served as an inspirational role model to many. I am grateful that I had the privilege and honor of knowing him," shared **Carol R. Bradford, MD, MS,** AAO-HNS/F President.

Neal S. Beckford, MD, who was a friend and colleague of Dr. Baugh's for over 35 years, remembered him as, "The model of a modern-day Renaissance man. With humble beginnings in North Dakota and Oregon, Reggie was a student athlete, excelling at academics, while always demonstrating a commitment to serve the 'least amongst us.'"

On the day of Dr. Baugh's passing, Dr. Bradford and **Duane J. Taylor, MD,** AAO-HNS/F Immediate Past President, were on a podcast discussing, "Prioritizing Diversity in Otolaryngology-Head and Neck Surgery: Starting a Conversation,"[1] a paper that Dr. Baugh had co-authored. "One of Dr. Baugh's many notable achievements in his remarkable career was, in fact, in helping us all prioritize diversity in our specialty," shared Dr. Bradford.

Dr. Beckford elaborated on that sentiment. "An innate sense of equity and fairness fostered his unapologetic passion for the parity of underrepresented minorities in healthcare. As a major contributing member of The Barnes Society, working with university admissions committees and diversity initiatives, and putting forth efforts in his church and community, Reggie mentored and inspired many young and aspiring students from all walks of life. A devoted husband, father, colleague, and friend whose abundant faith and humility guided all aspects of his life, he will be sorely missed."

The AAO-HNS/F was the honored recipient of his volunteerism. Dr. Baugh dedicated his time, expertise, and diplomacy to advancing the AAO-HNSF's clinical practice guidelines CPGs—specifically, his leadership led to the development of the Tonsillectomy CPG in 2011 and the Bell's Palsy CPG in 2013, both of which he served as chair, as well as the Benign Paroxysmal Positional Vertigo CPG in 2008 when he served as assistant chair.

For this work and countless other contributions, Dr. Baugh received the Presidential Citation in 2014 by AAO-HNS/F Past President **Richard W. Waguespack, MD.**[2] Upon receiving this recognition during the AAO-HNSF 2014 Annual Meeting & OTO Experience, Dr. Baugh noted in a press announcement from the University of Toledo College of Medicine, "Whether they recognized me or not, I would have done the same thing if I had to do it all over again. But it was nice to be recognized. It was very humbling."[3]

This is the attitude that Dr. Baugh exuded throughout his career—working to improve the field of otolaryngology, not for recognition and attributes, but for effecting progress via research, education, and mentorship with a laser focus on expanding opportunities for future generations of otolaryngologists.

"Reggie sought to use his gifts of intellect, curiosity, personal integrity, and an industrious nature to teach others and contribute to the body of knowledge in otolaryngology. His proclivity for organization and pragmatism enabled him to excel in healthcare administration, holding senior positions at a young age," said Dr. Beckford.

Dr. Baugh was a professor and chief of the Department of Surgery, Division of Otolaryngology, at University of Toledo College of Medicine. During his career, he held leadership roles in several hospital systems, including the University of Kansas and the Kansas City Veteran's Medical Center as the chief of otolaryngology; Kaiser Permanente of MidAmerica where he served as chief of otolaryngology and assistant

medical director for resource improvement; the Henry Ford Health System, where he served as medical director of clinical services; CIGNA, where he was one of six national vice presidents and senior medical directors; and Texas A&M University of Health Sciences Center, College of Medicine, as professor and chief of otolaryngology and vice chair of the Department of Surgery.[4]

Dr. Baugh lectured on a variety of topics in otolaryngology both nationally and internationally and had over 70 publications, presentations, and book chapters. He also served on the AAO-HNS/F Voice and Patient Safety and Quality Improvement Committees and on the Editorial Board of *Otolaryngology–Head and Neck Surgery.* Dr. Baugh earned his medical degree and completed his otolaryngology residency at the University of Michigan, Ann Arbor.

Reginald F. Baugh, MD, has left an indelible mark on society and the specialty. The breadth of his legacy will continue to radiate throughout otolaryngology-head and neck surgery, and his countless contributions and inspirational passion to education, quality, and patient care will thrive in current and future practice. He passed away on January 21, 2021. ■

References

1. https://journals.sagepub.com/doi/10.1177/0194599820960722
2. https://bulletin.entnet.org/article/annual-meeting-updates-2014-presidential-citations-reginald-f-baugh-md/
3. https://news.utoledo.edu/index.php/11_25_2014/professor-receives-presidential-citation
4. https://us.sagepub.com/en-us/nam/author/baugh-reginald

SHAPING OUR FUTURE TOGETHER
125 STRONG CAMPAIGN

#MakeOTOStronger: Become a Monthly Supporter of the 125 Strong Campaign

This year the AAO-HNS/F is celebrating its 125th anniversary as a specialty organization. As we reflect on the past 125 years, we're also looking ahead to continue shaping our future together.

Ensuring the AAO-HNSF raises the funds needed to complement our existing programs is a major component of shaping the specialty's next 125 years and beyond. The 125 Strong Campaign is a fundraising effort designed and driven by practicing otolaryngologists and will provide funds for programs for otolaryngologists locally, regionally, nationally, and internationally.

We are asking every member to contribute to the 125 Strong Campaign to help reach our goal of raising $5 million over the next two years. We are starting off with a small ask—requesting each member to become a monthly supporter of the 125 Strong Campaign. **By donating $12.50 per month ($150 per year), you will #MakeOTOStronger and will help us reach our goal.** Make your donation today by visiting www.entnet.org/125strong.

"Your gift will help us drive transformation and innovation, expand and magnify our programs, and collectively partner for the health and well-being of our members and those that we serve," says **Carol R. Bradford, MD, MS,** AAO-HNS/F President.

Under the leadership of Dr. Bradford, the Board of Directors has approved the following four general program areas that will be supported by the 125 Strong Campaign:

Diversity, Equity, and Inclusion

- Increase funding for underrepresented minorities' travel grants to the AAO-HNSF Annual Meeting & OTO Experience and for their otolaryngology residency away rotations
- Establish a CORE grant to study healthcare disparities and social determinants of health in otolaryngology

Education

- Develop augmented reality/virtual reality and otolaryngology gaming learning tools

Leadership Development and Mentorship

Establish education webinars and video materials in the following three areas:

- How to Get in the Game: specifically directed for residents and fellows-in-training, but suitable for all stages of career
- How to Thrive and Prosper: specifically directed for young staff and junior faculty, but also will be valuable to members of all age groups and practice types
- What Next?: specifically focused on mid- or senior-career individuals interested in leadership positions at academic centers, hospital systems, or local medical associations and would include information on end-of-career planning

Wellness

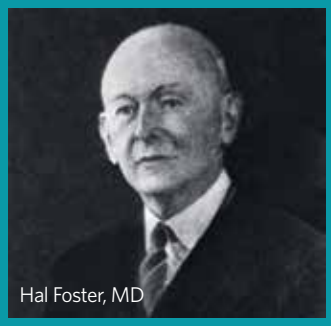
- Create and keep current a catalog of wellness and resiliency resources available for members
- Develop a "Wellness Certificate Program" that provides education and training for members to increase their expertise and knowledge of wellness that can then be implemented locally and shared with colleagues
- Create "AAO-HNS Wellness Ambassadors" composed of "Wellness Certificate Program" graduates and other volunteers who would help establish peer support networks and activities at the AAO-HNSF Annual Meeting & OTO Experience designed to increase wellness and track wellness offerings available

We extend a special thank you to two Past Presidents, **Sujana S. Chandrasekhar, MD,** and **Albert L. Merati, MD,** who are the co-chairs of the 125 Strong Campaign, and to the leaders of the four projects: Diversity, Equity, and Inclusion, **Angela M. Powell, MD**; Education, **Richard V. Smith, MD**; Leadership Development and Mentorship, **Kathleen L. Yaremchuk, MD, MSA**; and Wellness, **Dana M. Thompson, MD, MS.**

Show your support for the 125 Strong Campaign on social media by tagging @AAOHNS on Facebook, Twitter, or Instagram and using both of the following two hashtags:

- #WeAre125 celebrates the AAO-HNS/F's 125th anniversary
- #MakeOTOStronger encourages others to donate to this critical campaign ■

milestone moments



Hal Foster, MD

April 9-10, 1896

In response to an invitation by **Hal Foster, MD,** a group of practicing ophthalmologists and otolaryngologists gathered in Kansas City, Missouri. A two-day program of scientific papers was held followed by the formation of a new society, the **Western Association of Ophthalmologists, Otologists, and Laryngologists.**

1898

Name changed to **Western Ophthalmologic and Oto-Laryngologic Association**

1903

Name changed to the **American Academy of Ophthalmology and Otolaryngology**

2019 SIM Tank Winners (L-R): Justin R. Shinn, MD (third place); Fanny Gabrysz-Forget, MD (first place); and Tulio A. Valdez, MD (second place).

Call for Simulation Abstracts: Deadline March 1

Do you have an innovative simulator model or simulation activity that you would like to share with the otolaryngology community? The Academy is now accepting proposals to be considered for presentation at the Simulation Showcase held during the AAO-HNSF 2021 Annual Meeting & OTO Experience in Los Angeles, California. The top three proposals selected will present and compete at SIM Tank. Both events will be held Monday, October 4. The deadline for submissions is March 1. ■

HUMANITARIAN TRAVEL GRANT

Medical Mission in Mongolia

Zahrah M. Taufique, MD, traveled in May 2020, with the New York University (NYU) Department of Otolaryngology to Ulaanbaatar, Mongolia, for a humanitarian mission with physicians **Theresa Tuyet-Phuong N. Tran, MD,** and **Adam S. Jacobson, MD,** microvascular fellow **Jason L. Yu, MD,** and a team composed of a physician assistant and operating room nurses. The group traveled with the Virtue Foundation, a nonprofit organization that has been sending surgeons to Mongolia for over a decade.

There were two hospitals in Ulaanbaatar where the group attended clinic and operated: the military hospital and the National Cancer Center. Though team members performed a variety of surgeries ranging from rhinoplasties to oncologic resections, they discovered there was a great need for education on reconstructive techniques for oncologic, traumatic, and iatrogenic defects. Specifically, microvascular reconstruction is a relatively new field in Mongolia. The only hospital in Mongolia currently performing free flaps is the National Cancer Center, where the first free flap was performed about 10 years ago. Still, the demand for free flap reconstructive expertise is high, and the surgeons performing these surgeries were eager to learn from the NYU group throughout the week.

"By the end of the week, it was clear that a strong partnership developed between the American and local surgical teams, and there is ongoing discussion on how to continue this educational relationship in the future," said Dr. Taufique. ■

READ MORE ONLINE
Longer article available

ECS
Pediatric Drug-Induced Sleep Endoscopy

NEW! Expert Consensus Statement: Pediatric Drug-Induced Sleep Endoscopy

The new Expert Consensus Statement (ECS): Pediatric Drug-Induced Sleep Endoscopy (DISE) was published online in *Otolaryngology–Head and Neck Surgery* on January 5. **Cristina M. Baldassari, MD,** chaired the ECS development panel, which comprised a panel of content experts on pediatric DISE. The purpose of the ECS is to identify areas of consensus regarding the appropriate indications, perioperative protocols, and interpretation of DISE in children 0-18 years of age. The primary aim was to develop statements that would address areas of controversy with the goal of reducing practice variation and improving the quality of care for pediatric obstructive sleep apnea patients.

The panel was able to reach consensus on 26 statements after two iterative Delphi method surveys. An additional 11 statements failed to achieve consensus. The statements were grouped into the following categories: indications, protocol, optimal sedation, grading and interpretation, complications and safety, and outcomes for DISE-directed surgery.

Areas where knowledge gaps and lack of evidence exist identified opportunities for future research. In the meantime, clinicians can use these statements to improve quality of care, inform policy and protocols, and identify areas of uncertainty.

The AAO-HNSF recognizes the valuable contributions made by Dr. Baldassari and the panel in the development of this new ECS.

Read ECS: Pediatric DISE now by visiting **https://journals.sagepub.com/doi/full/10.1177/0194599820985000.** ■

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WORLD HEARING DAY: Hearing Care for All

The World Health Organization founded World Hearing Day to raise awareness on how to prevent deafness and hearing loss and promote ear and hearing care throughout the world. World Hearing Day is observed annually on March 3.

Looking for materials to share with your patients? **ENThealth.org** is a dynamic patient health website. It's a consumer-facing online resource for patient-centered otolaryngology-head and neck surgery information with extensive information on hearing-related conditions and treatments as well as wellness and prevention articles.

AAO-HNS/F
HONORARY AWARDS, LECTURESHIPS & GRANTS

2021 Call for AAO-HNS/F Awards and Lectures Nominees

Online applications are being accepted for the Academy's various recognitions of outstanding physicians, committees, and societies that have gone above and beyond this past year. Visit www.entnet.org/content/awards-lectureships-grants for additional information on each award and lecture, including past recipients, submission criteria, and how to nominate a deserving physician, committee, or society. The application deadline for all awards is **March 15,** except for the Nikhil J. Bhatt, MD International Humanitarian Award, Nikhil J. Bhatt, MD International Public Service Award, and Distinguished Award for Humanitarian Service, which is **April 15.**

Awards

- AAO-HNS/F Committee Excellence Award
- BOG Model Society Award
- BOG Practitioner Excellence Award
- Distinguished Award for Humanitarian Service
- Jerome C. Goldstein, MD Public Service Award
- Nikhil J. Bhatt, MD International Humanitarian Award
- Nikhil J. Bhatt, MD International Public Service Award
- The Holt Leadership Award for Residents and Fellows-in-Training
- WIO Helen F. Krause, MD Trailblazer Award
- **NEW!** YPS IMPACT Award
- **NEW!** YPS Model Mentor Award

Lectures

- Eugene N. Myers, MD International Lecture on Head and Neck Cancer
- H. Bryan Neel, III MD, PhD Distinguished Research Lecture
- John Conley, MD Lecture on Medical Ethics

Questions about the awards or lectures? Email awards@entnet.org. ■

Is OTO in Your Future?

Is OTO in Your Future?, which was the AAO-HNS first student forum of 2021, introduced medical students to the field of otolaryngology. Moderated by **Gregory W. Randolph, MD,** AAO-HNS/F Past President, the panelists shared their experiences and passion and emphasized why they love what they do.

Over 1,230 students registered for the forum, with more than 750 students participating in real time and submitting over 200 questions to panelists **William R. Blythe, MD; Zainab Farzal, MD, MPH; Stacey T. Gray, MD; Sonya Malekzadeh, MD; Albert L. Merati, MD,** AAO-HNS/F Past President; **Angela M. Powell, MD;** and **Ken Yanagisawa, MD,** AAO-HNS/F President-Elect.

With experience in private practice, academia, and diverse subspecialties, the panelists discussed a range of topics, including their average daily activities, the types of surgeries they perform, the OTO residency application process and matching, women in otolaryngology, work-life considerations, underrepresented populations in medicine, fellowships, and Academy membership opportunities.

The webinar was recorded and is available on the medical student web page at www.entnet.org/content/medical-student-resources. ■

INTERNATIONAL ADVISORY BOARD

Call for IAB Chair-Elect Nominees

A 2021-2022 International Advisory Board IAB Chair-Elect will be elected at the AAO-HNSF 2021 Annual Meeting & OTO Experience in Los Angeles, California.

After serving a one-year term as Chair-Elect, the individual will then serve a one-year term as Chair and assumes duties as the leader and "voice" of the global otolaryngology community. Candidates must be active international (non-U.S.) members of the AAO-HNS and formally affiliated with the AAO-HNSF International Corresponding Societies network. Deadline for submission of the nominee application is April 1.

Please visit www.entnet.org/content/call-nominees-iab-chair-elect or contact international@entnet.org. ■

Women of Baylor College of Medicine Otolaryngology Head & Neck Surgery gather for WIO Day in March 2019.

WIO Day

WIO Day is designated annually on March 8, in recognition of the significant contributions and accomplishments of women otolaryngologists. In conjunction with International Women's Day, March 8 is a global day to celebrate the social, economic, cultural, and political achievements of women. Please share your news and photos of the many ways in which you celebrate WIO Day with your institution, colleagues, and community on ENTConnect. ■

WIO WOMEN IN OTOLARYNGOLOGY

Mentorship and Networking in the Era of COVID-19

Cecelia E. Schmalbach, MD, MSc
Chair, WIO Leadership Development and Mentorship Committee

Each year during the AAO-HNSF Annual Meeting, the WIO Leadership Development and Mentorship Committee hosts a networking event for members. When COVID-19 forced the meeting to go virtual in 2020, the committee pivoted to sustain this vital platform. Thanks to the support of **James C. Denneny III, MD,** AAO-HNS/F Executive Vice President and CEO, and WIO staff liaisons Pamela Gilbert and Elise Swinehart, a one-hour networking and mentorship virtual event was created to include two 15-minute breakout rooms. Women leaders and mentors from across North America volunteered to share their experiences (right). The virtual networking event was extremely well received with 109 registrants within the first 72 hours (28% mid-career, 27.5% early career, 22% residents, 12% late career, and 9% fellows). A breakdown of registrants by career level and topics of interest is illustrated in Figure 1.

Although nothing replaces physical presence, this virtual event provided a flexible and cost-effective venue to meet WIO members' needs across the country. Polling conducted between breakout sessions revealed that two-thirds of attendees would not have been able to participate if the event was hosted during the traditional in-person 6:00 am (ET) breakfast meeting. Polling also revealed that networking and mentorship is a strong desire of WIO members, with two-thirds of attendees requesting additional events beyond the Annual Meeting. A post-event debrief among the mentors identified common themes transcending breakout rooms, including how to get involved in the Academy, strategies for work-life balance, handling micro- and macroaggressions, and how to overcome unrealistic work expectations from your boss.

Senior WIO mentors during a virtual call.

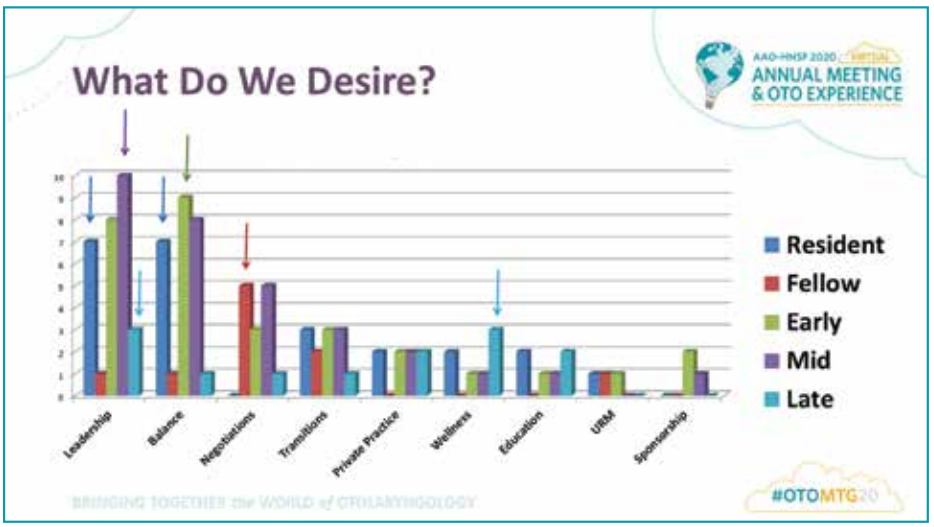

Figure 1. Breakout room topics of interest based on career level.

Feedback from this inaugural WIO virtual mentorship and networking event led to the establishment of small peer-mentoring groups to meet virtually throughout the year (26 members assigned to five communities based on career level). The committee is establishing a Virtual Leadership Library and will host an associated virtual book club in conjunction with the AAO-HNS/F 2021 Leadership Forum & BOG Spring Meeting. Given the high level of enthusiasm, WIO will continue networking via a series of virtual and interactive "Fireside Chats" and "Coffee Talks" to address common themes. While COVID-19 has been extremely disruptive, the pandemic afforded WIO the opportunity to expand its networking and mentorship program beyond a yearly breakfast meeting to better meet the needs of its members. ■

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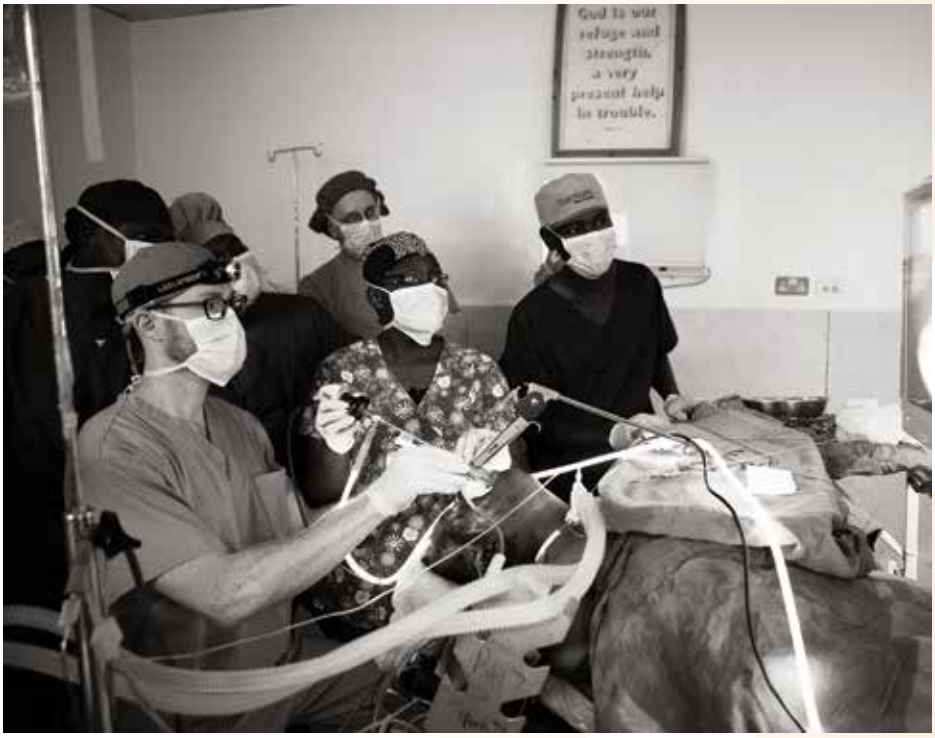
Spotlight: Humanitarian Efforts

David D. Nolen, MD

The AAO-HNSF International Affairs Program is pleased to spotlight the humanitarian efforts of **David D. Nolen, MD,** for his work with the AIC Kijabe Hospital and Serge Global.



Where do you currently practice, and what is your specialty area?

I work at AIC Kijabe Hospital, a mission hospital in Kenya. I specialize in facial plastic and reconstructive surgery, but I see and treat a wide variety of patients with various pathology and diseases of the head and neck.

What humanitarian efforts are you involved with currently?

I technically work for an organization called Serge Global, through which I can fundraise and work full time at no cost to the hospital. Over the past five years, my team and I have been working to develop a clinic that provides comprehensive care for patients and educates trainees. We work with otolaryngology residents from the national hospital and general surgery residents from the mission hospital.

How did you get started with humanitarian efforts?

During college, medical school, and residency, I spent time studying abroad in a few different countries doing research and participating in short-term medical trips. I really enjoyed experiencing different cultures and learning about different perspectives and ways of life, and I was also impacted by the need that I saw in various settings.

How does your work affect both the communities you serve and you individually?

The most obvious is that patients' lives can be directly impacted through patient care. I would like to think that I have had as much of an impact on others around me as my friends, patients, and colleagues here have had on me, but I know that is not true. I am often amazed at the warmth and consideration that people here have for total strangers.

What would you say to encourage others to support humanitarian efforts around the world?

If you are interested in serving in underserved or resource-constrained settings, then look for a reason to say yes and stick with it. ■

➲ READ MORE ONLINE
about Dr. Nolen's inspirations and passion for humanitarian efforts and ways to get involved.

pearls from your peers: Gaining Business Acumen for Practice Development

INTERVIEWEE

Ashli K. O'Rourke, MD, Medical University of South Carolina
Associate Professor
Director of Laryngology
Mark and Evelyn Trammell Endowed Chair in Otolaryngology

INTERVIEWER

Paul C. Bryson, MD, Cleveland Clinic Voice Center
Director, Cleveland Clinic Voice Center
Associate Professor of Otolaryngology-Head and Neck Surgery
Section Head, Laryngology
Surgical QIO - Enterprise ASCs, Surgical Operations
Head and Neck Institute

Ashli O'Rourke, MD, is the director of laryngology and holds the Evelyn Trammell Endowed Chair in Otolaryngology at the Medical University of South Carolina (MUSC). She originally trained and practiced as a speech-language pathologist before entering medical school. She completed her residency in otolaryngology-head and neck surgery at the University of Virginia, followed by a laryngology fellowship at the Medical College of Georgia. She has been with MUSC since 2012.

While Dr. O'Rourke is specialized in laryngology, this edition of Pearls from Your Peers, brought to you by the AAO-HNSF Education Committees, focuses on the rarely taught skills of practice development that may be useful to our readership. Dr. O'Rourke recently negotiated the creation of a new Voice and Swallowing Center that included additional staffing, space acquisition, and capital expenditures. In addition, she has operationalized advanced practice providers in a new funds-flow environment. Dr. O'Rourke spoke to me about her process of practice development, and following is an excerpt from our conversation.

"The development of our new center was a definite learning experience for me since I lack any formal business education. Although I knew that a new center would improve patient care, I had to be able to make this argument financially viable. As physicians, many of us are so busy in the trenches of clinical care that we do not think about all the behind-the-scenes financial operations that make the process happen. We may not ask ourselves: *Where does the money come from? What is my real overhead? What are we paying for staff salaries and benefits?* Successful business development depends on understanding revenue cycles, return on investment for capital expenditures, and monthly/ongoing operating budgets. Before this process, I had no idea how much it cost a month for my practice to function. After it, I can tell you how much we pay each month for saline vials or cotton balls. Financially successful practice development requires granularity and personal involvement.

"I started my journey by clearly defining what the center would be and creating a formal business plan. In crafting this it was important to understand the pathway early and build the partnerships and relationships needed to ask the right questions. I spoke with people from within the system informally to better understand trends within my organization. I took advantage of the expertise of hospital business analysts to teach me about proformas and understand my financial data, as well as review market projections and return on investment estimations. I learned to be flexible and critical of my own thinking as I digested the data. Understanding the costs and efficiencies led me to change my plan in some meaningful ways. I got better at telling my story and why it mattered.

"A **critical pearl** for success is to be prepared to appropriately present your business plan to others. Many of us have experience with public speaking, but the type of presentation required to relay a business strategy can be very different from our scientific podium presentations or didactic lectures. Your audience isn't fellow otolaryngologists but chief financial officers and other business-savvy individuals. I read many different sources, but a book I found particularly useful was *Thank You for Arguing* by Jay Heinrichs. It helped me think about understanding my audience and how to make others care about my vision and want to assist me reach my goal of a new Voice and Swallowing Center." ■

ADVOCACY IN ACTION

Report of the AMA House of Delegates Special Meeting

Douglas R. Myers, MD, Chair of the AAO-HNS Delegation to the AMA House of Delegates
Craig S. Derkay, MD, AAO-HNS Delegate to the AMA House of Delegates

The American Medical Association (AMA) held a virtual Special Meeting of the House of Delegates (HOD) from November 13-17, 2020, notably led by Speaker of the House, **Bruce A. Scott, MD,** an otolaryngologist. The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) was represented by **Douglas R. Myers, MD,** Delegation and Otolaryngology Section Council Chair; **Craig S. Derkay, MD,** Delegate; **Susan D. McCammon, MD,** Delegate; and **James C. Denneny III, MD,** AAO-HNS Executive Vice President and CEO, as Alternate Delegate. Due to the limitations inherent in conducting deliberations in a virtual environment, the resolutions submitted by the various delegations were screened by an appointed panel and selected for consideration on the basis of urgency. Three of the issues considered relevant to our specialty are highlighted below.

COVID-19 Federal Stimulus Programs

Federal financial relief for practices affected by the COVID-19 pandemic has been primarily directed to healthcare systems with minimal payments to physicians. Physician practices with few Medicare patients have received little or no assistance. The HOD passed policy, which was supported by the Academy, that calls on the AMA to advocate for the renewal and expansion of the Medicare Advance Payment Program, CARES Act, and Paycheck Protection Program, with increased payments for physicians, reduced interest rates, and lengthened repayment periods.

Telehealth Services

The Coronavirus Preparedness and Response Supplemental Appropriations Act waived certain Medicare telehealth payment requirements. The HOD passed policy, which was supported by the Academy, that calls for the AMA to facilitate the continuation of the current telehealth regulations post SARS-COV-2 in all locations, including patients' homes, and to advocate for continuing equitable payment for those services.

Insurance Preauthorization

Insurance companies with limited office hours inhibit patient care when preauthorization for urgent or emergent procedures is required at night or on weekends. The HOD passed policy, which was supported by the Academy, that calls for the AMA to advocate for all insurance companies that require preauthorization to maintain personnel on duty at all hours to process preauthorization requests.

The next meeting of the AMA HOD is scheduled to be held in Chicago, Illinois, in June. However, as the pandemic continues to affect in-person meeting attendance, this is subject to change. ■

MODELS OF OTOLARYNGOLOGY PRACTICE

Employment Dilemmas Stocked by COVID-19

Ken Yanagisawa, MD
AAO-HNS/F President-Elect
James C. Denneny III, MD
AAO-HNS/F Executive Vice President and CEO


Ken Yanagisawa, MD


James C. Denneny III, MD

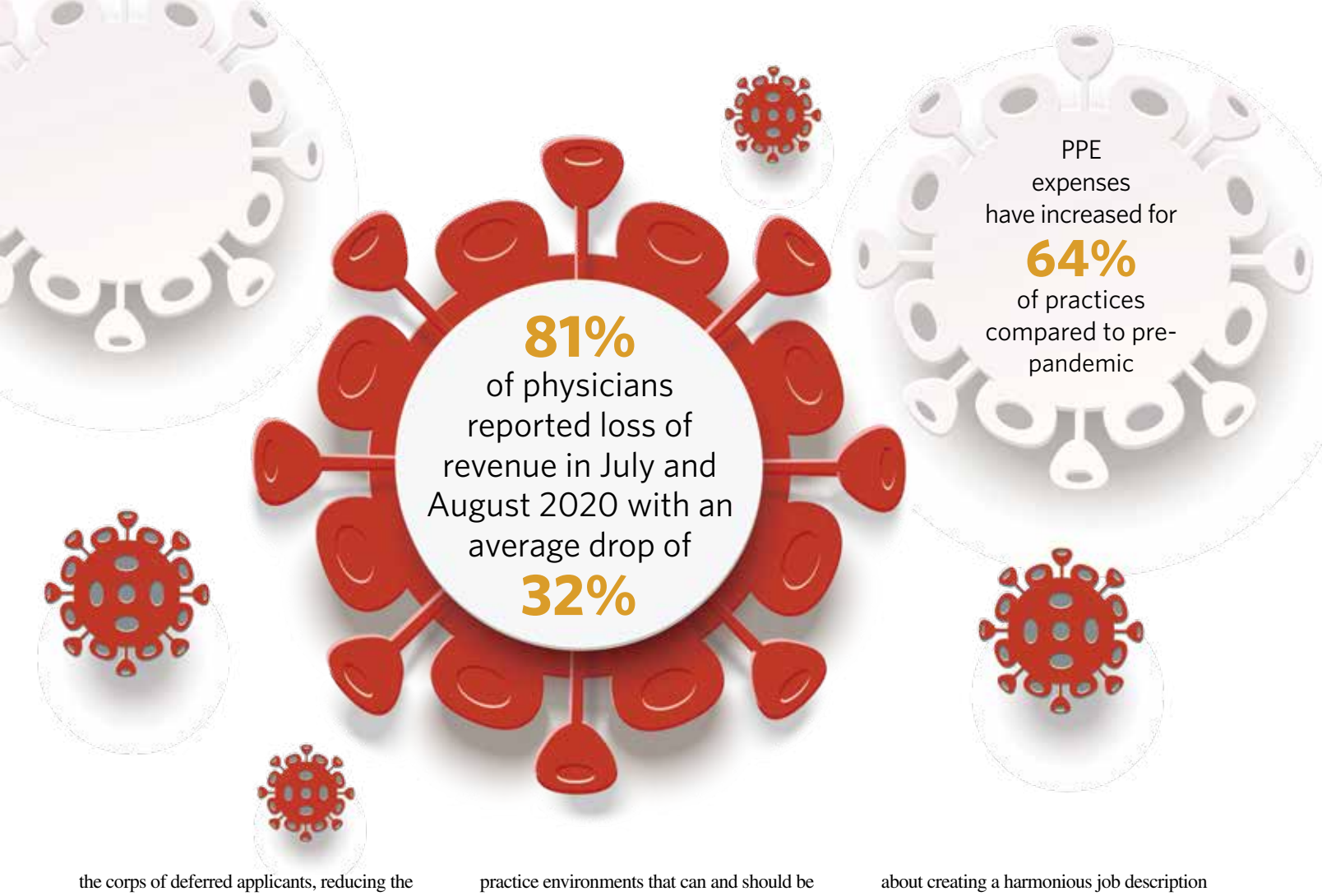
The COVID-19 pandemic has afflicted every person, every family, every medical practice, the entire healthcare industry, and the overall economic fabric of this nation and abroad. With shutdowns initially taking place in the spring of 2020, practices suffered enormous physical, emotional, and economic challenges necessitating a complete reconfiguration and overhaul of the normal workflows in our offices, hospitals, and surgery centers, including patient prescreens, office space modifications, protections for our staff, patients, and providers, and continuous cleaning and disinfecting of our office spaces, not to mention the personal health risks presented to ourselves and our staffs.

According to a recent American Medical Association (AMA) survey[1], 81% of physicians reported loss of revenue in July and August 2020 with an average drop of 32%. Patient volumes are dramatically decreased in many areas and capacities are limited due to the myriad safety measures required. Personal Protective Equipment (PPE) expenses have increased for 64% of practices compared to pre-pandemic, and the limited availability has led, at times, to price gouging behaviors that health centers and practices have had to endure and overcome.

Yet, we have managed to survive this onslaught, and as we have all learned how to practice as safely as possible in this new environment, practices are gradually rebuilding and rebounding, and patients are increasingly seeking in-person medical care.

Also significantly affected by all this turmoil have been our graduating otolaryngology residents and fellows who seek to identify opportunities that best fit their desired employment situations in academic and private-practice settings. Most traditional employment techniques and planning have been disrupted by COVID-19, and our graduates and members are facing a new set of challenges in procuring jobs as attending physicians. Frequent travel restrictions, as well as the unprecedented transformation of our AAO-HNSF 2020 Annual Meeting & OTO Experience from a live event to a virtual one, have prevented in-person interviews and meetings. Virtual conversations serve a valuable purpose but cannot replace live face-to-face meetings where physical workspaces can be toured; where the flow and interaction of staff, patients, and providers can be experienced; and for the crucial nonverbal cues that video conferencing cannot convey. The current situation prevents candidates from evaluating the full experience of employment locations that they are not already familiar with. Where they and their families will live remains a critical determinant in employment selection.

The dreams and aspirations of many 2020 and 2021 graduates have been adversely impacted by challenging obstacles in procuring attending jobs. Concerns for their future have also impacted their wellness. Offers that had been made were rescinded, positions were unilaterally changed from full-time to part-time, and employment deferrals for six or more months were enforced—all due to the markedly diminished patient flow and resultant financial impacts ushered in so rapidly and unexpectedly by COVID-19. In some cases, the positions that were deferred have already been filled by



the corps of deferred applicants, reducing the available openings for our current graduates.

Sadly, some practices were forced to close due to the pandemic. Others had to partner with larger systems to remain financially viable. Most practices that remained solvent had to reduce or temporarily close office hours, rapidly incorporate telehealth options, and were forced into the unanticipated and unimaginable need to layoff and furlough loyal office staff. The economic impacts even led to reduced hours and terminations of recently hired physicians in addition to deferred compensation for partner physicians.

Several strategies have proven valuable to mitigate these COVID-19-induced employment dilemmas for our graduates and members.

First, keep an open mind as you explore future practice opportunities. Flexibility can open doors. Rigidity will limit options. Be willing to think outside of the pre-2020 box. Opportunities do exist in both academic and private practice settings. Location and lifestyle considerations were among the most important factors prior to 2020 and remain important, but currently, availability and practice settings with economic stability and strong infrastructures are most attractive. There are many "hybrid" type practice environments that can and should be investigated, including private practice settings that offer academic involvement, teaching opportunities, and resident interactions, as well as practices that have partnered with hospital or healthcare systems to assist with onboarding and employment. Direct employment through a viable healthcare system has become an increasingly popular option. However, even these job settings were forced to reduce physician reimbursement and benefits during the pandemic.

Word of mouth may be the most valuable strategy. Connect with former residents, attendings, and mentors as well as former medical friends and colleagues for job openings. Reach out even when practices may not be obviously advertising for positions as their postings may have been on sites outside your radar. Social media has certainly streamlined this type of inquiry.

For the employer, most will pursue traditional recruitment avenues, job boards, etc. Personal contacts and word of mouth continue to be highly effective strategies. Reach out to former residents, medical students, attendings, and colleagues to inquire about candidates that may be seeking employment. Be flexible about creating a harmonious job description that meets the needs and expectations of the applicant, which provides appropriate workload and opportunities and offers pathways for partnership, mentorship, and local, state, and national leadership. For those that cannot find a resident or fellow graduate, consider nonphysician options like advanced practice providers who can provide high-quality care, excellent collaborative relationships, and valuable practice promotion and coverage.

The challenges of COVID-19 have forced us all to modify our workflows and our approaches and foster creative changes and improvements that have strengthened our practices. These modifications will continue to be utilized along with other yet unidentified innovations as we emerge from the pandemic turmoil in the coming year. These adaptations can result in an improved future practice environment that will benefit all providers and shepherd the advancement and success of otolaryngologist-head and neck surgeons around the globe. ■

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1. American Medical Association: COVID-19 Physician practice financial impact survey results. October 2020. www.ama-assn.org/system/files/2020-10/covid-19-physician-practice-financial-impact-survey-results.pdf

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Otolaryngology Discoveries Sharpened during the Call for Science

Daniel C. Chelius, Jr., MD
AAO-HNSF Annual Meeting Program Coordinator

With the AAO-HNSF 2021 Annual Meeting & OTO Experience Call for Science behind us, I think warmly of colleagues around the country and the world calling, texting, and emailing each other, excited with new ideas for Expert Lectures and Panel Presentations as well as refining previous presentations in response to attendee feedback. I think of trainees crunching numbers late at night making their abstracts perfect before sending them on for faculty review. I think of screens shared and ideas zoomed as groups of friends puzzle through how best to bring their simulation training to Los Angeles, California, in October. The thought paradigms that will guide the next 10 years of otolaryngology discovery and patient care are being conceived and sharpened in the connections between us during the Call for Science. It's a beautiful time.

With the Call for Science now over, the 55 members of the Annual Meeting Program Committee (AMPC) enter the busiest and most critical part of the Annual Meeting preparation lifecycle—proposal/abstract review and program construction. The AMPC is divided into the 12 specialty tracks of the Annual Meeting with a rotating specialty group leader for each track. Most committee members will review in at least two specialty tracks according to their content area expertise and interests. Over a four-week period, each of the 55 committee members will evaluate between 150 and 300 proposals and abstracts using a rubric that has been refined over the past decade. Each submission is reviewed both subjectively and objectively by multiple committee members, and then the results are compiled and analyzed.

In March, the specialty groups will meet virtually to begin organizing the Annual Meeting program with both breadth and depth of education opportunities in mind. They will discuss and rank the submissions in their track based on multiple factors, including the composite review scores and the education gaps identified from prior meetings. During a half-day retreat later in the spring, the AMPC will gather to collate the program with particular attention to presentations that cross specialty areas. In the end, we aim for an agenda that brings together the most current science, the best education opportunities, and the most inspiring discussions in otolaryngology. We aim for a meeting faculty who include both enthusiastic new perspectives and experienced thought leadership.

The AMPC is preparing diligently for the review period. We always hope to employ a fair process with as much precision and accuracy as possible. This year—to work toward ever-improving inter-rater reliability during proposal review—we have launched an Onboarding and Calibration Strategic Team under the leadership of **Clark A. Rosen, MD,** to develop an annual training curriculum for committee members. In parallel, **Minka L. Schofield, MD,** has led our new AMPC Diversity Champions Strategic Team to craft an Implicit Bias Training program for all AMPC members. While many of us are likely exposed to some sort of implicit bias training in our home institutions and communities, we believe that focusing on our potential biases as a group will elevate the quality of our reviews and keep the discussion fresh in our minds.

On behalf of the AMPC, I would like to thank the submitters to this year's Call for Science. There is no Annual Meeting without your support for the Academy. We take our review and program organization responsibilities very seriously and are grateful for your trust. ■

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Noise-Induced Hearing Loss in Children

Ryan H. Belcher, MD; Rose J. Eapen, MD; Clarice S. Clemmens, MD; Lindsay B. Sobin, MD; and **Margo M. McKenna Benoit, MD**

Over the past 30 years, the growing popularity of amplified sound in portable music and gaming devices has made noise-induced hearing loss (NIHL) a serious and growing public health issue.[1] NIHL can range from mild to moderate and may not be immediately apparent to the child. This can lead to significant communication challenges such as delayed language development, social isolation, or missing crucial information while at school—all of which can diminish education achievements.

It is estimated that 12%-15% of U.S. school-aged children have some degree of hearing deficit attributable to noise exposure.[2] NIHL can occur when sounds are too loud or if they are both loud and long-lasting. These sounds can cause damage to vital structures in the inner ear that are responsible for hearing. The National Institute on Deafness and Other Communication Disorders mentions at-risk recreational activities that can put children in danger for NIHL, including target shooting and hunting, snowmobile riding, listening to music or gaming devices at a high volume through earbuds or headphones, playing in a band, or attending loud concerts without hearing protection.

Sound is measured in units called decibels (dBA). A normal conversation between individuals is between 60-70 dBA, which is very unlikely to cause hearing loss after long exposure. Sounds that are at or above 85 dBA are known to cause hearing loss, and as the sounds get louder, the shorter amount of time it takes for hearing loss to occur. Figure 1 shows a list of activities and noises children are often exposed to with their associated dBA level.

Sound/Activity	Average dBA Range
Normal Conversation	60-70 dBA
Vacuum Cleaner Toilet Flushing Alarm Clock	70-80 dBA
Loud Traffic/Motorcycles/Dirt Bikes Noisy Restaurant Lawn Mower	80-90 dBA
Music with Maximal Volume through Headphones Loud Concerts Sporting Events	90-110 dBA
Ambulance Siren Jet Engine Rifle Shot	110-140 dBA
Fireworks/Firecracker Shotgun Shot	140+ dBA

Figure 1. Common sounds and activities children are exposed to and their associated decibel levels.

Prevention

NIHL is completely preventable. This starts with understanding the hazards of noise and taking steps to practice good hearing health. Here are several steps to take to aid in preventing NIHL:

- Use hearing protection for young children in environments where they are exposed to loud noise (e.g., sporting events, concerts, etc.). There are many applications that can be downloaded on smart phones to measure the noise levels to help in these environments.
- Ensure the volume is not turned to its maximum for long periods (i.e., hours) of time if your child is using headphones or earbuds. Some devices have parental control settings that can help with this.
- Familiarize yourself with hazardous noises in your environment, particularly those that are 85 dBA or more.
- Discuss with your family the importance of avoiding too much noise and the use of hearing protection.

What to Do if NIHL Is Suspected

If you are concerned about the impact of noise exposure on your child's hearing, you should not hesitate to have their hearing tested. Signs that your child could be developing hearing

loss include difficulty understanding what others are saying, especially in the midst of background noise; a persistent "ringing" in their ears; asking "what?" frequently; using a volume louder than normal when watching TV or using headphones; or needing to sit closer to the teacher in class to understand them better. It is important to evaluate your child's environmental noise exposure if these signs or symptoms develop and reduce their exposure. If they experience sudden hearing loss after a sudden loud noise exposure, such as an explosion or trauma, then it is important to see an ear, nose, and throat doctor immediately.

If you have questions or would like more information on this topic, please visit www.ENThealth.org. ■

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OUT OF COMMITTEE: EQUILIBRIUM

Vestibular and Balance Dysfunction in Children with Sensorineural Hearing Loss

Sharon L. Cushing, MD
Robert C. O'Reilly, MD

Sensorineural hearing loss (SNHL) is the most common congenital sensory impairment, occurring in three out of every 1,000 live births. The prevalence of vestibular impairment in children with SNHL is high, ranging between 20%-70% with 35% displaying severe/complete impairment of the vestibular end organs, which translates into balance impairments. Dysfunction is often missed as most children with vestibular dysfunction will never be vertiginous. Given this high prevalence and the challenges in recognizing these deficits, children presenting with SNHL should be regularly screened for vestibular and balance dysfunction.

Impact of Etiology

The risk of having concurrent cochleovestibular loss is dependent upon the etiology of the SNHL. The capacity of diagnostic tools, such as imaging, molecular genetic techniques, and virology testing, are enhanced by providing accurate and detailed phenotypic description of the child. This should include vestibular and balance assessment. The most common etiologies of

Table 1: Red Flags for Motor Milestones

Motor Milestone	Timeframe
Absence of head control	4 months
Unable to sit unsupported	7-9 months
Unable to crawl/bottom shuffle	12 months
Not attempting to walk	18 months

Table 2: Expected and Red Flag One-Foot Standing Times by Age

Age	Duration (sec) 1 foot standing
30 months	1 (briefly)
36 months	2
4 years	5

deafness associated with severe vestibular impairment are:

- Genetic causes nonsyndromic mimickers such as Usher Syndrome Type 1 and CHARGE syndrome
- Cochleovestibular anomalies such as incomplete partitions
- Acquired infections such as meningitis and congenital cytomegalovirus (cCMV)
- Ototoxicity (i.e., aminoglycosides or chemotherapeutics)

Just as SNHL can present with varying degrees of severity and any rate of progression, so too can vestibular impairment. Although the risk of vestibular impairment is highest in those with the most significant cochlear deficits, the co-existence of both sensory deficits with respect to degree and time course can follow any pattern.

Impact of Cochlear Implantation

No discussion about vestibular impairment in SNHL would be complete without considering the impact of implantation on inner ear function. The literature is heterogeneous as methodologies used to quantify impact are variable. Initial reports of dysfunction following cochlear implantation (CI) were based only on subjective complaints of dizziness, occurring in 2%-49% of patients and more likely in adults with increasing age. The risk of losing or significantly diminishing horizontal canal function based on caloric testing following CI ranges between 0 and 77%. The most robust data in the pediatric population comes from carefully obtained pre- and postoperative vestibular function testing. This data was used in order to estimate the risk of total bilateral vestibular loss following bilateral simultaneous CI. Overall that risk was felt to be in the order of 2%. Although this risk should not be ignored when considering bilateral CI in children, it is important to note that this risk of total bilateral vestibular loss is exceeded by the underlying etiology of the deafness itself. In summary, regarding the risk of vestibular injury from CI:

- Adults and children are different both in their risk of vestibular impairment at baseline and following CI and this primarily reflects differences in etiology.
- The great majority of children receiving a CI have a pre-existing vestibular impairment at baseline prior to surgery.
- Vestibular injury can be induced by CI.

Screening for Vestibular Impairment in Children with SNHL

Identifying vestibular and balance impairment is important in children presenting with SNHL. However, the challenges of doing so present barriers. A screening algorithm, such as the following, can be applied in the clinical setting to better identify those at risk of vestibular impairment who should receive more thorough testing:

- Review of motor milestones (Table 1)
- Assessment of balance – one-foot standing (Table 2)
- Assessment of horizontal canal function

Screening assessment of horizontal canal function can be done without specialized equipment using a clinical head impulse test. Additionally, infants younger than six months of age display a developmental inability to suppress their vestibulo-ocular reflex response allowing for easy assessment of the horizontal canal. This can be done by spinning the child (and the caregiver on whose lap they sit) on a stool and examining for postrotary nystagmus (fast-phase directed away from the direction of the acceleration). Ideally, all three items of the screening assessment would be performed; however, completion of any single one may identify a child at risk of vestibular dysfunction.

Functional Impact of Vestibular and Balance Impairment

At minimum, vestibular loss carries a number of safety concerns that should be relayed to patients. Absence of bilateral horizontal canal function (areflexia), saccular dysfunction, and poor balance measured on objective tests of function have been demonstrated to increase the odds of CI device failure 7.6 times, with failure defined as mechanical or electrical malfunction of the surgically implanted internal component.

It is expected that children who are deaf and have concurrent vestibular impairments will be delayed in their motor milestones. However, given the vestibular system's far-reaching projections throughout the brain, impairment leads to deficits beyond locomotion and plays a role in neurocognition, including perceptual and visuospatial ability, memory, and executive function. Neuroanatomically bilateral vestibular deficits are correlated with decreased hippocampal volume. The bulk of the literature examining the vestibular-cognitive relationship focuses on deficits resulting from acquired vestibular loss, but congenital absence of vestibular function may lead to a distortion of typical brain development as demonstrated in congenital hearing or other sensory losses. There is likely a critical period to develop accurate spatial representations akin to those for linguistic development. Much of the resulting cognitive deficits may occur from brain changes at the level of the hippocampus that result from an absence of vestibular input during that critical time period. The direct impact of this sensory deprivation could be a failure to develop a construct for the relative representation of both the body and other objects in space. Poor hippocampal development may contribute to broader issues with learning, memory, and executive function.

Balance deficits also occur in children with unilateral profound SNHL. Multiple factors are likely to contribute to their poorer balance skills including the following:

- Unrehabilitated unilateral hearing loss in early development that promotes an "aural preference syndrome" where hearing is biased to one ear, compromising spatial hearing.
- Combined impairment of both hearing and vestibular function with the prevalence of end organ specific dysfunction (otoliths and horizontal canal) ranging from 17%-48%.

This high prevalence of vestibular impairment again is likely related to the etiologies leading to unilateral hearing loss (i.e., cochlear nerve aplasia, cCMV, cochleovestibular anomalies, and sudden SNHL). It is becoming clear that the role of this dual sensory impairment is underestimated in children with unilateral SNHL and needs to be considered as we measure outcomes following intervention (i.e., CI for single-sided deafness).

Exploring Rehabilitative Strategies

Different therapeutic approaches can be used for the rehabilitation of children with loss of vestibular sensitivity by capitalizing on the developing brain's remarkable plasticity.

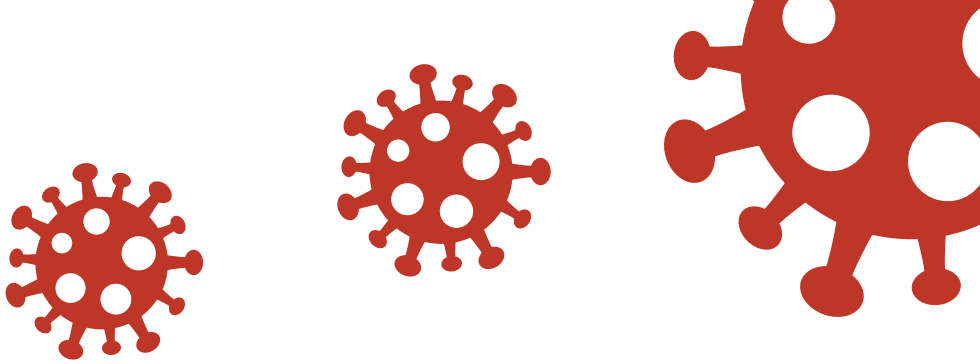
Children with SNHL and reduced/absent vestibular function may benefit from practicing balance strategies in various environmental contexts to prime their visual and somatic senses facilitating compensation. More specifically, a 10-day exercise program focused on activities of static balance can lead to significant improvement in standing balance duration in children with SNHL compared with untreated hearing-impaired controls.

While initial concerns were that CI may negatively impact vestibular function and balance, evidence exists that CI may actually positively influence balance function. Small improvements in performance have been documented on computerized dynamic posturography (CDP) in some individuals following CI activation. In addition, children with SNHL and implants perform better on standardized test of balance function (BOT-2 balance subset) with their CI on versus off, and this benefit is achieved both in settings of directional sound as well as nondirectional white noise. Although we recognize the importance of visual, somatosensory, and vestibular cues in the maintenance of balance, the contribution of hearing is rarely considered. A theoretical possibility is that balance improvement is related to extra-cochlear spread of current. Electrical activity from the CI is known to reach the vestibular end organs. Vestibular evoked myogenic potentials (VEMPs), a measure of otolithic function, can be elicited with electrical stimulation in children with CI. The presence of electric VEMPs in acoustically nonresponsive ears, along with their shorter latencies, suggests that electrical current can bypass the otoliths and directly stimulate vestibular neural elements. Additionally, the perception of visual vertical can be improved in the presence of CI stimulation. Building on this principle, the functionality of the intracochlear electrode array may be used to provide head-referenced cues to improve balance. Others have been working to more directly activate the vestibular end organs using separate electrode arrays targeting the posterior labyrinth.The hope is that ongoing advancements in all strategies will provide a number of potential therapeutic options to address the balance impairment due to vestibular dysfunction.

Summary

Vestibular impairment and balance deficits are the most frequent co-existing clinical features in children with SNHL. These dual sensory impairments often result from a shared etiology but can also occur as a side effect of CI. Recognition of vestibular deficits in children who are deaf is vitally important as they have impact on motor development, balance skills, and safety. These vestibular deficits increase the risk of implant failure and negatively affect cognitive development. Early identification and rehabilitation of these vestibular and balance deficits are necessary to optimize function over the course of a lifetime. ■

See the online version of this article for a complete list of references used.



FROM THE EDUCATION COMMITTEES

Pediatric Otolaryngology in the Time of COVID-19

Brianne Barnett Roby, MD, for the Pediatric Otolaryngology Education Committee

"Kids don't get sick from COVID." "Children are only contagious if they have symptoms."

These were statements made early in the pandemic about the pediatric population, so why did it feel like practicing as a pediatric otolaryngologist suddenly came to a halt in the spring of 2020?

The Governor of Minnesota issued a statewide mandate that all elective surgeries were put on hold. Surgeries that were allowed under the order were to "... prevent loss of life, permanent dysfunction of an organ or limb, or prevent spread of cancer." In some situations, such as a foreign body aspiration, severe subglottic stenosis, or malignancy, the guidelines to proceed with surgery were clear. However, this phrase "permanent dysfunction of an organ" created an ethical dilemma for many pediatric otolaryngologists. How long can one delay a cochlear implant in an infant with congenital hearing loss before long-term outcomes worsen? How long should cleft palate repair be delayed without impacting speech development? The internal debate between sacrificing for the good of society by limiting the amount of PPE I used versus advocating for my patients to ensure that they had the best outcomes was constant. Numerous conversations were held—not only among my partners, but among my friends and colleagues around the country—sharing the same struggles to do what is best.

As summer arrived and hospitals returned to "the new normal" with elective procedures, a recognition that the societal shift in working from home, distance learning, and avoiding social situations would impact pediatric otolaryngology was quickly realized at our institution. Young kids who don't go to daycare don't get ear infections and require PE tubes. Strep throat doesn't run rampant around a classroom so fewer patients need adenotonsillectomy. The most common cases performed in pediatric patients in the past have had a dramatic decline this last year, and with ongoing social distancing, it may be a long time before those cases increase again.

Locally there has also been a shift in pediatric facial trauma. Only time will ultimately give the final data, but anecdotally there has been an increase in dog bites to the face. This is likely a result of the phenomenon of "pandemic puppies" with a higher percentage of people in the United States getting puppies while they are working from home as well as kids spending more time at home instead of daycare or school. The combination of higher levels of stress, people more likely to spend time at home, and younger puppies is resulting in the local uptick in bites. Similarly, for quite some time, all team sports were cancelled. This meant fewer facial injuries from basketball, football, and hockey but more injuries from biking accidents, trampolines, and other activities at home.

What has become clear is that pediatric patients can and will get sick from COVID-19. Common pediatric problems, such as subperiosteal abscess from sinusitis, neck abscess, or croup, are being diagnosed in COVID-19 positive patients. What previously may have been simple decision-making for management now requires an additional step. "Should I do anything different since the patient has COVID?" "Is it better to do surgery sooner so they get out of the hospital faster or try to avoid surgery altogether and allow antibiotics to treat?" "Should I perform external approach for draining the orbital abscess instead of endoscopic?"

Ultimately the goal is to keep staff and patients safe. Pediatric patients aren't necessarily able and willing to wear masks in a waiting room. Many kids typically might drop a toy on the ground and then put in their mouths or grab for toys or other objects in a waiting area or exam room. Therefore we've drastically reduced the number of patients scheduled in clinic at a time to limit the number of patients and families waiting. Limitations have been placed so that siblings are not allowed at appointments, and it is strongly encouraged that just one parent attend the appointment. Simple procedures routinely done in a pediatric otolaryngology clinic, such as ear and nasal foreign body removal, were transitioned early on in the pandemic to be done in sedation units as the concern that an upset child could easily aerosolize secretions when agitated.

Initially we thought this pandemic would affect primarily adult patients, but it has become clear that it has had a significant impact on the practice of pediatric otolaryngology. The long-term impact remains to be seen. ■

WELLNESS

How to Create a Wellness Curriculum at Your Institution

Lessons Learned from the Graduate Medical Education Experience

Todd E. Falcone, MD

This topic was presented at the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience, with **Todd E. Falcone, MD; Ashley D. Agan, MD, MBA; Katherine Kavanagh, MD; Noriko Yoshikawa, MD;** and **Natalie A. Krane, MD.**

Physician burnout is a well-established phenomenon pervasive throughout the medical community and is detrimental not only to physicians, but also to the patients they treat. In addition to job dissatisfaction, burnout can lead to increased medical errors, poor scores on empathy measures, and early retirement. Otolaryngologists are not spared when it comes to burnout, as a 2008 study showed that 66% of academic otolaryngologists reported moderate burnout. A 2017 *Medscape* survey showed that 53% of otolaryngologists had burnout, placing them near the mean across all specialties (51%). Burnout affects learners at all levels of medical training, including medical students, residents, fellows, and attendings, and within both academic and private practice settings.

As a response to the growing trend in physician burnout and as a way to promote wellness, the Accreditation Council for Graduate Medical Education (ACGME) added "well-being" to the list of program requirements for all residency and fellowship programs in the country in 2017. While the ACGME does not provide specific details on how to teach well-being, it notes components that should be addressed by the curriculum and instilled through the philosophy of the training programs. This includes but is not limited to: supporting the psychological, emotional, and physical well-being of the trainee; emphasizing self-care, including allowing time to seek medical, dental, and mental healthcare during work hours; evaluating workplace safety; and promoting efforts to enhance the meaning that each trainee finds in the experience of being a physician. Furthermore, all residents, fellows, and faculty need to be educated on burnout recognition and provided with confidential, affordable mental health assessment, counseling, and treatment 24 hours a day, seven days a week. Cleary this goes above and beyond simply obeying duty hours, but how exactly do we, as academic faculty, teach our residents and faculty how to be "well?"

Otolaryngology residency programs were surveyed in 2018, one year following the ACGME's addition of well-being to the core program requirements, and while close to 90% of programs reported having at least one wellness lecture in the last year, less than 25% of programs were actually in compliance with the ACGME mandates, and under 50% had surveyed the emotional health of their residents. As a specialty, otolaryngology clearly has a long way to go to adequately promote and teach wellness

to our trainees, let alone engage in and practice our own well-being. Unfortunately, there is no magic wellness template that can be universally applied to all programs. However, bringing all invested parties to the table to discuss the topics of wellness and burnout is a great place to start. "Creating a culture of wellness should be an end goal in all wellness programs," said **Noriko Yoshikawa, MD,** the assistant program director at Kaiser Permanente East Bay. This means making wellness a priority, implementing ways to ensure mental and physical health while at work, and helping residents and faculty alike to adopt habits to improve their health and well-being, both at work and at home. In her program Dr. Yoshikawa engages her residents to take part in the institution-wide physician health and wellness program and resident-specific programs, which include resident gym memberships and a mindfulness course. At a department level, her institution has incorporated "wellness days" to allow for resident-led wellness initiatives as well as scheduling of personal health appointments. Her program also emphasizes resident/faculty social events and group volunteerism in the community and sponsors formal resident/faculty wellness retreats. Dr. Yoshikawa also performs "wellness checks" at the resident semiannual reviews and organizes exercise or camaraderie-building events at the outset of their department meetings as further ways to engage the faculty and residents alike. "A culture of wellness results in wellness concepts seamlessly arising in different aspects of work life to support the wellness of oneself as well as the wellness of others," said Dr. Yoshikawa.

Creating an effective wellness curriculum, however, takes intentional planning to tailor it to the real-time needs of the target audience. This goes beyond providing the important gym memberships and the ability to volunteer. We can all list barriers to our own wellness, which may include overall lack of control of our clinic schedules, the onslaught of daily emails, the multitude of EMR inefficiencies, the lack of protected administrative or research time, or hours of clinical work brought home at the end of the day. The list can go on and on. "Addressing the barriers to wellness head on and creating a wellness program after a careful needs-based assessment engage the residents and set [them] up for success," said **Katherine Kavanagh, MD,** associate professor of otolaryngology and simulation director at Connecticut Children's and UConn School of Medicine. Each year UConn otolaryngology residents participate in a formal focus group to identify barriers to wellness based on Maslow's hierarchy of needs. Many of these systemic barriers can be addressed immediately, such as the lack of emergency after-hours parking at the hospital or difficulties accessing call rooms. The residents also help design their own wellness curriculum by ranking a series of wellness topics based upon their wellness needs. These are then incorporated into their personalized curriculum for the year.

Mindfulness has been shown to be an integral part of successful wellness initiatives. "Mindfulness, which is simply the act of being fully present and attentive during an activity, can be a powerful stress reliever and can lead to a measurable reduction in resident burnout," said **Natalie A. Krane, MD,** a fellow in facial plastic and reconstructive surgery at the University of Kansas Medical Center. Dr. Krane created a 16-week, 32-session mindfulness-based intervention program for her own residency program while an otolaryngology resident at Oregon Health & Science University. Residents completed the Maslach Burnout Inventory–Human Health Survey for Medical Professionals before and after the program. Her data showed that 100% of participating residents found the training helpful, and residents who attended more than nine sessions had improvements in personal accomplishment and emotional exhaustion scores. Mindfulness training programs are relatively simple to initiate, and the results can be profound—one study showed a significant decrease in negative affect scores among otolaryngology residents upon completing a 10-minute web-based mindfulness session on their smart phones.

Similarly successful mentoring programs can instill a positive sense of well-being among residents. **Ashley D. Agan, MD,** assistant professor of otolaryngology at the University of Texas Southwestern, helped create a robust mentoring program for her residents and attests to its power in improving resident and faculty wellness alike. According to Dr. Agan, "Residents want mentors but not just to talk about career advice. They look for advice and role models to help them with managing stress and improving their work-life balance." Mentors should be invested volunteers who are approachable, supportive, and honest. Dr. Agan encourages all programs to start a formal mentoring program for their residents. The keys to getting started, according to Agan, are securing organizational support, establishing clear goals with buy-in from both mentees and mentors, defining a schedule allowing for flexibility, and maintaining accountability. This also lends itself to engaging in faculty development since faculty members may require and be open to receiving mentorship education.

In the end, wellness has to be a part of the everyday culture and part of the formal teaching requirements in our training programs. We know that resident and faculty engagement is critical when starting a formal resident wellness curriculum. How to create your own program is up to you, but it should involve all stakeholders. As faculty members we too can benefit from engaging in resident wellness initiatives, as teaching and promoting resident wellness will hopefully allow us to assess our own well-being and help us to have healthier work and personal lives. Our trainees, colleagues, families, and patients will thank us. ■

See the online version of this article for a complete list of references used.

WELLNESS

Climbing the Second Mountain: Introducing a Novel Resident Wellness Program

Nicholas A. Rossi, MD; Wasyl Szeremeta, MD, MBA; and **Harold S. Pine, MD**

"The main source of illness in this world is the doctor's own illness," wrote Samuel Shem in his 1978 classic, *House of God.* Perhaps the ultimate example of "the doctor's own illness," burnout has been increasingly recognized as a severe detriment to the well-being, medical judgment, and overall happiness of physicians and resident trainees. As a specialty, otolaryngology is not immune to the effects of physician burnout. In a 2010 questionnaire-based study by Contag et al., a staggering 75% of microvascular free flap head and neck surgeons were found to be experiencing moderate-to-high levels of burnout. In another 2008 study by Golub et al., moderate-to-high burnout was observed in 70% of otolaryngology academic faculty members. A more recent 2020 study by Reed et al. found a 50% burnout rate among otolaryngology residents. These astounding figures are a cause for alarm in our community as we aim to minimize these ill effects on our fellow faculty members and trainees.

There are two ways to change the system, in Samuel Shem's own words, "Firstly, on an individual level, by learning how to stay human in the system; secondly, on a collective level, by taking action." At a time before burnout was widely recognized as an issue among physicians, Samuel Shem eloquently identified it and emphasized the possibility of changing the system as a potential remedy. However, many physicians find the system to be hesitant to structural change. Here at the University of Texas Medical Branch (UTMB) Department of Otolaryngology, we have decided to act on both the individual and the collective levels with the introduction of a novel resident wellness program: the Second Mountain. During residency training, learning foundational information and sharpening surgical skills are the obvious "first mountain" for residents. In the Second Mountain program, residents are encouraged to choose an activity or goal outside of medicine that they actively work to pursue during their time in residency. With time and perseverance, we believe that the implementation of the Second Mountain program will provide an outlet for residents to de-stress, develop a well-rounded character, and ultimately become better physicians.

Several exciting resident wellness initiatives have preceded ours within the otolaryngology community. At the University of Colorado, a unique resident-run education system was created for both patients and nurses centered around topics pertinent to patient care. The system is designed with incentives for residents who participate in more of these sessions. The University of Michigan has taken steps to increase the personalization of patient-physician interactions as well as implemented a regular schedule of focus groups for residents to receive peer support. We are pleased to see our otolaryngology colleagues across the country putting a priority on wellness. Our program similarly involves a reward system to encourage resident participation and progress toward their Second Mountain, but it differs in that it emphasizes the need to spend time outside of the hospital as a key component of the program.

Resident response has been overwhelmingly positive, and some examples of the goals Second Mountain residents have chosen include learning how to surf, volunteering for animal rescue organizations, and advancing to a higher belt level in Brazilian Jiu Jitsu. The department assists the resident financially to participate

> By integrating all five mountains we can be "physically strong, mentally sharp, emotionally and morally mature, intuitively aware, and spiritually grounded."

in the program, making it easier for the resident to work toward their individual goal. Progress toward the Second Mountain is regularly tracked by a faculty mentor, many of whom have Second Mountain goals of their own. When milestones along the way are achieved, the resident is rewarded with custom-designed Second Mountain patches (Figure 1).

The core of the Second Mountain program was inspired from the ideas of retired Navy SEAL Commander Mark Divine in his book *Unbeatable Mind,* in which he describes five figurative "mountains" one must climb to maximize one's potential: physical, mental, emotional, intuitional, and Kokoro, or "spirit." Participants in the Second Mountain program may choose a goal within the realm of any of these five mountains. The physical mountain is the most straightforward to pursue and the most popular so far among participants. Examples of physical mountains include reaching a higher rock-climbing proficiency, losing weight, or training for a triathlon. The mental mountain involves stepping outside the realm of otolaryngology by doing something mentally stimulating such as learning a new language or reading nonmedical literature. The emotional mountain can be pursued in ways such as prayer, meditation, poetry, volunteering, or creative writing. Traversing the intuitional mountain is more difficult, and developing a refined sense of intuition takes experience and mentorship. Finally, the Kokoro mountain brings the ideas of all five mountains together. Japanese for "heart" or "spirit," the Kokoro mountain emphasizes the teamwork mentality and purpose-driven action. It can only be mastered in union with the other four mountains. By integrating all five mountains we can be "physically strong, mentally sharp, emotionally and morally mature, intuitively aware, and spiritually grounded."

Although the Second Mountain program was originally designed for residents within the Department of Otolaryngology, higher aspirations remain. The program has been officially opened to otolaryngology faculty as well as the Department of Audiology and Speech Language Pathology. Our ultimate vision is to share the Second Mountain program among all departments in our hospital so that eventually every department has a Second Mountain program of its own. We also hope other otolaryngology residency programs around the country will adopt Second Mountain programs. Even Samuel Shem said about hobbies, "You should have at least one."

Figure 1: A sample of a custom-designed Second Mountain patch.

With the introduction of our resident wellness program, we strive to fight resident burnout on both the individual and collective levels, as Shem himself advocated. Only with actionable changes can we effectively mitigate burnout, improve resident education, and, most importantly, maximize patient care. ■

See the online version of this article for a complete list of references used.

DIVERSITY,
EQUITY, AND INCLUSION

Unequal Treatment: How to Move from Detecting Healthcare Disparities within

Sarah N. Bowe, MD; Karthik Balakrishnan, MD; Uchechukwu C. Megwalu, MD; and **Regan W. Bergmark, MD**


Sarah N. Bowe, MD

Recently the coronavirus pandemic has illuminated long-standing social, economic, and health inequities in the United States. Initially less than a dozen states publicly shared data on the racial and ethnic patterns of COVID-19, and what emerged painted an alarming portrait. In New York City, deaths from coronavirus adjusted for the size and age of the population disproportionately affected Hispanic and Black people, occurring at a rate of 22.8 per 100,000 and 19.8 per 100,000, respectively, compared with 10.2 per 100,000 for White individuals. In Wisconsin's Milwaukee County, 50% of cases and 81% of fatalities were among Black individuals, yet they only accounted for 25% of the local population. As a result, the American Medical Association (AMA) wrote a letter to the then U.S. Department of Health and Human Services Secretary Alex Azar urging all healthcare agencies and institutions to immediately standardize, collect, and release race and ethnicity data. The AMA was not alone in its request—six other top physician organizations signed the letter. The Association of American Medical Colleges echoed similar concerns, with David A. Acosta, MD, chief diversity and inclusion officer, noting that "better data on the current pandemic will give us an opportunity to take decisive action to protect vulnerable communities."

The aforementioned comments and findings emphasize the critical starting point of health disparities work: detection. In 2006 Kilbourne et al. proposed a conceptual framework progressing from detection to understanding, followed by reduction. The first phase involves defining health disparities, identifying vulnerable populations, and developing assessment measures. Health disparities can be defined as "observed clinically and statistically significant differences in health outcomes or healthcare use between socially distinct vulnerable and less vulnerable populations that are not explained by the effects of selection bias." Vulnerable populations include any groups that face discrimination because of underlying differences in social status (e.g., race/ethnicity, sex/gender, age, socioeconomic status, literacy). The selection of measures will vary widely but should broadly include process measures, or differences in healthcare use (e.g., insurance, access to care), and outcome measures, or differences in health status (e.g., disease severity, mortality). Over the past decade, numerous studies have identified healthcare disparities within our specialty, yet few have progressed beyond detection to understanding.

In order to achieve understanding, it is important to recognize the complexity of factors that contribute to healthcare disparities, which can be very context dependent. Thus, while some collective information on health disparities can be shared, there is also a critical need to perform analysis on a more individualized basis, including unique patient, provider, and healthcare system factors. The detailed information that is obtained during the understanding phase can be used to drive the development and implementation of interventions that will ultimately lead to the reduction of healthcare disparities. Following are shared experiences and perspectives from notable leaders within otolaryngology as they work on understanding healthcare disparities within their own patient populations.

to Understanding and Reducing Otolaryngology

Karthik Balakrishnan, MD, MPH

Humans understand the world by categorizing experiences to form cognitive associations. We apply these associations to understand subsequent experiences and interpersonal interactions. The result is often inappropriate generalization from specific experiences, or bias, to which clinicians are particularly vulnerable due to the high cognitive demands of our profession. Because these biases are the result of the interaction of individuals and the societies in which they live, they also manifest on the societal level as privilege and disadvantage.

In healthcare, bias, privilege, and disadvantage directly affect health outcomes through every aspect of patient-provider interaction, medical decision-making, patient experience, and treatment adherence. Meanwhile multiple studies have demonstrated improved patient-provider interaction metrics when the patient-provider dyad is concordant for race or gender.

To counter these biases and move toward justice in healthcare, we must reduce both the effects of our personal biases and the systemic privileges and disadvantages experienced by our patients. Awareness of our biases is a critical first step, followed by a mindful approach to altering our cognitive associations. Meanwhile, as a specialty and a profession, we must confront biases in how we select, train, and promote colleagues, in order to reduce privilege and disadvantage in who enters and thrives in our specialty. This in turn will increase diversity among clinicians in otolaryngology, conferring downsteam benefits to our patients.

Uchechukwu C. Megwalu, MD

Sociodemographic disparities are becoming increasingly apparent in head and neck cancer (HNC). In addition to tumor-specific and treatment factors, nonclinical factors—such as race, gender, and socioeconomic status—are known to significantly impact patient outcomes. Of these, race/ethnicity and insurance status have been the most studied. Significant racial disparities exist in HNC outcomes. Black patients present with more advanced tumors, are less likely to receive appropriate treatment, and have worse survival outcomes than other racial groups, even after adjusting for disease stage and other clinically important factors. Significant insurance status disparities have also been demonstrated in HNC outcomes. Uninsured and Medicaid patients have worse outcomes compared with commercially insured patients.

Understanding the drivers of sociodemographic disparities is critical for designing and testing interventions aimed at reducing disparities. Some of the racial/ethnic and insurance status differences in outcomes may be explained by differential access to high-quality care. Several studies have shown that certain racial/ethnic populations are more likely than non-Hispanic Whites to receive care in low-quality hospitals. These racial/ethnic disparities may also be mediated by insurance status. Uninsured and Medicaid patients are also more likely to be treated in low-quality hospitals than commercially insured patients. However the role of insurance status and hospital quality as

drivers of HNC disparities has not been previously studied. Further investigation of these potential drivers is important, especially as these are actionable targets for interventions addressing HNC disparities.

Regan W. Bergmark, MD

The COVID-19 pandemic will exacerbate health disparities for diseases of the head and neck and more broadly through multiple mechanisms. First, the delays in care suffered by patients throughout the United States due to the pandemic are expected to most severely affect patients who are already at risk of having delayed care, including racial and ethnic minority patients and uninsured and Medicaid patients. Second, job loss is leading to loss of insurance or transitions to insurance programs with less coverage. These changes are expected to lead to worsening discontinuity of care as patients need to delay care or switch healthcare systems. Job loss additionally reduces personal or family resources, making healthcare costs more financially toxic. Third, hospital closures are expected—particularly in rural areas—due to the economic effects of the pandemic, reducing potential points of access. Fourth, the impact of the pandemic on education raises a longer-term risk to the diversity of our workforce.

A population health approach to diseases of the head and neck and leadership from otolaryngologists across the country can help mitigate these effects. Wait times for virtual appointments, in-person appointments, and surgical procedures should be determined based on clinical urgency and analyzed based on race/ethnicity and insurance status to try to ensure equity in real time. Partnering with community centers and primary care clinics in underserved areas can potentially expedite referrals from these communities. For the long term our specialty should be deeply involved in national discussions on financial incentives in the U.S. healthcare system. For lasting and deep change, insurance coverage should be expanded, and addressing and reducing healthcare disparities should be financially rewarded. ■

Acknowledgment: The content of this article was discussed in detail during the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience Panel Presentation "Unequal Treatment: How HealthCare Disparities Negatively Impact Our Otolaryngology Patients" and was sponsored by both the AAO-HNS Diversity and Inclusion Committee and the AAO-HNS Patient Safety and Quality Improvement Committee.

See the online version of this article for a complete list of references used.

OUT OF COMMITTEE: SLEEP DISORDERS

Update on the Management of Mild OSA in Children

Cristina Baldassari, MD, Chair of the AAO-HNS Sleep Disorders Committee

Pediatric obstructive sleep apnea (OSA) is still a relatively "young" field. It was not until the late 1990s that many of the sequelae of pediatric OSA, such as poor focus and behavior problems, became increasingly recognized and reported. In the years since, there have been significant advances in the evaluation and management of pediatric OSA. However, numerous controversies and challenges remain, including determining the best management strategy for children with mild OSA.

The optimal management of mild OSA in children is still being investigated. While adenotonsillectomy has been the traditional treatment for pediatric OSA, the recent multi-institutional, randomized Childhood Adenotonsillectomy Trial[1] demonstrated that watchful waiting might also be effective. This trial compared the efficacy of watchful waiting versus adenotonsillectomy for the treatment of non-severe OSA (average apnea hypopnea index (AHI) of 4) in over 400 otherwise healthy children. While the surgery group experienced more significant improvements in PSG parameters, behavior, and quality of life (QOL), approximately 50% of children in the watchful waiting group had resolution of their OSA on seven-month follow-up PSG. Despite resolution of their OSA on PSG, however, 85% of children in the observation arm of the trial continued to experience snoring and other sleep sequelae. One of the main limitations of this study was the limited age range of subjects (five to 12 years of age), which made it difficult to draw conclusions regarding younger children among whom snoring and OSA are common.

Hot off the presses this year is the Karolinska AdenoTonsillEctomy (KATE) study[2] that sought to clarify the role of adenotonsillectomy in the management of young children with non-severe (AHI > 1 and < 10) OSA. The authors randomized children two to five years of age to either adenotonsillectomy or watchful waiting,

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Future studies that directly compare watchful waiting, medical therapy, and adenotonsillectomy in children with mild OSA are needed so that definitive treatment protocols can be developed.

then repeated PSG and QOL assessments after six months. In children with mild disease (AHI > 1 and < 5), the surgery and watchful waiting group had similar AHI outcomes at follow-up. However, among children with moderate OSA, there was a clinically meaningful improvement in PSG parameters in the adenotonsillectomy group. Children in the adenotonsillectomy group had large improvements in QOL regardless of baseline disease severity when compared with the watchful waiting group. This study was limited by its lack of diverse sample with the majority of children being White and non-obese.

There is also a growing body of literature demonstrating the efficacy of anti-inflammatory medications, namely intranasal steroids and montelukast, in the management of mild OSA in children. Montelukast is a leukotriene modifier; research has demonstrated the presence of leukotriene receptors on the surface of adenoid and tonsil lymphoid tissue. A recent meta-analysis,[3] which included several randomized, placebo-controlled trials, noted significant reduction in the AHI in children with non-severe OSA treated with montelukast. In addition, research has demonstrated improvement in QOL and symptom burden in children managed with montelukast and intranasal steroids.[4] While montelukast has been used extensively to treat asthma and allergic rhinitis, the U.S. Food and Drug Administration recently warned of the mental health side effects of this medication. Montelukast should not be prescribed to children with a history of depression or behavioral problems. Prior research has also suggested that obese children, those older than seven years of age, and those with Down syndrome are less likely to respond to medical management with montelukast.[5,6] A final point of controversy regarding medical management of pediatric OSA involves duration of therapy. Most children are treated with a three- to four-month course of medical therapy, but data regarding long-term outcomes are lacking.

It can be challenging for providers to counsel caregivers of children with non-severe OSA regarding the best management strategy. Certainly the literature noted above supports managing children with milder symptoms with watchful waiting or anti-inflammatory medications and considering surgery for those with more severe disease burden. Instruments that assess symptomatology and QOL such as the OSA-18 may be useful in assessing the impact of OSA on a child's well-being and thus aid in management decisions.[7] The OSA-18 is a short questionnaire that is simple to introduce into an otolaryngology practice. Children with an OSA-18 score indicating a moderate to severe impact of sleep disturbance on QOL (total score > 60), benefit from medical or surgical treatment. In upcoming years, shared decision-making tools will likely play a role in pediatric OSA management. Future studies that directly compare watchful waiting, medical therapy, and adenotonsillectomy in children with mild OSA are needed so that definitive treatment protocols can be developed. ■

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How to Write Like a Pro:

Paper Sprints, Data, and Sparking Academic Productivity

John D. Cramer, MD; Nausheen Jamal, MD; Robin W. Lindsay, MD; and **Michael J. Brenner, MD**

Writing is hard. Taking an idea to fruition can be a lonely endeavor, littered with the skeletons of unfinished projects. We've seen many bright learners and faculty members spend hours, months, or years creating data sets without a clear vision of the final product. Others struggle endlessly before a blank screen, making little headway.

There is a better way.

In this article we provide tips for otolaryngology colleagues on how to turn early forays in scholarship from desolate paths fraught with frustration to rich opportunities to cultivate relationships and shared success. We present strategies on paper sprints, quality improvement projects, and data collection within the workflow of routine clinic practice.

What Is a Paper Sprint?

The paper sprint is a structured approach to rapidly develop and write projects. Sprints were initially developed by Google to help teams swiftly develop and prototype new products. Paper sprints were later adapted to academic medicine, in particular the University of Michigan School of Public Health Center for Evaluating Health Reform and Institute for Healthcare Policy and Innovation (sph.umich.edu/cehr/resources.html), and the approach has been used with great success by authors. Paper sprints bring collaborators together at the outset to develop an in-depth study plan. The structured paper sprint meeting not only breaks ground, but actually propels the project forward with a clear work plan.

All team members read the relevant literature prior to the paper sprint meeting and should be familiar with the data set, which allows shared input into study design. This approach is far more effective in building the product and relationship than merely having collaborators provide cosmetic changes just prior to manuscript submission. Setting expectations among collaborators around timelines and deliverables is critical. The keys to avoiding diversions that bog down research are having a focused study question, a clearly defined population, and a blueprint for the work product.

Roles need to be carefully delineated. The data analyst should leave the sprint meeting ready to perform a goal-directed analysis and draft tables and figures. The lead writer will simultaneously draft the abstract, introduction, and methods sections. The team can then schedule a second meeting two to three weeks thereafter to review tables, figures, and text. Alternately, the team can reconvene for a two-hour writing sprint to rapidly develop a draft. Once a final version is drafted, the team submits the manuscript to a journal.

How Can I Get Quality Improvement Work Published?

Quality improvement (QI) is a largely untapped reserve of academic productivity. Just as clinical research has gradually gained prominence on par with basic science research, QI has become a critical part of the academic landscape. QI is increasingly seen as a catalyst for improving the practice of medicine, and journals are vying for these articles. Ironically the majority of QI projects languish and are never submitted to an academic journal. This gap is a missed opportunity. QI projects afford valuable insights that can move our field forward.

To be publishable QI projects need to define the problem, engage stakeholders, and utilize established QI methodology. The SQUIRE 2.0 guidelines are a framework for ensuring excellence in QI reporting. QI projects should define methods, interventions, and measurable outcomes. Aligning QI project plans with institutional QI priorities can dramatically increase the resources at the clinician investigator's disposal. Furthermore, effective stakeholder engagement ensures that the multidisciplinary team can sustain successful interventions and meet QI educational requirements set out by the Accreditation Council for Graduate Medical Education.

What Data Streams Can Be Generated from My Clinical Practice?

Clinical practice is a rich repository of opportunities for research and publication; however, fortune favors the prepared mind. The data incidentally collected in the electronic health record (EHR) tends to reflect the chaotic and unruly character of our clinical lives. Such data are often fraught with limitations that limit suitability for research. In contrast using structured tools in a planned, systemic manner can produce a standardized resource for academic pursuits. A variety of strategies can improve both the quality and quantity of data available for analysis.

Patient-reported outcomes (PROs) are low-lying fruit for otolaryngology researchers in any of our fields' diverse subspecialties. In 2020, the AAO-HNS Outcomes Research and Evidence-Based Medicine Committee updated the listing of PROs relevant to otolaryngology-head and neck surgery, which are available to Academy members online **(www.entnet.org/content/outcome-tools).** PROs report health status directly from the patient, unfiltered by clinicians. The questions ask patients directly about their symptoms or perspectives. Many validated PROs already exist, and it is also possible to develop new PRO instruments that can be embedded in everyday clinical documentation. This approach builds a deep reservoir of information for either interventional or observational studies. Inviting patients to complete PRO instruments in the waiting room facilitates clinic flow, engages patients, and conveys commitment to their care.

Clinicians can also improve the quality of the data that they collect from their own clinical assessments. For example, EHRs often allow one to build customized fields for structured capture of data during the clinic. This approach can greatly facilitate data collection at later stages. For greater control of data, Research Electronic Database Capture (REDCap) is a particularly powerful tool that the authors have used for HIPAA-compliant studies. We have used this resource for applications ranging from analysis of the patient outcomes in rhinoplasty practice to benchmarking diverse outcomes for a global quality improvement collaborative that spans countries and continents.

How to Get Started

In summary, one need not accept isolation, long slogs, and unrewarded efforts that die quietly on a laptop as the "cost of doing business." Instead start small, have a plan, and don't go it alone. When it comes time to write, sit down and write something every day. Chip away at it. In 20-30 minutes you can write a paragraph. If you do this every day for two weeks, you will soon have a paper. The first draft does not have to be "good"—in fact it should be awful. Label the first draft a "bad draft" to make the quantum leap from nothing to something. For many writers the greatest hurdle is putting pen to paper. Some successful academics have even opted to dictate into a recorder during a commute to and from work and have it transcribed —a great way to create the bad draft. After submitting an abstract to a meeting, try to create a complete manuscript while the data set is fresh. Then reread and edit it before sending to collaborators who can help turn it into a polished final manuscript. Finally when the work is accepted, be sure to share the celebratory good cheer with collaborators! ■

This topic was presented as a Panel Presentation at the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience.

Gerald L. Gilroy, D.O.

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Icahn School of Medicine at Mount Sinai
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Direct inquiries to:
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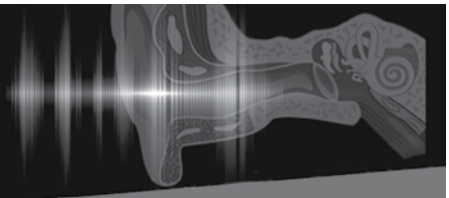

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