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bulletin

October 2021
Volume 40, No. 9

The Bulletin (ISSN 0731-8359) is published 11 times per year (with a combined December/January issue) by the **American Academy of Otolaryngology–Head and Neck Surgery**
1650 Diagonal Road
Alexandria, VA 22314-2857
Telephone: 1-703-836-4444
Member toll-free telephone: 1-877-722-6467

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Postmaster: Send address changes to the American Academy of Otolaryngology–Head and Neck Surgery, 1650 Diagonal Road, Alexandria, VA 22314-2857

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

BULLETIN ADVERTISING
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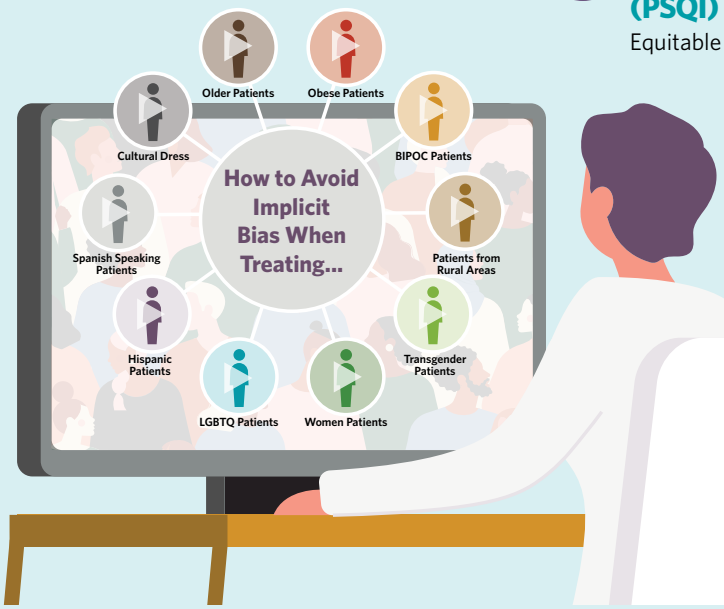

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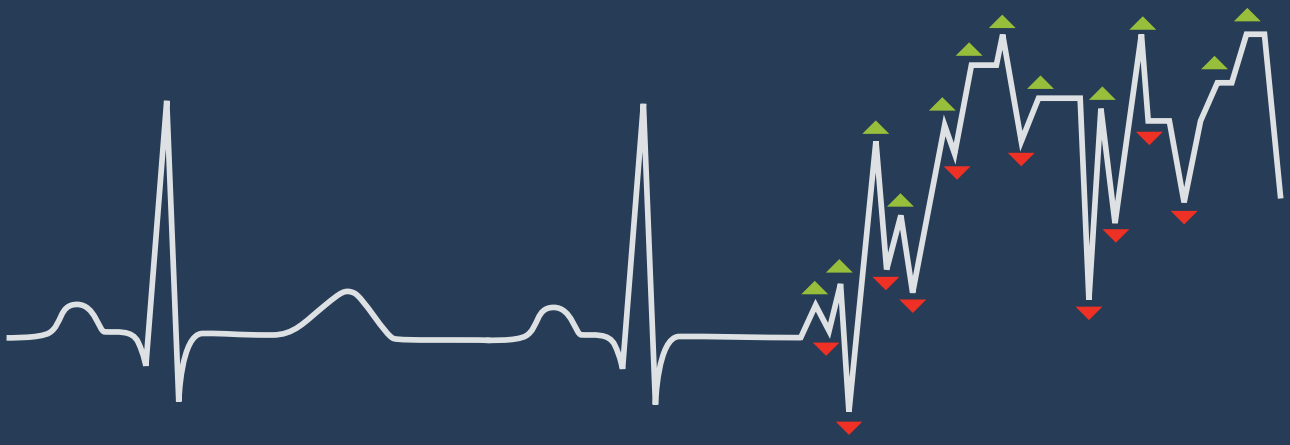
WHOSE INTERESTS

does your malpractice insurer have at heart?



Yet another medical liability insurer has transitioned from focusing on doctors to focusing on Wall Street. This leaves you with an important question to ask: Do you want an insurer that's driven by investors? Or do you want an insurer that's driven to serve you—one that's already paid $120 million in awards to its members when they retire from the practice of medicine?

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"Winter, spring,
summer or fall
All you have to do is call
And I'll be there
You've got a friend"

-James Taylor/Carole King

COVID-19 presented the world with an unexpected, unprecedented, and catastrophic global healthcare crisis. As incoming President of our AAO-HNS/F, I extend congratulations and utmost appreciation for the leadership of our two "COVID-19 Presidents" to date—**Dr. Duane Taylor** and **Dr. Carol Bradford**—as well as the vision and proactive actions taken by our incredible Academy team of **Dr. James Denneny III** and our dedicated Academy staff. This has been a perilous pandemic, and sadly, the end is not yet in sight. I am prepared to continue the battle to protect our providers, our patients, and our offices and staff.

In many ways, the Academy was our lifeline in the spring of 2020—a true friend to all members—whom we could trust and turn to in our moment of dire need. There were terrifying unknowns and fears of this organism's behavior, transmission, and potential for grave illness, not to mention the financial turmoil it produced with so many office shutdowns and serious jeopardy to practice viability. The numerous webcasts, podcasts, and publications were informative, timely, and valuable.

My mother used to say, "War unites a nation and its communities"—I always found it a bit peculiar to view war as anything but terrible. Yet, in many ways, we waged a war against this virus, and the unity that ensued early in the pandemic among our numerous otolaryngologic subspecialties, as well as colleagues from many medical communities, was remarkable, demonstrating a singular purpose to defeat the enemy. We all wanted to stay safe and healthy, protect one another and our families from infection, and ultimately take necessary measures to overcome the enemy and its multiple iterations, yet continue our mission of medical care. Healthcare workers were celebrated as brave heroes.

My original best friend and ally (before I met my wife, Julia) is my father, **Dr. Eiji Yanagisawa**, a pioneering otolaryngologist who immersed himself and his photographic/videographic talents toward advancing and benefitting his patients and our Academy. As he often stated, "In my unbiased opinion, otolaryngology is the best specialty." Turns out he was correct…as was so often the case.

During residency, I befriended many full-time academic and academically oriented private practitioners to create clinical projects, and submit them for presentation at local, regional, or if worthy enough, AAO-HNSF Annual Meeting submission and pray for acceptance. It was thrilling to attend all the meetings and to learn and crystalize new ideas and thoughts about shaping my evolving practice. It was exciting and inspirational to meet great leaders and revered colleagues in our field and to have the opportunity to shake their hands and chat. My father would always capture the obligatory picture (with perfect lighting and composition, of course), which chronicled so many cherished memories! Many of these individuals remain my most valued friends.

As we navigate through the upcoming year, I believe it is vital to communicate with each other about what is working in our practices and what obstacles confront us in maintaining practice success and solvency. COVID-19 and its multiple variants will undoubtedly continue to influence providers' lives, as well as our ability to provide safe and effective healthcare to our patients. There are also impending issues with reduced reimbursements due to governmental mandates and regulations and payer issues. I will dedicate my presidency to confronting these vital practice management concerns, seeking solutions and resolutions.

Many other topics of concern to our membership are on my radar and will be addressed in my upcoming *Bulletin* articles addressing wellness, priorities, advocacy, unity, and mentorship. I am very excited about the new Business of Medicine element of our AAO-HNS/F Strategic Plan that will assist ALL otolaryngologists, as well as the Private Practice Study Group, which will provide a voice for many practitioners on the front lines to share successes, challenges, and most importantly, directions and approaches to address the multitude of problems in our current healthcare quagmire.

The Academy has developed and honed a plethora of activities to benefit its members. As we embark on this journey over the next year together, I hope that all members will have the confidence and trust to reach out to me and the Academy as their friends and partners. We are genuinely interested in members' concerns and will listen intently to understand and hopefully resolve issues as a team. Reach out … "You've got a friend." ■

Ken Yanagisawa MD
AAO-HNS/F President

"As we embark on this journey over the next year together, I hope that all members will have the confidence and trust to reach out to me and the Academy as their friends and partners."

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Moving the Needle toward Wellness and Resilience

In preparation for her term as President of the AAO-HNS/F, **Carol R. Bradford, MD, MS**, and I met during the summer of 2020 to discuss areas that she would like to focus on during her presidential year. We both felt it was important that there was alignment between these goals, the upcoming strategic planning process, our 125 Strong Campaign, and most importantly, the needs of our members and their patients. We had just been informed that we would be unable to hold an in-person Annual Meeting in Boston, Massachusetts, due to the COVID-19 pandemic. Most projections at that time suggested that we would be able to hold a "normal" 2021 Annual Meeting that would mark our 125th anniversary as an organization. Planning had already begun for this celebration that would also need to align with her areas of focus.

Our celebratory event needed a relevant topic and an exceptional Opening Ceremony speaker. As the summer progressed into early 2021 after the completion of the Strategic Plan, it was clear that additional stressors were mounting continually on our members and medical providers in general. Wellness was being challenged and burnout more frequent and intense. We decided to search for an expert who was engaging and offered actionable solutions in distinction to more detailed analytics. We had the great fortune to come across a video of our eventual speaker, Neha Sangwan, MD, who matched precisely what we were after. She lived up to our expectations and more and delivered a fabulous talk based on science with numerous actionable takeaways for the audience. If you have not heard her presentation or would like to hear it an additional time, it is available on the meeting platform and through OTO Logic.

Additionally, Dr. Sangwan offered the opportunity for Academy leadership to take part in an eight-week course designed for the medical community. Several leaders and members of our staff, including me, took part in this course and reaped meaningful benefit from participation. Experiences shared during the course were instructional as she authors her next book as well as were directly beneficial to participants contemporaneously.

When I first began in my role as EVP/CEO in 2014, the recognition of the significance of "burnout" in medicine was in its early stages. We were all familiar with the situational stress and pressure that was increasing in all our practices, but I had never seriously thought about the subject. I began to look at it closely as our representative on an American Medical Association (AMA) Wellness Task Force, and the more I learned, I could see it in my friends in our specialty and in general throughout society. Early on there was a push to identify causative stressors and a great deal of data was published. The recognition that this is a systemic, not individual problem in most circumstances, is critical to moving forward. As a small specialty organization, we did not have the resources to devote to the problem that the AMA and other large organizations did. We therefore tried to advocate to relieve individual stressors, such as the electronic health record, work hours, and payer-related obstacles. We started a Wellness Task Force and scheduled many education presentations at meetings and through our continuing education program.

Unfortunately, most stressors were unable to be reduced and an additional major factor, COVID-19, appeared on the scene. Completing the short course with Dr. Sangwan has given me hope that we can move the needle without getting rid of all the stressors aggravating the problem.

Starting with the scientific basics, such as diet, sleep, and exercise, and extending to communications skills, including listening and understanding, and how to recognize difficult situations, such as Steven Karpman's Drama Triangle, are critical to navigating the difficult circumstances we all find ourselves in. Understanding your physical, social, and spiritual energy and what affects them, especially circumstances that cause you to "leak" energy and worsen the problem is a valuable step in mitigating current and preventing future occurrences.

As part of the Strategic Plan, we proposed the creation of a certificate course in wellness for our members that would include foundational knowledge and strategies that can be personalized for each participant. Those who complete the course will receive CME credit. They will also be part of our Wellness Ambassadors program to be available at meetings and participate as peer-to-peer resources for their colleagues as well as local/regional trainers if so moved. ■

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

> "How you understand and use your social, behavioral, cognitive, emotional, and physical intelligence can make all the difference in whether you experience a positive or negative outcome."

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

New Lifetime and 30-Year Members

The American Academy of Otolaryngology–Head and Neck Surgery congratulates the following members who have earned Lifetime status with the Academy and those celebrating 30 years of membership in 2021. Your commitment to the Academy is a testament to the dedication you have to your colleagues, your patients, and the healthcare community. Your support continues to help us strive to be the global leaders in optimizing quality ear, nose, and throat patient care through professional and public education, research, and health policy advocacy.

The following individuals are Lifetime members:

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milestone moments

1996: The Academy launched its first website at **www.entnet.org**.

2001: The new AAO-HNS Section for Residents and Fellows-in-Training was initiated, giving residents both support and an opportunity to shape their chosen specialty.

2010: The Women in Otolaryngology Committee transitioned to the WIO Section.

2015: The Young Physicians Committee transitioned to the Young Physicians Section.

2018: ENThealth.org launched as the AAO-HNSF patient-focused website.

Register Now: Upcoming Virtual Global Grand Rounds

The AAO-HNSF Global Grand Rounds series is an initiative of the Academy's International Advisory Board (IAB) to improve care of patients and physician education around the globe. It is a virtual event, held quarterly, that is open to all otolaryngologists around the world. Moderated by IAB leaders, each session includes world thought leaders and expert panel presentations followed by an opportunity for attendees to ask questions.

Topic: Thyroid Cancer: New Treatment Paradigms and Technologies in 2021

Date: November 20, 2021, 9:00 am (ET)

Register: **https://entnet-org.zoom.us/webinar/register/WN_3V-lsUj9Q4mIkzPO1ODOhw**

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Call for 2022 AAO-HNS Election Nominees

The AAO-HNS Nominating Committee is calling for recommendations of individuals to be considered for an elected office. Academy members must be in good standing, and it is recommended that they have held membership the last three consecutive years, have proven leadership qualities, be active in the Academy, be familiar with the strategic direction of the Academy, and be able to dedicate the necessary time to serve. Please contact any member of the Nominating Committee requesting he/she support your nomination for elected office and submit your application packet to Lisa Holman, committee staff liaison, at **election@entnet.org**. For more information and the application packet, visit Get Involved and select Annual Election**.** The application deadline is midnight (ET) December 6. No extension will be permitted. ■

Call to Action: Ask Congress to Pass Targeted Liability Protections for Physicians

Physicians who volunteer their time and services during a federally-declared disaster may find themselves subject to unjust lawsuits due to inconsistencies in federal and state laws regarding medical liability. To address this problem, U.S. Representatives Raul Ruiz, MD (D-CA-36), and Larry Bucshon, MD (R-IN-08), introduced legislation to create commonsense, targeted medical liability protections for healthcare professionals that provide care during a public health emergency or natural disaster. Please contact your U.S. Representative today and ask them to sign on as a cosponsor for H.R. 5239, the "Good Samaritan Health Professionals Act."
Click 'Learn More' to contact your U.S. Representative **http://entadvocacy.org/**. ■

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HUMANITARIAN TRAVEL GRANT

Medical Mission in Imus City

In 2020, **Marissa Schwartz**, MD, traveled to Imus City, Cavite, Philippines, with the Philippine American Group of Educators and Surgeons (PAGES). During the trip, Dr. Schwartz worked closely with her fellowship director, **Steven L. Goudy, MD**, as well as many local and international anesthesiologists and surgeons to repair cleft lip, cleft palate, and velopharyngeal insufficiency.

Although the majority of the patients were young children, they also cared for several adults who had been living with craniofacial deformities for their entire lives due to the large disparity between the high cost of care and low socioeconomic status. One adult patient divulged that he dropped out of school at an early age because of the embarrassment of living with his birth defect. A patient of Dr. Schwartz had a cleft lip repair by PAGES and brought her three-month-old daughter to be cared for exactly as she had been over 20 years before.

Given that the timing of the trip coincided with the eruption of the Taal Volcano and the emergence of coronavirus in China, there was an even smaller presence of volunteer anesthesiologists and surgeons than in previous years to provide care for those patients who had signed up for surgery weeks before the team's arrival.

"I am extremely grateful for the support provided by AAO-HNSF, which allowed me to pursue this formative experience. I met wonderful physicians from all over the world, developed meaningful connections with patients, and gained invaluable technical skills. I hope to continue to participate in international medical mission throughout my career," said Dr. Schwartz. ■

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WIO WOMEN IN OTOLARYNGOLOGY

WIO Virtual Speed Networking Event!

Join your WIO Section colleagues on Saturday, November 6, 6:00 - 7:15 pm (ET) for a virtual networking event. Twenty prominent women leaders from the field of otolaryngology-head and neck surgery will share their experiences and advice on topics ranging from wellness, work/life balance, leadership, sponsorship, career transition, underrepresented populations in medicine, financial health, private practice, philanthropy, negotiations, and growth mindset. Small virtual breakout sessions will facilitate networking. Click the following link to register: **https://www.eventbrite.com/e/wio-virtual-speed-networking-event-registration-168343815885** ■

OTO Journal

Don't Miss the Latest Podcasts from OTO Journal

The *Otolaryngology–Head and Neck Surgery* podcast series highlights research published in the official peer-reviewed publication of the American Academy of Otolaryngology–Head and Neck Surgery Foundation. Each podcast, which is moderated by **John H. Krouse, MD, PhD, MBA,** Editor in Chief, and includes the Associate Editor and author of the paper, offers an in-depth discussion about its significance to the global otolaryngology community and quality patient care. To access the library of podcasts, visit **http://sageotolaryngology.sageublications.libsynpro.com**. ■

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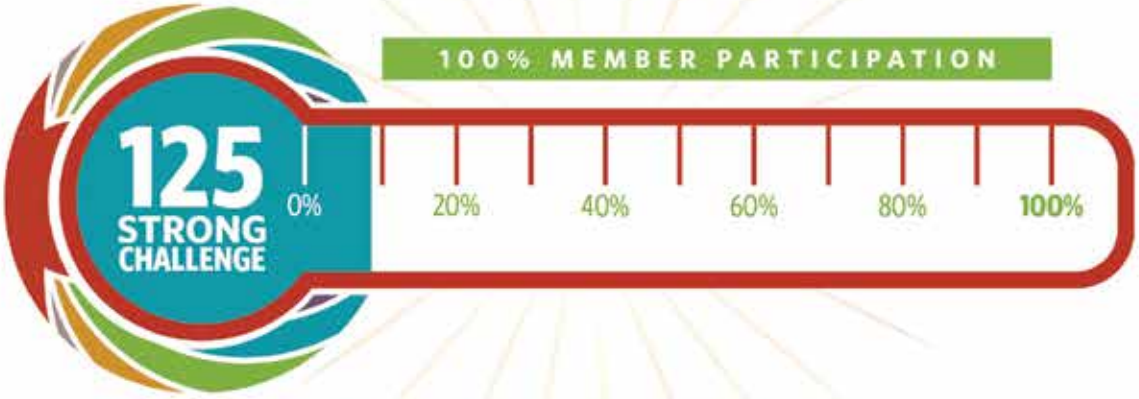

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Member Spotlight Interviews

Soha N. Ghossaini, MD

Private Practice, Queens, New York

Share a little about yourself and your journey to otolaryngology.

My journey started at the American University of Beirut in Lebanon, where I received my MD and did my otolaryngology residency training. I pursued a two-year clinical otology/neurotology fellowship at Columbia University College of Physician and Surgeons in New York City, where I then stayed for six years as an assistant professor. As a foreign medical graduate and someone who trained outside the United States, I had to work twice as hard to gain people's trust. After my time at Columbia University, I had the luxury of working at two other academic medical centers—Penn State Hershey Medical Center and University of Illinois at Chicago—before moving to private practice in New York City, which happens to be my favorite place in the U.S. In my current job I continue to have the privilege of working with residents in the operating room, something I cherish.

What are your guiding principles for practice and patient care?

My guiding principle for my practice has always been and remains to be striving for patient-centered care. Having the patients be my first priority and treating them as I would like my own family to be treated, help me find this balance and allow me to recommend the best possible treatment options for them.

What lies ahead for the specialty?

I believe that the greatest opportunity lies in us working together as one to identify new, unforeseen challenges and to address them appropriately.

How does your work impact you and the communities you serve?

Being involved at the Academy not only helps me be a better physician but allows me to gain more insight into the challenges our specialty face. Such an experience enables me to deliver the best care possible to my patients and advocate for them at the legislative level.

What would you say to encourage others considering volunteer opportunities with the Academy?

Being involved in the Academy adds another dimension to our lives as otolaryngologists and teaches us how to appreciate what we have as a specialty. I have learned a lot from the various volunteer opportunities. I would tell my fellow members that getting involved in the Academy is not difficult to do and is rewarding.

➲ READ MORE ONLINE
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David E. Tunkel, MD

Director of Pediatric Otolaryngology, Johns Hopkins Children's Center, Baltimore, Maryland

Share a little about yourself and your journey to otolaryngology.

I have been at Johns Hopkins in Baltimore, Maryland, as a student, a resident, and now as a faculty member for over 40 years combined. My journey to otolaryngology started in 1983, when great mentors like Bernard R. Marsh, MD, and **David W. Kennedy, MD**, first showed me the range of ear, nose, and throat conditions that are treated medically and surgically. My path to pediatric otolaryngology was guided by the vision of my chair, **Michael Johns, MD**, and I was fortunate to complete pediatric otolaryngology fellowship training with **Kenneth M. Grundfast, MD**, and **George H. Zalzal, MD**. I returned to Hopkins to practice this subspecialty in 1991, at an exciting time when **Charles W. Cummings, MD**, had become chair of our department.

What are your guiding principles for practice and patient care?

My principles that guide my patient care have not changed over time, but with experience I hope that I now follow them more consistently. I emphasize to my patients and to my staff that I want to be accessible, and I also want to deliver evidence-based care.

What lies ahead for the specialty?

In a way our opportunities and challenges for the future of otolaryngology are the same—we have rapidly advanced the science and practice of otolaryngology in so many areas, yet how to broadly deliver these advances to our patients in a cost-effective way is a daunting task.

Describe how your volunteer service to the Academy contributes to the specialty.

I have served the Academy in several ways during my career, but I am currently the Chair of the Guideline Taskforce. While these efforts are often time-consuming and effortful, these groups of talented "volunteers" create a synergy that advances the science and clinical practice of otolaryngology for all our members. The ability to work with Academy leaders and members has been a core part of my career development and satisfaction. Through this participation, I have been given the opportunity to shape the present and future of otolaryngology in ways that exceed the gratifying impact of patient care in the clinic and the operating room. ■

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AAO-HNS *foundation*
WIO
ENDOWMENT
INVESTING IN WOMEN IN OTOLARYNGOLOGY

WIO Endowment FY21 Grant Recipients

The Women in Otolaryngology Endowment (WIOE) was established in 2010 to provide a perpetual stream of funding in the form of grants for projects that support actionable research and projects that are designed to benefit the professional development of women in otolaryngology. We are pleased to announce the recipients of the 2021 WIOE Grants.

Anju K. Patel, MD
Harvard Medical School

Validation of a Surgeon Experience Instrument to Assess the Impact of Gender and Parental Status addresses the critical and time-sensitive need for a more comprehensive physician experience tool that addresses the full spectrum of items that may culminate in women leaving their current job or the profession, particularly within vulnerable groups such as young women and women of color.

Janice Farlow, MD
University of Michigan

Pratyusha Yalamanchi, MD, MBA
University of Michigan

Development of POWer: Podcast of Otolaryngology Women, designed for early-career women otolaryngologists, delivers both pragmatic advice and shares lived experiences to equip listeners with critical nonmedical skills and knowledge needed for successful, fulfilling careers.

Amanda Hu, MD
University of British Columbia

Exploring How Female Otolaryngologists Manage Gender Bias in the Workplace, a study using both quantitative and qualitative methods, assesses how female ENTs manage gender bias in the workplace. It is well established that gender bias occurs in the workplace in surgery. This study will address moving past the realization of gender bias and how to proactively address it.

Michele M. Carr, DDS, MD, PhD
Penn State Health, Milton S. Hershey Medical Center

Influence of Age, Gender, and Race of Otolaryngologists on Parental Seeking of Second Opinions looks at whether immutable characteristics of physicians are associated with changes in the probability of a parent seeking a second opinion in an otolaryngology context.

Deepa Galaiya, MD
Johns Hopkins

Eric Formeister, MD, MS
Johns Hopkins

Gender-based Differences in Operating Room Ergonomics and Musculoskeletal Pain among Otolaryngologists is an objective assessment of ergonomic considerations in real otolaryngologic surgeries and in simulated sessions with exaggeratedly unfavorable and favorable ergonomic positioning in a temporal bone laboratory setting.

Brittany Abud, MD
University of Illinois

Infertility and Pregnancy in the Female Otolaryngologist, a Comparison Study Between Females in Surgical versus Nonsurgical Specialties evaluates the rate of infertility in female surgeons and in particular, otolaryngologists, as well as the climate of pregnancy in surgical subspecialties. The relationship between physically demanding careers and potential effects on fertility and pregnancy, as well as attitudes toward pregnancy and fertility, will be examined. ■

WIO WOMEN IN OTOLARYNGOLOGY

WIOE: Supporting Research and Professional Development

Kelly Michele Malloy, MD
Chair, WIO Endowment Committee

Founded in 2010, the Women in Otolaryngology Endowment (WIOE) has become an increasingly important support source for actionable research and professional development of women otolaryngologists. Our grants have funded critical scholarship in gender disparities in our field—from gendered differences in resident evaluations and operative experience to the complex work-life wellness issues that women surgeons face. The WIOE grants have also supported projects aimed to develop leadership skills and celebrate our rich history, including the WIO documentary "Four Days in Boston: A History of the AAO-HNS Section for Women in Otolaryngology (WIO)," available to view at **https://www.entnet.org/get-involved/sections/women-in-otolaryngology/**.

To demonstrate the impact of WIOE grants on career development, scholarship, and the mission and vision of the WIO, we asked several grant awardees to share their experiences.

"The WIO endowment grant allowed us to host our first Local Women in Otolaryngology (LWIO) event featuring **Dr. Sujana Chandrasekhar** and develop a tool kit for other local groups to follow. By partnering with the state society, the LWIO expanded networking opportunities for women in our state and increased visibility of local women by including more female speakers. From a personal standpoint, the WIO endowment grant fostered my development of leadership skills, allowed for networking and mentorship, and led to additional opportunities within our local institutions, our state society, and the Academy."

— Katherine Kavanagh, MD

"I was able to survey female otolaryngologists identified through AAO-HNS membership to bring to light the unique challenges women in otolaryngology face with fertility and pregnancy. Key findings include women otolaryngologists have children later in life, a substantial proportion have faced infertility, and most women otolaryngologists have regrets about family-planning decisions and career decision making. These challenges are more pronounced than those for female physicians in other fields."

—Debbie Aviva Aizenberg, MD

"The Rx: Fierce podcast that the WIOE funded is alive and well! The WIOE grants support wonderfully creative and impactful ideas that may not find a home in more traditional spaces. It also serves as a launchpad and funding trail for those in academics with surgeon-scientist aspirations."

— Jennifer A. Villwock, MD

WIOE has awarded 20 grants since 2016, and this past year we were able to increase our available grant funds from $15,000 to $20,000. This was possible due to growth of the WIOE via the WIO2.0 campaign and the performance of the WIOE's investment portfolio. Ongoing support of such work requires continued cultivation of WIOE donors. If you would like to provide a high-impact gift this year, please consider the WIOE. Learn more at **https://www.entnet.org/resource/wio-endowment-grants/**. ■

Your donation to the WIO2.0 Endowment Fund will help sustain and grow a vital source of funding needed to support WIO projects including research grants, webinars and podcasts, online learning tools, professional skills training, local WIO Chapters, and will continue to lay the foundation for the next generation of women in otolaryngology.

FY22 WIOE grant application process to open in December 2021. Stay tuned for more information!

The American Academy of Otolaryngology–Head and Neck Surgery and its Foundation extend its sincerest appreciation to our sponsors for their corporate partnership commemorating our 125th anniversary.

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BOG BOARD OF GOVERNORS

Engaging, Building New Connections, and Advancing the Specialty

Lance A. Manning, MD,
Immediate Past Chair, BOG

Following the conclusion of my term as the 39th Board of Governors (BOG) Chair, I wanted to take a few moments to express my gratitude for the opportunity to serve as Chair and work alongside the members of the BOG Executive Council and the BOG Committees. As COVID-19 continued, we never let the pandemic interrupt the fine work of the BOG. We found new ways to engage, built new connections, and continued to advance the specialty.

Here are some of the significant accomplishments over the last year.

Outreach and Engagement with ASCENT. For the past couple of years, AAO-HNS/F has partnered with ASCENT (Administrator Support Community for ENT) on collaborative membership marketing activities. BOG initiated engagement conversations with ASCENT leadership around payment and coding policy and advocacy efforts. So much learning and resource sharing can take place from both sides. Collaboration and continuing dialogue between both organizations are vital, especially to Academy members working in private practice.

Virtual Leadership Forum & BOG Spring Meeting. The Zoom AAO-HNS/F Virtual Leadership Forum & BOG Spring Meeting took place on April 17, 2021, with 210 participants. The conference featured sessions on a wide breadth of advocacy and policy issues, a futuristic view of healthcare economics, analysis of the business of medicine, as well as learning training and best practices. The presenters were a prominent lineup of healthcare and healthcare economics luminaries, including entrepreneur Mark Cuban; Wendell Primus, the senior policy advisor on budget and health for Speaker Nancy Pelosi; Congressman Larry Buchson, MD (R-IN); diversity and organizational change expert Gabrielle Felder; and then president of the American Medical Association, Susan Bailey, MD. The conference participants rated the conference as 82% favorable or very favorable.

At this time, we are planning for the AAO-HNS/F 2022 Leadership Forum & BOG Spring Meeting to be in person at the Westin, Alexandria, Virginia, April 8-10, 2022. It is expected that Capitol Hill Day will be part of the activities.

Society Management Tool Kit. The BOG's Governance and Society Engagement Committee worked to develop a new Society Management Tool Kit that was presented at the Leadership Forum and accessible here: **https://www.entnet.org/wp-content/uploads/2021/06/StateandLocalSocietyManagementToolkit.pptx.**

The Society Management Tool Kit provides guidance on organization administration and governance principles, legislative and advocacy functions, and planning efforts associated with educational and CME programming. The Society Management Tool Kit joins several other tool kits developed over the past few years aimed at assisting regional and local level BOG entities.

Business of Medicine Strategic Focus. The BOG has heavily assisted in the Academy's increased strategic focus on the Business of Medicine. Recently, a new position was created for the Academy's Advocacy team that will emphasize Business of Medicine policy development. Additionally, the BOG held discussions with ASCENT leadership on the development of a Business of Medicine curriculum combining the elements of the current ASCENT certification with refinements related to employment negotiation, quality and performance measures, and strategic thinking components.

Seamless transitions are also part of good BOG governance. **Troy D. Woodard, MD,** took over as the 40th BOG Chair on October 1. Working closely with Troy over the last year, we are all looking forward to his leadership as Chair.

The mark of a strong organization is the talent of incoming leaders. Having worked with the professionals in the slate of candidates for several years, I can attest to the BOG's continuing strength.

Thank you again for allowing me to serve all of you as BOG Chair. It was one of the greatest honors of my professional life in otolaryngology. ■

The Slate of Candidates and BOG General Assembly

The BOG General Assembly was live this year in Los Angeles and was held Saturday, October 2. Thank you to all who attended. One of the critical functions of the General Assembly is to elect new BOG leaders every year.

The BOG Election Approved Slate of Candidates

Chair-Elect

Jeffrey S. Brown, MD

Karen A. Rizzo, MD

Secretary

Cristina M. Baldassari, MD

Boris M. Chernobilsky, MD

For election results, go to **https://www.entnet.org/get-involved/board-of-governors/bog-annual-election/**.

Spotlight: Humanitarian Efforts

Ryan H. Belcher, MD, MPH

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

I currently work at the Monroe Carell Jr. Children's Hospital at Vanderbilt University in Nashville, Tennessee, as a pediatric otolaryngologist. My clinical interests are pediatric thyroid, head and neck mass, global health, cleft lip and palate, and craniofacial disorders. I am on the Vanderbilt Cleft and Craniofacial Team as well as the pediatric ENT surgical director of the Vanderbilt Pediatric Thyroid Nodule and Cancer Program. I also just completed my Master's in Public Health with an emphasis on global health at Vanderbilt University.

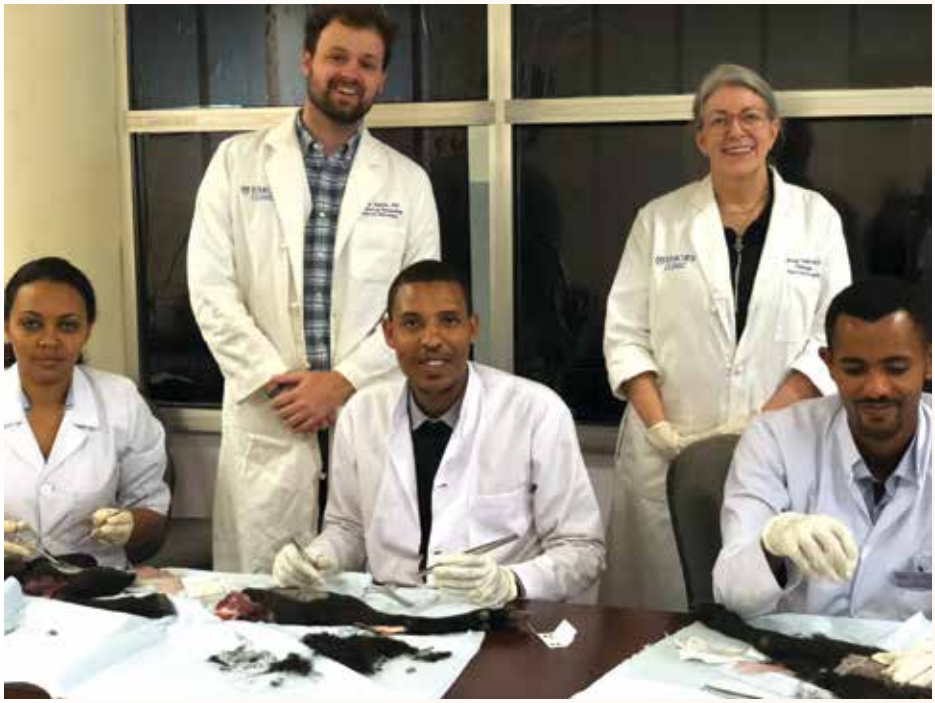
What humanitarian mission or organization are you involved with?

There are multiple organizations that all play a role in my involvement with humanitarian outreach and advancing the specialty.

I had a unique opportunity as a resident at Emory University to participate in a year-long global health curriculum that culminates in a month-long rotation with Addis Ababa University (AAU) in Addis Ababa, Ethiopia. I spent the entire month of March 2018 integrated into the AAU Otolaryngology Program at Black Lion Hospital. This opened my eyes to the wonderful humanitarian and educational work that AAO-HNS members **Miriam I. Redleaf, MD,** and **Glenn C. Isaacson, MD,** had been doing in Ethiopia for many years. I have since gone back to Addis Ababa with Dr. Isaacson to work at the CURE International Children's Hospital where we have continued the surgical and clinical teaching for the Ethiopian otolaryngology residents. We've hosted suture lessons using goats, temporal bone dissection courses, and audiology lectures, among other education activities. I still am in contact with many of the residents (who have now become staff); we keep open communication for clinical questions and requests they may have for education materials.

Most recently, I have been working with World Medical Mission (WMM). WMM supports long-term and short-term global surgery endeavors, and most of my work has been on the short-term side. While WMM has many humanitarian projects, our work with WMM is based at the CURE International Hospital in Kijabe, Kenya. This humanitarian trip focuses on cleft lip and palate and craniofacial surgeries for children. This is not a "fly-in, fly-out" surgery situation as we partner with the Cleft Team at AIC Kijabe Hospital, under the leadership of **David D. Nolen, MD,** for complex patients and continuity of care. We also partner with Nairobi residents for surgical education during the week as well. Dr. Nolen and I have developed a telehealth program for the Kijabe cleft patients that we are piloting soon.

During the past year, as international travel has been halted, I have worked with The Addis Clinic, which is a nonprofit telehealth organization. This program is designed for international clinicians to submit clinical questions and issues concerning pediatric otolaryngology, or other surgical specialties. I answer them electronically on an asynchronous timeline. It is essentially an e-consultation service that any clinician can sign up for.



What got you started in committing your time and practice to humanitarian efforts?

I originally went on a medical mission trip with my church when I was in medical school. This spurred my passion for humanitarian efforts. I was instantly aware that this first medical mission trip was helpful in some short-term ways but was not sustaining for the local population or for the local healthcare professionals. When I was a second year resident I knew a long-term otolaryngology missionary, **Gregg W. Schmedes, MD**, based in Cameroon, Africa, so I spent a week with him. It was there that I started to really understand the global surgery world and what it looked like to train local medical personnel; invest in the community, people, and resources; and concentrate your humanitarian efforts for a long-lasting impact. This invigorated my soul, and I knew that I wanted to make global humanitarian efforts a part of my career. In the following years of residency at Emory, I had role models in **Merry E. Sebelik, MD**, and **Steve L. Goudy, MD, MBA,** who were great examples of how this could be shaped into my career. As a third year resident, I spent a week in the Philippines with Dr. Goudy on a cleft lip and palate surgical trip. Dr. Sebelik and I traveled to Ethiopia for two weeks with Emory's Global Health Scholars Program. Getting started in global health is one endeavor, but the relationships I have been able to make along my journey have been a huge part of the continued practice. My role models in this field have encouraged me and supported me. Here at Vanderbilt, I have been fortunate to have **Dr. Ron Eavey** and **Dr. Jim Netterville** who have set great examples for me and mentored me. Vanderbilt has been a wonderful place to continue with humanitarian efforts with the relationship of our Department of Otolaryngology - Head and Neck Surgery with the Vanderbilt Institute of Global Health.

How does your work impact both you and the communities you serve?

I make it a point that where I do my work and the communities that I serve know that I want to be connected for life and have open communication through technology. I use

WhatsApp, email, or any available technology to continue with conversations that were stimulated during our time in their community. This means still communicating with residents and consultants on surgical advice, providing education resources and even bringing requested supplies and equipment on our next humanitarian trip to ensure the local physicians/surgeons can continue to operate. I believe and hope the advancement of knowledge and the experience that is able to be conferred to these communities will echo for decades as they pass on their experience to the next generations. The eventual and hopeful goal of these humanitarian efforts is that they are no longer needed—that the communities and health systems can sustain themselves, patients are able to get the care that they need, and high-quality surgery can be performed.

The impact my humanitarian efforts has on me has been the hardest question to answer. Not because I don't have an answer, but mostly because words will fall short detailing the full impact. More often than not, when I leave a humanitarian endeavor, I almost always leave better than I was before. The "better" is hard to quantify, but every humanitarian trip has its challenges; navigating and overcoming those challenges make me better. The unceasing joy and hope that the local staff, surgeons, nursing staff, and patients' families have, despite glaring health inequities, make me better as a human and fill me with hope. The continued relationships with local staff also make me better. They make me a better advocate, a better teacher, a better friend.

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

I do think it is easy to get overwhelmed with all the problems in the world and to question whether you can make much of a difference, but support comes in many forms. Just because you can't travel and be on the ground yourself or sit in meetings with the U.S. Agency for International Development, World Health Organization, etc., doesn't mean that you can't make an impact. Many of our colleagues, friends, trainees, and others are very involved with all kinds of projects around the world and are giving their own time and finances to make them successful. Help them. Ask for more information, support them financially, pray for them, and encourage them. Global is also local, so that includes helping local projects in your own city. The world is more interconnected at this time than it ever has been in human history, which means our ability to solve health inequities and global burdens of disease has never been more attainable. We legitimately can all play a role in this narrative.

Any other final comments or thoughts?

If you ever get a chance to go on a humanitarian trip, go! I have yet to meet someone who regretted it. The AAO-HNS/F website is a great resource to find organizations or other Academy members who have recurring trips. The Humanitarian Efforts section of the website has a list of them. Feel free to reach out to me or those listed on the website to get connected. ■

GOT FLEX?

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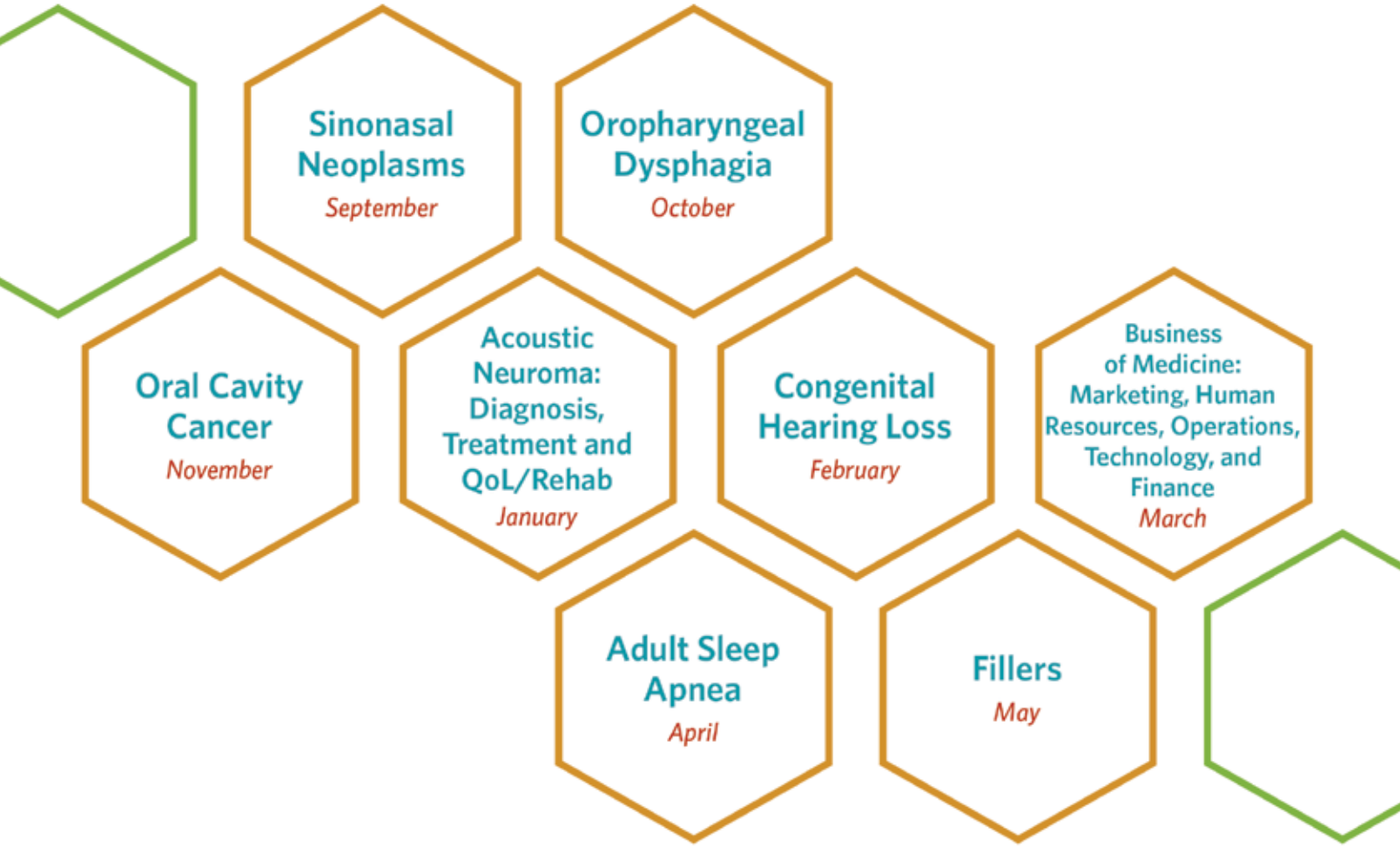

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www.entnet.org/FLEX

Addressing Representation of URiM Physicians in Otolaryngology

Sarah J. Burgin, MD, and **David J. Brown, MD,**
for the Diversity and Inclusion Committee

While underrepresentation is a problem for medicine as a whole, otolaryngology ranks near the bottom for physicians underrepresented in medicine (URiM). A recent study identified otolaryngology as the surgical subspecialty with the lowest percentage of URiM residency matriculants—at 8.5%—in 2018.[1] For comparison, 13.8% of all matriculants into surgical specialties identified as URiM in that study, and 36.2% of the U.S. population identifies as a race or ethnicity that is considered URiM in the most recent census.[1,2] To address this, it is important that we recruit URiM students to pursue otolaryngology.

13.8% of all matriculants into surgical specialties identified as URiM in that study, and 36.2% of the U.S. population identifies as a race or ethnicity that is considered URiM in the most recent census.[1,2]

Medical student choice of specialty is complex and multifactorial. An evaluation of the influential factors on the specialty of choice for all graduating medical students in 2019 found that "personality fit" was a strong or moderate influence for 99% of students, followed by "specialty content" (98%), "role model influence" (81%), and "work-life balance" (77%).[3] In seeking to identify factors for targeted interventions to increase URiM students choosing otolaryngology, "role model influence" is the most readily targeted, while many other identified factors are not readily modifiable. Personality fit is a highly variable metric that is difficult to target.

How can we as individual practitioners and the AAO-HNS as a whole encourage relationship development between URiM students considering otolaryngology and practicing otolaryngologists? First, we must acknowledge that responsibility for increasing URiM recruitment to our field falls to all of us, not only those who identify as URiM. Second, recognizing that these relationships develop most organically when centered on shared professional goals, such as joint research endeavors or shared clinical duties, we need to support and mentor URiM students in their research goals and visiting clerkships. Early, frequent contact with role models in our field can be fostered through partnerships with local Student National Medical Association and Latino Medical Student Association chapters and with historically black college and university medical schools, many of which do not have otolaryngology training programs. Our recent collective shift toward more virtual interactions, including virtual mentorship for research projects, may make it possible to remove some geographic barriers to the development of these relationships. These opportunities need to be publicized outside specialty-specific websites and publications in order to recruit students who have not chosen a specialty.

Otolaryngology as a specialty performs poorly compared to other surgical subspecialties in terms of matriculation of URiM physicians into residency positions. Supporting the development of relationships and mentorship with role models early in students' medical school experiences is an important component of a multifactorial approach to recruitment of URiM students. ■

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CPG

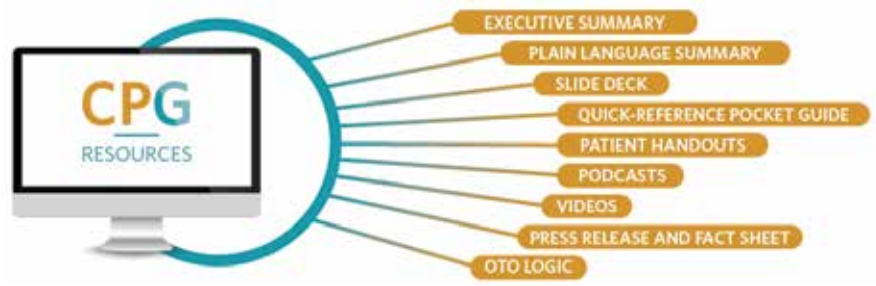
Clinical Practice Guidelines

CPG Resources and Tools

The AAO-HNSF develops Clinical Practice Guidelines (CPGs) on a variety of topics, which are published in *Otolaryngology–Head and Neck Surgery*. As defined by the Institute of Medicine, Clinical Practice Guidelines are "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[1] Guidelines are one way of increasing implementation of evidence into practice. They can serve as a guide to best practices, a framework for clinical decision making, and a benchmark for evaluating performance.

In addition to the published guidelines, the AAO-HNSF also develops a number of supplementary resources to raise awareness and promote the dissemination and implementation of the CPGs. Additional resources for AAO-HNSF CPGs include:

- **Executive Summary** – summarizes the key action statements for clinicians and offers a concise overview of essential text, tables, and figures. It is published simultaneously with the CPG.
- **Plain Language Summary** – shares the main concepts and recommendations from the CPG in clear, understandable, patient-friendly language. It is published simultaneously with the CPG.
- **Patient Handouts** – includes FAQs or other information from the CPG that clinicians can share with patients. They are available in English and Spanish and can be customized with a practice's logo.



- **Quick-Reference Pocket Guide** – provides highlights on the CPG in a booklet format developed by Guideline Central. It is available in print form, as a digital flipbook, and through a mobile app.
- **Slide Deck** – includes information on each CPG key action statement. It is originally presented as an AAO-HNSF Annual Meeting Panel Presentation and then made available to download from the website.
- **Podcast Episodes** – provides information, delivered by CPG authors, on the CPG's implications for otolaryngologists and for non-otolaryngologists.
- **Videos** – provides an overview of the CPG or a specific aspect of the CPG and shared online.
- **Press Release and Fact Sheet** – informs the media about a new CPG and shares important highlights.
- **OTO Logic** – makes each CPG available on the AAO-HNSF's Otolaryngology Learning Network, www.otologic.org.

AAO-HNSF CPGs are widely accessed and cited, and the supplementary resources promote the wider implementation of CPG recommendations. In addition to the Academy website, the CPGs are made available in the Guidelines International Network guideline library and registry of guidelines and the ECRI Guidelines Trust online repository of guidelines. The Academy continues to prioritize the development of new CPGs and updates of existing CPGs to further the goal of defining and promoting quality care in otolaryngology. As we continue in the future, we plan to develop additional resources to continue the growth of CPG dissemination and implementation.

CPGs and their resources are available to AAO-HNS members and the general public. We encourage everyone to check out these resources by visiting www.entnet.org/cpg. Each CPG title has its own webpage with details on the related available resources. ■

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pearls from your peers: Use of Biologics in Our Patients with Chronic Rhinosinusitis with Nasal Polyposis

This month's Pearls from Your Peers is from the Rhinology and Allergy Education Committee and focuses on the nuances of prescribing the relatively new class of biologics for patients with chronic rhinosinusitis with nasal polyps (CRSwNP). We ask Dr. Han about new evidence that can guide decision making, as well as his daily experience in the clinic with patients.

INTERVIEWEE

Joseph K. Han, MD

Professor, Chief of the Division of Rhinology and Endoscopic Sinus and Skull Base Surgery, and Chief of the Division of Allergy, Eastern Virginia Medical School; and President of the American Rhinologic Society

INTERVIEWER

Zara M. Patel, MD

Associate Professor, Director of Endoscopic Skull Base Surgery, Stanford University School of Medicine; and Chair, AAO-HNSF Rhinology and Allergy Education Committee

When would you choose to offer a biologic instead of surgery?

This depends on a lot of factors, and biologics and surgery are not our only options. There are other options available, such as steroid sinus implants, topical steroid rinses and sprays, oral steroids, etc. I truly believe deciding on a treatment option should be a shared decision-making process with the patient, to take their thoughts, preferences, and cost into consideration.

Do you have a preference for use of biologics before, or only after, surgery?

For the majority of CRSwNP patients who have never had surgery before they see me, surgery is my initial choice instead of a biologic. A recent publication[1] demonstrates that most experts, including allergists, agree on this point.

Have you seen an ability to stop other well-known topical therapies (budesonide rinses/fluticasone sprays, etc.) once patients are on this?

Yes, in a minority of CRSwNP patients, they have been able to stop topical steroids. However, I am finding that a lot of patients are still remaining on topical steroids, even with a biologic.

When would you choose dupilumab versus aspirin (acetylsalicylic acid, or ASA) desensitization in our aspirin-exacerbated respiratory disorder (AERD) patients?

I rely on the shared decision-making process to make this choice with the patient. However, both work. Based on my experience, dupilumab seems to have a better and quicker response than ASA desensitization. Also, the adverse effects seem to be lower with dupilumab.

Do you prescribe it yourself or send the patient to an allergist for them to prescribe?

We prescribe it ourselves. Each physician should choose what they feel comfortable with prescribing.

Can you tell yet which particular patients will benefit vs. not?

Yes, I am starting to see a pattern; however, more needs to be done to study this question before we have a definitive answer. Phenotype-endotype seems to help determine which NP patients will have a good response to a particular one of the three biologics approved for CRSwNP: Dupixent, Xolair, and Nucala.

What are the insurance/other logistical issues to consider?

Prior authorization is becoming an issue in prescribing these biologics for CRSwNP patients. However, assistance with this can be found by reaching out to the respective companies. ■

Disclosure:

Dr. Han is a research consultant for Sanofi Genzyme, Regeneron, Astra Zeneca, Novartis, Genetech, and GlaxoSmithKline and is involved in the clinical studies for biologics in CRSwNP.

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OTO Journal

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New Video Series Explores Common Examples of Implicit Bias

What is Implicit Bias?

Implicit bias is the unconscious collection of stereotypes and attitudes that individuals develop toward certain groups of people, which can affect patient access, relationships, care decisions and outcomes. Psychologists refer to implicit bias in healthcare as nonconscious or automatic feelings and beliefs about others that can result in subtle and overt signals affecting the patient experience and the care received.

Why did we produce this series?

The evidence that disparity in healthcare, which occurs on many levels, has been growing to the point that it is universally acknowledged as one of the most significant deficiencies of our current health system. One of the most significant factors identified is implicit bias within the medical team, which is correctable through education and training. Patients who have experienced implicit bias may leave an appointment with a negative and confused feeling, which leads to a lack of trust not only in the physician but in the treatment recommendations as well. These factors often result in the patient's noncompliance; an outcome which can, in turn, shape a physician's treatment decisions and a suboptimal end result. We feel that introducing this information to members of the healthcare team can significantly improve the current situation.

How was the series produced?

The Foundation, through the collaborative effort of the Diversity and Inclusion Committee, created 10 interactive videos that explore the most common types of implicit bias. Written BY practicing physicians FOR physicians, each video depicts two real-world scenarios—first an inappropriate interaction and then that same encounter repeated but free of implicit bias. After completing multi-level review, the scripts were sent to a professional production company that completed the project using professional actors after a thorough review and approval. Past President **Duane J. Taylor, MD**, provided the introductory video for the series.

Who can benefit?

As is graphically shown in this video series, all members of the healthcare team can benefit from a better understanding of and sensitivity to how implicit bias can present itself in patient care situations. We feel this can benefit physicians in the healthcare teams they work with in any setting where patients are seen, evaluated, and treated, including all outpatient and inpatient situations. We feel it is critical to disseminate this information as widely as possible. The series will be housed on the AAO-HNSF website and our Education platform OTO Logic and donated/distributed to all otolaryngology academic programs and to the American Board of Otolaryngology – Head and Neck Surgery. They will also be available for free download to our members and other interested parties. For all attendees at the Annual Meeting, the entire video series will be available through the Juno virtual meeting platform. We encourage you to show it to your office staff and other team members you regularly work with. You will be pleased with the benefits received.

The production of this valuable series was made possible by a successful staff effort to identify funding sources and secure the needed resources for the production. The Academy would like to thank the sponsors of this project—Medtronic, the Josiah Macy Jr. Foundation, Acumed, Integra Foundation, and Olympus Corporation—for their generous support that allowed production of this valuable resource.

A special thank you to the following members of the AAO-HNS Diversity and Inclusion Committee and Foundation staff for their dedication to this project and commitment to providing valuable resources to not only the members of the Academy but to the healthcare community as a whole.

Cristina Cabrera-Muffly, MD, University of Colorado School of Medicine
Christie A. Barnes, MD, University Nebraska Medical Center
Keith A. Chadwick, MD, Sean Parker Institute for the Voice
Basit A. Jawad, MD, Tulane University
Sanjay Parikh, MD, University of Washington Seattle Children's Hospital
Lonnie R. Smith, MD, Kaweah Health Medical Center
Rodney J. Taylor, MD, University of Maryland School of Medicine
Jeffrey Teixeira, MD, Madigan Army Medical Center

Additional Resources

Project Implicit: Explore and identify your own implicit biases by taking implicit association tests or through other means at **https://implicit.harvard.edu/implicit/education.html**.

The Joint Commission offers a free case example on health inequity and implicit bias at **https://www.jointcommission.org/-/media/tjc/newsletters/case-example-no-5.pdf**.

The Academy Created 10 Interactive Videos that Explore the Most Common Types of Implicit Bias:

70 million Adults 20+ are Obese *(CDC 2017-2018)*

When compared with adults at a healthy weight, obese individuals have an increased risk of developing serious health conditions including hypertension; Type 2 diabetes; heart disease and stroke; sleep apnea and breathing problems; some cancers; and mental illness such as depression and anxiety. Obese individuals experience discrimination and stigma, even in a healthcare setting.

41.99 million Black Patients and 6.6 million Indigenous Patients *(International Work Group for Indigenous Affairs, 2020)*

Large health disparities persist between Black and white Americans. The National Academy of Medicine released a comprehensive study concluding poverty cannot account for the fact that Black people are sicker and have shorter life spans than their white counterparts. Many factors likely contribute to the increased morbidity and mortality among Black people. One of those factors is the care that they receive from their providers. Black people are not receiving the same quality of healthcare that their white counterparts receive, and it is shortening their lives.

57.2 million Patients Living in Rural Areas *(www.statista.com, 2020)*

Stereotyping in medicine has serious consequences. Patients who feel judged by healthcare workers are less likely to follow medical instructions and more likely to mistrust their healthcare providers, are less likely to access readily available preventive care and put off treating health problems. In certain rural areas of the U.S., access to basic healthcare is limited and access to a surgical sub-specialist is often non-existent without significant travel.

1.4 million Transgender Patients *(UCLA Williams Institute, 2016)*

Transgender is a term for a diverse community—such as trans women (male-to-female) and trans men (female-to-male), gender queer individuals, and those whose gender identity or expression differs from the societal expectations of how they should look, act, or identify based on the sex they were assigned at birth. Many transgender people experience discrimination in their day-to-day lives that can affect access to healthcare. Transgender individuals may delay seeking medical care because of fear of negative treatment by medical staff.

Scan QR Code to Watch All Ten Videos and Learn More

166.7 million Women Patients *(U.S. Census Bureau, 2019)*

Throughout history, certain women's health complaints were often diagnosed as "female hysteria"– a term implying "it's all in her head." When presented with unexplained neurological complaints, women are 10 times more likely to be diagnosed with conversion or somatoform disorders, the modern terms for female hysteria. Research shows women are prescribed less pain medication than men after identical procedures, are less likely to be admitted to hospitals and receive stress tests when they complain of chest pain and are significantly more likely than men to be "undertreated" for pain.

60.6 million Hispanic/Latino Patients *(Pew Research, 2019)*

Hispanics, sometimes also referred to as Latino, Latina, or Latinx, are the largest ethnic minority in the United States, representing more than 20 countries, with widely differing social circumstances. Hispanics in the U.S. are disproportionately affected by barriers to healthcare. Limited cultural sensitivity, health illiteracy, language issues, access to available services, and a shortage of Hispanic healthcare providers creates challenges for treating this segment of the population.

Over 15 million LGBTQ Patients *(U.S. Census Bureau, 2020)*

The percentage of American adults identifying as lesbian, gay, bisexual, transgender, or queer, commonly referred to as LGBTQ, is rising. Studies have shown half of all respondents have experienced a healthcare provider's refusal to provide care or touch the patient; using excessive precautions, harsh or abusive language; blamed the patient for their health status; or being physically rough or abusive.

67.3 million Patients Where English is Not Their Native Tongue *(U.S. Census Bureau, 2018)*

With the dramatic increase in patients for whom English is not their native language, physicians can be challenged in terms of providing high-quality healthcare and maintaining patient safety. Growing evidence shows language barriers indirectly impact the quality of healthcare patients receive. Language barriers contribute to reducing satisfaction and communication for both patients and medical providers.

About 43% of Muslim Women Wear a Hijab *(Pew Research, 2011)*

The diversity of different religions and cultural norms can create challenges for healthcare teams to better understand how cultural competence impacts care. If the healthcare team is not working together to provide culturally competent care, patients are often left uncomfortable which can impact patient outcomes and satisfaction.

54 million Patients are Over 65 *(U.S. Census Bureau, 2019)*

Discrimination against older adults has an impact on the well-being of those citizens and is a potential barrier to health equality. Studies indicate that physicians may involve older patients in medical decisions less frequently, show less patience and respect, and act less involved and less optimistic. ■

Tech Talk

A Framework for Combating Ransomware

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

For most practices, cybersecurity is not your highest priority. However, a single incident could be catastrophic. Hackers are starting to target small businesses since these organizations are perceived as softer targets, particularly for ransomware attacks. Ransomware encrypts your data until you pay the ransom for the encryption key. To combat the threat practical guidance is needed for managing your cybersecurity risks. At a high level, information security encompasses people, processes, and technologies and concentrates on how to protect the confidentiality, integrity, and availability of information.

Possible impacts of an incident are:

- Loss of patient and other business data
- Adverse effect on reputation
- Decreased productivity
- Loss of income
- Recovery expenses

Based on the National Institute of Standards and Technology (NIST) Framework for Improving Critical Infrastructure Cybersecurity, this article provides practical guidance for managing the risk ransomware poses to your practice. NIST's framework helps organize actions into a standard methodology.

The NIST cybersecurity framework consists of five areas: **Identify, Protect, Detect, Respond, and Recover.** At right is the outline of the NIST framework, along with subordinate actionable steps in each of the five areas.

NIST Cybersecurity Framework

Identify: Increases your practice's understanding of your resources and risks

- Identify and control who has access to your business and patient information
- Require individual user accounts for each staff
- Create policies and procedures for information security (e.g., password policy, internet usage, etc.)
- Inventory all applications and identify the data these applications use and create
- Identify where these applications are hosted and who provides support

Protect: Supports the ability to limit or contain cybersecurity event impacts

- Limit data and information access to a need-to-know basis
- Install surge protectors and uninterruptible power supplies
- Patch operating systems and application software on a regular basis
- Use software and hardware firewalls on all equipment connected to your network
- Secure your wireless access point and networks
- Set up web and email filters
- Encrypt sensitive business information
- Dispose of old computers and media safely (Include printers, too, as they contain hard drives)
- Implement cybersecurity awareness training for all staff

Detect: Enables timely discovery of cybersecurity events

- Install and update antivirus, spyware, and other malware programs on all devices
- Maintain and monitor firewall logs
- Conduct regular health checks on all computers and devices on your network

Respond: Supports the ability to contain or reduce the impact of a cybersecurity event

- Develop a plan for disasters and cybersecurity incidents. The plan should cover roles and responsibilities, what to do when an incident is detected, and who to call in case of an incident
- Develop a communications plan
- Ensure the soundness of the plan with tabletop exercises

Recover: Helps to resume normal operations after a cybersecurity event

- Ensure full backups are done on all systems and data
- Make incremental backups of databases
- Ensure backups are stored off premise or in a different hosting environment
- Ensure you have an adequate number of days backed up (two weeks)
- Regularly test the ability to restore from backups
- Consider cybersecurity insurance
- Review IT processes/procedures/technologies regularly to foster improvements

Developing a robust cybersecurity protection plan to combat ransomware may seem like a daunting task. The NIST framework provides an excellent place to start. Balancing security with the needs and risks of your practice is not easy. Below is an exercise to help discover your risks.

- Identify what information your practice stores and uses
- Locate where is this information hosted (on-site server, Software-as-a-Service provider)
- Estimate impact on your practice if this information was compromised
- Determine if backups of this information are adequate to protect against loss or corruption
- Identify the last time restoration was tested. Backups are great. The ability to restore data is essential

Conclusion

In closing, ransomware attacks are insidious. From a technology perspective, the best defense is to ensure you have adequate backups and that your data can be restored. Addressing the human element may be even more important. Cybersecurity awareness training for all staff needs to be mandatory. Perhaps the most critical piece of advice is to get people to slow down and comprehend their email before responding. Today's work environment is stressful. When it comes to phishing emails designed to trick you into clicking the wrong thing, the axiom "speed wins" does not apply. If we took the time to carefully read our emails, we would more easily identify the ones that are fake. "Slow down and read your email" should be the new mantra for cybersecurity. ■

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Equitable Head and Neck Cancer Care

Evan M. Graboyes, MD, MPH
Carol M. Lewis, MD, MPH
John D. Cramer, MD
Chanita Hughes-Halbert, PhD

The delivery of equitable care is a pillar of quality according to the National Academy of Medicine (formerly Institute of Medicine).[1] Equitable care delivery is also a core component in the mission statement of many healthcare organizations. However, it has been recognized for quite some time that head and neck cancer (HNC) is a disease with profound disparities in outcomes among certain races and ethnicities and other medically underserved populations.[2,3] Although the disparities in outcomes among different groups of patients with HNC reflect a complex interplay of differences biologic/genetic factors, severity of comorbidity, exposure to carcinogens, social determinants of health, and cultural beliefs, a growing body of evidence supports that the failure to deliver timely, equitable care for patients with HNC is a critical driver.[3,4] Concurrently, the COVID-19 pandemic and societal reckoning around racial injustice in the United States have amplified the focus on preexisting racial/ethnic disparities for patients with HNC and catalyzed efforts to improve equity in access, care, and outcomes.[5]

Strategies to improve the delivery of timely, equitable HNC care are therefore desperately needed to improve survival and decrease disparities in outcomes for patients with HNC.[6,7] Delays initiating treatment,[8,9] commencing postoperative radiation therapy,[10,11] and completing the entire package of treatment (from surgery to the end of adjuvant therapy)[12,13] disproportionately burden particular racial/ethnic groups and underinsured patients. These treatment delays are strongly associated with poor oncologic outcomes such as higher rates of recurrence and worse survival.[14,15] The impact of these treatment delays on survival is large, comparable in magnitude to the excess mortality risk conferred by adverse pathologic features such as extranodal extension or positive margins.[14,15]

Prior to a diagnosis of HNC, suboptimal access to care and health literacy hinder detection and delay presentation to a healthcare provider. Regular dental visits are associated with an earlier stage at diagnosis for oral and pharyngeal cancer.[16] However, certain racial/ethnic groups are less likely to have ever received oral cancer screening and are less likely to be screened by a physician.[17,18] Once symptoms develop, patients with low health literacy are also more likely to hold fatalistic cancer beliefs such as "prevention is not possible" or "cancer is fatal" that may delay presentation to a healthcare provider.[19]

Once HNC is diagnosed, disparities in the delivery of timely HNC treatment lead to worse outcomes for certain groups. Several recent studies have begun to elucidate the underlying mechanisms for these delays. For example, a recent publication by Liao et al. identified the three most common reasons for delays initiating treatment as missed appointments, extensive pretreatment evaluation, and treatment refusal.[9] A study by Divi et al. found that the key drivers of delays starting adjuvant radiation therapy were delayed dental extractions, delayed radiation oncology consults, and inadequate patient engagement.[20] Others have expanded on these findings, suggesting that key determinants of delayed adjuvant radiation therapy also include inadequate education about the urgency and significance of timely adjuvant radiation therapy, postsurgical sequelae, insufficient care coordination and communication during care transitions, fragmentation of care across healthcare organizations, travel burden, and inadequate social support.[21,22]

Based on these studies, researchers have now begun applying quality improvement methodologies to improve the delivery of timely, equitable HNC care. A landmark paper from the head and neck team at Stanford University developed a multicomponent intervention targeting the three key drivers of delays starting adjuvant radiation therapy.[20] Examples of intervention components included placing dental consults at the new patient visit, extracting indicated teeth concurrent with the surgical resection, placing a referral for adjuvant therapy at the new patient visit, and providing patient

education about the timeline and steps necessary to start adjuvant radiation therapy. In this pilot study, the multicomponent intervention improved the delivery of timely guideline adherent adjuvant therapy by 11% (from 62% to 73%) relative to the time period prior to the intervention. A recent publication from the Medical University of South Carolina described the development of a navigation-based multilevel intervention targeting (1) patient education, (2) travel support, (3) a standardized process for initiating the discussion of expectations for adjuvant therapy, (4) adjuvant therapy care plans, (5) referral tracking and follow-up, and (6) organizational restructuring.[23] In this pilot study, the rate of timely, guideline-adherent adjuvant therapy was 86% overall and 100% for African American patients. Collectively, these studies provide exciting preliminary data that the HNC care delivery system (1) is potentially modifiable through quality improvement and health systems interventions and (2) represents an appealing target to decrease mortality and racial disparities in survival for patients with HNC.

As we develop strategies to improve the delivery of timely, equitable care for patients with HNC, we can look to cancer care delivery models for other types of cancer with racial/ethnic disparities in access to care (e.g., breast, colon, lung) for guidance.[24] For example, patient navigation is a patient-centered, healthcare delivery intervention that aims to eliminate barriers to cancer care, thereby improving outcomes and decreasing disparities in health. There is a strong evidence base showing that patient navigation improves cancer screening and treatment initiation and decreases disparities in these outcomes.[25] Although there is currently no screening test for patients with HNC, the principles underlying patient navigation are potentially applicable to improving timely HNC care. There is also growing recognition in other fields that quality improvement interventions to improve the delivery of timely, equitable cancer care should be multilevel in nature (e.g., target providers, healthcare team, and the organization).[26]

In conclusion, treatment delays are highly prevalent across the HNC treatment continuum, disproportionately burden racial/ethnic minorities and other medically vulnerable populations, and contribute to disparities in outcomes. Ongoing work is beginning to elucidate the mechanisms underlying treatment delay and resultant targeted quality improvement interventions have significant potential to improve the timeliness, equity, and quality of HNC care delivery. Continued efforts from academy members and collaborations between the American Academy of Otolaryngology–Head and Neck Surgery, the American Head and Neck Society, and other organizations will be necessary to drive meaningful change at the clinical practice and/or health system levels to improve the timeliness, equity, and quality of HNC care. ■

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FROM THE EDUCATION COMMITTEES

Hearing Loss and Cognitive Decline: What Does the Data Say?

Maura Cosetti, MD, Chair-elect, Otology and Neurotology Education Committee

Evidence published during the past decade has established an undeniable link between hearing loss and cognitive decline. Both diseases are increasing in prevalence, with estimates suggesting that 2.5 billion people worldwide will be living with hearing loss and 152 million with dementia in 2050.[1] The relevance of this association is obvious to otolaryngologists and has clear potential for broad and significant public health impact worldwide.

In some of the first, large-scale epidemiologic studies on this topic, Lin et al. and others found that hearing loss was independently associated with a 40% rate of accelerated cognitive decline.[2-4] Prospective cohort data with > 10 years of follow-up demonstrated a linear relationship between severity of hearing loss and dementia risk: Individuals with mild, moderate and severe hearing loss had a two-, three-, and fivefold increased risk of dementia compared to those with normal hearing.[3] Data suggests that even subclinical hearing loss may pose a risk for cognitive impairment.[5] Multiple subsequent meta-analyses have supported these conclusions.[6,7] Loughrey et al. analyzed published data from 20,264 unique participants across 12 countries and reinforced age-related hearing loss (ARHL) as a risk factor for cognitive impairment and dementia.[6]

Results from these population-based cohort studies are compelling both because of the size of the data sets and the consistency of the association across diverse populations. These high-quality epidemiologic investigations used regression modeling to control for confounding variables and covariates (most notably age, cardiovascular disease, and socioeconomic status) and found the strength of the association between hearing loss and

cognitive impairment was still significant.[2-4]

Importantly, however, association does not imply causation, and a number of models have been proposed to explain the possible directions of this association. One hypothesis is that the relationship between hearing loss and cognitive impairment is mediated by reduced socialization, a well-established sequelae of hearing loss. Social isolation and related socio-emotional states such as loneliness and depression are known to have a powerful and profound effects on dementia risk. Another proposed theory cites changes in brain structure and function caused by or resulting from ARHL. Emerging neuroimaging data support a possible neuroanatomical link between hearing loss and dementia, including atrophy of the auditory cortex and frontotemporal regions and increased presence of β-amyloid.[8-10] Finally, the concept of cognitive load and effortful listening may explain or mediate the relationship between hearing loss and dementia. Research suggests that the additional attentional effort required to understand speech in the setting of hearing loss may lead to decreased cognitive reserve and subsequent impairment.[11]

Though it remains unclear which of these mechanisms, independently or in concert, may explain this complex relationship, the potential implications have garnered substantial attention worldwide. Available data were so compelling that the Lancet cited hearing loss as the single most modifiable risk factor for dementia, larger than smoking, diabetes, and education.[12]

As hearing healthcare providers, we routinely witness the undeniable benefit of treating hearing loss, but is there evidence that treatment of hearing loss (either with hearing aids or cochlear implants) can diminish, slow, or prevent cognitive decline?

At present, data to answer this question are limited. Studies show hearing aids improve rates of loneliness and depression among users.[13,14] Comparisons between groups of hearing aid users to nonusers suggested lower rates of dementia in hearing aid users. Here again, however, an appreciation of confounding variables is needed to interpret these results. On average, hearing aid wearers have higher socioeconomic status, higher education, and have greater access to and utilization of healthcare—all factors that have been shown to protect against dementia. An inability to disentangle these confounders requires a nuanced interpretation of the data.

Limited available results from few randomized controlled trials (RCT) have been promising. Brewster et al. monitored improvement in depression scores and memory for adults with depression and ARHL treated with either a hearing aid or a sham aid (10 dB gain) for 12 weeks. Improvements in memory and cognition were seen in the appropriately amplified group, though blinding was incomplete.[15] Results of an ongoing, large RCT examining the efficacy of hearing aids compared with aging health education on cognition in adults with ARHL (Aging and Cognitive Health Evaluation in Elders, or ACHIEVE) began in 2017 and will hopefully provide long-awaited insight into the effects of hearing rehabilitation.[16]

Cognitive decline is one of many recently identified and diverse health-related risks of hearing loss, including falls, morbidity, and overall longevity. It is estimated that interventions delaying the onset of dementia by even one year could decrease the worldwide prevalence of dementia by 10%.[7] Increasing evidence for the individual and public health burden of untreated hearing loss should encourage us to educate our patients about these risks and the potential benefits of intervention. ■

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Psychosocial Aspects of Balance Disorders in the Geriatric Population

Sean P. Holmes, MD, and **Gauri Mankekar, MD, PhD,** members of the AAO-HNS Geriatric Otolaryngology Committee

Jeff is a 67-year-old retired accountant who was relatively healthy until a year ago. He woke up one morning with lightheadedness and imbalance. He was evaluated at an urgent care facility after his symptoms continued to persist. Medical workup and imaging studies ruled out life-threatening causes of his symptoms. The medications prescribed to him were making him drowsy but did nothing to improve his confidence. With persistent symptoms, Jeff became anxious and fearful of falling. He was unable to continue his part-time job, drive, or even work in his garden.

Approximately one out of five elderly persons experiences problems with chronic dizziness, balance, or both.[1] This has been attributed to several factors including age-related peripheral or central vestibular disease, cardiovascular disease, polypharmacy, vision or proprioceptive issues, cervical spondylosis, gait disorders, and psychiatric factors. Other causes that are commonly overlooked during the workup of dizzy elderly patients in the primary care and tertiary settings include cognitive decline and undiagnosed mental health conditions. Gait disorders have been reported in almost 60% of adults between 80 and 84 years of age and 25% of persons in the 70-to-74-year age group.[1] Psychological disorders commonly contribute or influence older persons with dizziness although they may not primarily cause the dizziness.[2] The psychosocial aspects of dizziness in the elderly require specific attention as we strive for mental and physical well-being for our patients of all ages.

Going for a walk in the fresh air or driving to a nearby park is a routine activity for a young healthy adult; however, it may be a complex task requiring a lot of planning for an elderly patient with chronic dizziness and imbalance. At least a third of the patients aged 65 and older reported difficulty walking three city blocks or climbing one flight of stairs.[3] Additionally, mental, physical, and emotional age-related changes can be difficult to cope with for the elderly. An event such as the loss of a spouse or global pandemic, for example, would require a strong and intact coping mechanism to overcome such hardships. Coping skills are dependent on a variety of physical and mental factors, not limited to the ability to move around or drive a vehicle safely.

Tinetti et al. studied a sample of community-living adults 72 years of age and older. Of the study population, 24% reported chronic dizziness.[4] Over a one-year follow-up, chronic dizziness was associated with risk of falling, worsening of depressive symptoms, decline in social activities, and self-rated health. Interestingly, the study results did not show any association of chronic dizziness with mortality, hospitalization due to any cause, or changes in activities of daily living. The authors, therefore, recommended that goals of care in the elderly should be redirected from simply identifying and treating individual diseases to alleviating the associated psychological, social, and physical disability.[4] Dizziness, imbalance, anxiety, fear of falling, and thoughts of losing independence can become a vicious loop for these patients. The fear of falling can alter people's gait, head movement, attention, and influence the initiation of the vestibulo-ocular reflex, all of which promote gaze stability.[5,6] This can negatively impact motor and postural control. A fear of falling in the elderly has been linked to an increase in depression, anxiety, confusion, and feelings of helplessness. These factors limit the ability of elderly patients to empower themselves and persevere through treatment, as well as limit desire for social outings and decrease comfort in social settings. This may worsen the underlying causes of the dizziness by promoting further isolation.

In addition to management of the cause of the chronic dizziness or balance disorder, individualized exercise-based therapy to improve physical conditioning, gait, and strength can help to avoid the dizziness-anxiety-fear loop. Assistance from occupational and physical therapy is inherent to global improvement of elderly patients with dizziness. Conditioning of the vestibular system, developing motivation and confidence with walking and moving, and fall prevention are all key to the psychosocial improvement of our patients. A multimodal team-based approach to treatment of patients with vestibular rehabilitation and adjunctive cognitive behavioral therapy should be considered when planning a patient-specific treatment regimen. ■

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The Head and Neck Cancer program within the Head and Neck Institute is a collaborative effort. Patient care is conducted within the state of the art Taussig Cancer Center (which is in the top 5 in the nation), where a multidisciplinary physician team of head and neck surgeons, medical oncologists, radiation oncologists, radiologists and microvascular surgeons work together to provide customized, coordinated care for patients. The Head and Neck Surgery Section has six Head and Neck Surgeons who perform over 1,000 surgical cases annually with more than 6,000 patients served. It is also home to a highly competitive accredited Head and Neck Oncologic and Microvascular Surgery fellowship program.

The ideal candidate for the Section Head of Head and Neck Surgery should be a recognized leader as an outstanding clinician, educator and scholar, who supports research and education within a multi-specialty organization. The Section Head will have ultimate responsibility for the clinical, educational, research and fiscal oversight in order to achieve personal and institutional successes. The successful applicant will receive a faculty appointment at a rank commensurate with academic accomplishments at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, one of the nation's leading Universities.

Cleveland Clinic is a nonprofit, multi-specialty academic medical center that integrates clinical and hospital care with research and education. Today, with nearly 1,400 beds on Cleveland Clinic Main Campus and 5,895 beds system-wide, Cleveland Clinic is one of the largest and most respected hospitals in the country. We offer a collegial work environment, balanced work schedule, competitive salary enhanced by an attractive benefits package including generous CME, medical malpractice coverage and no restrictive covenant.

Cleveland Clinic is an exciting institution, physician led and patient focused, where innovation is embraced. Career advancement is supported via best in class leadership training via the Mandel Global Leadership and Learning Institute. Advance your career interests through collaborative patient treatment with robust resources for professional development including leadership, education, and management tracks as well as a formal mentorship and coaching programs.

Interested applicants should apply by submitting a CV and letter of interest via link provided below. **(all inquiries will be held in strict confidence)**

https://jobs.clevelandclinic.org/job/cleveland/section-head-head-and-neck-surgery-and-oncology/27575/4461814880

Patrick Byrne, MD, MBA
Institute Chair, Head and Neck Institute
BYRNEP@ccf.org

From its natural treasures – such as Lake Erie and the Cuyahoga Valley National Park – to its many entertainment and cultural attractions, Cleveland is a hidden treasure. Cleveland is home to three professional sports teams, the nation's second largest performing arts center, the world-renowned Cleveland Orchestra and the Rock and Roll Hall of Fame. Cleveland is also a foodie town that ranks high on the global culinary map. A melting-pot culture with affordable homes and top-rated public and private schools and universities, Cleveland provides excellent resources to live and learn. Outstanding healthcare, technology and innovation companies provide the backbone to Cleveland's growing economy.

Cleveland Clinic is pleased to be an equal employment/affirmative action employer: Women/Minorities/Veterans/Individuals with Disabilities. Smoke/Drug Free Environment

Assistant Professor WOT -
Otolaryngology Head and Neck Surgery
University of Washington: Academic Personnel:
School of Medicine: Otolaryngology / Head and Neck Surgery

The University of Washington Department of Otolaryngology–Head and Neck Surgery is seeking one full-time academic clinician/scientist at the rank of Assistant Professor WOT. A major focus of this position is to develop the translational research mission of the Head and Neck Surgery division as Assistant (0113) Professor without tenure by reason of funding. This position would be a multi-year appointment with a 12-month service period (July 1 - June 30). University of Washington faculty engage in teaching, research and service.

This position will be based at both the University of Washington Medical Center and/or Fred Hutchinson Cancer Research Center. The individual will function in a multi-disciplinary practice environment which includes fellow, resident, and medical student teaching and clinical or basic science research. The anticipated start date is July of 2022.

The successful candidate must have expertise in academic otolaryngology. Candidates should have a background and a track record of clinical and scholarly productivity, and a documented record of head & neck cancer research as a major component of their activity.

Minimum qualifications include an MD (or foreign equivalent), certified or eligible for certification by the American Board of Otolaryngology, completion of head & neck surgery fellowship, and eligible for a Washington State medical license. In order to be eligible for University sponsorship for an H-1B, graduates of foreign (non-US) medical schools must show successful completion of all three steps of the US Medical Licensing Exam (USMLE), or equivalent as determined by the Secretary of Health and Human Services.

All applicants should submit a CV, letter of interest, and diversity statement.

Initial deadline for receipt of complete applications is November 1, 2021.

Application URL: https://apply.interfolio.com/91920

Contact Email: otohr@uw.edu

CLINICAL FELLOWSHIP IN
LARYNGEAL SURGERY AND VOICE DISORDERS
Massachusetts General Hospital

The Division of Laryngeal Surgery is seeking applicants for clinical fellowship positions. The fellowship training covers all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences, including phonomicrosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia. The fellow will participate in the management of voice disorders and clinical research as a member of a multidisciplinary team (voice scientists and speech pathologists) that has access to state-of the-art voice clinic and surgical engineering laboratory facilities. The research fellowship provides numerous opportunities to focus on grant-funded (NIH and private foundations) clinical and basic science research projects in collaboration with interdisciplinary teams of scientists and clinicians at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The option to collaborate with local music conservatories is also available. Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.

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

Opportunities

Geisinger Department of Otolaryngology

Wilkes-Barre/Scranton and State College, Pennsylvania

For over a century, Geisinger has created easy access to healthcare for our friends and neighbors in Pennsylvania. That spirit of innovation still drives us today with a 20-year clinical data warehouse (Geisinger was one of the earliest implementers of Epic), our groundbreaking population genomics program which links multiple generations of clinical data, and an unwavering commitment to value-based primary and specialty care. You'll have opportunities to better your life and make a difference in the lives of your neighbors – at home and across the country.

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- Otology
- Rhinology
- Facial Plastic Surgery

Fellowship training or experience in health services research is preferred.

As a physician-led system, we offer several convenient locations that are 2.5-4 hours from New York City, Philadelphia and Baltimore. We serve over one million residents in Pennsylvania in a system of nine hospital campuses, a 550,000-member health plan, two research centers and the Geisinger Commonwealth School of Medicine. With approximately 24,000 employees and more than 1,600 employed physicians, Geisinger boosts its hometown economies in Pennsylvania by billions of dollars annually.

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

Geisinger Commonwealth School of Medicine

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*Does not qualify for J-1 waiver. AA/EOE: disability/vet.

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