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

APRIL 2022

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President

Ken Yanagisawa, MD

Executive Vice President, CEO,

and Editor of the Bulletin

James C. Denny III, MD

Managing Editor

Tina Maggio

bulletin@entnet.org

INQUIRIES AND SUBMISSIONS

bulletin@entnet.org

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Fax: 1-913-344-1492

sdittbner@ascendmedia.com

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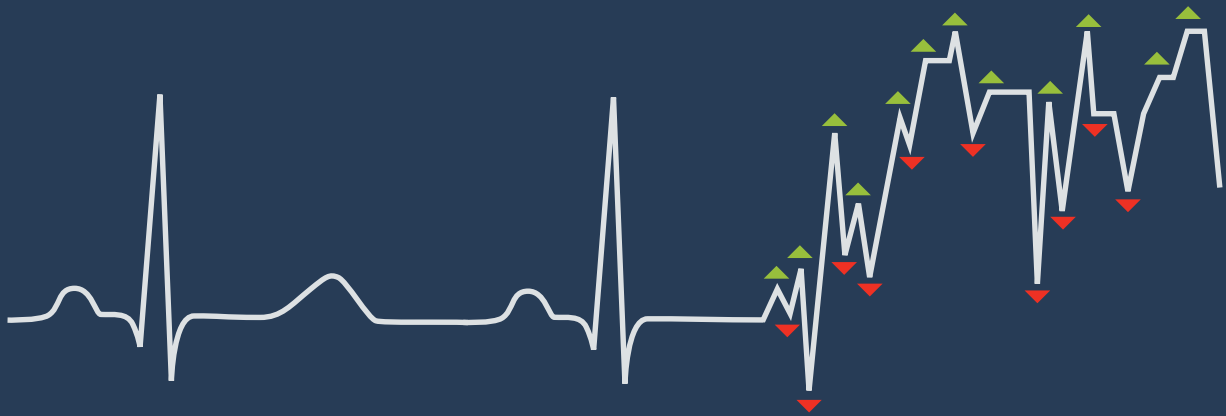
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WHOSE INTERESTS

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?

Join us and discover why delivering the best imaginable service and unrivaled rewards is at the core of who we are.



Communication: The Key to Understanding

Communication is so often the root of misunderstandings and errors.

As a young attending, I discussed by telephone the results of a patient's laryngeal biopsy showing mild dysplasia. Appropriate questions were asked and seemingly answered clearly and thoroughly about whether this was or could become cancer. Two weeks later, during an in-person office encounter, my patient looked haggard, depressed, and had even lost weight. Concerned about new health issues, I queried what was going on. "You told me I have cancer," was the stunning reply.

I immediately recognized the importance and impact of the words we choose to employ, the method of information sharing, and of course, inherent patient assumptions, concerns, and fears.

I looked my patient straight in the eye, and explained that there was no cancer. Once the "C" word was mentioned via phone, however, the patient tuned out any other input. Without visual or body language cues, all I had was a voice to gauge understanding. During the subsequent live visit, I felt assured that my patient finally grasped the results and details accurately.

Visual cues such as lip reading and interpretation of telling facial expressions are so crucial and missed by telephone communication. Masks for the past two years have had significant deleterious effects on this aspect of our communication.

Video communications, aka telehealth or Zoom, are better, but far from perfect. Texting, of course, is a set-up for dangerous miscommunication as words alone without vocal contexts (intonation, emphasis, volume) can and are often misconstrued.

The simple word "right," for example, can have a wide spectrum of meanings—a confirmatory declaration, an inquiring question, at times a sentence connector (a contemporary "um"), or even a sarcastic jab (with eyes rolling). Humor or sarcasm via texts, or social media for that matter, should be undertaken with extreme caution.

To highlight and hopefully improve the many ways we communicate with one another, the AAO-HNS designates certain times each year to celebrate various aspects of our communication offerings.

World Voice Day takes place annually on April 16. Originated in Brazil in 1999, the AAO-HNS officially

recognized and titled the day as "World Voice Day" in 2002. This day reminds everyone to appreciate, care, and value vocal health, and to recognize warning signs for voice disorders. From everyday conversations to professional speakers and singers, our voices allow sharing of emotions and expressions. Organizations celebrate World Voice Day with lectureships, vocal screenings/counseling, and celebratory speaking and singing events.

May is **Better Hearing and Speech Month** that provides opportunities to raise awareness about disorders ranging from childhood speech delay to presbycusis. The pandemic has added significant obstacles with challenges identifying school issues and timely provision of appropriate care. As our population ages, nearly 50 million adults are estimated to have hearing loss. With mounting recognition of hearing loss detriments including cognitive decline and social isolation, it is vital to identify, counsel, and treat this problem. The AAO-HNS has numerous [ENThealth.org](https://www.enthealth.org) links, resources, and tools to aid in raising awareness. On legislative fronts, the AAO-HNS continues to closely monitor and act upon activities surrounding audiology scope of practice, retention of physician clearance for hearing aids, and even challenges to hearing aid sales by physician offices.

World Sinus Health Awareness Day was established by the AAO-HNS in September 2021 to help raise awareness about sinus disorders, especially in light of the COVID-19 pandemic, and has included various anosmia issues. Smell is a less recognized yet important contributor to nonverbal communication—the pungent and distinct smell of certain infectious disorders, the unmistakable smell of smoke/tobacco/cannabis, and the odors of personal hygiene, which can be pleasing or not so pleasing.

The art of hearing and more importantly listening, the willingness to recognize and understand the verbal and nonverbal cues, and the ability to dialogue and discuss are crucial elements in attaining successful communications, fruitful interactions, and hopefully reduced misinterpretations. *"Communication is a skill that you can learn. It's like riding a bicycle or typing. If you're willing to work at it, you can rapidly improve the quality of every part of your life."* ~ Brian Tracy



Ken Yanagisawa, MD
AAO-HNS/F President

“ I immediately recognized the importance and impact of the words we choose to employ, the method of information sharing, and of course, inherent patient assumptions, concerns, and fears. ”



FORWARD TOGETHER

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The Unconscionable “Catch-22” of Current Practice

As I went through my typical morning routine on a recent Tuesday, checking my emails from the previous night and early morning prior to heading off to the office, there was a particularly interesting email from a comprehensive otolaryngologist friend of mine from Michigan. It led off: “Hi Jim, sharing some random thoughts with you this morning.” The more I delved into the document the more I realized that these were no ordinary random thoughts, but instead one of the most compelling poignant portrayals of current medical practice for the majority of physicians in this country.

Dr. Bobby Mukkamala had captured the “Catch-22” scenario physicians find themselves in as they plod ahead without complaining but questioning, “What can I do now?” and depicting a sense of isolation and helplessness we’ve all experienced. He has agreed to allow the *Bulletin* to reprint these shared thoughts, which you will find in “A Stream of Consciousness: Administrative Exasperation Getting in the Way of Our Purpose” on page 12.

Most physicians never envisioned spending the excessive number of hours on documentation, chasing down records, and the ever-expanding list of administrative duties added regularly by payers, hospitals, government mandates, and life itself. Few imagined spending well over 50% of their practice collections to run a practice. How did we get to this point? Why wasn’t the insidious decline in a physician’s health related to these requirements acknowledged early on as they were evolving? Instead, unlike other segments of society where opinions of discontent and concern for failed endeavors are encouraged, or at least tolerated, the same behaviors at academic centers and in the hospital hierarchy are dealt with punitively. Those daring to question the “company line” are labeled as malcontents and “hard to work with.”

For many, the fact that the two most overused terms of the era, “quality” and “value” used individually or in combination as the banner of justification for physician sacrifice, may never be achievable as promoted under current conditions only adds to daily frustration. The linchpin of the system, the electronic medical record (EMR), first codified in the American Recovery and Reinvestment Act of 2009, has added billions of dollars of extra cost to the healthcare system in the United States in addition to becoming a repetitive “top three” cause of physician burnout. The EMR with all its proprietary variations for the most part has failed miserably to truly advance patient care. We have not

been able to define outcomes, much less “best care.”

How could so many be wrong? The concept seemed failproof and was promoted almost without objection. The current situation was **absolutely predictable** from the beginning based on the government’s failure to establish and enforce a common platform that all proprietary products would use to exchange healthcare data and information from multiple sources in a language usable across the entire healthcare system. By failing to create a system with standards to ensure interoperability, the regulators doomed the full potential of this technological advance at its inception. Had they followed the model of the old telephone system and later cellular communications with towers that allowed different technologies to use the same base system, they could have fostered innovation and competition that would have moved things forward and avoided the mess we have today.

Most of the time, regulators and rule makers at all levels seem to have no problem in mass-producing and assigning a litany of supplementary tasks that add significant work and cost borne by the physician and/or their staff that does not improve care. Hospital administrations, private payers, and government agencies have certainly mastered this strategy and use it regularly. The fact that the required information and criteria vary so widely in the private insurance industry is obstructionist in itself and could be easily remedied by establishing uniform criteria and documentation requirements across the industry. This would not only save time and money for both sides but also create a climate of fairness and equity in healthcare to the ultimate benefit of patients.

The most egregious example that I recall is the recent regulations issued by the administration to operationalize the No Surprises Act (NSA). Legislative intent was to prevent out-of-network and uninsured patients from receiving large surprise medical bills. Aside from the Independent Dispute Resolution (IDR) that currently is undergoing judicial review following several lawsuits against the administration, the clerical tasks required to treat patients in these circumstances, particularly patients requesting a Good Faith Estimate (GFE), are untenable and unconscionable. There is no way that the average practice can comply with these requirements and have time to conduct a normal patient practice.

Enough is enough. Preservation of our profession may well depend on stopping this onslaught sooner than later. ■



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

“
The current situation
was absolutely
predictable from the
beginning based on
the government’s
failure to establish
and enforce a
common platform...
”

■ at the forefront



New Four-part Webinar Series on Hiring in Healthcare Today: The Diagnosis, Prognosis, and Treatment

The AAO-HNS Board of Governors is offering a new four-part webinar series, Hiring in Healthcare Today: The Diagnosis, Prognosis, and Treatment. This series tackles healthcare recruiting and gives practical expert advice on understanding the current environment by focusing on successful strategies to build, nurture, and grow a pipeline of candidates as well as how to maximize your website and social media channels as recruitment tools. In addition, the series will take a deep dive into what matters most to young physicians.

To learn more about the series and register, go to https://entnet-org.zoom.us/webinar/register/WN_quFCABYkSW6atNAKlhJPQ.

Hiring and the Changing Landscape

April 26, 8:00 pm (ET)

Unconventional Strategies for Recruiting: Thinking Short and Long Term

May 17, 8:00 pm (ET)

Leveraging Your Website and Social Media to Recruit

June 7, 8:00 pm (ET)

Remaining Relevant: What's Important to the Current and Next Generation

June 28, 8:00 pm (ET) ■



International Perspective on Publishing and Avoiding Predatory Journals

On March 3, 2022, **José Florencio F. Lapeña, Jr., MD**, presented “International Perspectives on Publishing, Peer Review, and Avoiding Predatory Journals” for the AAO-HNSF Resident Reviewer Development Program (RRDP) and International Community Curriculum. Dr. Lapeña has been a star reviewer for *Otolaryngology–Head and Neck Surgery* since 2015.

During the presentation, Dr. Lapeña shared these tips for avoiding predatory or pseudo journals:

1. Check to see if a journal claiming to be open access is listed on the Directory of Open Access Journals (DOAJ) at <https://doaj.org/>.
2. Ask questions. Is the journal indexed in reputable databases? Is the publisher a member of **COPE**, **STM**, **OASPA**, **EMAME**, or **APAME**? Does the journal uphold **WAME**, **ICMJE**, and **CSE** guidelines? Do not take the journal's word; check these scholarly organizations' websites.
3. Follow Think. Check. Submit. Please see <https://thinkchecksubmit.org/>.

Dr. Lapeña also revised the World Association of Medical Editors resources for editors, researchers, funders, academic institutions, and other stakeholders to help distinguish predatory journals from legitimate journals. If you missed this informative webinar, a recording is available at www.entnet.org/rrdp-international.

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ONLINE ➔



2022 International Visiting Scholarship Program

Are you an international otolaryngologist-head and neck surgeon, less than 40 years old, or within the first eight years of professional practice, and in a junior full-time teaching position?

You may be eligible for the AAO-HNS International Visiting Scholarship (IVS). The IVS program offers a limited number of scholarships to junior academics from low-resource countries to attend the AAO-HNSF Annual Meeting & OTO Experience and participate in an academic observership at a U.S. otolaryngology department or institution (arranged independently by the candidate).

IVS awardees receive a one-year membership to the AAO-HNS, a monetary award of \$2,000 (USD), and a waiver for the AAO-HNSF 2022 Annual Meeting & OTO Experience registration fees. The application deadline is May 1. <https://www.entnet.org/resource/international-visiting-scholarship/> ■



The Reg-ent registry has been addressing a number of priorities since its inception in 2015. Last year, the AAO-HNS team developed a patient-reported outcomes module focused on age-related hearing loss for use by Reg-ent practices treating this condition. Work continues on adding additional otolaryngology outcome modules to Reg-ent, including SNOT-22.

In addition, Reg-ent provides qualified clinical data registry (QCDR) guidance and education materials and has built new partnerships with additional electronic health records (EHRs) used by our participants. To date, Reg-ent has interfaces built with 24 EHRs. As the Centers for Medicare & Medicaid Services (CMS) plans to phase out traditional Merit-based Incentive Payment System (MIPS) reporting and move toward MIPS Value Pathways (MVPs)—a focused set of measures and activities that are more meaningful to our specialty—we are ready to help Reg-ent members prepare for this transition. It is crucial that we engage Reg-ent participants with the otolaryngology-specific measures in Reg-ent to set them up for success in MVP reporting. Our members can do this by reporting Reg-ent QCDR measures beginning in 2022 and participating in the data validation and measure refinements associated with these measures. We will be sharing more updates on our MVP collaboration with CMS in the research-and-quality-focused issue of the *Bulletin* in July.

One of the largest undertakings of the Reg-ent team in the past two years is developing the research capabilities of Reg-ent by working with FIGmd and OM1 to extract and curate the data set to ensure that Reg-ent is able to provide research grade data and opportunities for clinical research projects. These projects will allow otolaryngologist-head and neck surgeons to connect and collaborate on meaningful research and to elevate the specialty and improve care for the patients they treat.

To find out more about all Reg-ent benefits, please contact the Reg-ent team at reg-ent@entnet.org and sign up today! ■

Humanitarian Grant Awardees

Congratulations to the following residents who each received a \$1,000 travel grant for medical missions taking place during the first six months of the year (January-June 2022).

Britton P. Beatrous, MD

University of Mississippi Medical Center
Kenya Relief Organization
Migori, Kenya

Robert T. Cristel, MD

University of Illinois-Chicago
Kenya Relief Organization
Migori, Kenya

Cody B. Jeu, MD

University of Illinois-Chicago
Kenya Relief Organization
Migori, Kenya

Michael M. Li, MD

Ohio State University Wexner Medical Center
Project Ear, Inc.
Los Alcarizos, Dominican Republic

Akash N. Naik, MD

Ohio State University Wexner Medical Center
Project Ear, Inc.
Los Alcarizos, Dominican Republic

Gaelen B. Stanford-Moore, MD, MPhil

UC San Francisco
University Teaching Hospital Kigali
Kigali, Rwanda

Sarah M. Yang, MD

Loyola University Medical Center
Community Empowerment
San Juan de la Maguana, Dominican Republic

Deadline is May 31, 2022, to submit applications for missions taking place July 1-December 31, 2022. Visit <https://www.entnet.org/get-involved/humanitarian-efforts/humanitarian-travel-grants/> or contact humanitarian@entnet.org for more information. Applications, including support letters, must be submitted as a PDF to humanitarian@entnet.org. ■



■ at the forefront



Meet Our Academy Member Donors

<https://www.entnet.org/Donors>

It is with gratitude and appreciation that the AAO-HNS *foundation* sincerely thanks our donors for their generous support over the years and for creating a tradition of giving back to their specialty to provide opportunities for the next generation of otolaryngologists around the globe.

Commemorating the Academy's 125th anniversary as a specialty organization, the **125 Strong Campaign** was launched in 2021 to raise funding for four new programs: **Diversity, Equity, and Inclusion; Education; Leadership Development and Mentorship; and Wellness**. Join your colleagues and help shape the future of your specialty at www.givebutter/125Strong.



For more information about the AAO-HNS *foundation*, go to <https://www.entnet.org/about-us/aaohns-foundation> or contact Marylou Forgione, MBA, Senior Manager of Development, at mforgione@entnet.org. ■



WIO Day Celebrations

WIO Day is held annually on March 8 in conjunction with International Women's Day, a global day celebrating the social, economic, cultural, and political achievements of women, as well as a time to recognize the remarkable achievements of women in otolaryngology around the world. As part to the celebration, WIO members celebrated together and shared testimonials about their colleagues, which are posted on the Academy webpage of acknowledgments at <https://www.entnet.org/get-involved/sections/women-in-otolaryngology/wio-acknowledgements/>. Sentiments on the significance of the day were also shared on social media. To see a compilation, go to <https://wakelet.com/wake/OyWwawJiS0e9cuovkTryB>. ■



pearls from your peers:



Pediatric Tonsillectomy: Optimizing Pain Control and Minimizing Perioperative Risk

INTERVIEWEE

Kris R. Jatana, MD

Professor and Director of Clinical Outcomes for the Surgical Services, Nationwide Children's Hospital, Columbus, Ohio

INTERVIEWER

Patrick Walz, MD

Department of Otolaryngology at Nationwide Children's Hospital and Associate Professor of Otolaryngology-Head and Neck Surgery at Ohio State University College of Medicine

Pediatric tonsillectomy is a very common procedure with over 500,000 procedures performed in pediatric patients every year. Otolaryngologists regularly discuss the common risks of tonsillectomy, including postoperative pain that can last up to two weeks, dehydration, and the risk of post-tonsillectomy bleeding.

In some patients, postoperative pain can be severe and require opioid medications. Inadequate pain control can lead to dehydration requiring IV fluids. The need for urgent or emergent control of oropharyngeal hemorrhage can be anxiety-provoking for both patients and parents. The Department of Pediatric Otolaryngology at Nationwide Children's Hospital in Columbus, Ohio, led by **Kris R. Jatana, MD**, professor and director of Clinical Outcomes for the Surgical Services, approached these challenges from a quality improvement perspective. I sat down with Dr. Jatana to get a better sense of the efforts made and progress.

How are you balancing the goal of making sure postoperative pain is being controlled while still trying to minimize the use of opioid medications?

We initially optimized the use of nonopioid medications as first-line therapy. We developed a visual pain tracking form for use of nonsteroidal anti-inflammatory drugs and acetaminophen, including maximal weight-based dosing and frequency on discharge instructions. For patients admitted overnight or monitored in our short-term observation unit—if they did not require an opioid dose

during this period—they were not sent home with a prescription. For ambulatory surgery center patients, opioids were considered on a case-by-case basis by the surgeon.

One key driver was the ability to e-prescribe opioids, which allowed us to avoid the prior inconvenient requirement of a paper script. If pain was uncontrolled, parents could call in and discuss with our team 24/7. When we launched the project, we realized our surgeon-prescribing practices were quite variable. When prescribed, we now give an average of 14 doses.

Prior to prescribing, we utilize a written opioid consent that discusses the side effects, risk of addiction, proper storage, and disposal. This consent is signed by the parent or legal guardian, and one copy is given to them, with the other placed in the patient's chart.

What efforts have been made to decrease post-tonsillectomy hemorrhage?

In parallel, our department has tracked return to the operating room (OR) for control of post-tonsillectomy hemorrhage cases. As we utilized more ibuprofen to reduce opioid prescriptions, we saw our hemorrhage rate increase. We then incorporated the use of a new celecoxib protocol (no platelet dysfunction) instead of ibuprofen that includes a pre-prescribing discussion with families of its off-label use.

While postoperative pain control is an off-label indication for celecoxib, the medication has long been used for pain control in juvenile rheumatoid arthritis in pediatric patients and is FDA-approved over the age of two for that indication. In addition

to the celecoxib protocol, our surgeons now offer both total and intracapsular tonsillectomy techniques when appropriate.

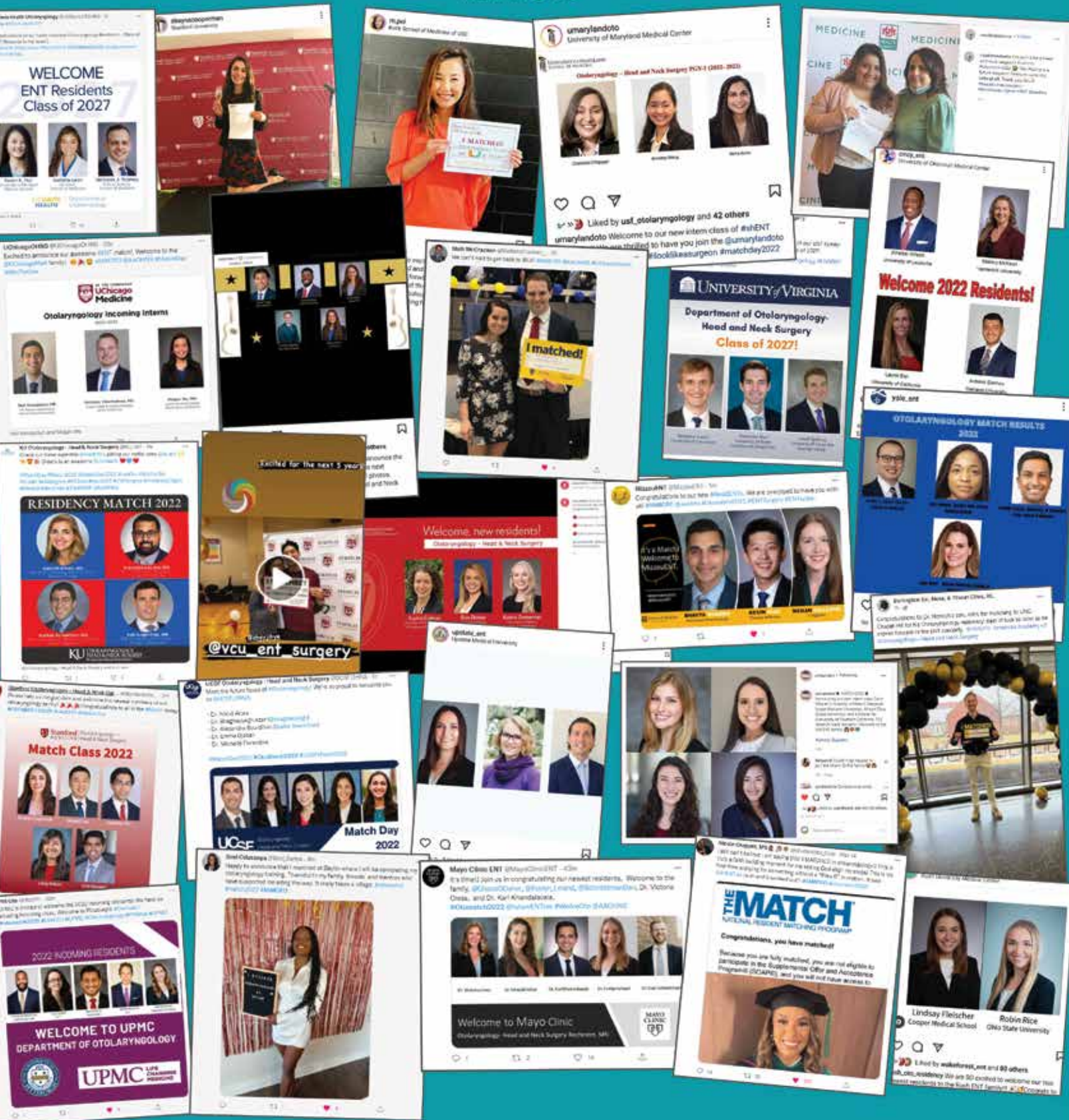
Our group worked collaboratively to educate surgeons who had not previously utilized the intracapsular technique, and utilization of intracapsular tonsillectomy has increased. As another risk-reduction strategy, we worked with our hematology colleagues to develop a focused and standardized preoperative bleeding risk assessment tool that is only six questions. If an elevated preoperative risk is identified with this instrument, a hematology evaluation is completed prior to surgery.

Let's talk numbers. What sort of impact has the group seen since initiating these efforts?

We went from about 90% of patients getting an opioid prescription in 2016 to 11% in 2021. When prescribed, the number of doses has been reduced by >50%. In addition, our group has reduced the operative control of hemorrhage rate by >60% since implementation.

In 2020-2021, by implementing these interventions in the context of our surgical volumes, we have prevented 91 children from returning to OR for control of hemorrhage. We have also reduced nonoperative readmissions and emergency room and urgent care visits for post-tonsillectomy complications by >50%. In the days of value-based care and continued commitment to quality patient care, these efforts have enhanced the quality and safety of one of the most frequently performed procedures on our pediatric patients. ■

**AAO-HNS Welcomes the Class of 2022
Otolaryngology-Head and Neck Surgery Matches
#IAMOTO**



Visit www.entnet.org/otomatch to see a compilation of Match Day activity shared on social media.

AAO-HNS SRF 2015-2019

Survey Results

Residents tell their stories



The majority of Residents plan to pursue or have matched into Fellowship.



Over the five-year period, the number one reason for pursuing Fellowship is surgical cases, followed by the nature of clinical and medical problems.



The subspecialties of choice for Residents are consistently Head and Neck, Facial Plastics, and Pediatrics.



In the past five years, Residents averaged over \$200,000 in debt.



SRF

SECTION FOR
RESIDENTS AND
FELLOWS-IN-TRAINING

Jake J. Lee, MD, SRF
Chair-elect



Do you know about the Section for Residents and Fellows-in-Training (SRF) annual

survey? The SRF conducts an important, anonymous survey to better understand the needs of our trainees in a longitudinal way, informing and connecting the Academy leadership with trainee perspectives. The survey follows trends in demographics, educational debt, fellowship interest, and anticipated practice setting. Other recent topics include social media attitudes, pandemic concerns, business of medicine knowledge, research engagement, and emotional intelligence.

Recently, the results from 2015 to 2019 were compiled and summarized.

Over 2,000 responses were submitted. The majority of respondents were identifying as male (1,169/2,027, 58%) and were mostly between 30 to 33 years of age (883/1,941, 45%) and 25 to 29 years of age (770/1,941 40%). Only 3% (55/1,904) of respondents were fellows-in-training.

Almost 40% (708/1,876) of respondents reported >\$200,000 of student loan debt, whereas 25% reported no debt. There have been general increases in respondents both without debt and with >\$200,000 of debt

from 2015 through 2019. Over the five years, fellowship interest (either matched or planning to pursue) has remained steady at around 70% until 2019, which dropped to 53%. The most important factors for fellowship were consistently surgical cases (729/2,351, 31%), the nature of clinical/medical problems (698/2,351, 30%), and personality match (290/2,351, 12%).

The most common subspecialty choices were head and neck (228/971, 23%), facial plastics and reconstructive surgery (207/971, 21%), and pediatrics (183/971, 19%). In general, the interest in each subspecialty has remained relatively stable except for a slight decrease in interest in otology/neurotology.

The most common anticipated practice settings were academia (835/2,138, 40%) and private practice (713/2,138, 33%), with 24% (518/2,138) as other. Academia was consistently the most common anticipated practice setting with the exception of 2017, when private practice reached a peak popularity of 49%.

The SRF appreciates the Academy's genuine interest and eagerness to gauge longitudinally and holistically the trainee population each year. We look forward to continuing to evaluate these outcomes and perform more robust analyses in the near future. If you are a trainee, please make sure you participate each year so we can better serve you! ■

Survey Conclusions

For additional Survey information visit
<https://www.entnet.org/srf>

- The top two anticipated practice settings (Academia and Private Practice or Hospital) remained constant throughout the five-year period.
- Head and Neck and Facial Plastics were consistently the two top Subspecialties of Choice.
- All seven subspecialties remained consistent throughout 2015-2019.
- Interest in pursuing Fellowship remained steady from 2015-2019. Matching continues to be highly competitive.
- The number one reason for pursuing Fellowship is Surgical Cases, followed by the Nature of Clinical and Medical Problems.

A Stream of Consciousness:

Administrative Exasperation

Getting in the Way of Our Purpose

Bobby Mukkamala, MD

Private Practice
Otolaryngologist,
Flint, Michigan



Monday Evening

I finish my last Zoom call at 9:15 pm. It would usually be the time to wrap things up downstairs and head up for a change into PJs and hit the sack. Surgery starts tomorrow at 6:45 am.

But tonight, I have to log in to the new Cerner EHR that McLaren Hospital System went live with about six weeks ago. I log in and do as much pre-charting as I can—H&P update, preliminary op note, discharge orders—anything I can do to make tomorrow go a little smoother.

It should be smooth already considering I did eight hours of mandatory training on the system as well as two days of surgery there already with Cerner support staff at my side. Yet, I know that there are a multitude of things that I will enter incorrectly that will generate a message or a phone call. I know that while my focus should be on the history and procedure of my patient, instead it is on the computer work that surrounds their care.

On Wednesday night, it will be the same routine *except* with an entirely different system. Hurley Hospital, where I operate on Thursdays, has an Epic EHR. I have been using it for a couple years and am reasonably

comfortable with it for the work that makes up 99% of my routine. Between Cerner and Epic, the companies have 56% of the EHR market share around the country.

Yet, if the patient I operate on tomorrow morning at McLaren has a bad car accident and needs to go to a level one trauma center later this week because of the snow and ice that is coming, they will end up at Hurley.

Their entire medical record, from history of previous surgery, medicines, cardiac, and other records will be *unavailable* easily when other doctors are trying to save their life. These doctors will once again have to rely on a history taken from a family member who is panicking and barely able to think clearly as they look at their loved one in a cervical collar stained with blood.

These hospitals are less than a mile apart. When I am looking out the window of one, I can see the other. Yet they are on opposite sides of the EHR universe.

My patients suffer. I suffer. My office staff suffers. The hospital staff suffers. The hospital suffers but in a predictable, calculated way because the suffering is justified by the ROI: Patients stay in their system.

Tuesday Morning

I get to the surgery center early. I say hello to my patients and answer any questions they have with smiles and reassurance. My mind, however, is thinking about what I ordered and

what I have not ordered that I am sure to get a call about.

While I sit at the computer and log in, no less than 10 times during those two hours and three surgeries, I am visited four times by different surgery center staff asking me to order this or that. I show them what I have ordered based on what I learned in my training sessions. Somehow, it is not what they are expecting, and I try again.

Meanwhile, I see my patient being rolled down to the operating room. Ordinarily I am there with them as they are being intubated. Ordinarily I am working with people I have worked with for years, but lately I see new faces on a weekly basis as the usual staff are working locums elsewhere.

I feel like a parrot asking one new tech after another *not* to remove the stickies on the drapes so they don't adhere to the ET tube and cause accidental extubation when they are removed.

Now I am down the hall staring at the no less than 200 clickable options on the screen in front of me, wondering what I am being asked to finish that I think is already done.

I pause and think about my purpose in life. It is to biopsy this patient's larynx lesion to r/o cancer. It is to remove the next patient's tonsils to relieve her of her chronic sore throats. It is to drain the obstructed sinuses of my last patient to relieve her headaches. This is where my mind should be.

So, I explain to the staff that I have done what I could and am going to take care of my patient. They are silent. They empathize with my frustration but are powerless to help. They have their instructions and fear for the consequences if they are not followed.

My documentation is a fraction of the quality of what it used to be. It has the mere basics. It is based on a template to make it easier to document. It lacks the personalization and specifics that my written notes used to. It looks completely different than the notes generated on a similar patient getting the identical procedure less than a mile away on the Epic system.

I entered an order for 1% lidocaine with epinephrine that I was planning to use to numb my patient's nose. In the OR I am told that this is back-ordered, and I will have to use 2% instead. No problem for the patient so I say, sure. Yet I have already entered an order in Cerner for a medication I am not using and have yet to enter an order for the medication I am using instead. I know that this will generate at least one more task that will require me to log in yet again to fix. One more distraction of my mind.

A mind that should be singularly focused on where I am inserting the needle on the lateral wall of this patient's nose. A mind that should be singularly focused on where my

microdebrider is removing tissue, millimeters from the bone that separates nose from brain and nose from eyeball.

The high road is to reject all of the distractions and keep my focus where it should be.

I am in my 22nd year of practice. I am pleasantly busy. If taking the high road has a consequence of making me fall out of favor with McLaren, I will survive. I will surely get a reputation for being difficult to train.

This despite spending eight hours in mandatory training, learning features and skills on Cerner that I will never use. Already, McLaren has hired four new otolaryngologists, all good people, to capture

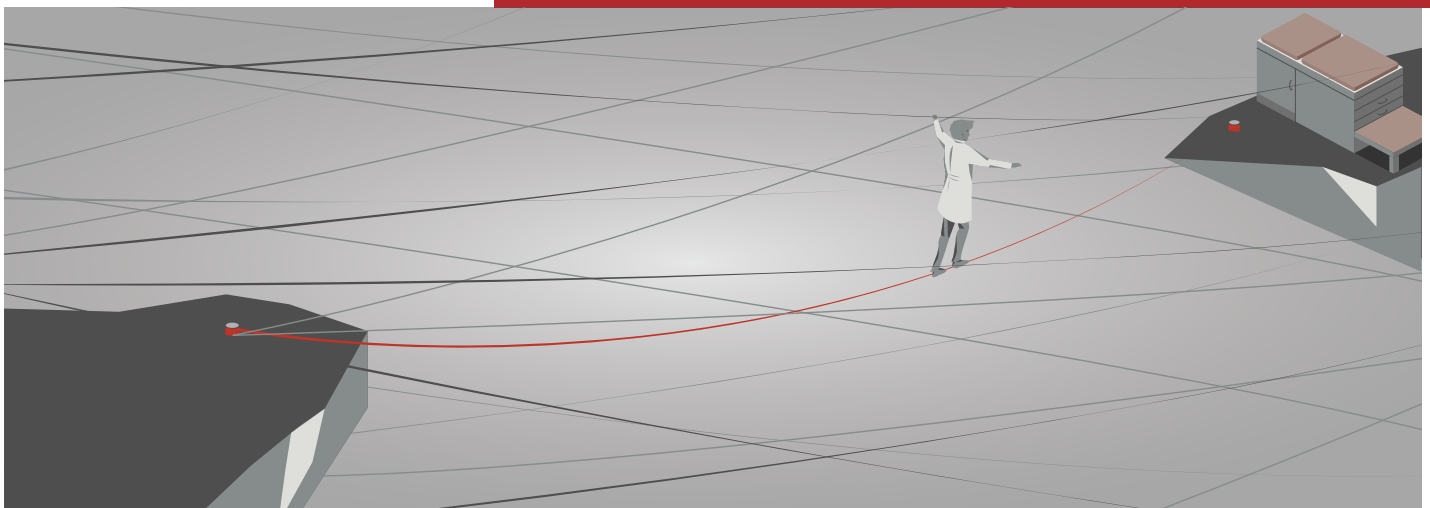
more market share for this work. I found out that there were four new ENT docs working within miles of me from an advertisement I happened to see in a local social magazine. McLaren does not need me; I do not need McLaren.

But the patients who need me to fix their ears, noses, and throats *need* McLaren because McLaren also has an insurance product, and they are covered by it. Healthcare is the biggest sector of employment in Flint, Michigan, now. It has surpassed auto manufacturing. This large sector of employees more often than not has insurance that requires them to use their employer's facility for their care or risk much higher copayments.

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I pause and think about my purpose in life. It is to biopsy this patient's larynx lesion to r/o cancer. It is to remove the next patient's tonsils to relieve her of her chronic sore throats. It is to drain the obstructed sinuses of my last patient to relieve her headaches. This is where my mind should be.

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I did complicated sinus surgery today using state-of-the-art scopes and monitors, and my work is electronically documented and then faxed. Fred Flintstone and George Jetson living next door to each other. We can no doubt do better.

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I don't want my patients to suffer financially because I can do their care without as much hassle across the street. So, they and I are captive audiences to McLaren. The same can be said for Ascension Genesys, the other hospital in town. Genesys has an EHR, but rumor has it that it too will be changing to another system in the near future. If it is Cerner or Epic, it will make the transition a little less traumatic for me, but it is still a transition for hundreds of staff and other doctors that *will* indeed be traumatic.

Even more traumatic is the fact that both Genesys and McLaren are on their second EHR in the past decade. Twice the training, twice the distraction, twice the pain. I have an EHR in my office and have had it since before the hospitals went electronic. It is not interoperable with *any* of the three area hospitals. If the hospital wants my medical record, or I want theirs, we have to fax it to each other.

Today's patients' H&Ps were faxed over from my office and scanned into to the

EHR. I did complicated sinus surgery today using state-of-the-art scopes and monitors, and my work is electronically documented and then faxed. Fred Flintstone and George Jetson living next door to each other. We can no doubt do better. But getting there will require doctors to *share* their thoughts as they jump through these hoops. Most are not as lucky as me to be able to walk away if the burden is too much to tolerate. Most are captive because their paycheck comes from the place they want to walk away from. Most are captive because their patients' insurance requires them to go to a particular hospital. Most are captive because the alternative is to change their entire routine and shift to a different facility with a different medical staff and a different EHR.

I write this to encourage others to share their thoughts. There are people and institutions that can improve this situation. But they will not do it out of the goodness of their hearts. They will only do it if they are not given a CHOICE. ■

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- Practice management resources offering guidance on a wide range of issues including reimbursement
- Subscriptions to the peer-reviewed scientific journal, *Otolaryngology-Head and Neck Surgery*, and the *Bulletin*, the official magazine of the AAO-HNS
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- Member-only registration discount for the AAO-HNSF 2022 Annual Meeting & OTO Experience in Philadelphia, Pennsylvania
- Access to OTO Logic—your otolaryngology learning network with 1,300+ courses covering the spectrum of the specialty and the opportunity to earn CME
- Member-only discount on our flagship education product, FLEX—Focused Lifelong Education Xperience, which spans across all eight specialty areas
- Your profile listed on "Find an ENT" on ENThealth.org, the Foundation's interactive patient information website (*practicing physicians only*)
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- Leadership and networking opportunities through AAO-HNS Committees and Sections
- And more!

RENEW TODAY at
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A large graphic featuring the text "CAST YOUR VOTE" in a bold, sans-serif font. The word "VOTE" is significantly larger than "CAST YOUR". The letter "O" in "VOTE" is a solid orange circle, while the other letters are black. Below "VOTE" is the text "Election opens May 9, 2022" in a smaller, bold, black font. The entire text is centered within a large, stylized orange shape that resembles a thick, curved arrow or a partial circle, pointing towards the bottom right. The background is a light orange gradient.

CAST YOUR VOTE

Election opens May 9, 2022

How to Cast Your Vote

AAO-HNS has partnered with YesElections (powered by Election America) to administer the 2022 election of candidates for leadership positions. To ensure your election-specific broadcast email arrives safely in your inbox on **May 9**, please make sure you have provided an individual email address to the Academy. You can check your email currently on file by logging into your profile at <https://myspecialty.entnet.org/>.

Video statements from the candidates are also available to view at <https://www.entnet.org/about-us/leadership-governance/annual-election-results/candidate-statements/>.

- Q:** What experience and attributes do you have that prepare you for this position and why?
A: What is the most important current need of Academy members, and how do you propose to tackle it?



Douglas D. Backous, MD

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Protecting the autonomy and integrity of otolaryngology practice requires attention to advocacy, billing, and coding, and making clear distinctions about our identity and what we offer across the healthcare marketplace.

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My core principle is for each of us to practice in our own way that works for our patients, partners, and communities. Protecting the autonomy and integrity of otolaryngology practice requires attention to advocacy, billing, and coding, and making clear distinctions about our identity and what we offer across the healthcare marketplace. We must maintain a “seat at the table” for critical conversations at local and national levels. I am high energy, relational, and focused on clear expectations to drive measurable results. I feel called to address the most important need for our members: to be able to build a meaningful career, respectful of our own wellness and resiliency, while focusing on excellent patient care with minimal non-value-added activities.

Academy advocacy efforts have never in history been as important as they are today. The current political climate creates an opportunity for the collective physician voice to shape policies that will impact our future healthcare system. This is an area where AAO-HNS serves all our specialty societies. With ongoing work on the 3P Workgroup, coordinated lobbying with AAO-HNS advocacy staff, relationships with key political leaders, and knowledge I gained through the Brandeis University Leadership Program in Health Policy and Management, I feel equipped to serve with the language and process understanding necessary to create legislative change.

The AAO-HNS has arrived at a critical time as we rise from the challenges of the pandemic in an uncertain world. Serving on the AAO-HNS Board of Directors and

Executive Committee during this time gave me an incredible appreciation of the importance of our organization and its many talented leaders, members, and dedicated staff. By harnessing the best learnings from dealing with COVID-19, we can be an even more effective organization that serves all otolaryngologists. We need to continue to bring together experts and serve as a platform to stimulate creative solutions to common and previously unthinkable problems. I am committed to growing the number of people from underrepresented backgrounds in our field and funding grants to understand the social determinants that create healthcare disparities. My hope is we will continuously enrich our cultural competence to ensure excellent ENT care for all people. I support our Annual Meeting Program Committee efforts to build an increasingly relevant, just-in-time education delivery platform accessible to all. The Academy as a reliable source of practical information is invaluable to reduce stress of members who manage complex disease.

ENT Connect and the Private Practice Study Group are examples of how members are engaging to identify innovative solutions to ensure new graduates and our early career colleagues can thrive in a practice model that they choose. My experience in employed and now independent private practice convinces me of the importance and power of shared ideas and representative leadership. I want each of us, at all career levels, to stand together.

Serving our specialty through the AAO-HNS continues to be one of the most satisfying aspects of my professional career. Thank you for the honor of running for President, and I ask for your vote. ■



Lance A. Manning, MD

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I understand the challenges we face but still remain confident that we can overcome these burdens by celebrating each other, promoting unity, and having a strong commitment to amplifying our diverse collective voice together.

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Colleagues and friends, it is a joy to serve in a specialty that unites the best and brightest to collectively care for patients, our communities, and each other. It is an honor to be nominated for President-elect. In preparation for this moment, I have had the privilege to serve in numerous high-level leadership roles within our Academy and elsewhere, and these experiences have provided a broad-based understanding of exactly how our organization and medical specialty operate at the local, state, and national levels.

As a leader on the AAO-HNS/F Board of Directors, Board of Governors, Education Steering Committee, and Executive Committee, I have been directly involved in developing and implementing our current Strategic Plan while creating content, writing policy, and advocating for our specialty. I have seen up close the actual needs and challenges that face practicing otolaryngologist-head and neck surgeons while working on the local level as the managing partner at a thriving single-specialty practice, regionally as the Chief of Staff leading an extensive, multi-hospital health system, as a key player in creating a large multi-state clinically integrated network, and at the national level serving in many leadership roles for our Academy and the American Medical Association.

I have a passion not only for providing excellent care to patients but also for healthcare policy, professional education,

and leadership development from our talented ranks. As an active member of our Physician Payment Policy (3P) workgroup and the RUC/CPT team, and as Chair of the Practice Management Education Committee, I am acutely aware of the reimbursement-related challenges within our current practice environment.

From my vantage point, I consider the need to correct fragmentation as one of the most critical needs facing our specialty and organization. The pandemic has caused many of us to contend with powerlessness, isolation, and socioeconomic uncertainty, and these factors have amplified the fragmentation of our practices and hampered our collective unity within the House of Medicine. Legislation aimed at budget neutrality has pitted clinic-based providers against surgical specialties, resulting in the lowest Medicare conversion factor for reimbursement in over 25 years. Budget limitations impede our ability to adapt to rapidly rising inflation and staffing shortages. Although we, as a single organization, cannot alone change these large-scale conditions, we can nonetheless be an influential voice that promotes multi-specialty collaboration, sharing best practices, and creating valuable practice resources intended to help us weather the storm together. I understand the challenges we face but still remain confident that we can overcome these burdens by celebrating each other, promoting unity, and having a strong commitment to amplifying our diverse collective voice together. ■

Q: What unique attributes do you bring to the Board of Directors?
What do you think is the most important item in the Academy's Strategic Plan, and how do you plan to maximize this for all types of practicing otolaryngologists?



Yuri Agrawal, MD

I am honored to be considered for the AAO-HNS Board of Directors, a group charged with ensuring that the Academy provides clear value to its members. The unique attributes I will bring to the Board of Directors are based on my experiences as an academic otologist-neurotologist and a clinician-researcher, from which I have

learned the importance of having diverse viewpoints to make good decisions, looking at data, and being open to new ideas. I have been fortunate to serve the Academy in a number of roles, including as a member of the Nominating Committee, as a reviewer for the Centralized Otolaryngology Research Efforts (CORE) Grants, as Chair of the Equilibrium Committee, and on the Guideline Development Task Force, and I understand much of the Academy's work and have met and served alongside many colleagues to further the Academy's goals.

I think the most important item in the Academy's Strategic Plan is Quality, specifically enabling our members to successfully deliver the highest quality of care to our patients. The Academy is uniquely positioned to pool resources to create

evidence-based guidelines for our specialty; to develop quality metrics that will allow our members in different markets to transition from volume to value-based payment; and to aggregate clinical data via Reg-entSM and lay the foundation for precision medicine in otolaryngology. These are critical efforts that the Academy needs to dedicate a substantial proportion of its resources toward. I think quality also encompasses several other elements of the Strategic Plan that I view as essential, including inclusive diversity and equity, given that the highest quality requires a diverse workforce delivering the highest quality of care to all our patients, and promoting wellness and resiliency for our members, which is also crucial for us to deliver quality care to our patients. ■



Jeffrey M. Bumpous, MD

I am honored to be considered for At-Large Director (Academic) for the American Academy of Otolaryngology-Head and Neck Surgery. I am an actively practicing otolaryngologist-head and neck surgeon for 28 years. I am professor and chair of otolaryngology-head and neck surgery at the University of Louisville School of Medicine. I have deep commitment to our

specialty, which I regard as the best job ever! We must continue to attract, train, and maintain a caring workforce that honors and serves all patients through support of excellence, compassion, and diversity. I have served on the Board of Governors, serving both my state of Kentucky and the Society of University Otolaryngologists. I currently serve as a Director on the American Board of Otolaryngology – Head and Neck Surgery and have served the board for more than 20 years. I am past president of the Society of University Otolaryngologist and the Association of Academic Departments of Otolaryngology, important organizations in the formative development of academic otolaryngologist-head and neck surgeons who form the bedrock for workforce development and our future. I have unbridled enthusiasm for the AAOHNS Strategic Plan: **Advocacy, Business of Medicine, Global**

Outreach, Inclusive Diversity and Equity, Quality, and Wellness and Resiliency. I have experience in each of these areas in my teaching, business, and professional life. Each of these important pillars for our Academy are vitally interrelated. Our workforce should aspire to reflect our patients and society broadly, while continuing to have the brightest and best enter our field and make strong commitments to those we serve. I advocate working through system-based approaches to make the work life of otolaryngologist-head and neck surgeons meaningful and unencumbered by administrative hassle and “too many clicks.” Our meaningful work must be acknowledged, advanced, reimbursed fairly, provided broadly, and administratively simplified in these complex times. I appreciate the opportunity to serve our great specialty. ■

Q ■ What unique attributes do you bring to the Board of Directors?
What do you think is the most important item in the Academy's Strategic Plan, and how do you plan to maximize this for all types of practicing otolaryngologists?



Marc G. Dubin, MD

Study Group and hopeful AAO-HNS Director. My goal is improving the logistics of medicine, regardless of practice type, despite the headwinds we face. Pre-authorization, declining reimbursement, and increasingly complex regulations impact us all. These burdens don't discriminate based on practice setting.

I feel that my professional experiences uniquely position me to advocate for all otolaryngologists on this issue. I serve as the president of The Centers for Advanced ENT Care, a 50+ physician otolaryngology group in the Maryland/Washington, DC, and Virginia area, with a clinical practice that focuses on tertiary rhinology. In these roles and throughout my career, I bridge the divide among my private practice, my general otolaryngology partners, and my academic colleagues in the leadership of

the AAO-HNS and American Rhinologic Society. Wearing these very different hats resulted in an appreciation for the importance of academicians and private practitioners working together for the best interest of our specialty. It is critical that we focus on our common goals and minimize the frictions that exist below the surface as both practices cannot thrive without the support of the other.

In summary, my varied professional, clinical, and academic experiences make me an unwavering advocate for the entire specialty. As such, I would look forward to the opportunity for continued leadership in the AAO-HNS with a specific focus on improving the day-to-day practice of medicine for all otolaryngologists. The business of medicine is much more than reimbursement and it profoundly affects us all. ■

In the spring of 2020, I was honored to participate in the AAO-HNS Future of Otolaryngology Task Force that assembled the COVID-19 guidelines for the return to practice. This focus on the day-to-day practice of medicine, now part of the Academy's Strategic Plan under the Business of Medicine, is my priority as Chair of the Private Practice



Jeffery J. Kuhn, MD, CAPT, MC, USN (Ret.)

otolaryngologist/neurotologist and in various practice types including military academic and non-academic, university academic, and now in private practice for the past seven years. I have served on six Academy/Foundation Committees and completed a three-year term as a member of the AAO-HNS/F Nominating Committee. I am a member of the recently established Private Practice Study Group. I received the Distinguished Service Award in 2015.

The 2021 Academy Strategic Plan added three areas of focus including Wellness and Resiliency. Physician burnout has become an important issue throughout the medical specialties and is now receiving increased attention within our Academy. As much as we attempt to maintain a work-life balance in our professional career, there is great potential for physical, emotional, and mental exhaustion.

Excessive bureaucratic tasks, long work hours, lack of respect from administrators/employers, insufficient compensation, increased computerization of practice, and lack of control/autonomy are several factors that contribute to the erosion of physician well-being. A recent large-scale survey of otolaryngologists (Medscape, 2021) showed that 33% reported burnout/burnout with depression and that 71% considered it serious enough to have at least a moderate impact on their lives. Seventeen percent (17%) of these otolaryngologists have had suicidal thoughts. I would expand the current "Wellness Team" initiative in the form of a Task Force that would interface with other Foundation Committees and Academy Sections to identify factors unique to the otolaryngologist and to propose evidence-based solutions. ■

The essential tasks of the Board of Directors are to assess the overall direction and Strategic Plan of the Academy, support its mission and vision, and establish new initiatives on behalf of the membership. The Directors should have leadership experience and have demonstrated integrity, ingenuity, and commitment in those endeavors. I have served in many leadership positions in the past 30 years as an

Q: What experiences have you had that will allow you to identify a diverse set of candidates for Academy leadership?
A: What are the most important attributes you look for when nominating a member for leadership within the Academy?

SEAT ONE



Nausheen Jamal, MD

The diversity of our organization is vast—with our mix of private and academic practice, urban and rural, and our various subspecialty and comprehensive colleagues—each adding valuable perspectives to the field.

However, we still have work to do to improve the inclusivity, equity, and racial and gender diversity in otolaryngology. Increasing representation of minorities in our field, especially at the leadership level, is critical to our future success. If elected, I commit to advancing inclusive representation in AAO-HNS at its highest echelons and will seek diverse candidates who embody values of integrity, diligence, and professionalism.

This focus on inclusive diversity is more than just words for me. As a former program director and as a current department chair and diversity and inclusion officer (DIO), inclusive diversity is at the core of everything I do. I am proud to serve at one of the largest minority-serving institutions in the country, with more than half of our otolaryngology faculty and over 60% of our house staff coming from underrepresented backgrounds. For years, I have committed to caring for populations with deep-seated healthcare disparities. If elected to serve, I will bring this same commitment to equity and diversity to the Academy in identifying our future leaders. ■



Rodney J. Taylor, MD, MSPH

It is with a great pride and purpose that I seek election to the Nominating Committee for the Academy. As an academic otolaryngologist and chair of the Department of Otorhinolaryngology at the University of Maryland School of Medicine, the call to service has always been a passion and priority. In addition to leading a department committed to excellence in education, patient care, and research, numerous experiences have shaped my ability to identify a diverse set of candidates for Academy leadership. Examples include my institutional leadership in curriculum development and instruction for unconscious bias in healthcare, service on the Academy Diversity and Inclusion Committee, and chair of University of Maryland Faculty Group Practice Nominating Committee. Recently, I was proud to receive the University of Maryland Dean's Faculty Award for Diversity and Inclusion for my work in advancing the values of inclusion and equity. When nominating a member for Academy leadership, demonstration of a record for valuing the perspective of a broad set of stakeholders and a commitment for including diverse talent when program building is important. It would be my honor to contribute to our Academy's future leadership, ensuring that it supports the values of fairness and equity, while protecting our stake in a competitive healthcare environment. ■

SEAT TWO



Michael J. Brenner, MD

The AAO-HNS/F is the largest organization of otolaryngologists in the world and capturing the diverse perspectives of our membership is critical for building a shared future. I am a talent scout, and one of the great joys of my career has been engaging, growing, and promoting diverse future leaders. I have done this as Chair of Centralized Otolaryngology Research Efforts (CORE), Chair of the Outcomes Research and Evidence Based Medicine (OREBM) Committee, Co-chair of Patient Safety and Quality Improvement (PSQI) Committee, and in Clinical Practice Guideline development. You inspire our excellence, and my greatest privilege is making your voice heard.

We are so much more than meets the eye, yet we are often judged faster than a blink. Serving on the Nominating Committee, I will champion evidence-based practices shown to improve both the rigor and quality of searches. An affinity for common subspecialty, gender, race, ethnicity, sexual orientation, or geography can eclipse foundational attributes of vision, integrity, and service necessary to propel our organization forward. By applying standards from National Academy of Medicine and other think tanks, we can sharpen our thinking on equitable leadership. Doing so values our diverse perspectives in private practice, academia, and military across the career continuum. ■



D. Gregory Farwell, MD

Bringing a slate of incredible and diverse candidates, with all their unique experiences, is the critical role of the Nominating Committee. Finding those ideal leaders requires broad insights and presence throughout the field and knowledge of the skills that would best address the issues facing otolaryngology. I have had the privilege to practice otolaryngology and chair departments from coast to coast. I have made innumerable connections with otolaryngologists in every setting. Through my leadership and significant involvement in the Academy, Society of University Otolaryngologists, American Head and Neck Society, and other societies, I have a deep understanding and appreciation of the immense talent within the AAO-HNS and am committed to nominating a diverse, skilled group of leaders for our Academy.

We need inclusive and passionate leaders who actively seek input from the members to guide decisions. We need leaders who are aspirational and dedicated to our specialty, with a proven track record of commitment and accomplishment. At such a dynamic time, nominating members to AAO-HNS leadership takes on extra importance. It would be my honor to work on behalf of our membership to find those candidates. ■

Q: What experiences have you had that will allow you to identify a diverse set of candidates for Academy leadership?
A: What are the most important attributes you look for when nominating a member for leadership within the Academy?

SEAT ONE



Stephen P. Cragle, MD

As a recent guest editor of *Otolaryngologic Clinics of North America* (February 2022) on “The Business of Otolaryngology,” I communicated with more than 40 diverse thought leaders in otolaryngology. I have spent many years networking in private practice and presenting at and attending the Annual Meeting. I am a founding member of the Millennium Society where I have met many Academy leaders. I am a member of Practice Management Education Committee with many networking opportunities in committee work. I am a founding member of the Academy’s newest study group, the Private Practice Study Group and am active on ENT Connect. I attend the Board of Governors’ Spring and Fall meetings, and the Young Physicians Section meeting.

I look for a sense of stewardship, of giving to the greater good; a passion for otolaryngology science and practice; a thought leader in our specialty who is able to collaborate well with other leaders. A clear vision of our specialty’s future means more than a list of past accomplishments. ■



D. Scott Fortune, MD

Academy service ranging from task force to Rhinology and Allergy Education and Legislative Affairs Committees, involvement in ENT PAC, attending Academy and leadership meetings during the Board of Governors exposed me to past, present, and future leadership of the Academy. Seeing who was previously chosen and how they function to run the Academy has given me the insight to help select the next generation of leaders.

Most important is commitment to the Academy mission, demonstrating care and concern for well-being of Academy members over their own advancement or recognition. Our leaders should be effective listeners and focused on development of talent, demonstrate innovative thinking, strategic planning, and adaptability to meet many challenges facing otolaryngology. Finally, leaders must be ethical and able to communicate effectively with a diversity of individuals and understand the needs of the broad spectrum of Academy members. Having seen such leaders in my Academy roles allows me to see these qualities and to help select the best candidates to serve the AAO-HNS. ■

SEAT TWO



Darius Kohan, MD

Emigrating as a teenager from communist Eastern Europe where my family belonged to a minority that experienced persecution, and later being welcomed in the melting pot of New York City, has shaped my views of the world to appreciate the contributions of diversity and tolerance. Participating in numerous Board of Governor and AAO-HNS committees over a 30-year career, I witnessed the outstanding leadership and dedication to patient care demonstrated by our membership. Most evident, the otolaryngology community was, dare I say, heroic during the pandemic, risking their personal health in managing the airway of patients before there were any vaccines. Private practitioners particularly took a severe blow during the pandemic trying to preserve their offices and staff, yet everyone did their best for our patients. Members organized, protocols were developed in collaboration with our peers in all fields of medicine, and patients benefitted. I witnessed leadership qualities come to the forefront. We have many challenges and opportunities facing us. I intend to nominate the most deserving otolaryngologists to leadership positions based upon merit and ability to represent our ever more diverse membership throughout the country. Leadership must reflect the needs of both private practitioners and academicians, the geography and demographics of our country, and the vision of the Academy for a brighter future. ■



Douglas D. Reh, MD

My career has provided a unique perspective and experience that has sufficiently equipped me for service on the AAO-HNS Nominating Committee. I began my career as an academic rhinologist and skull base surgeon at the Johns Hopkins Department of Otolaryngology-Head and Neck Surgery. After 10 years at Johns Hopkins, I left for a new opportunity. In 2018, I became a partner in The Centers for Advanced ENT Care, LLC. In this role, I have been able to continue to build a thriving private practice in Baltimore County, Maryland. In my career as an academic and private practice otolaryngologist, I have been active in both the AAO-HNS and American Rhinologic Society and have networked with both academic and private practice otolaryngologists. These experiences have afforded me a unique perspective on the goals and challenges for both physician member groups in the AAO-HNS.

As a member of the AAO-HNS Nominating Committee, I would seek to use my experiences to identify and recruit a diverse group of talented otolaryngologists whose skill sets are best suited for each position. I will nominate candidates who have demonstrated leadership in their academic or private practices, work well with others in a team environment, and whose peers respect their honesty and integrity. ■

Q ■ What qualifications or experience allow you to be an effective member of the Audit Committee of the Academy?



Cecelia Damask, DO

As a solo private practice comprehensive otolaryngologist in the greater Orlando, Florida, area, I am honored to be considered to serve as Audit Committee Member. The Audit Committee plays a unique role in sustaining the legacy of the AAO-HNS/F. The Audit Committee executes an important role in confirming that the budget is aligned with the Academy's Strategic Plan, thus ensuring that the AAO-HNS/F is financially sound and able to accomplish even greater things in the future. Having served on the Finance Committee for the American Academy of Otolaryngic Allergy (AAOA) for six years, I have training in the ability to evaluate and understand

financial statements, which will help me be an effective member of the Audit Committee.

During this rapidly spreading global pandemic, I have found a great sense of gratitude for our Academy. I have been an active member serving on various AAO-HNS/F committees. It is through this work and interactions with other Academy members that I have developed a deep appreciation of the value of the AAO-HNS/F to the practicing otolaryngologist.

If I am given the opportunity to serve on the Audit Committee, it will be an honor and a privilege to serve our Academy and its members ensuring the AAO-HNS/F's continued success in the future. ■

Let Your Voice Be Heard: Voting Opens May 9

Thank you for reviewing the thoughtful statements of the 15 candidates for elected office of the Academy. That is just the first step. It is critical that you follow through and cast your ballot for the candidate of your choice when **elections open on May 9**.

The process is streamlined and should take no more than a few minutes to complete.

Your Nominating Committee, chaired by Immediate Past-President **Carol R. Bradford, MD, MS**, has done a fabulous job in identifying and selecting these outstanding candidates who will help lead us through the evolving transition to our healthcare system.

This is your opportunity to have your voice heard. Please finish the job and cast your ballot during the 2022 election cycle.

The AAO-HNS thanks members of the Nominating Committee for their careful and meaningful deliberation of nominees. This is a very important and difficult task. They deserve our recognition and appreciation.

Members of the Committee are:

Carol R. Bradford, MD, MS (Chair); Samantha Anne, MD, MS; Andrew M. Coughlin, MD; C.W. David Chang, MD; Soha N. Ghossaini, MD; Eli R. Groppo, MD; Ken Kazahaya, MD, MBA; Steven T. Kmucha, MD, JD; Stella E. Lee, MD; Charles E. Moore, MD; Anna M. Pou, MD; Seth R. Schwartz, MD, MPH; Angela K. Sturm, MD; and Troy D. Woodard, MD.

Roger D. Cole, MD, and **James C. Denny III, MD**, also contributed as *ex-officio* members of the committee without vote.



The Everlasting Impact of Your Annual Meeting Experiences

Daniel C. Chelius, Jr., MD

Annual Meeting Program Coordinator

Connecting with Colleagues and Engaging with the Global Otolaryngology-Head and Neck Surgery Community. When I hear from attendees about engagement at the AAO-HNSF Annual Meeting & OTO Experience, there are typically three main areas of focus: the cutting-edge scientific program, the interaction with colleagues from around the world through both innovative events and Academy volunteerism, and the serendipity of meeting both old friends and new in the halls, restaurants, and lobbies of the host city. The latter part became increasingly more important and appreciated when we couldn't gather in 2020 due to the COVID-19 pandemic. So, when we finally could gather in 2021, the reunion that occurred during the Annual Meeting in Los Angeles, California, was one for the books, demonstrated by overwhelming joy at the mere opportunity to be together, in one place and time to commit our time, energy, talents, skills, and expertise to the specialty, each other, and patient care.



Daniel C. Chelius, Jr., MD
Annual Meeting Program Coordinator

A Connection that Can't Be Replaced. When I think about my first Annual Meeting and the lasting impressions I have, they are all centered on personal connections. The first Annual Meeting I attended was in 2008 in Chicago, Illinois. I went to the Section for Residents and Fellows-in-Training (SRF) General Assembly and was inspired at the

sight of my peers interacting with Academy leadership. Their voices were being heard by the greater Academy on critical issues in a way that I hadn't realized was both possible and so welcome until that moment.

During that SRF-sponsored event, leaders were speaking directly to us trainees and our ability to make a difference for our patients and our colleagues through platforms and opportunities readily available within the Academy. That experience energized me to immerse myself in our AAO-HNS community.

This feeling of community was further solidified during that 2008 meeting when I, along with some of my Baylor co-residents, were taken out to dinner by Baylor alumni. Being at dinner together with this group really drove home for me that I wasn't just preparing for a job; I wasn't just training to be a surgeon. I was becoming part of a supportive community. With every meeting over the years, that sense has grown stronger so that the Academy becomes less and less a nebulous concept and more concretely the dear colleagues at your side going through similar struggles, working toward common goals.

Community as the Core of the Annual Meeting. The community aspect that I witnessed and experienced during my first Annual Meeting is something that I have seen over and over again, year after year, and that community has grown each year as new encounters widen my network of friends and colleagues. Even though we are all spread to the wind, one of my favorite parts of the Annual Meeting is when we all come back together for those few days each year to re-engage.

If you are looking to grow your otolaryngology-head and neck surgery community or get more involved and engaged in

the Academy, attending the Annual Meeting is the conduit to making that happen. Reengaging (or engaging for first-time attendees) with the communities we have established at the Annual Meeting is the core of the meeting, and that is likely true for every generation of physicians since that first gathering in 1896.

The last few years, under the cloud of the COVID-19 pandemic, have not only demonstrated how resilient and responsive we are as a global otolaryngology community committed to patient health, but have also reminded us how appreciative we are of those moments when we can convene as a community, to learn, to plan, to reminisce, and be rejuvenated together. I am looking forward to being a part of it again and to seeing all the community reunions that will happen at the Annual Meeting in Philly this September. ■

There are still ways to get involved prior to the start of the meeting in September in Philly:

- Consider submitting to the SIM Tank or ENTpreneur Face-Off events
- Share your late-breaking science during our submission period coming up in May/June
- Contact your appropriate Section leaders to learn of volunteer opportunities this summer that will lead into heightened meeting engagement this fall

Look for more information about #OTOMTG22 in the May issue and online at www.entannualmeeting.org.

Annual Meeting International Guests of Honor

Federación Argentina de Sociedades de Otorinolaringología

The Federation of Argentine Societies of Otorhinolaryngology (FASO) is a nonprofit, public welfare institution that was founded on June 25, 1947, as an initiative of

Dr. Juan Manuel Tato and others. Dr. Tato was a greatly admired figure among the national and international otolaryngology community for his valuable contributions and his professional, teaching, intellectual, and human qualities.

FASO, whose main function is to provide postgraduate teaching and education, is made up of all the ENT societies in the country.

As part of its education activity, FASO organizes the annual Congresses on the specialty, offers different retraining courses, and is one of the academic units of the



specialist career dependent on the Faculty of Medicine of the University of Buenos Aires—focusing attention on prevention and treatment of ENT diseases.

Beyond this, FASO works in an integral way for the improvement of the specialty through:

- Professional recertification
- Accreditation of residence services in health teams through the Ministry of Health of the Nation
- Referent of the specialty before the official organisms of Argentina
- Scientific journal that is included in the Latindex catalog and indexed in the LILACS Database (BIREME - OPS/OMS)
- Different prevention campaigns, including World Hearing Day, World Day of the Voice, and World Sleep Day

For more information, visit www.faso.org.ar or email info@faso.org.ar or eventos@faso.org.ar. ■

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Japanese Society of Otorhinolaryngology-Head and Neck Surgery

The Japanese Society of Otorhinolaryngology-Head and Neck Surgery (JORL-HNS) was founded in 1893

and has a history of 129 years, making it the longest-running medical association among those affiliated with the Japanese Medical Science

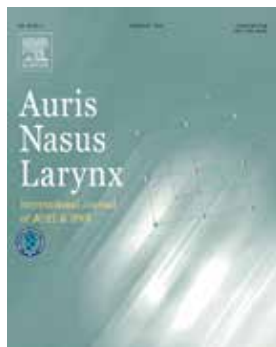
Federation. The organization has over 11,000 members, and the society is comprised of 15 subspecialty societies related to ORL-HNS. Each society has an annual meeting and



an official journal, which contains topics, guidelines, and educational materials in its own field. Each society presents awards for

outstanding papers and presentations annually.

Auris Nasus Larynx (ANL) is the official



journal of JORL-HNS and accepts high-quality clinical and scientific papers from across the world. The acceptance rate is as low as about 20%, and the impact factor reaches near 1.8. ANL covers a wide range of areas related to otolaryngology, such as otology, neurotology, rhinology, laryngology, head and neck cancer, skull base, balance, voice, swallowing, sleep apnea, pediatric otolaryngology, and airway.

For more information about the Japanese Society of Otorhinolaryngology-Head and Neck Surgery, visit www.jibika.or.jp/english/. ■



The AAO-HNSF International Guests of Honor program is a time-honored tradition at the Annual Meeting & OTO Experience where four countries or territories are recognized for their contributions to the specialty and global otolaryngology community. The 2022 International Guests of Honor are **Argentina, Japan, Nigeria, and Spain.**

Otorhinolaryngological Society of Nigeria (ORLSON)

Otorhinolaryngological Society of Nigeria (ORLSON) was conceived and formed a half century ago as an organization to promote the growth, interests, and other issues related to the practice and training of otolaryngology and otolaryngologists in Nigeria. It was formed by the second generation of ENT surgeons in Nigeria.

Currently, the society has about 320 members (full and associate). ORLSON is affiliated with the Pan African Federation of Otorhinolaryngology Societies (PAFOS) and International Federation of Otorhinolaryngological Societies (IFOS) and is also a corresponding society of the American Academy of Otolaryngology-Head and Neck Society. ORLSON currently focuses on development of subspecialization and holds an annual gathering of members for scientific meetings.

The society is delighted to be one of the guest nations of the AAO-HNSF for the 2022 Annual Meeting & OTO Experience. For more information about the Otorhinolaryngological Society of Nigeria visit <http://orlson.org.ng/>. ■



Abiodun D. Olusesi, MD
ORLSON President



Spanish Society of Otorhinolaryngology and Head and Neck Surgery



The Spanish Society of Otorhinolaryngology and Head and Neck Surgery (SEORL) was founded in 1948 and has over 3,000 members currently. In October 2021 the Society's new presidential board took office and focused on the main challenges the specialty is facing, such as the extension training, the incorporation of head and neck surgery as part of the official specialty name in Spain, and the recertification of specialists to ensure the best quality of care.

To achieve these objectives, SEORL is working both at an institutional level, promoting the changes needed at a national and European level, and at the educational level, supporting the highest clinical competence through continuous education and specialized training and carrying out diverse training actions, such as courses,

meetings, and apps.

In addition to the Society's annual congress, with more than 1,600 ORLS and trainees attending, SEORL has also developed a cross-platform web update tool (<https://seorl.net/acceso-webapp/>) that has entailed a true revolution in education support and encompasses all aspects of the specialty, offering updated information and immediate access.

The SEORL publishes a bimonthly, bilingual journal (Spanish-English), which is a scientific benchmark in the Spanish-speaking scientific community aiming to become a reference for research (<https://www.elsevier.es/esrevista-acta-otorrinolaringologica-espanola-102>).

Furthermore, the activities of SEORL go beyond science and education. The Society supports medical-humanitarian missions organized by members (Ethiopia, Central America, Sahel) that bring training and medical assistance to these regions.

For more information about SEORL, visit www.seorl.net. ■



Advances in Laryngeal Surgery: An International Perspective

Taner Yilmaz, MD; Vyas M.N. Prasad, MSc, FRCS;
Ismail Kocak, MD; and Ahmed M.S. Soliman, MD

The field of laryngology arguably had its start in Europe with such giants as Benjamin Guy Babington, Johann Czermak, Morell Mackenzie, and others in the 19th century. Since then, the field has continued to flourish in the United States and internationally. Below are excerpts from an International Symposium on advances in laryngeal surgery, which included contributors from Turkey and Singapore. This was presented during the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience.

Anterior Glottic Webs

Anterior glottic webs, whether congenital or acquired, present a treatment challenge for otolaryngologists. Acquired webs are usually iatrogenic and occur most commonly after multiple papilloma surgeries. Although not all glottic webs require surgery, common indications for surgical intervention include airway obstruction and dysphonia. Historically, surgical treatment of glottic webs involved endoscopic resection followed by repeated lysis of adhesions. Fortunately, this has been largely abandoned. Current surgical treatment is performed endoscopically or transcervically, in one or two stages, using the laser or cold instrumentation, and may or may not use a stent. Endoscopic single-stage procedures have obvious advantages for the patient and are most commonly used today.

McGuirt et al. first described a one-stage endoscopic single mucosal flap procedure without keel placement in 1984.¹ In 2002 Schweinfurth described an endoscopic single-stage, double mucosal flap procedure without

stenting where all mucosal surfaces are covered.² Xiao et al. reported their experience with 32 patients using this technique.³ More recently, Yilmaz described his experience in 2019 with 12 patients using a double mucosal flap that he named the “butterfly mucosal flap technique.”⁴

In this procedure, the web is divided in the axial plane. The superior mucosal layer of the web is elevated laterally using cold instrumentation and kept attached to one vocal fold while the inferior half of the web is preserved as a flap based on the contralateral vocal fold. The superior mucosal flap is then sutured with multiple 6-0 polyglactin sutures to the inferior surface of the vocal fold upon which it was based, and the inferior mucosal flap is similarly sutured to the superior surface of the vocal fold to which it is pedicled. This results in all surfaces being covered with mucosa, thus minimizing the risk of reformation of the web. Although technically challenging, the butterfly mucosal flap technique is a highly effective single-stage endoscopic surgical option for the treatment of anterior glottic webs.

Bilateral Vocal Fold Immobility

Bilateral vocal fold immobility is a potentially life-threatening condition that can present acutely or subacutely. Otolaryngologists should be able to quickly diagnose and select the appropriate treatment option. Although tracheostomy remains the mainstay of treatment in the acute setting, other surgical options that maintain phonation and deglutition should be considered thereafter. These include posterior cordotomy, temporary or permanent suture lateralization, and arytenoidectomy. Although debate exists regarding which technique is best, subtotal laser arytenoidectomy has been successfully employed to treat bilateral true

vocal fold immobility at two tertiary care medical centers in Belgium and Singapore. The advantage of subtotal arytenoidectomy lies in the fact that it maintains a certain degree of rigidity along the posterior limit of the arytenoid frame, preventing inward collapse of the mucosa and thus lowering the risk of aspiration. Remacle first described a series of 41 patients from Belgium with a mean follow-up of 56 months in 1996.⁵ Voice outcomes were minimally affected, and peak expiratory flow rates were markedly improved after the procedure. Prasad presented a series of five patients aged 57-82 years who underwent endoscopic CO₂ laser subtotal arytenoidectomy over an 18-month period for bilateral vocal fold immobility by the same senior surgeon. Their diagnosis varied from previous stroke, thyroid surgery, as well as idiopathic causes. Eighty percent were successfully decannulated, and of those still alive, none have had any further stridor. One patient failed decannulation due to poor swallowing function and aspiration.

Sulcus Vocalis

Sulcus vocalis is an uncommon laryngeal lesion that appears as a longitudinal depression on the vocal fold parallel to its free edge on laryngoscopy. Histologically, there is a disruption of the vocal fold microarchitecture, which involves the epithelium, superficial lamina propria (SLP), and vocal ligament to some extent.⁶ This results in impairment of vocal fold vibration and consequently vocal quality that may be breathy, high pitched, or diplophonic. Although the etiology and pathologic process have not been well defined, there appears to be a genetic basis.^{7,8} Three types of sulci have been defined: physiological, sulcus vergeture, and pocket type, with progressively increasing depth and



worsening vocal quality.⁹

Treatment depends on several factors, including depth and extent, location, vocal expectations, and the presence of secondary pathologies.^{10,11} With minimal complaints no treatment may be necessary. Sometimes the warmth in tone may be beneficial for a professional voice user; however, the elevated pitch may be problematic for males as it causes a feminine voice quality. Voice therapy is effective at elevating subglottic pressure that improves glottic closure and vibration resulting in increased power and timbre but may also cause undesired pitch elevation.

Vocal fold augmentation by injection or medialization thyroplasty improves glottic closure in patients with breathiness, but in cases with high-pitched dysphonia, it has a very limited effect in reducing the fundamental frequency. In these cases, relaxation thyroplasty is more effective at reducing the pitch and improving vibration as well as ease of phonation.

The sulcus vergeture and pocket types result in a shallow, stiff SLP and increased likelihood of secondary pathologies, respectively. Consequently, they more often

require treatment. The location of the sulcus is important in choosing the treatment as well as predicting subsequent outcomes. Kocak classifies sulci anatomically as “supraconal,” “periligamentary,” or “compensatory.” Supraconal sulci may be difficult to detect preoperatively as the medial margin of the vocal fold often hides the pathologic indentation. Insertion of the flexible laryngoscope to the glottic level improves visualization; however, they may not be diagnosed until operative direct laryngoscopy is performed. Surgical treatment is best performed through an incision made lateral to the sulcus and undermining medially. A fascia or fat graft is then placed in the pocket developed and the incision reapproximated with 8-0 polyglactin sutures. Periligamentary sulci may be both the vergeture or pocket type with the latter often diagnosed when they collect keratin debris and form a cyst. Careful excision of the sulcus epithelium and cyst sac results in excellent outcomes. For compensatory sulci, surgical elevation of the ligament from the underlying musculature alone improves vibration whereas surgical excision may result in worsening of the voice and should be avoided. ■

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World Voice Day 2022

Lift Your Voice

Anne F. Hseu, MD, Voice Committee member

It's easy to feel down by what is going on in the world around us, as we enter the third year of the pandemic. We touch our faces, wondering when we can safely remove our surgical masks and N95s.



Parents sit on edge with each phone ring, wondering if it's the call alerting them to pick up their kids to quarantine for days without childcare. We feel sadness about missing the events and celebrations, big and small, that make up the essential part of living life. In this moment, it has become more evident that self-care must be addressed before effectively caring for those around us.

This year's World Voice Day theme is "Lift Your Voice." The inspiration came from the famous African American hymn, "Lift Every Voice and Sing," a poem written by James Weldon Johnson in 1900. "Lift Your Voice" has many meanings, some of which are obvious. Literally, lifting one's voice requires focusing on vocal health. We remind patients to drink plenty of water,

avoid smoking, and to rest the voice when ill. We talk about voice budgeting and paying attention to when one's voice isn't meeting its demands. Lifting one's voice can also reflect the need for human beings to speak proudly of their heritage, beliefs, and traditions. Over the past few years, diverse voices and opinions have necessarily been lifted during this tumultuous time of civil and racial unrest.

To me, "Lift Your Voice" has a deeper and more self-empowering meaning: listening to one's inner voice and then speaking up to achieve what one needs for oneself as an individual first. This inward-looking approach to personal health and well-being ultimately allows us to serve our community better as physicians, parents, friends, and partners. Healthcare workers have a tendency to put others before themselves, relishing in the caregiver role. It's common to silence the inner voice, thinking that no one wants to hear what you have to say, particularly when times are tough and everyone's nose is to the grindstone. Now, more than ever, is the time to speak up about what you need. What do you require to be well? Is it relaxation time? Connection with others? Being outdoors for a



breath of fresh air? Even if it's just for a few moments, we all need a moment to reflect and refresh.

In a hallway leading to one of our operating rooms, there is a quote haphazardly taped to the wall: "Be kind whenever possible. It is always possible." These words from the Dalai Lama remind us that even the smallest of gestures can make someone else's day better. Although self-care is a priority and something we continuously work on, our outer self and interpersonal interactions simultaneously influence how others feel about themselves. A smile as you pass a colleague in the hallway is not just the firing of cranial nerve VII, it is a moment of saying to someone, "I see you. I acknowledge you. I appreciate that YOU are present." Sometimes that's all that is needed to brighten a day of fatigue, stress, and worry.

These days, the importance of one's voice becomes ever more significant when your tone, intonation, and words are perceived but your emotive features remain hidden behind a mask. Assumptions are made based on how one's voice sounds. We, as otolaryngologists, are in a unique position to help our patients. We focus on pathologies that allow individuals not only to sense and interact with the world but to uniquely express themselves. Having one's voice is critical for all of us to be fully engaged. Part of our role as physicians is to prevent injury through education. Educate those around you to keep their voices healthy so that they can speak up for themselves and help and continue to lift those around them. ■

Download the World Voice Day 2022 Poster

Share the poster featured here with your patients and spread the word about the importance of a healthy voice. Visit www.entnet.org/worldvoiceday to print your 2022 poster and access other World Voice Day resources.



Q & A

with James J. Daniero, MD, Chair,
Thomas L. Carroll, MD, and Libby J. Smith, DO

Want to offer your patients some timely advice on taking care of their voices for World Voice Day? Three AAO-HNS Voice Committee Members offer answers to questions you may hear in clinic.



Libby J. Smith, DO

My voice is getting hoarse. Why?

Dr. Smith: “Hoarseness” is defined as an abnormal change in voice quality, such as raspy, strained, breathy, weak, higher or lower in pitch, inconsistent, fatigued, tremulous, or requiring more effort to talk. This usually happens when there is a problem in the sound-producing parts (vocal cords or folds) of the voice box (larynx). While breathing, the vocal folds remain apart. When making sound, the vocal folds come together and, as air leaves the lungs, they vibrate, producing sound. Anything that alters vibration or closure of the vocal folds results in hoarseness.

What can cause hoarseness? And what can be done to help?

There are many reasons hoarseness can develop. The following are some of the most common causes of hoarseness. General rule is that an examination of the larynx by an otolaryngologist (ear, nose, and throat doctor) is necessary if hoarseness persists more than four weeks, or sooner if a professional voice user or if they have risk factors for developing malignancy (i.e., smoking).

Acute Laryngitis: The most common cause is acute laryngitis. Swelling of the vocal folds can happen with a common cold, breathing tract viral infection, or from voice strain.

Serious injury to the vocal folds can occur when talking while having laryngitis.

Treatment: Supportive care (AKA: be gentle with your voice, hydrate). Antibiotics and steroids are often not needed. This is often managed by primary care practitioners.

Benign Vocal Fold Lesions: Nodules, polyps, and cysts usually occur after prolonged trauma to the vocal folds from talking too much, too loudly, or with bad technique.

Treatment: After looking at the larynx to confirm this diagnosis, treatment includes learning proper voicing technique with voice therapy, adequate hydration, and sometimes require surgery.

Precancerous / Cancerous Lesions:

Precancerous or cancerous lesions on the vocal folds lead to hoarseness. If hoarseness lasts four weeks, or if you are at higher risk of developing throat cancer (i.e., smoker), then your larynx needs to be evaluated by an otolaryngologist.

Treatment: Biopsy is needed to confirm diagnosis. Based upon the location and extent of disease, treatment can include surgery, radiation therapy, and/or chemotherapy.

Neurological Diseases or Disorders:

Hoarseness can happen in those with Parkinson’s or after a stroke. A rare disorder called spasmodic dysphonia can also create hoarseness or breathing. A paralyzed vocal fold, commonly after surgery or viral illness, may also cause of a weak, breathy voice. Determining the cause of vocal fold paralysis

is important and helps determine treatment. This is often done in conjunction with a neurologist.

Treatment: Treatment differs greatly depending upon the type of neurologic disorder. There are specialized voice techniques for patients with Parkinson’s disease, but evaluation is also very important for them even if they do not feel they have swallowing problems. A stroke can result in a myriad different disorders, such as dysarthria (mumbled speech), vocal fold paralysis (vocal fold does not move), and dysphagia (difficulty swallowing). Speech therapy or the use of assistive communicative devices can often help. Vocal fold paralysis, regardless of if it is due to a neurologic condition or more likely from surgery, is often treated with surgery to augment of the vocal fold. Spasmodic dysphonia and essential tremor of voice are traditionally treated with repeated botulinum toxin injections.

Vocal Fold Atrophy / Presbylaryngeus:

As we age, our vocal folds become thinner (decreased bulk) and floppy (decreased tone). This is not due to talking too much or too little, it is just a fact of life. Voice inconsistency, decreased projection, and raspiness are common.

Treatment: Sometimes reassurance that hoarseness is not due to cancer is all that is needed for peace of mind. Treatment of vocal fold atrophy includes voice therapy and sometimes vocal fold injection.

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**Thomas L.
Carroll, MD**

My voice gets tired toward the end of the day. Should I be concerned?

Dr. Carroll: There are many potential causes for the voice getting tired after a day of talking, also called vocal fatigue, and nearly all are benign. Age-related thinning of the vocal folds (atrophy), decreased motion of one vocal fold (paresis), benign vocal fold lesions (nodules, polyp, cyst) and scarring of the vibration layer of the vocal fold can all lead to recruitment of other muscles inside and outside the larynx to compensate for the changes in how the vocal folds are not normally functioning.

This compensation has a common name: muscle tension dysphonia (MTD). The gap that forms between the vocal folds from any of these causes creates a “leaky valve,” allowing excess air to escape inappropriately through the vocal folds during phonation. This inappropriate loss of air from where the vocal folds meet (the glottis) is called glottic insufficiency; it causes the changes that people experience in vocal quality, effort, strain, and fatigue. Because the same muscles outside the larynx

that compensate for voice problems elevate our larynx during swallowing, many people with glottic insufficiency also complain of a lump in their throat when they swallow. This is one of the many causes of a “globus” sensation.

The most important step in addressing vocal fatigue is an appropriate workup, including examination of the vocal folds themselves and, in many centers, an evaluation by a speech and language pathologist (SLP). The vocal folds are often visualized with a common in-office examination called a laryngoscopy. This exam is performed with a flexible camera introduced through the nose or a rigid telescope introduced through the mouth.

Stroboscopy, a special adjunct to laryngoscopy that can reveal the vocal folds vibrating in slow motion, is used to diagnose more subtle pathologies and assess how the pathology is affecting how the vocal folds meet during vibration. These exams are essential for both confirming the suspected diagnosis and differentiating the more common pathologies from other, less common but more concerning causes for voice changes. MTD is often given as a primary diagnosis when otolaryngologists exam the larynx with a flexible laryngoscope under normal light and see the muscles and structures above the larynx squeezing together, blocking the view of the true vocal

folds during phonation. Stroboscopy is an excellent adjunct when the flexible exam does not clearly reveal a pathology beyond this observed squeezing; it can reveal the underlying pathology and reason for the patient’s MTD. SLPs, when available early in the patient’s workup, are invaluable to understanding if the patient’s complaint and vocal problem are amenable to voice therapy.

Treatment of vocal fatigue usually consists of voice therapy and/or a surgical intervention to treat the underlying disease process. The order of which treatment is administered first depends on the patient and pathology. Some patients will do well with voice therapy alone, while others with larger benign lesions and significant atrophy require vocal fold augmentation or lesion excision before therapy begins in order to achieve their ultimate improvement. The goal of these treatments is to increase the efficiency of vocal fold closure during vibration, thus improving the glottic insufficiency, relieving MTD and ultimately improving vocal fatigue, hoarseness, and other associated complaints.

Various quality of life studies show that patients with vocal fatigue are often quite happy with the results they achieve. Previously avoiding social gatherings or other engagements that involve talking later in the day, these patients find they withdraw less, and that everyday communication becomes easier.



**James J. Daniero,
MD, MS, Chair**

My throat always feels dry, and it often also affects my voice. How can I get rid of my dry throat?

Dr. Daniero: Of course, the easy answer is to drink more water. Despite our best attempts, in our busy day-to-day lives we often do not reach the recommended eight glasses of water per day. However, there are also hidden ways that we lose extra water each day that should also be avoided. These include eliminating caffeine sources, such as coffee, tea, and sodas. Although these beverages are often consumed when we are thirsty, this does not mean that they add to the body’s overall hydration. In fact, highly caffeinated beverages like energy drinks and coffee are powerful diuretics that actually subtract from one’s water glass tally, pushing the overall goal well beyond the recommended eight glasses. There are also many common medications—particularly those used for allergies, blood pressure, chronic pain,

and depression—that create dry mucus membranes of the throat and vocal cords. Medication induced dryness can easily be overlooked, especially when there is a long list of medications, which can overlap in their combined drying potential.

In addition to total body dehydration, breathing dry air can be a significant contributor to throat dryness. Regions with low humidity and cold temperatures requiring the building heat to be turned on can draw the moisture out of the sinuses, throat, and lungs as we are breathing.

The nose is the humidifier and filter for the air we breathe and therefore adding hydration to the nasal cavity can help the body counteract dry air passing down into the throat and airway. This can be improved by using nasal saline sprays frequently throughout the day. Furthermore, mouth breathing can bypass this system and introduce dry air directly to the throat. Addressing nasal congestion with nasal steroids or possibly even surgery for severe cases can help reduce mouth breathing and increase overall airway humidification.

Ultimately, adding external humidification and lubrication to the airway can also help reduce dryness. This can be achieved by using a steam inhaler device, available



Offers Information for Your Patients

at most pharmacies, or using a bedside humidifier. Similarly throat lozenges and certain decaffeinated teas can help with coating the throat due to the effect of their demulcent ingredients. Demulcents, such as pectin, glycerin, honey, and syrup, are ingredients that form protective coatings of the mucus membrane lining of the throat and vocal cords. Menthol-based lozenges, while temporarily soothing, may cause irritation of the throat when used for prolonged periods. Lozenges based on fruit pectin and/or glycerin can lubricate the throat and vocal cords without the other effects of menthol.

Finally, a good indicator to determine if your vocal cords may be dry is to correlate it with dryness in the mouth. If your mouth is dry, then you can assume your vocal cords (only a few inches away) are also dry and less likely to vibrate efficiently—this relationship is often underrecognized. ■



FROM THE EDUCATION COMMITTEES

Acute Laryngeal Injury and COVID-19: The Perfect Storm

William S. Tierney, MD, MS, MS; Paul C. Bryson, MD, MBA, Chair, Laryngology and Bronchoesophagology Education Committee; **Alexander Gelbard, MD**

Acute Laryngeal Injury

Acute laryngeal injury (ALgI) is ulceration, and/or granulation tissue of the laryngeal mucosa. It is frequently encountered following prolonged intubation when the curvature of the cervical spine and the displacement of the sedated tongue base force the endotracheal tube posteriorly against the laryngeal framework.¹ Pressure injury to the laryngeal mucosal injury can lead to fibrotic contracture, which tethers the cricoarytenoid joint complexes and can result in posterior glottic stenosis.² ALgI has been prospectively observed in 57% of patients after ICU mechanical ventilation and is associated with significantly worse breathing and voicing 10 weeks after extubation.³

Pre-pandemic research showed that patients with comorbid diabetes mellitus, elevated BMI, and an endotracheal tube larger than 7.0 had an increased incidence of ALgI after prolonged intubation.³ The data suggest that intensivists should consider using ETT sizes

less than 7.5 for patients to limit laryngeal injury and highlight the importance of adhering to recommended guidelines on appropriate ETT size based on height. This is the one established risk factor for ALgI that can be directly modified (in partnership with intensivists and emergency physicians) to immediately benefit patients. Further research is needed to confirm if decreasing ETT size beyond current height-based sizing nomograms further reduces the risk of laryngeal injury.

Once ALgI has been identified, early intervention to prevent scarring reduces the number or required operations and the need for open airway reconstruction compared to intervening following the development of mature scar.⁴ Early intervention in patients with ALgI and tracheostomy reduces the duration of tracheostomy dependence and the number of interventions required to achieve decannulation.³ Intervention to treat ALgI in the acute phase consists of endoscopic removal of granulation tissue and fibrinous debris, injection of corticosteroids. Protocolized approaches to early intervention for ALgI and large prospective studies are needed.

The impact of ALgI on recovery from

critical illness coupled with the proven benefit of early intervention to promote laryngeal function after prolonged intubation elevate the importance of post-extubation surveillance of high-risk patients. Individuals with high BMIs or diabetes are particularly vulnerable and benefit from close airway monitoring after extubation.

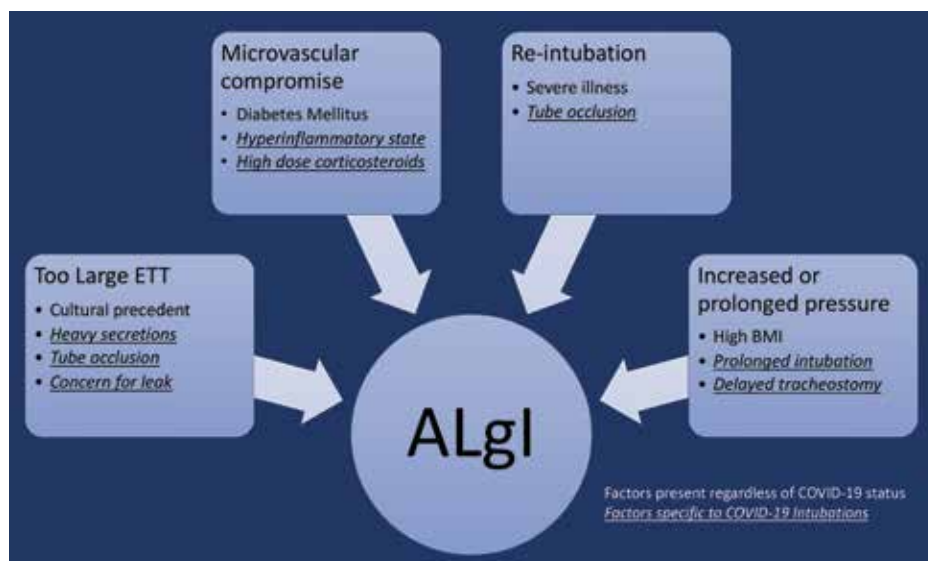
Laryngotracheal Impact of COVID-19

As with so many research efforts, the work to improve outcomes for patients with ALgI has already been shaped by the COVID-19 pandemic. In early 2020, as the COVID-19 pandemic escalated in the United States and around the world, initial responses from professional societies emphasized the risk of disease transmission sometimes at the cost of departing from existing patterns of care. Many hospitals protocolized delaying tracheostomy for two to four weeks and preferentially selecting large endotracheal tubes to maximize secretion management and minimize ventilatory leak with droplet escape.

Even as expanded clinical experience with COVID-19 improved survival from severe disease, insults to laryngotracheal health continued to accumulate. Molecular evidence



Figure 1: Acute Laryngeal Injury – example of posterior glottic granulation tissue representing ALGI.



of dramatic inflammation in the proximal airway mucosa reinforced the susceptibility of the airway to injury from elevated cuff pressure.⁵ Corticosteroids became a mainstay therapy for severe cases of the disease.⁶ This was accompanied by increasing rates of adrenal insufficiency, unmasking of diabetes mellitus, and muscle atrophy.¹ Microvascular vulnerability and impaired wound healing also contribute to proximal airway injury after prolonged intubation.

Perhaps unsurprisingly, laryngotracheal injury in real-world settings increased.^{8,9} In one U.S. laryngology practice, 40% of sequentially collected patients seen in clinic after COVID-19 intubation reported unilateral vocal fold paralysis, 15% had posterior glottic

stenosis, and 10% had subglottic stenosis.⁸ In Italy, a large prospective cohort evaluated after mechanical ventilation for COVID-19 showed that 22.5% had fixed obstruction on PFTs consistent with laryngotracheal stenosis.⁹

ALGI in the Time of COVID

Anecdotally, patients with laryngeal, subglottic, or tracheal scar after severe COVID-19 have represented an increasing proportion of patients in tertiary airway centers. Even this information is likely to dramatically under-represent the problem as patients continue to rehabilitate from their illness with a tracheostomy that masks the underlying anatomic derangement in the proximal airway. Experience to date across multiple centers suggests that laryngotracheal

scar will be a fixture of COVID survivorship for a large proportion of patients. Now more than ever, we believe focused approaches to early ALGI detection and treatment after extubation can serve to reduce the rates of laryngotracheal stenosis and promote functional recovery from critical illness. For patients with laryngotracheal stenosis secondary to prolonged intubation for severe COVID-19, expedient diagnosis, early treatment, and rapid referral of recalcitrant patients to tertiary care centers will be increasingly important as we work to restore laryngeal function after prolonged intubation resulting from COVID-19. ■

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Tech Talk

Practice Primer on HIPAA and Related Privacy Regulations

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

Understanding the Health Insurance Portability and Accountability Act (HIPAA) and related acts is not easy. Complying with the privacy and security regulations promulgated under HIPAA and related legislation can be overwhelming. Unfortunately, ignoring these regulations is not an option. This article provides practical insights for understanding from a practice perspective.

The guiding principle behind HIPAA and other privacy regulations such as the European Union's General Data Protection Regulation (EU GDPR) is this: An individual's data belongs to the individual. Your practice is a steward of the patient's data. At all times, the practice must be respectful of an individual's rights regarding their own data.

HIPAA created the first national set of standards protecting patients' health information as well as addressing the flow of health information across systems. Interoperability is a complex topic. This article focuses on the patient data protection component.

The three major components of HIPAA are:

1. the Privacy Rule
2. the Security Rule
3. Breach Notification

Here is how they relate to one another. The Privacy Rule establishes what information needs to be protected and how it is handled. The Security Rule identifies how electronic data is to be protected (i.e., cybersecurity aspects). And Breach Notification says what needs to be done in case protected information gets exposed to unauthorized parties.

Privacy Rule

The Privacy Rule centers around protecting data that is identifiable back to an individual as well as a patient's right to access their own information. The 21st Century Cures Act specifies the following eight types of clinical notes among electronic information that must be made available to patients when they ask:

- Consultation notes
- Discharge summary notes
- History and physical
- Imaging narratives
- Laboratory report narratives
- Pathology report narratives
- Procedure notes
- Progress notes

Of major importance to a practice is what is at the center of the 21st Century Cures Act. If a patient asks for their data, the practice has several options, including the following:

- Printing the data from your electronic healthcare records (EHR) system
- Exporting it through a Continuity of Care Document (CCD) in the EHR
- Directing patients to view and download data using a patient portal

Below are the rules governing a patient's information request:

- The patient or personal representative has the right to medical and billing records. If a person has a healthcare power of attorney, then they are a personal representative.
- Even if they have not yet paid for services, a patient cannot be denied a copy of their records.
- A reasonable fee can be charged for copying and mailing records. A fee cannot be charged for searching or retrieving a patient's records.
- Clinicians are only required to provide access to protected healthcare information (PHI) that the patient requests.
- Patients only have the rights to access information used in decision making for their care.
- Clinicians have 30 days to provide patient-requested medical records at reasonable cost. Recent penalties paid to the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) for noncompliance range from \$10,000 to \$160,000.

Security Rule

The HIPAA Security Rule protects all individually identifiable health information a practice creates, receives, maintains, or transmits in electronic form. The Security Rule calls this information "electronic protected health information" (ePHI). The Security Rule does not apply to PHI transmitted orally or in writing (paper based).

When developing your practice's HIPAA security policies and procedures covering administrative, physical, and technical safeguards, keep in mind the following principles:

1. Ensure the confidentiality, integrity, and availability of all ePHI created, received, maintained, or transmitted as follows:
 - a. **Confidentiality:** ePHI is not made available nor disclosed to unauthorized people
 - b. **Integrity:** ePHI is not altered, changed, or destroyed in an unauthorized manner, while in transit or at rest
 - c. **Availability:** accessible and usable on demand by authorized staff
2. Identify and protect against reasonably anticipated threats to the security and integrity of ePHI
3. Protect against reasonably anticipated, impermissible uses, or disclosures
4. Ensure compliance by the practice's staff

In a nutshell, ePHI, needs to be encrypted while in transit (between systems or to a secure web portal). Careful consideration should also be given to encrypting PHI while at rest (stored in a database).

Breach Notifications

A breach is generally an impermissible or unauthorized use or disclosure of PHI. Exposure of encrypted data is not considered a breach if the encryption is strong enough to prevent decoding. These are the key points as

identified on the U.S. Department of Health and Human Services (HHS) website:

- Unsecured protected health information is unencrypted or easily decipherable data that can then be attributed to an individual.
- If a breach affects 500 or more individuals, the HHS Secretary must be notified within 60 days.
- If a breach affects fewer than 500 individuals, it must be reported within 60 days of the end of the calendar year.

Please visit <https://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html> for details on reporting a breach.

Recommendations

HIPAA requires practices to conduct a risk assessment to help ensure compliance with HIPAA's Security Rule safeguards: administrative, physical, and technical. The assessment will help reveal areas where PHI may be at risk. Here is the link to the Security Risk Assessment (SRA) tool developed by the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with the HHS Office for Civil Rights (OCR), <https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool>

The outcome of the security risk assessment should help drive next steps. The following are additional recommendations pertaining to each of the three main HIPAA components:

Privacy

- Create a secure patient portal giving patients self-service access to their health information.
- Develop policy and procedures for how to address patient requests for their health information, including any associated fees.

Security

- Develop policies and procedures for addressing appropriate administrative, physical, and technical safeguards for electronic protected health information (ePHI).
- Develop a robust cybersecurity plan. Reviewing the article "A Framework for Combating Ransomware" is a good place to start. <https://bulletin.entnet.org/aao-hnsf-2021/article/21759592/tech-talk-a-framework-for-combating-ransomware>

Breach

- Review the HIPAA Breach notification requirements and develop your policies and procedures accordingly.

Concluding Remarks

HIPAA and privacy regulation compliance is not easy. Fines can be stiff. Loss of reputation can be even more damaging. Adopting the mindset that your practices are stewards of patient data is as important as developing an in-depth cybersecurity posture. On an annual basis, conduct an in-depth risk assessment and use the results as a guide to develop and review policies and procedures related to Privacy, Security, and Breach Notification. ■



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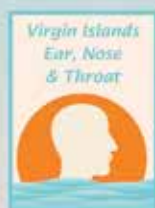
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Pittsburgh is a vibrant and exciting city, offering diverse culture, world-class arts and music, prestigious colleges and universities, proximity to state and local recreational parks, and a nationally recognized culinary scene. Pittsburgh's beautiful landscape, rivers and bridges and affordable cost of living make it an attractive option for both individuals and families.

Email your CV and direct inquiries to:
Dan Bobbitt | Physician Recruiter | Allegheny Health Network
(412) 330-2650 or Daniel.Bobbitt@ahn.org

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Please contact Bonitamedsurg@aol.com.



Do you have a position, course, or meeting you would like to promote?

The Bulletin is the perfect vehicle to reach your audience. Contact **Suzee Dittberner** today at **913-344-1420** or **sdittberner@ascendmedia.com**.





THE OHIO STATE UNIVERSITY

WEXNER MEDICAL CENTER

Department of Otolaryngology-Head and Neck Surgery Come Grow with Us!

The Department of Otolaryngology at The Ohio State University Wexner Medical Center is experiencing tremendous growth and offering multiple opportunities to join one of the top ranked departments in the country. Applicants must demonstrate excellence in patient care, research, teaching and leadership. Current openings are:

- General ENT:** The medical center is currently opening multiple state of the art ambulatory clinic locations throughout the greater Columbus area. This is a great opportunity to kick-start your practice. The division currently consists of two general otolaryngologists and two nurse practitioners.
- Otologist/Neurotologist:** Seeking an academically productive Otologist/Neurotologist for a clinician or clinician/scientist position. Applicants must be board certified/board eligible in otology/neurotology and fellowship trained. The division has nine full-time clinical and research faculty, several research scientists, a robust audiology division, and a vestibular program.
- Rhinology Division Director:** Seeking an academically productive Rhinologist for the position of division director. Applicants must be board certified/board eligible in rhinology and fellowship trained. A history of research funding is desirable, but not required. Collaboration with department leadership to create a vision for the future of the program is a high priority. The ideal applicants will be highly motivated to set up a successful clinical or basic research effort, work well independently, and be funded or on track to submit for NIH or equivalent funding. There are currently two full-time clinical faculty and a dedicated full-time research faculty member.

Located in the heart of Ohio, Columbus is the fastest growing city in the Midwest and offers a population of over 1.5 million people. Voted as one of the most-livable cities in the USA, Columbus has excellent cultural, sporting, and family activities.

To build a diverse and inclusive workforce, all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status or protected veteran status. The Ohio State University Wexner Medical Center is an Equal Opportunity/Affirmative Action employer.

Send letter of interest and CV to:
James Rocco, MD, PhD, Professor and Chair
The Ohio State University Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212

Contact the Department Administrator via
Email: mark.inman@osumc.edu
Fax: 614-293-7292 or
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