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

NOVEMBER 2022

– Eric M. Genden, MD, MHCA, FACS
Isidore Freisner Professor and
Chair Otolaryngology –
Head and Neck Surgery,
Mount Sinai Health System

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– George B. Wanna, MD
Executive Vice Chair and
Chief of Otology-Neurotology
Otolaryngology -
Head and Neck Surgery
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inside this issue

features

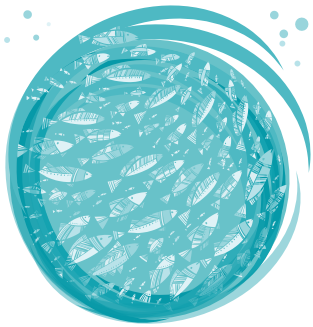
departments

The leading edge

The Perfect Storm

I recently visited the Pacific Northwest and enjoyed hiking and kayaking on a chain of lakes. The trout were running, and it was an amazing pattern of individual fish, swimming in the same direction and in alignment. This pattern of swimming, I have learned, is a survival tactic and is termed in philosophy as "emergence." It occurs when fish, geese, or groups of people demonstrate properties or behaviors that emerge only when the parts interact as a wider whole. When there are large numbers together, it is much harder for a predator to find its prey while the lone fish is easier to pick off and take advantage of.

In the school of fish, everyone is the leader and no one is the leader. There is deliberate coordination to stay close, but not too close to impede forward progress. As the school continues its journey, a set of rules evolves that focuses on avoiding predation. If you are a fan of TED Talks, Nathan S. Jacobs does a much better job explaining this in his presentation, "How Do Schools of Fish Swim in Harmony?"



Schools of fish, geese migrating, the sand on the beach, or snowflakes during a storm individually do not have the impact that is seen when they gather together. The takeaway is it isn't necessary for someone to be in charge if there are rules and conditions in place so that habits develop that turn chaos into order. Last month, we discussed how we as academics, private practice, and employed otolaryngologists are stronger together. The theory of emergence explains how we can move forward with strength without impeding one another.

All of that led me to think about the 8.42% Medicare cuts that are scheduled to occur January 1, 2023. How did we get to this significant cut again? It may be described as the result of a perfect storm or an example of kicking the can down the road. This time, there are two different hits that are coming our way:

1. Medicare PAYGO

- The American Rescue Plan Act (ARP) of 2021 increased spending without offsets to other federal programs. Under statutory Pay-As-You-Go (PAYGO) rules, increases to the federal deficit automatically trigger an additional series of across-the-board reductions to federal programs. According to the Congressional Budget Office, the ARP created a **4.0%** cut or $36 billion for Medicare providers per year, which would have a substantial impact on the delivery of care to our patient community.

2. Changes to the Medicare Conversion Factor

- Last year, Congress passed a temporary 3% patch to the Medicare conversion factor, which converts the relative value units into an actual dollar amount. Medicare updates the conversion factor on an annual basis according to a formula specified by statute, within the constraints of Medicare's budget-neutral financing system. Although the patch allowed for a temporary stabilization in provider reimbursement, proposed changes to the Physician Fee Schedule for 2023 will once again cut reimbursement to providers during a critical time. Next year's proposed Medicare Physician Fee Schedule would decrease the conversion factor by **4.42%**.

The above-mentioned 8.42% pending cuts set to take place January 1, 2023, are on top of the additional 2% Medicare sequester cuts that already took effect on July 1, 2022.

To try and tie everything together, the idea that any one otolaryngologist can impact Medicare reimbursement on their own is futile. However, the Academy's 8,800 U.S.-based otolaryngologists who are impacted by this can "swim" in a way that can impact the reimbursement war and prove once again, we are stronger together.

As providers, we are being seen as prey by insurance companies and the government. We are needed to provide access and yet are being expected to provide services for less remuneration while we experience increasing inflation, supply chain delays, and staffing shortages.

The way forward is for us, as individuals and institutional stakeholders, to come together and respond to our legislators, regulators, and government. Our practices and healthcare institutions are currently experiencing losses and the pending 8.42% decrease by our single largest payer is not sustainable for 2023. No matter how we see ourselves, we have a much better chance of not being picked off individually if we support each other in advocacy by the Academy and other medical societies to prevent the planned Medicare reimbursement decreases for physicians. ■

Kathleen L. Yaremchuk, MD, MSA
AAO-HNS/F President

> "The way forward is for us, as individuals and institutional stakeholders, to come together and respond to our legislators, regulators, and government."

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Re-imagining the *Bulletin* for the Future

I am excited to announce the next phase of our organization-wide re-imagination of our publication strategy. The Academy and Foundation have been engaged in upgrading our product lines in publications and education over the last five years. To guide us on how to best reach our goal of providing members what they want, when they want it, and how they prefer to receive it, we rely on fact-finding surveys and interviews with stakeholders, research and review of current industry standards as well as projected evolution in each area, and evaluation of pilot project changes. We have seen these strategies result in the launch of FLEX, achievement of the highest Impact Factor to date for *Otolaryngology–Head and Neck Surgery*, and increased innovative programming for the Annual Meeting.

During this time, we have also expanded the *Bulletin's* digital footprint by enhancing the reader's online *Bulletin* experience and elevating the distribution of the content in the electronic table of contents (eTOC), both with very encouraging results. Over the last three years, reader engagement is over 50% based on the eTOC open rate and now stands 26% higher than the average in the healthcare publications category. Additionally, activity on the online *Bulletin* webpages demonstrates that the average reader spends 2:35 minutes on a page. Based on this trending and increasing digital engagement, the Academy is excited to announce that, starting with the February 2023 issue, we are moving the *Bulletin* to a totally digital and online publication.

We feel that there will be immediate benefits to both our general readership and the contributors to the *Bulletin*. We will be able to add timely, real-time content as it is ready and available, incorporate all forms of multimedia to enhance content, and increase the number and types of articles as the limitations of print are eliminated. This will allow us to increase subject matter variety and special topics of interest to provide more in-depth content on each topic as the word limitation also evaporates. This also will enable submissions incorporating additional mediums such as video and podcasts.

The digital version of the *Bulletin* will be available through all devices and content will be distributed twice monthly. Next month's December-January edition will contain a more detailed review of the transition. And we will be looking to gain even more feedback from members as we transition the *Bulletin* in 2023 from its current, combined print and digital format to digital only.

Tracking the Changing Workforce

The Workforce and Socioeconomic Survey created by the Workforce Task Force under the leadership of Immediate Past President **Ken Yanagisawa, MD**, recently closed, and I want to thank the Task Force, chaired by **Andrew J. Tompkins, MD, MBA**, for their outstanding effort. This will be a yearly survey going forward to more accurately determine complexities of the changing workforce and how they fit into population needs that will influence training paradigms and career opportunities. I also would like to thank the 1,700+ individuals who gave their time to take the survey.

The preliminary results were presented at the Annual Meeting in Philadelphia, Pennsylvania. Once the final analysis has been completed, it will be submitted for publication. The most concerning information to me reflected the severity of "burnout" affecting the otolaryngology community. When asked "If you could retire tomorrow, would you?" 30% said, "Yes."

Finally, it came to our advocacy team's attention that there was a severe shortage of tracheostomy tubes in the United States, particularly at children's hospitals. This triggered an immediate investigation into the situation in collaboration with pediatric otolaryngologists and the American Society of Anesthesiology, which resulted in multiple conversations with the Food and Drug Administration (FDA) and with both American and European suppliers. We found that this was a multifactorial supply-chain issue with no simple solution. We sent a formal letter to the FDA and worked with them in trying to identify additional supply. Special thanks go to **Julie L. Wei, MD**, President of American Society of Pediatric Otolaryngologists, **Soham Roy, MD**, and **Ken Kazahaya, MD**, who provided us with instrumental data. Dr. Wei led the efforts to acquire critical data requested by the FDA through a survey completed by 130 pediatric otolaryngologists.

This is an inspirational example of how a comprehensive, effective response to a critical problem can be addressed rapidly when affected stakeholders can work together to identify the full extent of a problem and help create a reasonable solution. It also highlights the benefit and need for all areas of otolaryngology to work effectively together to improve care. ■

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

"Based on this trending and increasing digital engagement, the Academy is excited to announce that, starting with the February 2023 issue, we are moving the *Bulletin* to a totally digital and online publication."

In Memoriam: Jack L. Gluckman, MD AAO-HNS/F President 2000-2001

Jack L. Gluckman, MD, who was known as a natural and charismatic leader, served as President of the American Academy of Otolaryngology–Head and Neck Surgery and its Foundation (AAO-HNS/F) from 2000-2001.

"Jack was an internationally renowned head and neck cancer surgeon; revered for his integrity and humanistic approach to the care of his patients and their families," said **David L. Steward, MD**, Helen Bernice Broidy Professor and Chair, University of Cincinnati College of Medicine, Department of Otolaryngology-Head and Neck Surgery.

Dr. Gluckman was Professor-Emeritus of Otolaryngology-Head and Neck Surgery at the University of Cincinnati. He was born and raised in South Africa attending Grey High School in Port Elizabeth and medical school at the University of Cape Town. After completing his otolaryngology residency at the University of Witwatersrand in Johannesburg, he joined the faculty at Groote Schuur Hospital in Cape Town and then subsequently entered private practice for several years in Port Elizabeth.

In 1977 Dr. Gluckman moved to Cincinnati, Ohio, for a fellowship in head and neck oncologic surgery and remained on the faculty at the University of Cincinnati (UC). He became Chair of the UC Department of Otolaryngology-Head and Neck Surgery in 1991, a post he held through 2004. During his more than 30 years on the faculty, he served in many leadership roles in the UC College of Medicine and at the University Hospital, including Associate Dean for Clinical Affairs and the first Chief of the Medical Staff.

"As our leader, he epitomized the ideal of the philosopher king. During his tenure, he attracted outstanding physicians and researchers to the department whom he credited as instrumental in the department's recognition as one of the finest clinical departments and resident training programs in the country," said Dr. Steward.

Dr. Gluckman also provided extraordinary guidance and direction throughout his term as AAO-HNS/F President, but in particular, it was the unforgettable events on 9/11 and his subsequent leadership that marked his presidency. The tragedy of 9/11 occurred on the Tuesday of the AAO-HNSF 2001 Annual Meeting & OTO EXPO in Denver, Colorado. Dr. Gluckman quickly convened the Academy leadership to make the swift decision to cancel the remainder of the meeting. "This was a moment when one saw Jack's significant leadership qualities," shared **Michael Setzen, MD**, Clinical Professor of Otolaryngology at Weill Cornell Medical College, and who served as the Board of Governors Chair from 2000-2001.

In Dr. Gluckman's own words published in his profile in the *Legacy of Excellence*, "What was most impressive was how all the delegates closed ranks and all those without accommodations were found rooms, and those who wanted to leave were able to get a ride to their destinations!"

Beyond the events of 9/11, Dr. Gluckman focused his presidency on improving relationships with other specialties, including plastic surgery and audiology, and more clearly defining scope-of-practice issues. Dr. Setzen recollected proudly, "Jack and I were both thrilled to be at the helm of the AAO-HNS/F, he as AAO-HNS/F President and me as Chair of the Board of Governors, both of South African heritage."

In addition to serving as AAO-HNS/F President, Dr. Gluckman also served as President of the American Board of Otolaryngology – Head and Neck Surgery, Board member of the American Head and Neck Society, and Vice President of the Triologic Society. Internationally he was Regional Secretary for North America, Mexico, and the Caribbean for the International Federation of Otolaryngologic Societies.

Dr. Steward shared the vast impact Dr. Gluckman had on those who crossed his path.

"As a leader, scholar, teacher, compassionate physician, skilled and empathetic surgeon, Jack exemplified qualities admired by colleagues around the world. At a local, regional, national, and international level, Dr. Gluckman's reputation has always been based on his unimpeachable integrity and high standard of ethics by which he comported himself. His service to the specialty and his patients will be missed by his family, friends, colleagues, and patients alike.

"He inspired and mentored many future leaders in the field and taught the importance of taking care of the person rather than just their cancer. Human dignity was sacrosanct in his mind. When he reassuringly placed a hand on his patient's shoulder, he committed to being there throughout their journey, and it made all the difference." ■

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PERSPECTIVES OUT OF COMMITTEE: Veterans Affairs

Easing Out of Active Practice: What Are You Going to Do Now? Consider Part-Time VA Employment!


David E. Eibling, MD

Many retired surgeons have emphasized that the dramatic changes of sudden retirement for many of us active older surgeons can lead to a lesser than anticipated quality of life. Like many approaching retirement (I am 74), I know that I thrive on interactions with my patients, trainees, and colleagues. For many, perhaps most of us, the sudden loss of our decades-long sense of purpose and interactions with others may set us adrift. When coupled with other major changes such as health issues or a change in location, this sense of loss may be even greater. The Panel Presentation, "Retirement—Are You Ready for the Next Chapter?" at the AAO-HNSF 2022 Annual Meeting & OTO Experience provided insight. The panel was moderated by **Lance A. Manning, MD**, and included panelists **Lee D. Eisenberg, MD, MPH, Richard W. Waguespack, MD,** and **Pell Ann Wardrop, MD**. All three panelists emphasized the need to plan ahead for one's future, and for many, these plans should consider some less intensive work in our specialty.

I was personally impacted by comments to this effect by **Roger L. Crumley, MD, MBA**, in a keynote address at the 2019 American Society of Geriatric Otolaryngology (ASGO) meeting.[1] Dr. Crumley is former chair of the Department of Otolaryngology-Head and Neck Surgery at the University of California, Irvine, School of Medicine. He spoke of his semi-retirement and how it clarified how gratifying seeing patients and teaching were to him. He, therefore, recommended that if these are passions for others as well, then they should continue—whether by scheduling fewer patients, volunteering, or putting in time at a free clinic. I took his advice and am following it for my own gradual winding down to retirement.

However, this is not always as straightforward as it might seem. For many in private practice, they must consider ongoing financial commitments such as office costs if no successor is available, malpractice insurance (and "tail"), licensing fees, etc. These and other expenses may mandate continuation of a higher-than-desired effort when one really would prefer to slow down.

Dr. Waguespack noted during the panel another option you might wish to consider—that is, seeking to provide part-time help at a local Veterans Affairs (VA) hospital. I have been a VA employee for 32 years and am currently at the Pittsburgh VA Medical Center. As I have slowed down over the past several years, I have found the experience continues to be rewarding. In my case, I no longer do elective scheduled surgical cases. I spend about half of my time doing virtual visits from home and two days in the general clinic. Recall that the VA covers malpractice, and in some states (such as Pennsylvania) there is no cost for a license to practice only within the VA. A valid license in any state is sufficient, so that if you are looking to relocate, there is no need to seek licensure in your new state. I have a part-time appointment, but many work under a fee-based arrangement. There seem to be a number of permutations as to compensation arrangements, and, of course, volunteer work (without compensation [WOC]) is often welcomed.

An even more critical factor is the need for your services as a part-time otolaryngologist. The recent MISSION Act, which facilitates care of veterans in the local community outside the VA, has paradoxically heightened the need for our care. This is particularly true at smaller VA facilities and so-called community-based outpatient clinics (CBOCs), of which there are literally thousands. These smaller remote sites do not have sufficient need to support a comprehensive otolaryngology section but are linked to a larger facility. Among my other roles, I spend one day per month at a smaller VA hospital two hours from Pittsburgh. My presence there assists in expediting care for patients who require tertiary care.

I hope I have piqued your interest! If so, the first step is to contact your local VA facility to inquire whether a need exists. You should talk to a VA otolaryngologist, then an in-person visit would probably be the next step. The credentialing process is VA-hospital specific, but the online form "Vetpro" is used by all VA hospitals so does not need to be completed again if you are working in more than one facility or move during retirement. A fairly intensive online training is required of all employees in order to be granted access to the VA computer system, but yearly refresher courses are less challenging to complete. Re-credentialing requires ongoing continuing medical education, and you will need to maintain basic life support certification, but this is usually provided by the VA facility.

To conclude, you may wish to use your skills to enhance ENT care for our nation's veterans; for me it has been an honor. ■

Reference

1. Crumley, RL. Retirement and life after practice: reflections on retirement. Speech presented at: American Society of Geriatric Otolaryngology Meeting; May 3, 2019; Austin, TX.

What It Means (Meant) to Me to Be a Military Otolaryngologist

Scott Bevans, MD
Lieutenant Colonel U.S. Army,
Facial Plastic & Reconstructive Surgery, Head & Neck Oncology, Microvascular Surgery, Department of Otolaryngology, Tripler Army Medical Center, Honolulu, Hawaii

I joined the Army after 9/11 when the U.S. went to war in Iraq. Despite ideologic differences, we can all agree that war is ugly. The greatest costs of war are the human costs, and often incurred by the least deserving. As military surgeons, we have the opportunity to redeem those injured in conflict. If done well, we can save lives and restore those injured in the line of duty or innocently caught in the crossfire.

Some time ago, I deployed to Iraq as a part of a Head and Neck Trauma Team. I recall meeting some members of the elite units that we supported. They came by the Combat Support Hospital to look into the eyes of the people who would work to save their lives if they were injured. With every mission, the young men and women who joined the military to defend our nation's freedoms, placed their lives on the line for us. We are their life insurance policy. Our unit's motto was "Reviresco," which means "to renew or revive." Across the world, we strive to practice good medicine in the worst places, to revive our nation's defenders. Those four and a half months I spent in Baghdad were the epitome of what it means to me to be a military otolaryngologist. Every day since, I have worked to prepare the next generation of head and neck surgeons to be prepared should they be asked to do the same.

Reviresco! ■

Reena Dhanda Patil, MD
Chief of Otolaryngology, Cincinnati Veterans Affairs Medical Center, Ohio

As a chief resident leaving Washington University in St. Louis in 2003, I never dreamed I would become a career Veterans Affairs (VA) otolaryngologist. Although I loved my time rotating through the VA during residency, I initially planned to pursue comprehensive ENT in private practice. But fate intervened, and I ended up working at a VA in Florida for my first job, ultimately transferring to my current position for the last 15 years.

Over the past two decades as an attending, I think often to myself that I am lucky to provide care to such a grateful, kind patient population. Our nation's veterans have sacrificed a part of their lives to serve our country, and I consider it a privilege to serve them in kind. Although the VA is not always the easiest place to work from a bureaucratic standpoint, I have never felt limited in my ability to provide cutting-edge care for our patients; in some ways, working for a single-payer system allows me the freedom to do what is right for my patient and not worry about day-to-day details. In addition, I am fortunate to work with our residency at the University of Cincinnati as a faculty member and enjoy the energy and motivation of the three residents rotating with me at any given time. With the opportunity to pursue my research interests as well as to educate and provide outstanding care, I am always glad to be at work and look forward to more fruitful days in my clinic and OR as a VA doc! ■

READ MORE ONLINE

Philip A. Gaudreau, MD
Commander, Medical Corps, U.S. Navy
Navy Medicine Readiness and Training Command, San Diego, California

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. Government.

Military otolaryngology provides an opportunity to practice otolaryngology in diverse locations around the world supporting our active-duty members, their families, and the retirees who have given their careers to military service. This is in addition to the incredibly rewarding work of treating our service members and their families while at home. The ability to provide this care and help reduce the burden to our service members, often as they prepare to deploy, are already deployed, or have just returned from deployment, provides a significant degree of personal satisfaction.

Beyond the day-to-day work of caring for patients, being a military otolaryngologist means being a part of a community. The sense of shared sacrifice associated with a career of deployments, shared training locations, and the challenges associated with a career in federal service creates a bond with our fellow military otolaryngologists, the other medical specialists with whom we have the pleasure of working, and our patients.

As a residency program director, military otolaryngology offers a constant sense of looking to the future. Although my focus is certainly how to prepare my current residents to be safe and competent otolaryngologists, I am also looking at the best way to position and prepare our specialty for any future conflict in which we may find ourselves engaged. Enhancing the ability of military otolaryngologists across the range of subspecialties to respond to traumatic injuries that may result from future conflicts is critical to the survivability of our active-duty members and to ensuring that our specialty remains relevant to higher level military medical planners.

Being a military otolaryngologist is a fascinating and rewarding career. I have had the opportunity to train the future of our specialty and care for patients who believe in shared sacrifice to improve our ever-changing world. ■

Celebrate #GivingTuesday by Supporting the 125 Strong Campaign

According to its founding organization, #GivingTuesday was created in 2012 as a simple idea: a day that encourages people to give back. Since then, it has become a "global generosity movement unleashing the power of generosity." Following Thanksgiving and the widely recognized shopping events of Black Friday and Cyber Monday, this year's #GivingTuesday will take place on November 29. As the two-year **125 Strong Campaign** comes to an end this year, the Academy and its Foundation humbly ask you to consider making a tax-deductible gift in support of the otolaryngology community.

The **125 Strong Campaign** commemorates the 125th anniversary of the Academy and is a critical component to shaping our future together. While the AAO-HNS/F officially celebrated its 125th anniversary in 2021, there is still time to invest in the advancement of the specialty today by donating to the **125 Strong Campaign** before December 31. Every donation counts. Your individual support is needed to help build these four programs that will have an immediate impact:

- **Diversity, Equity, and Inclusion:** Advancing equitable, ear, nose, and throat care and attracting a diverse otolaryngology community
- **Education:** Using digital learning tools and resources to advance otolaryngology education while optimizing and advancing remote learning
- **Leadership Development and Mentorship:** Creating and building a strong pipeline of capable, future leaders
- **Wellness:** Enhancing the quality of otolaryngology care by cultivating physician well-being and resilience

The Academy and its Foundation sincerely thank you for your generosity and support in shaping the future of our specialty together. To learn more about the **125 Strong Campaign** and donate, please visit **www.entnet.org/125Strong**. ■

Call for 2023 AAO-HNS Election Nominees

The AAO-HNS Nominating Committee is calling for recommendations of individuals to be considered for an elected office. Academy members must be in good standing, and it is recommended that they have held membership the last three consecutive years, have proven leadership qualities, be active in the Academy, be familiar with the strategic direction of the Academy, and be able to dedicate the necessary time to serve.

Please contact any member of the Nominating Committee, request they support your nomination for elected office, and submit your application packet to Lisa Holman, Committee Staff Liaison, at **elections@entnet.org**. For more information and the application packet, visit **https://www.entnet.org/about-us/leadership-governance/annual-election-nominees/**. The application deadline is midnight (ET), December 5, 2022. No extension will be permitted. ■

APPLY FOR A COMMITTEE TODAY!

Three Reasons to Submit Your Application:

1. Connect with Other Academy Members
2. Share Your Input on Special Areas of Interest
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Apply Today: www.entnet.org/committees | **Deadline**: December 31, 2022

OTC HEARING AIDS FAQS

WHAT ARE OVER-THE-COUNTER (OTC) HEARING AIDS?

Over-the-counter hearing aids are devices that consumers can buy directly from traditional retailers and pharmacies without the need for a visit to a hearing health professional.

WHY ARE HEARING AIDS NOW BEING OFFERED OVER THE COUNTER?

In 2017, Congress passed bipartisan legislation requiring the U.S. Food and Drug Administration (FDA) to create a category of OTC hearing aids, but it was not fully implemented until now, with OTC hearing aids available in traditional retail and drug stores as soon as October 17, 2022, when the rule took effect.

WHO IS A GOOD CANDIDATE FOR OTC HEARING AIDS VERSUS PRESCRIPTION HEARING AIDS?

OTC hearing aids are for adults 18 years of age or older who think they have mild-to-moderate hearing loss. You may have mild-to-moderate hearing loss if, for example:

- Sounds or speech seem quiet or muffled to you.
- You have difficulty hearing in a group setting, with background noise (e.g., restaurant), speaking on the phone, or need to face people when talking to understand them.
- You ask others to repeat themselves or speak more loudly.
- People complain that you turn up the TV or radio too high.

CAN CHILDREN USE OTC HEARING AIDS?

Currently, the FDA regulations state that OTC hearing aids are for adults (18 years of age or older). Children should see a hearing health professional for evaluation and obtaining a hearing aid.

WHAT ARE THE BENEFITS AND CONCERNS ASSOCIATED WITH OTC HEARING AIDS?

The primary benefit of OTC hearing aids is the lower cost and ease of purchase of these devices compared to hearing aids obtained from a hearing health professional. Concerns related to OTC hearing aids start with the most basic question: **Does the customer have hearing loss and is it the type for which OTC hearing aids are designed?** Additional consideration should be given if the individual's hearing loss comes from a medical problem that can be corrected (eliminating the need for a hearing aid) or addressed to prevent worsening the hearing loss or more serious problems. These conditions would be missed without an evaluation by a hearing health professional. Obtaining the best result and avoiding pain and infection depend on a properly fitting hearing aid. If your OTC hearing aid becomes painful to put in your ear, you should see an ENT (ear, nose, and throat) specialist, or otolaryngologist.

HOW MUCH WILL OTC HEARING AIDS COST?

The cost of OTC hearing aids will depend on the complexity and features of the device as well as other provisions included in the sale, such as service, returns, and the degree of support the manufacturer provides. Companies that provide telephone-based help and remote programming of the devices charge approximately $1,500 to $3,000 for a pair of OTC hearing aids. Off-the-shelf devices that do not offer those services may cost approximately $200 to $800 for a pair of devices.

WILL MY INSURANCE, MEDICARE, AND/OR MEDICAID COVER OTC HEARING AIDS?

Medicare currently does not cover any hearing aids. Medicaid coverage for those over 18 years old will vary by state, and you have to check with your Medicaid program. Some private health insurance plans do not cover the cost of hearing aids, so you should check with your particular insurance regarding coverage for OTC hearing aids.

HOW WILL I KNOW WHICH KIND OF OTC HEARING AID TO SELECT? WHAT IS THE RETURN POLICY?

The marketplace for OTC hearing aids has just opened (as of October 17, 2022) and identifying the right device for you may be challenging. As more devices become available, it may become easier to select the right device for you. You should also consider these issues:

- Is it waterproof?
- Does it block out background sound?
- Does it have Bluetooth capability?
- Is it compatible with your smart phone?
- Does it come with an app to help customize my individual hearing profile?
- How long does the battery last? Is it rechargeable?
- Does it have adequate and understandable sizing choices?

Last reviewed October 2022. For more information, visit: www.ENThealth.org.

OTC HEARING AIDS FAQS

Manufacturers of OTC hearing aids are required by the FDA to report their return policy; however, OTC sales do not require a return policy, so you should review that policy before buying an OTC hearing aid. Most reputable prescription hearing aid dispensers offer a one-month trial period, and you should look for something similar for your OTC hearing aids before purchasing them.

WHAT TECHNOLOGICAL ISSUES SHOULD I CONSIDER?

Different OTC hearing aids will offer different features, may be programmable, and will likely be offered at different price points, but most OTC hearing aids will probably be compatible with other devices. If compatibility is important to you, be sure to check if your OTC hearing aids will work with your smart phone before purchasing them.

ARE THERE OTHER TYPES OF HEARING DEVICES I SHOULD CONSIDER?

For people with the type of hearing loss that would benefit from OTC hearing aids, there are additional options you may consider:

- A personal amplification device may be helpful and possibly less expensive than OTC hearing aids. These devices are typically a "boxy" receiver attached to headphones and are therefore bulkier than what you would expect from hearing aids. One example is a pocket talker.
- Personal sound amplification products (PSAPs) amplify sound for the user but are intended for people with normal hearing to amplify sounds in certain situations, such as recreational activities like birdwatching, according to the FDA. PSAPs are regulated as consumer electronics and not medical devices.
- Traditional, prescription hearing aids from an ENT specialist or audiologist are a good choice if you are not getting the boost you would like from OTC hearing aids. OTC devices are not tuned to a hearing test, but prescription hearing aids are tuned to your exact level of hearing.

WHAT ARE FDA "RED FLAG" CONDITIONS AND WHAT DO THEY MEAN?

The list below describes conditions that need medical attention to prevent additional problems and complications. You should see a doctor—preferably an ENT specialist—if you have any of these red flag conditions indicating that there is a medical condition causing your hearing loss, including:

- Your ear has a birth defect or an usual shape or your ear was injured or deformed in an accident.
- You have had blood, pus, or fluid coming out of your ear during the past six months.
- Your ear feels painful or uncomfortable.
- You have a lot of ear wax, or you think something could be in your ear.
- You feel dizzy or have a feeling of spinning or swaying (called vertigo).
- Your hearing changed suddenly in the past six months.
- Your hearing gets worse then gets better again.
- You have worse hearing in one ear.
- You hear ringing or buzzing in only one ear.

WHO SHOULD I TALK TO IF I HAVE QUESTIONS ABOUT OTC HEARING AIDS?

If you need help deciding if you have hearing loss, if OTC hearing aids are right for you, or if you need prescription strength hearing aids, a hearing specialist—ENT specialist or an audiologist—can help you. Tell them if you are experiencing any red flag conditions listed above. And be sure you know the return policy of the OTC hearing aid you are considering.

ARE THERE OTHER RESOURCES AVAILABLE TO LEARN MORE ABOUT HEARING LOSS?

https://www.nia.nih.gov/health/hearing-loss-common-problem-older-adults

Last reviewed October 2022. For more information, visit: www.ENThealth.org.

AAO-HNS Advocacy Leadership on Display: Lance A. Manning, MD, and U.S. Representative Steve Womack

One of the most effective ways for the Academy to shape healthcare policy is through grassroots advocacy. Last month, **Lance A. Manning, MD**—Immediate Past Chair of the AAO-HNS Board of Governors (BOG)—hosted a successful In-District Grassroots Outreach (I-GO) meeting with his Member of Congress, U.S. Representative Steve Womack (R-AR). This opportunity's genesis resulted from a productive day on Capitol Hill this past May when Dr. Manning and Academy staff visited with the healthcare policy staff of six different congressional and senatorial offices. After meeting with Representative Womack's staff in Washington, DC, Dr. Manning invited his Member of Congress to visit his clinic, ENT Center of the Ozarks in Springdale, Arkansas, when Congress was not in session.

Lance A. Manning, MD

This meeting was a unique opportunity for Representative Womack to see firsthand the challenges that otolaryngologist-head and neck surgeons and their practices currently face in delivering the highest-quality care to patients. For example, during the meeting, Dr. Manning thanked Representative Womack for being an early cosponsor of H.R. 3173, the Improving Seniors' Timely Access to Care Act. This legislation, which passed the U.S. House of Representatives in September, would reform prior authorization under the Medicare Advantage (MA) program and have a significant impact on physician workload and practice operations. Enactment of H.R. 3171 would free physicians from a subset of burdensome regulatory requirements, allowing them to spend more time providing care to patients.

Dr. Manning and Representative Womack also spoke about the importance of mitigating looming cuts to Medicare physician payment rates that would threaten seniors' access to healthcare in Arkansas and across the country. To that end, Dr. Manning urged the Representative to cosponsor H.R. 8800, the Supporting Medicare Providers Act, led by Representatives Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN). The AAO-HNS endorsed this critical legislation, which would stop a nearly 4.5% cut to Medicare physician payment rates set to take place on January 1, 2023. On a priority issue for the specialty that is unique to the AAO-HNS, Dr. Manning spoke with Representative Womack about the Academy's concerns with current legislative efforts to expand federal scope of practice for audiologists.

In a related but separate advocacy activity, Dr. Manning met with health policy staff for U.S. Senator John Boozman (R-AK) to discuss the pending Medicare payment cuts both in person in May and online in October. Following these meetings, and supplemental outreach by AAO-HNS advocacy staff, Senator Boozman announced his intention to lead Senate efforts to reverse the Medicare physician payment cuts scheduled to take effect on January 1.

Through grassroots efforts like the I-GO program, Academy members can amplify the advocacy work that AAO-HNS members and staff conduct in Washington to impact healthcare policy. Ultimately, Members of Congress prefer to hear from their constituents directly, to demonstrate their responsiveness to the concerns of voters at home in their states and districts rather than special interests in Washington. The I-GO program provides direct value by giving Academy members the opportunity to educate their lawmakers about the specialty's legislative priorities and demonstrate the real-world impact of these issues.

As the 117th Congress draws to a close, Members of Congress will be traveling throughout their districts to meet with constituents and host town hall events, fundraisers, and worksite visits. Academy members should use the time that Members of Congress spend in-district to their advantage and engage with their lawmakers at home. After all, in addition to your role as a practicing physician, Academy members are also researchers, small business owners, employers, and voters. Your ability to vote and make your voice heard is a powerful tool for protecting the House of Medicine and the otolaryngology-head and neck surgery specialty.

To set up an I-GO meeting with your Member(s) of Congress, please visit **https://www.entnet.org/advocacy/grassroots-advocacy/in-district-grassroots-outreach-i-go/** or contact the AAO-HNS Advocacy team directly at **govtaffairs@entnet.org**. ■

Private Practice Study Group Survey: Emergency Room Coverage in Private Practice

Marc G. Dubin, MD (PPSG Chair), **David E. Melon, MD** (PPSG Vice Chair), and **Daniel R. Gold, MD, Annette M. Pham, MD,** and **Melanie Wilson Seybt, MD** (PPSG Executive Committee Members)

The Business of Medicine in 2022 is challenging. Decreasing reimbursement, increasing workloads, and skyrocketing overhead means that every workday minute spent not providing reimbursed patient care negatively impacts a practice's financial viability. One of these challenges for physicians and independent practices is health systems' mandate for the provision of emergency coverage. Time out of the office as well as the mental and physical toll of this uncompensated coverage has led some to question, "Is this too much in the current environment?" The Academy's updated Position Statement: Reimbursement for Taking Hospital Call suggests the answer is, "Yes."

The Position Statement highlights that: *"Otolaryngologists have graciously accepted this responsibility in the past as a requirement related to their utilization of hospital services. Many otolaryngologists no longer have the former tight hospital links, in addition to lacking contractual relationships with the hospital's payers, and this effectively results in the physician providing uncompensated or undercompensated care. Additionally, such in-hospital care often delays care to the ill patients waiting in their office and can adversely affect the physician's quality of life. Given the evolving reimbursement models and increasing overhead expenses, including the additional liability associated with providing emergency care, these costs to physicians can no longer be sustained. Most otolaryngologists still practice as a small business, a small group, or a solo practice. Accordingly, providing uncompensated hospital services adversely impacts their business and compromises their ability to provide quality care to their patients.*" (Source: **https://www.entnet.org/resource/position-statement-reimbursement-for-taking-hospital-call/**)

Compensation for Call Coverage: Have Efforts Been Successful?

In 2017, the AAO-HNS Board of Governors (BOG) surveyed their constituent societies' membership and received 677 responses. Among the heterogenous practice settings of academics, hospital-employed, military, and self-employed independent physicians, a reported 50% were financially compensated for on-call coverage. Additionally, 90% were mandated to provide unassigned emergency call either by hospital bylaws, departmental requirements, or employer mandates. (Source: **https://bulletin.entnet.org/home/article/21246964/board-of-governors-socioeconomic-grassroots-committee-emergency-room-call-survey-results**)

Recently, the Private Practice Study Group (PPSG) surveyed its membership (n=566) on the matter. Members expressed unique challenges to providing efficient emergency care: lack of support/infrastructure, physical distance from the health centers, lack of electronic health record interoperability, and financial loss for uncompensated emergency care among others. Given these unique demands that uncompensated emergency call coverage places on private practitioners, the goal was to assess the evolving emergency room coverage trends.

298 PPSG members responded with a response rate of 52.7%. Among respondents, 93.6% were a partner/owner or employed in a physician-owned independent practice. The remainder were employed by or contracted by a healthcare system. 48.7% were less than 50 years old, 20.7% were between 50-65 years old, and 7.4% were over age 65. Interestingly, 20.1% of respondents were in solo practice while 74.8% of respondents were in groups of seven physicians or smaller **(Figure 1)**. 74.5% were not fellowship trained and 66.2% were at institutions that have a trauma center (any trauma level designation).

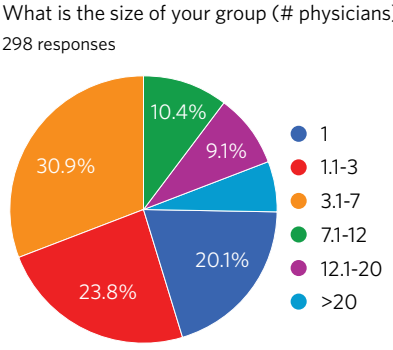


Figure 1. Size of physician group.

Most respondents (64.5%) take call at one or two hospitals, while 9.7% take call at four or more **(Figure 2)**.

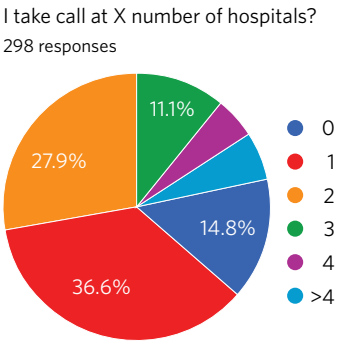


Figure 2. Number of hospitals covered on call.

Regarding the frequency of call, 32.2% had four or fewer ENTs in the ER rotation, while 3.4% responded that they were the only ENT on-call for their center. The most frequent response was five to seven physicians in the call rotation with 29.2% **(Figure 3)**.

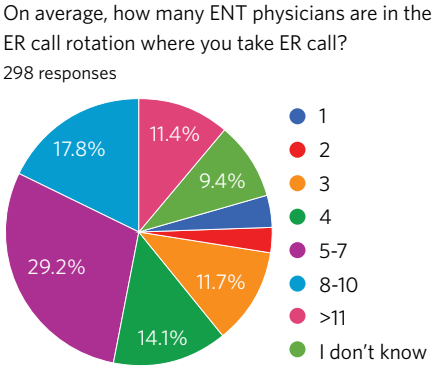


Figure 3. Number of ENT physicians in call rotation.

Of this population of private practitioners, 83.3% took emergency call coverage, with 74.8% of the respondents being required by their hospital to do so. Of those that take emergency call, 66.8% do get paid. However, only 47.9% of respondents are compensated at all the hospitals they cover **(Figure 4)**. Interestingly, of those that knew the answer (n=226), 23% responded that although they do not get paid for call at their hospital, they know that other service lines at their hospital are paid for call.

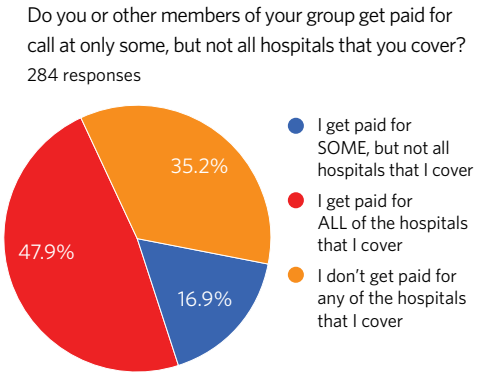


Figure 4. Percentage of paid emergency call.

Although the survey intentionally did not seek to measure specific compensation amounts for on-call coverage, 64.8% who are compensated were able to negotiate their call remuneration with the hospital. Only 14.4% reported a negotiated compensation based on a national metric (i.e., MGMA data), while the majority (53.4%) did not know what the compensation was based upon **(Figure 5)**. Furthermore, 56.5% of those who were paid for ER calls felt they are not compensated adequately for their services, and only 25.9% confirmed that they were being compensated for the uninsured patients whom they provide care for while on ER call.

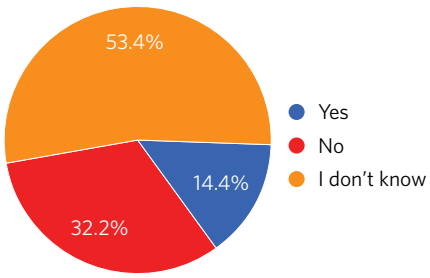


Figure 5. Call compensation based on national metric.

Regarding assistance when on call, only 21.1% had an advanced practice provider (APP) who helped "all the time" (12.4%) or "sometimes" (8.7%), while only 8.7% had a resident who assisted "all" or "some of the time." Of those that used an app, 90.3% paid for this coverage assistance themselves or within their call group. Additionally, consistent with the previous BOG survey data from 2017, 47.9% felt that they were at least sometimes asked to consult, render an opinion on, or direct care outside the scope of practice of an otolaryngologist.

When taken as a whole, these data present an interesting picture of ER call coverage in the otolaryngology private practice community in the United States. Although a majority of the respondents are being compensated, most do not feel that this compensation is adequate, and a majority are being compensated based on unknown metrics.

It is hoped that knowing that the supermajority of private practice otolaryngologists are now being compensated—albeit at what many feel is a below-market rate—we will be empowered to advocate for ourselves and negotiate from a position of strength that supports compensation for call at fair market value. ■

PPSG PRIVATE PRACTICE STUDY GROUP

The PPSG is a network of private practice otolaryngologist-head and neck surgeons who collaborate in addressing the common challenges facing their delivery of high-quality patient care. The PPSG offers an open forum to discuss the Business of Medicine issues that confront their practices, patients, and communities. It has quickly become an invaluable resource to take the pulse of the private practice community, help identify advocacy needs, direct AAO-HNS positions, and provide support to its members.

Want to stay connected to your private practice colleagues? Join the PPSG ENT Connect Community!

The PPSG ENT Connect Community is open to all current Academy members in private practice.

Complete the online request form (**https://bit.ly/dubinsurvey**) to be added to the discussions impacting private practice and patient care today!

GRATITUDE & GROWTH: Renewing the Academy's Commitment to Promote the Highest Standards in Clinical Care Worldwide

Mark E. Zafereo, Jr., MD, AAO-HNSF Coordinator for International Affairs


Mark E. Zafereo, Jr., MD

The month of November marks the beginning of the end of the calendar year. For many around the world, it signals the start of the holiday season with Thanksgiving celebrations approaching in the United States and beyond. During this season of gratitude, we want to share our genuine appreciation for the international otolaryngology community, including the AAO-HNSF's global network of International Corresponding Societies (ICSs), as well as many humanitarian outreach programs and AAO-HNS physicians who support training and medical aid efforts in lower-resourced countries. Although 2022 has had its fair share of challenges, from the global health perspective, this year has also presented opportunities. In 2022, the otolaryngology-head and neck surgery community has witnessed firsthand the benefits of effective international collaboration—from the 2022 Global Grand Rounds Webinar Series, to renewed collaborative in-person meetings including the AAO-HNSF Annual Meeting & OTO Experience and the 2022 Pan American Congress, to renewed humanitarian outreach opportunities.

As the data below highlight, global and humanitarian engagement increased at the Academy over the past year. With the continual ease of pandemic-related travel restrictions, the AAO-HNSF is excited to further in-person international collaboration and outreach and to renew our commitment to foster a global otolaryngology community. As the AAO-HNSF Coordinator for International Affairs, it is a privilege to work with you and for you to promote the highest standards in clinical care worldwide through education, research, collaboration, and outreach. Over the coming year, the Academy will continue to build upon our existing effective global initiatives and to partner with our ICS network and the larger global OTO community to achieve this vital goal. ■

AAO-HNSF 2022 Annual Meeting & OTO Experience

Thank you to all those who were able to join us in Philadelphia, Pennsylvania, at the AAO-HNSF 2022 Annual Meeting & OTO Experience. While visa and COVID-related issues presented challenges for the international community, global attendance was back up in 2022.

- Close to 1,000 international registrants from 79 countries
- 30+ sessions included in the International Symposium

Mark your calendar for September 30-October 4, 2023, for the AAO-HNSF 2023 Annual Meeting & OTO Experience, which will take place in Music City—Nashville, Tennessee. The Call for Science opens December 1. **www.entnet.org/annual-meeting** ■

FORWARD TOGETHER
AAO-HNSF 2022
ANNUAL MEETING & OTO EXPERIENCE
SEPTEMBER 10-14 PHILADELPHIA, PA


Global leaders at the 2022 International Advisory Board General Assembly.

virtual GLOBAL GRAND ROUNDS

Global Grand Round Webinars

Open to all otolaryngologists at no cost, the 2022 Global Grand Rounds Webinar Series welcomed, educated, and connected physicians from ALL over the world!

- 5,250+ physicians registered from over 123 countries

The 2022 series included four webinars with presentations from 22 prominent global OTO thought leaders. The following recordings are available at **www.entnet.org/ggr**

- Chronic Rhinosinusitis with Nasal Polyps and Biologics
- Artificial Intelligence in Otolaryngology-Head and Neck Surgery
- Head and Neck Cancer 2022
- Disruption and Innovation in Otology and Neurotology

The 2023 Global Grand Rounds Webinar Series kicks off on Saturday, February 18. More information to come! ■

INTERNATIONAL VISITING SCHOLARSHIP PROGRAM

International Visiting Scholarship (IVS) Program

The AAO-HNSF awards scholarships annually through the IVS Program aiding junior academics from lower-resourced countries to attend the AAO-HNSF Annual Meeting & OTO Experience and participate in an academic observership at a U.S. otolaryngology department or institution.

- Although COVID-19 restrictions at U.S. institutions and visa processing delays have impacted the program, in 2022 the Academy pushed the program forward and awarded nine IVS scholarships to recipients from eight countries.
- The 2023 IVS program launches in early 2023. With more U.S. institutions lessening pandemic-related restrictions and beginning to reengage with observership opportunities, the IVS program is slated to grow in the year ahead. For more information visit **www.entnet.org/international-visiting-scholarship** ■

CONFEDERATION OF EUROPEAN ORL-HNS

ICS Network & Joint Meetings

- Over the summer the AAO-HNSF welcomed our 76th partner to the ICS network—Confederation of European ORL-HNS!
- Throughout 2022, the AAO-HNSF collaborated on 12 Joint Meetings with our ICS partners. We look forward to even more opportunities in 2023!

For more information visit **www.entnet.org/international-joint-meetings.** ■

Award Winners

Congratulations to the recent Humanitarian and International Award Winners honored at the AAO-HNSF 2022 Annual Meeting.

Niels van Heerbeek, MD, PhD

2021 Nikhil J. Bhatt, MD International Humanitarian Award

Thana H. Nassir, MD, PhD, FICMS

2022 Nikhil J. Bhatt, MD International Humanitarian Award

Emmanuel D. Kitcher, MBChB, FRCS, FWACS, FGCPS

2022 Nikhil J. Bhatt, MD Public Service Award

Edward E. Dodson, MD

2022 Distinguished Award for Humanitarian Service

Humanitarian Outreach


Gregory J. Basura, MD, PhD

Since the pandemic began, medical humanitarian outreach trips have been postponed, canceled, restructured, and reimagined. At the Humanitarian Efforts Forum, sponsored by the AAO-HNSF Humanitarian Efforts Committee and held during the 2022 Annual Meeting, attendees learned about the massive impact the COVID-19 pandemic has had on humanitarian trips and how programs are rebuilding to move forward, including ways to develop sustainable fellowship training programs and initiatives around the world that have the potential to become embedded in a low-resource country's medical education system.

Panelists shared the out-of-the-box ideas they implemented during the pandemic to keep work and momentum moving forward. Recipient of the 2022 Distinguished Award for Humanitarian Service, **Edward E. Dodson, MD**, who since 1995 has helped the underserved population of the Dominican Republic through Project Ear, commented that COVID-19 pushed him and others to implement ways to train remotely. With the emergence of Zoom, he was able to attend weekly otology conferences at a residency program in the Dominican Republic and to give lectures virtually. Additionally, at The Ohio State University, where Dr. Dodson serves as a professor and neurotologist, work is now being done to increase the number of Dominican residents coming to the United States to train. Ohio State is also working to provide additional mentorship opportunities. Panelists agreed that many ideas launched because of the pandemic will continue moving forward even as more humanitarian outreach programs return to the field.

With the easing of some travel restrictions around the world in 2022, physicians and teams began diving back into humanitarian outreach travel. **If you are considering entering or re-entering the medical humanitarian outreach field or are already actively planning, the AAO-HNSF has resources to help.** To learn more about outreach programs, what to expect and how to prepare, and to get information about the AAO-HNSF Humanitarian Efforts Committee, visit **www.entnet.org/humanitarian-efforts**. ■

> "Humanitarian outreach has a tangible and intangible impact on all who are involved. It should be about building sustainable partnerships—partnerships that endure and contribute positively to people's lives currently and in the lives of future generations."
>
> **Gregory J. Basura, MD, PhD**, AAO-HNSF Humanitarian Efforts Chair

GETTING STARTED: Humanitarian Efforts Map

Interested in making a difference in the world but unsure what programs are available? Check out the AAO-HNSF Humanitarian Efforts Map! The map, which can be accessed at **www.entnet.org/get-involved/humanitarian-efforts/map/**, includes links to information on humanitarian outreach programs available for medical professionals. Some programs are still impacted by the COVID-19 pandemic, but many have already returned to the field and are looking for volunteers. ■

Have you participated on a recent humanitarian outreach trip through a program not included on the AAO-HNSF online map? If so, let the Academy know at **www.entnet.org/submit-a-humanitarian-effort-initiative**.

GETTING FUNDING:
Humanitarian Travel Grants

Resident Academy members who are PGY3, PGY4, or PGY5 are eligible to apply for $1,000 Humanitarian Travel Grants through the AAO-HNSF.

The AAO-HNSF awarded 20 grants in 2022 and aims to distribute up to 25 in 2023. The Academy is now accepting applications for humanitarian outreach trips taking place January 1 – June 30, 2023. Submit your application by November 30, 2022. For trips occurring July 1 – December 31, 2023, the application deadline is May 31, 2023. ■

> "Communication is absolutely key to a successful relationship. Before the trip, make sure the hosts and visitors are on the same page about what to expect. During the trip, ensure all is going according to plan and team members are supported. After the trip, maintain the relationship with the host team. Follow-up on patients and discuss how the trip went and what could be improved in the future. Keep records as best as you can. Gather as much data as possible from the start, it often proves invaluable in future endeavors."
>
> **Susan R. Cordes, MD**
> AAO-HNSF Regional Liaison to Africa
> Stockton, California

"Do what you can. If you dream too big, you'll never do anything."

Wayne M. Koch, MD
Johns Hopkins, Baltimore, Maryland

"My cardinal rule: Always involve local providers."

James E. Saunders, MD
Dartmouth Hitchcock Medical, Lebanon, New Hampshire

Looking for Humanitarian Outreach Advice?

Do you have best practices to share? Join the conversation or pose a question on ENT Connect in the Humanitarian Community. Engagement on the platform has been low during the pandemic, but with outreach trips resuming, now is the time to reinvigorate the dialogue and connect with others involved in this incredibly rewarding work! **https://entconnect.entnet.org/home** ■

GETTING ADVICE:
Tips from Your Peers: Humanitarian Outreach Advice & Best Practices

"Teaching is the keystone of international humanitarian efforts. Teaching that engages surgeons, develops long-term relationships, supports visits back to our home institutions, and creates joint research projects are examples of ways to expand beyond a one-week surgical camp model.

In Zimbabwe our recent surgical effort had two surgeons: myself and a Zimbabwean surgeon, Dr. Manana, who learned cleft lip and palate surgery with our group for the past five years. Dr. Manana visited Boston on an observation trip, was sponsored to attend hands-on courses in the United States, and has been a coauthor on joint publications. This year, Dr. Manana operated as an independent cleft surgeon among the group. He now serves as the first Zimbabwean surgeon on the team, and most importantly, treats patients with cleft lip and palate deformities in Zimbabwe year round. This is the new measure of success."

David A. Shaye, MD, MPH
Massachusetts Eye and Ear, Boston, Massachusetts

"WhatsApp has been amazing! When I operate on children through humanitarian trips, I now try to give the family access to my contact information through WhatsApp. I request that they send photos on a specific post-op day so we can talk about wound care and address any other issues. I know it sounds small and simple, but it has really helped a lot, and WhatsApp also allows me to communicate with the local doctors."

Mai Thy Truong, MD
Stanford Medicine Children's Health, Stanford, California

WE ARE HERE FOR YOU!

AAO-HNSF 2023

ANNUAL MEETING & OTO EXPERIENCE

SEPT. 30 - OCT. 4 | NASHVILLE, TN

CALL FOR SCIENCE

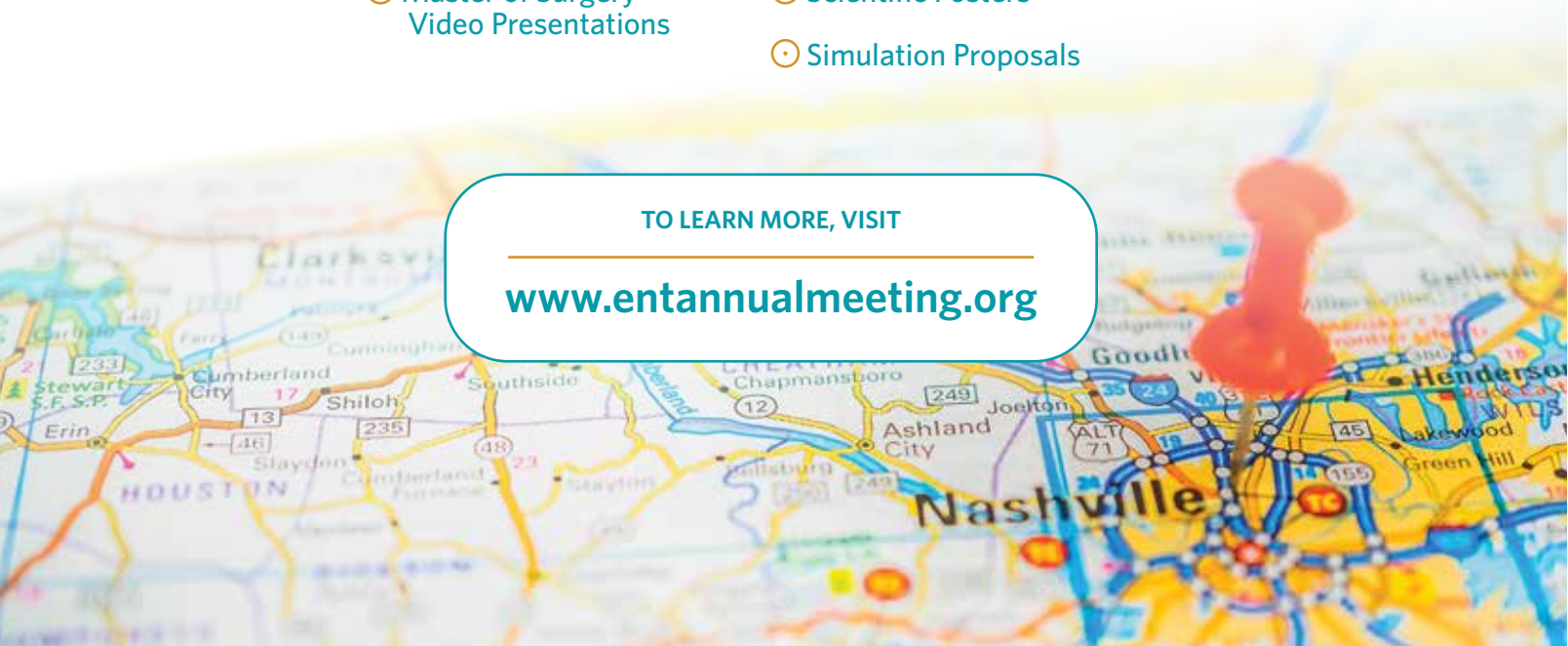
The American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF) invites you to submit an education proposal for presentation at the AAO-HNSF 2023 Annual Meeting & OTO Experience. This meeting is the premier education and networking event for the otolaryngology-head and neck surgery community.

SUBMISSION WINDOW:

December 1, 2022 – January 23, 2023

THIS TIME FRAME IS INCLUSIVE OF ALL FORMATS:

- Expert Series
- International Symposium
- Master of Surgery Video Presentations
- Panel Presentations
- Scientific Oral Presentations
- Scientific Posters
- Simulation Proposals



TO LEARN MORE, VISIT

www.entannualmeeting.org

The AAO-HNSF 2023 Annual Meeting & OTO Experience Call for Science: Nashville

With over 2,200 submissions, the Call for Science for the AAO-HNSF 2022 Annual Meeting & OTO Experience in Philadelphia, Pennsylvania, was one of the largest ever. The response indicated our commitment to teaching and research as a community and our desire to get back together. Some of the most common comments we heard in Philadelphia were that the 2022 program balanced the critical core knowledge of our field with exciting lines of inquiry as well as highlighted both critical controversies and a rising generation of speakers. That's a tremendous credit to our meeting faculty and scientific presenters and sets a high bar for the 2023 meeting in Nashville, Tennessee!

With the impressive submission turnout, there was obviously more competition for the precious speaking opportunities in 2022. We anticipate the same for Nashville in 2023. Here is some advice on preparing a successful submission as you plan to answer this year's Call for Science.

How to Create a Successful Panel Presentation or Expert Lecture Series Abstract

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

Like successful scientific submissions, a great presentation abstract begins with a great question. Brainstorm the key questions in our field with friends and colleagues to come up with areas of inquiry. If you're having trouble getting started, review the Gap Analysis Topics in the Call for Science Guidelines for ideas. Once you have a topic area, consider reviewing prior meeting programs to ensure that the topic isn't already robustly covered at the Annual Meeting.

Once you have a topic in mind, consider whether it is an area already well informed by the medical literature and standard of care. If so, it would be most amenable to an Expert Lecture Series presentation, and a successful abstract must demonstrate the faculty's expertise through different forms of scholarship on the topic. If the topic is still open to robust debate and discussion, it is ideal for a Panel Presentation. Panels that involve problem-solving and active conversation are typically more successful.

As you organize the faculty for your presentation, be sure to consider both expertise and a diversity of experience and representation. The Annual Meeting Program Committee has the dual responsibility of selecting a world-class education program for Nashville while also supporting the development of our future teachers and experts. Consider seeking a well-recognized mentor to guide the discussion of a complex topic among up-and-coming leaders. For previously presented Expert Lecture Series courses, there will be an option this year to include three faculty members by bringing on a new junior instructor and designating one of the senior presenters as a formal "Course Mentor."

Finally, remember to have fun with your colleagues! A successful abstract should promise an interesting and engaging session next fall in Nashville. ■

"The best abstracts command attention through a clear rationale for the research, a lucid description of what was done, innovative findings, and key implications for practice. A great abstract is the hallmark of a great project!"

Michael J. Brenner, MD
Annual Meeting Program Committee Member

How to Create a Successful Scientific Abstract

Michael J. Brenner, MD
Annual Meeting Program Committee Member

Crafting a winning Scientific Oral or Poster Presentation requires both effort and intentionality. Months, or even years, of work need to be distilled into a concise, coherent summary. A well-written abstract that is built on strong science will be rewarded with a podium session, often leading to a peer-reviewed publication. In contrast, a hastily prepared abstract that lacks organization and substance invariably falls to the wayside. Although great abstracts can take a variety of forms, a few time-tested principles can maximize prospects for success in the peer review process.

A strong abstract begins with a compelling research question. High impact projects address clinically important problems, deepen understanding, and expand current knowledge. Hypothesis-driven studies test assumptions, address challenges in patient care, and inform clinical practice. Randomized trials or propensity matched studies that control for covariates and confounders minimize risk of bias. Solid database or survey studies also have a role, but they must report a breadth of findings and acknowledge limitations. Valid statistical procedures are critical.

After the investigation and analyses are completed, the abstract needs to showcase the science effectively. Not only do reviewers score abstracts, but attendees use the abstract to decide whether to attend a Scientific Oral Presentation or visit a Poster. Make the abstract easy to understand and highlight the salient findings. The best abstracts command attention through a clear rationale for the research, a lucid description of what was done, innovative findings, and key implications for practice. A great abstract is the hallmark of a great project! ■

OUT OF COMMITTEE: Otolaryngology Cleft and Craniofacial

Introducing the Newest AAO-HNS Committee: The Otolaryngology Cleft and Craniofacial Committee

Brianne Barnett Roby, MD, Krishna G. Patel, MD, PhD, and **Rajanya S. Petersson, MD**

History tends to repeat itself, so we are all told. The specialty of otolaryngology was born out of need for specialized surgical skills localized to the head and neck. Naturally this led to overlap with other surgical specialties involving surgeries such as thyroidectomy, bronchoscopy, and repair of facial fractures. Similarly, surgical care for children with cleft lip and palate are performed by otolaryngologists and other surgical disciplines, with a common goal for optimizing outcomes in speech, hearing, and aesthetic form. Our training in otolaryngology concentrates heavily on these outcomes and competencies, which enables otolaryngology-head and neck surgeons to the highest level of care for these complex patients.

> “Not only do otolaryngologists trained in cleft and craniofacial surgery demonstrate excellent outcomes, but they also have the background and training to treat the associated potential hearing, feeding, speech, and airway issues, allowing broad and comprehensive care for these patients.”

A 10-person Task Force on Cleft and Craniofacial Surgery within the AAO-HNS was established in 2019 consisting of **Sydney C. Butts, MD, Patrick J. Byrne, MD, Steven L. Goudy, MD, Larry D. Hartzell, MD, Laura E. Hetzler, MD, Krishna G. Patel, MD, PhD, Rajanya S. Petersson, MD, Brianne Barnett Roby, MD, Andrew R. Scott, MD,** and **Travis T. Tollefson, MD, MPH**. In fall 2021, we learned the task force would be recognized as an official committee. After two years of demonstrated effort, the new committee was formed with an intentional selection of a diverse mix of pediatric otolaryngologists and facial plastic and reconstructive surgeons from around the country who specialize in the care of patients with cleft and other complex craniofacial abnormalities.

The newly formed committee built upon the task force’s vision on research, education, strategy, humanitarian efforts, and increasing awareness of cleft and craniofacial care within otolaryngology. This includes creating presentations at the AAO-HNSF Annual Meeting, applying for National Institutes of Health funding, and having multiple publications within the AAO-HNSF's journal, *Otolaryngology–Head and Neck Surgery*. In terms of support for otolaryngologist-head and neck cleft surgeons and our patients, a WhatsApp group, including over 85 head and neck cleft surgeons, was created to allow for discussion and facilitate referrals when our patients move across the country.

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Importantly, the members of this committee are passionate about increasing awareness of the care for complex patients with cleft and craniofacial differences and recognizing that otolaryngologists are well suited to care for these patients' needs. Many of these patients require care as newborns, and even prenatally, and will continue to require care into adulthood. Otolaryngologists are optimally positioned to advocate for the needs of such patients. Not only do otolaryngologists trained in cleft and craniofacial surgery demonstrate excellent outcomes, but they also have the background and training to treat the associated potential hearing, feeding, speech, and airway issues, allowing broad and comprehensive care for these patients. Otolaryngologists have often not been recognized for their cleft-related work and patient advocacy. Prior to the formation of this committee, acknowledging otolaryngology cleft care fell on individual cleft and craniofacial teams as there was no consolidated "home" to highlight these stories.

Currently, 10% of multidisciplinary cleft teams approved by of the American Cleft Palate-Craniofacial Association (ACPA) are directed by otolaryngologists. Training of residents and fellows in cleft care is required by the American Board of Otolaryngology - Head and Neck Surgery, yet there has not been a cohesive interdisciplinary group that develops best practices and educational content related to the complex care and procedures these patients require. The goal of this committee is to demonstrate excellent outcomes, share best-care management strategies, and create a more consistent training strategy for residents and fellows, all while helping to support the increased involvement of otolaryngologists within cleft teams.

As a committee, we strive to continue improving communication within the otolaryngology-head and neck surgery cleft community, as optimizing communication allows us to provide the best care for our patients. We hope to develop training milestones that currently do not exist and educational materials for residents, fellows, and members of the AAO-HNS. And finally, by having the support of the AAO-HNS, we can best serve our patients with complex cleft and craniofacial differences from birth into adulthood by supporting our fellow otolaryngologist-head and neck surgery cleft surgeons. ■

"The goal of this committee is to demonstrate excellent outcomes, share best-care management strategies, and create a more consistent training strategy for residents and fellows, all while helping to support the increased involvement of otolaryngologists within cleft teams."

OUT OF COMMITTEE: Voice

Acid Reflux: Week In and Week Out, What We See, What We Know, and What We Are Learning

Jordan I. Teitelbaum, DO, and **Lee M. Akst, MD**

What We See

Acid reflux is a common condition in the general population that can present with both acute and chronic symptomology. Gastroesophageal reflux disease, GERD, is estimated to affect one out of five adults. It causes recurrent and burdensome issues that can decrease quality of life and also may lead to dangerous sequelae.[1] Typical GERD symptoms include heartburn, esophageal discomfort, dyspepsia, and regurgitation. However, as otolaryngologist-head and neck surgeons, our training and experience demonstrate that reflux may also present with extraesophageal symptoms. Chronic cough, throat clearing, dysphagia, and other complaints may all be related to reflux. This concept of laryngopharyngeal reflux (LPR) was described in a Position Statement by the Academy in 2002.[2] Since then, our knowledge of this prevalent disease has only deepened.

What We Know

Prevalent symptoms of LPR include excess throat phlegm, throat clearing, globus sensation, postnasal drip, and trouble with voice or swallowing.[3,4] In comprehensive otolaryngology, the aforementioned list of chief complaints makes up a large portion of clinical practice. LPR and GERD have even been implicated in rhinitis, chronic sinusitis, recurrent otitis media, and eustachian tube dysfunction.[4-8] With myriad manifestations that cross the breadth of our specialty, it is important for otolaryngologists to maintain an appropriate clinical awareness of the role that reflux may play in their patients' complaints. GERD Awareness Week (November 20-26) is a good time to review these issues.

In the past two decades since the AAO-HNS Position Statement was released, many astute clinicians, surgeons, and researchers have tried to come up with strategies for accurate diagnosis of LPR. There are concerns that LPR and GERD in the ENT office may be under diagnosed or over-diagnosed, as presenting complaints are nonspecific and have many other etiologies. Though these presenting complaints are quite familiar to all of us, examination findings[3] may be nonspecific and clear-cut diagnosis can be elusive.[9-12]

What We Don't Know

As the most prevalent gastrointestinal disorder in the United States, the epidemiology GERD is well established.[13] Likewise, the diagnosis pathway for GERD, as distinct from LPR, is straightforward. However, for reflux disease affecting the upper aerodigestive tract, pathophysiology remains less well understood.[4] It is certain that refluxate that reaches the pharynx passes through the esophagus, and classic GERD symptoms may increase our confidence in a reflux etiology for extra-esophageal complaints.[1,4,13,17] However, not all patients with laryngopharyngeal manifestation of reflux have classic GERD complaints. This gives rise to concerns about "silent reflux," with possible explanations relating to degree and nature of reflux that are adequate to cause laryngopharyngeal complaints remaining beneath whatever threshold might trigger patient awareness of heartburn, acid brash, and more classic GERD complaints. In this setting, establishing that reflux is related to laryngopharyngeal complaints can be difficult.

This heterogeneity can present subtle challenges in evaluation. For one, consensus on diagnosis criteria of LPR is still unclear.[16,17] Although some authors have offered state-of-the-art reviews[16] and best practice statements,[18] it may still be difficult

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- LPR Management and Lifestyle Changes

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

to sort through the controversy of whether to treat LPR the way we treat GERD in clinical practice.

What We Can Offer

As head and neck specialists, we are inundated with patients coming to us for chronic cough, globus sensation, and throat clearing. That reflux may play a role in our patients' complaints is a commonality that connects us regardless of subspecialty or comprehensive nature of our practices or our practice settings.

Evaluation of these patients should focus on creating a differential diagnosis based on history followed by a directed exam. For any extraesophageal complaint, this differential might include—but should not be limited only to—reflux. History for any presumed reflux patient should include asking about typical GERD symptoms, as their presence may increase pretreatment probability that reflux is driving extraesophageal complaints. Inquiring about reflux influences such as diet, stress/anxiety, and association of rhinologic and laryngologic symptoms is paramount. Likewise, red flag symptoms such as hemoptysis, lymphadenopathy, and referred otalgia also need to be elucidated. Guidelines and algorithms exist to help us and our colleagues evaluate symptoms and sort through the confounding factors in GERD/LPR diagnosis.[4]

In our hands, flexible fiberoptic laryngoscopy (FFL) can be beneficial in most patients with LPR complaints, and videostroboscopy may also be indicated.[2,17,18] FFL can also provide useful information on the nasal cavity, paranasal sinus inflammation, and the nasopharynx. With that in mind, it is worth noting that the value of an endoscopic exam is evaluating for other conditions (rhinitis, sinusitis, vocal fold motion impairment, etc.) that might mimic reflux complaints – laryngopharyngoscopy itself should not be considered diagnostic of reflux. Many of our patients will have erythema and edema on laryngopharyngeal exam, even if they don't have pathologic reflux; even rigorous scoring of endoscopic findings has shown that exam doesn't correlate with symptoms, pH probe data, or response to treatment when it comes to using exam to "diagnose" reflux.

For treatment, empiric antireflux medication with proton pump inhibitors (PPI) has been part of otolaryngologic practice for decades now.[2] Improvement in patient education and multifactorial disease management has also led to better discussion of dietary and lifestyle changes. Certainly, an empiric trial of PPI medication once or twice daily can be straightforward for both the otolaryngologist and the patient.[17] Nonetheless, our recent endeavors into categorization and treatment of GERD and LPR suggest that PPI therapy protocols may need to evolve with our updated understanding of this condition.[16]

Current Directions and (Nonacidic) Food for Thought

Acid reflux disease, in the form of GERD or LPR—or perhaps concurrence of both—is prevalent. In ENT practice, this constellation of complaints is pervasive, and it requires keen evaluation and potentially multidisciplinary management.

It is likely that LPR is being over diagnosed, and that PPI therapy is being over prescribed.[3,4,16,18,19] PPI safety has been questioned not only in our literature, but also in the public eye. The efficacy of PPI therapy remains poorly understood, and meta-analysis of randomized controlled trials did not show superiority of PPI over placebo for chronic laryngopharyngeal complaints such as throat clearing, throat irritation, and hoarseness.[4,19,20] Conversely, it may be that nonacid LPR is underappreciated, and pepsin might mediate reflux-related tissue inflammation in the larynx, pharynx, and related structures even if acid itself is pharmacologically suppressed.[16] This leads to an increasing focus on lifestyle modifications for reflux as well as use of barrier therapies such as alginates. Continued emphasis on objective testing with hypopharyngeal-esophageal multichannel intraluminal impedance-pH monitoring (HEMII-pH), despite debates on diagnostic thresholds,[19] may aid in clinical diagnosis and also improve our understanding of LPR overall. A reasonable goal in this era of personalized medicine is that non acid reflux be considered along with acid reflux, and treatment plans extending beyond PPI alone to also include possibilities of lifestyle changes, H2-blockers, and alginates should be advocated.[4,17,19]

While an empiric trial of PPI or other reflux medication may be convenient, an astute ENT must be prepared to abdicate a presumed diagnosis of GERD if an empiric trial has no effect. Likewise, while we focus on GERD awareness, we also encourage awareness of new literature that contradicts outmoded paradigms for evaluation and treatment of these disorders.

In many respects, we have entered a new era of reflux therapy. Increased patient cognizance of GERD and common medication toxicity demands thoughtful management in our field. Diagnostics such as pH probe testing, nutritional considerations, and multidisciplinary collaboration with internists, speech pathology, and GI will be very helpful toward precise patient care. Treatment algorithms have also entered a new era, with minimally invasive procedures such as transoral incisionless fundoplication (TIF) or TIF with concomitant hiatal hernia repair (cTIF) being studied in both GERD and LPR patients and demonstrating safety and efficacy in both populations.[21-23]

In treating acid reflux as ENT specialists, we must be aware of the changing data and trends in GERD and LPR diagnosis. Taking a balanced history and awareness of the broad differential can be just as essential as a comprehensive therapy plan. This presenting symptomology is a hallmark and mainstay of otolaryngology-head and neck surgery, and we must be ready to treat accordingly and yet also ready to abandon our previous algorithms and to cohesively and collectively embrace new management strategies for this provocative entity within our field. ■

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Tech Talk

Medical Device Cybersecurity: What You Need to Know

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

Ever since the first iPhone was released in June 2007, things have become more connected. Today, there is an app for everything. Medical devices are no exception. They have become an important subset of the Internet of Things (IoT) discussed in the May 2022 edition of the *Bulletin*.[1] This article expands on the earlier IoT piece to discuss what you need to know to keep medical devices cybersecure.

Medical devices are a broad category, not all are apps. Cybersecurity is one aspect. It would be impossible to cover everything within a single article. Still, medical device cybersecurity, along with data protection and privacy, is an emerging and important topic. The intent here is to provide background material and preliminary guidance for further investigation.

Everything Is Connected

Like IoT devices, medical devices may be made up of various components: the physical device, the network interface, the mobile app used to control the device and exchange data, and a cloud service used to collect and share the data. Each of these components can represent different attack vectors.

To be properly protected, security must be designed in at every layer including hardware and software. A complete understanding requires knowing how each of the components are constructed and how these interact with one another. This is difficult and time consuming to do. Many decisions are based on the reputation of the manufacturer and, in the United States, the medical device's approval from the Food and Drug Administration (FDA).

From an overview perspective, keep in mind aspects of the Health Insurance Portability and Accountability Act (HIPAA), Zero Trust cybersecurity framework, and Universal Design as they apply to medical devices.

With respect to the data associated with a medical device, the three principles of HIPAA still apply:

1. **Confidentiality:** Data are not made available nor disclosed to unauthorized people
2. **Integrity:** Data, while at rest or in transit, are not altered, changed, or destroyed in an unauthorized manner
3. **Availability:** Data are access assessable and usable on demand by authorized people

Zero Trust is the National Institution of Standards and Technology (NIST) modernized cybersecurity framework. Perimeter-based security is no longer enough. With cloud-based computing, it is harder to even define the perimeter. Zero Trust brings to light four principles:[2]

1. There are multiple points of attack
2. An attack at one point puts all at risk
3. User privileges should be minimized
4. The assumption that the network has already been compromised must prevail; every device needs to be continuously protected and authenticated

Zero Trust applies more to medical devices used in a hospital or clinical setting. Nevertheless, Zero Trust is important background to know, especially when medical devices are connected to a network.

Depending on their purpose, medical devices' usage and effectiveness are related to how the seven Universal Design Principles are applied:[3]

1. Equitable use: Design for all
2. Flexibility in use: Design for each—is the device ADA compliant?
3. Simple and intuitive: Design for the mind
4. Perceptible information: Design for the senses
5. Tolerance for error: Design for error—make sure the device requests confirmation before taking irreversible or potentially critical operations
6. Low physical effort: Design for limited strength or stamina
7. Size and space for approach and use: Design provides usability for all regardless of body size, posture, or mobility

Not all Universal Design Principles will apply in every case. Keep the principles of HIPAA,

Zero Trust, and Universal Design in mind as you review the manufacturer's literature describing a medical device and its purpose.

Software Bill of Materials (SBoM)

From a cybersecurity perspective, it is crucial to understand the software components included in a medical device. Open-source software is prevalent in the development of smartphone apps and cloud-based software. This is not a bad thing since most widely used open-source software have large programmer communities that keep the code bug-free and feature rich. However, new software vulnerabilities are reported every day.[4] Without knowing the software components embedded in a medical device and regular checks for the latest vulnerabilities, you cannot know if its usage is at risk.

The audience for most of the recent medical device cybersecurity literature are the manufacturers. Latest developments in the public sector have placed emphasis on SBoM. Executive Order 14028 on Improving the Nation's Cybersecurity led to the U.S. Department of Commerce (DOC) releasing guidance on the minimum elements for a SBoM.[5] The FDA's recent draft guidance on medical device cybersecurity[6] includes a large concentration on SBoM.

To be more effective, SBoM information needs to be received electronically[7] so that software components can be more easily associated with updated vulnerabilities. This is an essential part of Vulnerability Management—the ongoing, regular process for identifying, assessing, and remediating cyber vulnerabilities across medical devices in use.

What You Need to Know

For physicians, in addition to the SBoM, look for the manufacturer's label and regularly check the manufacturer's post market reporting.[8] If the medical device transmits data, make sure it uses strong encryption. Make sure you have the manufacturer's contact information and understand the expected level of support the manufacturer can provide. Keep an inventory of the medical devices used by patients.

Patients need to know what to do to maintain the device's cybersecurity over its lifetime. Users need know how to keep the device patched as well as understand the device's potential risks and other relevant information. These things need to be kept in mind as the patient reviews the device's literature. Equally important, does the patient know who to contact if the device malfunctions? Do they understand what data are collected and to whom the data are transmitted?

This article covered a lot of ground. Several subject areas such as Zero Trust and Universal Design may be tangential to medical device cybersecurity, but in today's world, everything is connected. With attack vectors at every component, security is essential at all layers. Vulnerability Management is crucial to staying on top of daily susceptibilities and exploitations. Users need to be informed on how to mitigate new risks in a timely manner. At the end of the day, you must weigh the benefits of a medical device against how important it is for the patient to read and understand a 200+ page users guide. ■

DOC's guidance defines the minimum list of SBoM data fields needed as:

Data Field	Description
Supplier Name	The name of an entity that creates, defines, and identifies components
Component Name	Designation assigned to a unit of software defined by the original supplier
Version of the Component	Identifier used by the supplier to specify a change in software from a previously identified version
Other Unique Identifiers	Other identifiers that are used to identify a component or serve as a look-up key for relevant databases
Dependency Relationship	Characterizing the relationship that an upstream component X is included in software Y
Auhor of the SBoM Data	The name of the entity that creates the SBOM data for this component
Timestamp	Record of the date and time of the SBOM data assembly

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Revamping NIH Clinician-Scientist Training Pathways with T32 to R25 Transition: Expansion of Programing and Preparation for Change

Allison K. Ikeda, MD, John S. Oghalai, MD, Jay F. Piccirillo, MD, Debara L. Tucci, MD, MS, MBA, and **Michael J. Brenner, MD**

Otolaryngology has a long tradition of scientific innovation, and the National Institutes of Health (NIH) T32 research awards have been a mainstay of research training, providing yearlong blocks of protected time for research during residency. Exposure to research in medical school or residency can be a defining experience that influences individuals' career trajectory, affording a foundation for maturation into an independent clinician-scientist.[1] These programs have played a vital role in cultivating scientific leadership in the specialty; the T32 awards provide structured scheduling of research experiences, integrating research with clinical activities, coursework tuition, and budgeting of stipends or training-related expenses. However, a challenge with T32 programs involves the requirement for adherence to restrictive National Research Service Award (NRSA) fellowship criteria, which can limit flexibility and customization to specific department residency research training needs.

There is also a need to enhance diversity among clinician-investigators in surgery. In otolaryngology, women and individuals from underrepresented racial and ethnic groups constitute only a small portion of funded investigators.[2] A pool of investigators that is more reflective of society offers the promise of greater breadth in research endeavors, more representative enrollment in clinical trials, and progress in mitigating longstanding health inequities.[3] Such considerations have provided the impetus for developing a more flexible and inclusive approach to expanding the scientific workforce in otolaryngology. The new programs involve phasing out T32-based resident research funding and rollout of five new R25 research education program funding mechanisms **(Figure 1)**.

The five NIH R25 programs are designed to:

- Complement and/or enhance the training of a workforce to meet the nation's biomedical, behavioral, and clinical research needs;
- Encourage individuals from diverse backgrounds, including those from groups underrepresented in the biomedical and behavioral sciences, to pursue further studies or careers in research;
- Help recruit individuals with specific specialty or disciplinary backgrounds to research careers in biomedical, behavioral, and clinical sciences; and
- Foster a better understanding of biomedical, behavioral, and clinical research and its implications.[4]

Current T32 programs that fund resident research are expected to transition to the new National Institute of Deafness

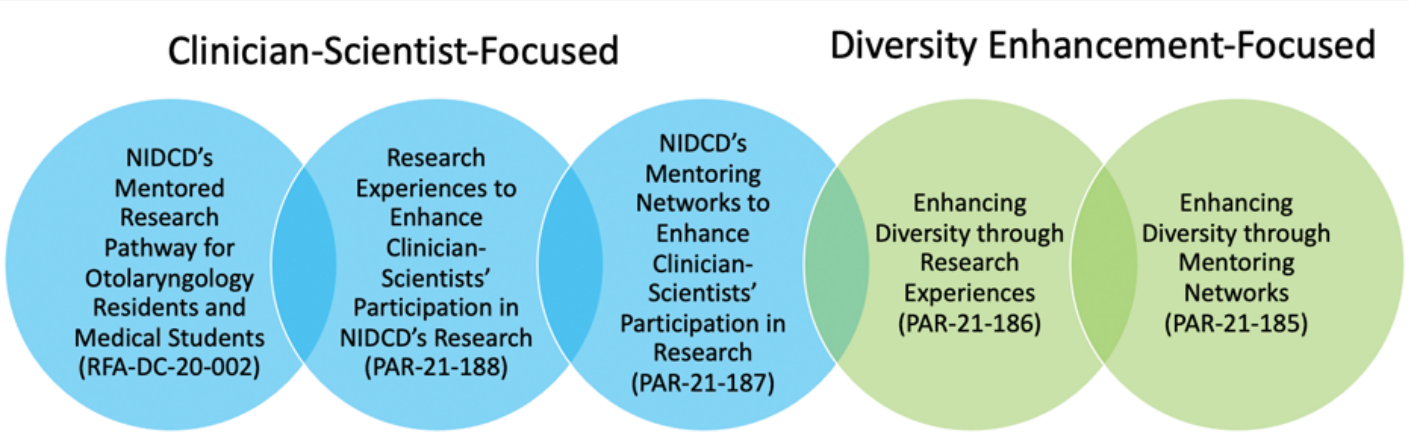

Figure 1: New R25 mechanisms that offer opportunities.

and Other Communication Disorders (NIDCD) Mentored Research Pathway for Otolaryngology Residents and Medical Students (R25) at time of renewal. The change will allow institutions to customize research training to their programs, considering residency program structure, the variable research experience levels of residents, and need for flexibility in research experience and budget. Research during medical school and residency can serve as an on-ramp to an academic career, instilling investigative curiosity and equipping individuals with technical skills. Research experience garnered during these formative years prepares individuals for future clinician-investigator careers. Individuals supported by the R25 programs not only engage in experimental studies, but also develop mentoring relationships and enhance their competitiveness for future career development awards. These programs connect medical students and resident-investigators with experienced investigators who can support and engage their research ambitions.

There are important differences between the new R25 pathway and the T32 programs that have long been the workhorse mechanisms for supporting medical student and resident research. For example, medical students can undertake either short-term research experiences or research experiences that span an academic year (nine months). Resident-investigators engage in funded research for 12 to 24 months, completed within the residency at 80% effort. In a major shift from the T32 mechanism, resident research activities are no longer constrained to one-year increments and instead have the added flexibility to occur in shorter increments, at a minimum of three consecutive months **(Figure 2)**. Funds are available to support resident research during clinical rotations, to provide for continuity and sustained research effort during the residency training years. Additionally, the R25 will cover tuition for coursework (up to specific dollar limit), whether in a degree-earning program or not. Several questions remain, including how the changes will affect medical students, residents, program directors, and the specialty. To better understand these perspectives, we connected with various stakeholders to discuss the reasons for the changes and potential advantages of the new programs.

In 2020 **Debara L. Tucci, MD, MS, MBA**, Director of the NIDCD, and Alberto Rivera-Rentas, PhD, NIDCD research training officer, organized focus groups with T32 directors, department chairs, and clinician-scientists with T32 training to assess the current state of resident research training. Several obstacles were identified (including grants appointments in one-year increments, a one-year pay back agreement for residents, and preset stipends and training-related expenses, in accordance with NRSA policy), providing a rationale for the transition of T32 to a new mechanism of residency research training. Dr. Tucci shared, "We developed the new grant mechanisms to provide otolaryngology residency training programs with the flexibility to tailor programs to their needs and create the best possible residency research training experience."

The changes address many of these hurdles but also present new challenges, such as implementation and integration with new or existing programs. A summary is provided in the online supplement, and full details are at https://grants.nih.gov/grants/guide/rfa-files/RFA-DC-20-002.html#.

The University of Southern California (USC) is one of the first institutions to be awarded the NIH R25 funding. Its two-year research component will occur before clinical residency training begins and includes four days in the research laboratory and one day for clinical experience per week. According to **John S. Oghalai, MD**, department chair of otolaryngology-head and neck surgery at USC, "Doing some clinical work during the research time is important in teaching and training residents how to do both simultaneously. Our residents who choose the clinician-scientist career path are going to have to do that their whole careers. It is only 20% clinical, but at least it gives them the chance to start learning duality of lives, and I think it's a terrific mechanism."

Other programs with longstanding T32 programs are awaiting review of their R25 applications. **Jay F. Piccirillo, MD**, T32 program director at Washington University in St. Louis, shared his perspective on the pending application. "To have two years where you focus on your research is a wonderful time to think deeply about important problems that research can solve." He explained, "The second year is very valuable to consolidate all the learning, and the uninterrupted mentored research is foundational with the relevant coursework and career development. At WashU, we feel the combination of two uninterrupted years of mentored research, formal coursework in research design and biostatistics, and career development with T32 trainees from other specialties is critical to training the next generation of physician-scientists."

Discussions with other T32 directors expressed some concerns about the transition, including added scheduling complexity if applying scheduling flexibility, given rigid residency training structure and requirements for clinical coverage, and low-yield training during intermittent 20% clinical experiences. Other T32 programs face decisions about expansion versus reduction to fit four-resident limit and opportunities to make changes, regarding timing and scheduling of research within existing frameworks.

The transition of the NIH T32 to R25 otolaryngology resident research training award stimulated awareness and interest and led to awards at institutions that did not previously have NIH T32 otolaryngology resident research training. This change may also mean lower levels of funding for programs that have historically supported multiple positions. Future studies are necessary to understand benefits and pitfalls of the R25 program. Lastly, developing a pipeline of clinician-investigators from diverse backgrounds is critical for cultivating a scientific workforce prepared to meet the needs of a growing diverse society. ■

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Current NIH T32	New NIH R25
One-year increments	Minimum 12 months, in increments of at least three months
100% FTE	80% FTE
No trainee specific research training budget	Up to $20,000 per trainee for research training expenses, such as biostatistician support
Tuition contribution for coursework related to project, not excluding degree-earning programs	Tuition contribution for short-term coursework and workshops, whether in a degree-earning program or not
Up to $800 per trainee for travel	Up to $3,000 per trainee for travel

Figure 2: Comparison of current NIH T32 and new NIH R25.

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Otolaryngologist
Department of Otolaryngology- Head and Neck Surgery

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine in St. Louis, MO is seeking a Board certified or Board eligible physician(s) to provide patient care with a focus in comprehensive otolaryngology. Teaching of residents and medical students is expected. A variety of research opportunities are available. The clinical environment may include the main campus, as well as community locations in West, and/or South St. Louis County but it is expected that the prime focus will be at our North County clinic. Applicants may apply for an assistant, associate or full professor appointment based on prior experience and training. The department has vast opportunity to provide cutting edge patient care in addition to basic, translational and clinical research experience. Collaboration with existing departmental clinical and basic investigators is encouraged. Salary is negotiable and commensurate with rank, training and experience.

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Professor and Chair
Department of Otolaryngology
University of Rochester
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HEAD AND NECK SURGEON - OTOLARYNGOLOGY - The Department of Otolaryngology at the University of California, Davis, School of Medicine, located at the UC Davis Medical Center in Sacramento, California, is seeking a full-time Assistant or Associate Professor in the clinical series to participate in clinical, teaching and research programs. Candidate is required to have an MD degree, be board certified or board eligible in Otolaryngology, and be eligible for a California medical license. Additionally, candidate must have fellowship training in head and neck surgery and, preferably, microvascular training.

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For more information, please contact: Dr. Marianne Abouyared - **mabouyared@ucdavis.edu**, or Dr. Andrew Birkland - **acbirkeland@ucdavis.edu.** For full consideration, applications must be received by June 30th, 2023; however, the position will remain open until filled.

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About Joe DiMaggio Children's Hospital

Joe DiMaggio Children's Hospital is a 226 bed free-standing children's hospital in Hollywood, Florida located near Fort Lauderdale, and is one of six hospitals that are part of Memorial Healthcare System. Located in South Florida, residents enjoy a high quality of life – including year-round summer weather, exciting multiculturalism and no state income tax.

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Application Procedure:

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PEDIATRIC OTOLARYNGOLOGIST

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- Fellowship training required

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Stil Kountakis, MD, PhD, Professor and Chairman -
skountakis@augusta.edu

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BC/BE fellowship trained neurotologist at any rank is sought to join four neurotologists on a faculty of twenty-five otolaryngologists. Applicants must contribute to resident and medical student education. Protected research time and resources are available if candidate seeks a career as a clinician-scientist Interest in lateral skull base surgery and adult otology/neurotology desired. Candidate will eventually assume the practice of retiring senior neurotologist.

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Interested candidates should send their curriculum vitae and letter of interest to:

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.
Professor and Chair
Department of Otolaryngology
University of Rochester
601 Elmwood Avenue, Box 629
Rochester, NY 14642
(585) 273-1943
shawn_newlands@urmc.rochester.edu

Assistant/Associate Professor
Facial Plastic and Reconstructive Surgery
Department of Otolaryngology-Head & Neck Surgery

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine in St. Louis, MO is seeking a Board certified or Board eligible physician who has completed a facial plastic and reconstructive surgery fellowship. This position allows for opportunities to practice in St. Louis City and St. Louis County at an academic tertiary care medical center, a separate facial plastic and reconstructive surgery office and a surgery center. Washington University School of Medicine is dedicated to enhancing subspecialty care provided in the greater St. Louis area community. Teaching of fellows, residents and medical students is expected. The department has vast opportunities to provide cutting-edge patient care in addition to basic, translational and clinical research experience. Collaboration with existing departmental clinical and basic science investigators is encouraged. Salary commensurate with experience.

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50 North Medical Drive 3C120
Salt Lake City, Utah 84132
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LSU Health SHREVEPORT

Department of Otolaryngology-Head and Neck Surgery

ACADEMIC OPPORTUNITIES

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Once you have applied, please complete the following:
Please send curriculum vitae, a statement of current interests, and names of three references to:
Cherie-Ann Nathan, MD, FACS
Professor and Chair of Oto/HNS,
Director of Head and Neck Surgical Oncology
1501 Kings Highway, 9-203
Shreveport, LA 71103-33932
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