

Quarterly Report

AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Summer 2007, Vol. 42 No. 3

Make plans to attend the 2007 Mid-Year Seminar

Being held at the Westin Detroit Metropolitan Airport Hotel in Detroit, Michigan on Saturday and Sunday, September 8th and 9th.

If you register before July 1st, you'll spend \$285.00, after July 2nd, \$305.00, and after August 2nd, \$325.00.

CALL THE AOCCO-HNS OFFICE AT 800-455-9404 AND WE'LL REGISTER YOU OVER THE PHONE . . . HAVE YOUR CREDIT CARD AVAILABLE!

CME Credits: The AOCCO-HNS Foundation designates this educational program as a 1A CME opportunity offering up to 15 hours in ophthalmology and otolaryngology-head and neck surgery.

BOOK YOUR ROOM AT THE WESTIN DETROIT METROPOLITAN AIRPORT HOTEL EARLY: Call 1-734-942-6500. Rates per night are \$159/single or double. Reservations must be made by Monday, August 6, 2007. After this date, the AOCCO-HNS Foundation cannot guarantee a room at this meeting rate.

The Westin Detroit Metropolitan Airport Hotel, located in the new world-class McNamara Terminal, offers a private security entrance, the latest in technology, and Detroit's most stylish and comfortable surroundings—a place where you can actually relax while you travel and attend the 2007 Mid-Year Seminar of the AOCCO-HNS Foundation.



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2007-2008 Committees



2007-2008 Officers and Members of the AOCOO-HNS Board of Governors

President: Shoib Myint, DO
President-Elect: Thomas E. Brandeisky, DO
Vice President: Sidney K. Simonian, DO
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Past President, Kenneth H. Rogotzke, DO
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Michael S. Hauptert, DO
Jeffrey N. Holtzman, DO
Donald M. Rothen, DO
David G. Short, DO
Brian E. Wind, DO

American Osteopathic College of Ophthalmology

President: Shoib Myint, DO
Vice President: Sidney K. Simonian, DO
Members-at-large: Robert J. Franchi, DO, Jeffrey N. Holtzman, DO, David D. Gossage, DO, Brian E. Wind, DO, *CRR representative*: Steven Sherman, DO

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Vice President: Kirk W. Steehler, DO
Members-at-large: Paul E. Burk, DO, Michael S. Hauptert, DO, Donald M. Rothen, DO, David G. Short, DO, *CRR representative*: Mahmoud Ghaderi, DO

Executive Vice President:

Alvin D. Dubin, DO

Staff:

Debra L. Bailey, Administrative Director
Cynthia Carleton-Simon, Administrative Assistant
Deborah Garber, Administrative Assistant

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Views and opinions expressed in the *AOCOO-HNS Quarterly Report* are not necessarily endorsed by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery.

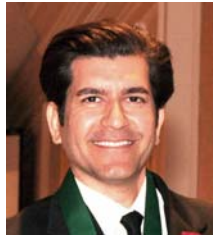
Quarterly Report Schedule

SUMMER: copy deadline May 15th
mailing June 15th
FALL: copy deadline August 15th
mailing September 15th
WINTER: copy deadline November 15th
mailing December 15th
SPRING: copy deadline February 15th
mailing March 15th

PRESIDENT'S REPORTS

AOCO & AOCOO-HNS President

Shoib Myint, DO



ACCEPTANCE SPEECH - May 6, 2007

As I mentioned during my acceptance speech, I am honored, privileged and excited to have been elected as your next President. I want to thank Drs. Rogotzke and Surer who have done a wonderful job in keeping this College on course with the issues on the table.

The theme of my speech was enthusiasm.

I learned something when I got involved with this College. I learned that people of accomplishment rarely sat back and let things happen to them. They went out and happened to things. My hope this coming year is that you will not sit back and let things happen to you. It wasn't too long ago I remember asking myself what is this College doing for me? The more I educated myself and got involved, the more I asked what can I do for the College. I encourage you all to educate yourself and do the same. There have been many positive changes made to this College, which has made it much easier for you to get involved and have your voice heard. Don't wait. We need you.

Nothing could give me more joy than to generate enough enthusiasm this year from the strong committees and the general membership to power this College for the future. Remember that knowledge is power but enthusiasm pulls the switch. We need more of your enthusiasm, your capabilities, talents, direction, mission, and calling. Will Rogers once said, "even if you're on the right track you'll get run over if you just sit there."

Don't just sit there. Come forward and voice your opinion. We may not all share the same ideas but at least we can move forward towards the same goal which is to do what's in the best interest of this wonderful College and not just one group or individual.

The Board has many issues on it's

plate for this year: the most important being MOC (Maintenance of Certification). The AOCOO-HNS, in collaboration with the AOCOO-HNS will be laying a foundation for future certification examinations. We have recognized the committees to make them more accountable and hope to generate excitement and enthusiasm from the chairmen. The Board has also gotten closer in establishing through the AOCOO-HNS Foundation an International Clinic for the residents. Your financial support to this endeavor will help shape the future of our residents. Please give to the Foundation. The Foundation is in the process of getting a facelift as well by establishing an Advisory Board of physicians and non-physicians with experience in fundraising. If you have such experience, please come forward. The Search Committee is in the process of reviewing applications for an individual, who when selected, will enter into a mentorship program with Dr. Dubin, and then continue in the position of Executive Vice President. We will be interviewing and selecting the right candidate. Lastly, we will continue to fight on your behalf regarding advocacy issues that face us all.

Your knowledge, your suggestions and your talents, are much appreciated this year. Please get involved and let us know where your expertise is so we may all work together.

I'm not telling you it's going to be easy. I'm telling you it's going to be worth it.

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PAST PRESIDENTS



Jacques Surer, DO (left) and Kenneth Rogotzke, DO (right) served the AOCO and AOCO-HNS from May 2006 through May 2007. Both are celebrating their Presidencies during the Annual Ceremonial Banquet.

AOCO-HNS

Thomas E. Brandeisky, DO

ACCEPTANCE SPEECH -
May 6, 2007

Good evening ladies and gentlemen and honored guests. I regret that I cannot be with you this evening, as I am installed as the new Chairman of the American Osteopathic College of Otolaryngology-Head and Neck Surgery, President-Elect of our Board of Governors. I will endeavor to honor these offices by serving you and our profession to the best of my ability. Dr. Kenneth Rogotzke and Dr. Jacques Surer have set a standard of dedication and principled action that will guide me through my tenure. I look forward to working with Dr. Shoib Myint who I know will distinguish himself as our President.

I have learned much from the many Boards and Board Members who I have served these past years, but I have learned from our history, that it is a dedicated membership that is the indispensable factor in the advancement of our organization.

In 1908 the osteopathic physicians practicing ophthalmology and otolaryngology met officially for the first time during the American Osteopathic Association Convention as the Eye, Ear, Nose and Throat Section of the AOA. This is the 100th meeting of our specialists. By 1928, in order to offer specialty training to osteopathic physicians the International Society of Ophthalmology and Otolaryngology was organized by the first group of certified osteopathic specialists. In 1944 the Osteopathic College of Ophthalmology and Otolaryngology was established, and since then there has been a name change or two, creation of distinct boards for the Colleges and finally establishment of a Charitable Fund that was reorganized as a Foundation.

Clearly since the first time osteopathic physicians practicing our specialties met with the AOA, an array of organizational, professional, and public pressures have led to changes in how we present ourselves to the public. Due to the process of institutional Darwinism, these various internal and external pressures have caused this organization to evolve. But no cause for change has been more important than the need to provide our membership with the tools that they need for success in their chosen fields.

Looking around this room tonight, if I could, I would see success that the original section members might only have

imagined. Today, we not only advocate for the rights and privileges of osteopathic specialists, but we train our residents, provide for their credentials, and offer additional training in otolaryngic allergy through a certificate of added qualification.

We maintain the credentials of our members through continuing medical education programs and will soon offer a maintenance of certification process that we can all live with.

In 1908 the members of the eye, ear, nose and throat section started a journey down an uncharted road. Their path started in cities like Kirksville and Kansas City - Chicago and Philadelphia, and as our profession grew, that road became a highway with new on ramps in Pikesville, Kentucky and Erie, Pennsylvania - Stratsford, NJ and Blacksburg, VA, as well as many other cities and towns across America.

Imagine their surprise if they were to know that after 100 years the road led to Sarasota, Florida.

But it doesn't end here. Next year it's on to Phoenix, Arizona at the Camelback Inn where I'm sure we'll have another fine meeting and I look forward to seeing everyone there. So please, enjoy yourself tonight for tomorrow each of you gets back on the road that leads to all the small towns and the big cities where osteopathic ophthalmologists and otolaryngologists practice their art.

Although no one knows exactly where the road leads, I do know that the next 100 years of progress for our Colleges will once again, and as always, depend upon the hard work, commitment and dedication of our membership.

I'd like to thank everyone for your support of our great organization. Thank you one and all for this wonderful honor. Thank you to all those who have provided me with education and encouragement, like my Mom and Dad, like Alvin Dubin, Ed Scheiner, and our new honorary member Frank Marlowe.

Please join me in thanking Dr. Dubin and the College Office Staff for all their fine work this past year and for putting together another fine meeting. I'd like to also thank Drs. Rogotzke and Surer for their many years of service, and their promises of continued support as past presidents.

Now let's remember that while others have made for us a profession we're each responsible for it's continued evolution. So give yourself a round of applause, because without YOUR interest, YOUR input, and

YOUR involvement our Colleges would have no future. It has always been about our membership and it always should.

Thank you and good night - I'll see you all next year.

Thomas E. Brandeisky, DO

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Email: tbrandeisky@msn.com

EXECUTIVE VP REPORT

Alvin D. Dubin, DO



On behalf of your Colleges, we thank those of you that were able to attend the ACA in Sarasota, Florida in May. We sincerely hope that all of you will join us next year in Scottsdale, Arizona.

We continue to gain great support from you in our membership numbers, attendance at our seminars, and at the ACA. The Colleges have awarded over 27,000 CME hours during the past three years. These facts are a credit to the efforts of our committees, Program Chairmen, and their tireless efforts to continue to improve our educational standards. Your support is appreciated and necessary for us to continue in this manner.

At the opening of our meeting, Dr. Hershey Bell, a nationally recognized educator, delivered the A.B. Crites lecture, and his comments on Professionalism were significant in helping define our role in guiding our future. His comments helped us see more clearly, not only our place in the medical Community, our responsibilities to ourselves, but also to the public, and our patients. All of the above—Professionalism.

Your President has taken his charge and given the Board, and its committees, directives to have initial reports back to the Board in a timely fashion. I sense a renewed vigor by the Board this year as evidenced by their participation in our recent "retreat", workshops, seminars, all directed to re-assess their values and help guide future Colleges' activities.

During these various meetings, many topics were reviewed in detail. Advocacy for our Specialties, not only to various agencies, and governmental offices, but to our Osteopathic Medical Schools and

students as well. We must continue to bring our Specialties to the forefront to all of the above in order to continue to give the necessary quality care to the public.

Educating our members is a high priority and requires both Member's and Colleges' staff involvement. We must continue to keep you updated on changes that will affect your practice, and your role needed to guide your practice and treat your patients.

With the new Congress, changes in payment will ensue, and you should be informed about these changes in the payment structure.

This will be linked to performance and quality patient care—our Specialties have to be involved in the development of these criteria.

In the overall plans for our Continuing Development issues, we have to realistically review our financial sheets. Our members dues, and their voluntary contributions, are the primary support to the running of the AOCOO-HNS and Foundation activities. We are fortunate to have this support. But, we have to help fund the remaining needs of these organizations. We must do all that is possible to enhance our operating capital, by members increasing their support using various modalities such as estate planning, various philanthropic endeavors, and other programs to grow our Foundation assets. Our leadership is at present reviewing plans to bring about a full commitment to this end. We are actively communicating with both Academies in order to seek advice from their staff in matters of seeking additional avenues of financial support and I am pleased to state they have been extremely open and helpful in these matters. Details in securing serious financial support from all potential areas are being developed.

Our Colleges will be better served as we continue to improve our communications to you through email, publications, and web site listings, and by prioritizing items of higher value of service. Your feedback is always appreciated.

Board of Governors Leadership training will ensure that a high level of service will continue, and College Staff will also engage in continued training as well.

The Colleges are actively engaged in "Strategic" planning and budgetary issues such as adapting to change in certification and education, and developing future leaders.

Bottom line—YOUR support is still our most precious commodity—so—thank you all for your support in the coming months and years ahead.

Enjoy your summer months!

2007 AWARD RECIPIENTS

Honorary Member

Bestowed by the College in recognition of a physician who has made a significant professional contribution to the Colleges.

Otolaryngology

Frank I. Marlowe, MD

Presidential Achievement

Awarded by the President of the College in recognition of noteworthy professional achievement, or other valuable service performed on behalf of the Colleges or Board of Examiners.

Ophthalmology

Arlin H. French, DO
Sanjay D. Kamat, DO
Sirtaz Singh Sibia, DO

Otolaryngology/Facial Plastic Surgery

Mahmoud M. Ghaderi, DO
Joseph P. Olekszyk, DO

Governors Achievement

Bestowed by the Board of Governors to members who have distinguished themselves by a great level of accomplishment or demonstrated meritorious service to the Colleges or to the Board of Examiners.

Ophthalmology

Ralph P. Crew, DO
Shoib Myint, DO
Robert L. Peets, DO
Nicholas A. Sala, DO

Otolaryngology/Facial Plastic Surgery

Paul E. Burk, DO
Mark E. Reader, DO
Wayne K. Robbins, DO
Kenneth H. Rogotzke, DO
Edward D. Scheiner, DO

Distinguished Service Bestowed

by the Board of Governors for exceptionally meritorious service in a position of major responsibility in the Colleges or in the Board of Examiners.

Ophthalmology

Carlo J. DiMarco, DO
Rudy R. Manthei, DO

Otolaryngology/Facial Plastic Surgery

David N. Madgy, DO
George W. Vogelgesang, DO

Special Board of Governors

Bestowed by the Board of Governors for exceptionally meritorious service to the Colleges in a series of duties of great responsibility.

Ophthalmology

Jacques L. Surer Jr., DO
Otolaryngology/Facial Plastic Surgery
Warren L. Brandes, DO
Douglas F. Hegyi, DO

2007 Fellows

Ophthalmology

- ◆ Mark A. Cascairo, DO, Tulsa Regional Medical Center, OK—1993, Certified 1995, Pro. Dir. J. Harley Galusha, DO
- ◆ Clairann M. Farr, DO, Highland Park, MI—1992, Certified 1995, Pro. Dirs. Oran Anderson, DO and Michael Rubin, DO
- ◆ Norma Jean Flack, DO, Philadelphia College of Osteopathic Medicine, PA—1976, Certified 1992, Pro. Dir. Donald Thome, DO
- ◆ Steven M. Frame, DO, Grandview Hospital, OH—1983, Certified 1987, Pro. Dir. Charles Schrimpf, DO
- ◆ Luis Christopher Galang, DO, Pontiac Osteopathic Hospital, MI—2000, Certified 2001, Pro. Dir. Sidney Simonian, DO
- ◆ Anthony F. Grosso Jr., DO, Metropolitan Hospital, MI—2002, Certified 2003, Pro. Dir. Jeffrey Holtzman, DO
- ◆ Sanjay D. Kamat, DO, Philadelphia College of Osteopathic Medicine, PA—2002, Certified 2003, Pro. Dir. Carlo DiMarco, DO
- ◆ Marnie O'Brien, DO, Philadelphia College of Osteopathic Medicine, PA—1999, Certified 2001, Pro. Dir. Carlo DiMarco, DO
- ◆ Jeffrey R. Pyne, DO, Midwestern Univ./Chicago College of Osteopathic Medicine, IL—1994, Certified 1995, Pro. Dir. Richard Multack, DO
- ◆ Kristin E. Reidy, DO, Tulsa Regional Medical Center, OK—2002, Certified 2003, Pro. Dir. Richard Mills, DO
- ◆ Roy E. Tuller, DO, Philadelphia College of Osteopathic Medicine, PA—2001, Certified 2002, Pro. Dir. Carlo DiMarco, DO

- ◆ Daryl J. Zelenak, DO, Pontiac Osteopathic Hospital, MI—2001, Certified 2002, Pro. Dir. Michael Rubin, DO

Otolaryngology/Facial Plastic Surgery

- ◆ Benjamin S. Chack, DO, Philadelphia College of Osteopathic Medicine, PA—1989, Certified 1992, Pro. Dir. Theodore Mauer, DO
- ◆ James DiMuzio Jr., DO, UMDNJ/Kennedy Memorial Hospital, NJ—2001, Certified 2003, Pro. Dir. Edward Scheiner, DO
- ◆ Joshua E. Goldberg, DO, Philadelphia College of Osteopathic Medicine, PA—2002, Certified 2003, Pro. Dir. Theodore Mauer, DO
- ◆ Shannon T. Radgens, DO, Pontiac Osteopathic Hospital, MI—2001, Certified 2002, Pro. Dir. Gregory Roche, DO
- ◆ Eric D. Reed, DO, Tulsa Regional Medical Center, OK—2001, Certified 2003, Pro. Dir. Thomas Nunn, DO
- ◆ Shaun R. Roof, DO, Doctors Hospital North, OH—2001, Certified 2003, Pro. Dir. Robert Pema, DO

New Members

Ophthalmology

- ◆ Todd A. Adelson, DO, Philadelphia College of Osteopathic Medicine, PA—2005, Pro. Dir. Carlo DiMarco, DO
- ◆ David W. Boone, DO, Tulsa Regional Medical Center, OK—2005, Pro. Dir. Marc Abel, DO
- ◆ Christopher P. dePalo, DO, Doctors Hospital North, OH—2004, Pro. Dir. Jeffrey Hutchison, DO
- ◆ Rachna Gupta, DO, Genesys Regional Medical Center, MI—2005, Pro. Dir. Robert Zandler, DO
- ◆ Thomas K. Ison, DO, Grandview Hospital, OH—2006, Pro. Dir. Robert Peets, DO
- ◆ Jan Lei Iwata, DO, Midwestern Univ./Chicago College of Osteopathic Medicine, IL—1999, Pro. Dir. Richard Multack, DO
- ◆ Victoria L. Landolt, DO, Pontiac Osteopathic Hospital, MI—2006, Pro. Dir. Michael Rubin, DO
- ◆ Daniel W. Langley, DO, Tulsa Regional Medical Center, OK—2006, Pro. Dir. Marc Abel, DO

- ◆ Christin L. Sylvester, DO, Philadelphia College of Osteopathic Medicine, PA—2005, Pro. Dir. Carlo DiMarco, DO

- ◆ RaShawn W. Venerable, DO, St. John-Oakland General Hospital, MI—2006, Pro. Dir. Sidney Simonian, DO

Otolaryngology/Facial Plastic Surgery

- ◆ Arthur H. Allen, DO, Genesys Regional Medical Center, MI—2006, Pro. Dir. Wayne Robbins, DO
- ◆ Susan K. Anderson, DO, Doctors Hospital North, OH—2006, Pro. Dir. Robert Pema, DO
- ◆ Lisa M. Ayers, DO, Philadelphia College of Osteopathic Medicine—2006, Pro. Dir. Mahmoud Ghaderi, DO
- ◆ Mark A. Bickert, DO, Freeman-Oak Hill Health Systems, MO—2006, Pro. Dir. Larry McIntire, DO
- ◆ Laurie A. Brigandi Porter, DO, UMDNJ/Kennedy Memorial Hospital, NJ—2006, Pro. Dir. Edward Scheiner, DO
- ◆ John Andrew Brinkman, DO, Grandview Hospital, OH—2006, Pro. Dir. Michael Helfferich, DO
- ◆ Steven T. Constantine, DO, Doctors Hospital North, OH—2005, Pro. Dir. Robert Pema, DO
- ◆ Kristin Lee Fredrickson, DO, Des Peres Hospital, MO—2006, Pro. Dir. Paul Burk, DO
- ◆ Larry Kyle Gambrell, DO, Philadelphia College of Osteopathic Medicine, PA—2006, Pro. Dir. Mahmoud Ghaderi, DO
- ◆ Kevin M. Hanks, DO, Genesys Regional Medical Center, MI—2006, Pro. Dir. Wayne Robbins, DO
- ◆ Phillip L. Khalil, DO, Doctors Hospital of Stark County, OH—2006, Pro. Dir. Richard Klapchar, DO
- ◆ Paul V. Lanfranchi, DO, UMDNJ/Kennedy Memorial Hospital, NJ—2006, Pro. Dir. Edward Scheiner, DO
- ◆ Troy E. Major III, DO, Freeman Hospital and Health Systems, MO—2005, Pro. Dir. Larry McIntire, DO
- ◆ Jay R. McMaster, DO, Tulsa Regional Medical Center, OK—2006, Pro. Dir. Sammy Worrall, DO
- ◆ Peter Trong-Ngoch Nguyen, DO, Pontiac Osteopathic Hospital, MI—2006, Pro. Dir. Carl Shermetaro, DO

- ◆ James W. Osborne, DO, Metro Health Center, PA—2006, Pro. Dir. Kirk Steehler, DO

- ◆ Donald M. Sesso, DO, Philadelphia College of Osteopathic Medicine, PA—2005, Pro. Dir. Mahmoud Ghaderi, DO

- ◆ Jonathan J. Wiggernhorn, DO, St. John-Oakland General Hospital, MI—2006, Pro. Dir. Warren Brandes, DO

Special Thanks

2007 ACA Exhibitors

- Acclarent, Inc.
- Alcon Laboratories, Inc.
- ALK-Abello
- Allergan/Inspire
- Allergychoices, Inc.
- Alletess Medical Laboratory, Inc.
- AllMeds, Inc.
- Anthony Products/Gio Pelle
- ArthroCare ENT Corporation
- Bausch & Lomb, Inc.
- Carl Zeiss Meditec, Inc.
- E.C. Medical Products
- Ellman International, Inc.
- Endure Medical, Inc.
- GE Healthcare-Surgical Navigation
- HYCOR Biomedical, Inc.
- InfluENT Medical
- InHealth Technologies
- IRIDEX Corporation
- JEDMED Instrument Company
- Lifestyle Lift Holding II Inc.
- Medical Technology Industries, Inc.
- Medtronic ENT
- Micromedics, Inc.
- NeuroSensory Centers of America
- Prescott's Inc.
- QUEST Medical Inc.
- Reliance Medical Products, Inc.
- Rhytec, Inc.
- Starkey Laboratories, Inc.
- Xlear Inc.
- Xoran Technologies, Inc.

SPECIAL THANKS TO...

Arlin H. French, DO
Ophthalmology Program Chairman

Joseph P. Olekszyk, DO
Otolaryngology/Facial Plastic Surgery
Program Chairman

2007 Resident Award Recipients

Patrick Murray Awards

Ophthalmology

- ◆ 1st place-Lee T. Bottem, DO, Tulsa Regional Medical Center, Pro. Dir. Marc Abel, DO
- ◆ 2nd place-Scott J. Westhouse, DO, Tulsa Regional Medical Center, Pro. Dir. Marc Abel, DO
- ◆ 3rd place-Gary T. Gillham, DO, Genesys Regional Medical Center, Pro. Dir. Robert Zandler, DO

Otolaryngology/Facial Plastic Surgery

- ◆ 1st place-Ryan W. Leonard, DO, Genesys Regional Medical Center, Pro. Dir. Wayne Robbins, DO
- ◆ 2nd place-Aleksandr V. Guchinskiy, DO, NYCOM/Union General Hospital, Pro. Dir. Richard Scharf, DO
- ◆ 3rd place-Jeffrey S. Milewski, DO, Henry Ford Bi-County Community Hospital, Pro. Dir. Donald Rothen, DO

Resident Paper Awards

Ophthalmology

- ◆ 1st Place, Victoria L. Landolt, DO, "Combined Scleral Buckle and Pars-Plana Vitrectomy vs. Scleral Buckle Alone in the Management of Pseudophakic Retinal Detachment", Pontiac Osteopathic Hospital, Pro. Dir. Michael Rubin, DO
- ◆ 2nd Place, Alexander Demidenko, DO, "A Case of Late Onset Leber's Hereditary Optic Neuropathy", Genesys Regional Medical Center, Pro. Dir. Robert Zandler, DO
- ◆ 3rd Place, Paul Andrew Brown, DO, "The Role of Bevacizumab in Retinal Vein Occlusion: A Case Series", Metropolitan Hospital, Pro. Dir. Jeffrey Holtzman, DO

Otolaryngology/Facial Plastic Surgery

- ◆ 1st Place, P.H.L. Joseph Belanger, DO, "The Use of the Mobile Voice Laboratory in the Operating Room During Type I Thyroplasty with Gore-Tex", Pontiac Osteopathic Hospital, Pro. Dir. Carl Shermetaro, DO
- ◆ 2nd Place, Thomas S. Sellner, DO, "Nasopharyngeal Carriage of Respiratory Pathogens in Children Undergoing Pressure Equalization Tube

Placement in the Era of Pneumococcal Protein Conjugate Vaccine Use", Millcreek Community Hospital, Pro. Dir. Kirk Steehler, DO

- ◆ 3rd Place, Ninh H. Nguyen, DO, "The Minimal Access Cranial Suspension Technique; A Safe and Less-Invasive Rhytidectomy", Henry Ford Bi-County Community Hospital, Pro. Dir. Donald Rothen, DO

Resident Poster Awards

Ophthalmology

- ◆ 1st Place, Brian J. Mihok, DO, "Bull's-Eye Maculopathy in Canthaxanthine Retinopathy", Grandview Hospital, Pro. Dir. Robert Peets, DO
- ◆ 2nd Place, Brooke E. Geddie, DO, "Relapsing Devic's Neuromyelitis Optica in 6-Year-Old Female", Metropolitan Hospital, Pro. Dir. Jeffrey Holtzman, DO
- ◆ 3rd Place, Ayaz O. Khan, DO, "Cryptococcal Pepilledema: A Rare Ocular Finding in AIDS—Case Review and Discussion", St. John's Episcopal Hospital, Pro. Dir. Steven Sherman, DO.

Otolaryngology/Facial Plastic Surgery

- ◆ 1st Place, Rizwan Aslam, DO, "Reversible Cilia Ultrastructure Changes in a World Trade Center 9/11 Rescue Worker", Millcreek Community Hospital, Pro. Dir. Kirk Steehler, DO
- ◆ 2nd Place, Thomas F. Mazzoni, DO, "Dermatologic Manifestations of Sarcoidosis", Botsford General Hospital, Pro. Dir. Christine Lepoudre, DO
- ◆ 3rd Place, Patrick M. Fitzpatrick, DO, "Human Papilloma Viruses: Implications and Role in Carcinogenesis of Squamous Cell Carcinoma of the Head and Neck", St. John-Oakland Hospital, Pro. Dir. Warren Brandes, DO

The College of O&O - The Joe Wyatt Era My Personal and Historic Reflections on the Time and Events

By J. Harley Galusha, DO

There is no doubt that what we are enjoying in our College today is the result of Dr. Wyatt's seizing the vision and the opportunity of ophthalmology as a young practicing Eye, Ear, Nose and Throat specialists in Detroit in the 1950's and thereafter. Before dealing with him and his background personally, I think it is quite appropriate that we look at the practice of Eye, Ear, Nose and Throat on a practical basis and understand why it is that the Wyatt era was so important. First, I must apologize. I was first involved in this with my life commitment and profession right from the beginning and I must ask that you allow me to indulge in some personal reflections because at least for me that is what makes the Wyatt era so important. My memory is not perfect so if I miss someone or some event please let me know!

Ancient History

The American Academy of Ophthalmology says their beginnings were in 1896. Our College reports its first meeting and activities in 1916 some twenty years later. In Kansas City, when I was a resident, an old pro, Leland Larimore who was finishing his years of practice told me that he had started in 1907 – 100 years ago! He had done general practice but had become very interested in taking out tonsils, treating various eye diseases and had developed a full time Eye, Ear, Nose and Throat practice in the pre-World War I days. He told about the first meetings of the College in which it was very difficult for everyone to get together. The United States was large and train rides were often long and expensive, so the meetings represented a very low percentage of our College members. Even so, there was a very active group on the West coast, and a very active group, particularly in the Philadelphia area not to mention Ohio, Detroit, Kirksville and Kansas City.

Most of the specialists became specialists because they were specialists. However, some were given fellowship opportunities and some of the very exceptional ones like A.B. Crites in Kansas City arranged training in Europe since they were not welcome in the institutions of the medical profession here in the States.

Dr. Crites was quite successful in

general practice in Kansas City during World War I and as he stated, he made “a mint” during the influenza epidemic of 1918. He was always interested in the stock market and of course did well in the raging market of the early 20’s. He saw an opportunity to spend that money by going to Europe and studying in various European centers, and he came back well qualified in facial plastic surgery skills, ophthalmic surgery skills, as well as multiple Ear, Nose and Throat procedures. A large number of doctors came to him and paid him a fee to be a fellow for a year in order to qualify as an Eye, Ear, Nose and Throat specialist. A west Texas EENT graduate of Crites hit a good oil investment and made a contribution to the College thereby endowing the A.B. Crites annual lecture. Such was the practice during the 30’s and 40’s. Similar environments were enlarging our specialty college in Detroit, Philadelphia, Columbus and Dayton and of course the Los Angeles area. This ancient history of the College provided the basis for post World War II growth, and names like DuPont and Blasdell in Los Angeles, Stein in Philadelphia and the Seyfrieds in Detroit, Lydic in Dayton, Licklider in Columbus, Jim Walker in Sandusky, as well as A.B. Crites in Kansas city, became prominent. So much for Ancient History.

Middle Age of the O&O

Following World War II, our College began to grow very rapidly because we were able to bring into our classrooms (war veterans) who added maturity and dedication to the profession. This was truly a springboard for growth. Meanwhile, in the College of O&O, the outstanding people from the ancient era were evolving into key leaders: Clifford Foster was the Executive Secretary of the Examining Board while Arthur Martin and his wife served as Executive Secretaries to the governing Board of Eye, Ear, Nose and Throat. The old pros on the Board included James Walker from Ohio, Edward Hersh from Florida and Arthur Martin from Kirksville. The 1950’s however, saw a sprinkling of new faces joining the College leadership including Owen Rice of Michigan and Joe Wyatt of Detroit.

In Los Angeles the county hospital offered one of the finest training opportunities in the profession. Dr. Wyatt received his residency training there along with Drs. Blasdell and DuPont; they were practicing optometrists who capitalized on their location and background to create the best center for ophthalmology in the profession. Dr. Wyatt’s close connection with them inspired his interest in practice and ophthalmic training. The major trauma for the College at this time come in the separation of the profession in California from Osteopathy to join the MD profession.

The Osteopathic ophthalmologists in that community were very, very strong and were therefore critical leaders in education and politics for our profession. The first meeting of the College of O&O that I attended was in Florida in 1961 and was the first meeting for our group after the departure of the California D.O.’s. As I look back, it was a very tense meeting for most of the profession. Many of the key members had departed and enrollment was one of the lowest in the post war period, with only 62 registrants. One of the people on the program at that meeting was Dr. Wyatt and because I had a particular interest in intraocular ophthalmic photography, he asked me if I would bring some of my slides and show them at the meeting. It was a technology that not many had seen before and it created a good deal of interest. For me, it was a very significant time because we couldn’t afford the plane tickets and drove our Volkswagen all the way from Tulsa to Florida to take part in the meeting. There were other “young” people there like Bob Belf who was a resident in Detroit and Alvin Dubin who started in practice in Philadelphia. It was certainly a time for the College to reorganize and look to the future and was in many ways a time of concern about our ultimate survival.

We should take a moment to consider the practice of Eye, Ear, Nose and Throat at that time. MD physicians were still practicing as Eye, Ear, Nose and Throat specialists but their numbers in that combination of specialty began to decline in 1939 and by the 1950’s some were going into subdivision such as Otolaryngology. However, most of our graduates continued to practice Eye, Ear, Nose and Throat strictly for economic reasons. It was very hard practice to get started in Ophthalmology and make it an economic success. The College meetings still reflected the combined specialties and it continued that way for a number of years. Our College politics were the same as there was one President for the whole College and the Board administered the Executive duties for the College. Since this is the way things were when I arrived, I’ll ask your indulgence in some personal background. Emanuel Kant the great German philosopher said that “You see things not as they are – but as you are.”

My Personal History as a Physician

My father was a pressman in the newspaper industry. During the 1930’s he worked in an unventilated basement six days a week and began having terrible headaches. The company doctor said he had a brain tumor. My aunt said, “Why don’t you go over and see the new Osteopath? He’ll pop your neck, your headache will go away and you won’t have to go down to Oklahoma City”. It sounded pretty good to my mother and father so they went to see this doctor. He kept them

in his office all afternoon. Later on, Dr. Streitenberger told me that he examined my father then went in and read his books, then went back and looked at my father and announced to him that he had lead poisoning! The furor of a D.O. making that kind of statement in the late 1930’s was considerable and my father’s boss fired him. The workmen’s compensation people insisted that he go to Barnes Hospital in St. Louis for a second opinion which confirmed what our personal osteopathic physician had said. After that, I wanted to be a doctor like him! When I was an undergraduate I kept having well-intentioned people say “Why don’t you be a real doctor”? The frustration of that caused me to change my major to physics with the intention of going to work for an oil company. But then things changed. Before returning to school for my junior year I was dissolving some pure sodium from a chemistry set. The hydrogen gas exploded and burned my eyes.

My personal physician, Dwight Streitenberger who had gone to Kansas City to study Eye, Ear, Nose and Throat with Dr. Crites, took care of me. I spent three days in the hospital with my eyes bandaged thinking about what I was going to do with my life. I decided then to be an eye doctor. I tell you that because that caused me to select an internship in Dayton where there was one of the only ophthalmologists in our profession practicing. Dr. Lydic was really good medicine for me. Incidentally, in Dayton Dr. Lydic and Dr. Jack Miller divided their practices. Lydic taking the eye patients and Dr. Miller the ENT. Later after I finished my residency and went to Tulsa, I had some influence in directing Don Dushay to Dayton for ENT and on to Detroit for his final year!

After internship I came back to Kansas City for my residency at the College with Dr. Crites who was the Program Director. I found an environment that was decidedly dedicated to Eye, Ear, Nose and Throat. The Chiefs in the Department only spoke of it in those terms. There was, however, a resident ahead of me by the name of George Bretts from Bangor, Maine. George wanted to be an ophthalmologist and only an ophthalmologist, and his example and logic plus my basic background caused me to decide that was just what I would do as well. Between the two of us we talked Patrick Murray, the next resident into the “ophthalmology only mindset” and when Charlie Schimpf showed up, Patrick, Charlie and I became what Cliff Foster called “The Three Musketeers”. All of us had the enthusiasm and encouragement of George Bretts. In the course of our residency we were allowed to go to Los Angeles and work with Drs. DuPont and Blasdell in their practices and to attend some special courses in ophthalmology. We heard the head of

Clinics at Moorefield Eye Hospital in London in a basic series of lectures on the practice of ophthalmology. These meetings attracted Eye, Ear, Nose and Throat specialists from all over the country but they were primarily for those in the profession who were particularly interested in ophthalmology. It was in this environment that I first encountered Joe Wyatt. We had extensive conversations which impressed me and I guess to some extent impressed him because as a result he invited me to come to Detroit to see about the possibility of practicing with him. He and LeRoy Benoay who were on the DOH staff decided that they would separate their practices with Benoay taking the ENT patients and Wyatt becoming the staff ophthalmologist. Needless to say, such an invitation to practice was a very high compliment. During our visit to Detroit his wife Maxine and he treated my wife and me as family. We went to church and to a Lion's football game. Maxine took us with her daughter to a Girl Scout program and shared her ideas of a doctor's family life. This made it extremely difficult to decide to go to Tulsa, Oklahoma where there were 150 D.O.'s in a large hospital and no major ophthalmic procedures being carried out.

The fear of the big city Detroit and the attraction of my home environment was what tipped the scales. This close association between Joe Wyatt and me was only beginning because whenever I had a tough decision to make I would always call him. He would settle me down and say, you did the right thing and keep on doing it. Yes, all his residents thought of him as "The Chief" – and so did I.

Meanwhile back at the College of O&O, all of us felt academically isolated. The Academy meeting was a great source of education but the only way we could attend the meetings was by being on "the staff" of the Mosby or some other book company and admitted to the meeting doors with appropriate nametags. Fortunately I didn't have to go through this. My first chance to attend the Academy meeting was in 1961. Dr. Wyatt had become a good friend of Adolf Posner, a world renowned glaucoma specialist practicing in New York, and Dr. Posner who had been impressed by Joe arranged for us D.O.'s to come to the Academy as guests. It was 1961 and a signal event and extremely important.

The permission to attend the academy culminated in a consistent and persistent effort by Dr. Wyatt. This event as important as it was – was indeed the first chapter in a continuing closer alliance between the two groups. Subsequently, we were asked to send a delegate to the committee of advisors and Dr. Moretsky was our first. While Wayne Bizer was representing us this counsel recommended to the Board of Trustees that

certified members of our College be accepted as fellows of the Academy.

I had resolved to use one month out of 12 in my first ten years of practice in education efforts and the Academy of course was a very important feature of that decision. The Academy meeting was always held in the fall and we ultimately decided to move our O&O meetings to the spring so that they would not conflict. Our College continued with its increased residency training and slowly grew to the point that Dr. Wyatt was setting the pace for the College. At the time that they decided to separate the Examining Board from the College Board, Dr. Wyatt moved to the Examining Board and chaired its activities for many years. It was then that a place became available on the General Board and I was elected to serve there. It is my appraisal that this was the middle phase of development for the College from World War II up to a major event which marked the era of what I call modern maturity of the College.

Modern Maturity of the College of O&O

I attended my first Board of Governors meeting which was chaired by Ed Hersh and included most of the old pros who had been running the College for the previous ten years, and I was certainly the youngster in the group. Typically, there was a lot of work to do and the meetings went on and on. I carefully withheld any comments or participation because I wanted to get an idea of how it was conducted and what was going on. Once all the business had been transacted and Dr. Hersh asked if there was other business, I said that I would like to make a motion that we set up a committee to study the separation of the training programs into Eye and into Ear, Nose and Throat. Almost universally, those in attendance reacted rather angrily because they considered Eye, Ear, Nose and Throat to be a "holy concept" and above all they decided they didn't want some young pup coming in and changing things just because he was on the Board of Governors. Listening to these conversations which went on for some time, I waited for them to pause and then I said, "Okay fellows, if you don't even want to set up a committee to study this then maybe there is not any room for me to be on this Board because studying it is all that I recommend that we do." This was met very quietly and Dr. Hersh said that he would appoint a committee, which he did. The Chairman of the Committee was Dr. Joseph Wyatt. Also serving on the committee was Dr. Stein from Philadelphia who was a great Ear, Nose and Throat man and I. Throughout the year, I would send different documents to Dr. Wyatt and I didn't hear a thing. When we got to the Greenbriar the next year for our meeting, the three of us met. Dr. Stein said, "You know, I

think that we ought to recommend to the Board of Governors that they set up a process for dividing the training programs into Eye and into Ear, Nose and Throat and those who are in progress we'll continue as they started and that ultimately will have the programs separated." Dr. Wyatt said, "Well, that sounds good to me, what do you think Harley?" And I said it sounds good to me and we went to the bar to have a drink. Of course it was an idea whose time had come and it was an example of how Dr. Wyatt worked quietly to make things happen and they happened.

As the 1960's passed, it was very evident that Dr. Wyatt had decided to dedicate himself to becoming the best ophthalmologist that he could be. In view of that, he had to have contact with the medical profession and indeed he did it with such style and grace, he pulled all of the rest of us along with him. His contact with Dr. Adolf Posner got us into the Academy meetings. He arranged with Dr. Rizuti of Brooklyn Eye Hospital to come up there for a corneal transplant course and paved the way for me to come the very next year. Consequently, I was the first Tulsa ophthalmologist to do a corneal transplant.

Dr. Posner introduced me to Dr. Keman who invited me to watch cataract surgery. He was trying something new – delivering intracapsular lenses with a primitive chryoprobe. Probably most critical of all, however, was Dr. Wyatt's decision to make the residency as competent as possible. His contact with the Kresge Eye Institute at Wayne State University resulted in an enrollment in a basic science course that enabled the residents to set off in a training program with an excellent background in basic sciences in ophthalmology. Jesse Cardellio was the first resident in this program and we were all quite excited about the potential of producing residents with such high quality training. Following this lead, similar programs developed across the country for our residents. My last day of duty as a resident found me helping Dr. Crites with some surgery. He said it was important for me to be there and he spelled it out to me that I owed the profession service in the area of education and he was sure that I would be a good program director for an ophthalmology residency. He put their idea in my head and with Dr. Wyatt's example in 1969 in Tulsa, I began a program that was modeled to some extent after the Detroit and Kresge program.

In 1969, I heard from my brother who was an agricultural missionary in the Belgian Congo that the surgeons out there did all kinds of surgery but they did not do eye surgery. Additionally, I found out that in a country of 18 million people there was only one ophthalmologist and he was a Belgian

surgeon who was taking care of mostly European people in the large capital of Kinshasa. My wife and I and our three young daughters decided that we could do something about that and after corresponding with the general surgeons who were there, we planned a trip to Africa. Congo enabled me to see ocular leprosy and onchocerciasis and also be awakened by a conversation with a young man from England who asked me, "Why don't you put lens implants in their eyes." I said, "Nobody does that any more, all that has been disproved." He said, "Well, there is a man in our town who puts them in everybody's eyes." I said, "Wait a minute, how do you know that?" He replied that he was an optician. This surgeon's patients need ordinary spectacles after surgery and everybody else had aphakic spectacles which were big, thick and heavy. I was immediately impressed and asked him about this man and so he gave me Peter Choyce's name, telephone number and address.

I called Peter from Holland on our way back home and he said, well if you are in Holland you need to go down and see Dr. Binkhorst! There and then, I had the names and addresses of two out of four of the world's leaders in lens implant surgery and that knowledge caused me to pursue the study of it even though I did it very secretly, knowing that almost everybody would disapprove.

Does anyone know who Stanley Prusiner is? He in the 1970's and 80's was a neurologist on the staff of the USCSF. He with others studied the 1987 "mad cow" outbreak in Britain. His discovery and description of aberrant proteins – not bacteria – no fungus – not viruses but prions caused him to receive the 1997 Nobel Prize in Medicine. As that famous Tulsa Boy Paul Harvey would say "this is the rest of the story." His radical theory brought condemnation from the establishment. A vote was held at the Medical Society of San Francisco to expel him from membership.

Harold Ridley with Peter Choyce as assistant did the first AOL surgery in 1948. Led by Sir Stewart Duke Elder the ophthalmic Medical Society of Britain vigorously and repeatedly attacked him professionally and personally. Led by the American lens implant pathologist David Apple he was finally given credibility for his work and was knighted by the Queen in 2000. In Holland, Binkhorst was given similar treatment by the ophthalmic establishment. He carefully documented his work first with the four loop iris supported lens after intracapsular surgery progressing to the two loop capsule supported lens after extracapsular surgery. He was invited by the American Academy to present his work which was received in a very cool manner. No one talked to him or wanted to be seen

talking to him! I enjoyed two very nice visits and asked about coming to see his work. He said to be sure to write before I came!

Finally, Henry Hirshman in Long Beach, California announced an IOL course in which I was one of the six enrollees.

I had collected five patients who had monocular cataracts and who in that era could only be cared for with post-operative contact lenses. I did lens implant surgeries on them and then went to Holland to continue my studies. The day that I decided to do that was the day that I called Joe Wyatt and he said, "As I said before, I am very, very interested and you must go right ahead, you have prepared yourself well." Later on there was quite a lot of excitement and a condemnation of people like myself and so forth even in my own hospital, and in my own state of Oklahoma. Never the less, the quality was far too good and the patients were far too happy to have anything else happen. There was some talk that the Food and Drug Administration would regulate devices for medicine including lens implants. It was reported that they would stop anybody who was not doing it from starting implant surgery. With that in mind, I did not want our College to be left behind so, organized and carried out four programs for training doctors to do lens implant surgery. One of my first enrollees was Joe Wyatt who came to Tulsa for a visit and served as a cheering section for getting us off and running as a College group.

A number of M.D.'s in my community also came to take part in these courses. I suppose one way or another I would have gone ahead without his encouragement but believe me it meant so much to me to have him validate the effort.

Clinical Assembly

Not only had the Wyatt Detroit influence permeated the training programs but it seems brought about a change in our clinical assemblies. Little by little, various leaders in ophthalmology decided that it would be quite all right for them to come and take part in our clinical assembly. This was led off by Adolf Posner and Saul Sugar, truly world authorities in the field of glaucoma. They were simply big enough and important enough in the Academy that what they decided to do was perfectly and totally acceptable, and coming to our meetings and taking an active part in education was something that they did very largely because of what Dr. Wyatt had done in contact with them.

Before the formation of the National Lens Implant Society which was the forerunner of today's ASCRS, our College program featured the presentations on the topic and inspired a spirit of innovation among our members so that the manufacturers of lenses took notice with

considerable enthusiasm. One representative donated a large sum of money to the College which we chose to designate for funding the Patrick Murray award. One of the quality features built into the renovation of the residency program was an annual taking of the Academy of Ophthalmology Knowledge Assessment Test. The resident who scored the highest each year on that was awarded the Patrick Murray award and is today a quality feature of our training programs. Colleagues from all over the country come together for formal lectures, and yet for me our College has in many ways improved my practice just from casual conversation. I am forever in debt to Leonard Sells from Columbus who in the late 60's had the operating microscope for ophthalmology on his mind. His continual enthusiasm caused me to have the first ophthalmic microscope in my state and thus to be well qualified to start lens implants. In contrast with most meetings we did not do a quality presentation with question and answer time and not just a rapid fire lecture from the presenter. In recent years while we have had visitors who have presented good papers, a review of last years meeting caused me to decide that most of the best papers were presented by members of our College.

In 2006, the comparison of multi-focal lenses presented by Bill Ranelle was so comprehensive and so exhaustive that it would have been a great presentation for any meeting, but most of the big time meetings wouldn't give him that much time.

AAO-HNS Board of Governors Report

By Paul M. Imber, DO, Chairman Interorganizational Committee

The Board of Governors of the American Academy of Otolaryngology-Head and Neck Surgery met March 3 and 4, 2007, as part of Washington Advocacy Conference. The most significant meetings were the Legislative Representative Committee and the Carrier Relations Committee.

LEGISLATIVE REPRESENTATIVES COMMITTEE

Issues of scope of practice were discussed in detail. There are several invasions into the scope of practice of ENT-HNS by audiologists, oral surgeons, and speech pathologists, primarily at the state levels. The audiologists are trying to redefine themselves to be the entry point to the healthcare system for hearing, ear health and balance. They are presenting federal and state by state legislation to be

permitted to have direct access to Medicare funds without physician referral or review. They also are trying to change the Licensing Boards scope of practice definitions as noted above. There are also issues of false advertising, when audiologists with Aud.D. degrees market themselves as “Dr.” without clarification of their degree. The AAO-HNS is working to rectify this, so the description of the degree must be incorporated in all advertisements.

The Oral Surgeons have successfully expanded their scope of practice in the state of California, in spite of aggressive protests from the AAO-HNS, the American Academy of Facial Plastic Surgery, the American Society of Plastic Surgeons, and the American Academy of Ophthalmology, AOA and AMA. The recently enacted bill includes scope of practice for dentists/oral surgeons to evaluate and treat all related structures of the mouth and oral cavity. This would include all aspects of Facial Plastic Surgery, parotid and submandibular salivary gland surgery, and procedures for sleep apnea.

The Speech pathologists want to expand their scope of practice to include primary entry for all speech, language and swallowing disorders, without physician referral or oversight. In fact, in one legislative attempt they would have been given full GI endoscopic privileges, had the ruling passed.

Your diligence at the state level is very important, and you should be aware of these issues as they arise.

CARRIER RELATIONS COMMITTEE

This meeting focused on guidelines and measures for quality improvement in otolaryngology. The goal is to be able to look at ENT care nationally, and develop improvements and solutions to identified barriers to ideal patient care and delivery. Plans are then implemented, monitored, and standardized protocols can then be developed. This of course is in the ideal world.

Unfortunately, the next topic of discussion was Pay 4 Performance. This year P4P will be enacted as a voluntary program beginning September, 2007. The reporting physician must file, with 80% compliance, on at least three parameters determined by CMS. These criteria were not necessarily developed through evidenced-based, scientific medical process, but it is what will be used for now. The big reward will be a 1.5% bonus check on all Medicare billing, to be paid in February, 2008. SO, if you generate

\$250,000 in Medicare payments per year, you will receive a 1.5% bonus on 4 months of revenue—a massive \$1,250. This might cover half of the cost of developing a reporting protocol for your billing system—our federal government at work.

PUBLIC RELATIONS COMMITTEE

Dr. Paradise (University of Pittsburgh) has published a study regarding long term speech development and the impact of PE tubes. This study was not favorable for PE tubes, and with all of its flaws, was picked up by the media in most major markets. The AAO-HNS has prepared a response to the article, which is enclosed in this newsletter. There was much discussion about the tardiness of this response, which was taken to heart by the staff and the officers.

Washington Advocacy Conference Report

By Paul M. Imber, DO, Chairman Interorganizational Committee

This year the focus of legislative issues was Pay 4 Performance and the Medicare reimbursement formula (based on the Sustainable Growth Rate-SGR). The desire is for the P4P program to base its guidelines for quality on a multi-disciplinary, evidenced-based process for performance measure development. The goal is to:

- 1) Work with Congress and the Administration to develop a reasonable pay-for-reporting framework to ensure the highest level of quality care.
- 2) Develop evidence-based clinical practice guidelines and performance measures that can apply to all ENT's.
- 3) Continue to support the Physician Consortium for Performance Improvement, emphasizing the importance that all measures used by CMS meet the high standards of the Consortium.

You must be aware of the last minute block by Congress of the proposed 5% reduction in Medicare physician reimbursement that was planned for 2007. This action replaced the cut with a freeze, but did not address comprehensive reform. The budget for 2008 projects a 9.9% payment cut, and projects over 30% reductions in Medicare physician payments

between 2008 and 2015. The SGR must be replaced by a method of calculating Medicare physician payments with an annual update system that accurately reflects the natural increases in the costs of delivering high quality healthcare.

The need for comprehensive medical liability reform is still at the forefront of all physicians concerns; however, it is unlikely that any significant bill will be addressed by the Senate in the next two years. There is the possibility of attaching some level of tort reform into the P4P program, to offset costs and losses. The ongoing issues are caps on non-economic losses, sliding scale attorney fees, a “fair share” rule, and qualifications for expert witnesses.

These issues were taken by those in attendance to our respective congressmen and senators, during prescheduled meetings through Tuesday afternoon. I would encourage as many of you as possible to participate next year and send your residents as well (partial travel grants are available). If March is not good for your calendar go to Washington, DC with the AOA during DO Day on the Hill. I also encourage you to contribute to the ENT-PAC and the DO-PAC, so that focused legislation can be achieved on your behalf. As they say in Washington—“IF YOU'RE NOT AT THE TABLE, YOU'RE ON THE TABLE!”

AOA Council on Federal Health Programs Report

Washington, DC, April 28, 2005 By Jacques L. Surer Jr., DO

The President's Fiscal Year 2008 Budget Proposal includes a 75.9 billion dollar cut in the Medicare Program and 25.7 billion cut in Medicaid, both over the next five years resulting in a 101.6 billion dollar budget cut. The proposed reductions in overall Medicare spending provided little opportunity for increased physician payments (anybody expect more for pay for performance).

Medicare plans to provide beneficiaries with information on physician performance as part of its “better quality information to improve care for Medicare beneficiaries.” Under the project, Medicare data will be combined with data from other insurers to produce information on the

performance of health care providers.

MedPac Report, calls for a greater investment in CMS. While the MedPac Commissioners could not agree on how or whether to use expenditure targets for the Medicare payment system they did agree that a major investment should be made in Medicare's capability to develop and implement and refine payment systems (interesting how bureaucracies always find ways to fund themselves). In its report on alternatives to the sustainable growth rate system, no decisions have been made and nothing is going to be happening regarding the sustainable growth rate for at least another three to four years. CMS states that the Medicare physician payment is at a crossroads and told members that the agency is anticipating a 9.9% cut in physician payments for 2008 and continued reductions over the next decade. This will result in approximately a 40% reduction of payments to physicians over the next decade.

As part of the effort to transform Medicare, the agency is developing the Physician Quality Reporting Initiative (PQRI). There is a list of 74 measures posted on the PQRI website. This is a voluntary program and participants are eligible for a 1.5% bonus if they meet all the requirements. This voluntary program will begin July 1 and run through December 31. In order to participate you must have the National Provider Identification number and the final date for obtaining that number is May 23, 2007.

The buzz word or phrase currently in Washington is "the future of comparative effectiveness research". Gail Wilensky, PhD, Senior Fellow at Project Hope, gave a talk regarding this emphasis on comparative effectiveness, and as you might expect it means a bigger bureaucracy. There will be creation of a new entity to develop evidence for decision making based on effectiveness. The Medicare Drug Benefit Program heightened interest in better information. The amount Medicare spent on drugs is only ten cents on the dollar. They expect a much bigger payoff in evaluating medical procedures for effectiveness.

The United States spends much more per capita than other developed countries on health care. We spent \$5,267.00 per capita in 2002 compared with only \$3,446.00 per capita in the next highest spending country, Switzerland. There are many reasons that explain the high U.S. levels of spending, such as higher incomes and greater system capacity. On average, however, spending on health care has

increased about 2.5% faster than the economy.

There already exists an agency for health care research and quality, however it is now proposed to place a second bureaucracy under AHRQ and the funding for this agency will be in the range of five billion dollars. So you can see bureaucrats are doing what they do best, going to the trough of the taxpayer and feeding themselves at the expense of physicians, hospitals and pharmaceuticals.

The second thing that is happening is increased centralization of our freedoms in Washington, D.C. When will we wake up to the fact that our founding fathers did everything they could to prevent centralizing power in the hands of a few in central government. Many countries have centralized for performing clinical and economic assessments, but all of these countries also have a centralized payer system. Financing for this comparative effective center will be through direct appropriation by Congress (in other words, the taxpayer). Secondly a small charge or fee could be assessed on all users, providers, or suppliers of health care.

Regarding the Physician Quality Reporting Initiative, for 2008 CMS is required to publish a proposed set of quality measures for 2008 in the Federal Register no later than August 15, 2007. The 2008 measures will include structural measures such as electronic health records or e-prescribing.

Regarding the National Provider Identifier, on or after May 23, 2007, physicians and other health care providers are required to use their National Provider Identifiers on standard electronic transactions adapted by HIPAA. In addition, physicians and other providers need their NPI to be identified on electronic transactions performed by other entities. Pharmacies must use the NPI of a prescribing physician to submit the claim; hospitals must use the NPI of an admitting and attending physician to submit electronic claims to the health plan. Health care providers will need the NPI of the referring physicians to submit claims electronically. Without proper use of your National Provider Identifier you can see a slow down in payments. Resources are available through the CMS website: www.cms.hhs.gov/NationalProvIdentStand/.

The President calls for most Americans to have access to electronic health records by 2014. The President by executive order established a position of national coordinator for health information

technology. In 2005 Secretary Leavitt, announced the formation of the American Health Information Community, a federal advisory committee. In May 2006, the American health Information Community delivered its first set of recommendations. The Secretary officially accepted these unanimous recommendations in four work group areas: one, consumer empowerment to create a consumer directed and secure electronic health care registration information and medication history for patients; two, chronic care to use secure messaging such as 3-mail for communication between patients and their health care providers; three, electronic health records to create standardized records of past and current laboratory test results as accessible by health professionals; and four, to enable and transfer standardized and anonymous health data to authorized public health agencies within 24 hours.

Regarding medical transparency, Medicare plans to provide its beneficiaries with information on physician performance as part of its better quality information to improve care for Medicare beneficiaries. Under the project, Medicare data will be combined with data from other insurers to produce information on performance of health care providers. The performance information will be given to physicians and to Medicare beneficiaries.

A number of bills have been introduced regarding a way to reduce the number of uninsured Americans and expand health care to all in need. The one that appears to have the backing of the AOA is the Healthy Americans Act, Senate Bill 334, submitted on January 18 by Senator Ron Wyden, Democrat of Oregon, and this bill would provide universal health coverage to all Americans by requiring each adult to purchase the Healthy Americans Private Insurance Plan.

Regarding the physician work force and graduate medical education, there was a Resident Physician Shortage Reduction Act of 2007 HR1093/Senate Bill 588. The purpose of the bill is to enhance America's health care infrastructure by expanding the number of residency training positions in states with an existing shortage of residents. Also regarding the funding of resident education, there have been proposed changes in Medicare policy on the training of residents in non-hospital settings. This is a complex formula that will require hospitals to reimburse training done outside the hospital in private physician offices or clinics.

Again, several bills have been

attempted in Medicare liability reform. Medicare Access Protection Act of 2007, Senate Bill 243, and Healthy Mothers and Healthy Babies Access to Care Act of 2007, Senate Bill 244. These bills are not likely to be considered as stand alone measures, nor will they receive committee attention. However, their introduction makes them available to be used as amendments to other legislation.

The Osteopathic Graduate Medical Education Department Initiative early this year developed a new initiative to assist non-teaching hospitals that went to start Osteopathic medical Education Programs. Assistance from the initiative also will be available to existing teaching hospitals with Osteopathic Programs that are struggling. Today, eight new Colleges of Osteopathic Medicine or branch campuses are seeking accreditation as several other institutions are considering similar action. The key of the initiative is a core of consultants knowledgeable about OGME, and ready to work with perspective teaching hospitals. Working with the OPTIs, the consultants will meet with hospital and physician leadership, answering questions about OGME and the AOA and provide information about Medicare payment, educational program accreditation, OPTI requirements and the profession.

During the meeting the committee identified the following barriers to the development of new OGME programs: cost, resources, uncertainty, lack of internal support, availability of AOA Board Certified DME's, Program Directors and Faculty, administrative requirements, paper work and student perceptions of quality. One proposal was that specialty colleges should be urged to remove barriers to beginning new programs where AOA trained personnel is not immediately available. Given expanding needs for post-graduate training, the profession faces a paucity of OGME leadership. As Osteopathic and Allopathic enrollments increase, Osteopathic graduates will be forced out of ACGME programs. Osteopathic students also could be put at a competitive disadvantage by Allopathic schools that pay hospitals for student rotations.

These issues will hit us in the face within a very few short years. We need to make efforts to expand our programs now to be prepared.

2007-2008 COMMITTEES

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AWARDS—Drs. James Gaunt and Glen Hatcher, Co-Chairman, Dr. John Alway, Advisor.

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EDITORIAL —Dr. Donald Rothen, Chairman, Dr. Edward Scheiner, Advisor, members: Barry Edison, Donald Sesso and Leonid Skarin.

EDUCATIONAL NEEDS REVIEW SUBCOMMITTEE—Dr. Thomas Brandeisky, Chairman, Members: Drs. Arlin French and Joseph Olekszyk, Senior Advisors, Drs. Mahmoud Ghaderi and Sirtaz Sibia, junior members and 2008 ACA program chairmen, Drs. Sanjay Kamat and Benjamine Mark Welch, sophomore members and 2007 midyear seminar program chairmen, Drs. Libby Smith and Daryl Zelenak, freshman members.

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Human Papilloma Virus Linked to Throat Cancer

By Paul E. Burk, DO

Human papilloma virus (HPV), known to cause a range of anogenital cancers, has also been associated with a dramatically increased risk of some throat cancers, according to researchers.

In a case-control study of newly diagnosed oropharyngeal squamous-cell carcinoma, infection with virus type 16 was associated with nearly a 15-fold increase in risk, according to Maura Gillison, MD, PhD, of Johns Hopkins.

And seropositivity for the type 16 virus—regarded as a measure of lifetime exposure to the virus—was associated with a 32-fold increase in risk, Dr. Gillison and

colleagues reported in the May 10 issue of the *New England Journal of Medicine*.

Oral sex is probably the main way the virus is transmitted, the researchers said, although mouth-to-mouth transmission—as in kissing—can't be ruled out.

"It is important for health care providers to know that people without the traditional risk factors of tobacco and alcohol use can nevertheless be at risk for oropharyngeal cancer," said Cypsyamber D'Souza, PhD, of the Johns Hopkins Bloomberg School of Public Health, a study co-author.

The HPV link has been suspected for some time, Dr. Gillison and colleagues said, mainly because molecular evidence shows that 26% of all squamous-cell carcinomas of the head and neck have signs of oncogenic HPV and the proportion is higher for oropharyngeal cancer.

A recent study sampled participants' blood and saliva, collected information—using an anonymous questionnaire—on sex practices, tobacco and alcohol exposure, family history, and oral hygiene.

The study found that genetic material from HPV 16 was present in 72% of the tumors. Also:

- Oropharyngeal cancer was associated with active oral HPV-16 infections, with an odds ratio of 14.6 and a 95% confidence interval from 6.3 to 36.6.
- Cancer was also associated with oral infection with any of 37 types of HPV, with an odds ratio of 12.3 and a 95% confidence interval from 5.4 to 26.4.
- Cancer was associated with seropositivity for the HPV-16 L1 capsid protein, with an odds ratio of 32.2 and 95% confidence interval from 14.6 to 71.3.

The analysis also found that a high lifetime number of vaginal-sex partners—defined as 26 or more—was associated with cancer. The odds ratio was 3.1, with a 95% confidence interval from 1.5 to 6.5.

The same was true for a high lifetime number of oral-sex partners (defined as six or more), where the odds ratio was 3.4 with a 95% confidence interval from 1.3 to 8.8.

The researchers found that the link became stronger as the numbers of vaginal-sex and oral-sex partners increased—the P-values for the trends were 0.002 and 0.002, respectively.

Interestingly, although tobacco and alcohol use are traditionally considered the key risk factors for oropharyngeal squamous-cell carcinoma, the study showed no added risk for tobacco and alcohol users.

This study raised the following thoughts by Dr. Syrjänen, including:

- Is there a need to screen high-risk groups, such as smokers and drinkers, for persistent oral and oropharyngeal HPV infection.
- Whether HPV-associated cancers should be treated in the same way as those that are HPV-negative, but linked to heavy smoking and drinking.
- Whether some oral, oropharyngeal, and laryngeal cancers might be prevented by HPV vaccination.

Ref: *MedPage Today*, May 9, 2007.

Baucus, Grassley Continue Work for Independence of Continuing Medical Education

In a letter sent to the Accreditation Council for Continuing Medical Education (ACCME), the senators urged greater oversight by the council to better ensure that the content of CME programs is independent from the business interests of the drug companies who fund the programs. Their letter follows an extensive report issued by the senators.

The Finance Committee report was two years in the making and addresses the pharmaceutical industry's use of educational grant funding to promote the use of their drugs, including unapproved uses of some medicines. Earlier, Eli Lilly and Company announced that it will begin posting online all educational grant funding that it provides. Lilly is the first pharmaceutical company to disclose its grants to medical societies, academic centers, patient groups, commercial continuing medical education providers, and non-profit institutions. Baucus and Grassley said they hoped that other drug companies would take similar action.

Baucus is Chairman and Grassley is Ranking Member of the Senate Committee on Finance.

The text of their April 25, 2007 letter to the Accreditation Council for Continuing Medical Education is below.

LETTER: April 25, 2007
Murray Kopelow, MD
Chief Executive, ACCME

Dear Dr. Kopelow: Thank you for your informative response to our letter of December 14, 2006. The insight you provided on the accreditation process for CME helped us in our exploration of the pharmaceutical industry's use of educational grant funding.

Given the increasing Medicare and Medicaid expenditures on prescription drugs, the United States Senate Committee on Finance (Committee) has an interest in reviewing how pharmaceutical manufacturers use grant funding in ways that may increase program costs or endanger beneficiaries. On April 25, 2007, we released a Committee Staff Report summarizing the results of our inquiry. The full text of this report is available on the Committee's website at www.senate.gov/~finance/press/Bpress/2007press/prb04257.a.pdf

Our inquiry revealed that the pharmaceutical industry spends more than a billion dollars a year to fund CME programs that are accredited by the ACCME. Funding of ACCME-accredited programs represents a substantial portion of drug company spending on educational grants. Our inquiry also revealed that drug companies typically fund CME as part of a broader business strategy to support the company's brands. Many of the drug companies informed us that they rely on a provider's ACCME-accreditation to demonstrate that their grant money is spent on education and not on marketing. In keeping with ACCME's policies, ACCME-accredited CME should differ from the drug company's own marketing and promotional activities in that the drug company should not exercise control over the content of CME. Our letter to ACCME sought information about how ACCME ensures that the CME providers it accredits actually operate with the required level of independence, and without allowing program content to be controlled or influenced by the drug company sponsors.

Your response helped us understand the process by which ACCME oversees the activities of CME providers. You reported that ACCME reviews accredited CME providers at intervals of two, four, or six years, depending on the CME provider's past history of compliance. In conducting these re-accreditation reviews, ACCME primarily relies on three sources of information: (1) self study reports—written by the CME provider and submitted to ACCME; (2) accreditation interviews—conducted by two individuals from ACCME involving an interview of representative(s) of the CME provider; and (3) sampling of CME activities—ACCME selects a sample of the CME provider's CME activities (usually 15 activities per provider) and asks the CME provider to submit a documentary file on each activity. ACCME then reviews the documents submitted to look for policies and procedures indicating that the CME provider complied with ACCME policies.

Based on your response, it appears that ACCME review of CME providers relies exclusively on information supplied by those

providers. ACCME review also appears to focus on the documentation surrounding the process for funding and creating CME activities, as opposed to the substance of the activities themselves. For example, it does not appear that ACCME review involved analyzing the content of the educational activities created for accuracy, to determine whether the activities include a fair and balanced discussion of competing therapeutic options, or whether the activities favor products manufactured by the commercial sponsor.

We understand that CME activities typically involve in-person lectures, broadcasted lectures, web-based content, self-assessment questions, and various other types of written materials. In addition to the scripted material, CME programs may involve answering questions from the audience. ACCME representatives conducting re-accreditation reviews do not sit in on CME lectures, or review recordings of these lectures, to assess the speakers' core presentations or their responses to audience questions. Similarly, ACCME representatives conducting re-accreditation reviews do not routinely assess the written materials used in CME activities for scientific accuracy or balance.

Based on your response, it appears that ACCME conducts a retrospective view that relies on information supplied by the CME providers, and does not involve independent investigation by ACCME staff or collection of information from physicians or other audience members who participated in CME activities. Given the nature of ACCME review, it does not appear that ACCME would detect CME providers' voluntarily catering to their drug company sponsors by developing CME content that favorably presents the sponsors' drug products, nor would this practice necessarily violate ACCME policy. Although we suspect that the drug companies preferentially fund CME activities that they expect will promote sale of the company's products, we do not know how pervasive this is. ACCME does not collect data on whether ACCME-accredited CME providers product activities that disproportionately discuss favorable message, either on-label or off-label, for products marketed by the drug companies that fund the activities.

ACCME uses the re-accreditation review process to determine whether the CME provider should retain accreditation. Your response indicates that ACCME conducts this review to determine whether or not a CME provider generally complies with ACCME standards, as opposed to whether an individual CME activity was conducted in compliance with ACCME standards. Your

letter described the re-accreditation process as follows: "ACCME compliance findings are determined at a provider level, not the activity (or presentation) level. Generally speaking, when the ACCME finds that 80% of activities are found 'in compliance' from documentation review, then the ACCME will find the provider 'in compliance' with the accreditation element." The Committee found this troubling, to the extent it means that a CME provider would be deemed to be in compliance with ACCME standards even if ACCME determines that some of the provider's educational activities failed to comply with all ACCME standards.

Your response included results of re-accreditation reviews recently completed by ACCME. You reported that ACCME has reviewed 76 accredited CME providers for compliance with the ACCME standards for commercial support that were promulgated in 2004. ACCME found that 18 of these CME providers were not in compliance with at least one element of the ACCME standards. Examples from ACCME's written findings of non-compliance include:

- The provider does not ensure that decisions regarding the planning and implementation of CME activities are made independent of commercial interests. A commercial interest influenced where and how many presentations were scheduled for three years of a CME activity.
- The provider does not ensure that decisions regarding the planning and implementation of CME activities are made independent of commercial interests. Evidence from one activity reviewed indicates that a commercial interest was involved in the selection of faculty and other activities that interfered with independence.
- The provider does not ensure that a mechanism(s) has been implemented to identify and resolve all conflicts of interest prior to education activities being delivered to the learner.
- The provider does not demonstrate appropriate management of commercial promotion associated with educational activities. One commercially supported activity contains recurring use of one company's product trade name at the exclusion of other products.

Your response also described the series of events that may occur if ACCME determines that a CME provider is not in compliance with ACCME standards. To summarize, the CME provider enters a multi-year corrective action process that might eventually result in losing accreditation.

You informed us that when ACCME finds that an accredited CME provider is not

in compliance, the CME provider is afforded an opportunity to provide ACCME with a written submission that describes the provider's compliance. The CME provider is generally allowed one year to submit this progress report to ACCME. If ACCME decides that the progress report adequately demonstrates compliance, no further action is taken. If ACCME decides that the progress report does not adequately demonstrate compliance, then the provider may be allowed six additional months to submit another progress report. If that second progress report also does not demonstrate compliance, ACCME may put the provider on probation. If the CME provider does not resolve the problem after two years on probation, ACCME may rescind accreditation. ACCME's finding of non-compliance is merely the first step down a long road to potentially losing accreditation, which may occur up to 3.5 years after the initial finding of non-compliance and, depending on the review cycle, as many as nine years after the problematic educational activities occurred.

The Committee's inquiry suggested that whether an educational program is independent is a critical feature distinguishing CME from advertising and promotion. Because drug manufacturers cannot legally promote their products for use that have not been approved by the FDA, it is particularly important for educational programs that discuss off-label uses to be independent. Whether a drug company is breaking the law by promoting off-label use of its drugs hinges on whether a CME provider independently touts an off-label use or whether the promotion can be attributed back to the drug company.

Given the importance of the concept of independence, the Committee's request for information from ACCME also sought delineation of the scope of independence the CME provider must have in selecting the topic for a commercially-sponsored CME program. ACCME's response indicated that a commercial sponsor can designate the topic (e.g., diagnosis or treatment of a particular disease) for the CME activity, without being determined to control content or otherwise violating ACCME policies. This would appear to afford drug companies substantial opportunity to direct their grant funding to support programs that are likely to promote sales of their products.

We do not have information about the extent to which this is the case in practice. ACCME does not keep track of how many CME programs favorably discuss a drug sold by the commercial sponsor, either for an FDA-approved indication or for an off-label use. ACCME does not gather information

regarding whether the CME providers' educational activities favorably discuss uses of the commercial sponsor's products in a fashion that is disproportionate to what might be expected from an independent activity that does not cater to the sponsor's commercial interests.

Our review suggests that CME providers could say that they "control content" and have "full independence" in developing CME activities, even though they allow the commercial sponsor to influence content. The drug companies' response to our inquiries indicate that some companies' policies for funding CME allow the drug companies to offer CME providers suggestions for CME topics and speakers. Some policies also allow the drug companies to provide data, including data regarding off-label uses, for inclusion in CME programs, so long as the CME provider requests this assistance. Thus, the CME provider can technically maintain "control" of content—to the extent that the commercial sponsor's suggestions are not imposed in an explicitly mandatory fashion—while continuing to accommodate suggestions from the companies that control their funding.

Based on our analysis of the information you provided, we find it interesting that, even though ACCME's reaccreditation process relies almost exclusively on information supplied by the CME providers under review, ACCME still detects a significant number of incidences of noncompliance. It also appears that compliance with ACCME standards still allows CME providers to accommodate the business interests of their commercial sponsors and affords drug companies the ability to target their grant funding at programs likely to support sales of their products. The full extent to which drug companies influence the content of putatively independent CME programs cannot be estimated from the information we currently have.

Thank you for your assistance with this matter. We greatly appreciate your cooperation with the Committee's inquiry.

Sincerely,
Max Baucus of Montana
United States Senator
Chairman, Committee on Finance

Chuck Grassley of Iowa
United States Senator
Ranking Member, Committee on Finance

Job Opportunity **AOCOO-HNS Executive Vice President (CEO)**

The American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery is seeking an experienced and dynamic physician-leader to serve as the Executive Vice-President (CEO) for the AOCOO-HNS Board of Governors. This would entail a period of time serving in a mentorship program with the current EVP prior to assuming the position.

The principal responsibilities of the position include:

- Overseeing staff employees
- Carrying out administrative work of the corporation
- Establishment of administrative policies
- Implement directives of the Board
- Coordinate meetings and activities of the Board
- Prepare annual budgets and review all financial activities
- Maintain fiscal responsibility of all Colleges' activities
- Maintain close working relationships with the AOA and activities of the Colleges'
- Serve, together with the President, as spokesperson for the Colleges' and Foundation
- Maintain the legal integrity of the Corporation
- Work with the Boards to plan meetings and develop strategies and agendas
- Attend all College associated meetings including the AOA (approximately 12-14 per year)
- Perform all on-site inspections of proposed meeting locations.

Interested candidates should have a working knowledge of the AOA and in particular, the workings of the Bureau of Education, its committees, and the AOA Board of Trustees.

Please request an application form, which is to be sent together with your current CV to Carlo DiMarco, DO, c/o AOCOO-HNS at 4764 Fishburg Road, Suite F, Huber Heights, OH 45424.

Direct all inquiries in writing to the Search Committee Chairman, Carlo DiMarco, DO at the address listed above.

Ophthalmology Opportunities

ARIZONA

- Busy eye group with heavy medical and surgical caseload seeks BE/BC comprehensive ophthalmologist for full/part-time. Fellowships welcome. Competitive salary and benefits package leading to partnership. Contact Craig Cassidy, DO at 480-833-0014 or email: cassidyeyes@aol.com.

KENTUCKY

- Excellent opportunity to join a solo ophthalmologist, desiring to slow down. Opportunity for partnership after one year. Competitive salary and benefit package. Brand new office equipment. New office building. Associate with optometrist. New hospital with state-of-the-art outpatient surgery. Call Dr. Kay Hazelett 606-424-8721.

NEVADA

- Established otolaryngology/ophthalmology practice seeking BC/BE ophthalmologist to compliment group. The practice has three state-of-the-art offices in Henderson and Southwest Las Vegas Valley. All offices are located in community oriented high profile areas with one of the offices adjacent to the Seven Hills Surgery Center and the new Southwest office, located next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. Contact Judy Duncan at jduncan@nveyepa.com or 702-492-6928.

OHIO

- Opportunity in Ohio—small town north of Dayton. General ophthalmology practice with partnership/ownership. Send C.V. and indicate intentions to: Gregory T. Schamaun, DO, 6050 St. Rt. 571 East, Greenville, OH 45331.
- Excellent anterior segment/glaucoma surgeon needed for group practice in Maumee, Ohio. Practice in a new state-of-the-art facility and ambulatory surgery center with all amenities. Salary plus incentive with buy-in after two years. Send CV to Ronald m. Kendrick, DO, 3509 Briarfield Blvd., Maumee, Ohio 43537. Phone 1-800-782-9214, FAX 419-865-3451..

PENNSYLVANIA

- Opening in a busy ophthalmology practice. Contact: Jane Kokinakis, DO, office # 800-845-8424.

WEST VIRGINIA

- Glaucoma specialist wanted. Join a team of two ophthalmologists and one optometrist bringing high quality care to Southern West Virginia. Best equipment available. Starting salary up to \$250,000.00. Shape your own practice but surgical opportunities are limited only by your skills. Contact mkrasnow@marshall.edu or call Bettie Chapman at 304-697-0393.

WASHINGTON

- OPH wanted in beautiful Washington State. Opportunity for someone interested in aggressively expanding a practice, or someone interested in working half-time and sharing the practice. A new DO medical school is being built in Yakima. There is opportunity for any level of participation. Hospital owned ASC with all new equipment. Call Dr. Leo Figgs 509-952-8545.

Ophthalmology Fellowship

OHIO

- Refractive fellowship position available, LASIK Plus, Cincinnati, Ohio. Contact Vincent Marino, DO at 513-652-9585 or email marino@fuse.net.

Otolaryngology Opportunities

ALASKA

- ENT wanted. Kenai Peninsula, S.W. of Anchorage. Excellent salary and benefits. Call or email: James Zirul, DO, 220 Spur View Drive, Kenai, AK 99611, call 907-283-5400, email jzirul@acsalaska.net.

ARIZONA

- 320 days of sunshine per year! Become part of a busy, expanding otolaryngology/head and neck/facial plastic surgery practice with full audiology services in the metropolitan Phoenix area. Seeking a BC/BE associate with early partnership opportunity to join our successful team. Competitive salary and benefits. Attractive lifestyle. Please contact Dr. David Mendelson (480) 894-5550 or fax CV to (480) 894-9469 or email to info@entsoa.com.

COLORADO

- Dr. Patrick Henderson is looking for an otolaryngologist to join established practice in beautiful Montrose, CO. Small and growing community at the base of San Juan mountain Range. Within 1 hour drive of Telluride Ski Resort, hiking, trophy fishing, mountain biking and camping facilities. Town of Montrose is top 10 growing communities in the nation with abundant sunshine for outdoor enthusiast. Call office (970) 249-6968 or email coentpc@frontier.net.

FLORIDA

- Central Florida Otolaryngology group is recruiting BC/BE otolaryngologist to join rapidly expanding practice. Two clinic sites, Leesburg and The Villages and our main OR site has accreditation from AAAASF. We have four BC ENT physicians, one of which is BC in Facial Plastic & Reconstructive Surgery. We have an Allergy department and complete audiology services with two doctors of audiology and a BC hearing aid specialist on staff plus electronic medical records. We offer good schools with a suburban lifestyle in beautiful Lake County. Excellent salary with partnership anticipated. Contact info: michelle.lakeent@earthlink.net or call 352-728-2404.
- Outstanding opportunity to join very busy otolaryngology/facial plastic surgery practice with partnership track income. Hollywood — Pembroke Pines, Florida. Contact: Dr. Craig Shapiro, 954-437-5333 or fax: 954-437-6252, shap62@aol.com.
- ENT job opportunity located in Ocala, Florida, one hour north of Orlando. Practice is looking for BC/BE general ENT/facial plastic surgeon to join group of 3 general ENT's. Contact Dr. Scott Nadenik, cellular 362-895-0285.

MASSACHUSETTS

- Work in the heart of beautiful New England. Extremely busy practice in North Central Massachusetts seeking associate. Currently one physician doing all aspects of general ENT. Shared call with three others. Community hospitals. This is an excellent opportunity with close proximity to mountains, beaches, and Boston. Contact Dr. Daniel Ervin at (978) 874-7368.

MICHIGAN

- Northwest Michigan practice opportunity. A busy 2 physician practice seeking BC/BE ENT to join practice affiliated with 2 community-based hospitals. For further information contact Andrew Mendians, DO at 231-843-6557 or mendians@voyager.net.

NEW MEXICO

- Second BE/BC general otolaryngologist needed for rural practice area in Carlsbad, New Mexico. Mild climate year round in high desert country with nearby mountains and endless outdoor activities. Guaranteed compensation the first year

with incentive bonus. Triad owned community hospital. For more information contact Fred Woody, CEO at Carlsbad Medical Center, 505-887-4570.

OHIO

- Seeking an otolaryngologist for position/ownership in an established practice located in Troy, OH. The practice has a well established patient base in Otolaryngology, Allergy and Facial Plastics. The practice has been in this location 20+ years. If interested, please contact Deborah or Georgia at 937-335-7278 or fax to 937-335-1783.

- ENT BC/BE needed in Newark, OH thirty minutes east of Columbus. Need an additional solo practice physician, 167 hospital undergoing continual upgrading. Additional information can be obtained by calling Michael Ehler at 740-788-6010.

PENNSYLVANIA

- Busy otolaryngology practice in greater Philadelphia area looking for associate with partnership potential. Excellent compensation and benefit package. Contact: Dr. Ben Chack, 301 Oxford Valley Road, Suite 1201A, Yardley, PA 19067, phone (215) 321-6660.
- Excellent job opportunity in Chester County, minutes from Philadelphia. Very busy 3 physician ENT practice seeking an additional BC/BE otolaryngologist to join our practice. Unbelievable opportunity for early partnership. Contact Alex Keszeli, DO, at 484-437-8745.

TEXAS

- ENT practice opportunity in Corpus Christi. Large group, full practice with speech, audio, balance center, C.T. MRI and surgery center. Need two ENT and one neuro-otologist. Con-tact Troy Creamean, DO at 361-854-7000.

WASHINGTON

- Practice opportunity in the beautiful northwest. Seeking associate in general ENT and proficiency/interest in FPS, otology and allergy desirable. New Osteo. Med. School to open fall 2008 with op. for ENT academic position in addition to private practice. Merging two separate ENT groups to form a single group by 2008 that serves 300K regional patient draw with a current ENT manpower shortage. Strong and respected D.O. community, two hospitals and two ASC's. Contact: Palmer Wright, DO, 3999 Englewood Ave. #201, Yakima, WA 98902, 509-453-5300 or email palmer@yvn.com.

Otolaryngology Fellowships

MICHIGAN

- Training program in otolaryngic allergy as a one year continuous or two to three year interrupted, program at St. John Oakland Hospital in Madison Heights, Michigan under the direction of Donald M. Rothen, DO. This program became effective July 1, 2001 and is approved by the AOA for three positions. To be eligible, the candidate must be certified in otolaryngology. For further information, please contact Dr. Rothen at 248-541-0100 or email rothenph@hotmail.com

NEW YORK

- Pediatric otolaryngology fellowship starting 2004, 2005, 2006 at the Women & Children's Hospital of Buffalo. Exceptional opportunity for a 1 or 2-year fellowship covering all aspects of pediatric otolaryngology including complex otolaryngology, cochlear implantation, treatment of vascular birthmarks, laser surgery, airway management, maxillofacial trauma, facial plastics and sinus surgery. Clinical and basic science research is encouraged. Practice has five fellowship-trained pediatric otolaryngologists. Address inquiries to Philomena Behar, MD, email: pmbear@aol.com.