

Quarterly Report



AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Fall 2008, Vol. 43 No. 4

Mid-Year Seminar... a Success

The 7th Mid-Year Seminar sponsored by the AOCOO-HNS Foundation held at the Westin Detroit Metropolitan Airport Hotel on September 6-7, 2008 was another huge success. We are proud to report an attendance of 220, approximately 50 of which were medical students and interns.

Special Thanks to

Libby J. Smith, DO
Otolaryngology Program
Chairman

Daryl J. Zelenak, DO
Ophthalmology Program
Chairman

SPEAKERS

Wayne F. Bizer, DO
Thomas L. Carroll, MD
Richard C. Chu, DO
Matthew E. Citron, DO
John G. Dodd, DO
Jacqueline L. Gartner-Schmidt, PhD
Mahmoud M. Ghaderi, DO
David D. Gossage, DO
Roxann Diez Gross, PhD
Michael L. Habryl, DO
Michael S. Hauptert, DO
David B. Krebs, MD
Kevin T. Lavery, MD
Sayoko E. Moroi, MD, PhD
Leslie K. Norris, DO
Timothy P. Page, MD
Maria Donna Oahwash, DO
Steven A. Shanbom, MD
Sirtaz S. Sibia, DO
Libby J. Smith, DO
Glenn Sussman, BS
Brian E. Trainor, DO
Mikhail Vaysberg, DO
Kevin L. Waltz, MD
David O. Wilson, MD, MPH
Charles J. Zeller IV, DO

Mid-Year Seminar Exhibitors

Alcon Laboratories, Inc.
ALK-Abello
Allergan/Inspire
AllMeds, Inc.
Elsevier/Mosby/Saunders
GE Healthcare-Surgical Navigation
HUB Pharmaceuticals
IRIDEX Corp.
JEDMED Instrument Co.
OASIS Medical, Inc.

The 8th Mid-Year Seminar will again be held at the Westin Detroit Metropolitan Airport Hotel - September 12-13, 2009.

Mark Your Calendars - 94th ACA
May 6-10, 2009

Hyatt Regency Lost Pines Resort in Austin, TX

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

Quarterly Report Timelines

As a member of the AOCOO-HNS, you may submit articles for publication. Times for our Quarterly Report are listed below.

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

Thomas E. Brandeisky, DO



For those of us who did not attend the ACA at the Camelback Inn, it was the best attended meeting of our organization, surpassing the 2005 ACA by approximately 40 registrants. The venue was very attractive, offering comfortable accommodations, outdoor activities and incredible weather, similar to many of our conference sites. However, it is the sincere hope of the members of your Board of Governors, and me as Educational Needs Review Committee (ENRC) Chair, that CME programming will become the overriding reason to attend our functions.

The ENRC has been functioning for approximately three years. Members commit themselves to four consecutive years of service in order to learn what is needed to put on a program, and chair one Mid-Year Seminar and one ACA meeting. Ideally the ophthalmology and otolaryngology subcommittees of the ENRC function separately to develop their programs and cooperate on common elements such as the A.B. Crites Memorial Lecture and academic or practice related topics of collective interest.

The June 21, 2008 ENRC conference call concluded that each specialty subcommittee will keep three successive meetings in development at all times. This will allow programs to be advertised on our website for critique and improvement by the membership, who could then plan to attend our meetings based on program content, not just CME requirements.

The Education Committees of the AOCOO-HNS are working to determine the curriculum items that would help our members with Osteopathic Continuous Certification. They will be busier when the AOCOO-HNS Task Analysis is complete. Their recommendations will be used by the ENRC to shape our CME programs. This data will help us focus on up-to-date issues that are of importance to our everyday practice. We hope to develop educational methods and materials that facilitate learning and ultimately help us improve practice patterns for the benefit of our patients.

These are the goals of the new CME process and the ENRC.

To accomplish these goals dedicated men and women of our Colleges must make themselves available to take ownership of our goals and partnerships in this process. But greater numbers on the various committees will not answer the challenge before us. For the past three years the ENRC has worked through conference calls, a format which facilitates decision making but produces little work. Program chairs have worked largely on their own to develop their curricula, without planned linkage to prior or upcoming programs. This challenge of program linkage must be met if our meetings are to continue to improve.

Since last year, the Board of Governors has been considering adding a CME coordinator to our administrative staff. This person would greatly impact on this issue by tracking all programs in development, while coordinating the work of the ENRC. Additionally, the ENRC members must be given the time and place to be productive. As an example, the productivity of the Council of Medical Education depends on face-to-face sessions where work is completed and information is disseminated. To establish the ENRC on the same footing, the Board of Governors reassigned the ENRC to the Foundation, and the Foundation approved a budget for the ENRC to travel to work meetings twice a year. The model of work session coordinated by a dedicated coordinator should effectively provide for our CME needs.

We will be instituting two educational initiatives to enhance resident and student involvement in our Colleges. First, I'm asking the Council of Residents and Fellows (CRF) Chairs to become resident members of the ENRC with the specific goal of formulating a program for the students who attend our ACA meeting. The topics covered initially will help them on rotations, prepare them for residency positions, and give them a perspective on the workings of the Colleges and the service opportunities that await them. Second, because our residencies must produce better quality academic papers and encourage research, a Research Forum will be made part of the Mid-Year meeting. The Research Forum would be a preview of the posters to be presented at the ACA, give students a chance to get involved with

resident projects, and be an opportunity for residency program directors and residents to share thoughts on each other's projects, stimulate research, and maintain the quality of the projects. The Editorial Committee will be instrumental at these sessions, where the fine points of paper writing can be taught, and research ideas can be reviewed, enhanced and improved. Residents ideally would work all year on their projects, preparing first for the Research Forum, then bringing their projects to fruition through a quality academic paper and poster presentations.

I am confident that our ENT members will soon have the opportunity to obtain a Certificate of Added Qualification in Sleep Medicine. Benjamin Murcek, DO, the AOBOO-HNS President, has been working to make your interest known by petitioning to join with the newly formed Conjoint Examining Committee. In support of his efforts, I have requested a copy of the Training Standards in Sleep Medicine from the AOA. Submitted by the American Osteopathic Board of Internal Medicine, American Osteopathic Board of Preventive Medicine and others, the document was approved by the AOA Board of Trustees at the meeting I attended July 14-20. Once available, the Standards will be reviewed by Donald Sesso, DO who will make recommendations regarding changes appropriate for our specialty. However, a certificate can only come through examination. The dedication of Dr. Murcek and the AOBOO to the growth of our specialty and the support of our membership in this way is exemplary. I offer them my sincere thanks and those of our Otolaryngology College members.

On September 20th I was in Chicago for the American Academy of Otolaryngology's Board of Governors meetings. Conferences on leadership development and public relations were the focus.

The AAO-HNS has budgeted \$100,000 for public relations campaigns that will raise awareness of the American public by defining the ENT specialty, helping them choose otolaryngologists to care for them.

Multiple examples were cited at the Legislative Representative meeting of successful efforts on the part of the AAO-HNS to block state house and congressional action that would adversely impact the ENT specialty. Bill AB 610/SB 389 in Wisconsin "sought to expand the scope of Audiology to include diagnosis, treatment, and management of hearing, vestibular, or any other related abnormal condition and

likened audiologists to physicians with regards to providing medical advice prior to dispensing hearing aids." The AAO-HNS and Wisconsin Society of Otolaryngology-Head and Neck Surgery worked with the Wisconsin Medical Society to defeat this bill. In Maryland, HB 614 sought to impose a 6% elective cosmetic procedures tax, but was defeated by concerted efforts of the AAO-HNS and other stakeholders in the issue. And Illinois HB 5497 was aimed at limitless expansion of the scope of practice for Speech and Language Pathologists (SLP) allowing them to perform "instrumental procedures, including flexible and rigid endoscopic procedures, with little or no physician involvement." Because the AAO-HNS members in Illinois intervened at an appropriate stage, the bill has been delayed and will not move out of committee until an agreement had been forged between SLP and ENT.

For years Wayne Bizer, DO and Paul Imber, DO have been working tirelessly on advocacy issues for our members at the Bureau of Federal Health meetings in Washington, D.C. The Ophthalmology College, in concert with the American Academy of Ophthalmology, has also shown us how important prioritizing advocacy is in today's practice environment. Advocacy is not just for ophthalmology anymore, as these three examples demonstrate. Therefore, I will ask our representatives to the Bureau of Federal Health to participate in our Board of Governors meetings twice a year. I hope with time others will join them in their efforts and support the Board's activities through this channel.

The Foundation continues to search for a charitable outlet through the efforts of our past resident, Shoib Myint, DO. We hope including a charity in our social events will enhance the mutual success of each organization and increase the opportunities for membership involvement. We are looking closely at the National Coalition on Deafblindness (NCDB), but others will be considered.

Finally, the Executive Vice President Search Committee held their final meeting in Philadelphia, at the Union League, in June. At our September meeting, the Board of Governors received, considered, and adopted the recommendation of the committee. Carlo J. DiMarco, DO was selected to be the next Executive Vice President. He will mentor with Alvin D. Dubin, DO until assuming all of his duties in 2010. The Search Committee's task was a difficult one. I can only say this about

their service to you. Dr. Imber and his committee members completed their task with all due diligence, prudence, and foresight. During my years of participation in the governance I can recall no single decision of greater meaning, and thanks to the Presidents who served before me, this committee was given the time it needed to complete their mission. From beginning to end I have witnessed your past, present, and future College leadership collectively engaged to secure this organization. And I call on every member of our College to support the Search Committee and the Board of Governors.

Preliminary programs for the ACA will be sent out early in December. Be sure to register early. I am looking forward to seeing you all in Austin.

Have a safe and happy Thanksgiving holiday with your family and friends.

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EXECUTIVE VP REPORT



Alvin D. Dubin, DO

It is certainly rewarding to be able to share with you the continued success of the Mid-Year Meeting that took place in Detroit this past September 4-7, 2008. Together the Colleges, Certifying Boards, Program Chairman and Presenters have worked hard and delivered successful meetings, and well accepted CME course presentations. It is gratifying also to see so many Students from our Colleges of Osteopathic Medicine, Interns and our own Residents attend and be part of the entire program.

We would like to tell you more, at this time, about the Council of Regional Representatives (CRR) and the Council of Residents and Fellows (CRF). A few years ago, these Councils were formed for the purpose of developing better working relationships between the Membership and the Colleges. We felt then, and even more so now, that the Membership should be involved in College activities, and the Board of Governors should encourage, welcome, and utilize the input of its Members (both in practice and resident status) in forming policy activities.

Great care was taken to change the Bylaws in order to reflect those endeavors

of the Board of Governors, and to enable the Council Members to be part of the Board, to have access to Board activities, and to be part of the decision making process.

I am pleased to inform you that the Council of Residents and Fellows have come together in a meaningful way and are beginning to reach their potential in being an active participant, not only with the Board of Governors meetings, but also in relating back to their fellow residents the Colleges' activities. The CRF leadership will continue to assess resident survey responses and these will be distributed to the Board of Governors for their review.

The Council of Regional Representatives activities have lagged behind and have not reached their potential in Board activities. This problem can and must be addressed. The CRR falls short of the intent to give our entire membership a say in the governance matters. The Colleges have made it possible for the membership to truly participate in all Board of Governor activities. The Councils should do their job by continuing to improve communications within their sphere, and by bringing issues to their representatives.

We refer you to the Colleges' website for further details and help in understanding the structure of the Council. The Administrative Staff and I are there to help you in every way possible to help the CRR continue to do its job in a more meaningful way.

Only by taking advantage of the opportunity to have greater input on the Colleges' Boards will we truly have a membership driven College.

Please be part of the team by calling or writing to your representatives on these Councils, or to us in the administrative areas, about matters of concern or questions that you may have—we are there for YOU—no matter what the topic might be!

With the support and involvement of the membership of the Colleges, we will all benefit and continue to have a proactive body representing all osteopathic ophthalmologists and otolaryngologists.

Member News

*Carlo J. DiMarco, DO
Inducted July 18, 2008 as
AOA President*

Monday, July 21, 2008

AOA PRESIDENT'S BLOG

Hello everyone. Like my predecessors, this is my first foray into the blogging world, but I'm going to give it my best effort and keep the AOA President's Blog going for the third straight year.

As you may already know, I was inaugurated on Saturday, during the AOA's House of Delegates meeting, as the 112th president of the AOA. (If you weren't able to attend, the AOA is going to post my address in text and video if you want to view it. I'll let you know when they are available.)

For my first post, I thought that I'd give you some background about me. Originally from South Philly, I now work in Erie, PA, where I am a professor and regional dean of clinical medicine at LECOM. (Hello to all my students out there!). I also serve as the director of the ophthalmology residency program at LECOM and practice Ophthalmology in Erie.

I am married to Maria and have two grown sons. I come from a strong family of physicians – mostly DOs but some MDs too whom I admire and respect.

During my term, I plan to further the progress made by our past presidents in regards to our Greatness Campaign, with a focus on one critical issue that I believe is at a crisis point – Osteopathic Graduate Medical Education or OGME. I'll elaborate more in future posts, but I invite you to share your thoughts and concerns with me on a regular basis about OGME as well as any other issues.

I will use the AOA President's Blog primarily to encourage discussion between DOs and osteopathic medical students about issues and ideas. The feedback you leave on this blog is very valuable and will help me to stay in tune with your thoughts on the many issues that are so important to the osteopathic family.

Visit Dr. DiMarco's Presidential Blog at <http://blogs.do-online.org/aopresident.php>.

*Frank A. Brettschneider, DO
MD NEWS Cover Story*

April, 2008, Southeast Michigan Edition

PORT HURON ENT

Both chronic sinusitis and nasal polyposis have had the reputation of being incurable whatever the modality of treatment. This was true in the early days, but fortunately things are changing today. The introduction of endoscopes, image-guided minimally invasive functional endoscopic sinus surgery, balloon sinuplasty, sublingual immunotherapy, food allergy assessment and fungal therapy are a few of the innovative treatments that work to cure these conditions.

Approximately 37 million Americans suffer with sinusitis symptoms, making it one of the most common reasons for visits to primary care physicians. "Sinusitis can considerably affect the quality of one's life," says Frank Brettschneider, DO, Port Huron ENT. In addition, sinusitis is responsible for over \$8 billion in health care expenditures per year. In the US, sinusitis is the fifth most common condition for which antibiotics are prescribed. With such a large community problem, both Dr. Brettschneider and Neal Obermyer, MD, continue to make advances and use the most innovative techniques to battle this complex disease.

Overlapping Signs and Symptoms

Different sinus diseases often have similar symptoms. Symptoms such as cough, congestion, dizziness, sneezing, fatigue, headaches, facial pain, halitosis, runny nose and postnasal drainage all may be attributable to many sinonasal conditions. "It's important to match a patient's symptoms to their condition," says Dr. Obermyer. Conditions such as chronic inflammatory rhinosinusitis may mimic other conditions such as fungal sinusitis, sinonasal tumors, allergy or structural problems such as a deviated nasal septum.

"Understanding and appropriately diagnosing these conditions may be difficult in the primary care setting because symptoms, physical findings, radiologic signs and histology may overlap one another. It's important to share information and embrace effective emerging technologies so we can better define our practice, which leads to better patient care," says Dr. Brettschneider.

Maximal Medical Management is a Complex and Frustrating Concept

Medical management of sinusitis focuses

on eradicating bacteria and reducing inflammation. Often this is not effective for a wide variety of reasons. For the acute sinusitis patient, viral infections are self-limiting and antibiotics are ineffective. If the patient has sinus symptoms over three months, other causes such as obstructed sinuses or fungal infections need to be considered. Bacterial resistance has also been a challenge when choosing the correct antibiotic. "When treating for acute bacterial rhinosinusitis, antibiotic therapy should last for 10-14 days and cover *H. influenzae* and *S. pneumoniae*," says Dr. Obermyer. Treatment with antibiotics, corticosteroid nasal sprays, oral steroids, and decongestants are some of the options for the primary care physician. Indications for an ENT specialist referral may include chronic headache, weather-sensitive headache, facial pressure under or over the eyes, suspected orbital or intracranial spread or symptoms lasting longer than eight to twelve weeks.

Innovative, Less-Invasive Surgical Techniques

Surgical treatment of sinusitis is aimed to break the patient's constant cycle of symptoms and improve their quality of life. Goals of surgery are 1) to clear blocked sinuses, 2) to restore sinus drainage and function and 3) to preserve natural anatomy. "We have many surgical options for our patients," says Dr. Obermyer.

Functional endoscopic sinus surgery (FESS) has become an important treatment for patients who do not respond to medical treatment. With the advent of CT imaging, sinus endoscopes and microdebrider technology, FESS has evolved to become the standard for chronic sinus conditions. FESS is performed through the nose and provides greater visualization, which provides safety during this procedure. FESS has evolved to become minimally invasive FESS, or MIST. "Minimally invasive sinus technique (MIST) first allowed us to use endoscopically powered instrumentation," says Dr. Brettschneider. This improves visualization and accuracy in surgery with much less bleeding and tissue trauma. Of course, this translates into more patient comfort and a quicker recovery.

Balloon sinuplasty is a new advance in the field of sinus surgery. The FDA has approved the use of catheter-based devices for opening the sinus cavity. Using these balloons is much less invasive and is still safe and effective.

Image-guided CT scanning and sinus surgery is another great advance

offered by both Dr. Brettschneider and Dr. Obermyer. The sinuses are physically close to the brain, orbit and many arteries. Visualization with the endoscope allows surgeons to see these structures so they operate safely. Image-guided surgery adds another level of safety. Image guidance is a near three-dimensional mapping system that combines computed tomography (CT) scans and real time information about the exact location of the surgical instruments. This type of technology is helpful for severe forms of chronic sinusitis or in cases when previous sinus surgery has altered landmarks, or where a patient's anatomy is very unusual, making surgery difficult.

Otolaryngic Allergy Diagnosis and Treatment

To be a complete sinonasal treatment center, one cannot ignore the allergic condition. Dr. Brettschneider is board certified with a certificate of added qualifications in otolaryngic allergy, and is well trained in allergy and integrate this into his practice. Allergy testing for inhalant allergens, IgE foods and delayed medications for allergies is a large part of their practice. Chemical testing (metals, plastics, rubber, preservatives) is also available at Port Huron ENT. Treatment for the allergic condition encompasses 1) counseling for avoidance, 2) medical treatment, 3) subcutaneous immunotherapy (SCIT) and 4) sublingual immunotherapy (SLIT). Dr. Brettschneider and Dr. Obermyer are the first to offer allergy drops for treatment of allergies. SLIT is a treatment for desensitization that can be done at home and is as effective as SCIT.

Food allergy testing and treatment is an important part of sinonasal allergy care. Dr. Brettschneider and Dr. Obermyer provide complete food allergy testing and counseling.

Rhinoplasty for Function and Beauty

As part of a complete sinonasal center, rhinoplasty, both open and closed, can be performed. Rhinoplasty can be done to correct impaired breathing caused by structural abnormalities in the nose. It can also be done to improve the appearance and proportion of the nose, enhancing facial harmony and self-confidence. Dr. Brettschneider and Dr. Obermyer are uniquely well suited for this procedure as they combine beauty with function.

Dennis J. Kitsko, DO

Membership Achievement

We are pleased to announce Dennis Kitsko, DO appointed to Assistant Professor of Otolaryngology, Department of Pediatric Otolaryngology at the University of Pittsburgh School of Medicine, Children's Hospital of Pittsburgh on July 1, 2008.

We congratulate Dr. Kitsko on his recognition.

Sanford L. Moretsky, DO **LETTER TO THE EDITOR**

August 11, 2008

Dear Gilbert E. D'Alonzo, Jr., DO, Editor in Chief of the JAOA

In the article "Alpha-Adrenergic Receptor Antagonists in Older Patients with Benign Prostatic Hyperplasia: Issue and Potential Complications," by Shari R. Fine, DO and Phillip Ginsberg, DO, JD, one very important point is not identified and addressed. Since the widespread use of tamsulosin for BPH, cataract surgery side effects associated with the use of alpha-adrenergic receptor antagonists drugs has become a serious problem. The article makes a reference based on articles from 2005 and 2006 that "in some patients"... intraoperative floppy iris syndrome [IFIS] has been observed." More current literature reveals that with tamsulosin (a selective alpha-adrenergic receptor antagonists) IFIS occurs often and with (terazosin, doxazosin, and alfuzosin, non-selective alpha-adrenergic receptor antagonists) it is more sporadic.⁽¹⁾ Dr. Fine and Dr. Ginsberg do an excellent job of identifying this issue and describing the condition. However, the matter of screening patients for cataracts before initiating treatment for BPH, by urologists and family physicians, is not addressed. The specialty of ophthalmology has been slow in educating their brethren in urology and primary care regarding this matter. There is a concerted effort now by the American Academy of Ophthalmology and American Society of Cataract and Refractive Surgery to stress to the American College of Physicians and the American Academy of Family Physicians the importance of screening patients for cataracts who are being considered for treatment of BPH, before starting alpha-adrenergic receptor antagonists.⁽²⁾

The "take home" message of this letter is to stress that **before** patients are started on systemic alpha blockers, they should be asked by their urologist or primary care

physician about the status of their vision. In other words, do they have cataracts and not know it yet, do they know they have cataracts and will need surgery in the near future, or have they already had cataract surgery in the past, (if they had cataract surgery already, then this is a mute point). A survey conducted in the United Kingdom showed 97% of physicians, who prescribed alpha blockers, were not familiar with IFIS. Four out of five surveyed physicians were writing at least five new prescriptions for tamsulosin a month.⁽³⁾ Patients who already have significant cataracts should be educated about IFIS before starting chronic non-emergent treatment with systemic alpha-blockers, such as tamsulosin. As inferred in the article by Fine and Ginsberg, it has been shown that even after discontinuation of alpha blockers, permanent effects on the iris may occur which will complicate future cataract surgery. Years from now, we can expect patients not remembering drugs they formally used. This creates a ticking bomb for the eye surgeon, when their patients need cataract surgery in the future and don't recall use of systemic alpha blockers. Granted, when their ophthalmologist knows about systemic alpha blockers in their current medical history, it enables their ophthalmologist to better prepare with devices and intraocular pharmaceuticals, but what surgeon wants to have to deal with unknown variables in a standard surgical procedure. A competent and thorough ophthalmologist should already be asking about these drugs in their history, prior to cataract surgery.

A recent survey of ophthalmologists showed an overwhelming vast majority of ophthalmologist who had a known history of BPH and early cataract would choose a non-specific alpha blocker, avoid alpha blockers all together, or consider cataract surgery first before treatment based on their intraoperative experiences of IFIS.⁽⁴⁾ Urologists and primary care physicians must be proactive in identifying patients who will be at risk with future cataract surgery, who may be considered for these drugs. Other treatment options may be more appropriate for those patients who will require future cataract surgery. There may come a time when BPH patients may require an ophthalmology consultation first before starting a systemic alpha-blockers, as a matter of standard care.

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4. Chang D.F. Braga-Mele R et al. Clinical experience with intraoperative floppy-iris syndrome: Results of the 2008 ASCRS member survey. *J. Cataract Refract. Surg.* 2008; 34; 1201-1209)

Richard F. Multack, DO Involvement in National Academies of Practice

I am the Chairman of the Osteopathic Academy of National Academies of Practice (NAP). NAP is a ten profession interdisciplinary national health care advisory forum. We are mandated to inform Congress of health care issues involving every day clinical practice.

We have recently addressed Access to Care and health care manpower shortages. I am always looking for osteopathic physicians who have an altruistic bent and an interest in influencing government policy. I am actively recruiting interested members. Since the AOCOO-HNS has been in the forefront of AOA leadership, I thought my own group might have some interested members. Below is a description of our current project. I would appreciate any interest. Contact me at my office phone: 708-481-8883 or my email: eyewolf357@aol.com.

First-Ever NAP-Sponsored Field Hearings on Access to Care

Under the leadership of Vice President of Public Policy, Dr. Marie DiCowden, the "Health Care for All-Florida and Human Services Coalition" has been formed. This multi-organization coalition, including such organizations as the AARP and countless other groups, is holding the only regional "field hearing" on access to care to keep the pressure on politicians to solve this health care problem. The hearings took place in Ft. Lauderdale, FL on September 20, 2008.

Invited speakers included Congressman John Conyers, sponsor of the health care access reform legislation discussed at the 2007 Forum. NAP is working closely

with Joel Segal of his office to try to make this dream a reality.

These field hearings represented the NAP Fall Meeting. Also make plans to attend the NAP Annual Forum in the Spring of 2009. For more details on the Forum go to <http://www.napnet.us/events.htm>.

Ted H. Schwartzfeld, DO Known as Doc Rock

They call him Doc Rock for good reason. Ear, nose and throat specialist Dr. Ted Schwartzfeld moonlights as the No. 1 doctor on call for pop and rock singers performing in metro Detroit's concert venues.

The coveted gig fell into Dr. Schwartzfeld's lap about three years ago after a singer from the band Kansas requested that a doctor examine his sore throat before a concern. A friend working for the promoter called Dr. Schwartzfeld.

BOOGIE-WOOGIE FLU: Dr. Schwartzfeld has been backstage for most big-name performers, including Kiss, Celine Dion, Elton John, Bruce Springsteen, the Rolling Stones, Aerosmith, Ozzy Osborne, U2, Crosby Stills Nash and Young, and the Jonas Brothers. You might see him in the aisles handout out free ear plugs before a concern.

He stitched Kiss drummer Peter Criss' face after a fan hit him with a lighter and treated Madonna's daughter, Lourdes Leon, for an ear infection. Gloria Estafan cancelled a show after Dr. Schwartzfeld diagnosed her with a vocal cord injury. He met Van Halen lead singer David Lee Roth for a consult at the St. John Oakland emergency room.

SURPRISE, SURPRISE: Elton John and Celine Dion signed a cast on Dr. Schwartzfeld's leg after surgery. He had it mounted. Kiss members invited his daughter backstage to meet them without makeup when no one knew what each looked like unmasked. He watched fondly as Britney Spears spent more than 30 minutes talking with a group of special needs children when she was a backup act.

SATISFACTION: "They are most appreciative of what I do for them," Dr. Schwartzfeld said. "They are on the road all the time, their schedules get out of whack, and they get sick."

Differences Between DOs and MDs Are Not as Important as What We Can Accomplish Together.

An often asked question: "What's the difference between an MD and a DO ophthalmologist?" Some DO ophthalmologists would reply: "Practically speaking, very little, or nothing." My own reply, and then the intent of this article is to go beyond the "practically speaking" response, and the offer another perspective.

Personal History

My osteopathic heritage begins with my father, a 1952 graduate of Kirksville College of Osteopathic Medicine (where osteopathy originated). He received his postgraduate training in orthopedic surgery at the Detroit Osteopathic Hospital, lovingly referred to as the "mecca" of osteopathic specialty training.

My own path started at Michigan State University College of Osteopathic Medicine, followed by an osteopathic internship. Ophthalmology residencies were scarce in the DO world when it was my turn to apply — only two openings were available in the entire United States. I was fortunate to have been accepted to the Kresge Eye Institute. Having just married a DO ophthalmologist whose medical educational route mirrored that of my father's, I found myself in a unique position to compare the educational experiences and philosophical differences.

Osteopathic principles and philosophy were founded by Andrew Taylor Still, MD, toward the end of the 19th century. He noted that the medical treatments of the day were killing more people than they were curing.

He felt strongly that the body has an inherent ability to heal itself, and that structure and blood supply are vital to that healing process. He developed manipulative techniques that strive to restore skeletal alignment and improve blood/lymphatic flow throughout the body. One of the many tenets of osteopathic medicine states that the body has the potential to make all substances necessary to ensure its health. No medical approach can exceed the efficacy of the body's natural defense systems if those defenses are functioning properly. Teaching the patient to care for his own health and to prevent disease is part of a physician's responsibility.

Today's Model

Today's osteopathic medical education utilizes the core competency model plus an additional competency of osteopathic principles and manipulative treatment. Osteopathic ophthalmology emphasizes the concept of treating eye disease in a holistic context. Patient evaluation should include examination and consideration of the entire medical and psychological picture.

There are about 54,700 osteopathic physicians practicing in the United States, representing 5% to 6% of the total number of physicians (MDs and DOs) currently delivering patient care. However, DOs attend to about 8% of all patient visits in the United States. Over half of the DOs are delivering primary care, 15% in underserved/rural parts of the country. But contrast, about one-third of MDs deliver primary care. DO ophthalmologists comprise about 0.7% of all practicing DOs, and about 2.5% of all ophthalmologists in the United States.

There are several thousand DOs in the rest of the world, including 4,000 in Great Britain. DOs are licensed and fully recognized physicians in all 50 states, and there are currently 25 osteopathic schools of medicine in the United States with a total enrollment of over 8,000 students.

DOs train in all fields of medicine, either through osteopathic training programs or in the allopathic (MD) programs. 10% of the physicians in the military are DOs. Several professional sports teams employ osteopathic physicians. George H.W. Bush's personal physician was a DO. Prince Charles of Great Britain recently revealed that he is attended by a DO.

The American Osteopathic Association (AOA) conducts and maintains its own board certification for its members. Many of our members trained in the MD world are eligible for MD board certification as well. Board certified DO ophthalmologists enjoy the status of Fellow in the American Academy of Ophthalmology and the majority of us maintain AAO membership. The American Osteopathic College of Ophthalmology (AOCO) holds a seat on the AAO Council.

Political Action

In the political arena, DOs stand side by side with the allopathic leadership, advocating for Medicare reform, promoting the patient-centered medical home model of care, pushing for mandatory physical education in schools to help combat the childhood obesity crisis,

and many other critical health care issues.

The AOCO, with its approximate 400 members, is a vocal supporter of the scope of practice initiatives of the AAO and has been recognized for its contributions. As noted, many DO ophthalmologists practice in underserved areas. This demographic strength has assisted the AAO in its scope of practice arguments in states such as Oklahoma. Past President of the American Osteopathic Association and ophthalmologist, Phillip Shettle, DO, was recently honored by the AAO for political leadership. Ophthalmologist leadership continues this year at the AAO level with president Carlo J. DiMarco, DO.

In Practice

In Detroit, there are four ophthalmology residency training programs, including the osteopathic program of which I am a part. Our residents interact with those of the allopathic programs on a daily basis, whether it's grand rounds at Kresge Eye Institute, monthly guest lectures at Henry Ford Hospital, or subspecialty lectures and rotations with the physicians at William Beaumont Hospital. In addition, Michigan State University links us with other osteopathic ophthalmology programs for monthly on-site didactic programs and weekly Internet conferences.

Our residents receive one-on-one clinical exposure in the private office setting, where they see firsthand how physicians in practice interact with patients. We also maintain a resident training clinic, located in an indigent area of Detroit, where our residents work together, supervised by an attending ophthalmologist. Together, they care for patients with pathology reflecting the health problems of the inner city.

Our residents also participate in the OKAP, with established scoring requirements for graduation. We enjoy a cordial relationship with the other training programs in the city, and our residents receive much of their subspecialty training locally. Many of our graduates have continued their professional education in prestigious fellowships in Detroit and throughout the country.

What's the Difference?

So, with all this said, what are the differences between DO and MD ophthalmology training? Our curriculum is built on the core competencies identified by both allopathic and osteopathic schools, but the additional competency of osteopathic principles and philosophy makes it unique. In ophthalmology, this

may consist of soft tissue techniques to the neck prior to cataract surgery for relaxation.

Equally as relevant is the approach we take with our patients. Osteopathy emphasizes a level of communication based on respect for the patient as a whole. It is our responsibility to treat patients with eye disease, not just the disease. It is a thoroughness of history and examination that then guides the physician and patient together to chart a medical course of action for a particular ocular condition. Sometimes this requires a lengthy conversation. As we all know, if you let patients talk, they are likely to reveal their diagnosis. If you take time to listen, you will also learn about the patient's personality, living situation, financial constraints, and family pressures, all of which may define his/her illness and determine the best course of treatment.

It is in the listening that we learn. It is in the art of asking the appropriate questions that we arrive at a complete diagnosis. Then the emphasis is on communicating with the patient to ensure understanding, as well as giving treatment options and in many cases, hope. I have learned that there are diseases for which we have nothing medical to offer. However, an attitude of compassion on our part can certainly make the patient feel better for having seen us.

And even in ophthalmology, it is this patient-oriented approach that may make us different. Actually, I have met many MDs who, I feel, treat their patients with an "osteopathic attitude." The recently-defined core competencies of communication, professionalism, system-based and evidence-based medicine, as well as medical knowledge, are just a renaming of those aspects of patient care that DOs have been championing since the days of A.T. Still.

The Projected Shortage

The scope of osteopathic residency training is certainly dwarfed by the size and number of allopathic training programs. We currently have 12 programs scattered throughout the country and graduate approximately 20 ophthalmologists per year.

The predicted shortage of physicians nationwide in the near future has encouraged all medical schools to increase class size. However, with the current government caps on post-graduate funding, the questions are: Where are all of those medical school graduates going to get their specialty training? Who is going to

establish new programs or expand existing programs without funding? And how many of our current graduates in ophthalmology are driven to teach residents, with declining fee schedules and student loan repayments in their immediate futures?

This particular crisis will take health care in this country backwards by decades if new models of post-graduate training aren't available soon. MDs and DOs have many issues in common. The time has arrived when collaboration of MD might and DO tenacity would produce some substantial solutions to the health care problems we face.

Renewed Passion

In writing this article, I find renewed passion in my own choices of being a physician, a DO, an ophthalmologist. Living the principles of osteopathy has made my practice unique and has enriched my life. My career as a DO has been met with little of the past discrimination in the history of osteopathy, but often with mild curiosity. Hopefully, with this article, I've satisfied some of this curiosity. I am most proud that my two daughters have also chosen the osteopathic profession. Many thanks to my husband and my residents, who gave me a true sounding board for my answers to the original question.

William W. Waugh, DO

It has been four years now since I suffered a C-2 fracture in a fall. The days on the ventilator, the months of being fed while in a wheelchair, the frozen shoulders, all are becoming distance memories. Oh, I am reminded daily that I cannot jog or run, ride a bike, use a fork correctly (chopsticks are definitely out), and that I need some help dressing. But I am mobile, and I can drive. I even went back to work on a limited basis.

When I am asked how I improved, I really do not have the answer other than that my "over the top" optimism, my wife's help and constant encouragement, therapy and hard work despite the pain, and a whole lot of luck all have played a part in my recovery. I also think that the body has the innate ability to heal itself if given the chance. Your body wants to get better if you help it along. Also, I do not think that there is a time line where no further improvement will occur as I continue to be able to do new things every so often even four years out. And, finally, with research and knowledge gained through organizations such as Kali's Cure for Paralysis Foundation, the devastating

effects of spinal cord injury will become distant memories for all of us who are affected.

Clifford N. Steinig, DO

We are pleased to announce that Dr. Clifford Steinig has been appointed by Pennsylvania Governor Ed Rendell as a member of the State Board of Examiners in Speech-Language and Hearing. This appointment is a three year term, renewable one time for another three years.

We congratulate Dr. Steinig on his recognition.

Timothy W. Winter, DO

Letter to the Foundation

June 7, 2008

Dear Directors and Administrative Staff,

My name is Timothy Winter, and I would like to thank you for sponsoring my attendance at the 2008 AOCOO annual clinical assembly at the Camelback Inn in Scottsdale, Arizona. I am currently an intern in the track ophthalmology residency program at Oklahoma State University Medical Center in Tulsa. As a physician-in-training who is married, with two children under the age of 5 and a child on the way, it is difficult to find additional funds to participate in educational activities such as the ACA. It was wonderful to receive the \$250 resident travel grant from the Foundation!

I enjoyed attending the educational courses, social events, basic/clinical lectures, and workshops that offered a host of opportunities to brainstorm new research ideas and network with fellow ophthalmology residents from across the country. Of special mention was the EYEsi phacoemulsification simulator workshop. I signed up for the course hoping that I would learn a little bit about what real cataract surgery was like. My expectations were far surpassed, and I ended up spending more than two hours fiddling with the virtual vitrectomy and internal limiting membrane peels, as well.

This was my first year participating in the annual meeting as a physician, however this was not my first time to attend. As a second year medical student, I presented a poster about how retinal prosthesis affect circadian rhythms. It was a wonderful experience, and I want to thank the Foundation for allowing me the opportunity to participate those three years ago. This year I noticed that there were several medical students in attendance — many of them presenting posters. I would

like to applaud the Foundation for recognizing the benefit of allowing early exposure to such proceedings for the medical students interested in our field. My experience with the AOCOO ACA has long-lasting effects on my career decision and will no doubt guide the interests of future impressionable medical students hoping to become eye surgeons.

The AOCOO's goal is to promote the interests of Osteopathic Ophthalmologists and Osteopathic Otolaryngologists, to continue to improve their quality of training and education, and to advance the practice of osteopathic medicine through a system of quality and cost-effective health care measures in the profession. It was an honor to have received support from and to be affiliated with such an influential institution. Thank you again for the honor to be awarded financial assistance to participate in this awesome educational experience. I look forward to working with the AOCOO in the future.

Report of the AOA Bureau of Federal Health Programs

**April 25, 2008 Renaissance Hotel
Washington DC**

**Wayne F. Bizer, DO & Paul M. Imber, DO
REPRINTED**

Greetings from Washington, DC. Paul Imber, DO and I had the pleasure of representing you at the most recent meeting of the AOA Federal Health Programs Bureau Meeting. It was so pretty in Washington this spring with the Dogwoods in bloom and the last of the Cherry Blossoms in flower. I even got to look out the window of the taxi traveling back and forth to the airport and got a glimpse to enjoy it all. Other than the flowering plants, it seems that there is very little fruit that will be harvested in Washington until after the 2008 elections.

Paul attended the "DO on the Hill Day" that the AOA plans every April. It is a wonderful opportunity for you to come to the Nation's Capital and stand up for what you believe is right for your patients and your family and yourself. It would have been nice for some of you to have attended.

The Government Solution to the Health Care Conundrum. WFB

A conundrum is a riddle that is almost impossible to answer, like how is our

government, that so broke and is deeply in debt, going to pay a proper fee for the health care of the 78 million additional baby boomers and 45 million uninsured without raising taxes or going deeper in debt?

Our luncheon speaker was Mark McClellan, MD, PhD Senior Fellow and Director of the Engelberg Center for Healthcare Reform of the Brookings Institute. He is the former administrator of the Centers for Medicare and Medicaid Services.

He advised that chronic disease amounts to 75% of US Healthcare spending, 95% of Medicare spending and 90% of Medicaid spending. He said that obesity is perhaps the greatest cause of these chronic diseases

He asked us what we could do in our practices to save costs and make healthcare less costly for the government. He advised that incremental changes in the current fee for service program are not likely to save any real money for the government. They are looking for larger savings on a broader scale. They look to issues like electronic medical records, e-prescribing, and other technology changes to be of some help, but they know that the government is going to have to look elsewhere for big savings.

He opined that if the Democrats win the fall elections they are likely to increase the allocation of revenue for health care at the expense of drastically increased taxes. He addressed the proposed fee cut of July 2008. He thought that the price tag for putting of the fee cuts of 10% and of increasing physician reimbursement by 0.5% over the next 18 months would cost the government \$60 billion. He had no idea where to find that amount of money.

If you study the healthcare financial problem with the preconceived idea that there will be no significant increase in the net revenue for health care spending, the only answer that is left is to divide the pie differently. And that is exactly what the Republican health policy experts are talking about doing.

Government wants to use Quality Reporting to insure better health care for patients and at the same time save money because we would practice better medicine. They believe that if we were all doing our jobs like we were supposed to doing them that there would be plenty of revenue for physicians and patient care. Many in Washington have convinced themselves that this is true.

One of the ways they see the future unfolding is through the "Medical Home." I reported this concept to you from the last

Federal Health Programs Bureau meeting. Instead of giving tons of money to Medicare HMOs (Medicare Advantage Programs, Gold Plus or whatever they are called in your area) who make enormous profits and pay their executives and shareholding a great deal of money, the government would pay similar amounts directly to a group of primary care doctors. These doctors would be their own care centers, would have to provide a wide range of care and specialty and drug supplies, computerized records and 24 hour availability along with a lot of other requirements. You are going to hear a lot more about the "Medical Home" and I suggest that each of you take some time to educate yourself about this big change in the future of healthcare in America. Do an internet search. At our last Bureau meeting we were told that these businesses will shift revenue from specialists to primary care doctors.

AOA Partnership with Public and Private Organizations WFB

It's hard to know what the AOA is doing for you. From where you sit, you might have come to the misconception that nobody is out there working for you. This could not be further from the truth. The AOA has networked with other health care organizations, non-health care organizations, and everyone that it can in order to build coalitions to support you and your needs. The AOA recently met with the PAHQR US Preventive Services Task Force and the Partnership for Prevention Health Professionals Roundtable.

Physician Quality Reporting Initiative (PQRI) WFB

It just depends on how you want to see it. Physicians have been barraged by this concept that if we document the quality of our care and report that care to the government we will enjoy a financial windfall. CMS reported the voluntary program was a great success in 2007 with 100,000 physician participants (out of 630,000 possible). As you know the program is moving forward in 2008 again as a voluntary opportunity.

On the other hand, one of the DOs in attendance referenced an article in the New England Journal of Medicine which reviewed 10 practices that participated in the 2007 P4P 2007. They reported that 8 of the 10 of these groups got no money at all and that the two that did get money back found it to be so little that they lost money on the reporting. The government is used to running in the red and perhaps

hopes to teach us how to do the same. I guess it's all in the eye of the beholder.

Health Information Technology WFB

The support for HIT continues to grow in Washington. The financial burden for HIT is still a mystery. Some of the Democrats are supposedly in favor of legislation that makes the government pay your cost to computerize your medical records. The Republicans are less generous with your tax money and would let you pay for this expense yourself.

Medicare WFB

Senator Debbie Stabnow (D-MI) introduced the "Save Medicare Act of 2008" bill S-2785. If enacted as written this bill would do away with the impending 10% cut in physician reimbursement scheduled to go into effect July 1 of this year and replace it with a 0.5% increase for the remainder of 2008 and provide a 1.8% increase in 2009. It would extend PQRI through January 2010. I hope that those of you in Michigan will make yourselves known to this Senator and express your support of her bill and remember her as the friend she has been.

E-Prescribing WFB

E-MEDS, the Medicare Electronic Medication and Safety Protection Act of 2007 would, if passed, require physician participation by 2011 to avoid penalty. There will be more to come on this if the bill passes.

Fiscal Year 2009 Federal Budget Appropriation WFB

On February 4 President Bush sent his fiscal year budget to Congress in the amount of \$3.1 trillion. Does anyone really know how much a trillion of anything really is? I just calculated that if each dollar were a day, then \$3.1 trillion would equal more than 8 million years.

The administration proposed budget has cut (let me repeat myself, CUT) \$178 billion from Medicare over the next five years through legislative action and another \$5 billion through administrative changes. The administration proposed budget would cut Medicaid spending by \$17 billion over the next five years. Have you seen where they can cut \$200 billion from healthcare over the next five years. Maybe if all of those fat people lost weight and got healthy the government could find \$200 billion to cut. Does anyone think that this can happen?

Summary WFB

I submit that we have national insanity leading the health care reform in America. They barely know where they are. They don't understand the problems in health care, and have no idea how to fix it or how to pay for it. What a way to run a railroad! What are you going to do? Perhaps more of the insanity that you have done for the past years: the do nothing and let someone else take care of it mentality.

I submit that if you don't make this the year that you support O-PAC that you will live to regret your indecision. The cavalry is not coming. The government is about to push your head under again and this time it will be deeper and longer. You must do something to protect your patients and your families. Since none of you is about to give up your career and enter politics, I urge you to champion those who do this work for us, the AOA and O-PAC. **Pick up the phone now and call Kristin Beaubien on her direct line at the AOA in Washington at 202-414-0142 AND DO SOMETHING!!!!**

Intro- PMI

Well! After reading Dr. Bizer's erudite but pessimistic summary, I'm slowly approaching the ledge, and contemplating taking that final "Thelma and Louise" leap into the gorge of healthcare despair. Fortunately, I have taken my serotonin-inhibitor for the day, and will be able to complete my portion of this report before the angst takes over my psyche once again. There may be some iota of good news, it is very difficult to pass new legislation. All of the plans coming out of the think tanks are very complex, multifaceted programs involving many committees on both side of the Hill. This will necessitate the input of hundreds of Congressmen and dozens of Senators. The likelihood of anything substantial passing through the legislative process in the near future is very slim. The question of course- Is this good news or bad news? Again, it's a matter of perspective.

Agency for Healthcare Research and Quality-PMI

A presentation was given by Carolyn Clancy, MD, the director of the Agency for Healthcare Research and Quality (AHRQ) under the Department of Health and Human Services. She is a brilliant, incredibly well educated physician with an acerbic wit and some perspective of where we might be going. She has been

in private practice in Internal Medicine in the past, but entered the AHRQ in 1990 (her perspective might be a little ivory tower).

The AHRQ is the lead Federal agency charged with improving the quality, safety and efficiency of healthcare for all Americans. AHRQ is the agency that supports the quality of healthcare and promotes evidence-based medical decision-making. The agency's focus and goals are-

Safety and Quality—Reduce the risk of harm by promoting delivery of the best possible healthcare.

Effectiveness—Improve healthcare outcomes by encouraging the use of evidence to make informed health decisions.

Efficiency—Transform research into practice to facilitate wider access to effective healthcare services and reduce unnecessary costs.

Organizational Excellence—Use efficient and responsive business processes to maximize the Agency's resources and the effectiveness of its' programs.

She stated that achieving these goals will provide safety standards for patient care, and safety for the Ambulatory Care Center. It would be able to develop Medical Expenditure Panel Surveys which, combined with Comparative Effectiveness Recommendations of Therapeutics will provide Best Healthcare for Patients in America. (The capitalizations are apparently a bureaucratic necessity.) The hope is to develop an updated data base of information, accessible to all physicians of evidence-based practice guidelines to facilitate our decision making in patient care. This will be developed through a research network of HMO's and universities (who already have the HER database developed to collect the outcomes data) across the country as Evidence-Based Practice Centers (yet even more caps.) This format has already begun, and created the Guide to Clinical Preventative Services 2007. The agency also is developing the Communications Science Center, to present information to patients and physicians about treatment options, medications, technology, research reports, systematic reviews and patient consumer guides. Some of this data is already available at www.effectivehealthcare.ahrq.gov.

Dr. Clancy enforced the need for strong healthcare informatics as a foundation for safety studies in

healthcare, documentation of adverse events and reactions, maintaining a patient medical history data base, and e-prescribing. Of course, she offered no solutions for the cost and lack of guidelines for the purchase of the software and hardware for said EHR systems. She did recognize the limitations of the small one to three doctor, single-specialty practices to invest in these programs, particularly with the current ambiguities. Her desire is lofty, to develop a value-initiative learning network, which would be an information rich enterprise, allowing for "the highest care for the most people at the best cost." This would bring to the floor the best care in evidence based medicine with real time information with an understanding of the value of different medications, procedures and services, as well as developing advances.

Legislative Update-PMI

As Dr. Bizer alluded above, it is unlikely the 10.5% cut in physician reimbursement by Medicare will care through. The Senate Budget and Finance Committee is completing a bill that will be floated around the House and the White House in mid-May, with the hope of averting the cuts by July 1, 2008. It is expected to be a bill that will have a 12-18 month life, with a nominal 0.5-1.5% increase over the short life of the bill. There will also be a mandate for a restructuring of the physician reimbursement formula for CMS.

There are a number of bills floating around the House of Representatives related to healthcare. These bills usually never make it through committee, but it's nice to know they are thinking of us. There is the "Medicare Electronic Medication and Safety Protection Act of 2007 (H.R. 4296)", which mandates e-prescriptions for all Medicare patients by 2011. Then there is the "Technologies for Restoring Users' Security and Trust in Health Information Act (H.R. 5442) that would require each patient's consent to have their records included in a health IT network, inform patients of any security breach into the IT network, mandate the use of data security safeguards and encryptions, and establish a public-private partnership for development of health IT standards. This is just of taste of what is in store for us, gentle reader. And you thought HIPAA was a fiasco!

Of course, the biggest problem is how to pay for everything everyone wants. President G.W. Bush solves all of the problems by increasing discretionary spending in the 2009 budget by \$46.2

billion. Almost all of these tax dollars (where do you think the money comes from?) would be spent on defense, homeland security and international affairs. Meanwhile, the Department of Health and Human Services would be cut by \$2.2 billion. But, "Wait," you say. "How will we pay for all of the wants and needs of our great country's people?" The answer of course is Congress. The House and the Senate adopting non-binding resolutions to allot more discretionary spending for the 12 annual appropriations bills. Where the President decreases Medicare spending by \$178 billion over the next five years, the House and Senate propose to block these cuts, and provide reserve funds that could be used to accommodate future Medicare legislation.

Graduate Medical Education-PMI

You should be aware by now, that CMS is balking about carrying the cost of GME on its shoulders through it's reimbursement program to teaching hospitals. There are several projections for deep cuts to the program through both Medicare and Medicaid. There is a Coalition for DGME Fairness to increase reimbursement for all direct GME payments to all teaching hospitals to 100% of the national average. This plan sits as a bill in the House Ways and Means Committee, with companion legislation in the Senate.

The AOA, in anticipation of the predicted physician shortages in the near future, is launching the OGME Development Initiative to assist non-teaching hospitals develop osteopathic GME programs. A core of consultants would be available to facilitate all aspects of the process, interacting with hospital CEO's, CFO's, DME's and lay and physician leadership. There are already over fifty consultant volunteers, and a Task Force Handbook has been developed.

Summary- PMI

A conundrum? That would be kind. The solution will not come from the Government, because the politicians all have to live within their election cycle and the choices are going to be hard, costly and painful for many different sectors of our country. The solution for where the money comes from is not that difficult. It's the choices that would have to be made that are hard to sell. For example, if the profits of the health insurance companies were redirected to patient care, there would be another 20-30% of current dollars available for patient care. Of course, this would

require a mandated single payer system- government run- with no private sector option. The choices are hard. Also, if effective medical tort reform could be simultaneously enacted, another 10-20% of current healthcare dollars could be available for true patient care, instead of current defensive medicine practices. The choices are painful for different sectors. The access of care would have to be partially restricted, based on best practice and cost established by outcomes of evidence based medicine. Should the 60 year old smoker have the option of bypass surgery when outcomes show no advantage to his longevity? Sell that to his wife and children. The choices are painful. So, I agree with Dr. Bizer. You must participate. "If you are not sitting at the table, you are likely to find yourself on the menu." Your contributions to O-OAC, ENTPAC, and or DO-PAC are an essential part of your involvement. It sends a message to Congress, that physicians are "Mad as hell, and not going to take it anymore!" The number of members participating as well as the number of dollars raised tells Congress just how angry and frustrates we are. So, come with me off of the ledge, Thelma and Louise had it wrong. I will skip my serotonin-inhibitors, and put the money into PAC funds instead. Be part of the solution, the choices have a cost to you as well.

Ophthalmology Opportunities

COLORADO

- Established Ridgeway, Colorado integrative medical clinic seeks doctors/practitioners to complement our coalition of independent professionals offering comprehensive, personalized holistic health care. Stellar reputation, spectacular setting, superb quality of life—973-626-9877.

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

FLORIDA

- Seeking ophthalmologist w/w/o glaucoma fellowship. Alternate call for hospital ER with Trauma Center. No glaucoma trained doctor in the area. Call 772-979-0850 or email Joe Morgan, DO at joesocrates@aol.com. Ft. Pierce, FL

GEORGIA

- Partnership opportunity for cataract surgeon with Imhoff Eye Center in Southeast Georgia. Largest referral surgical practice working from multiple locations, covering 150 mile service area. Contact Rex Buchanan at 561-504-4017 or 912-267-0565 or email: rbuchanan@imhoffeye.com.

MICHIGAN

- Ophthalmologist wanted to join growing practice in Big Rapids, Michigan. Guarantees salary, opportunity for partnership. Please contact Ralph Crew, DO., 2310796-0010 or email: ralphcrew@hotmail.com.

NEVADA

- Established ophthalmology practice seeking BC/BE general ophthalmologist who would take an active role in our ophthalmology residency program. The practice has 4 state-of-the-art offices with three located in community oriented high profile areas and the fourth in the center of multi-hospital complex. Also within one medical complex is a physician owned surgery center and an on-site excimer laser. Our doctors include fellowship trained glaucoma, pediatric and cornea, external disease specialists. Practice partnership and ASC opportunity available. Contact Rudy R. Manthei, DO at rmanthei@nee-nv.com or 702-492-6928.

OHIO

- 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.
- General ophthalmologist needed for solo practice featuring a new ASC with 3 satellite locations. Large referral base with high surgical volume. Excellent salary with benefits and partnership potential. Respond to Bob Swoger at Valley Eye Institute. Call 937-492-3755 or email bswoger@bizwow.rr.com.

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 Figs 509-952-8545.

Ophthalmology Fellowship **MARYLAND**

- NRI fellowship program at the National Retina Institute offering hands-on opportunities to hone diagnostic and surgical skills as a vitreoretinal specialist with a large patient base in the Baltimore-Washington-Virginia area. Contact Ruth Zeller via rzeller@bmgri.com or call 443-921-4154.

OHIO

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

NEW LOCATION

- University Eye Surgeons has moved: 5187 US Rt. 60, Suite 6, Huntington, WV 25705—304-691-8800. Have 10,000 sq. ft. including 2 surgery suites, 11 exam lanes and the most up-to-date technology. The staff includes 3 ophthalmologists and 1 optometrist. Dr. Parveen Nagra is subspecialty trained in cornea and Dr. Krasnow is fellowship trained in glaucoma. University Eye Surgeons is a division of Marshall University School of Medicine. Students are welcome to rotate in this facility.

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.

ARKANSAS

- Cooper Clinic of Fort Smith is seeking 2 BC/BE otolaryngologists to join this expanding department in a physician-owned multispecialty clinic. Exceptional earning potential with a competitive package including a two-year guaranteed of \$350K/yr, malpractice/health/dental/disability/life insurance plus moving allowance, 401K and ASC profit sharing from the start. Eligible for partnership after two years with NO BUY-IN. The community has many cultural and outdoor activities, quality schools and family-oriented atmosphere. Contact Christopher Greer, DO at 479-478-4800 or cgreer@cooperclinic.com.

CALIFORNIA

- Unique opportunity in private practice for well-trained BE/BC physician in general otolaryngology or subspecialty in this premier coastal community north of Los Angeles. Office is fully equipped. Includes audiology, sound booths and HAD dept. Adjacent to Outpatient Surgi-Center and area's major hospital. For more information, contact Joseph DiBartolomeo, MD, 2420 Castillo Street, Santa Barbara, CA - 805-563-1111, or email: dibartolomeo@md@aol.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 enthusiasts. Call office (970) 249-6968 or email centpc@frontier.net.

- Established Ridgeway, Colorado integrative medical clinic seeks doctors/practitioners to complement our coalition of independent professionals offering comprehensive, personalized holistic health care. Stellar reputation, spectacular setting, superb quality of life—973-626-9877.

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.
- 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 352-2741570.

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.
- Wanted: ENT associate to join busy 2 office practice with 1 in 6 call. Unique opportunity for new graduate to work into a busy practice with fast track to partnership. In Mid-Michigan with easy access to northern Michigan outdoor activities. Contact R. Borenitsch, DO at rborenitsch@hotmail.com.
- Detroit Medical Center is looking for a general otolaryngologist. Large referral base; major urban academic medical center; new residency program for support. If interested, please contact Dr. David N. Madgy at 313-745-5402.

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.
- Fabulous opportunity. 36-year-old otolaryngology practice in Stark County, Ohio offering excellent salary benefit. Office fully equipped for allergy and audiology. If interested, please contact Dr. George Vogelgesang at 330-837-3559 or email: drgwv@hotmail.com.

PENNSYLVANIA

- Suburban Philadelphia—4 physician otolaryngology practice looking for highly motivated ENT. Practice includes all phases of otolaryngology, head and neck surgery, otology and allergy. Competitive salary, bonus and benefits, partnership track. Contact Benjamin Chack, DO, 215-280-6993.

- 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 Keszei, DO, at 484-437-8745.

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: pmbekar@aol.com.

RHODE ISLAND

- ENT BC/BE to join 3 physician practice. Two new offices. Main office is 5 minutes from 250 bed community hospital and brand new ENT surgical center. Staff includes 1 NP, 3 allergy nurses, 2 audiologists and 1 hearing aid specialist. Shared flexible call is 1 in 4. Competitive salary with production based income, 2 year partnership opportunity with minimal buy-in and potential buy-in to new ENT surgical center. Email your CV to Mark Andreozzi, DO at nosedr@aol.com or call 401-692-0451.

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 **FLORIDA**

- 1-year clinical fellowship in otology-neurotology starting July 1, 2009 at the Ear Research Foundation/Silverstein Institute, Florida. Extensive hands-on surgery, research and patient care including chronic ear cases and surgeries, otosclerosis surgery, menieres disease, minimally invasive surgery, Cochlear implants, implantable hearing devices and acoustic tumors. Large temporal bone lab and medical library. Contact Herbert Silverstein, MD via jmoss@earsinus.com.

MICHIGAN

- Pediatric otolaryngology fellowship available at Children's Hospital of Michigan in Detroit, MI, July 2008. Please contact Dr. Michael Haupert or Dr. David Madgy at 313-745-5402.

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: pmbekar@aol.com.