


Quarterly Report

AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Winter 2008-2009, Vol. 44 No. 1



The Board of Governors, Committees and Council Members Wish You and Your Family a Happy Holiday and a Healthy and Prosperous New Year!

2nd Annual Faculty Development Seminar

The AOCOO-HNS is pleased to offer a 2-day seminar in Orlando, Florida this February 7-8, 2009 to all those interested in furthering their educational skills.

We invite all those involved in training/teaching of osteopathic medical students, interns and ophthalmology and otolaryngology residents to attend.

OTHER TEACHING FACULTY, DMES AND THEIR FACULTY ARE ENCOURAGED TO ATTEND AS WELL.

Registration Information on Page 15

Mark Your Calendars - 93rd ACA

May 6-10, 2009

Hyatt Regency Lost Pines Resort in Austin, TX

2008-2009 Officers and Members of the AOCOO-HNS Board of Governors

President: Thomas E. Brandeisky, DO
President-Elect: Sidney K. Simonian, DO
Vice President: Kirk W. Steehler, DO
Secretary-Treasurer: David D. Gossage, DO
Immediate Past President: Shoib Myint, DO
Paul E. Burk, DO
Robert B. Chambers, DO
Robert J. Franchi, DO
Michael S. Hauptert, DO
Donald M. Rothen, DO
Edward E. Scheiner, DO
Sirtaz S. Sibia, DO
Brian E. Wind, DO
CRF representatives:
Karen A. Alvarez, DO
Charles W. Guy II, DO

American Osteopathic College of Ophthalmology

President: Sidney K. Simonian, DO
Vice President: David D. Gossage, DO
Members-at-large: Robert B. Chambers, DO, Robert J. Franchi, DO, Sirtaz S. Sibia, DO, Brian E. Wind, DO,
CRR representative: Steven Sherman, DO

American Osteopathic College of Otolaryngology-Head and Neck Surgery

President: Thomas E. Brandeisky, DO
Vice President: Kirk W. Steehler, DO
Members-at-large: Paul E. Burk, DO, Michael S. Hauptert, DO, Donald M. Rothen, DO, Edward E. Scheiner, DO, *CRR representative:* Mahmoud M. Ghaderi, DO

Executive Vice President:

Alvin D. Dubin, DO

Staff:

Debra L. Bailey, Administrative Director
Cynthia Carleton-Simon, Administrative Assistant
Diane Turner, Administrative Assistant
Jennifer Hoskins, Administrative Staff Support

The *AOCOO-HNS Quarterly Report* is published quarterly by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery, 4764 Fishburg Road, Suite F, Huber Heights, OH 45424, (937) 233-5653 or (800) 455-9404, FAX (937) 233-5673. Send email correspondence to: aocoo-hns@aol.com. The AOCOO-HNS website is located at: www.aocoo-hns.org.

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



I want to open my message to the membership by reporting that Carlo J. DiMarco, DO received special recognition at the American Academy of Ophthalmology's 2008 Joint Meeting

with the European Society of Ophthalmology (SOE) on behalf of the AOA as President. AOA Past President Philip Shettle, DO, and our President-Elect Sidney K. Simonian, DO and other members of our Ophthalmology College were in attendance at the meeting. The AAO recognized the AOA and Dr. DiMarco for collaborative efforts on advocacy issues in Oklahoma, Medicare payment reform, graduate medical education expansion, and other practice expansion efforts in the states.

I encourage everyone to consider registering early for the 2009 ACA which will be held at the Hyatt Regency Lost Pines Resort in Austin, Texas. Dr. Sirtaz Sibia and Dr. Mark Welch have been working hard to bring you a quality CME program, and we anticipate the facility will be both very comfortable and a good value economically.

Preceding the ACA by three months is the Faculty Development Seminar. This will be held following the Board of Governors, Council of Medical Education, and Educational Needs Review Committee meetings at the Hyatt Regency Orlando International Airport. Anyone who is involved in Osteopathic Graduate Medical Education, whether teaching in our specialties or contributing to other residency or post-residency programs, should make plans to attend the third installment in this CME series. Please contact the administrative staff for a conference itinerary. There will be a work session dedicated to developing the general surgical curricula for the OGME 1 years in our specialties.

The Committee of Residents and Fellows continues to become more involved. Charles Guy, DO and Donna Qahwash, DO are developing student oriented discussions and workshops for resident faculty to share with students who attend our meetings. They may also be organizing the residents to answer student questions on a student blog.

Finally, they are working to shape the Research Forum for our mid-year meeting. I ask that our resident members support Drs. Guy and Qahwash in their efforts and plan on being involved at any upcoming meeting. The CRF chairs can be reached by emailing them through our Administrative Office.

Mahmoud Ghaderi, DO, the Chair of the Council of Regional Representatives, is planning a Region 1 meeting in the Spring to precede our Annual Board meetings in May. I strongly encourage other Regional Representatives to contact Dr. Ghaderi to discuss his plans. If any evening meeting can take place in each region in March, Dr. Ghaderi will be able to report your issues directly to the College Board. Please contact your representative and help them develop a forum for your region. The Board will review your agenda.

On the evening of November 17, 2008 the Board of Governors held a conference call to approve the ballot for this year's election. In past years, the Nominating Committee and BOG has tried to emphasize choice for the membership. However, a balance must be struck between the addition of new members to the Board and the exit of experienced leaders from the conference table. Each year a level of frustration has been experienced by the Nomination's Chair and the Board of Governors, attributed to how a choice should be offered, while retention of experience is balanced. This year, Sidney Simonian, DO and the Nominating Committee worked hard to develop a unique ballot which gives the membership greater choice than ever before, and they were unanimously supported by the Board of Governors. When you receive your ballots, you will see that this year two candidates will run for Secretary/Treasurer, and at the same time run for Member-at-Large. This will allow the membership to shape the Board of Governors and choose their future President by electing the Secretary/Treasurer, while simultaneously deciding if the unsuccessful candidate should remain on the Board as a Member-at-Large. This solution reconciles the need for continuity in the development of our leadership and the need for the membership to have a choice. To provide consistency in the process in the future I have appointed an Adhoc Committee to write this process down as a Rules and Regulations that will guide the Nominating Committee in the future. It will go into the Orientation Book

with our Bylaws. In the future the Board of Governors and the Nominating Committee will be responsible for searching for qualified candidates, but all the choices will be left to the membership.

We are now halfway through the year and the Board has done much on your behalf. Please contact the Office with any issues you feel we need to place on our next agenda, and consider how you can become more involved in your organization.

On behalf of the entire Board of Governors, best wishes to you and your family for health and happiness for the holidays and the year to come. This holiday season more than ever, remember to take time to reflect on what is truly important while you enjoy time with those you love.

Thomas E. Brandeisky, DO

732-458-8575, Ext. 26

Fax 732-458-7411

Email: tbrandeisky@hotmail.com

Check Your CME Credits

AOA members may check their CME credits by going to <https://www.do-online.org> and typing in their AOA ID and password and then clicking on CME. Alternately, AOA members may contact the AOA Division of CME to obtain a copy of their CME activity report via fax or email by calling 1-800-621-1773, Ext. 8262. CME activity reports are available online 24 hours a day, 7 days a week.

EXECUTIVE VP REPORT

Alvin D. Dubin, DO



2008 is coming to a close, and for many, not soon enough. The overriding doom and gloom seems to cast its shadows over much of what we do. So many have written and spoken about the many problems that we, and the rest of the world, face that I ask you to join with me in reviewing the many positive things we have enjoyed this past year.

Our Faculty Development Seminar was well attended by nearly all of our Program Directors, and many others with academic interests. It was so well received that the "Second Annual Course" is scheduled to take place in Orlando on February 7-8 2009. The Program is planned to continue to help all those involved with Training Programs.

The ACA in Scottsdale was successful in many ways. Record attendance and high ratings of the CME program via exit surveys gave much appreciated support to all those who worked so hard to make this a fine Program.

Those attending the AOA House of Delegates Meeting Chicago in July, had the pleasure of seeing our Carlo J. DiMarco, DO, installed as the AOA President 2008-2009. His theme for the year is dedicated to making OGME better in every way for the entire Profession. This is a truly awesome task, and one to be supported in every way by all of us.

The Midyear Meeting in Detroit also saw record attendance by Members, Residents, and Students from several of the Colleges of Osteopathic Medicine in the country. Their interest and support was so gratifying for all to see.

With all of the above accolades, I must admit we still have a lot of things to work on and improve.

We are always seeking ways to improve communications with you, the Members, and to be able to respond to your concerns as quickly and competently as possible.

Yes, in many ways it has also been a difficult year for all of us, both personally and professionally. And yet, our Colleges' have accomplished much to be proud of, with much more work ahead for us to do in the coming year. I believe that your Boards have planned wisely to select Austin, Texas as the site for the ACA 2009. The Resort is stunning. The price is RIGHT, and the

many activities are exciting for the entire family.

I heard from the Hyatt Corporation that they will make our registration for the ACA as effortless as possible. I encourage all of you to make your plans to come to Austin in May and reserve your rooms at the Hyatt Lost Pines Resort as soon as possible. I plan for it to be "OUR RESORT." It will be a great time for all, and a great time of the year as well!

My wish at this time to all of you is simply "Health and Happiness" for you and your families.

The Best of Holidays to all of us.



Letter from President DiMarco to President- Elect Obama

November 5, 2008

The Honorable Barack Obama
President-Elect
P.O. Box 8102
Chicago, IL 60680

Dear President-Elect Obama:

On behalf of the nation's 64,000 osteopathic physicians represented by the American Osteopathic Association, it is my distinct honor to congratulate you on being elected the 44th President of the United States.

Your message of change was ratified by over 64 million Americans on November 4th in a decisive victory for you and your campaign. The AOA and our members pledge our support for your efforts to transform the nation's health care system, ensuring health care coverage for all. We also look forward to working with you to ensure that enhanced coverage is met with increased access to physician and other health care services.

As you begin the process of forming your Cabinet, filling positions within the Administration, assembling your staff, and preparing your agenda, please do not hesitate to call upon the AOA and our members for assistance. We stand ready to assist you and your team in any manner needed.

Again, congratulations on your historic election.

Sincerely,
Carlo J. DiMarco, DO, President

2009-2010 BOARD NOMINEES

AOCOO-HNS Nominees for Board of Governor Secretary/Treasurer



Paul E. Burk, DO (incumbent)

I am honored to have served on the Board as a Member-at-Large/Member in the past, and I thank you for your continued support in nominating me for the position of Secretary/Treasurer. I have been a member of our College since 1987, board certified in 1989, and I became a Fellow in 1991.

As a member of our College, I have attended every annual meeting since 1987.

Within our College, I have served on several committees: 1999-2001 Annual Program, chairman, 2001; 2001 Image-Guided Sinus Surgery Workshop; 2004-2005 Ethics Committee, chairman 2005/2006; 1996 to present, Residency Ad Hoc; and 2004-present, chairman, Communications, which has also involved contributing articles with the help of our residents for our "Quarterly Report." In 2004, I received the Presidential Achievement Award and in 2007, the Board of Governors Award.

An important aspect of our College is the residency programs. In 1989, I was instrumental in establishing our residency training program here in St. Louis, and we have graduated a resident almost every year since then. As resident trainers, our role is invaluable to the College with respect to increasing our membership and the continuation of a high level of excellence among our membership. I feel it is extremely important to continue the support of our residency programs. The future of our College rests with today's residents.

I feel one of my biggest strengths is my ability to listen to problems and try to facilitate solutions. As an example, members have mentioned that the large amount of time spent doing paperwork is problematic. One project I have recently spearheaded is the establishment of the computerized surgical logs for Ophthalmology and Otolaryngology/Facial Plastic Surgery. This program allows the residents to store their surgical cases with more ease and transmits this information to the College electronically, avoiding paperwork. The computer program has been written and sent to all program directors. We are hoping to see all computerized surgical logs from the residents by the end of the year. The computerized year-end resident trainers report is progressing well—it should be completed and ready for implementation by February. Last, the resident program inspection computerized report will also be presented at the February meeting. Ideally, the thought is to eliminate as much paperwork as possible for the residents, trainers, residency inspectors, and the College.

I will continue to work to meet the College's needs, and I would be honored to serve as Secretary/Treasurer of the Board of Governors.



Donald M. Roehen, DO (incumbent)

I am very honored that I have been nominated to serve on the Board. I have been an active member since 1973 and have seen the College grow and flourish over these many years. I became a program director for Otolaryngology-Head and Neck Surgery in 1985. I assisted Dr.

Alvin Dubin in establishing the otolaryngic allergy program for our College, and I began the first training program in otolaryngic allergy.

I have been on the Council of Medical Education for many years, where I hope I have been of help in guiding the residents and the programs, leading to new successful ENT physicians. On this committee, I am chairman of the newly formed subcommittee, the Editorial Committee of the C.O.M.E.

I was on the Osteopathic Board of Ophthalmology and Otolaryngology for a number of years guiding the otolaryngic allergy examination process and helping with the general ENT examinations before I was elected to the Board of Governors of the College as a Member-at-Large. I have been on the Board for four years and serve as chairman of the Editorial Committee and a member of the Audit and Practice Committees.

Through my many years of service, I have gained a lot of experience dealing with small and large projects and a variety of issues. I have learned that teamwork and cooperation are two of the keys that are needed to getting things done and to have the ability to continue to develop a viable and strong organization of which its members can be proud. It is important that the members on the Board reflect the ideas and input of the membership and be accessible and accountable. This is what I hope I have done in the past and what I shall continue to do in the future, if elected.

We live in very uncertain times that affect all of us. We need to work together to make things better with a positive attitude and hard work. If elected, I will continue to do my best to represent the membership of this College.

AOCO-HNS Board Member Nominees

Members-at-Large to be Elected to a One-Year Term:

Paul E. Burk, DO (incumbent)
Michael S. Hauptert, DO (incumbent)
Donald M. Rothen, DO (incumbent)
Edward D. Scheiner, DO (incumbent)
B. Mark Welch, DO

The Board has asked that each nominee submit a statement outlining his service to the College and/or desire to serve on the Board and reasons why he should be elected.



Michael S. Hauptert, DO

(incumbent)

It is my honor to be nominated as a candidate for an AOCO-HNS Board Member-at-Large. I have had the privilege to serve in this capacity for the past two years. I have always felt it is important to give back to the College and Osteopathic Medicine. It is a crucial element in maintaining the success and longevity of our profession as well as paying respect to our predecessors and mentors. Having served as an examination question writer, designated examiner, and on the Board of Examiners prior to being elected to the present position has helped broaden my perspective of Osteopathic Otolaryngology. It has been a privilege to lecture at several of the Annual Clinical Assemblies and Mid-Year Meetings. The opportunity to help train residents while they have rotated with us at Children's Hospital of Michigan has been an exciting way for me to help in the education process of our future Otolaryngologists.

During my time on the Board, I have seen significant positive improvements being made. The ENRC has done an excellent job of standardizing and improving the quality of lectures at the Annual and Mid-Year Meetings. The attendance at these meetings continues to rise. The formation of the Council of Regional Representatives and Resident Representation on the Board of Governors have been positive steps to better unite the membership of our College. The Board strives to engage the membership and encourages participation by all members. I want to continue to build upon these successes as well as always being open to exploring new and innovative ways to benefit the College, its membership, and our profession. I would be honored to be allowed to continue to serve our College and you, my colleagues. I respectfully ask for your thoughtful consideration to serve another one year term as an AOCO-HNS Board Member-at-Large.



Edward D. Scheiner, DO

(incumbent)

I have been a member of the AOCOO-HNS since the start of my residency training in 1981. I have attended every Annual Meeting since 1988. Since starting in practice, I have been involved in the training of residents. I have been program director of the residency training program at UMDNJ-SOM/Kennedy Memorial Hospital since 1996. I have also been a member of the Council of Medical Education since 2001, and I was elected a Member-at-Large of the Board of Governors two years ago.

My desire to continue in my current role as a member of the Board is fueled by my concern for the significant issues facing our specialties over the next several years. My involvement with residency training at both the local and national level has given me insight into the many deleterious factors facing our organization and specialties. It is extremely important that the officers of our College continue to advocate on behalf of our specialties the need for improved support by the AOA and the federal government, particularly concerning the increasing need for continued and improved funding to allow our training programs to maintain high standards in training, as well as the need to increase the number of residents trained to meet the growing needs of the osteopathic profession and the overall population.

I feel that it is imperative that members of our College, particularly those with many years of experience on a clinical and managerial level, contribute their talents to our organization. After 24 years in practice, I feel that I have acquired a good understanding of the issues facing physicians in otolaryngology on a national level, as well as on a local level. I very much want to be a part of the continued growth and strengthening of our organization.

Certainly a major issue concerning the continued welfare of our organization is the need to strengthen our current residency programs and increase the number of trainees graduating from these programs. The upcoming increases in numbers of graduates of medical schools must be accompanied by increased opportunities for these graduates to pursue careers in Otolaryngology. My experience as a Program Director, member of the Council of Medical Education, and Member-at-Large of the Board gives me an opportunity to contribute towards achieving this goal, as well as addressing the many issues affecting medicine in general that affect all of us.

I would appreciate your support for my candidacy for a continued position on the Board, and will do my best to represent each of you.

B. Mark Welch, DO

AOCO Board Member Nominees

Members-at-Large to be Elected to a One-Year Term:

Robert B. Chambers, DO (incumbent)
Robert J. Franchi, DO (incumbent)
Jeffrey N. Holtzman, DO
Brian E. Wind, DO (incumbent)
Sirtaz S. Sibia, DO (incumbent)

The Board has asked that each nominee submit a statement outlining his service to the College and/or desire to serve on the Board and reasons why he should be elected.



Robert B. Chambers, DO

(incumbent)

It was an honor to have been nominated to serve as a Member-at-Large of the AOCOO-HNS. My desire to serve these Colleges reflects an ongoing commitment dating back to 1989 when I was appointed as a designated examiner for the

American Osteopathic Board of Ophthalmology and Otolaryngology-Head and Neck Surgery. After examining in each subsequent year, I was asked to join the Examining Board in 1993 where I served as secretary, Vice Chair and Chairman of the Board. Because of some transitional issues on the Board, I was asked to serve two years as Board Chairman. In 1998, I received the Governor's Achievement Award for service to the AOCOO-HNS. I have also been a member of the Council of Medical Education and have served the College as a program inspector for residency certification. I have also served on several ad hoc committees at the request of the Board and the Colleges. I was residency program director at Ohio State University for 12 years and received Teacher of the Year award three times from the Department and once from the Ohio State University College of Medicine for the department.

Since my term on the AOBOO-HNS expired in 2006, I have missed the interaction with individuals dedicated to the preservation and betterment of osteopathic ophthalmology and otolaryngology. While most of my experience has been on the educational and examining side of things, I look forward to the possibility of working with the Board of Governors of these Colleges on advocacy issues. I would hope that my experiences on the Board of Examiners would help me provide insight regarding issues that affect both of these important missions of our organization.



Robert J. Franchi, DO

(incumbent)

I am flattered to have been nominated once again for an at-large position to the American Osteopathic Board of Ophthalmology. To date, I have served our College in several different capacities which include: Chairman of the professional program for the Ophthalmology section in Miami, Florida and Scottsdale, Arizona. I have submitted written test questions for ophthalmology certification examinations and served on subcommittees including that of Continuing Medical Education for the AOCO.

Having served the College and its membership, I have interacted with many Board members in a spirit of cooperation and teamwork. Most recently, I have served your College as a Member-at-Large for the past two years including chairmanship of the Communications Committee and membership on the Ethics Committee. In my charge, our committee has helped to improve access, usability and provided more pertinent information to our College website. I feel my prior experience and willingness for our College to grow in national stature will continue to serve me well as an elected Board Officer.

Thank you again for your confidence in nominating me for this position.



Jeffrey N. Holtzman, DO

It is again an honor to be nominated to serve on the Board of Governors as a Member-at-Large. I have gained a great deal of knowledge about the workings of the AOCOO-HNS. I feel that this knowledge and experience on the Board will help me serve the membership well. My interests and strengths have allowed me to serve on the

Council of Medical Education this year. The strength of our organization rests on the continual improvement of our residency programs and involvement of our new members. As a program director for many years, I have mentored young ophthalmologists. I hope to be able to encourage these new members to increase their commitment to our profession and our College. I am convinced that by increased involvement by more members, our organization will grow and impact our patients for the better. We are our patients' best advocates.

Over the past several years, our Board has revised their structure and Bylaws. I would like to continue to assist in this evolution as secretary. The focus on improving education, both on the CME level and in residency training, is impressive. We need to look critically at ourselves to improve and grow. I hope to be able to represent you in this manner.



Sirtaz S. Sibia, DO (incumbent)

I am honored to be nominated again for the position of Member-at-Large of our College. For those of you who do not know me, I would like to give you some background. I graduated from the Detroit Osteopathic Ophthalmology Consortium in 1999. I then completed an Ophthalmic and Facial Plastic

Surgery Fellowship at the Beraja Medical Institute in Miami. I am currently in private practice in Boynton Beach and Lake Worth, Florida.

I have been actively involved in our College for the past nine years since I graduated from residency. I have been a speaker at the Mid-Year Meeting twice and have run a workshop at our Annual Clinical Assembly on four different occasions. I have been a member of the Communications Committee and Educational Needs Review Committee for our College for the past several years. I also was chairperson for the 2006 Mid-Year Seminar in Philadelphia and the 2008 ACA meeting in Scottsdale, Arizona. Currently, I am the chairperson for the 2009 ACA meeting in Austin, Texas.

I hope you, the membership, will continue to give me the opportunity to serve as a Member-at-Large. Thank you for your support.



Brian E. Wind, DO

(incumbent)

It has been my privilege to serve on the AOCO Board for the past two years, and I am again honored to be nominated for the Member-at-Large position. As a Board member of this organization and chairman of the Practice Committee, I feel it is my responsibility to promote, support and advance the AOCO. As medicine continues to become fragmented by external forces, it is important that our organization increase efficient communication between AOCO physicians and utilize the untapped resources and talents of our membership.

Having recently completed my third year on the Board, I have gained much insight into our College and the challenges that our organization faces in the future. I enthusiastically look forward to continuing to serve as a Member-at-Large and promoting the high standards of the AOCO. Thank you for your support and confidence in considering me for this position.

Member News

2009 ACA

Ophthalmology Coding Seminar

During the upcoming 2009 Annual Clinical Assembly, an ophthalmology coding seminar is being offered. The ACA Program Chairman, Dr. Sirtaz Sibia, asks that members submit billing and coding questions for our professional coder to answer. These coding questions should be emailed to the College Office by January 31st, 2009 (aocooHNS@yahoo.com). These will be collated and submitted to the presenter so that answers to your specific questions can be provided.

Carlo J. DiMarco, DO

During the recent American Academy of Ophthalmology meeting, Dr. DiMarco was presented with the 2008 Special Recognition Award:

"In recognition of the commitment of the American Osteopathic Association and its members to excel in ophthalmology by helping meet the vision related health care needs of individuals, families, and communities; through commitment to supporting the preservation, correction and rehabilitation of vision. The President and Board of Trustees of the Academy gratefully take this opportunity to honor you with this expression of our appreciation and welcome you to our Joint Meetings in Atlanta, Georgia 2008."

Custom Implants

By Paul E. Burk, DO

A new market is developing in the world of Craniomaxillofacial (CMF) plating. Custom CMF plating has developed in response to the growing number of patients with severe craniofacial trauma. The wars in Iraq and Afghanistan have greatly increased the number of US soldiers with similar injuries. Custom CMF implants are manufactured using a 1mm cut CT with 3D reconstruction. The result is a tailor made polymer implant to fit the patient's specific defect.

According to Millennium Research Group's US Markets for Devices 2008 report, this is an emerging market with great potential. They claim that the plate and screw fixation market will grow from

less than \$200 million in 2007 to nearly \$300 million in 2012. This growth will be primarily driven by custom implants. Both orthopedic and CMF devices are currently on the market.

Our practice is currently in the process of ordering a custom implant for a patient with multiple severely comminuted craniofacial fractures. It has taken over two weeks for our implant to be manufactured. Our patient was too ill for reconstruction within a standard time period and this delay has not hindered his care. However, for patients who are healthy enough for optimal timing of their surgery, this may be an excessive delay. I expect that the process will soon be streamlined and that custom implants will soon be available in an appropriate time frame.

Report of the AOA Bureau of Federal Health Programs

September 26, 2008

Capital Hilton, Washington, DC

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

(Dr. Imber and I divided up this report at lunch. Paul presents the morning session, and I report the afternoon session. If the same topic is presented more than once, that is the way it happened. The presenter's initials are included with each report in case you wish to ask for additional information from that person.)

On Friday, September 26, 2008, Senator Barack Obama, Senator John McCain, President George W. Bush, and the leadership of the US House of Representatives, the leadership of the US Senate, along with the AOA Bureau of Federal Health Programs, Paul Imber, DO and Wayne Bizer, DO had meetings in Washington, DC. Unfortunately, the first group met in the Cabinet Room of the White House, and the DOs met less than a mile away at the Capital Hilton Hotel. So close, yet so far away. History has shown that the DO meeting was more successful than the one in the White House.

I open this AOA Federal Health Programs report in this manner to focus your attention of the perspective of where we, Eye and ENTs, DOs and the entire House of Medicine, stand in relation to the greater needs of our country.

Some say that America has never been in as much trouble as we find ourselves in today. Certainly, we can say that health

care, your needs, and the needs of your patients have never been in as much trouble as they are in today. The list of crises seems never ending. The credit crisis, the banking crisis, the housing crisis, the fall of the dollar, the national debt, the trade deficit, the wars in Iraq and Afghanistan and on terror, the crisis in education, the crumbling infrastructure of America, the physician manpower crisis, the uninsured Americans, the baby boomers on the way to entitlements, the health care crisis and most severe, a nation divided into two camps, each of which shows very little respect or appreciation for the position of the other.

And into this chaos of unsolvable problems, conundrums if you will, a few of us came to Washington to represent you, your family, and your patients. Talk about David and Goliath! Yet, to do nothing is to ensure failure, and to do something is to dare to make progress. WFB

Intro

PMI

Well! We dodged another bullet in July. As you are well aware, the SGR 10.6% cut was delayed, along with the 5% cut scheduled for January, 2009. The bad news is that the projected physician Medicare payment for January, 2010 is now 20%. You see, Congress did not find the money, they just delayed the cut for us to pay the following year. In fact, by 2016 our Medicare payments are projected to drop by 40%, while our practice expenses are projected to increase by 40%. 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 release 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.

Thomas Russell, MD (Executive Director, American College of Surgeons)

PMI

Well, quite obviously, politics make for strange bedfellows. The last bastion of

allopathic resistance to DOs (ACS) is now joined with the AOA in a coalition of organized medicine. Dr. Russell is an erudite speaker with a strong depth of knowledge and perspective on the future of the American Health System. He explained that we (the Doctors of the USA) can either “defend the past and protect from the future, or plan for the future of the Medical Profession.” Our old environment was that of physician autonomy, with docs in control and with authority (maybe 20 years ago). The future environment will be one of collaboration, evidence-based medicine, with transparency and accountability. There will have to be a “*Professional transformation of the ethics of what we physicians do!*”

As noted above, Dr. Russell confirmed the reversal of the Medicare cuts was just a postponement. We are scheduled for 20% cuts in 2010, and a total of 40% cuts by 2016. The interesting, and absurd, fact is that E&M and major surgery expenses have been flat over the past several years. The massive increase in Medicare expenditures has been imaging studies and pharmaceuticals. Of course, the cuts do not affect those costs. There must be some governmental logic course that I foolishly failed to take in college, for I can not bring the facts to justify the government’s conclusion.

Meanwhile, the costs are further inflated by over utilization. It is estimated that “defensive medicine” costs up to \$100 billion a year in unnecessary studies and procedures. Costs are further inflated by patient expectation “I want it and I want it now.” Why order treatments and studies based on the results of evidenced-based studies, when your patients can read the latest and greatest treatments in their rag mags and then demand those services. Who are you to fight with your patient (read “customer”), who is always right and really not worth your spending 15 minutes arguing (read “I could have done another level 3 follow-up visit”). Dr. Russell also suggested that direct access to specialty care is also increasing medical costs; smells like gate-keeper, referral, capitation days are coming back to haunt us.

His conclusion is that we will be practicing value-based medicine, with an emphasis on wellness and preventative care, early intervention and prevention, and with treatment protocols developed from evidence-based medicine.

Medicare

PMI

The Medicare Improvements for Patients and Providers Act of 2008 is described

above, both the good, the bad, and the very ugly. Also in this legislation is an extension of the PQRI program as a voluntary adventure with bonus payments increasing to 2% (that calculates to \$4,000 if you collect \$200,000 from Medicare, and you have met all of the criteria- over half of those reporting last year did not). In addition, e-prescribing will now be mandatory by 2011. Another 2% increase will be applied when you institute e-prescribing between 2009 and 2011. There will be penalties applied for non-compliance after 2011.

Health Information Technology

PMI

There are several bills being proposed and constructed in the House of Representatives concerning the implementation of Electronic Health Records (EHR). A recent hearing of the House Ways and Means Committee has been informed by the Congressional Budget Office that aggressive adoption of EHR coupled with comparative effectiveness research could yield savings of \$700 billion. The difficulty is how to encourage physicians to implement EHR into their daily practices. Opinions vary from the carrot or the stick. Many believe that cost relief would encourage adoption. The Congressional Budget Office believes this would only pay for those systems that would have been implemented anyway. It suggests the stick, stiff penalties for lack of compliance within a reasonable timeframe. It was also suggested that EHR be a requisite for Medicare participation. “We’re your Federal Government, and we’re here to help you!”

Med PAC

PMI

The Medicare Payment Advisory Committee (Med PAC) is examining the economic and financing challenges facing Medicare as part of its March 2009 report. The purpose is to put Med PAC’s recommendations within the broader budget, policy, and health care delivery context in which the Medicare program operates. Major factors in the growth of health care spending are technology, income, insurance, prices, changes in longevity and demographics, and changes in health status. This all reads great, but the reality is the desire to cut payments to providers.

So, how are they proposing to pay less? This is a progressive program. It began with PQRI, or P4P. Remember, over 50% of medical practices participating in PQRI received less than they anticipated when they entered the program. Now, they

have instituted the Never Events. This allows non-payment for “never event” complications and their treatment. This currently applies to hospital reimbursements, but it is anticipated to extend to physicians soon. They are also looking closely at hospital re-admissions, which are about 30% of all hospital admissions. The Med Pac wants to reduce reimbursement for these re-admits. Next will come the Medical Home. This promotes a patient-centered program with a Personal Medical Navigator. Call me naïve, but sthis ure sounds like the old HMO gatekeeper program. Further, they will institute Primary Care Payment Reform, going to capitation, payment per patient per month. This will bundle payments for the Medical Home. For the Medical Home to be successful, it must be in a nice Medical Neighborhood. These are the most absurd euphemisms for managed care, HMO, and capitation I have ever heard. We have seen all of these attempts fail in the past, with abuses abounding.

Other concepts for the future include “gain sharing,” where large multi-specialty integrated groups can share the savings by reducing costs, in a global capitation plan, kind of like Kaiser Permanente. Another novel idea. The there is the program recently instituted by Geisinger Clinic. They are offering Episode-Based Medicine, giving a 90-day warranty on all services for any and all complications. Their payments are bundled, and of course their physicians are employees.

The reality is we are being herded into an organized system of healthcare delivery, with practice guidelines from evidenced-based medicine, extrapolated from the EHR data provided from our practices, and paid for by us. Sounds pretty Draconian. However, CHANGE IS INEVITABLE.

We must work together, as part of the collective process. We must recognize that there will be sacrifices by all parties, tensions will be high, and the desire to only watch our individual backs will pervade. But, we must rise above the pack, remember our Osteopathic Oath, and participate in developing the program. As Wayne Gretsky said, “I don’t skate where the puck is; I skate where it is going to be.”

Graduate Medical Education

PMI

You should be aware by now, that CMS is balking about carrying the cost of GME on its shoulders through its 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 CEOs, CFOs, DMEs and lay and physician leadership. There are already over fifty consultant volunteers, and a Task Force Handbook has been developed.

2009 Medicare Physician Fee Schedule

Proposed Rule

WFB

The final CMS rules concerning 2009 physician reimbursement will not come out until November 2008. Currently, physicians can expect a 1.1% increase in fees in 2009 instead of the 5.4% decrease in fees that was planned. (2010 is scheduled to have a 10% fee cut and 2011 a 20% cut). There is supposed to be improved coverage for preventative services (yet to be explained), a 2% incentive for Physician Quality Reporting Initiative, incentives for electronic prescribing, and expanded access to primary care services. Don't go to the bank yet.

2008 Physician Quality Reporting

Initiative

WFB

In July, CMS sent out bonus checks to physicians and other eligible professionals who successfully participated in PQRI 2007. Approximately 16% of all physicians participated in the program and approximately 50% of them received a bonus. Many participants were surprised to find that they did not qualify and were miffed to find that they failed to qualify due to reporting errors like not including the NPI number with their claims. For more information you may go to www.do-online.org

ICD-10 Proposed Rule

WFB

Just what we need, new codes. HHS has released a proposed rule that would modify the way we file diagnoses and procedures. We currently use a code set called ICD-9. The new ICD-10 would have new codes for all diagnoses and all procedures and would have an effective implementation date of October 1, 2011. The new codes are expected to improve health care by

making it possible to identify resource consumption differences and outcomes and more precisely describe what is actually done to a patient. This conversion to a new code set will be confusing and costly, and the AOA has requested HHS to require a comprehensive impact analysis of all covered services.

Americans with Disabilities Act

Proposal

WFB

Amendments have been proposed by the Department of Justice to the 1990 American with Disabilities Act that may impact you and your practice. The proposed amendments include a provision that would require physician's offices and other facilities to provide auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities and their companions that have disabilities. The AOA agreed in principal with these efforts but pointed out that this is an unfunded mandate that can cause a significant burden on physicians with translator/interpreter services ranging anywhere up to \$150 per visit with no ability to recoup that expense.

Practicing Physician Advisory Council

(PPAC)

WFB

PPAC met in August and dealt with many issues including difficulties with the National Practitioner Identifier (NPI) and many other issues. Particularly interesting was the fact that many hospitals seem to be making a windfall by readmissions of patients recently discharged. Approximately 40% of the revenue of some hospitals is coming from re-admissions.

Health Information Technology

WFB

The alphabet soup is working and is smoothing the transition into EMR and HIT. Sources told us that we can expect this subject to move into law in the near future and that there will be some form of financial incentive/disincentive attached to the yet-to-be-formulated plan.

Martin Doperak, DO

WFB

Martin Doperak, DO, a Major in the US Army, gave an interesting presentation on DOs in the Army. I found it interesting that Robert McNamara was the Secretary of Defense in 1966 when he made the rule change that DOs could serve in the US Army as Physicians and officers equal to allopathic physicians. The first DO in the Army was Harry J. Walter, DO. I also found it interesting that in 1998, Ronald Black, DO rose to the top of the physicians

in the Army and was appointed Surgeon General of the Army.

Much of Dr. Doperak's talk was about the advantages of Graduate Medical Education in the Army. I noted from a very busy slide that there are 34 Army residents in Ophthalmology and 37 Army residents in ENT. I was also impressed that 95% of Army-trained residents pass their board exams, while only 82% of civilian residents pass their boards.

Dr. Doperak did discuss his tribulations with the computerized medical system used by the military, AHLTA, which he said some say stands for "Aw Heck, Let's Try Again."

Special Order of Business: Health

Policy Fellow Reports

WFB

You may be aware that Barbara Ross Lee, DO heads the AOA Health Policy Fellowship Program. One of our members, Mike Krasnow, DO (ophthalmology), completed this year-long intensive study course that focuses on government, health policy, and how and why things happen in the entire field of health care. Three of the fellows who were completing their course gave reports to the Bureau. I found one of them particularly interesting and want to share some of the information I learned with you.

The presentation was by Harry E. Manser, DO MBA, and it was titled "Access to Affordable Health Care through Retail Medical Clinics." You may have heard that Wal-Mart and Walgreen's and other retail stores are in the process of opening "Nurse in the Box" offices within their retail stores. This report studied the current state of that process.

Dr. Manser advised that Walgreen's will have 200 locations in 2008, and Wal-Mart expects 400 locations by 2010. In addition to providing primary patient care from nurse practitioners, these store front locations will be open 24/7 and will offer preventative services, patient education and referral to appropriate physician services.

The data suggests that the average cost for these services is between \$40 and \$70 per visit. Many insurance companies and managed care plans (BC/BS, Aetna, Cigna, United, and Humana) are waiving co-pays for patients who choose to go to one of these centers instead of to emergency rooms or the doctors' office.

There were 141,000 nurse practitioners in 2004 and that number is expected to grow by approximately 10,000 per year, while we expect a shortfall of primary care physicians of 50,000 by 2010. Can you see the mega-trend here?

One of the DOs in attendance mentioned that his studies concluded that none of these Retail Medical Clinics was making money despite the large amount that was being spent by patients and their families while shopping in the retail store. He advised that these Retail Medical Clinics had little choice but to expand their scope of services and practice, and that would bring them into greater competition with primary care providers.

Even more interesting is the effort of certain large vertical health care entities to co-brand with these retail care centers. St. Vincent's Hospital in New Jersey is "co-branding" with Wal-Mart. Your local hospital or teaching institution may soon announce a partnership with these retail medical offices and direct referrals to the health care center.

DO ON THE HILL DAY 2009 WFB
DO on the Hill Day will be held in Washington, DC on March 5, 2009. This meeting is earlier in the spring than past years and will make "DO on the Hill Day" the first medical lobbying "Hill Day" of any medical group in 2009. Registration for this important lobbying effort will begin in November. This year is going to be special as the American College of Osteopathic Family Practice will hold its annual meeting in DC to allow its 800 or so attendees to participate in Hill Day. These 800 DOs will be joined by approximately 800 osteopathic medical students and hundreds of other DOs like yourself, who give up a day in the office to come, many with their entire families, to Washington, DC to see how America works. Please stop for a moment and seriously consider if you and your family can join us on March 5, 2009. You are needed here, and you and your family will find it a great family memory of a lifetime. Wouldn't it be a great parenting event to take your kids to Washington, DC and meet your legislators in a group lobbying effort like this one?

O-PAC WFB
I always close my report with O-PAC because I always save the best and most important for last. O-PAC, the DO Political Action Committee, is now \$77,000 short of joining the most successful health care PACs in America, the ones that raise \$1M or more per two year election cycle. This added muscle gives us the power to become a bigger and more important player in health care advocacy. Does that sound like

something that you need?

This is a very successful organization, it works for you and your patients, and it deserves your financial support. There are 66,000 DOs. If you divide the \$923,000 that O-Pac has already collected by those 66,000 Dos, you see that the average DO has contributed only \$14.00. Are any of you unable to afford a \$20 donation to O-PAC? Can you think of any reason not to make a contribution to O-PAC? **WAKE UP AND SEND YOUR CHECK TO O-PAC NOW. Make your check payable to O-PAC and mail it to Kristen Beaubien at the AOA at 1090 Vermont Ave. NW, Suite 510, Washington, DC 20005. NOW!**

**DON'T BE A "FREELOADER,"
CARRY YOUR OWN WEIGHT AND
MAKE any CONTRIBUTION TO O-
PAC TODAY....any contribution!**

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 to 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-PAC, ENT-PAC, and or Eye-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 frustrated 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.

AOA Washington Update

TAKE ACTION - Register for DO Day on Capitol Hill 2009

Registration has opened for DO Day on Capitol Hill 2009. DO Day on Capitol Hill is the osteopathic profession's premier advocacy event. For veteran and first time advocates alike, DO Day provides you with your first opportunity to come to Washington, DC and lobby a new Congress and Administration on key health care issues.

Each year, hundreds of your colleagues come to Washington and make their voices heard. Are you planning to be one of them? Join us on March 5th and impact health policy at its source. Register now at www.do-online.org/ today.

Medicare Conversion Factor Announced

Effective January 1, the Medicare conversion factor for physician services will be \$36.0666, which includes a 1.1 percent payment update resulting from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), according to the 2009 Medicare Physician Fee Schedule final rule.

The AOA provided lengthy comments on the proposed rule on issues such as diagnostic imaging, incentive payment/shared savings programs, hospital acquired conditions (HAC), Physician Quality Reporting Initiative (PQRI) and the MIPPA provisions.

The Centers for Medicare and Medicaid Services (CMS) have decided not to finalize their proposal at the present time to require physicians to enroll as Independent Diagnostic Facility Centers and have reopened its comment period for the incentive payment/shared savings provision for an additional 90 days. CMS is looking to expand its Value-Based Purchasing initiatives and plans to hold a public listening session to discuss the expansion of the HAC payment provision, specifically targeting both the inpatient and hospital outpatient department (HOPD) settings of care.

For the 2009 PQRI, eligible professionals who satisfactorily report data on quality measures for covered professional services furnished between January 1, 2009 and December 31, 2009 will receive an incentive payment. The incentive payment is equal to 2.0 percent of the total estimated allowed charges submitted by no later than February 28, 2010 for all covered professional services furnished between January 1, 2009 and December 31, 2009.

In addition, CMS is establishing an Electronic Prescribing Incentive Program, as authorized under MIPPA. The new program will provide an incentive payment of 2.0 percent if the professional meets the program requirements for being a successful e-prescriber.

Between the 1.1 percent payment update and the two percent incentive payment for PQRI and the two percent incentive payment for e-prescribing, physicians may see a pay boost of 5.1 percent in 2009. For more details on the 2009 Medicare physician fee schedule, go to www.cms.hhs.gov.

FTC Postpones "Red Flag" Rule

The Federal Trade Commission (FTC) has suspended enforcement of the new "Red Flag Rules" until May 1, 2009. The rules, which require financial institutions and creditors to develop and implement written identity theft prevention programs, were supposed to go into effect Nov. 1. However, the FTC recently acknowledged that many entities were unaware of the requirements and did not know that their activities could fall under the definition of financial institution or creditor. The identity theft prevention programs must provide for the identification, detection, and response to patterns, practices, or specific activities - known as

"red flags"- that could indicate identity theft. The definition of creditor has raised several concerns for the physician community. According to the final rule, a creditor is "any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew or continue credit." Some FTC attorneys have taken the position that physicians are creditors if they do not require full payment upfront at the time they see patients, but bill patients after the services are rendered.

The AOA, along with other physician associations, are calling on the FTC to not apply the rules to the physician community. The inclusion of physicians under the creditor definition could force practices to require payment upfront from their patients and have the patients deal with their insurance companies, disenfranchise low income patients, and put practices at risk for denying care to those with suspicious identification or who lack identification. In addition, it is the AOA's belief that physicians already are required to protect patients' medical information under the HIPAA privacy rule. The AOA is closely tracking developments and will provide updates on FTC's actions.

Recovery Audit Contractors on Hold

The Centers for Medicare and Medicaid Services (CMS) plan to expand their Recovery Audit Contractor (RAC) program nationwide is temporarily on hold. CMS recently announced four contractors for the RACs, but the contracts are being protested by two unsuccessful bidders. Due to the protests filed, an automatic stay will stop work for all four RAC regional awards until a determination is made by the General Accountability Office (GAO). The GAO has 100 days to issue its decision, after which the program will go forward.

The agency has made several changes to the RAC to make the program less burdensome to the provider community and to assure more accuracy. For example, to minimize burden, CMS is limiting the number of medical record requests and the RAC "look-back period." For accuracy, each RAC must have a physician medical director and certified coders. CMS also calls for a new issue review board (greater oversight), an independent validation

contractor, and annual accuracy rates for each RAC.

CMS gave some advice on how to prepare for a RAC audit: 1) know where previous improper payments have been found (OIG, CERT, Demo RAC Reports); 2) know if you are submitting claims with improper payments; 3) get ready to respond to RAC medical record requests fully and promptly; 4) appeal when necessary; 5) keep track of overpayments and underpayments the RAC finds in claims.

FDA Seeks Comments and Issues Rule on Reporting Adverse Events

FDA Establishes New Site for Online Reporting of Adverse Events; Seeks Comments

The FDA is seeking comments on the new web portal it is developing which would provide one place to report adverse events of regulated products. Comments are due to the agency by December 22. Complete information can be found at: http://www.access.gpo.gov/su_docs/fedreg/a081023c.html

The new system, MedWatch Plus Portal, is an improved, web-based version of its current MedWatch system. This new electronic system will be for collecting, submitting, and processing adverse event reports and other safety information for all FDA-regulated products. The portal will include a data collection tool called the Rationale Questionnaire. Anyone will be able to use the questionnaire to submit adverse events, product problems, consumer complaints, and medication use error reports to the FDA.

FDA Issues Final Rule on Toll Free Number for Reporting Adverse Events

The FDA issued a final rule entitled "Toll-Free Number for Reporting Adverse Events on Labeling for Human Drug Products." The Best Pharmaceuticals for Children Act (BPCA) (Public Law 107-109) directed FDA to issue a final rule requiring the labeling of medications approved under section 505 of the Federal Food, Drug and Cosmetic Act. The labeling includes a statement that has listed a toll free number maintained by the FDA for the purpose of reporting adverse drug events and advises that the number is to be used only for reporting side effects and is

not intended for medical advice. The statement is as follows: "Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088." This final rule also affirms the interim final rule's addition to the regulations requiring distribution of the side effects statement by pharmacies and authorized dispensers in an outpatient setting.

The final rule is effective November 28, 2008, and all affected entities are required to comply by July 1, 2009.

New Drug Safety Web Page

FDA has announced a new web page on its site where patients and health care professionals can go to find a variety of information regarding prescription drugs: <http://www.fda.gov/cder/drugSafety.htm>. Among the items on the site:

- Drug labeling information, including patient labeling, professional labeling, and patient package inserts
- Drug-specific safety information, including safety sheets with the most recent information and related FDA press releases, fact sheets, and podcasts
- Warning Letters, Import Alerts, Recalls, and Safety Alerts
- Regulation and guidance documents, consumer information about safe use of medications, and information on disposing of unused medicines.

2008 Election Results

On Tuesday, November 4, the Honorable Barack Obama was elected the 44th President of the United States. President-Elect Obama defeated Arizona Senator John McCain in an impressive and convincing manner. President-Elect Obama received 66.9 million votes (53%) to Senator McCain's 58.3 million votes (46%). He collected 365 Electoral College votes. Senator Obama secured the largest popular vote margin by a Democrat since 1976.

Democrats also enjoyed broad success in races for seats in the United States Senate and House of Representatives. Democrats picked up at least 56 seats in the Senate (3 races are not final) and over 20 seats in the House of Representatives.

The following is a breakdown of the 2008 Election:

Electoral College Vote

Obama 365, McCain 173

Popular Vote

Obama 66.9 million (53%), McCain 58.3 million (46%)

United States Senate

Democrat 56, Republicans 40, Independents 2

Undecided

Minnesota and Georgia

House of Representatives

Democrats 257, Republicans 176

Undecided

4 races: LA-2, LA-4, OH-15, CA-4

Hill Fact: Library of Congress

The Library of Congress is the research arm of Congress. It is also the oldest and largest library in the world.

The original collection of books was housed in the Capitol building, which was burned by British troops in 1814. In 1815, Congress approved the purchase of Thomas Jefferson's personal library of 6,487 books for \$23,950 to help rebuild the collection.

Now, the Library of Congress is home to more than 138 million items on approximately 650 miles of bookshelves. Much of the Library's size is due to its role as the United States Copyright Office. The Library receives a copy of every book, pamphlet, map, print and piece of music registered in the United States.

The Library of Congress' primary mission is researching inquiries made by members of Congress. The building is open to the public but only legislators, Supreme Court justices, and other high-ranking government officials may check out books.

AAO News

Glycemic Control Appears to Reduce Type 1 Diabetics' Retinopathy Risk; Night Vision Symptoms May Predict Macular Degeneration Progression

Highlights of the November 2008 issue of "Ophthalmology"

This month's *Ophthalmology*, the journal of the American Academy of Ophthalmology, reports on the conclusions from a population-based study of risk factors related to progression or regression of diabetic retinopathy over a 25-year period in people with Type 1 diabetes, and on the associations found between night vision symptoms and progression of age-related macular degeneration (AMD) in a cohort study within the Complications of Age-Related Macular Degeneration Prevention Trial (CAPT), a multi-center randomized clinical trial.

Risk Factors for Retinopathy in Persons with Type 1 Diabetes

Many people who have Type 1 or Type 2 diabetes develop retinopathy, a serious disorder that damages the eye's retina, the area of the back of the eye where images are focused and relayed to the brain's visual cortex. Ophthalmologists (Eye MDs) monitor their diabetic patients for signs of retinopathy and use lifestyle recommendations, medications, and surgical approaches as appropriate to reduce the risk that diabetic retinopathy (DR) will progress to the proliferative stage (PDR), in which abnormal blood vessel growth leads to visual impairment. In recent years the diagnosis, prevention and treatment of DR and PDR have improved markedly.

The Wisconsin Epidemiologic Study of Diabetic Retinopathy (WESDR) is a large, long-term study that confirmed and expanded on results of other significant DR studies such as the Diabetes Control and Complications Trial. Ronald Klein, MD, and colleagues evaluated factors associated with the progression or regression of retinopathy over a 25-year

period in people who had been diagnosed with Type 1 diabetes before the age of 30 years. The key finding was that glycemic control assessed via blood levels of glycosylated hemoglobin A1c, a reliable measure of average blood sugar at the time of the baseline exam and throughout the study was strongly related to whether a patient's DR worsened or improved. This confirmed findings of a number of earlier large studies. Better glycemic control was associated with significant reduction in DR progression and increased improvement in DR independent of how long the patient had had Type 1 diabetes and the level of DR at the baseline exam. Other risk factors found by the WESDR to be associated with progression to PDR included male gender, higher blood pressure level, presence of protein in urine (a manifestation of diabetic kidney disease) and a greater body mass index as measured at baseline.

WESDR participants were 955 insulin-taking Type 1 diabetics who received baseline exams between 1980 and 1982 and were either evaluated again four years later or died before the four-year follow up. Additional follow up exams were done at 10, 14 and 25 years post-baseline, and 520 of the original participants completed the 25-year follow-up.

Based on WESDR findings, the researchers estimate that over a 25-year period, 185,000 to 466,000 Americans with Type 1 diabetes will develop PDR. Dr. Klein adds the caution that these numbers may be an overestimation, because PDR incidence has declined in people diagnosed with Type 1 diabetes in recent years, possibly due to proactive and improved treatment of glycemia and blood pressure.

What Might Declining Night Vision Mean for AMD Patients?

The Complications of Age-Related Macular Degeneration Prevention Trial (CAPT) Research Group assessed night vision in a cohort of 1,052 CAPT patients. The main purpose of CAPT, a National Eye Institute-sponsored multicenter randomized clinical trial conducted from 1999 to 2005, was to investigate whether low-intensity laser treatment could prevent vision loss in patients with early stage age-related macular degeneration (AMD). In advanced stages, AMD destroys the macula in the eye's retina, the area that normally provides the

detailed, central vision we rely on for reading, driving and other daily tasks. The CAPT results did not show that the laser treatment prevented vision loss, but data from the CAPT cohort did identify a new way to predict AMD progression.

Earlier studies had shown that loss of photoreceptor (light sensitive) cells, particularly "rod" cells involved in night vision, occurs before the disease progresses to advanced AMD in the retina, which indicated that assessing night vision might be a good way to track AMD progression. In the CAPT, patients with signs of early AMD, defined as 10 or more large deposits known as drusen on the retina and vision 20/40 or better, initially completed a 10-item night vision self-assessment questionnaire that rated difficulties with night driving and problems with vision deficits during low-light activities like reading or watching movies. The patients were followed-up annually up to five or six years. Data analyses led by Gui-shuang Ying, PhD, showed that those who had the worst night vision at baseline were the most likely to develop geographic atrophy (GA), or choroidal neovascularization (CNV) and to experience reduced visual acuity. GA is also known as advanced "dry" AMD, and CNV as "wet" AMD.

Since the association of night vision symptoms and AMD progression is clear, and the 10-item questionnaire is simple and inexpensive to administer, Dr. Ying concludes that this could be a useful way for ophthalmologists to identify patients at high risk and intervene early to prevent vision loss and the progression to advanced AMD.

Eds: Full texts of the studies are available from the Academy's media relations department.

AAO-HNS News

Smokeless Tobacco

Insight into its physical and mental effects

- What chemicals are in smokeless tobacco?
- Who uses smokeless tobacco?

- How to break the habit? and more...

Three percent of American adults are smokeless tobacco users. They run the same risks of gum disease, heart disease, and addiction as cigarette users, but an even greater risk of oral cancer. Each year about 30,000 Americans are diagnosed with oral and pharyngeal cancers, and more than 8,000 people die of these diseases. Despite the health risks associated with tobacco use, consumers continue to demand the product. In 2001, the five largest tobacco manufacturers spent \$236.7 million on smokeless tobacco advertising and promotion.

What is smokeless tobacco?

There are two forms of smokeless tobacco: chewing tobacco and snuff. Chewing tobacco is usually sold as leaf tobacco (packaged in a pouch) or plug tobacco (in brick form). Both are placed between the cheek and gum. Users keep chewing tobacco in their mouths for several hours to get a continuous high from the nicotine in the tobacco.

Snuff is a powdered tobacco (usually sold in cans) that is put between the lower lip and the gum. It is also referred to as "dipping." Just a pinch is all that's needed to release the nicotine, which is then swiftly absorbed into the bloodstream, resulting in a quick high.

The chemicals contained in chew or snuff are poisonous and addictive. Every time smokeless tobacco is used, the body adjusts to the amount of tobacco needed to get a high. Consequently, the next time tobacco is used, the body will need a little more tobacco to get the same feeling. Holding an average-sized dip or chew in the mouth for 30 minutes gives the user as much nicotine as smoking four cigarettes.

Is smokeless tobacco less harmful than cigarettes?

In 1986, the U.S. Surgeon General declared that the use of smokeless tobacco "is not a safe substitute for smoking cigarettes. It can cause cancer and a number of noncancerous conditions and can lead to nicotine addiction and dependence." Also since 1991, the National Cancer Institute has recommended that the public avoid the use of all tobacco products due to their high levels of nitrosamines.

In a recent study, cancer researchers found that oral tobacco products including lozenges and moist snuff are not a good alternative to smoking, since the levels of cancer-causing nitrosamines in smokeless

tobacco and lozenges are very high. Some smokeless products contain the highest amounts of nicotine that can be readily absorbed by the body.

What are the ingredients in smokeless tobacco?

- Polonium 210 (nuclear waste)
- N-Nitrosamines (cancer-causing)
- Formaldehyde (embalming fluid)
- Nicotine (addictive drug)
- Cadmium (used in batteries and nuclear reactor shields)
- Cyanide (poisonous compound)
- Arsenic (poisonous metallic element)
- Benzene (used in insecticides and motor fuels)
- Lead (nerve poison)

Who are the most common smokeless tobacco users?

According to the 2000 National Household Survey on Drug Abuse conducted by the Substance Abuse and Mental Health Services Administration, young adults between the ages of 18-25 are the most common smokeless tobacco users. This trend may be influenced by innovative marketing tactics targeted at a younger audience.

Smokeless tobacco manufacturers are marketing flavored smokeless tobacco. A 2005 American Legacy Foundation and National Cancer Institute study noted, "Tobacco companies are using candy-like flavors and high tech delivery devices to turn a blowtorch into a flavored popsicle, misleading millions of youngsters to try a deadly product."

What are the physical and mental effects of smokeless tobacco use?

Cancer. Smokeless tobacco is a cancer-causing agent or carcinogen. Cancers are most likely to develop at the site where tobacco is held in the mouth, but it may also include the lips, tongue, cheek, and throat.

Leukoplakia. Smokeless tobacco users may develop a condition in which white spots form on the gums, inside of the cheeks and sometimes tongue. It can be caused by the irritation from the tobacco juice. The disorder can be considered pre-cancerous. Therefore, if a white patch does not heal within one week, a doctor should be consulted.

Heart disease. The stimulating effects of

nicotine, an organic compound made out of carbon, hydrogen, nitrogen, and sometimes oxygen, increase the heart rate and blood pressure and may trigger irregular heart beats.

Gum and tooth disease. Smokeless tobacco permanently discolors teeth, causes halitosis (bad breath), and may contribute to tooth loss. Smokeless tobacco contains a lot of sugar which forms an acid that may eat away the tooth enamel, causing cavities and mouth sores. Also, its direct and repeated contact with the gums may cause them to recede.

Social effects. Bad breath, discolored teeth.

What are some early warning signs of oral cancer?

- A sore that bleeds easily and does not heal
- A lump or thickening anywhere in the mouth or neck
- Soreness or swelling that does not go away
- A red or white patch that does not go away
- Trouble chewing, swallowing, or moving the tongue or jaw

Tips to quit using smokeless tobacco for a lifetime

Write down a list of reasons to quit. For example:

- Don't want to risk getting cancer.
- Family members find it offensive.
- Don't like having bad breath after chewing and dipping.
- Don't want stained teeth or no teeth.
- Don't like being addicted to nicotine.
- Want to start leading a healthier life.
- Pick a quit date and throw out all chewing tobacco and snuff.
- Remember daily the decision to stop chewing tobacco.
- Ask friends and family to help stay committed to the decision to quit by giving support and encouragement.
- Find alternatives to smokeless tobacco, such as sugarless gum, pumpkin or sunflower seeds, apple slices, raisins, or dried fruit.
- Engage in recreational activities to keep the mind off of smokeless tobacco.
- Develop a personalized plan that works best; set realistic goals.
- Reward successes.

Hay Fever May be Best Treated with Self-Adjusting Dosing

Hay fever, the often seasonal allergy that affects between 10 and 20 percent of the American population, is best controlled through a course of patient-adjusted dosing, according to new research published in the September 2008 edition of *Otolaryngology – Head and Neck Surgery*.

During the study by Thai researchers, hay fever, known clinically as allergic rhinitis, was observed in 69 patients, who were then treated over the course of 28 days with the intranasal corticosteroid triamcinolone acetonide. Patients with mild symptoms were instructed to use the treatment only after symptoms occurred once a day; patients with more severe symptoms were told to continue morning daily dosage until they were symptom-free for 24 hours. However, as opposed to the normally prescribed once-daily dose, patients were instructed to adjust their use pattern based on the frequency and severity of symptoms, and it was emphasized to them not to tolerate any mild or transient symptoms. As a result, during the course of the study, all patients saw improvement in their nasal symptom scores (which include blocked sinuses, rhinorrhea/runny nose, sneezing, and nasal itching).

The authors believe in this self-adjusted dose regimen, which allows patients to increase or decrease the regularity of their dose based on their level of symptoms, the intranasal corticosteroids remain effective, while the treatment prevents priming responses and increased sensitivity that might otherwise occur over time. As a result, the authors determined that almost maximal symptomatic control could be achieved with three-fourths of the recommended regular once-daily dose by varying the daily dosage according to the severity of disease. They believe this approach would be a reasonable way to optimize both treatment efficacy and patient compliance.

Allergic rhinitis occurs when the body's immune system over-responds to specific, non-infectious particles such as plant pollens, molds, dust mites, and animal hair, among others. This causes skin redness and swollen membranes in the nasal passages, combined with sneezing and congestion. It is estimated that hay fever accounts for approximately 2 percent of all visits to a doctor's office.

2nd Annual Faculty Development Seminar

As ophthalmology and otolaryngology/facial plastic surgery program directors, you are called upon to be skilled in a great number of different areas. Residency training prepares us to be knowledgeable surgeons, skillful at procedures, good communicators, and effective at multi-tasking. Rarely, however, does it prepare us to be educators and program administrators.

Faculty development is a term used to describe growth as educators. The goal of this seminar is to provide a guide for program directors to advance their skills as educators and program administrators.

SATURDAY, FEBRUARY 7TH

11:30am Registration
 12:00 noon **THOMAS E. BRANDEISKY, DO** - "Welcome, Official Opening and Review of the Program"
 12:15-12:30 **FRANKLIN J. MEDIO, PhD** - "Review of the 1st Annual Faculty Development Seminar"
 12:30-1:00 **FRANKLIN J. MEDIO, PhD** - "Incorporating the Adult Learner Model into Residency Education"
 1:00-2:00 **KENNETH E. WOLF, MD** - "Writing for Publications: Practical Tools to Improve Writing Skills"
 2:00-2:15 Break
 2:15-4:30 **FRANKLIN J. MEDIO, PhD and SIDNEY K. SIMONIAN, DO** - "Critical Assessment of OGME 1 Curricula for Ophthalmology and Otolaryngology Programs"
 4:00-5:00 **J. MICHAEL FINDLEY, DO** - "Expanding Residency Programs and the Future of the Specialty"
 5:30-7:00 Reception and Dinner
 7:00 **CARLO J. DI MARCO, DO** - "OGME Future of Our Specialties"

SATURDAY, FEBRUARY 8TH

7:00am Continental Breakfast
 7:45-8:00 **CHARLES W. GUY II, DO** - "Report of the Council of Residents and Fellows"
 8:00-10:00 **TOM GENTILE, MS** - "Compelling Funding Options for Residency Programs"
 10:00-10:15 Break
 10:15-11:15 **BRYAN G. KANE, MD** - "Internet-Based Teaching and Learning"
 11:15-12:00 **MICHAEL RUBIN, DO and THOMAS E. BRANDEISKY, DO** - "Conference Summary and Topics for May Program Directors Workshop"

Attendees should plan to fly in Saturday morning and fly out Sunday late afternoon/early evening.

CME Credits The attendees of this program will be required to sign in both days. Attendees will also have program evaluation forms and a CME credit statement included in their registration packets. The evaluation form and CME credit statement **MUST** be completed and returned in order to receive CME credits.

The AOCOO-HNS designates this educational program activity as a 1B CME opportunity, offering up to 9.5 hours in ophthalmology and otolaryngology.

Hyatt Reservation The AOCOO-HNS Administrative Staff will prepare a reservations list for all guest room reservations. **No reservations will be accepted by the Hyatt Regency from individuals.** After your Registration Form has been received (you must indicate your arrival and departure dates), a reservation will be confirmed for you, and your Hyatt Regency confirmation number will be emailed to you. Upon your arrival at the Hyatt Regency, a reservations specialist will request your credit card for payment. **OVERNIGHT ROOM RATE IS \$197.00.**

REGISTRATION FORM

		DATE	
Name (indicate first and last for name badge)		Specialty	AOA #
Mailing Address		City	State Zip
Telephone Number		Email Address	



FOR YOUR HYATT RESERVATION YOU MUST PROVIDE: Arrival Date _____ Departure Date _____

REGISTRATION FEE: \$375.00 - If you register before January 1st **\$395.00** - If you register after January 2nd

METHOD OF PAYMENT _____ Check (Make check payable to: **AOCOO-HNS**)

_____ Credit Card _____ MasterCard _____ Visa _____ Discover _____ American Express

ACCT. # _____ EXP. DATE _____

SECURITY CODE (3 or 4 digit number on back of card) _____

Signature: _____

Return your registration to: AOCOO-HNS, 4764 Fishburg Road, Suite F, Huber Heights, OH 45424 or FAX to **937-233-5673**

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@bizhow.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.

FOR SALE

- SAGINAW, MI:** Refractive practice and/or equipment, 3 lanes with flat panel monitors, B & L Dual Workstation (Orbscan and Zywave), pachymeters, furniture, etc. Contact Dr. Jeff Rohr, 810-516-5858 or email jrohr@michiganlasik.com.

Ophthalmology Fellowship

MARYLAND

- NRI fellowship program at the National Retina Institute offering hands-on opportunities to home 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: dibartolomeomd@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 coentpc@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 Keszeli, DO, at 484-437-8745.
- Premier Southeastern PA private practice of 4 physicians, 2 PAs seeking BC/BE otolaryngologist starting in 2010. Attractive salary and benefits package, early partnership opportunity and generous loan repayment offered. Comprehensive range of ENT-Head & Neck Surgical Services, separate allergy suite, 4 office locations, speech therapy, specialty audiologic testing and hearing aid dispensing distinguish our practice in the community. Please direct your letter of interest and CV to: practice.mgr@earthlink.net.

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: pmbehar@aol.com.

RHODE ISLAND

- ENT BC/BE to join 3 physician practice. Two new offices. Main office is 5 minutes to 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@yvm.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: pmbehar@aol.com.