THE SCOPE

AMERICAN OSTEOPATHIC COLLEGES OF OPHTHALMOLOGY AND OTOLARYNGOLOGY, HEAD AND NECK SURGERY

SAVE THE DATE

2018 ANNUAL CLINICAL ASSEMBLY

April 28 – May 6, 2018
Hyatt Regency
Coconut Point, Florida

Plans are already underway for the 2018 Annual Clinical Assembly.

More information coming soon!

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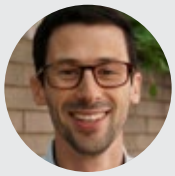

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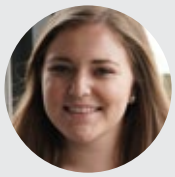

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GETTING TO KNOW YOUR NEW STAFF

2017 has already been a year of incredible change for AOCOO-HNS. Longtime leader, Alvin Dubin has retired. Kristin Reidy has taken the helm as the new President. The Single Pathway looms on the horizon, and new initiatives at the Midyear Meeting and Annual Clinical Assembly are being planned year-round. During this change, a new management team has taken over the day-to-day operations of both the College and the Foundation.

Working together with AOCOO-HNS and Foundation leadership, your new staff has been hard at work to bring members the tools needed for success. A new logo and look set the tone for a year of progress where staff worked hard to continue the legacy of pioneers such as the legendary Debra Bailey.

Attendees at the 2017 ACA could access conference materials through a new app that boasted easy access to lecture materials, updated agendas, and more. Attendees were also able to attest to CME information online for the first time ever.

A new website offers easier access to pertinent information and communication. An online member center offers simple access to updated records, conference registration, and dues renewals. And Facebook and Twitter provide an online community for members to connect and get the latest information.

More improvements are on the way, including increased member benefits, conference enhancements, and more. In the meantime, please feel free to reach out to staff with any questions or concerns you may have.

PRESIDENT'S MESSAGE

KRISTIN EILEEN REIDY, DO, FAOCO

Hello Members! It gives me great joy to introduce myself to you.

I have been a member of AOCOO-HNS for almost 18 years, joining as a resident member from Oklahoma in 2000. I became a fellow of our Colleges in 2007 and shortly after began serving on the Board. I attended medical school at UHS-COM in Kansas City and was an intern and resident at Tulsa Regional Medical Center. My involvement in the leadership of AOCOO-HNS has only made me more thankful for the opportunities that osteopathic medicine and our colleges have made possible for me.

I am a second-generation ophthalmologist, working at Eye Associates of New Mexico with my father, Dr. Robert Reidy. I am a comprehensive ophthalmologist, specializing in cataract surgery in northern New Mexico for more than 15 years. My practice cares for much of the state of New Mexico and is made up of 50 Ophthalmologists and Optometrists, with 14 clinic locations and 11 optical shops. We were the first physician group in New Mexico to establish a stand-alone eye surgery center.

In New Mexico, as the President of the New Mexico Osteopathic Medical Association, I work closely with the leadership of the new Burrell College of Osteopathic Medicine on political and educational issues. Nationally, I have represented AOCOO-HNS attending the Ophthalmology Advocacy Leadership Group and serving on the American Academy of Ophthalmology-Political Action Committee.

I am married and have three teenage children, Brigid, Thomas, and Nina. My husband, Matthew, is a professionally trained chef, which I highly recommend for anyone who works the hours that we work. I am passionate about the opportunity to serve as your President and lead the AOCOO-HNS into its next century. May I carry the torch of Dr. Alvin Dubin and Deborah Bailey as high and as far as I can. During my presidential year I hope to leave our membership with tools to improve their quality of life, starting with recognizing the importance of physician self-care and second with the introduction of technology applications to better mange our patients' needs and our practices.

Bring on the second century of AOCOO-HNS!

FROM THE DESK OF THE PRESIDENT ELECT

DENNIS KITSKO, DO

First, I'd like to thank everyone who participated, both as attendees and organizers, in the 2017 Annual Clinical Assembly in Las Vegas. It was a beautiful venue and a wonderful conference, and we have received some great feedback from the membership, which we will certainly utilize moving forward to make sure our programs are as strong as they can be.

You may have noticed some new faces, as we transitioned over to our new 1500 Management team and this was the first ACA in which they participated. As they had only been involved with us from the beginning of the calendar year, there were certainly some worries about getting together our largest meeting in just a few short months. But the hard work of the Board, particularly Dr. Dubin, Dr. Scheiner and Dr. Reidy, in conjunction with Jan Wachtler and Stephanie Whitmer made the transition very smooth and allowed the meeting to run with very few glitches. In fact, I was told without provocation from several members they were impressed at how easy it was to find a team member when they had a question or issue, as well as how well the registration process was run. I am confident that our programs will thrive moving forward as we continue to work with 1500 Management.

Speaking of moving forward, I am hoping that you are looking forward to the changes in store for the 2017 Midyear Meeting and Scientific Seminar in Detroit! A couple of years ago, we as a Board of Governors in conjunction with the Education Committee, decided to try a format change for the Midyear Meeting. Thanks to the tireless effort of Dr. Don Morris and Dr. Sirtaz Sibia, it will come together for the 2017 Seminar. Rather than the traditional didactic lectures occurring on Saturday, two concurrent sessions will take place. One session is a scientific paper writing workshop in the morning with short lectures in the afternoon from students, residents and program directors. The second is a practice management curriculum, and the list of topics and speakers are absolutely tremendous. Hopefully, if you will join us as we continue to try to tailor our programs to your needs and suggestions.

Looking forward to seeing everyone in Bonita Springs in May!

EDUCATION COMMITTEE UPDATES

DONALD MORRIS, DO

Your Education Committee has been hard at work on our upcoming meetings and are excited about this October's Midyear Meeting. We revised the meeting in a way we hope fits the needs of our College members now and in the future. These changes include a Saturday lecture schedule to assist the members, and features lectures on business, finance, and personal and patient mental well-being.

Running concurrently is a morning Scientific Paper Writing Course and an afternoon Scientific Seminar. The paper writing course is devoted to teaching interested members what is required in a publishable paper, how to work with ideas, how to go about getting the research, and how to put this all together. This course features a medical librarian on site as well as published author who will act as lecturer and helper. Attendees are asked to come with an idea, and and any preliminary research to build upon.

The Scientific Seminar is a chance for physicians to get the experience of presenting at a national meeting. Participants will present 15 minutes talks on their research and interests. Last year, was well received and is a great way to get scholarly activity. The Sunday programming consists of clinical lectures for each specialty.

We continue to work on the 2018 ACA and are looking forwarded Florida. New Chairs, Lyndsay Madden for Otolaryngology Chair, and Julia Agapov for Ophthalmology, are excited for this opportunity to bring members, cutting-edge lectures, and education. If you have ideas for lectures, would like to join the faculty, or would like to help in any way, Director of Education Kristen Kennedy (KKennedy@aocoohns.org) can put you in touch with our team. We have some fun ideas that we are working on and much to look forward to. Like the Scientific Poster Crawl and perhaps drinks and appetizers with the medical experts.

As I close, I'd like to thank all the hard-working members of the Education Committee for their creativity and caring. If you are interested in joining this group, the Education Committee is made up of volunteers who strive to bring the best educational programs we can to our members. Please contact the AOCOOHNS office and let us know of your interest.

REPRESENTING OUR COLLEGE AT THE AOA HOUSE OF DELEGATES

KRISTIN EILEEN REIDY, DO, FAOCO

As your President, I served as the AOA Delegate at the AOA Annual Business Meeting July 17 - 23, 2017 at the Chicago Marriott Downtown Magnificent Mile Hotel. During this time, I was able to visit our new AOCOO-HNS office in Chicago and I was one of 500 osteopathic physicians and medical students that gathered to debate and refine AOA policy.

At an ACGME reception in Chicago, I met with Pamela Derstine, PhD, MHPE. Dr. Derstine is well known to the otolaryngology residency directors, but for the rest she is the Executive Director, RC for Colon and Rectal Surgery, Neurological Surgery, Orthopedic Surgery, and Otolaryngology Residencies and Fellowships for the ACGME. She wished to extend her thanks to our otolaryngology program directors for their hard work and persistence as they work through the single accreditation process. I also met with the new Executive Director for RCs of Obstetrics and Gynecology, Ophthalmology, and Urology, Kathleen Quinn-Leering, PhD. Dr. Quinn-Leering is willing to field questions from ophthalmology program directors at any time to help pull together their applications.

At the AOA Business Meeting, Boyd Buser, DO updated the delegation as to the course of ACGME Single Accreditation process. As of July 2017, 56% of 1,244 osteopathic programs are ACGME accredited or pre-accredited. The breakdown was as follows: 71% of 862 residencies, 20% of 261 fellowships, and 21% of 121 internships are ACGME accredited or pre-accredited. Furthermore, since July of 2015, 30 new AOA programs have opened adding 446 new training positions. While this was applauded and seen as positive by the majority of the AOA delegates, for the AOCOO-HNS membership we want to know about the smaller subspecialty programs. Most of these such programs are among the 44% of osteopathic programs that are not yet accredited.

Dr. Buser acknowledged the efforts of David Parke, MD, the Executive Vice President of the American Academy of Ophthalmology, who with Steve Feldon, MD, MBA, the Executive Vice President of the Association of University Professors of Ophthalmology (AOUPO) together are offering their assistance in "preserving as many osteopathic ophthalmology programs as possible in the transition to ACGME accreditation." I am confident that more of our programs, otolaryngology and ophthalmology alike, will gain pre-accreditation and full accreditation this year as they fine tune their skills at presenting their training programs to the RCs.

John Potts, MD is the senior vice-president of surgical specialty accreditation at the ACGME. He was very encouraging when I met with him in Chicago. He fully understands how most subspecialty practices are located outside of large university institutions and he echoed the sentiment that size of a residency program will not be grounds alone for denying pre-accreditation to osteopathic residency programs. However, he strongly emphasized that despite this, it is imperative that the applications elaborate on how our programs, sometimes having only one resident a year, create a robust academic environment.

At the House of Delegate Meeting, some of the resolutions that got the most attention were concerning:

(1.) Physician self-care, H-348,

(2.) Opposing the merging state licensing boards, H-637,

(3.) Encouraging the AOA to become ACCME accredited to be able to offer CME for DOs and MDs, H-231

(4.) Promoting residency positions for COCA medical student graduates in light of the rapidly enlarging osteopathic medical school class size and the increase in the number of osteopathic medical school.

The AOA July Business Meeting is always a lively gathering and great place to make connections in the AOA that I believe will benefit the AOCOO-HNS as we go forward. Please consider attending; The AOA's next Annual Business Meeting will take place July 16-22, 2018, at the Chicago Marriott Downtown Magnificent Mile.

ECLIPSE AFTERMATH

BY ALEXANDER SZELES, DO

The total solar eclipse on August 21, 2017 captured the attention of our whole nation. For a short period of time, the typical office small talk and social media posts about politics, sports, and baby photos were overrun by information about when and where to view this once in a lifetime astronomical phenomenon.

People took off work and traveled from all over the country to sites where prime eclipse viewing could take place. Offices held "eclipse parties" with food and drink enjoyed outside for the duration of the eclipse. The American Astronomical Society compiled a list of reputable vendors of solar filters and viewers, while some online stores allegedly sold counterfeit filters that were unsafe for viewing the solar event. People had a lot of questions about this whole scenario. The unique situation of working in an Ophthalmology private practice lent itself to even more specific questions. One patient on the day of the event asked us, "What about looking at the solar eclipse is different than looking at the sun any other day? I look at the sun all the time!" A staff member at our office asked me, "How quickly should we have people with blurred vision from looking at the eclipse come into the office? Right away? Tomorrow? Should we send them to the emergency room?" For those of you out there in need of quick answers, I share with you a synopsis of this disease and how to counsel your patients and staff about it.

Solar retinopathy, also known as foveomacular retinitis or eclipse retinopathy, occurs as you would expect: after prolonged viewing of an eclipse or the sun at any particular point in time. Similar damage also occurs after unprotected viewing of welding arcs, lasers, and even prolonged exposure to operating microscope lights. The thermally enhanced photochemical damage occurs due to exposure to blue light and UV radiation. Your patients may report bilateral decreased vision, metamorphopsias, dyschromatopsia, photophobia, central scotomas, and headaches. These symptoms usually start within hours of the sun exposure, however patients may have delayed presentation to your office, in the hopes that these symptoms will go away on their own. Young people are at a particular increased risk of damage, due to the fact that their crystalline lens is clearer and allows more of the damaging wavelengths of light to reach the posterior segment of the eye. Fundoscopic examination of these patients several days after exposure may reveal a yellow-white spot in the fovea that evolves over several days into a reddish dot. However, mild cases may show no macular changes at all. After several weeks, patients may develop a permanent 100-200 micron lamellar hole at the site of original injury. If a fluorescein angiography is performed, early leakage with late window defects are often found at the site of the lamellar hole.

There is currently no evidence based treatment for solar retinopathy. Patient education in the form of primary prevention is the best means to combat this disease. Patients should also be educated and encouraged to educate others that the solar eclipse itself is not the inciting factor that causes retinal damage, but rather sun gazing at any period of time will always put patients at risk. The only exception for this rule is during the totality phase of the eclipse, or when the moon is completely blocking the sun. Should you have a patient present to your office solar retinopathy of any stage, diligent observation should be at the treating physician's discretion. Patients may be advised that the majority of cases resolve slowly over the course of one to six months, but educated on the fact that some symptoms and funduscopic changes may remain permanently.

The total eclipse has come and gone, without a hitch for most people. Fitness trends and pictures of meals have taken back their rightful place on our social media platforms. Perhaps though, as days turn into weeks and weeks to months we may find ourselves in an exam room with a patient whose life is not back to normal and we will be called upon to address this topic in a clear and concise manner. It is my hope this information provided here will be of use in this unusual and potentially devastating clinical scenario.

REFERENCES

1. American Academy of Ophthalmology. "Solar Retinopathy." Section 12: Retina and Vitreous. United States of America, 2015-2016. 320.
2. Friedman NJ, Kaiser PK. The Massachusetts Eye and Ear Infirmary Review Manual for Ophthalmology. 3rd Edition. "Solar/Photic Retinopathy". 2009. 391.

2017 ANNUAL CLINICAL ASSEMBLY

Last May, 559 attendees converged on Las Vegas, Nevada for the 2017 Annual Clinical Assembly. The 2017 ACA was significant for many reasons. The conference celebrated the incredible contribution of Alvin D. Dubin, DO, as he retired as long-time executive vice president and CEO.

The most popular aspects of the conference were the hands-on labs. An offsite Balloon Eustachian Tube Lab boasted unanimous approval by all attendees. The Cataract Wet Lab and Sculpting of the Nose Workshop were likewise successful and the Education Committee is excited to build upon this success. Furthermore, work is already underway to bring exciting topics and engaging speakers to the 2018 event in Florida.

It was also the first opportunity that members had to meet the new staff serving both the Colleges and the Foundation. Staff has worked hard to create new initiatives enhancing the learning experience at the ACA. These included online attestation, a conference app to download lecture materials and up-to-date agendas, a streamlined conference program, and an increased social media presence.

The Board and Members send a big thank you to the faculty, planning committee, and all who worked hard to make the ACA as valuable as possible and we look forward to continuing the hard work to create a leading conference where attendees can earn CME and improve their practice in meaningful ways.

FOOD ALLERGIES

ANTHONY J. D'ANGELO, DO

Food allergies, and the knowledge base surrounding them, are ever expanding. Over the last decade the number of articles regarding this has dramatically increased. Public awareness and lay coverage has increased; therefore, the understanding of food allergies is critical in an Otolarynogology practice. It is a controversial topic and confusion exists over diagnosis and treatment.

As many as 90% of self-reported food allergies are not allergies at all. In the United States, food allergies are present in about 5% of children and approximately 4% of adults. Although there are possibly 170 different foods that one can be allergic to, nine or ten foods make up 80 to 90% of food allergens.

A food allergen is a specific ingredient, for example the protein/Hapten, is recognized by allergen specific immune cells that elicit specific immunologic reactions mediated by IgE AB and/or T cells resulting in characteristic symptoms. Food allergy reactions occur minutes to hours after smelling, touching, or ingesting a specific food trigger resulting in hives, itching, tachycardia, wheezing, or swelling. Food reactions are usually reproducible: the trigger does not change but the intensity of the response would vary from event to event. For example, one could ingest a peanut and have local swelling of the tongue and mouth and then, on subsequent ingestion, have a full blown anaphylactic reaction.

Sensitization versus true food allergies is a concept that needs to be understood when treating patients with food allergies. One could develop an immunological sensitization, for example produce IgE to certain foods, without having a true food allergy. To have a true food allergy, one needs to have both the presence of sensitization as well as the development signs and symptoms in response to the foods.

Food allergies versus intolerance: Again 50-90% of self-reported food allergies are not mediated by the immune system. Nonallergic food reactions—often referred to as food intolerances can-occur 3-4 hours after ingestion, producing signs/symptoms which vary depending on intolerance. (example: Lactose intolerance: one of few food intolerances that is understood is not a true food allergy.) Food allergies may share some signs and symptoms. Food intolerances may mimic food allergies but the underlying mechanism is not an immune response. Food intolerances, or non-immunological reactions can be metabolic, pharmacologic, toxic, or involve a component of food or additive such as lactose, caffeine, MSG, Tyramine, artificial color, or sulfate.

For the diagnosis of food allergies the patient has to have signs and symptoms after eating a food on one or more occasion, but one needs more than a history and physical to make a diagnosis. Objective testing consists of serum specific IgE levels. This test cannot be used as a sole diagnostic test but does tell us about sensitization. One needs supporting clinical signs and symptoms of food allergies to confirm a food allergy. IDT type testing is not recommended. Skin prick testing can assist in underlying true causes. Oral food challenge testing is recommended or use elimination diets or a symptom diet if one cannot undergo an oral food challenge.

Oral food challenge is the gold standard for allergy diagnosis. It is a double blind placebo controlled food challenge. It is best for diagnosing food allergies but is often done in a tertiary hospital research center due to expense and risk. The second is a single blind open food challenge. A negative challenge can rule out food allergies. A positive test supported by the history and physical can help with diagnosing but the oral food challenge often needs to be performed in an office with the ability to treat anaphylaxis.

Up to a 170 different foods can cause food allergies but 85% of food allergies are made up of egg, milk, peanut, tree nut, wheat, shell fish, soy, fish, and sesame. At present, the management of food allergies is avoidance to the food that provokes the immunological response. Again, if there are multiple food allergies dietary restrictions, food counseling, growth monitoring and education is important as they could cause developmental and growth problems in children.

Patients at risk for food allergies include parents or siblings with allergies, atopic dermatitis, asthma, or allergic rhinitis, history of reactions to food on one or more occasions minutes to hours after ingestion triggering hives, itching, wheezing, or anaphylaxis.

To understand food allergies one should look at the natural history and the onset of the food allergy. For example, peanut/treenut—only 20% outgrow the Peanut allergy, as opposed to cow milk, soy, and wheat which most patients outgrow by the teen years. For the food allergies that are developed more in adulthood such as shellfish/seafood allergy they are not likely to be outgrown. The indicators for improvement would be a decrease in the skin prick test/IgE levels and resolution of atrophic dermatitis.

Food allergy is a controversial and complex topic. At present there is no treatment other than avoidance, prescribing an Epinephrine pen, educating the family including a food action plan, and food allergy bracelets. Avoidance is the cornerstone for most food allergies with reactions ranging from mild to moderate to anaphylaxis.

YOUR MEMBER CENTER

AOCOO-HNS Members now have access to the exclusive member center, your secure online home for conference registration, dues renewals, and member benefits.

To log in, simply use your email address and Password1 (case sensitive). You must customize your password immediately after your first time logging in to ensure the security of your account.

If you have any questions, please do not hesitate to email sstephens@aocoohns.org.

Please take a moment to log in and make sure that all of your contact information is correct, including email address, so that you can stay up to date with all of the exciting progress of AOCOO-HNS!

We Want to Hear from You!

Our members are AOCOO-HNS's greatest resource and we want to hear from you. We are looking for contributors for articles for the newly relaunched Member Newsletter. Share your views, clinical research, resources and more.

For more information, contact Erin Sernoffsky, Director of Media Services, at esernoffsky@aocoohns.org

FACING THE OPIOID CRISIS

KYLE MITTS, DO

As with almost every medical specialty, the burden of the opioid epidemic is increasing across the country. Otolaryngology has specifically seen the effects. Overdoses with these substances have become the leading cause of death for Americans under the age of 50. Overdoses now claim more lives than car crashes, gun deaths, and the AIDS virus did at their peaks. Drug cartels have been replacing heroine with Fentanyl, an opioid that is fifty times stronger than heroine and one hundred times stronger than morphine. Law enforcement has initiated the carrying of Naloxone in an attempt to help save the multitude of individuals becoming subject to overuse. They respond to calls with the intent of using it upon arrival to a non-responsive individual. There are times this can happen multiple times in a single night.

In the hospitals, otolaryngologists have seen an influx of neck abscess. These abscesses are no longer stemming from odontogenic sources, or abscessed lymph nodes, but are arising from individuals using the external neck vasculature for entry into the systemic circulation. This is complicated by the use of unsanitary needles with the eventual progression to an abscess. In our residency, we average one to two neck abscess consults a month on patients as described above. These are persons who have destroyed all viable veins in the extremities and have moved on to the larger, easily accessible vasculature of the neck. These patients are more often in their twenties to thirties. Most also have some type of blood borne pathogen they have contracted from prior IV drug use. Our service will address the neck abscess with formal drainage in the operating room, but ultimately, the patients will end up being discharged against medical advice because of the inability to offer them strong enough pain medications for relief. The cycle then, repeats and otolaryngology gets consulted yet again.

This subject matter also leads a deadly course. It starts with a phone call to Emergency Medical Services informing them of the discovery of an unresponsive individual. There is usually suspicion of an overdose at this point. Upon arrival, it is unknown how long the patient was down and unresponsive requiring intubation for airway protection. They are admitted to the Intensive Care Unit and have a prolonged hospital course with bacteremia, cardiac valve vegetations, septic emboli, and failure to respond or wean from the ventilator. After a long, expensive, non-progressive hospital course, the medical team and the family decide to opt for a tracheostomy. The Otolaryngology Service is then consulted for surgical intervention for this individual even though there is minimal to no neurologic function. With further discussion with the family, it is discovered that the patient is a 32-year-old father of two and that they are electing for surgery in the hopes for a miracle recovery. This patient died the following week.

This has become the norm in our city, and unfortunately across the country. We must reevaluate our opioid prescribing practices. Realistically, medical professionals are not to blame for this epidemic, but can they be held partially responsible for putting opioids into so many people's hands. The social and economic burden that is being placed on the health care system from this opioid cycle of events is astounding.

ALVIN DUBIN: PIONEER, VISIONARY, AND MENTOR

2017 heralded a changing of the guard at AOCOO-HNS as longtime Executive Vice President and CEO Alvin Dubin retired. Dr. Dubin, well known to any member who has attended an AOCOO-HNS event, or engaged at all with the leadership, has long been a champion of AOCOO-HNS advancing the prominence of the College, as well as osteopathic medicine.

In 1958 as a resident, Alvin Dubin began his long career with the Osteopathic College of Ophthalmology and Otolaryngology. From 1965 to 1976, he served as a Board Examiner and in 1976, he was elected to his first term on the Board of Governors. In 1980, he became the Board President and in 1990, he began an eight-year run as the Executive Director. In 1998, he transitioned into the roles of Executive Vice President and CEO, a position he held for nearly 20 years.

"Honestly, Dr. Dubin is AOCOO-HNS. He has devoted his life to the College and has kept it going for years and is the reason we are who we are," says Don Morris, DO, Education Committee Chair. This sentiment is shared by countless members and affiliates of AOCOO-HNS. "I admire his passion and vivacity. He is so passionate toward the College and its continuing ability to thrive and be there for Osteopathic Ophthalmologists and ENT's. He is always looking ahead, and moving the College forward and most importantly, he has been such a good friend to me. I have loved really getting to know him over the last few years."

Dr. Dubin's continued legacy is evident in the College and the Foundation's commitment to education, development of subspecialty areas, and dedication to members. He reflects that he has worked hard to "have an organization that is flexible in its resolve, keeps current, listens to its members, and continues to offer maximum member benefits."

One of his main goals was to create a college that builds community between specialties, while still maintaining dedicated educational opportunities. He worked hard "Keeping the two specialties together, by developing areas of commonality in management," he said, "and still allowing the separate specialty interests to still be supported. Not an easy task!"

AOCOO-HNS's new Executive Director Jan Wachtler has a long friendship with Dr. Dubin, meeting him for the first time in 1978. "I think we are kindred spirits; we are both sticklers about courtesy and manners, but we both don't mince words. If you have something to say—say it—don't goof around and waste time dancing around the subject. We developed of good relationship of never being afraid to say what we thought. That was probably dangerous on his part, because I can be pretty outspoken," Wachtler laughingly reflects. "He likes understanding, educated in policy and Robert's Rules

(which we've both read cover-to-cover) and we both like to laugh. I enjoy his honesty and friendship. He represented the College and Committees well; he is articulate and passionate about education and the practice of ENT. In many ways, he's still the face of AOCOO-HNS."

While Alvin Dubin may have retired, he remains an important presence with AOCOO-HNS. The value of his wealth of information and experience is incalculable and his ongoing participation and support makes AOCOO-HNS the strong community it is.

WHAT IS COMPETENCE?

JANICE A. WACHTLER, BAE, CBA

In the last issue of the Journal of Medical Regulation there is an interesting article on the topic of determining competence for professionals, and what exactly is the best method for doing so.

For years, the subject of Maintenance of Certification has been a hot button issue in medical circles. Some organizations have opted to do yearly required readings and short, easy, on-line tests to ascertain if the physician comprehends what they've read and can apply that knowledge. Other groups have had physicians chart types of cases and do follow-up to ascertain that they've had sufficient encounters with illnesses and procedures routinely seen in their specialties. Both, it seems have been deemed onerous, costly, time-consuming, and unnecessary.

This article looked at a sampling of health professionals, from chiropodists to traditional Chinese medicine practitioners and non-health professionals from agronomists to veterinarians in Ontario Canada and selected professionals in medicine, nursing, engineering, dentistry, law, teaching and pharmacy in British Columbia, Massachusetts, California, England, Qatar, Australia, and New Zealand. The overall study included these areas based on the regulations of both health and non-health professionals.

The gist of the study was to determine how professionals from varying fields define continued competence. Most, it seems used a Continuing Education Model that required the professional to take a certain number of programs or hours in continuing education over a three-to-five-year time span. Others, had a process called an Educational Portfolio with specific courses that had testing modules associated with them, and yet others used a peer-to-peer system that involved learning, observation, and evaluation.

It turned out that most of these systems failed to truly deem the participant competent in their practice; although the one associated with testing modules probably did the best in identifying areas that needed attention or improvement.

As all national certifying and accrediting bodies try to develop true models that will assess the adult learners' ability to professionally practice, it appears that there is no panacea for judging professional competence in the adult learner that is easy, cost-effective, and relevant. As the models for education have changed to evidence-based medicine and not just medical knowledge, the process of assessment has become more difficult, and assessment processes have not always changed to this evidence-based model of learning.

So, is there a best practice for assessing competence? Probably not. CME that provides the participant with pre-tests – to assess current knowledge; post-tests – to assess what the learner took away from the program or lecture, and then a six-month re-assessment of what knowledge was retained and used, is probably the best mechanism. However, while agencies can produce this information, it's solely up to the learner to participate.

My question to readers is, if our association produced CME with these modules for testing and assessment, would you participate in them? The pre-and post-tests would be given on-site, but the six-month follow-up is the key to success. Would this be amenable to you to gauge your competence in procedures, knowledge, practice?

Tell me at info@aocoohns.org

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IN LOVING MEMORY

REMEMBERING THE LIFE AND LEGACY OF DEBRA BAILEY

On July 23rd the AOCOO-HNS family was forever changed with the passing of beloved Administrative Director Debra Bailey.

Anyone who attended an AOCOO-HNS conference, called the office, or engaged with fellow members was impacted by Debra and her dedication to her work and building a strong community. For over 25 years Debra worked tirelessly to create a lasting home for physicians and to genuinely welcome all she met.

"Debra impressed me with her ability to organize and retrieve material when needed and her memory for details of the organizations," says Alvin Dubin, AOCOO-HNS Executive Vice President and CEO Emeritus, who perhaps knew Debra best of anyone in the Colleges. "She appeared to be bright, cheerful and anxious to work."

Debra was generous with her time and talent, wearing every possible hat in association management. From event planning, to design, to accounting, Debra took on all tasks with zeal and passion, and she knew the organization inside and out.

"Debra impressed me with her ability to organize and retrieve material when needed and her memory for details of the organizations," says Dr. Dubin. "[She] cared about her duties and the organizations she represented. Debra was the right person at the right time and her caring, ability, and sense of responsibility are unfortunately too rare today. My personal friendship and the Colleges' direction both benefited with the help of Debra."

The entire AOCOO-HNS community owes a great debt to Debra for her hard work, and determination to see the organizations succeed.

Debra is survived by her husband, E. Robert Bailey, daughter Beth (Don) Wheeler, sons Jeffrey and Brian Burdine, and grandchildren Margaret, Dominik and Lily Wheeler, Kylah Burdine, and Conner and Kaylee Owen.