



SPRING 2019

SCOPE

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



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PRESIDENT

Dear AOCOO-HNS members,

On Jan. 1, 2013, all American Osteopathic Association specialty certifying boards implemented a continuous certification process for osteopathic physicians, called "Osteopathic Continuous Certification (OCC)." This "AOA CME Guide for Osteopathic Physicians" is intended to outline the requirements for OCC Component 2: Lifelong Learning/Continuing Medical Education (CME), and the activities that may serve to meet those requirements. These requirements are required of all physicians who hold osteopathic board certification through the AOA and its 18 specialty-certifying boards (also known as diplomates).

Time-Limited Diplomates certified by the AOA are required to meet specified CME credit hour requirements for the 2019-2021 CME cycle as part of OCC Component 2. The number of CME credits needed is set by each specialty-certifying board. Physicians entering the program mid-cycle will have their credit requirements pro-rated. A physician's CME activity report will outline their total CME requirements and the amount of credits needed in Categories 1 and 2. Diplomates who hold time-limited certifications must complete the Lifelong Learning/CME requirement in addition to the other components of OCC.

For the 2019-2021 AOA CME cycle, all Non-Time-Limited Diplomates will be required to complete 120 total CME credits regardless of their specialty. For those non-time-limited diplomates who choose to voluntarily participate in OCC, due to the increased physician engagement of continuous certification, the reduced requirements will apply. The AOA specialty-certifying boards will no longer require diplomates to obtain specialty-specific CME during the 2019-2021 CME cycle. All faculty of Category 1-A and Category 2-A CME must be board certified by an AOA or ABMS board or have been appropriately credentialed to qualify as Category 1-A or 2-A.

The new standards eliminate the requirements for specialty-specific CME. Each individual certifying board has set its own CME standards for osteopathic continuous certification. In addition, 120 hours of CME per cycle is now required for diplomates holding non-time-limited certification.

Also, changes were made to the types of CME credits awarded for specific activities.

CME will now be awarded for:

- Residency and fellowship
- Exams taken for the purpose of initial board certification
- Unlimited hours of standardized life support classes


Thank you for supporting the Colleges, your community and osteopathic medicine, and I look forward to seeing most of you at the 2019 Annual Clinical Assembly in Orlando, FL.

Sincerely,



DENNIS J. KITSKO, DO, FACS, FAOCO
AOCOO-HNS President



A hiker with a large backpack is standing on a rocky mountain peak. The hiker is wearing a light-colored shirt, dark pants, and a large red and black backpack. The background shows a vast, hazy mountain range under a clear sky. The hiker is looking towards the right side of the frame.

**If you don't Sacrifice
for what you
want, what you want
will become the
sacrifice.**

AOCOO-HNS EXECUTIVE DIRECTOR

I believe customer service is made up of five elements: Convenience, Helpfulness, Attitude, Professionalism, and Stewardship or "C.H.A.P.S" for short and are measured by the members we serve.

Is something convenient if the member can not access it when they need it? Are we being helpful if we are not providing a member with what they are seeking? I often use this antidote: "If someone was drowning and I swam out with a glass of water because I saw them thrashing about under the hot summer sun; would the person drowning think I was being helpful?"

Attitude: The attitude of the staffer helping a member ultimately determines the outcome of the encounter. If the person serving the member has a bad attitude, the member will be left thinking negatively about the encounter, even if all elements are done precisely. Additionally, professionalism is the competence and skill of the staff which leaves a member feeling confident and satisfied with the outcome.

Stewardship is the ability to care for an organization as if it were your own. Stewardship often gets mistaken for servitude; however, there is a big difference between the two. Stewardship gives one a sense of pride and selflessness and leaves members feeling grateful to the steward, and although the demands of good customer service resemble being subject to someone more powerful, this is far from the case.

Convenience is the reason our staff adopted a 24/7-member commitment. We really are available to address any concerns or situations our members deem important. Many members have already taken advantage of this service via telephone/text/fax by using the (855) 266-6646 office number or via email by writing to ralpheaocooahns.org and have been very pleased they were able to speak to someone when it was convenient for them.

Along with our 24/7 availability, we revamped the website and added some great new features to help members expedite their ability to register for events, store their CME Certificates, and store their receipts of purchase made from the AOCOO-HNS. We also added a "find a D.O." feature for patients and physicians to search for AOCOO-HNS member specialists.

We are offering discounted Medical Malpractice, Disability, and Life Insurances. We are investigating an opportunity to create an Association Health Plan for our employer-members/sole practitioners to help them cover personal/family health issues at a reasonable rate.

We are exploring the ability to "live-stream" most of the lectures during the 2019 ACA and offer Ophthalmology and Otolaryngology lectures "on-demand" for our member specialists who need their CME but were unable to attend our live events. Finally, we have "Social-Media" experts available to our members, at a substantially discounted rate, to help members interested in social media marketing.

We listen to you, our members, and we are here to serve you to our fullest ability. We want to say thank you for allowing us to be the stewards of this organization, your organization, the AOCOO-HNS.

"Convenience is the reason our staff adopted a 24/7-member commitment." - Ralph McClish



Ralph McClish
Executive Director, AOCOO-HNS

New 2019 CME Requirements Opioid Prescribing Abuse

The new year begins with new CME requirements. Many states are mandating 2 CME's on Opioid Prescribing and Abuse and are needed for renewal of CSR for Osteopathic and Allopathic Physicians. Deadline to achieve your CME's on Opioid Prescribing and Abuse is October 31st, 2019.

There are several options available to complete those requirements, including many online programs. For those planning to attend the 2019 Annual Clinical Assembly in May, an opioid training will be offered, so if you are missing those credits, you will be able to receive them at this event. Another great resource for additional information regarding the CME requirements and, how to obtain them, are the government websites.

As for me, I received a pamphlet with online instructions from the IN.CME.EDU. The material was well-organized and allowed me to obtain the required CME's without having to travel or lose office time. There were two options to complete the training; mail in or online submission; I preferred the mail in option. This allowed me to review the material and answer the discussions at my own pace; once completed, my test was ready to send out. If you choose the online option, plan on about 2 hours of listening to the program to complete the training. It takes about that long due to being unable to advance to the next screen until the allotted time has passed, allowing for plenty of time to fully digest the information. The pros to online submission are immediate test results; as well as, being able to print out your certificate of achievement.



Understandably, there has been a swing in prescribing scheduled drugs compared to several years ago when we were advised not to allow our patients to suffer; however, in doing so, we have created more suffering. As an ophthalmologist, I do not prescribe opioids; however, on occasion, I have had (and will continue to have) some patients asking me if they might need them. My response has been and will always be the same; if you are experiencing pain severe enough to think you may need an opioid, then I need to see you immediately. I also advise that most of my surgeries will not require an opioid to relieve pain. After this discussion, the patient may not return to my office, but if they do, they return with the understanding that I do not prescribe scheduled opioids.

The AOCOO-HNS is always looking to the future with great plans for all future events. Midyear will now be held every even year, with the next event being held in 2020. The next ACA will be held in May of 2019. In a few months, I will become the new President of the AOCOO-HNS and am very excited at the opportunity to lead this wonderful group of members. As always, do not hesitate to forward any suggestions or concerns that may need to be addressed.



Judy L. Davis, DO, FAOCO
AOCOO-HNS President Elect

AOCOO-HNS SECRETARY/TREASURER

As we approach the upcoming ACA, I again want to thank the members of the education committee for all of their hard work and dedication to the college. I especially want to thank Leo Skarin DO and Cody Buchanan DO for the amazing jobs they have done putting together fantastic ACA programs for this year, and Lyndsay Madden DO for being my wonderful Co-chair of the education committee this year. Lyndsay will move up to chair of the education committee this upcoming year, and I know that I leave the committee in great hands for the future.

We have strived to create relevant and amazing programs for our college members over the years, and we owe a great deal of thanks to Sirtaz Sibia DO and Wayne Robbins DO for getting the committee moving along the right track. I hope I have continued to fulfill the expectations set for us and have moved the committee forward, as Lyndsay will continue to do. We know that education is and will continue to be one of the major functions of our college.

With that in mind, we continue to ask for your help in letting us know what you would like to see at our conferences. If you have thoughts on lectures or ideas that you find interesting or have heard a fantastic speaker that you feel would be great for our members, please feel free to let us know. Our goal is to always move our education conference forward. We know there are several options for our CME available to us, which is why we want the ACA to continue to be something special for our members.



Our major speakers, both MD and DO, always tell us how much they enjoy talking at our conferences. They really enjoy the fact that our members are invested in their lectures and ask questions and spend time talking with them. They love that our members will sit with them at the bar or pool and just talk. I cannot think of any other conferences where I have had such great access to some of these well-known world experts. I hope everyone will take advantage of the opportunity to meet and speak with them.

It has been my pleasure to serve as your education chair, and I look forward to continuing to serve as the councilor to the American Academy of Ophthalmology and on our Board of Governors.



Donald Morris, DO
*AOCOO-HNS Secretary/Treasurer/
Education Committee Chair*





KEYNOTE

2019 ACA Keynote Speaker Highlight

Dr. Giliberto completed his residency in otolaryngology at the University of Cincinnati / Cincinnati Children's program in 2015 and earned his medical degree through the Dartmouth/Brown program. After completing his fellowship training at the University of Washington in 2016, he was an assistant professor at the University of Cincinnati treating the full breadth of laryngology including voice, swallowing, and breathing disorders.

Dr. Giliberto's specific clinical interests include medical laryngology (chronic cough, globus, throat pain), open/endoscopic airway, and neurolaryngology. Dr. Giliberto is a member of the American Academy of Otolaryngology - Head and Neck Surgery, where he is actively involved in the Young Physician Section.

Dr. Giliberto is passionate about improving information technology use in the medical center through customization. He is a member of the National Epic Otolaryngology Specialty Steering Committee and has his physician builder certification. His focus of Epic optimization involves custom procedure SmartForms and prospective automatic data collection to improve clinical documentation, billing, and research within the medical center.



J.P. Giliberto, MD
2019 ACA Keynote Speaker

2019 ACA Speaker Overview

We have worked hard to find the most knowledgeable and innovative medical professionals in the industry, to improve the quality of training, education, and patient care for our members. Here is a highlight of some of the speakers featured during the 2019 Annual Clinical Assembly.

Excellence and Efficacy in Cataract Surgery **Nadley Phillips, DO**

Since being a resident in ophthalmology at Detroit Osteopathic Hospital graduating in 1982, I have always had a passion for performing cataract surgery. I was trained in intra-capsular surgery and suturing iris-fixated IOL's. Over the past 35 years, I have seen our profession progress through the development of extra-capsular surgery followed by phacoemulsification.

Although many experts in our profession are pleased with the efficiency of today's standard procedure, I find it interesting that we have made cataract surgery much more complex than it really needs to be. I have strived to streamline my cataract procedure to make it into what I feel is very safe and efficient, and can be used in all types of cataract surgery.

I am looking forward to sharing many "pearls" with you at the AOCOO-HNS meeting this May in Orlando. With both a slide and a video presentation, I hope that you will pick up a few ideas or maneuvers that you could take home and possibly incorporate into your cataract procedure.

Scleral Lens Management of Ocular Disease **Muriel Schornack, OD**

Scleral lenses are large-diameter rigid gas permeable lenses that land on the conjunctival tissue overlying the sclera, completely vaulting the cornea and limbus and maintaining a post-lens fluid reservoir. Although scleral lenses were first described in medical literature of the late 1800's. Original scleral lenses were fabricated from blown glass; manufacturing challenges and induced corneal hypoxia during lens wear presented considerable barriers to wide acceptance of the lenses immediately after their introduction. The first description of modern scleral lenses (lathed lenses made from oxygen-permeable polymers) was published by Don Ezekiel in 1985. Over the next several decades, scleral lenses were prescribed primarily in tertiary care centers for management of severe corneal irregularity and ocular surface disease. The introduction of commercially available lens designs within the past 10-15 years has fueled dramatic expansion of scleral lens prescription into community eye care

The primary indications for scleral lens prescription are corneal irregularity and ocular surface disease. Patients with significant corneal irregularity frequently report discomfort and even spontaneous dislocation of corneal lenses. Since scleral lenses are designed to vault the cornea completely, comfort is improved for these patients. Scleral lenses can be up to 20 mm in diameter; the edges of these large-diameter lenses frequently rest beneath the upper and lower lids. Lens dislocation is exceedingly rare. Studies have shown that scleral lenses provide visual acuity that is comparable, or even superior, to that which can be achieved with corneal lenses. The post-lens fluid reservoir can provide significant protection for the cornea in patients with severe ocular surface disease. Not only does the reservoir act as a "liquid bandage", but the lens itself protects fragile epithelium from damage due to shear forces generated by the lid margin during blinking. Improvements in vision, comfort, and corneal epithelial integrity have been reported with scleral lens treatment of keratoconjunctivitis sicca secondary to graft versus host disease, Sjogren's syndrome, Stevens Johnson syndrome, neurotrophic keratopathy, exposure keratopathy, limbal stem cell deficiency, and other conditions that can lead to corneal compromise.

Scleral lenses provide reversible therapeutic option for patients who would otherwise require surgical intervention. Prescription of scleral lenses can delay or even eliminate the need for more aggressive therapy, and can provide improvements in vision, comfort, and quality of life for patients with ocular disease.

(Article continued on page 9)



2019 ACA Speaker Overview (Continued)

Intraocular Tumors: A Flock of Rare Birds

Carol Shields, MD

Ever wonder what you are looking at when you peek through your patient's pupil to examine the fundus. What is this amelanotic choroidal mass with overlying retinal edema and a trough of fluid? How do you sort it out? What diagnoses should you anticipate and let's get a strategy for management together? Hey, could this be life-threatening?

Let's understand the various features of intraocular tumors and know general principles of different tumor types with clinical points, imaging findings, and management.

In this short one-hour course, we will cover the gamut of intraocular tumors. Like a flock of rare birds, you will be taught clinical pearls to spot the melanoma with its orange lipofuscin pigment, or recognized the metastasis by the classic imaging "lumpy bumpy" features on OCT, or know when to sit back and take a breath when the tumor is only a nevus with autofluorescence findings indicating RPE atrophy. New imaging using OCT, autofluorescence, and fluorescein/indocyanine green angiography all play into establishing the correct diagnosis.

So now we know what "rare bird" we are dealing with - how do we manage it. Some intraocular tumors require laser photocoagulation or photodynamic therapy, others need plaque radiotherapy or external beam radiotherapy, some need chemotherapy or immunotherapy, some need corticosteroids, and others we simply watch. The management depends on the specific tumor and its threat on vision and life.

Don't miss this course. You could save a patient's vision ... or life!



The Spectrum of Conjunctival Tumors

Carol Shields, MD

Just like a rainbow, there is a complete spectrum of conjunctival tumors, varying in color, size, location, local threat to the eye, and systemic associations. If you want to brush up on these various tumors - that you will see in your practice - then this course is for you.

There is a broad variety of conjunctival tumors, but the 5 most common malignant tumors include ocular surface squamous neoplasia (OSSN), lymphoma, and melanoma. Regarding OSSN, predisposing factors include chronic sun exposure, immune deficiency related to HIV, organ transplant, or autoimmune conditions, xeroderma pigmentosum, and chronic exposure to cigarette smoke. Warn your patients that smoke excessively that not only are they at risk for lung cancer, but also eye cancer (OSSN) and they could be putting those near them at risk due to second-hand smoke. OSSN can be managed surgically or by topical/injection interferon, mitomycin C, or 5-fluorouracil and metastatic disease is very low.

Regarding lymphoma, predisposing conditions include benign reactive lymphoid hyperplasia, chronic immune deficiency from HIV or other immune dysfunction syndromes even including autoimmune conditions, and chronic inflammation/infection. There are four basic subtypes of conjunctival lymphoma including the low grade types: extranodal marginal zone lymphoma (ENMZL) and follicular lymphoma, and the high grade types: diffuse large B cell lymphoma and mantle cell lymphoma (MCL). Treatment involves surgical resection, cryotherapy, radiotherapy, systemic chemotherapy or rituximab. Rituximab is a well-established biologic targeted therapy to eradicate B cells with CD 20 markers - a huge treatment with little toxicity. Survival depends on subtype and is most favorable for ENMZL and poorest for MCL.

Regarding melanoma, predisposing conditions include primary acquired melanosis (PAM), nevus, and chronic sun exposure. Treatment of PAM or nevus can prevent melanoma. Melanoma management involves complete surgical resection using "no touch" technique. The first surgery is most important to minimize tumor seeding and eventual tumor recurrence. Conjunctival melanoma demonstrates metastasis in 25% at 10 years, typically in larger tumors >2 mm thickness or those located in the fornix, caruncle, or orbit. Newer therapies targeting BRAF mutation in melanoma and the use of checkpoint inhibitors has prevented metastasis and death in some cases.

Know the big 5 malignancies of the conjunctiva - understanding their features and recognize them when they march into your office. You could save the patient's life. (Article continued on page 10)

2019 ACA Speaker Overview

(Continued)

Cases You Don't Want to Miss - Test your Knowledge Carol Shields, MD & Jerry Shields, MD

Ok guys, you have a patient with an odd-looking lesion in the eye. How would the experts look at this, what tests would they order, what would they do? Is it ok to take a biopsy or might that seed the tumor and create a worse problem. Work through some easy, some tricky, some fun, some unusual cases with the Shields and see how they think?

How would they approach a common suspect choroidal nevus. Should we get a fluorescein angiogram or is an OCT sufficient. What are the risk factors for transformation into melanoma and how do we apply them? How many are necessary to really worry about that nevus?

This challenging case presentation is guaranteed to keep you on the edge of your seat. Learn a practical way to approach tumors of the eye. Make yourself comfortable and confident with your judgment.

These are cases you don't want to miss. See you there!

Ophthalmic Presentations of Headache Disorders

Michael Doerrler, DO

Headaches afflict a significant portion of the population, with upwards of 20% of adult women and 5% of adult men having migraines. They are among some of the most disabling conditions noted by the WHO. However, public awareness and public access to professionals who specialize in headaches is limited. Nearly all physicians and other healthcare providers will encounter headache patients during the lifespan of their profession. A greater understanding of headache disorders by all levels of care would be beneficial for patients.

There is a close relationship between headache syndromes and the eyes. Patients may report symptoms such as diplopia, vision loss, or migrainous visual aura. Other findings may be discovered upon examination including ptosis, papilledema, lacrimation, and ophthalmoplegia. It is important to be aware of the various phenotypes of headaches that can be encountered with a patient so they can receive the appropriate workup and care for their underlying condition.

At this year's ACA, we will discuss the relationship between the eye and various headache diagnoses as well as common symptoms and exam findings to help better direct patient care.

Locoregional Flaps for the Head and Neck Rizwan Aslam, DO, MS, FACS

Dr. Aslam is a member of the faculty at Tulane University School of Medicine in New Orleans, Louisiana, where he is Assistant Professor of Otolaryngology. He also serves as Associate Program Director of the Otolaryngology Head and Neck Surgery Residency.

Dr. Aslam is an Attending Surgeon at University Medical Center in New Orleans, which provides superior care for patients from Louisiana and throughout the Gulf Coast, to include the VA Medical Center in New Orleans.

Rizwan Aslam | Fellowship-Trained Surgical Oncologist

Originally from Western Pennsylvania, Dr. Aslam graduated Magna Cum Laude from Syracuse University. Thereafter, he earned his Doctorate at Lake Erie College of Osteopathic Medicine.

Dr. Aslam's advanced training includes an internship at the Albert Einstein College of Medicine/Montefiore Medical Center in New York and a rotation at The University of Texas MD Anderson Cancer Center in Houston. He earned a Master's degree in Medical Education from Lake Erie College of Osteopathic Medicine.

In 2010, he completed a fellowship in Head and Neck Surgical Oncology Reconstructive Surgery at the University of Cincinnati, as a member of the Otolaryngology/Head and Neck Surgery clinical staff. During his time in Cincinnati, he was also a member of the clinical staff at the Cincinnati Children's Hospital Medical Center at the VA Medical Center.

In addition to sub-specialty training in removal of tumors from the head and neck, Dr. Aslam has had extensive training in microvascular reconstruction of head and neck defects. He maintains a special interest in robotic surgery, thyroid surgery, and malignant tumors of the head and neck.

Board-Certified Head and Neck Surgeon

Dr. Aslam is Board Certified in Otolaryngology Head and Neck Surgery, with a particular focus on Facial Plastic Surgery.

He is a fellow of the American College of Surgeons, and an active member (serving on national committees) of the American Head and Neck Society and the American Academy of Otolaryngology - Head and Neck Surgery. He is also a member of the American Osteopathic Colleges of Ophthalmology and Otolaryngology - Head and Neck Surgery. *(Article continued on page 11)*



2019 ACA Speaker Overview

(Continued)

Eyelid Biopsies for the General Ophthalmologist: A Practical Guide

César A. Briceño, MD

César A. Briceño is an assistant professor of ophthalmology at the Scheie Eye Institute of the University of Pennsylvania in the division of oculoplastic surgery. His clinical focus is thyroid eye disease and complex reconstructive surgery of the ocular adnexa. His academic focus is on surgical instruction of residents and medical students. This year he will be giving an update on the management of thyroid eye disease, including the latest medical and surgical options for management of difficult clinical cases. His talk will touch on exciting new medical options in the pharmaceutical pipeline as well as cutting edge techniques for customized orbital decompression surgery.

He will also focus on pearls for successful eyelid biopsies in the clinical setting. His talk will touch on his most trusted techniques to obtain a good sample, even with small lesions, strategies to avoid eyelid malposition when removing larger lesions and the best way to code these procedures to ensure compliance and optimize reimbursements.

Dr. Briceño will participate in our periorbital reconstruction panel where he will review techniques to minimize lid malposition when reconstructing eyelids after trauma or tumor excisions.

Low Vision Rehabilitation in the 21st Century

Dennis W. Siemsen, OD, MHPE

When I was in optometry school, one of my rotations was at the Chicago Lighthouse. In the beginning, I wondered why anyone would choose to work with blind people we couldn't seem to help much. Then we had a patient with a profound loss of vision who needed a few more inches of reading distance and a bit more enlargement in order to work in an office. When we reached his goal, he cried and we cried and then I understood.

Since then, we have expanded our tool kit to go beyond magnifiers and strong glasses. With today's technology, we are helping more people lead active, independent lives. Couple this with better treatment for macular degeneration, corneal dystrophy and diabetes, and low vision practitioners have a better acuity base to work with.

Low vision rehabilitation now supports not just ophthalmology and optometry, but also brain rehabilitation, pediatric neurology, return to work, behavioral neurology, sports medicine, physical medicine and rehabilitation, as well as vocation rehabilitation and teachers of the visually impaired. We are in an exciting time with more optometrists and ophthalmologists choosing to specialize in low vision. It adds value to ophthalmic care and the patients and families we serve.

Featured Workshop Highlight

Hands on Injection Training for Botulinum Toxins and Various Facial Fillers

Overview:

This CME program is designed to assist in keeping the members informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care as it relates to evidenced based medicine for ophthalmology, otolaryngology-head and neck surgery, facial plastic surgery, and otolaryngic allergy. Specifically, the Annual Clinical Assembly (ACA) includes hands-on workshops to allow for the support of practice and correction on various aesthetic scenarios in the specialty fields of ophthalmology and otolaryngology.

Professional Practice Gap & Educational Need:

The demand for nonsurgical injection-based facial rejuvenation products has risen enormously in recent years. Used independently or concurrently, botulinum toxin and dermal filler agents offer an affordable, minimally invasive approach to facial rejuvenation. Due to this spike in demand, physicians must be knowledgeable on the current botulinum facial fillers and the best practices for the application of such fillers, to not only meet this demand but most importantly offer the best patient care.

Source: UpToDate® is an evidence-based, physician-authored clinical decision support resource which clinicians trust to make the right point-of-care decisions.

Learning Objectives:

Upon completion of this workshop, participants will be able to:

1. Describe indications for botulinum toxins and multiple facial filler injections.
2. List the clinical uses of botulinum toxins and facial fillers.
3. Specify the limitations of botulinum toxins and facial fillers in clinical practice.
4. Identify the recommended timeline for evaluation of patients during treatments with botulinum toxins and facial fillers.
5. Demonstrate competency with botulinum and facial filler injections.

Workshops: Thursday will be botulinum toxins only. Friday will be fillers **we encourage attendees to bring your spouse or a model** they want to inject for hands on training at this workshop.



Sirtaz Sibia, DO, FAOCO

"As patient demand for facial rejuvenations increase, physicians who administer facial aesthetic products such as botulinum and other facial fillers must stay up-to-date with the latest techniques and keep their skills fresh to ensure patient safety and care."

-Dr. Sibia

Future Certification Is Where It Is At

Coming Changes In Osteopathic Content In AOA Board Certification Exams

The AOA Board of Trustees announced in February the approval of the creation of two pathways for AOA board certification: to become board certified in the osteopathic practice of their specialty; or to become board certified in their specialty only (taking an exam without formal osteopathic content).

The existing osteopathic specialty board certification exams will continue to serve DOs who wish to validate their expertise of osteopathic principles and practice. The AOA feels this “realignment” will provide options that the new diverse group of DOs want. Our profession is made up of DOs who practice osteopathically and perform OMT and others who practice osteopathically, but do not perform OMT. Additionally, our profession is also made up of DOs who trained in ACGME residencies who have not studied osteopathic principles or practiced OMT since medical school. These changes in board exam content aim to appeal to all DOs and interested MDs. However the ramifications of these changes are unknown and only speculation and time will answer our obvious questions.

Review Of Eligibility For Initial Certification in Ophthalmology & Otolaryngology

Osteopathic Ophthalmology and Otolaryngology candidates for AOBOO certification must currently be graduates of an AOA-accredited college of osteopathic medicine. They must satisfactorily complete a one-year internship in an AOA-approved training program and complete their AOA-approved residency training in ophthalmology or otolaryngology. They must hold an active license to practice in a state and abide to the AOA Code of Ethics. There is a six year window to become board certified, after which time a candidate must apply for exemptions from the AOA. The initial written exam fee is \$1,500 and any reexamination is \$1,500. The three-hour written examination consists of 150 multiple-choice questions

Subsequently, an oral examination is necessary for board certification. An oral exam fee of \$2,000 must accompany completed applications. A fee for re-examination is \$2,000. Oral board examiners will present the candidates with patient cases, including lab findings, and imaging studies.

Currently only DOs can sit for these exams, both those who trained in AOA-accredited or ACGME-accredited programs. However, the direction of the AOA points to their future interest in offering AOBOO certification to MDs.

Review of Osteopathic Continuous Certification

There are four components to Osteopathic Continuous Certification: (1.) Active Licensure, (2.) Lifelong Learning & Continuing Medical Education, (3.) Cognitive Assessment, and (4.) Practice Performance Assessment & Improvement.

To fulfill Component 1 for Active Licensure for Osteopathic Continuous Certification (OCC) in Ophthalmology, Otolaryngology and Facial Plastic Surgery the AOBOO requires that the candidate to provide proof of a valid state medical license annually and abide to the AOA Code of Ethics.

To fulfill Component 2 for Lifelong Learning & Continuing Medical Education, a candidate is required to “pursue” lifelong learning through continuing medical education. Candidates without time-limited certificates must provide 120 CME credits in the 2019-2021 AOA CME cycle. Candidates with time-limited certificates must complete 60 CME credits in the 2019-2021 AOA CME cycle.

To fulfill Component 3 for Cognitive Assessment in Ophthalmology, Otolaryngology/Facial Plastic Surgery, a physician must pass a written examination once per 10-year OCC cycle. The AOBOO-HNS offers OCC written exams in Ophthalmology, Otolaryngology, Facial Plastic Surgery, and Allergy twice each year in the spring and fall. Candidates may apply to take the exam three years prior to the expiration date of their certificate. The AOBOO is exploring alternative options to the traditional OCC exam.

For physicians holding time-dated certification, failure to successfully complete the OCC process will result in the inactivation of certification when their current certification expires. For physicians with non-time-limited, non-dated, non-expiring certifications, OCC participation is not required, although they may elect to do so voluntarily.

(Article continued on page 14)

Future Certification Is Where It Is At (Continued)

The Ophthalmology OCC exam consists of multiple-choice questions on the following topics: External Disease and Cornea; Fundamental Principles of Ophthalmology; General Medicine, Anesthesia; Glaucoma; Intraocular Inflammation and Uveitis; Lens and Cataract; Neuro-Ophthalmology; Optics, Refraction and Contact Lenses; Orbit, Eyelids, Lacrymal System; Pathology and Tumors; Pediatrics and Strabismus; and Retina and Vitreous.

The Otolaryngology & Facial Plastic Surgery OCC exam is also a multiple-choice covering the following topics: Allergy, Audiology, Congenital, External Ear, Facial Plastics, Head And Neck

Inner Ear, Laryngology, Mastoid, Middle Ear, Nasopharynx, Nose, OMT, Oncology, Otolaryngology, Otolaryngology, Otolaryngology, Otolaryngology, Otolaryngology, Pediatric, Physiology, Recertification, Reconstructive, Rhinology, Saliva/Endocrine, Sinus, Sinusitis, and Skull Base.

The OCC cognitive assessment exam can be taken within three years of your certification's expiration date. Applications for the spring exam are due March 1 and applications for the fall exam are due August 1. The OCC annual fee is \$150 and the written exam is \$2,000. For physicians holding time-dated certification, failure to successfully complete the OCC process will result in the inactivation of certification when their current certification expires.

To fulfill Component 4 of Practice Performance Assessment & Improvement, candidates will be required to attest to participating in a Quality Improvement (QI) Activity. Examples of QI activity include participation in clinical registries like the Intelligent Research in Sight (IRS) and the Sleep Medicine Registry (PCMH). Other national clinical registries are listed on . The attestation form is available on the AOA Physician Portal. If a candidate has not participated in a quality improvement activity, they will be asked to complete two practice performance assessments for a fee.

The AOCOO-HNS Certifying Board Members:

As members of the AOCOO-HNS, we are gratefully indebted to our fellow AOCOO-HNS members and AOA staff who serve and have served for many years on our AOCOO certifying boards: Nicholas A. Sala, DO Chair, Paul S. Biedenbach, DO Vice Chair, David B. Auerbach, DO Secretary, Steven J. Kin, DO Treasurer, Ralph G. Del Negro, DO, Melissa G. Kress, DO, Kevin D. Meakin, DO, William W. McLaughlin, DO, Steven Sherman, DO, James E. Silone, Jr., DO, Libby J. Smith, DO, Mark J. Van Ess, DO, Joseph L. Muscarella, Jr., DO, Richard Walker, DO, Benjamin W. Murcek, DO Physician Executive, Gregory E. Stone, PhD Psychometric Consultant and Libby Strong, Certification Director.



Kristin E. Reidy, DO
AOCOO-HNS Immediate Past President

Marriage Minute: Keep the love alive!

Turn off the electronics. "There used to be talk about 'quality time,'" says Kathy McMahon, PhD, president and CEO of Watertown, Massachusetts-based Couples Therapy Inc. "I think that's a message. It's just time. Time for slow, unpredictable, 'being' conversation. You don't develop intimacy without time, and it has to be time without electronics. You think it's tough to take away an Xbox from a teenager? Try to take a cell phone away from a physician." Make a rule to electronics in bed.



The Importance of Strategic Planning

In today's market flexible and adaptable strategy can help institutions beat the competition. This business concept could also apply to health care institutions and private practices throughout the medical industry as well. Whether you are looking to hire the best in the business, expand your target market, or increase your profit margin, strategic planning can help you get there.

Why are so many companies investing in strategic planning?

Articulating a plan, setting goals, expressing priorities, and generating an institutional strategy takes time and resources. Many companies are finding it is worth the investment.

With a long history rooted in business schools like Harvard and MIT, strategic planning has evolved to serve a complex and unpredictable market. Consulting firms, according to IBIS News, had a revenue of \$241 billion in 2018. This upward trend is expected to continue to grow as small and medium size institutions take advantage of this resource management tool.

What you should expect.

Strategic planning is a process, and growth takes planning. Expect to be challenged. During a strategic planning session, a seasoned facilitator can help you problem solve and create strategy that will push your team and move your business, non-profit, or board to the next level.

Ms. Sasha Pellerin serves as Project Director at Southwest Creations Collaborative (SCC), a 24-year, women-driven contract manufacturing company and social enterprise, with a mission to alleviate poverty and build economic opportunity across generations.

Her strategic leadership addresses the challenges in educational and economic outcomes of minorities in New Mexico. Through strategic planning, she has successfully managed the growth of Hacia: Toward the University, a program that successfully mends the gap between Latino and Anglo students. Hacia has achieved a 98% high school graduation, and 95% college acceptance rate in a state with less than 70% high school graduation. At Southwest Creations Collaborative, they have expanded disciplines of their market driven social enterprise to invest in their community based model to improve education and employability. Under Sasha's leadership, 500 first generation college-bound students have graduated high school and attended college.



Sasha Pellerin

Executive Director, Hacia: Toward the University



Changing the World Starts with our Children

After working with AOCOO-HNS, I have been inspired by countless stories of triumph, perseverance, and inspiration. In particular, I was impressed by a young medical student I met who was the first in her family to go to college. As an immigrant, she became the first in her family to graduate high school, attend college, and become a medical student. She faced unbelievable circumstances and overcame poverty, language barriers, and a glass ceiling.

I have noticed a common thread of passion among physicians, usually related to helping people and changing the world, and this was no different for her. For many physicians, the goal of becoming a doctor was a goal set at a very young age. As an artist, I can understand the drive that many doctors talk about: the late nights studying, the interest in the abnormal, and the calling that will push you to your limits. So how does a doctor become a doctor? What is the journey that leads them to the decision to take on such a lengthy and exclusive educational process?

As parents, we believe it is important to have conversations with our children about college and careers. I find myself asking my ten year old son, Fermir: What do you want to be when you grow up? His answer changes from time to time; however, the answer that stands out to me the most is: a surgeon. He is a technical, mathematical thinker and unlike most kids his age, does not get queasy at the sight of blood. For the holidays, we gave him a cow eye dissection kit as a gift. What ten year old is interested in a cow eye when they have an iPhone? My son,

Does this type of exposure at a young age help develop interest and perspective in our children, or is it purely passion that sets people in the medical field apart? What about children whose parents did not go to college and do not know how to navigate the educational system?

The answer is a dubious one, and something I encourage our bright, young medical students to explore. Doctors seem to be getting younger and younger (or maybe I am just getting older and older) and by encouraging our children, we can lay the foundation and give them the tools for academic, emotional, and life success. What I do know, and what seems to be clear for me, is the medical field would be a good fit for my son, and our encouragement can be that spark that leads him to a field of exploration and healing, if he chooses to go in that direction.

I encourage you to use this article to reflect on what inspired you - a teacher, a mentor, a parent - and pay it forward.



Gerald Lovato

Monstully LLC., Creative Director





AMERICAN OSTEOPATHIC ASSOCIATION

DO student wins prestigious AMA award for eyesight restoration research

Second-year TouroCOM-Harlem student earns a first-place win from the AMA.

Ben Souferi, a second-year medical student at Touro College of Osteopathic Medicine in New York City, recently won a first-place award from the American Medical Association (AMA) for his research in eyesight restoration.

Award-winning research

Souferi earned the first-place honor in the medical student Basic Science category during the AMA Expo Research Symposium this past November for his study involving the regeneration and implantation of new cone cells, the primary photoreceptors that impact vision acuity and color.

Over the past five years, in the laboratory at City College of New York, Souferi developed and tested his research. Souferi's mentor, Mark Emerson, PhD, assistant professor of biology, helped him during each step of the process.

"Regeneration of cone photoreceptors is one of the most promising therapies for vision restoration," Souferi said. "Their loss is one of the main causes of blindness." He is hopeful that his research will aid in restoring vision to patients that have lost cone receptors or were born without them.

Souferi's research is now under review for publication. "I hope that my findings will help other scientists gain further insight into their own research," he said.

Research & development

Research has played a tremendous role in his life as an undergraduate student, a master's student, and a medical school student, Souferi says. "I think all aspiring physicians should do research. All the things you learn in class are not always tangible, but once you're in the laboratory and you can actually see the things you learn, it helps you understand even more." With undergraduate and graduate degrees in biology, Souferi was excited to delve further into his passion as a medical student. "I love the small aspects of biology and biological intricacies. I only learned about these topics in the classroom, but once I learned to apply this knowledge within the laboratory, I gained a deeper understanding of biology," he says.

Trust the process

Souferi says it was difficult to summarize five years of research and data into a 45 x 45-inch poster and a 5-minute presentation. He began by putting all of his ideas into a Power Point and then slowly shortened it without sacrificing the message. "That's when I stopped to make the poster," he said. "The process of preparing for this conference provided me the opportunity to piece together years of experimentation into a clear and concise story. All my findings led up to this point."

A challenge that Souferi is learning to manage is trying to be at the forefront of something when the next step is not always clear. "I review recent literature, discuss my findings with my peers and mentor, and with all my resources, I apply my own knowledge and take the next stride forward," he says.

The next level

While he's been involved in research since his undergrad days, medical school allowed Souferi to take his research skills to the next level. "Touro does a great job of solidifying our basic science knowledge and teaching us the various clinical manifestations of disease and research that the medical field uses to support its findings," he says.

In the immediate future, Souferi is looking to gain a greater understanding of different kinds of laboratories and delve into clinical research.

Article written by Nikitta Foston, courtesy of American Osteopathic Association.



Ben Souferi, OMS II

State of the Osteopathic Otolaryngology Residency Programs

And Then There Were Fourteen

The members of ACCOO-HNS who are not involved with residency training programs may not be aware of the dramatic changes that have been occurring with our programs. As we enter another residency match season, I wanted to inform the members of our college what the Memorandum of Understanding (MOU) is and how it has affected residency training as it relates to otolaryngology. As of this writing, the AOA residency match has already taken place and the allopathic National Residency Match Program (NRMP) takes place March 11, 2019.

The 2014 signing of the Memorandum of Understanding (MOU) was an agreement between the American Osteopathic Association (AOA), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME) with the goal to have all osteopathic residency programs accredited under ACGME by June of 2020. Prior to this agreement, there were twenty-one osteopathic residency programs in otolaryngology across the country. As of March 2019, we are down to fourteen residency programs recruiting residents for a total of eighteen residency spots available for the 2019-2020 academic year.

“I feel undergraduate students interested in a career in medicine need to be educated about these changes to residency training to help them decide on applying to allopathic versus osteopathic medical schools.” - Dr. Shermetaro

To Review How the MOU Came to Be

In 2009, the ACGME was working to change the accreditation system, which would have restricted non-ACGME residents from matriculating into ACGME fellowship programs starting in July 2016. This change in accessibility of fellowship programs for DO residency trained physicians led to a joint task force of the AOA, AACOM and ACGME to propose the single accreditation system for Graduate Medical Education. The agreement called for a five-year timeline beginning April 1, 2015, through June 30, 2020. All osteopathic residency programs wanting to transition to ACGME had to apply during the five-year timeline. The programs that do not achieve ACGME accreditation by June 2020 will no longer have AOA accreditation. However, residents in those programs will be able to sunset, meaning they will be able to complete their training, although the programs would no longer be able to recruit new residents. Some osteopathic residency training programs may benefit from this change. However, surgical sub-specialty programs will lose residency positions for osteopathic students due to some programs not being able to achieve accreditation through the ACGME.

This year, there were fourteen osteopathic otolaryngology residency programs available to our osteopathic medical students. There were six residency programs participating in the AOA Match, which took place in early February 2019. There were eight positions available with these six programs. There are seven programs participating in the NRMP Match for a total of ten positions. There were thirteen programs participating this year for resident recruitment, one program did not recruit.

(Article continued on page 19)



State of the Osteopathic Otolaryngology Residency Programs (Continued)

There were eight positions available in the 2019 AOA Match. The following institutions participated:

- Beaumont Hospital-Farmington (Farmington Hills, MI); one position available
- Doctors Hospital (Columbus, OH); one position available
- Grandview Hospital and Medical Center (Dayton, OH); one position available
- St. Elizabeth Boardman Hospital (Boardman, OH); one position available
- Oklahoma State University Medical Center (Tulsa, OK); one position available
- Philadelphia College of Osteopathic Medicine (Philadelphia, PA); three positions available. There will be ten positions available in the 2020 NRMP Match. The following institutions will be participating:
 - McLaren Health Care/ Oakland/MSU Program (Pontiac, MI); two positions available
 - Henry Ford Macomb Hospital (Clinton Twp., MI); one position available
 - Detroit Medical Center Corporation Program (Commerce Twp., MI); two positions available
 - Ascension Macomb-Oakland Hospital (Warren, MI); two positions available
 - Kansas City University of Medicine and Biosciences-GME Consortium (KCU_GME Consortium)/Freeman Program (Joplin, MO); one position available
 - Western Reserve Hospital Program (Cuyahoga Falls, OH); one position available
 - UPMC Medical Education (Erie) Program (Erie, PA); one position available. Of the fourteen remaining osteopathic residency training programs, eleven have achieved initial accreditation through ACGME. The remaining programs still working on accreditation are: Oklahoma State University, Doctors Hospital, and St. Barbara's Medical Center (New Jersey).

This will be the last year osteopathic medical students have to navigate with two residency match programs. Starting in 2020, there will only be the NRMP Match for osteopathic medical students to apply to.

Since I have been a residency program director (for the past seventeen years), there has always been a strong interest in the field of otolaryngology amongst our osteopathic medical students. Unfortunately, an unintended consequence of the MOU has been the significant reduction in the number of osteopathic otolaryngology residency programs and the overall number of resident positions available to our osteopathic students. The accreditation from ACGME also means the traditional osteopathic residency programs are available for allopathic students to apply to. Unlike many primary care allopathic residency positions available to osteopathic students (and always have been prior to the MOU), the surgical sub-specialty allopathic programs are not nearly as likely to match an osteopathic student.

With the very limited number of positions available for many of the surgical subspecialty programs for osteopathic students, I feel undergraduate students interested in a career in medicine need to be educated about these changes to residency training to help them decide on applying to allopathic versus osteopathic medical schools. If they have a strong surgical interest, there are many more positions available through the allopathic pathway versus the osteopathic pathway.



Carl Shermetaro, DO

Residency Program Director
Otolaryngology/Head & Neck Surgery
McLaren Oakland Hospital Pontiac, MI

Meet the 2019-2020 Board Nominees

Ankur Patel DO MPH graduated from Ohio University Heritage College of Osteopathic Medicine. He completed a residency at Ohio University Grandview Medical Center and went on to complete a Pediatric Otolaryngology Fellowship at Pittsburgh Children's Hospital. He is currently a Clinical Assistant Professor at Ohio University Heritage College of Medicine and an Assistant Professor at Wright State School of Medicine. He currently practices at Dayton Children's Hospital and practices all aspects of Pediatric Otolaryngology.

At the council meeting there were presentations from the many subspecialty organizations that are part of the collective council. I did present the status of our college including the decreasing residency spots that will be available with the closure of some of the Ophthalmology programs.

There was also a large emphasis made during the meeting about advocacy and meeting with both state and national legislators and supporting the surgical scope fund and the academy lobbyists. If you are like me, every time this conversation arises, I cringe. Here is someone again asking me for more money and more time.



Ankur Patel, DO
Secretary/Treasurer

As nominee for the ophthalmology Member-at-Large position of the Board of Governors, it would be my pleasure to serve you, the great members of our AOCOO-HNS. My interest in serving you has come from a desire to help organize and prepare the teaching at our annual meetings. One opportunity for me to continue to preserve high standards for our educational conference comes in 2020 as your Ophthalmology Education Committee Chair. Please join me in support of educational excellence by maintaining this priority with our Board of Governors!

(Article continued on page 21)



Timothy Winter, DO
Member-at-Large

Meet the 2019-2020

Board Nominees (Continued)

My esteemed colleagues, I am seeking a position on the Board of Governors to serve our college as an advocate for the preservation and promotion of Osteopathic Otolaryngologists and Ophthalmologists. As a program director and educator of the residency program at Henry Ford Macomb Hospital for the past 10 years, I serve as vice chairman of Medical Education Committee for Henry Ford Health System where I have had an active role in the transition of accreditation to the ACGME for the health system. At the national level in our College, I have been an outspoken member of the program director committee as well as the steering committee of program directors at Michigan State University College of Osteopathic Medicine (MSUCOM).

My goals as a program director have been to be an advocate for residents, to have excellence in education and research with exposure to diverse learning opportunities. With this philosophy I have been successful in positioning our Osteopathic graduates as exemplary physicians in otolaryngology. As an educator, I have been an active researcher, organizer of regional surgical didactic conferences through MSUCOM, lecturer for regional grand rounds and a proctor of sinus surgery for conferences at the University of Michigan and Henry Ford Hospital.

As a fellowship trained sleep medicine physician, I have served as a member of the Sleep Medicine Committee for the American Academy of Otolaryngology and Head and Neck Surgery, where I have developed policy for sleep surgical procedures and treatment standard of care. At the local level in Michigan, I have developed a sleep medicine registry and have helped to develop quality of care metrics for patients with obstructive sleep apnea for local insurance carriers.

My experience as the program director during this uncharted territory of transitioning our Osteopathic AOA accreditation to ACGME accreditation has culminated in Henry Ford becoming the first and only Osteopathic otolaryngology program to achieve ACGME initial accreditation. My connections in both the ACGME and AOA affords me with a unique perspective to understand the challenges that will face our College in the future and options for success in this process. I pledge to my fellow members and residents, that I will uphold our Osteopathic identity as specialists to be a primary importance for the preservation of our college. If elected to the Board, I will continue to be an outspoken advocate for education, research, service and highest quality Osteopathic focused medical care.



Douglas Kubek, DO
Member-at-Large

Dr. Carissa Wentland is an ENT-otolaryngologist in Beachwood, Ohio and is affiliated with University Hospitals Cleveland Medical Center. She received her medical degree from A.T. Still University School of Osteopathic Medicine in Arizona and has been in practice between 6-10 years. She is one of 25 doctors at University Hospitals Cleveland Medical Center who specialize in Otolaryngology (ENT).



Carissa Wentland, DO
Member-at-Large

LETTER TO THE EDITOR: OD, OS, and OU: Talking in Code?

The Electronic Health Record has become our standard method of communication between physicians and for our own use to memorialize a patient's findings over time. The clear statement of observations, assessments, and plans form the work output of a patient encounter, and increasingly patients view the encounter note as their property, to be immediately provided at the conclusion of an encounter.¹ The Open Notes movement argues for this transparency, urging all notes be made available to patients through the patient portal as soon as the physician signs them.

Rule #16 of Strunk and White's "The Elements of Style" [use definite, specific, concrete language] becomes more important when it is clear that we are now writing our notes not only for ourselves and our peers but also for our patients as well.²

Given the changing nature of the patient record, it is time to re-evaluate the use of several time-honored and (for some) cherished abbreviations: OD (Right Eye), OS (Left Eye), and OU (Each Eye). For patients, often without medical training, this terminology we use to delineate eyes can serve as a barrier to understanding their own health status with respect to their vision. More importantly, the use of OD, OS, and OU have been repeatedly cited as "error-prone abbreviations" by multiple entities including the Institute of Safe Medicine Practice (ISMP).³ The Institute of Safe Medicine Practice goes as far as to recommend the use of "right eye, left eye, and each eye" over the use of OD, OS, and OU as a means to eliminate medical error.⁵ The Joint Commission Journal on Quality and Patient Safety also cite multiple cases of medical errors stemming from the use of OD, OS, and OU in a study they conducted in 2007, indicating that this has been an issue that has been examined for more than a decade.

Those hesitant to adopt simpler terminology to document left, right, and each eye may argue upholding existing terminology is important because it maintains universality in communication between researchers. Lysanets and Bielaieva⁴ argue for the continued use of Latin terminology in the medical literature because it "promotes conciseness." However, "concise" language is not necessarily straightforward and understandable. Increasingly, machine translation (e.g., Google Translate) is used when patients receive instructions in other than their preferred language. Using simple declarative sentences free of abbreviation is more safely machine translated.⁶ For example, the Google Translate Spanish translation of "OD" is "De."

It does not matter whether we as ophthalmologists know what OD, OS, and OU mean. It does matter if others who read our notes do not know what the terms mean. It has become more important than ever to use simple terminology. Electronic Health Records should promote safe communication by eschewing the use of these Latin terms.⁷

Retrolental fibroplasia provides us with a case example that establishes precedence for changing terminology and gives insight as to how the change plays out in the academic world (Fig. 1). The first use of the term "retrolental fibroplasia" was in 1942, by T.L. Terry, in the American Journal of Ophthalmology.⁸ Language evolves over time. Just as "retrolental fibroplasia" is now a historical term, replaced by the more informative "retinopathy of prematurity", it is time to replace the use of the abbreviations OD, OS, and OU with the "definite, specific, concrete language" of Right eye, left eye, and each eye.

(See Figure 1 on page 23)

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Wolters
Kluwer

Article courtesy of Wolters Kluwer Health www.journalpatientafety.com
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LETTER TO THE EDITOR: OD, OS, and OU: Talking in Code?

(Continued)

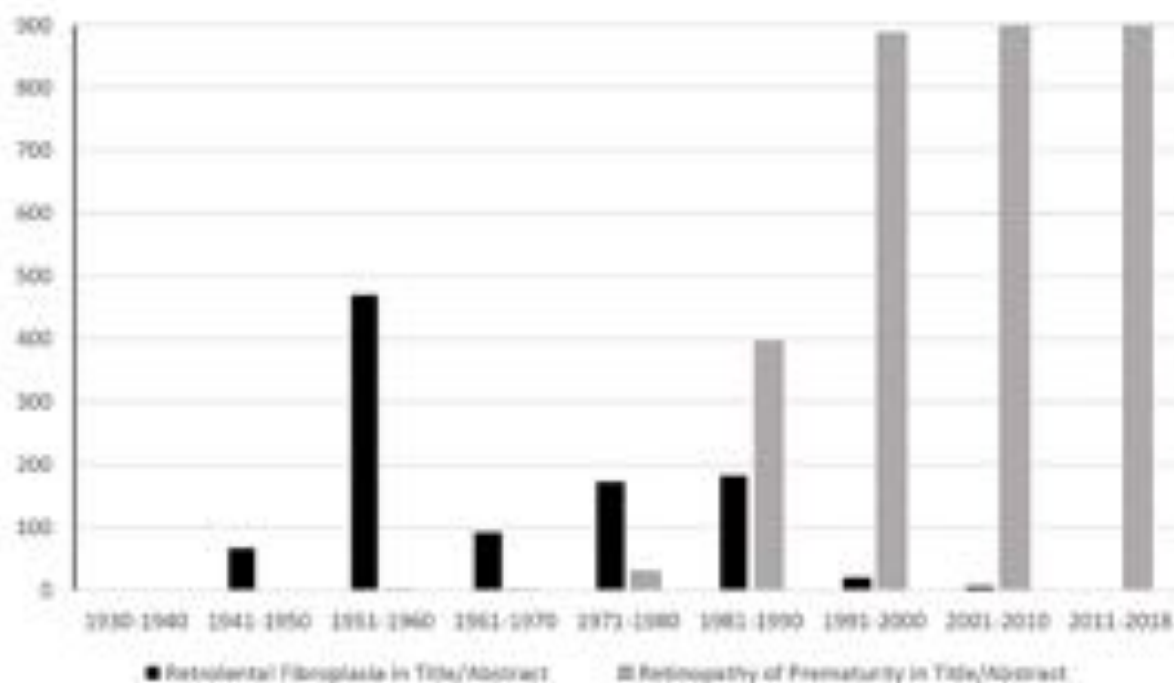


FIGURE 1. Data in figure one retrieved from PubMed search engine. Multiple advanced searches done by decade to include only one term in the title/abstract (retrolental fibroplasia or retinopathy of prematurity) and to exclude the alternative term (retrolental fibroplasia or retinopathy of prematurity) yielded above results.

The authors disclose no conflict of interest.

REFERENCES

1. Delbanco T, Walker J, Bell S, et al. Inviting patients to read their doctors' notes: a quasisystematic study and a look ahead. *patient experience. Am J Med Qual.* 2017;32: 58-65.
2. Strunk W, White E. *The Elements of Style*. 4th ed. Tucson, Arizona: Turtleback; 1999:50-52.
3. List of Error-Prone Abbreviations. Institute for Safe Medication Practices. Available at: <https://www.ismp.org/recommendations/error-prone-abbreviations-list>. Published October 2, 2017. Accessed September 17, 2018.
4. Brunetti L, Santelli JP, Hicks RW. The impact of abbreviations on patient safety. *Jt Comm J Qual Patient Saf.* 2007;33:576-583.
5. Iyannets YV, Bielakova OM. The use of Latin terminology in medical case reports: quantitative, structural, and thematic analysis. *J Med Case Reports.* 2018;12:45.
6. Miller J, Harvey E, Bedrick S, et al. Simple patient care instructions translate best: safety guidelines for physician use of google translate. *J Clin Outcomes Manag.* 2018;25. Available at: <https://www.mdedge.com/jcomjournal/article/135605/practicemanagement/simple-patient-careinstructions-translate-best>. *Ann Intern Med.* 2012;157:461-470. Accessed September 22, 2018.
7. Advanced search - PubMed - NCBI. <https://pubmed.ncbi.nlm.nih.gov/>
8. Nazi KM, Turvey CL, Klein DM, et al. VA OpenNotes: exploring the experiences of early patient adopters with access to clinical notes. *J Am Med Inform Assoc.* 2015;22: 580-589.
9. Weinert G. Giving doctors' daily progress notes to hospitalized patients and families to improve e2 www.journalpatientsafety.com. <https://www.ncbi.nlm.nih.gov/pubmed/advanced>. Published 2018. Accessed October 5, 2018.
10. Terry T. Fibroblastic overgrowth of persistent tunica vasculosa lentis in infants born prematurely*. *Am J Ophthalmol.* 1942;25:1409-1423.

8 years of marriage in and out of medical training: How we did it, and what we're still doing to make it work. Kids included.

When I met Jenn I knew she was the type of woman that would stick out some pretty rough environments. But nothing could have prepared us for what would lie ahead: Our journey to ophthalmology.

When our first son arrived 10 days before medical school I remember sitting in our rented patio home in Phoenix in the 118°F dry heat wondering, "How am I going to be a good dad and a good medical student?" Now looking back those were the easy days. Lectures and tests passed. Year after year I found myself asking the same question, just in a different setting: "How am I going to be a good rotating student, intern, surgery resident?" Four kids, med-school debt, and years of exhaustion have been humbling but they have made us that much stronger. Here's what I think helped my wife and I the most along our journey:

1. We saw the end from the beginning and didn't forget it. Its going to get crazy busy, but don't let that blur your vision of what life is all about. Remember at the end of the day that "who" you spend your life with is more important than "what" you spend your life with. Set daily and weekly goals and make them into habits. Adopt the mentality that you CAN have good relationships and deserve them in medicine.

2. When we stretched we grew, but we realized the pain and accepted it. Fully accept that you chose a hard route full of adventure, discovery, emotion, blood, sweat, and tears. You didn't do it for the money you did it because you wanted to make a difference. With that acceptance comes an understanding that will help you keep perspective. There were many times when my wife and I thought that perhaps we had chosen the wrong path. Maybe medicine just isn't conducive to family or spouses? Nope—don't buy into that! Medicine can and should be a family friendly work environment and until our generation continues to place emphasis on this, then it won't be. When a road block came, or bad news struck, we turned to each other and problem solved together.

3. We committed to put each other first, but accepted that short term sacrifice did not negate this commitment. Sometimes that late night or early morning came instead of a date or time together, and that was okay, but we never accepted it as typical and never made it a habit. Often this meant I had to wake up early and study so that we could do other things in the evening. Sometimes this meant taking a break early on a Friday or Saturday to go out. Realize that if you do not learn balance and flexibility early in your career/-medical training, that it only becomes harder to as time passes on.

4. We kept connecting daily in little and semi-predictable ways. A little text message works wonders, but written cards, notes, phone calls, or other memorable things go much farther. I must admit I am still working on this, and I think that is a healthy way to look at it. Listen to your significant other and/or children and be fully present when you're at home. The last thing your family wants to see you do is absorb into your smart phone after work, don't do it.

5. Less is more. Simplify. Don't say yes to everything—our generation is prone to this. Plan out time to spend together. For us this meant a walk, a quick hike, or a date to the farmers market. When it was difficult to find a babysitter an online yoga session was always a good fallback. Realize that weekly date nights will be much cheaper than marriage counseling and divorce.

As we all practice preventive self care in both our personal and family lives we will be empowered to provide better care to our patients.



David Felsted, DO
AOCOO-HNS Member

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- Editor-in-Chief: The American Journal of Orthopedics


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The 2019 ACA will be held at the Hyatt Regency Cypress in Orlando Florida on May 2nd - 4th, 2019. Room rates are \$225 single/double, \$250 triple and \$275 quadruple occupancy.

For bookings: aocohns.org

Upcoming Events

Information: aocohns.org

2020 Mid-Year Event:
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2020 ACA Event:
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