WINTER 2022

SCOPE

The Madgy Malawi Mission

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

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president's letter

DEAR COLLEAGUES AND FRIENDS, as we approach the end of this year, I would like to take a moment to wish you and your loved ones a wonderful holiday season and a happy, healthy new year. We've had a productive year, with the education committee working diligently to put together an outstanding program for our members at the ACA. Similar to last year, we are looking to continue providing experiential CME events.

We continue to provide support for our Osteopathic residents through grants from the college to attend our meetings, as well as other educational opportunities. Additionally, we continue to offer DocMatters to our members as a way to connect and provide an open forum to discuss clinical topics in Otolaryngology and Ophthalmology.

As always, our college is here to help our members. I invite all of you to share with us any ideas, thoughts, or concerns you may have. I look forward to another productive year as your president of the AOCOOHNS, and connecting with you in 2023.

Best,

Ankur Patel DO MPH

Feeling the Burn

By Ralph McClish

GROWING PATIENT VOLUMES, inadequate staffing and a demand to do more with less is turning physician "burnout" into an epidemic.

It's a problem with no "silver bullet" in sight as health care companies and non-profit health networks begin prioritizing financial returns over patient care.

Some physicians and healthcare professionals are turning to organizations like the Union of American Physicians & Dentists (UAPD) to begin pushing back; ensuring that patient care remains the top priority by easing pressures on providers to deliver the care patients need.

"Over the years, we have seen policies implemented in hospitals, clinics, and state-run facilities threatening the medical profession and patient lives. With the strength of the union, our members fight back and demand their voices be heard in decisions affecting patient care." said Dr. Stuart Bussey, UAPD Board President.

What's the scope of the problem? The American Medical Association states that physician burnout and stress is nearing crisis mode across the United States healthcare system.

Faced with constraints from private insurance, physicians navigate a complex and stressful environment leaving little to no-time for themselves and their families. Contrary to what healthcare companies are suggesting – stress relief techniques like Yoga, meditation, and improved sleep – these are not meaningful solutions.

UAPD is among the strongest advocates for giving healthcare providers a bigger role in solving the crises.

With more than 5,000 members and growing, UAPD is the union of choice for physicians when it comes to negotiating wages, benefits and improved working conditions for physicians and advanced practice clinicians in the country. UAPD has more than 50 years of experience representing both private and public-sector medical professionals. The union represents medical professionals in California, Washington and New Mexico. Meanwhile, the organization is gaining interest from providers from across the nation.

Negotiating a contract means providers can bargain for better work conditions, higher wages, improved benefits packages, and new rights not currently in provider contracts.

Individuals looking to organize a union have rights and protections under the law and cannot be penalized for forming, joining, or assisting a union at the workplace. For more information about how to organize a union, *visit www.uapd.com or call 1-800-585-6977.* □

The Power of Listening

THE AOOCOHNS had our virtual midyear conference in September. I think it was a great midyear, and I thank Ralph, Mackenzie, Dr Singh and all of the other presenters for all of their hard work in putting it together. It was geared toward physician wellness. It was my honor to participate and present for the conference. For those of you who attended, this is my abridged version of my presentation.

I tend to think of myself as a relatively happy person and physician, but like all of us, I do feel frustrated and unhappy about certain

aspects of medicine. I do worry that with our day to day grind and craziness, that one day I am going to turn around and 10 years will have passed, and I won't be able to remember feeling joy and satisfaction from it. I don't want to find myself falling into the trap of just waiting until I retire to feel like I have accomplished my goals, and to feel that at last I have succeeded and can feel joy and accomplishment, and that I have made it.

When I met with Dr Singh, who was the facilitator for this conference, I told him I was somewhat skeptical of all of this, but I was willing to keep an open mind as I did the activities. He told me that was fine and basically we would see where I ended up.

I started off by doing a strengths assessment and watching some videos. The strengths assessment showed that my strongest attributes are Fairness, Teamwork, Leadership, Prudence, and Honesty. When I took the time to look at how I use my strengths, I realized that they are truly important and affect my world view. However, they can sometimes be a double edged sword. Learning what my strengths are, and how I use them to my advantage and disadvantage has been enlightening.

My big takeaways from the videos were that my worldview is generally shaped by what I see and hear going on around me. The best example of this is the news. The news is in general, 95 percent negative and 5 percent positive. We all know that negative sells, but if we are not careful, we start to perceive the world as 95 percent negative and only 5 percent positive. After doing one of my activities, which was three good things, I can definitely share that the world is much more positive than negative. We just have to move outside of what we are bombarded with to get the big picture.

My other big takeaway from the videos is that we are allowed to feel accomplishment and joy and even satisfaction when we reach a milestone. If I think about my life, I was always taught to strive for something more, and there is nothing wrong with that, but when are we able to say we have made it. I know

personally, that every time I reach a goal, I just move the endpoint further up. I did learn that I need to let myself feel the accomplishments of reaching a goal and luxuriating in that for a bit, before starting for the next goal. If we don't take the time to enjoy things as they happen, we will turn around and be nearing the end of our lives, wondering what we did the whole time.

I did a series of activities over a period of 8 weeks. The activities that were the most successful for me were: 1. Three good things that happen each week and why. 2. Being present where you are. 3. Active, constructive listening and responding I started with 3 good things and why. In my life, I continuously remember the bad things such as a bad patient experience, a bad surgery, or a fight or issue with a loved one or partner. I realize that I rarely remember the good things. I rarely remember a patient being happy and complimenting me for my skill, reuniting with old friends, or taking satisfaction in my family's accomplishments. It turns out that if you really listen to your patients at the end of your time with them, a vast majority of them thank you for your skills and expertise and for helping them. I had no idea how often that happens in a day or week and mostly would just brush it off, without feeling it. Listing three good things that happen to me in a week and why they made me happy has helped me to balance my worldview and try to realize that when a bad interaction happens, it is the rarity and the good interactions are the majority.

Being present where I am. This means taking some time each day to breathe and look around and make sure I am truly experiencing the day. To tell the truth, this one has been the hardest activity for me. Our lives as doctors make every day busy, and there are some days that go by so fast that when I finally look up from seeing patients or doing paper work, the day is already done, and I don't feel like it was anything. I am trying to remind myself to be present daily, but I am still having trouble with this. As I said before, I don't want to turn around and have 10 years go by, without really experiencing the time.

My last activity was active constructive listening and responding. This was extremely hard for me, but I have found it to be so worthwhile in my interactions with others. When someone has talked to me in the past, as they are

reciting their story, I am always thinking in my mind, what kind of similar story do I have that will connect me with them. I then tell my story, many times without really hearing what they were saying. Other times, someone will tell their story and I say congratulations , or I am sorry , or some other mundane comment and move on to what I want to say. I never realized that I was listening but in a non constructive way. I thought I was trying to relate to the person. I have been practicing truly active constructive listening and responding to what someone is saying. An example of this is, if my wife is having a good issue or a bad issue, I try to truly listen and actively respond by having her bring out more. My responses to her are, tell me how that made you feel, or tell me how it happened, or how did you respond to that? This is so much better received than a response of thats great, now what are we doing for dinner. Our conversations are definitely better. Active constructive listening and responding takes more time, but it is so worth it. I have found it has definitely enhanced my relationship. The biggest issue is that it really does take time and you have to have time for it. I would love to apply it to my patients, but with our time constraints with medicine the way it is now, it is next to impossible.

So where did I end up? I do see some successes in my outlook and world view after having completed these activities. I do think that I have learned things about myself that will help me in moving forward. Some of these activities have made a lot of difference, some a small difference, and some not at all. That is the beauty of being an individual. We all respond to different things. I will say that the most successful activities for me were active constructive listening and responding and three good things. Active constructive listening and responding has been wonderful in my relationships, and three good things are helping me to remember the world is mostly good, and to realize that for every bad interaction, there are many many more good ones.

If you ever get the chance to participate in a conference like this, I highly recommend it. Finding out more about my mindset and adjusting my world view has been good for me. I am also happy to have found out that I still have the ability and desire to learn new things.

Respectfully, Don Morris, DO

Libby Smith, D.O. FAOCOO-HNS

Libby Smith,D.O. is now a full professor in the Department of Otolaryngology-Head and Neck Surgery at the University of Pittsburg School of Medicine

Libby J. Smith, DO completed her Otolaryngology/Facial Plastic Surgery residency at Grandview Medical Center in 2004. She took a job as Assistant Professor at the University of Pittsburgh Medical Center after completing a fellowship in Laryngology, Care of the Professional Voice in 2005. She has been there since then, moving up the ranks. In 3/2022, she was promoted to full Professor in the Department of Otolaryngology. She is currently the only female faculty in the department with this distinction. She is dedicated to student and resident teaching, research in her specialty interests of vocal fold paralysis, surgical ergonomics, and quality care initiatives. She has authored 61 peer-reviewed manuscripts and 10 book chapters. She currently is the only osteopathic-residency trained physician in the Triological Society and American Laryngological Association. She also currently holds the osteopathic position on the ACGME Review Committee.

Dr. Smith is currently Division Chief and Director of the UPMC Swallowing Disorders Center and Division Chief and Director of the Voice and Disorders Center UPMC Mercy.

In addition to her activities at the University, Dr. Smith has been very active in the College serving on the Board of Examiners and Laryngology Chair of the Education Committee. She has also given many courses and lectures to the group.

Malawi Calls Us

Musings on my mission to Malawi

By Wayne Robbins, DO, FAOCO

WHILE I HAVE READ about third world countries and have seen my share of news stories and documentaries, I must admit that I had no sense of the reality of this existence. The degree of poverty is unimaginable for even the poorest I have cared for in the United States. Families of inpatients and many potential surgical patients lived outside in the courtyards on the hospital grounds. Here they slept on the ground, scrounged for food, and dug the roots of the limbless trees for fuel to cook their meals. Public transportation was unaffordable for most, making walking the most common mode of transportation. However, few could afford shoes either. With no real industry people lined the roadsides selling carvings, coal, and trinkets. I suspect they earned less than people I see here in Columbus panhandling at traffic lights for cash. We were transported to and from the hospital in three hospital vans. Twelve white individuals wearing scrubs in three vans was an unusual site for the crowd of people that lined the city streets. At stop lights our vans would regularly be surrounded by people asking for money or food. Spending a week in Blantyre Malawi has touched me deeply. It is impossible to unsee the suffering existence of the general population that we worked with and among each day.

Perhaps even more impressive was the conditions of the medical care in the ENT

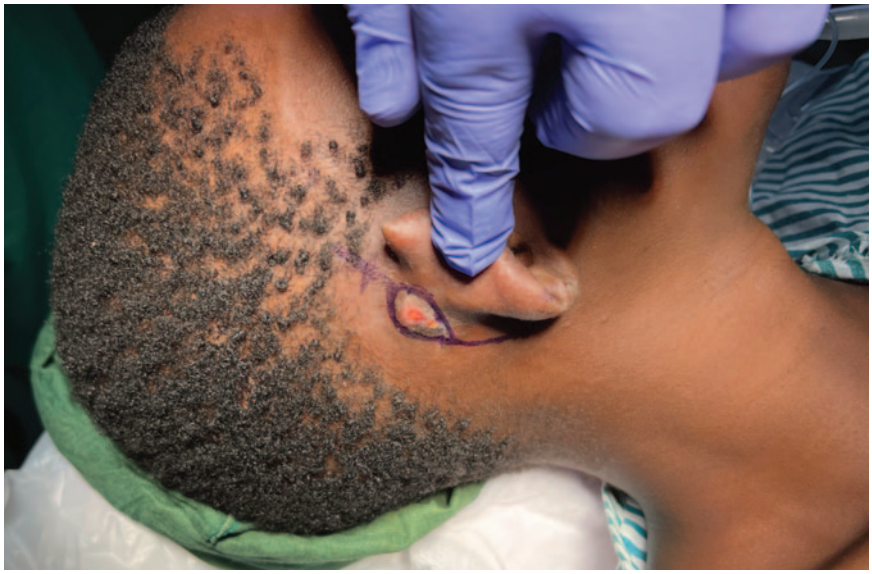
unit at the city hospital, The Queen Elizbeth Central Hospital. Operating rooms are a far cry from sterile and would never pass Joint Commission Accreditation. Most impressive was the cleaning and reuse of disposable equipment. Suctions tubing, Endotracheal tubes, and IV tubing were washed in a sink and hung to dry before finding its way back into the next procedure. The clothes lines they dried on were strung outside the "backdoor" of the OR exposing the surgical procedures to the outside regularly during cases. Disposable grounding pads were reused case after case until even taping them on a leg with fresh ultrasound gel still resulted in a grounding fault. At one point we used one cautery unit to service two simultaneous procedures, switching the cords at the source as either case required. As an Otologist I was concerned about having a supply of drill burrs. I quickly found this was not an issue as we just sterilized the old burrs in Cidex between cases. I suspect each of these burrs has seen 50 or more surgical procedures. Flies seemed to enjoy the OR and were certainly plentiful. Likewise, the roaches held the low ground being careful to scurry away to hide during the quick mop between cases.

"Poverty is like a punishment for a crime you didn't commit."

– Eli Khamarov, writer

I have spent hours since our return thinking about the experience. I found many quotes online written by others that have likely had similar experiences and more completely summarize my thoughts. Please allow me to share some of my "musings" here in this writing.

By no effort of my own I was born to a white middle class family in Boston Massachusetts. I never felt my life was privileged. I worked hard for all that I have received and achieved in my life. BUT my hard work pales in comparison to the everyday struggle of the people I met in Malawi. No car, no transportation, no work, no shoes. They walked barefoot everywhere they needed to go. Many that worked at the hospital walked an hour to work every morning and the same home again at night. We drove to a distant village two hours from Blantyre and throughout our travel isolated people walked along the dirt road with bare feet, carrying a load of goods on their heads, with no destination anywhere in sight. By no lack of effort on their part they were



born to one of the poorest nations in the world. No gross national product, no work and no significant government working on their behalf. But for the grace of God this could have been the lot of any of us reading this article.

An English ENT surgeon Dr. Chris Beem was in attendance for our entire mission. Dr. Beem spends 3 weeks in Malawi one to four times per year. Chris impressed me with some of his philosophy, I have always enjoyed deeper thought on topics. Chris asked me how as physicians we could consider ourselves ethical when we all know about the conditions of third world medical care and the struggle of the impoverished to treat their disease. The truth is I have always felt I was doing my part for humanity by treating patients in Michigan with Medicaid instead of Blue Cross or the local HMO. In my first world ignorance I never imagined the conditions of medical care in a third world country like Malawi. Where we were based at The Queen Elizabeth Hospital, the largest hospital in the

country, there were. no radiation treatments available for cancer patients and many would not live long enough to make it to the top of the list for their turn at chemotherapy. Indeed, how can we as physicians, educated people in high social positions, live a life of luxury and be blind to the suffering of entire nations of human beings? Give your time, your money is not as valuable. Raise consciousness, be ashamed.

"Where you live should not determine whether you live, or whether you die."

– Bono, lead singer of U2 and the founder of ONE

Malawi has a low life expectancy and high infant mortality rate. HIV/AIDS is highly prevalent, which both reduces the labor force and requires increased government expenditures. There is a high adult prevalence rate of , with an estimated 980,000 adults (or 9.1% of the population) living with the disease in 2015. There are approximately 27,000 deaths each year from HIV/AIDS, and over half a million children orphaned because of the disease. (2015) rates are high, and at birth is 50.03 years. There is a very high degree of risk for major infectious diseases, including bacterial and protozoal diarrhea, hepatitis A, typhoid fever, malaria, plague schistosomiasis, and rabies .

Malawi is one of the world's least developed countries.. The economy based on agriculture, and it has a largely rural and rapidly growing population. Malawi has one of the lowest per capita incomes in the world. The in Malawi is decreasing through the work of the government and supporting organizations, with people living under the poverty line decreasing from 54% in 1990 to 40% in 2006, and the percentage of "ultra-poor" decreasing from 24% in 1990 to 15% in 2007. The country has been "performing dismally" on reducing maternal mortality and promoting . (FGM), while not widespread, is practiced in some local communities.

I was astounded by the extent of disease in Malawi. One day we were walking the grounds of the hospital for an impromptu tour, when we walked by a large group of potential patients and family members that were living in a grassy courtyard. We started to hear crying, wailing and loud voices. I immediately shrunk away from what I felt was a fight for food or position amongst the group. "Don't worry" said our guide as he explained this was a religious healing, an "exorcism." Here in the middle of the hospital grounds religious elders continued to banish evil spirits from the giant cancers, extensive tumors and chronic infections that afflicted so many. While many groups and foundations have made significant cash donations these only offer temporary assistance in a country that has not developed or valued their system

of medical care. While there was an MRI unit on the hospital grounds this was no longer functional do to the lack of maintenance and the lack of funds for repair. Similarly, “Sound Keepers” has donated a significant amount of audiology equipment and training but has since moved on to help in other needy areas. Much of this equipment; audiometers, computers and electrophys equipment, was not functional or not calibrated. While Cochlear

implants have been done in Blantyre, further mapping is not possible without governmental support.

I spent many hours talking about residency training with our physician host. Dr Wakisa Mulwafu is the only public Otolaryngologist in Malawi. There are two other Otolaryngologists practicing at private institutions but they do not treat the public. Private care is not an option for the majority of Malawians as few could afford the most basic care such as pain medicine or antibiotics after surgery. There are many graduates of the University of Malawi College of Medicine that would sign on as an otolaryngology resident but there are not government funds to support their training or salary. The cost to train a resident in Malawi is about $8000 per year. For $30,000 total, significantly less than the annual salary of my first year resident, another Otolaryngologist could be in full time practice at the Queen Elizabeth Central Hospital. While Malawi is a signatory to the WHO campaign there is little evidence of Governmental support.

The recent Covid pandemic showed us how the smallest living particle could affect the entire world. After two and a half years we are still trying to recover from the effects of this infection worldwide. We no longer live in a small local community. We live in a world community, we share a world economy and a worldwide health environment. Today our nation is the world. Each of us who believes in some higher power than ourselves, is obligated to acknowledge the existence and suffering that exists in our world community. Let us all reflect on the oath many took as graduating medical students that included these words;

I will remember that I remain a member of society, with special obligations to all my fellow human beings. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help, those sound of mind and body as well as the infirm.

Malawi calls us to live this oath as physicians. The Bible calls us to live these words as human beings.

Despite these conditions the dedication of the staff, nurses and physicians was most

remarkable. While we were there, surgery started early and ran late every day. Since some had to walk considerable distances to work, their days were even longer. Rarely did our scrub nurses or circulators take a break. Some served more than one role working in the clinic and the ward depending on the need. Hamilton was a great example of this dedication. Hamilton is a wood carver and brought his wares on the first day we were there. He sold some prepared carvings but took orders for so much more that he delivered on our last day. We chatted for some time while he was making his final sales that day. I realized he must have sold $1500 dollars or more of woodwork to our group. I asked him if he and his four boys would be going out to a nice dinner to celebrate that night. No, he informed me. I run a home for the mentally disabled and we rarely have enough money to buy their medications. All of Hamilton's income from carvings goes to that purpose.

Please, consider giving your time, money, or talent to support this mission and the people of Malawi. While only a small bite out of a big need, together we can make a difference for many. □

My Chance to Serve

By Taylor Colvin, DO

I **RECENTLY HAD THE GREAT PRIVILEGE** of going on a service trip to Blantyre, Malawi. It had been my dream ever since I was young to go on a surgical service trip. When I was around 5 years old and met the founder of Operation Smile, he had a slide show of his most recent trip that he showed my family. Since that day that I knew I wanted to become a surgeon and do something similar. Fast forward almost 30 years, when the opportunity presented itself to go to Malawi with Madgy Malawi Foundation, I instantly jumped on board with going. Upon arrival to Blantyre it was immediately apparent how poor the country was and knew I was in the right place to be of the most help.

We arrived at the hospital where the ENT clinic and operating rooms were located in its own building on the hospital grounds, which had minimal equipment and bare bones staffing. It was amazing to me seeing the how well our team instantly gelled and worked together to take on the seemingly impossible task of keeping things organized and getting all of the surgeries done in a safe and efficient manner. When we first walked out into the ENT hospital wards where we first met all our patients, it was daunting seeing so many patients with such large head/neck masses and other obvious pathologies (that we would rarely see in the US) with such little time and limited medical supplies. Little did we know there was a second wave of patients coming just a few days later. Everyone we met during the week and a half trip was amazing and kind, between the patients, hospital staff, and those outside the hospital; that will stick with me most about this service trip.

Throughout the week we worked from dawn to dusk with three operating tables going simultaneously. Each operating table had a 4th year resident, 5th year resident, and an attending, with the 4th year resident doing most the surgery. One of the more difficult aspects from a surgical standpoint was the limited imaging and work up some of the patients had undergone. This resulted in several surgeries being booked as a relatively simple procedure and resulting in a full day process. Despite the limitations, setbacks, and other challenges we faced, the team was able to collectively adapt and overcome any roadblocks. As a result, we were able to treat almost every patient who was referred to us. Special thanks to Dr. Wakisa Mulwafu and his senior resident Dr. Tabeh Freeman for handling all of the logistics, post-operative care and countless other aspects of the trip that makes this all possible. □

The Madgy Malawi Foundation

The Heart of Africa

By Steven Engebretsen, DO

I THOUGHT I KNEW what to anticipate with an international surgical mission trip, but the words of the team leader, Dr. Troy Creamean, echoed in my head from day one. He said, " This will be an experience like none other. It is hard to explain… You will have to think outside of the box, adapt, and overcome; both in and out of the OR." In preparation for this trip, I read up on Malawi and listened to experts on global surgery, recommendations for surgical mission trips, and the evolving world that is global health in macro terms. After now having spent time on this trip to Blantyre, Malawi, I can say that I agree with Dr. Creamean completely. It is truly difficult to describe the experience and all that it means for both the traveling practitioner and the people of Blantyre.

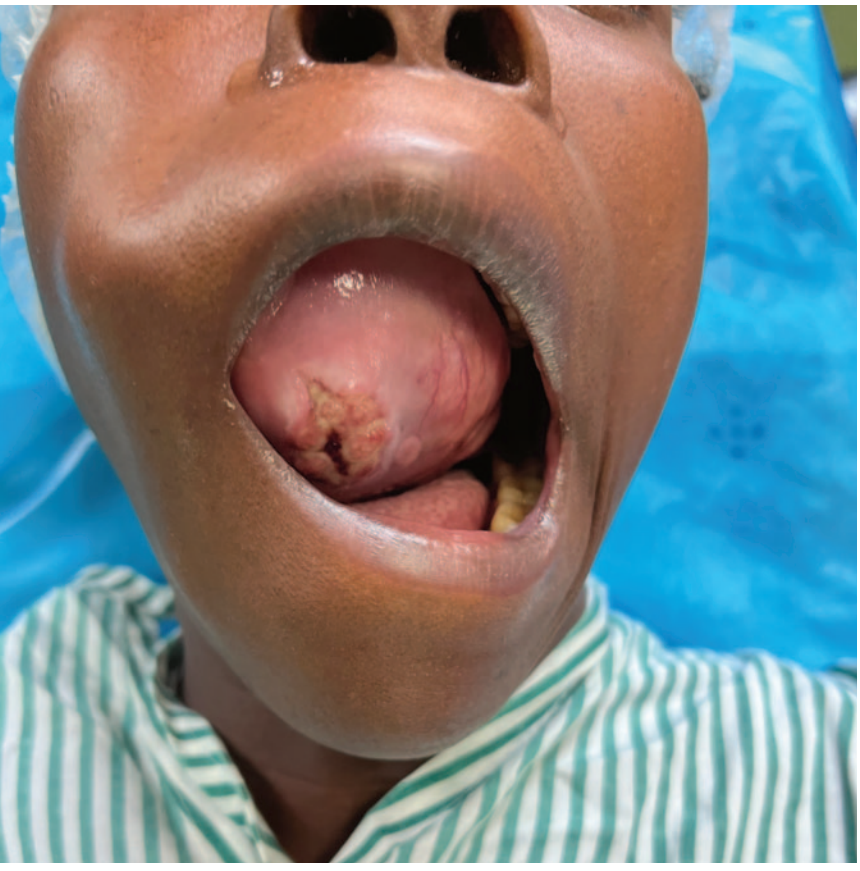
The best comparison I have is what I felt starting clinical rotations as a medical student. You start to experience something you wish everyone could see, understand and learn from. Your view of humanity, the human experience, and medical morbidity develops during those years. The intimate challenges are apparent and the feeling of truly making an impact in someone's life for the first time. In Malawi, it was like having this sensation over again but magnified. I will do my best to describe three points I would like our ENT community to know about Malawi and the Madgy Malawi Foundation (MMF) trip.

First, the people of Malawi are gracious and full of gratitude. They have been called the "Heart of Africa" due to their warm nature and kindness. Many of these wonderful

people travel for days on foot to obtain care at the only Otolaryngology clinic in the southern part of the country. They additionally may wait for weeks to be treated for a condition they have been burdened with for years. For example, four sweet women all arrived at similar times and became friends in the ENT ward. Three of the four had a large benign thyroid goiter, while the 4th had papillary thyroid cancer. They were all liberated of their neck masses without complication. This

friendly and patient attitude was common among the people treated in our time in Blantyre.

Second, learning is bi-directional. The only practicing otolaryngologist in the country, Dr. Wakisa Mulwafu, hosts several Malawi based residents. These residents train for three years in general surgery and then three years in otolaryngology. Their surgical education from Dr. Mulwafu is supplemented by visiting surgeons from the United Kingdom at various times as well as the brief time the MMF team are present. These true ENT pioneers in their country are taking on as complicated cases as they can handle with limited resources, and yet still finding success. We had the privilege of working with three of these residents during our time, providing opportunity for their practice, growth, and conversely their sharing tips of how to work with limited resources. The senior ENT resident in Malawi, Dr. Tabeh Freeman, will be the first Otolaryngology provider in his home country of Liberia (beginning near the time of this publication). He will be an incredible force in his country thanks to his attitude and training.



Third, there is more to do than just surgery. This was probably best exemplified by Dr. Jaishree Palanisamy, who would take any extra food we had from our team dinners each night to feed the patients on the ENT ward and their families. Actually, each of the residents and MMF team found ways to share their personal touch with the people there. Art kits, stickers, and toys were distributed to many of the children in and around the wards; and an unannounced trip to an elementary school was met with a reception none of us will ever forget! There are a number of opportunities to assist these wonderful people and their incredible local medical providers.

With help from many in our community, I anticipate the MMF to blossom even more in the upcoming years. It is clear that the vision Dr. Madgy had for this trip is only growing in the leadership of the foundation. All those involved can attest to the real benefits being both experienced and provided. Thanks to the generosity of the AOCOO-HNS Foundation providing travel grants, this time will go down as one of my most defining personal and career experiences.

—Steven Engebretsen, DO

A Malawi Experience

By Rebecca Mahoney, DO

PRIOR TO MY international medical mission trip to Malawi, I felt confident that my exposure in residency would be some the most challenging patient encounters of my career. However, after arriving in the country of Malawi, I quickly realized the week ahead would be the most challenging yet rewarding week of my career. The leaders traveling with our group, the Madgy Malawi Foundation, prefaced the trip, warning that we would be pushed to adapt in ways we have never experienced or imagined possible. The truth to their words became immediately apparent when we met our patients who had waited weeks, some months, for our arrival.

One patient experience embodied the difficulties of health care in Malawi. She had traveled for weeks via foot with her family to Blantyre in anticipation our trip. Many of our patients had no modes of transportation other than walking, and traveled with their families from great distances to the hospital. Witnessing the strength and camaraderie these strangers provided for each other was inspiring. Friendships between patients developed throughout our time there, and families helped one another in making meals and providing child care. Multiple families noticed our struggling patient early on, and helped with postoperative care and encouragement while they were recovering themselves.

Our patient immediately stood out with an obvious neck mass and audible stridor. We learned quickly of the limited resources available, making our 'routine patient work up' a difficult task to perform. The patient was unable to get imaging, which continued to be a large obstacle during our time. Our first objective was to secure her airway. She was taken for an awake tracheostomy with biopsies on the first day, to allow for adequate time for pathologic review. The patient was understandably anxious, and unfortunately, no one in our group or the local physicians spoke her language. Luckily, members of the operating room staff were able to translate and console the patient during the tense situation. The support we received from the community and local staff was astonishing and made our success possible. Without their involvement and willingness to help, the MMF would have not been able to complete the 40+ cases we performed.

In Malawi, pathology review typically takes over one week, requiring us to strategically expedite certain specimens during our visit. Additionally, multiple patients were unable to afford the pathology fee, which was roughly the equivalent of 20 USD. The incredible local physicians often provide the payment with their own money to help. Once pathology

was confirmed, the patient was taken to the OR for a total laryngectomy. Intraoperatively, the patient had more extensive disease than expected due to lack of adequate preoperative imaging. This quickly became a complex case that proved to be a learning experience for everyone involved, including the attending surgeons present. This was one of the many cases we performed that would not have been possible with only the local tools or teams. Fortunately, the local trainees were eager to learn new skills which they can utilize in the future. The relationship built with these physicians was invaluable. We engaged them in all patient management discussions and cases, and they imparted their immense ability to adapt and overcome in diverse environments.

Completing medical training in the United States provides opportunities to work in prestigious health care centers, with access to an enormous amount of resources. As such, we have some of the best medical education around the world, however rarely are we faced with the major obstacles the majority of the world must overcome. After operating in another country with extremely limited resources, such as Malawi, it emphasized the importance to adapt and overcome obstacles by sticking to the fundamentals.

The knowledge and skills that I learned as a resident working with this foundation was immeasurable. One subject that was particularly striking, was the daily ethical dilemmas faced by the local ENT surgeon. As one of the few otolaryngologists in the entire country, his time is spent devoted to caring for the greatest number of patients possible. He is forced to make the difficult decision of which patients can have their necessary procedures, an issue not typically faced in the United States. We performed multiple complex surgeries for patients that not have received the appropriate treatment without the work of our tremendous team lead by fellowship trained head and neck surgeons.

The relationships created by The Madgy Malawi Foundation with the local surgeon and staff is truly amazing. The support allows for the continued success and positive impact with each trip to Blantyre. As a resident, working with this incredible group has provided me with irreplaceable experience that will forever impact my career. Not only did it make me a more confident and adaptive surgeon, but also broadened my knowledge of global health care. Without the grant from the AOCOO-HNS, this experience not have been possible for myself or the residents involved. It was a tremendous opportunity to work with these physicians and witness the continued development of the MMF. The leaders are constantly strengthening the foundation to fulfill its ultimate mission, which will continue to expand with our support.

—Rebecca Mahoney, D.O.

One Step Closer

By Jaishree Palanisamy, DO

GROWING UP IN another country, I was not unfamiliar with traveling. I've been to foreign countries, for both work and pleasure. However, going on a mission trip to Africa was on a whole different level. I've been wanting to go on the mission trip ever since I was a second year resident. Unfortunately, the year that I was supposed to go also happened to be the year of the pandemic. I anxiously awaited until the next trip, not knowing when it would be, and not sure if it would happen before I graduated residency. When I heard that the trip would happen in 2022 for the first time since the pandemic, I could barely contain my excitement. I immediately asked for the supply list so I could start gathering the necessary medical items we would need. Every item

gathered felt like one step closer to when we would be going.

Finally, the day of departure arrived. I checked in the two large suitcases full of the medical supplies I had been gathering over the last few months. Getting to Africa by plane is not easy, especially to a smaller country such as Malawi. It required a total of 4 stops and a long flight segment of 16.5 hours from Atlanta, Georgia to Johannesburg, South Africa. We spent the night in Joburg and did our last segment the next day. When we arrived in Blantyre, Malawi, the weather was pleasantly warm and it was delightfully sunny, a nice change from the dreary weather back home in Michigan. The airport was very small, only one flight could land or take off at once. We were the only plane in the airport. Our gracious host, Wakisa, picked us up from the airport and dropped us off at the various places we would be staying. The residents stayed in a guesthouse less than 1000 ft from the ENT ward, and the attendings stayed at a nearby hotel only 10 minutes away. □

The Greatest Gift

By Ian D. Bowers, DO, MBA

IN THE MIDST OF RESIDENCY, it has been easy to get caught up focusing on all the demands on my time; taking call, preparing for cases, research, presenting lectures, etc. The stress has, at times, made me question whether it's all worth it. However, in those moments, I remind myself of how great a gift it is to be able to learn these skills and how being a competent and caring surgeon can change the lives of the people we treat. No other experience can highlight this great gift like a humanitarian service trip.

Malawi is one of the most impoverished nations in the world. Its economy relies heavily on a rural population working mainly in agriculture. Health outcomes are poor, with the life expectancy in 2020 being estimated at 65 years and only one doctor for every 20,000 citizens. This creates a situation of extreme need, where a little can go a long way. The Madgy Malawi Foundation was created to help provide the much needed

expertise of otolaryngologists for this community.

With only one otolaryngologist in the country who actively operates, difficult cases build up in a queue each year in anticipation of our team's arrival. The patients were strewn across the ENT ward and many of the patients and families, many with small children, waited outside in the parking lot in hopes of being seen. One family had traveled over 100 miles and had been waiting for over a month for their daughter to be seen. As a PGY5 on this trip, my responsibilities included: screening patients to assess their need for surgery, performing surgical procedures under the supervision of board certified otolaryngologists, providing immediate post-op care, and helping to provide education to the local residents who assisted in our mission.

Many of the patient's ailments were readily apparent, a large necrotic mass on the nose or a massive goiter. Others were more difficult to see. I was introduced to a two-

year-old child who, on closer inspection, was actively stridulous. The condition had been worsening over the previous four months and he could no longer participate in active play. Later that day, direct laryngoscopy revealed extensive papillomas obstructing his airway, a common finding with recurrent respiratory papillomatosis. Following a procedure to remove the papillomas his airway was widely patent once more. After his recovery, I saw him running in the parking lot with the other children with a smile on his face. This case is a perfect example of how much good can be accomplished by medical mission trips, and how gratifying an experience it can be for a resident physician.

I'd like to thank the AOCOO-HNS for its generous humanitarian travel grant that made this mission possible for me. It provided an unparalleled learning experience and gave me a much needed motivational boost as I approach the end of my residency. I hope the college continues to provide these grants in the future so residents can continue to participate in mission trips. □

Ophthalmic Eponyms: Behind the Name

By Zurriat Syed, MS and Leonid Skorin, Jr., DO, OD, MS, FAAO, FAOCO

EPONYMS ARE STRUCTURES, techniques, instruments, and medical conditions associated with the name of the discovering scientist or physician. When it comes to naming and discovery, eponyms have become both a tradition and a point of controversy in anatomy and medicine. Arguments against them have stemmed from named individuals' unethical actions and backgrounds, evolving definitions, and inaccuracy with language differences. Eponyms abound in ophthalmology from instruments, pathologies to anatomical eye structures.

Eponyms allow for quick identification due to name recognition. Unfortunately, some conditions have the same eponym. This can be seen with Fuchs, which can be found in 25 different identified findings, symptoms, instruments, and ophthalmic diseases. Ernst Fuchs' identification of a pale corneal clouding which he noted on slit lamp examination is now known as Fuch's corneal dystrophy.

Fuchs was also able to identify the grouping of clinical findings that came to be called Fuchs heterochromic iridocyclitis. Another notable mention is the clinical finding of a black macular spot from pathologic myopia related macular degeneration. This is known as Fuchs' spot. Eponyms should have enough information in the name to allow their distinction. Unfortunately, Fuchs can cause confusion due to the multitudinal variances of his eponyms. Most of the time, mention of Fuchs would point to Fuchs' corneal dystrophy but, in other cases, it remains imperative that there should be additional information for clear identification.

Unlike the Fuchs' eponyms, other ophthalmic eponyms can be very specific to their finding or disease. After identifying plaques of cholesterol in the retina, the Hollenhorst plaque was named after the Mayo Clinic

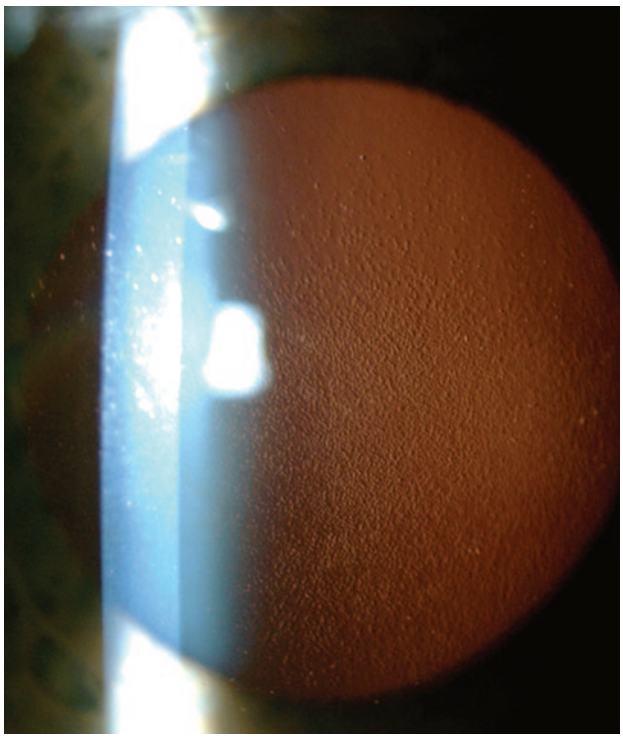


PHOTO: ©2015 MONIKA OLDAK ET AL.

Image 1 shows the dimpled appearance of corneal epithelium. This represents pathological guttae that are distinctive of Fuchs' corneal dystrophy

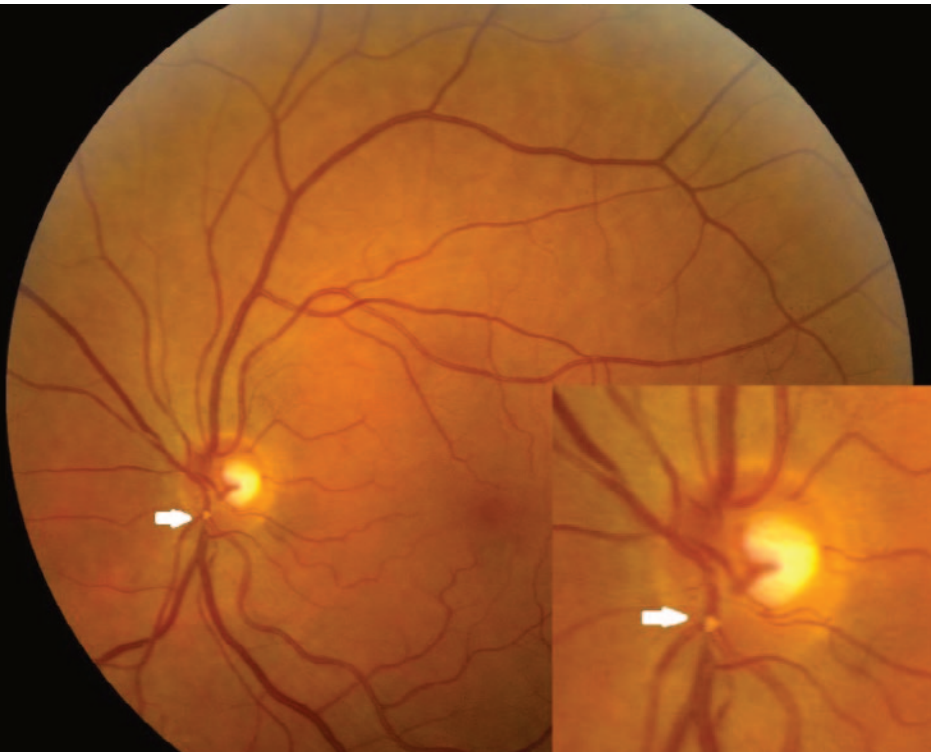


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Image 2 has a white arrow pointing to a Hollenhorst plaque. In the lower right corner, a magnified image of the optic disc and plaque are shown.

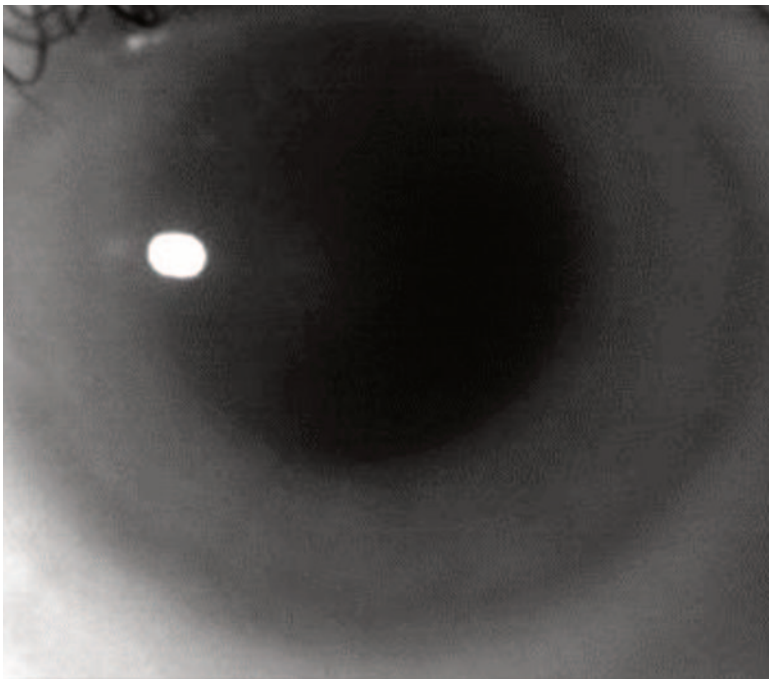
ophthalmologist, Robert Hollenhorst. It is a clinical finding of retinal embolus and can be a cause of central or branch retinal artery occlusion. Hollenhorst plaques are specific not only to color, shape and origin, but also in meaning. There is no misconstruing identity or pathology of the disease. Another interesting point to note is that Dr. Hollenhorst was not the first to document retinal plaques. His research into the pathophysiology of retinal plaques led to an eponym crediting his work. Although eponyms are traditionally named for those who discovered the disease or finding, some like the Hollenhorst plaque are named after the physician or scientist who showed scholarly work and research towards the condition.

Another noteworthy ophthalmic eponym is the Drance hemorrhage, used in glaucoma. Stephen M. Drance, the ophthalmologist who recognized that glaucoma development is not dependent on high intraocular pressure, has been credited with much of the research into risk factors and clinical findings. Drance's work was so extensive and it brought significant additional clinical knowledge to the field such that the finding of splinter-shaped, optic disc hemorrhage was named after him.

Like other eponyms discussed in this article, most in ophthalmology are named after men. When it comes to eponyms, it is uncommon to find female scientists and physicians who have been credited. This is mostly due to the late acceptance of females into the field of anatomy and medicine. However, there are some notable eponyms which have been credited to females. Hurler syndrome was identified by Gertrud Hurler, a pediatrician, who noted the distinct corneal clouding in these patients. Gröenblad-Strandberg syndrome or pseudoxanthoma elasticum (PXE) is named after Ester Elisabeth Gröenblad, an ophthalmologist, who identified the clinical ophthalmic findings of PXE. She observed retinal angioid streaks, retinal hemorrhage, peau d'orange (the retina resembling the skin of an orange) and a change in the elastic fibers through mineralization of ocular tissues.

There are also eponyms that have challenged the medical community, particularly those named after individuals with unethical and historically criminal backgrounds. Reiter's syndrome is named after Hans Reiter for his studies of reactive arthritis with

Image3 shows the corneal clouding that is distinctive in Hurler Syndrome



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conjunctivitis/uveitis. Reiter's wartime activities and alignment with the Nazis became a point of contention and his eponym is now under petition to be retracted. Another discovery tainted by crimes against humanity is named after Friedrich Wegener. Although Wegener's cases were the first documentation of airway granulomatosis, Wegener's early association, leadership, and actions with Nazis led to a petition for name change in 2002. Since then, the condition is called granulomatosis with polyangiitis (GPA). GPA still often appears with a mention of its previous eponym. GPA has many ocular manifestations and can present with reduced visual acuity, conjunctivitis, scleritis, and proptosis.

It may be time to consider retiring certain eponyms, particularly those with unsavory ethical histories. A formula should be followed when crediting medical discoveries. This formula should include a clear definition, accurate historical background, and ethical responsibility. When all these are present, eponyms will represent a distinction that should be continued. Eponyms have been a source of pride and an honor in the medical community. Their significance credits the individuals who researched and contributed to the advancement of ophthalmology. □

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