

PRESIDENT'S ADDRESS

Thank you Keith – I have enjoyed an exciting and fortunate life, this opportunity is one of its highlights and through it all my family has kept me on track. In particular Alice, my mate of 33 years, has helped me find balance in life and has given love and the most constant wisdom I know.

In 1999 Drs. Shaha and Robbins delivered the inaugural presidential lectures, which highlighted the traditions and history of our two founding societies. (Ref) Last year President Medina drew our attention to some formidable challenges with respect to workforce, the direct consequences of poor reimbursement and the potential that we might lose our impact on head and neck disease if we fall prey to "tragic optimism". (Ref)

These concerns were recently echoed by Academy President, Jack Gluckman --- who identified head and neck surgery as a "specialty in crisis"(ref)

Last October the AHNS council met for a long-range planning retreat, which took note of our history, digested our challenges, and produced a foundation and a vision for the future. The meeting was characterized by commitment and energy. I decided to use the presidential lecture to summarize the retreat and offer a view of our future using the metaphor -----harnessing the energy of fusion. Fusion has various definitions:, 1. a merging of diverse elements into a unified whole, 2. a political partnership or 3. the union of atomic nuclei...resulting in the release of enormous energy. One could say that the formation of the AHNS touches all three variations of meaning. My focus today will be the latter. You, the members, are a well of energy, some kinetic, but much in its potential form. It is the role of leadership to harness and direct energy and that was the purpose of our retreat.

The retreat format progressed from a review of our Mission Statement, to then define our fundamental goals and strategies and then to discuss some specific issues

At the core of society activity is our mission statement, which indicates that we are “a unique surgical oncology society dealing with malignant or benign neoplasm of the head and neck.” Our purpose is:

- To promote knowledge of prevention, diagnosis, treatment and rehabilitation.
- To improve care and outcomes.
- To encourage and support research and training.
- To promote the highest professional and ethical standards.

This identifies our goals but it is indistinct with respect to direction and methods. We moved next to articulate operational philosophies. That is to say, upon what principles will we approach challenges and decision making in the future. We concluded that we must be inclusive, multifaceted, efficient and broad in scope.

Under the banner of inclusiveness we reflected on our heritage and the struggle that consumed much energy in the parent societies. We committed our society to a different course ---based on that experience; we will focus all effort on the disease that is our common interest. Our society will recognize and embrace other disciplines; we will encourage international dialogue and foster mutual respect. Being inclusive will offer a challenge --since inclusion of one group has the potential to be perceived as

exclusion of another. That said, we would continue to challenge one another intellectually. We will expect of our associates and ourselves a dedication to the highest scientific and professional principles.

Multifaceted was chosen to signify, that our society, -----dominated by surgical oncologists----- is cognizant of the future of head and neck therapeutics. We wish to include representation from the various related disciplines in our meetings, ----our research, and the fabric of our society. We will do this in anticipation of a better day for our patients when refinements of imaging, non-surgical therapeutics and genetic research will eliminate the need for surgical intervention.

A pace of professional and personal life that simply did not exist a few decades ago confronts us all. This climate dominated by regulatory compliance, e-mail and cell phones promotes the expectation of immediate availability and seems to consume our discretionary time for contemplation or for participation in professional societies. If we are to fulfill our mission, the head and neck society needs to tap the energy of its members. But to win your commitment we must not be wasteful of your time. We will take care to avoid redundant effort by aligning our committees in conjunction with those of our natural partners . We will also emphasize fiscal efficiency. Your Council has already made decisions to decline proposals that would sap our limited financial resources. We will strive to focus on the most productive opportunities.

We also resolved that beyond our stated emphasis on research and education we must broaden our scope and actively engage the issue that has emerged as an immediate threat to the practice of head

and neck surgery. The inappropriate level of reimbursement will impact the health of cancer patients. As a non-profit organization we cannot directly participate in lobbying or negotiate regarding reimbursement. But our membership does have a direct interest in this issue and as individuals we can and must be actively involved and our society can galvanize such action

We also resolved to make a concerted effort to increase public awareness of H&N cancer.

Using these principles we have addressed some specific areas.

Our Executive Committee will consist of the president, president-elect, vice president, secretary and treasurer. Action by our society will largely be the result of committee work. It is the role of the vice president to oversee committee functions and maintain close communication with the committee chairs.

We will support selected Presidential initiatives ----to provide an incentive for leaders to develop projects with the knowledge that they will not founder. The first example is the H&N Foundation, which was championed by Jesus Medina who will be its president for the next three years. I remind you that it is Jesus' goal to raise \$2M.

In the interest of time I will discuss only three committees

The **Research Committee** - Traditionally, we supported a series of \$10,000 research grants. While these awards will continue ----we will allocate the majority of our funding to more substantial young faculty awards --- we believe this is the best long-term investment of our research funds. Recently we have been able to leverage our funds to achieve two new awards. A \$ 70,000 two-year junior faculty

award in conjunction with the AAOHNS, and an \$80,000 two-year award in conjunction with the ACS.

The **Website Committee** is actively evaluating various options for our society. We will soon provide a membership roster, meeting information, abstract submission as well as educational material. In the interest of efficiency we will emphasize the use of linkages to other web sites.

Through our **Public Education Committee** we intend to pursue a campaign for prevention and early identification of head and neck cancer

I would like to expand on three issues, fellowship training, reimbursement, and the head and neck database

Last September the Advanced Training Council under the leadership of Paul Levine held a meeting of fellowship program directors. The primary stimulus had been articulated by President Medina last year, namely that potential candidates had voted with their feet, our applications are down significantly. Among program directors there was a clear preponderance of opinion that in requiring 2-year fellowships we had effectively strangled the pipeline. We resolved to adopt a more flexible model not only to attract candidates but because, in many ways, it is a more rational and inclusive approach.

We have agreed to recognize 1, 2 and 3-year fellowships. The longer ones will have substantial research emphasis. Gary Clayman is leading a group, which will define a minimum core curriculum and develop a rigorous system to monitor

program effectiveness. In making these changes we hope to stimulate a spectrum of fellowships that will foster not only academic clinician-researchers--- but also highly trained community specialists in H&N surgical oncology. We will avoid rigidity and encourage institutions to accentuate unique strengths. We are also very optimistic that the recent improvement in career development award salary structure and the associated educational loan repayment program will reverse the fellowship exodus by making the income of the young translational researchers quite reasonable.

I cannot shy from commenting on a related topic. I believe that the leadership of Otolaryngology must recognize that what drove us to change fellowship design is a harbinger of things to come. I think there is trouble in River City and I point to the drop in the resident candidacy pool. Data from the Otolaryngology Matching Program documents that after eight years of stable registration the last four years saw 30% reduction in the applicant pool. After averaging 660 candidates per year for eight years we have dropped in each of the past 4 years to 449 (ref) The issues which drove us to change H&N fellowship program requirements (family obligations, educational debt, reduced reimbursement and changing practice patterns) will soon be recognized as reasons for training in Otolaryngology to become shorter and more flexible.

Current policies of the ABO, RRC, and NIDCD limit creative solutions, some are even mutually exclusive. It is essential that our leadership organizations jointly take on the challenge of modifying residency program requirements. Last week, I attended a presentation by David Leach, Executive Director of ACGME and was pleased to learn of the dialogue between the various Boards and the

ACGME. But the projected time frame for evaluation and change of the system extends to 2016.

We must expedite constructive change, sooner than that.

Reimbursement for major H&N procedures has long been problematic and undervalued. An attempt to rectify the situation 5 years ago was unsuccessful. Recently the American College of Surgeons supported a proposal to increase the value for deep neck biopsy by approximately 50%. This proposal was favorably considered by the RUC and has been forwarded to HCFA where it has a good chance of passing. Upon HCFA approval, an opportunity will exist to revalue many head and neck codes using the rationale of a "rank order anomaly." I have asked 50 of our members to serve on a committee should this unique opportunity arise. The response to my request has been swift and positive. This is a critical event for the long-term financial health of head and neck surgery. I would be pleased to hear from members who wish to be involved.

I have saved the topic of my post presidency initiative for last. I refer to the immense potential of the head and neck database.

Multi-institutional trials are recognized as the gold standard to compare treatment options. However many significant issues in head and neck cancer will never be assessed by randomized trials due to limitations of funding and patient access. In fact, less than 10% of all treated cancer patients in the United States are entered on clinical trials as demonstrated by data regarding the total number of bone marrow transplants for breast cancer compared to the number of patients that were entered on trials to test the efficacy of the procedure

sufficient numbers for statistical analysis were not achieved for more than 5 years (ref NY Times)

There remains a vast amount of untapped patient data that might provide a better perspective on cancer treatment outcome. Local cancer registries are a potential source of such information and have received considerable emphasis by the American Joint Commission and the American College of Surgeons. However, due to limited funding, hospital registries collect rudimentary information and have a major problem with complete follow up data. The challenges associated with hospital based cancer registries were well summarized by Eberle *et al.* (ref) The dominant problems identified were inconsistent data collection, poor staging information, inefficiency and wasted time for tumor registrars and ultimately, inadequate data for detailed studies. Other large databases include Medicare, which is limited to inpatient data on patient's age 65 and older; and the SEER system, which, by design, covers only 10% of US population.

Prospective data collection using modern software provides an opportunity to study cancer more effectively and efficiently in a wide range of clinical settings and to move us beyond the inherent biases and statistical limitations of single institutional studies. In 1997 the parent societies jointly supported the development of a H&N database. Since then Dr Marc Coltrera has dedicated countless hours to create this tool for clinical data gathering and research. The Council and other members of our society have participated in beta trials and have helped to refine the end product. I am delighted

to report that recently, 350 copies of the latest version were mailed to national and international participants from 31 countries.

The system presents a consensus driven minimum standard data set.

It will work well for the busy practitioner or an academic group. It runs on PC or Mac platforms, Data can be rapidly entered using pop up windows and the system now includes sophisticated encryption and the capability of sharing files by e-mail.

What is most important is the unique conceptual framework of this system. It has been designed to allow each physician or group of physicians to function independent of a central entity. Individuals or groups may share subsets of data at their own discretion. The data sharing structure allows for transfer of clinical data without provider or patient identifiers; a major benefit with respect to human subject confidentiality.

The database represents a chance for the membership of our society to exert true leadership. By contributing accurate, prospectively gathered data we can move clinical research beyond single institutional studies to a much larger scale. In agreeing to use a common system we can avoid the uncertainty of meta-analysis and we can begin the process of comparing treatment outcomes in the community where the vast majority of cancer is managed. This is especially true for early cancer where we should be addressing the issues of cost effective management at the community level. If each member of this society contributed 10 cases we would have than 16,000 cases registered in one year.

In closing, we must recognize that we are the only society specifically dedicated to H&N cancer. As such, we have both

an opportunity and an obligation. Our greatest resource is you, the members of this society and I urge you all to become more actively involved especially through our committees and by contributing data.

Our potential is great and we have the tools and the strategies to make a difference.

There is much to be done and I know Keith is eager begin his tenure. Thank you for privilege of serving as president; in closing let me say to the current and prospective members of AHNS we want you!