

ALACHUA COUNTY MEDICAL SOCIETY

House Calls



SPRING 2023



Ear Disorders & Hearing Loss Issue

Featuring A Special Section on The Florida School for The Deaf and The Blind



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Tracie Snow is the President for the Florida School for the Deaf and the Blind in St. Augustine, FL and has been with the school since 1995. She earned her master's degrees in Deaf Education from Gallaudet University and Educational Leadership from the University of North Florida. She earned her Teaching Certification in Elementary Education, Reading, Deaf or Hard of Hearing, and Educational Leadership. Tracie and her husband, David, are proud parents of two sons who are Deaf and use ASL.



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Dr. Smith is the current Advanced Otolaryngology Fellow at the University of Florida. He completed his combined MD/MPH at the University of New Mexico in 2016 and Residency at the University of Tennessee Health Science Center in 2021. He and his wife met in Albuquerque and they couples matched to Memphis for residency at UT and now have two boys.

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Carolyn G. Carter is a general pediatrician with the College of Medicine at the University of Florida. She received her Medical Degree from the University of Florida, followed by a Residency at UF COM in Pediatrics. Dr. Carter has been in practice for over 25 years and has a special interest in nutrition and preventative medicine. She has worked with medical students on medical mission trips to the Dominican Republic and Haiti and actively participates in community programs such as the Alachua County Sheriff's Office annual Safety Patrol trip to Washington, DC.



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Dr. Antonelli is a professor of Otolaryngology; Neuroscience; and Speech, Language, and Hearing Sciences at the University of Florida. He completed medical school and otolaryngology residency at the University of Minnesota, followed by neurotology fellowship training at the Michigan Ear Institute. He joined the University of Florida in 1994, serving as Chair of Otolaryngology 2004 – 2022. Dr. Antonelli maintains a busy neurotologic practice and an active research program. Dr. Antonelli has been recognized with numerous awards for teaching, research, and clinical service.



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June Ann LeFors is the American Sign Language Director at Flagler College in St. Augustine, FL. She is a freelance certified deaf interpreter and ASL translator in the central and northeast Florida areas. She is a member of the Early Hearing Detection and Intervention Advisory Committee for the FDOH and serves on the FSDB Board of Trustees. A state-certified K-12 teacher, LeFors previously worked at FSDB for 10 years in several roles. She earned her master's degree in deaf education/deaf studies from Lamar University and a bachelor's in elementary education from Gallaudet University. She and her husband, Eric, have six daughters - three of whom are deaf or hard of hearing.



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Tom Zavelson, MD
FSDB Board Member

Thomas Zavelson, MD, serves as an FSDB Board Member and is a retired Pediatrician and Clinical Professor of Pediatrics at the University of Florida. Previously, he was a founding and senior partner with the Pediatric Associates of Gainesville Group; a Pediatric Consultant for Children's Medical Services; Chairman of the North Florida Regional Medical Center Department of Pediatrics; and a member of the North Florida Regional Hospital Board of Trustee.



Summer Crider
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Originally from Gainesville, Florida, Summer Crider has over 15 years of experience teaching in Cultural Studies, Deaf Studies, and Nature & Forest Therapy. Graduating Valedictorian from the Florida School for the Deaf and the Blind, she holds a Bachelor's degree in Expressive Arts Therapy, and a Master's in Deaf Studies from Gallaudet University. As an educator, she has taught at Texas School for the Deaf, Austin Community College, and Gallaudet University.



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David Snow currently serves as the Media Specialist at the Florida School for the Deaf and the Blind in St. Augustine, FL. He previously served as an English Teacher at FSDB, and an instructor of ASL and Deaf Culture at the University of North Florida. He earned his bachelor's degree in English from Gallaudet University and master's degree in Deaf Education from McDaniel's College. He earned his Teaching Certification in English, Reading, Deaf or Hard of Hearing, and is the FSDB Educational Media Specialist.



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Dr. Hall is an Audiologist at UF Health. She received her Doctor of Audiology degree from the University of Florida, and her Master of Arts degree in Communication Sciences and Disorders from the University of Central Florida. She is dually certified and licensed as an Audiologist and a Speech-Language Pathologist. Dr. Hall serves on the board of the American Cochlear Implant Alliance as the Vice Chair. She also is a member of Envoy Medical's Cochlear Implant Advisory Board.



Scott Medley, MD
Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Medley served in the U.S. Army, completing his Residency in Family Medicine. He founded Gainesville Family Physicians, enjoying 20 years in Private Practice. He served as a Hospitalist and Chief Medical Officer at NFRMC. Dr. Medley is a Past President of the ACMS and of the Florida Academy of Family Physicians. Currently retired and volunteering at Haven Hospice, he has served as Executive Editor of *House Calls* for the past 25 years, and has authored over 104 editorials and articles for this publication.



Joseph Sparks, AuD
Retired Audiologist

Dr. Joe Sparks retired as an audiologist with 40 years of professional experience. He received his Doctorate, Masters and Bachelor degrees from the University of Florida. Clinical training in Audiology includes Gainesville's VA Medical Center, numerous UF Health/Shands Clinics, as well as the Multi-County Hearing Impaired program with the Alachua County School system. He established Gainesville's first private practice in Audiology. Areas of interest include adult hearing assessment and the art and science of fitting and dispensing advanced hearing aids.

Celebrating 40 Years at the Robb House and Our Wonderful Volunteers



Jackie Owens, ACMS Executive Vice President



This past November, the ACMS celebrated 40 Years of the Robb House Medical Museum and the generous volunteers who made it happen. In the next few issues of *House Calls*, I plan to thank those who were recognized at this event, as there is not sufficient space to recognize everyone in a single column. The first individual we'd like to recognize is Florence Van Arnam, who received the Lifetime Achievement Award for her contributions to the Robb House.

For a little background on the Robb House - it is a Victorian cottage, built in 1878, which became the home and medical office of Sarah Lucretia and Robert Lee Robb, two of Alachua County's first physicians. "Horse and buggy doctor" Sarah Lucretia Robb, was the first woman physician in Alachua County and nearly the first in Florida. She practiced from 1884 to 1917 and lived in the house until her death in 1937.

Slated for demolition, the house was purchased by the ACMS and moved to this site in 1981, then restored and dedicated in 1982 as the home of the Alachua County Medical Society, Medical Alliance and Robb House Medical Museum. The museum is maintained by generous donations from the ACMS members and the Gainesville community. The unique museum collection contains the medical bags, books, furniture, and homeopathic remedy kits of Doctors Sarah and Robert Robb, as well as birth records, an operating table and a surgical room light from the 1928 Alachua County Hospital, and many other medical contributions dating from the 19th and 20th centuries.

Florence Van Arnam was recognized with a Lifetime Achievement Award at the event last November. She was among those individuals who originally established the museum. Florence dedicated much of the next 40 years to the museum, restoring, collecting, cataloging (along with Glenna Brashear and Libby Furlow) and creating historic displays.



Florence Van Arnam
1929 - 2023

Born in 1929, Florence Rogers Van Arnam, was a fifth-generation citizen of Alachua County, graduating from Gainesville High School and receiving an AA from Virginia Intermont College. She received her nursing degree from Vanderbilt University (BSN, 1952), graduating Summa Cum Laude. She moved to Oregon and California after college, meeting Dr. Carl Van Arnam (ACMS Past President), whom she later married. They settled in Alachua County, had four children, and recently, four grandchildren.

Florence passed away last week at the age of 93, and will be greatly missed. We became good friends over the last 14 years, as she would stop by the museum weekly to see how she could help out - and always did! There will be a Memorial Service for Florence at a later date.

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Community Hospice & Palliative Care is looking for a **Part-Time Medical Director** of clinic-based palliative care (must be a licensed physician in the State of Florida – MD or DO). If you, or someone you know, may be interested in this position, please forward this notice. Thank you!

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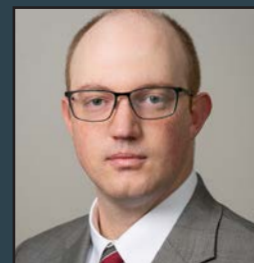
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Update on Cochlear Implants and the Treatment of Hearing Loss

By: Patrick Antonelli, MD, UF Health Otolaryngology/Neuroscience
 Samuel Smith, MD, UF Health Otolaryngology/Head & Neck Surgery
 Melissa Weaver Hall, AuD, UF Health Audiology



Dr. Patrick Antonelli



Dr. Samuel Smith



Dr. Melissa
Weaver Hall

Hearing Loss

Hearing loss is one of the leading causes of disability globally and can affect individuals across the lifespan. Congenital hearing loss occurs in two to three per 1,000 live births.¹ Among adults, 50% of individuals over age 60 and 80% over age 85 have hearing loss that affects communication.² Hearing loss occurring prior to language development, “pre-lingual,” can impede speech development and severely limit educational potential. Even mild and unilateral hearing loss in childhood can dramatically impact language and cognitive development. At any age, hearing loss can have major consequences for interpersonal communication, psychosocial well-being, quality of life and economic independence. Hearing loss has now been established as one of the primary modifiable risk factors for developing dementia. The degree of adult hearing loss parallels the decline in cognition in and the pace of temporal lobe volume loss over time.³ Since hearing loss and its effects are often insidious, they’re often not fully appreciated.

Fortunately, treatment is available for all types and degrees of hearing loss, which can mitigate the neuro-cognitive impact.^{4,5} Conductive hearing loss usually results from problems in the outer and middle ear. Many of these are transient or easily treated, including cerumen impaction and otitis media. Sensorineural hearing loss (SNHL) results from problems in the inner ear, auditory nerve, and the brain. Genetics, advancing age, and noise exposure are the most common causes. As the name implies, mixed hearing loss has both conductive and SNHL. This problem results from either a narrow range of issues involving the inner ear or a combination of conditions that involve the inner ear as well as the middle or outer ear.

Hearing Aids

Hearing aids are the mainstay of treatment for all forms of hearing loss. Most work by picking up sound with one or more microphones, processing the sound, amplifying this sound, and delivering

it into the ear canal (ie, air conduction). Sound energy may also be delivered directly to the inner ear via the skull (ie, bone conduction). Relatively recent legislation has made hearing aids available “over-the-counter,” such that they no longer need to be fitted solely by a licensed audiologist or hearing aid dispenser. This change has led to the availability of less expensive appliances, more similar to “personal sound amplification products” (PSAPs), which largely work the same, but may lack the more sophisticated components found in conventional hearing aids. To mitigate the negative impact of hearing loss, access to sound is a critical first step for many patients. PSAPs may serve as an important start for those who are seeking to improve their quality of life as a result of hearing loss. Hearing aids and other assistive listening technology, such as remote microphone technology, help to further improve access to sound and can mitigate social, emotional, and occupational interferences.

Cochlear Implants

More severe forms of hearing loss may not be satisfactorily rehabilitated with hearing aids. In such cases, patients can usually be helped with a cochlear implant (CI). CIs are not hearing aids. They do not amplify sound. To the contrary, these devices bypass the normal auditory pathway, stimulating the cochlear nerve directly.

Current cochlear implant systems consist of an external sound processor, which is worn and removed on or behind the ear like a hearing aid, and an internal

Continued on Page 7

device that is surgically placed under the scalp behind the ear (Figure 1). The sound processor's key components include a battery, microphones, sound processing circuitry, and a transmitter. The actual implant consists of a receiver-stimulator and an electrode array. Both the internal and external components have magnets that hold the components in place and alignment. The external processor sends the power and auditory signal to the receiver-stimulator through induction. This in turn generates the electrical signal that is sent down the electrode array, across the mastoid, and into the cochlea, where the auditory nerve endings reside. Electrical stimuli sent across the electrodes stimulate the adjacent auditory nerves. The electrodes at the tip of the array stimulate the auditory neurons that convey the lower frequency sounds and those near the base stimulate the nerves that convey higher frequencies. Once the auditory neurons are stimulated, the rest of the afferent auditory pathway functions as it does in normal hearing.

Cochlear implants may be placed in individuals at any age, in anyone with a structurally intact cochlea and cochlear nerve. At UF Health, 5-month-old infants have received cochlear implants. They are currently FDA-approved for use in patients age 9-months and above. There is no upper age limit.

Determining candidacy for CI requires a team evaluation. A CI surgeon will evaluate medical and anatomical suitability for surgery. Either CT or MRI is obtained to ensure that there is no pathology that would preclude surgery or compromise the auditory benefit. A CI audiologist will assess the hearing using testing paradigms that are more reflective of real-world hearing than conventional diagnostic audiometry (eg, inclusion of background noise). Exact audiometric criteria may vary by insurance provider, but all are based on speech perception abilities. This criteria has evolved over time. The current audiometric criterion for a cochlear implant is a score < 60% open set speech recognition with properly fit hearing aids. As the higher frequencies are the most important for word understanding, individuals with good hearing in the low frequencies may still be a candidate for a CI. Individuals with single sided deafness (ie, profound hearing loss in one ear and normal hearing in the other) are also FDA-approved to receive a CI. This has afforded CI recipients a host of benefits in auditory, behavioral, and quality of life gains because of improved sound localization

and word understanding in noisy environments.

CIs do not restore natural hearing. CIs generally raise an individual's pure tone detection, also known as their access to speech frequency information, to a normal sensitivity level, but there is variability in how well the signal is processed in the auditory cortex. The vast majority of CI recipients develop significant improvement in their word recognition, but this is not universal. This situation may be the result of many factors, including compliance with post-implant rehabilitation programs, duration of profound hearing loss prior to implantation, and other central nervous system pathology. Becoming a proficient user of the CI is a skill and requires daily use in a rich sound environment during all waking hours. Though this may happen quickly with some recipients, this process can take months. Most adults report an improved quality of life, an improvement in tinnitus, hearing without needing visual cues of lip reading, listening in background noise, and sound localization, among other benefits.

Surgery for a CI is usually performed under general anesthesia in the ambulatory setting with operative times under 2 hours. CI is an elective procedure that can be performed at a patient's convenience. A notable exception is hearing loss following bacterial meningitis, where over a third of patients may develop ossification of the cochlea that may render CI placement much more difficult, if not impossible. Thus, these patients should have a CI placed expeditiously. Pre-lingually deaf children should be implanted as soon as possible after failing a trial of amplification for optimal auditory benefit. Children that do not receive auditory stimulation by 6-years of age will be unlikely to develop meaningful auditory benefit from a CI.

Special Considerations for Cochlear Implants

The presence of a CI impacts many aspects of a patient's care. As a rule, it is prudent to communicate with the patient's CI surgeon or the CI manufacturer to determine if or how additional care might be impacted by the presence of the CI.

MRI Compatibility: As CIs include an internal magnet, MRI compatibility can be a concern. The magnets in older devices had a fixed polarity, making them vulnerable to displacement upon entering the MRI bore. While this would not cause

Continued from Page 7

any serious medical issue, magnet displacement would commonly cause significant pain and could damage the receiver-stimulator, requiring CI repair or replacement surgery. With very old devices, MRIs were contraindicated. Next generation CIs allowed for surgical removal of the magnet and placement of a titanium blank. Current CIs offer magnets with polarity that spins upon entering the MRI bore. This improvement makes new models safe for MRIs, but the magnets still create tremendous imaging artifact in the area under the CI, which would be no problem for a study focused below the head, but a real problem for imaging of the brain.

Use of Electrosurgical Devices:

Monopolar electrosurgical instruments are contraindicated for surgery on the head and neck of CI recipients. Use of such instruments could damage both the CI receiver-stimulator and the auditory nerve, possibly requiring CI replacement and compromising

long-term auditory benefit with even a new device. Bipolar electrocautery is recommended on the head and neck. Other devices, such as the Harmonic Scalpel, Plasma Knife, and Coblator have also been safely used for head and neck surgery following CI placement.

Conclusions

Hearing loss is a common condition that may have major and diverse impacts on our patients, but is largely treatable. Most people with hearing loss can be effectively rehabilitated with hearing aids. For those that cannot benefit from hearing aids, CIs provide an excellent hearing rehabilitative option. As our aging population continues to grow, so will the prevalence of hearing loss and the number of people who could benefit from a CI.

References available upon request

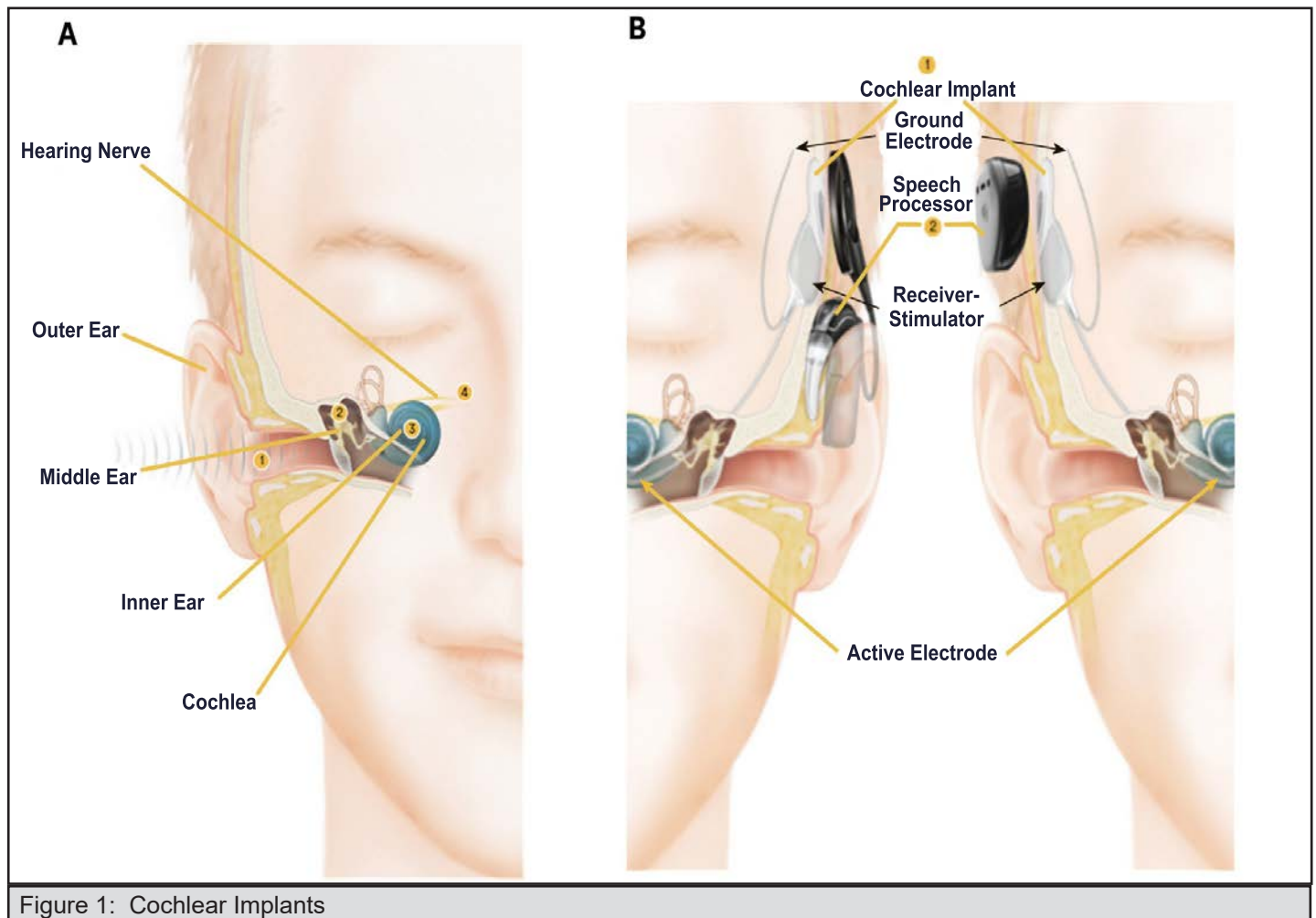


Figure 1: Cochlear Implants

The Current Conundrum with Hearing Aids - "Can You Hear Me Now?"



By: Scott Medley, MD

[Editor's Note: For this "Ear Disorders and Hearing Loss" issue of House Calls, I reluctantly decided to "research" the current baffling situation with Hearing Aids, where confusion reigns, especially since the approval of "over-the-counter" Hearing Aids went into effect just during the past couple of months. In speaking with my family, friends, colleagues and others there seems to be more confusion than clarity around this subject. Presented herein are my actual experiences with actual quotes from some of the participants. My "consultant" for this editorial is Dr. Joseph Sparks, Au D, a recently retired audiologist who practiced in this area for many decades. I referred several patients to Joe over my years in Private Practice. He is known for his expertise, fairness, integrity, and professionalism, and for being a really nice guy].

But first of all, what actually is a Hearing Aid? ⁽¹⁾ A Hearing Aid (H.A.) is a tiny electronic gadget worn over or in the ear to address different hearing issues, including tinnitus. It consists of a microphone to pick up sounds, an amplifier to make the sounds louder and cleaner, a receiver to send sounds into the ear, and (optionally a rechargeable) battery. (Dr. Joe Sparks defines today's digital hearing technology as a "tiny computer hanging on your ear".) Hearing Aids can "resolve issues resulting from diseases, loud noises, medications, and most frequently, from aging". ⁽¹⁾

Nearly all of today's Hearing Aids are digital sound processors. Analog H.A.s are rarely available. Simple in form and function, they make electric signals from sound waves and amplify them. They are generally less expensive than digital H.A.s and may feature volume controls. Digital H.A.s make numerical codes from sound waves and precisely shape the sound to amplify them according to one's hearing needs. These codes include factors such as volume, pitch, presence of non-speech noise and direction of sound. Digital H.A.s are generally smaller, more powerful, and more expensive. These technologically sophisticated devices are computer-

programmed to match a prescription according to your hearing needs.

Behind-the-ear H.A.s come in plastic cases. Sitting behind the pinnae they may have a transparent tube connected to a custom ear mold or more likely, they will have a nearly invisible wire connecting them to a speaker that is inserted into the ear canal.

Because of their durability, behind-the-ear H.A.s are often considered better for children than a custom molded in-the-ear type. In-the-ear aids are generally custom molded from an ear impression. They are smaller, less visible, typically more expensive and may require more maintenance, as all components are placed in the warm, moist and possibly ceruminous external ear canal.

Most digital H.A.s now have Bluetooth compatibility and can connect to TVs, cell phones, and other Bluetooth-enabled devices. Some models feature "fall detection" technology for those at-risk for falls. Many of the Bluetooth and other wireless functions are controllable at the user's discretion. Some public venues (like the Hippodrome State Theatre in Gainesville) have a 'loop' system that wirelessly connects the performance to the hearing aids, allowing for much better speech understanding. I personally am not very comfortable with technology, so for me – "The Simpler the Better."

There are generally several ways to purchase a H.A. – on-line; in retail stores or wholesale clubs (like a COSTCO) or from stores owned by H.A. manufacturers; and from licensed Audiologists or Hearing Aid Specialists

On-Line Purchase:

As one can imagine, there are numerous H.A.s available on-line. My quick survey through the omniscient internet found 30 varieties of H.A.s

Continued on Page 10

Continued from Page 9

ranging in price from \$89.97 to \$4,598.00 per pair. (TABLE I) These include rechargeable, digital, smart-phone controlled, and noise-reduction models. Many come with free shipping and with guarantees and warranties, which will be described later.

TABLE I: ON-LINE HEARING AIDS		
SOME HEARING AIDS OF 2022		
BOSSA		\$ 89.97
NEOSONIC (Rechargeable)		299.00
NANO CIC (digital)		476.00
MD VOLT (Rechargeable)		299.98
NANO sigma plus (smart phone controlled)		597.00
New "smart" app controlled		676.00
Eargo max (BEST BUY) (eargo store)		1450.00
Eargo 6 or 7- (invisible , rechargeable)		2950.00
Oticon More 1		4598.00

THE RETAIL TALE

CVS: I walked briskly through the large store and back to the Pharmacy. "Do you sell Hearing Aids?" I asked the Pharmacy Tech. "I don't think so," she said. She then turned and asked her colleague, "Do we sell Hearing Aids?" "I don't think so" he replied "ask the Pharmacist." "No, we don't (yet)," stated the pharmacist.

On to WALGREEN'S: I trudged through the store. To the young Pharmacy Tech I asked, "Do you sell Hearing Aids?" "Not really", was his surprising answer. "What do you mean 'not really'?" I asked. His reply was "Well we sell one, but it costs \$800." "May I see it or at least some information about it?" I asked. He handed me a brochure and said, "Yeah, but it's \$800." I perused the 2-page brochure which described the "Lexie" H.A. - Bluetooth enabled, remote supported, only available on-line for \$799.00 with no mention of warranty or guarantee. "I'll get back to you," I stated without much enthusiasm. As I walked away I overheard the young tech state, "whatever! - \$800!"



WALMART: I shuffled (by now I was shuffling) through the huge store back to the "Pharmacy Consultation Area". No one approached me, so I yelled out to the Pharmacist, "Do you sell Hearing Aids?" "No", she replied in a very loud and emphatic voice, "we only sell Hearing Amplifier and Hearing Assist devices - we do not sell actual Hearing Aids - what we do have are located in the VISION area with the eyeglasses." Now it was my turn to say "Whatever!" - Hearing ASSIST DEVICES IN THE VISION AREA.?

On to the "VISION AREA", where the nice lady pointed to a display of five "Hearing Assist" devices on a small table. She was again quick to point out that these devices "are basically fancy amplifiers" which have never required a prescription. The devices come in 5 types, with costs ranging from \$499 to \$799 (just like Walgreen's) in convenient increments of \$100. You can select the model that's "right for you", depending on where your lifestyle "current or desired" lies along the "Listening Environments" spectrum. That is: "QUIET - TV, telephone conversations, one-on-one interactions vs. "MODERATE" - social activities, shopping, restaurant dining, attending meetings, etc. vs "CHALLENGING"- substantial background noise

Continued on Page 11

such as concerts, sporting events and parties. Most models are rechargeable, some are smartphone and Bluetooth compatible, and all come with a 60-day guarantee. As for "customer support" she gave me the "1-800-NUMBER."

I did not compare H.A.s at Costco or other "wholesale clubs," although I understand that their products and costs are generally similar to Walmart.

AUDIOLOGISTS

Audiologists are state-licensed professionals who by University Doctoral level training, education and having passed a national examination are specialized in the non-medical management and treatment of hearing and balance disorders.

The most exact way to choose and purchase a H.A. is through a licensed Audiologist. Using "probe microphone measurements" and "real-ear measurements" they verify H.A. conformity to your hearing needs. Via calibrated speech, they take measurements from inside your ear while you wear your H.A.s. They can determine if your H.A. is "underfit" with not enough amplification to allow you to understand speech clearly or "overfit" with too much amplification causing discomfort and risking hearing damage. An evaluation by an Audiologist may cost about \$75 –\$150—well worth it in my estimation. They can make sure you're buying a "verified and regulated device that is clinically designed to treat your type and severity of hearing loss"⁽¹⁾. They also provide "ongoing customer support."

HEARING AID SPECIALISTS

Must have a high school education or its equivalent, complete a 6-month sponsored traineeship and pass a State examination for licensure to fit and dispense hearing aids.

Their roles can vary from state-to-state.

The O-T-C SITUATION

Previously, the FDA required either a medical clearance signed by an M.D. or an informed consent waiver of medical evaluation from the patient. But as of October 2022, over-the-counter H.A.s can be purchased without a medical clearance. The O-T-C hearing aids can be purchased on-line and at retail stores.⁽²⁾

While researching this subject, I came across a very timely article – "Clearing up confusion about O.T.C. Hearing Aids".⁽²⁾ In this piece, Audiologist Dr. Sterling Sheffield offers the following advice: "When choosing

O-T-C Hearing Aids, make sure the company you're buying from offers good customer support or you have another source of support, such as a hearing professional." "Those direct-to-consumer H.A.s are designed for people with mild to moderate hearing loss and will not provide sufficient benefit for people with more extensive hearing loss."

Dr Joe Sparks says: "Only about 30% of the U.S. population that needs H.A.s gets them. In Europe where H.A.s are covered under National Health Care only 40-44% of those who need them get them. I don't think price is the leading factor in the low adaptation rate. I believe it's a matter of access. The hope is that the new O-T-C ruling will improve that access. By the way, the state of Florida mandates a 30-day right-to-return H.A.s for refund when purchased from a licensed professional".

PRICE

The wide variety of prices for H.A.s is mentioned earlier in this article – from \$89.97 to \$4,598.00. Dr. Sheffield:⁽²⁾ "With regard to price, our research has shown that the price of the hearing aids doesn't necessarily predict the best device. We tested several devices within the range of about \$400 to \$1500 (per pair) and there was no correlation of price with quality". But at the same time, Dr. Joe Sparks reminds us that "As with everything else, you pretty much get what you pay for. A good pair of basic entry level H.A.s may cost \$2800 a pair".

WHAT ABOUT MEDICARE?

Most basic Medicare plans cover only ear-related medical conditions, not routine hearing care, H.A.s or exams for fitting H.A.s. It is possible to negotiate H.A. prices. H.A.s usually last from about 5 to 7 years. Most insurance plans do not cover H.A.s. Many hearing aid providers do not accept Medicare or Medicaid. Florida Medicaid does provide hearing aids. Some "Medicare Advantage Plans" do cover H.A.s. For instance, one plan covers routine hearing exams and exams to diagnose and treat hearing and balance issues. This includes \$375 - \$1425 copay for each H.A. provided through United Healthcare Hearing... "delivered directly to you with virtual follow-up care through Right 2 You (select models), offered only by United Healthcare Hearing."

IS THERE A MIRACLE IN THAT EAR?

So happens I was preparing this article during Thanksgiving week. I noticed in my USPS curb mailbox (and other mailboxes on my street) a large colorful flyer announcing "Hearing Aid sale on

Continued from Page 11

Black Friday – Buy one, Get One 70% OFF!“ Well,” I thought, “that’s timely, I must investigate”. Turns out that Miracle ear (Miracle ear.com) is a H.A. company consisting of a network of some 1200 franchised and corporately-owned retail outlets. Originally founded in the U.S. in 1948 by Dahlberg Electronics, the company is now a subsidiary of Amplifon, a world-wide distributor of H.A.s based in Italy. The cost is about \$1000 - \$4000 per device. Most models are rechargeable and Bluetooth compatible. I phoned the number on the ad-flyer. The nice sales lady said she could make an appointment for “about a 90-minute Interview and hearing test”, leading me to purchase one of their ‘EXCLUSIVE’ H.A.s. I declined, stating I might purchase a hearing aid elsewhere.

Don’t be surprised at a price of more than \$4500 or more per pair. Some offices include a 3-to-5- year warranty, covering loss damage insurance, batteries, cleaning and maintenance.

For further more detailed information, check out Youtube: drcliffaud,⁽³⁾ where you can find dozens of brief videos with as many details as you could ever want and more about H.A.s

MORE ANECDOTES

While writing this piece over the past days, I came across several friends who wear H.A.s themselves, or whose family members wear H.A.s. Of course, I asked many nosy questions and received the following types of responses: All of them used the service of an Audiologist and are glad they did. All have rechargeable H.A.s – none of them like “fooling with those darned tiny batteries.” Most prefer the “behind-the-ear” type so as to avoid most issues with ear canal moisture and cerumen. Some pairs of H.A.s last only a few years, and some users buy insurance on them. The good H.A.s are not cheap, usually costing about \$4-6,000 a pair. Most reputable dealers will arrange payment plans with you if necessary, especially if you have a long-term customer support relationship with them. Remember, hearing care is health care and best provided by a licensed professional.

Dr. Sparks advises the most critical components to success with hearing aids are: “choose a competent caring professional with whom you are comfortable. You will be interacting with them regularly for years. Commit to daily regular hearing aid use and recognize that follow-up care and hearing aid programming adjustments are routine and necessary for your success. Be patient with yourself and your significant others. Your hearing is likely as frustrating to them as it is for you. Your brain needs time to rewire to your new listening experience”.

BONUS NEWS: Veterans are eligible for hearing aids provided at your local VA for ZERO cost. There is no need to prove service connection. These hearing aids are top of the line, using the latest technology.

GOOD LUCK!

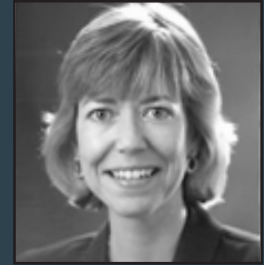
References available upon request.

TABLE II	
Consensus Best H.A.s of 2022 with prices per pair. All have improving technical innovations.	
1. Phonak Audio Life Bluetooth, moisture-resistant	\$1975.00 - \$4550.00
2. Oticon Open, Oticon More 2 OR 3	\$2999.99
3. ReSound ONE	\$3498.00 - \$4458.00
4. Augmented SIGNIA AX	\$1595.00 - \$2275.00
5. Starkey evolve ai	\$2175.00
6. EARGO 6 or 7 Can stream from Android and I-phones (From TV commercial, 1-800-98 EARGO) Fall detection available if the wearer is likely to fall	\$2500.00

THE BOTTOM LINE – HOW TO SELECT A HEARING AID

- Consult a licensed Audiologist
- Determine the style – size, type you like
- Review the features – are they available as rechargeable?
- Not tech oriented – choose a simpler device
- Tech savvy – Bluetooth, smartphone compatible
- Ask for a trial period of about 30 days and ongoing customer support from your audiologist (If your device is not comfortable, you won’t wear it).
- Check guarantees and warranties
- Compare costs – average \$2000 - \$8000 per pair

Frequent Otitis Media or Middle Ear Infections in Children and When to Refer for Tympanostomy Tubes



By: Carolyn Carter, MD, Professor of Pediatrics, UF Health

Otitis media is an inflammation or infection located in the middle ear. It can occur because of a cold, sore throat, or respiratory infection. Ear infections are extremely common in children and are among the top reasons parents take their children to a doctor. The National Institute of Health reports that more than 80% of children will have at least one ear infection by their third birthday.

There are three main types of otitis media:

- Acute Otitis Media (AOM) is the most common ear infection. Parts of the middle ear are infected and swollen and trap fluid behind the tympanic membrane or eardrum. This situation causes pain in the ear.
- Otitis media with effusion (OME) sometimes happens after an ear infection has run its course and fluid stays trapped behind the eardrum. A child with OME may have no symptoms, but a doctor will be able to see the fluid behind the eardrum with an otoscope or look for movement of the tympanogram (or lack of movement) with a pneumatic attachment.
- Chronic otitis media with effusion (COME) occurs when fluid remains in the middle ear for a long time or repeatedly returns, despite no infection. COME makes it harder for children to fight new infections and can affect their hearing.

Children are more likely than adults to suffer from ear infections for several reasons:

- Their immune systems are underdeveloped and less equipped to fight off infections.
- Their eustachian tubes (ETs) are smaller and more horizontal, making it difficult for fluid to drain out of the ear.
- Their ETs are also narrower, making them more likely to get blocked.
- Their adenoids, gland-like structures behind the nose, are larger and can interfere with the opening of the eustachian tubes.

Reducing the Risks for Ear Infection

Although parents cannot prevent all causes of infection, they can take steps to reduce their children's risk of developing otitis media:

- Wash hands frequently. Washing hands prevents the spread of germs and can help keep a child from catching a cold or the flu.
- Avoid exposing an infant or child to cigarette smoke. Studies have shown that babies who are around smokers have more ear infections.
- Avoid bottle feeding while the infant or child is lying on his/her back.
- Breastfeed infants for the first year. Breast milk has many substances that protect the baby from various diseases and infections. Because of these protective substances, breastfed children are less likely to have bacterial or viral infections.
- Avoid exposure to sick people.
- Vaccinate against influenza every year.
- Vaccinate against pneumococcal bacteria, which can contribute to meningitis, pneumonia, and ear infections.

Treatment for middle ear infections per the American Academy of Pediatrics (AAP) guidelines:

- AOM management should include evaluation and treatment of pain.
- Antibiotics should be prescribed for bilateral or unilateral AOM in children aged at least six months with severe signs or symptoms (moderate or severe ear pain or ear pain for 48 hours or longer or temperature 39°C or higher) and for non-severe, bilateral AOM in children aged 6-23 months.
- Based on joint decision-making with the parents,

Continued on Page 14

Continued from Page 13

unilateral, non-severe AOM in children aged 6 -23 months or non-severe AOM in older children may be managed either with antibiotics or with close follow-up and withholding of antibiotics unless the child worsens or does not improve within 48-72 hours of symptom onset.

- Amoxicillin is the antibiotic of choice unless the child received it within the previous 30 days, has concurrent purulent conjunctivitis, or is allergic to penicillin; in these cases, clinicians should prescribe an antibiotic with additional β -lactamase coverage.
- Clinicians should re-evaluate a child whose symptoms have worsened or not responded to the initial antibiotic treatment within 48-72 hours and change treatment if indicated.
- In children with recurrent AOM, tympanostomy tubes, but not prophylactic antibiotics, may be indicated to reduce the frequency of AOM episodes.

When Should a Physician Refer for Tympanostomy Tubes or Ear Tubes?

Ear tubes are often recommended for children with:

- Frequent middle ear infections (chronic otitis media) that are challenging to treat with antibiotics, especially if children retain fluid between the infections.
- Hearing loss caused by the buildup of fluid in the middle ear (otitis media with effusion).
- A collapsing eardrum, a condition known as atelectasis. In children who have had chronic negative pressure, the eardrum can, over time, stretch, thin out, and collapse onto the ossicles (the three tiny bones that transmit sound) of the middle ear, the floor of the middle ear, or both. The pressure exerted on the ossicles can lead to permanent bony erosion and conductive hearing loss.

The decision to refer a child for ear tubes is typically made after considering the child's medical history, the frequency and severity of ear infections, and the child's overall health. The procedure is usually performed by an otolaryngologist or ear, nose, and throat (ENT) surgeon.

The general guidelines for tympanostomy tube placement as provided by the American Academy of Otolaryngology (AAO) in 2022:

- Three or more acute otitis media infections within the last six months or four or more AOMs in the past 12 months, especially if the child tends to retain fluid in between episodes.
- Fluid that is always present over three months with diminished hearing.
- A collapsed drum that is draped onto the middle ear bones, causing decreased hearing, the potential for eroding those bones, or both.

Ear tubes effectively reduce or eliminate middle ear infections, persistent middle ear fluid, and hearing loss related to middle ear fluid. According to the AAO, ear tube insertion is the most common outpatient surgery for children in the United States and, therefore, the most common reason a young child would receive general anesthesia.

Ear tubes are inserted through the ear canal, into the tympanic membrane with a tiny incision about 1/20th of an inch. The tympanic membrane is about 1cm in diameter or just under 1/2", so the ear tube occupies only a small part when in place. Tubes have a tiny hole in the middle that allows air to enter the middle ear helping to keep the area dry. This function leads to the term "ventilating tube" that is sometimes used to describe them. Tubes allow fluid to drain should it build up, and they eliminate the negative pressure (vacuum) that may have caused the fluid buildup, ear infection, or both. Ear tubes essentially bypass the eustachian tube, and the ventilation allows the lining of the middle ear space to heal. The tubes also allow an ear infection to be treated with antibiotic ear drops in place of oral antibiotics.

Frequent ear infections can lead to decreased hearing; speech and balance problems; and changes to the child's eardrum. Tympanostomy tubes may help, but the benefits and risks of ear tube insertion are different for each child. Therefore, it is essential for physicians and parents to discuss all the benefits and risks and jointly decide what is best for the child.

References available upon request.

Florida School for the Deaf and the Blind - One of Florida's Truly Hidden Gems



By: Tom Zavelson, MD, FSDB Board Member

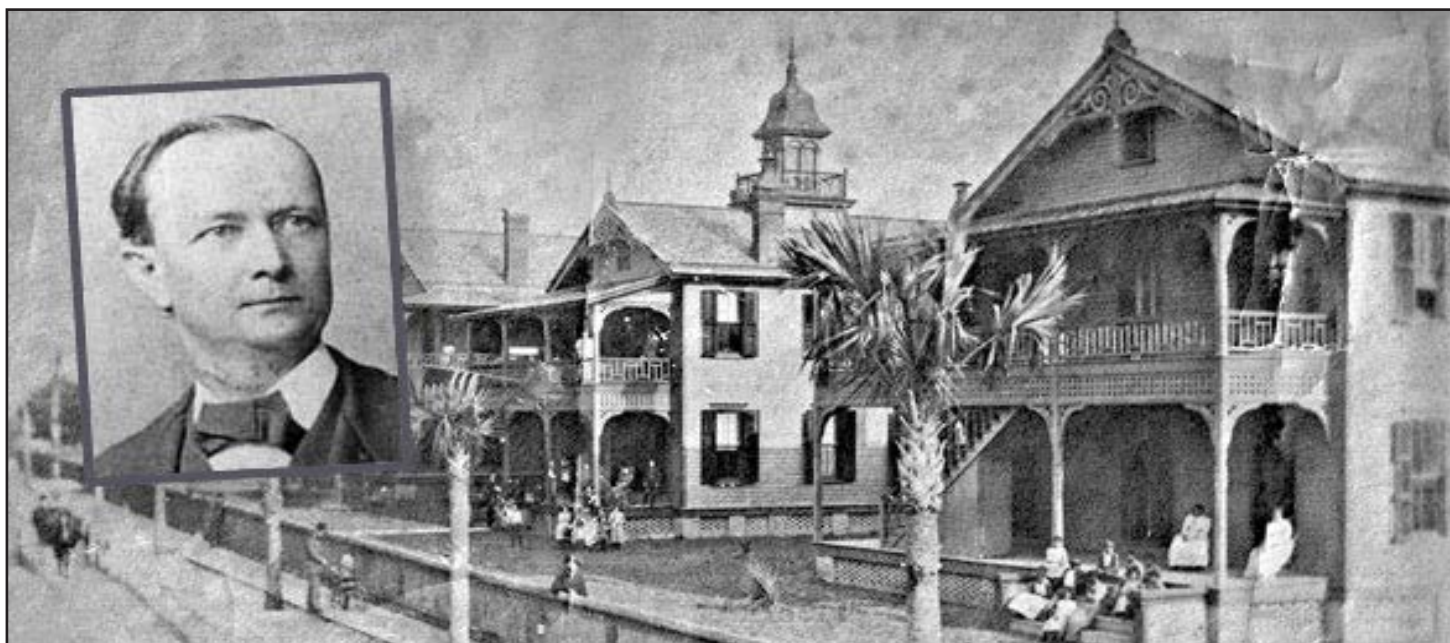
Now that basketball season has begun, we will repeatedly be hearing "nothing but net." On a clear, warm day in the spring of 2009 what I heard was nothing but laughter, saw nothing but happiness and felt nothing but love. For the very first time in my 38 years living in Florida I had finally stepped onto the campus of The Florida School for the Deaf and the Blind in St Augustine. Upon my retirement from Pediatric practice in 2007, I had decided to no longer take on any additional outside obligations. On the strong encouragement of a former UF Department of Pediatrics mentor, I finally agreed to at least visit FSDB that just happened to have a vacant seat on their 7-member Board of Trustees (BOT). This encouraging faculty member, having a child with total blindness secondary to bilateral Retinoblastoma, had developed a close relationship with the School. He stressed that since its inception, 125 years had passed without a single gubernatorial appointment of a physician to the FSDB board. So on that spring day, Gail and I met with the President of FSDB and several others

from the School. It certainly didn't take long for us to fall in love with the students, faculty, staff, concept, mission and ambience of this institution.

Located in St Augustine, surrounded on two sides by the Intercoastal Waterway at the junction of A1A and San Marco Ave and north of where the historic Carousel once stood, is the 80-acre campus of FSDB. Nestled beneath magnificent Live Oaks and huge Sable Palms, sit dormitories and classrooms that, by appearance, could have been left behind by the original Spanish settlers.

In 2010, then Governor Charlie Crist appointed me to the BOT of FSDB, followed by subsequent reappointments by Governors Scott and DeSantis. **What I have seen and learned since is that FSDB, is indeed, one of the true hidden secrets in Florida.**

I am embarrassed to say that after 38 years of



Above, the first three buildings of the Florida School for the Deaf and the Blind were completed in 1884 in St. Augustine after the state, led by Gov. W.D. Bloxham (inset), allotted \$20,000.

Continued on Page 16

Continued from Page 15

Pediatric practice and having recommended to several of my hearing and visually impaired patients that they might want to explore possible admission to a facility that I knew almost nothing about and didn't even know where it was located; Boy was I, like so many others, ignorant about this real gem.

FSDB established by the Florida legislature in 1882, is one of the first and largest schools for the deaf/hard of hearing, blind/visually impaired and deaf/blind students in the country. Originally named the Florida School for the Deaf and Dumb, the name was subsequently, in 1909, changed to The Florida School for the Deaf and the Blind.

FSDB, like UF, FSU and FAMU, falls under the control of the Florida State Board of Control and is regulated by the Florida Department of Education; it is not connected with the St Johns County School Board. Any student in the State of Florida who meets the State's deaf/blind criteria is eligible to attend, totally free of charge, including housing, board, subacute medical care and transportation from their home town to St Augustine. FSDB's fleet of buses transport students from St Augustine and the immediate area daily and, for boarding students, from their home town to the School every Sunday afternoon and then back to their families every Friday afternoon. FSDB is an all-inclusive home to children ages 6 months to 21 years. Our Montessori based infant-parent program is for local day-students ages 6 months to 5 years, whereas the older students can attend as day-students for local residents or as boarding students for those living elsewhere. Presently the total enrollment is 497 students, 306 in the Deaf School and 169 in the Blind School. Enrolled are 22 PreK students, 177 day-students and 320 boarders.

On the campus stands the Coleman Health Care Center, a modern clinic/subacute infirmary that includes a part-time Pediatrician, a Pediatric Nurse Practitioner, an onsite pharmacist, a dental and eye clinic with part-time physicians, multiple full-time nurses, multi-level social and mental health counselors, a short-term subacute four bed treatment and stabilization unit, and several consulting subspecialty physicians.

What I have learned from so many former students, is that the FSDB experience did, indeed, positively change their lives. I saw firsthand how Eric, the blind student previously mentioned, through encouragement and direction from the faculty and staff, never let his loss of vision interfere with anything. By the time that he had graduated from FSDB, two years ahead of his peers, he had become an accomplished pianist and scholar. He

attended Duke University and graduated with a double major in Computer Science and Classical Music. He then worked for the Office of U.S. Naval Intelligence followed by 12 years with the Environmental Protection Agency.

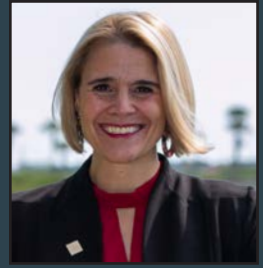
My second patient, Summer, whom you will hear from in a separate article, was the 3-year-old daughter of two musician parents, surrounded each day with signing and music. While performing outside of Gainesville, her parents realized that Summer was not feeling well. She developed a significant fever and rapidly became somnolent and barely responsive. They immediately returned home where I treated her for Pneumococcal meningitis with full recovery except for a total bilateral hearing loss. This child who, like her parents loved to sing, now lived in a silent world. Fortunately, her parents took a very positive approach and began to explore avenues for her future development and education. Her story will follow.

In addition to Summer's article, you will read an article by Mrs. June Ann LeFors, a deaf member of the FSDB Board of Trustees who will discuss Deaf Culture as well as an article by David Snow, a deaf FSDB faculty member, that will help explain what American Sign Language is all about. As for David's comments, parenthetically, I strongly recommended the use of ASL for several of my former hearing patients who, for various reasons, had a significant delay in speech - resulting in frustration and delayed development. Being able to communicate early on through basic sign language enabled them to develop much faster and never had an adverse effect on their eventual acquisition of oral speech.

Most parents and children with significant hearing and/or vision loss desire to lead as normal a life as possible compared to their peers. For many, that included attempting to "mainstream" in school. For many of these children, they came to realize that their peers and others begin to see them as "different." With time they came to feel isolated and alone. As much as they attempted to assimilate, they found it increasingly more difficult to do so. Enter FSDB and an opportunity for them to experience inclusion, camaraderie and support in their journey to find ways to maximize their full potential.



FSDB's Educational Journey



By: Tracie Snow, FSDB President

At the Florida School for the Deaf and the Blind (FSDB), students gain the edge to Do MORE, Be MORE and Achieve MORE. The FSDB experience makes it possible for eligible deaf/hard of hearing, blind/visually impaired or deafblind students to accomplish more than they ever imagined.

The Florida School for the Deaf and the Blind is proud to be a parent choice school for educating Florida students and an accredited state public school that is nationally recognized for its specialized educational programs, services, and advanced technologies, serving more than 1,000 children each year.

What truly sets FSDB apart from other schools and why parents/guardians choose FSDB are our highly qualified teachers, specialists and staff members; small class sizes; advanced technologies; specialized support services; and much more. Learning at FSDB is made possible through the support of dedicated teachers and specialists who hold multiple

certifications in specific academic content areas, especially for students who are either deaf/hard of hearing or blind/visually impaired.

Academic programs at FSDB are based on Florida academic standards, and students work toward their attainment of their standard diplomas. Student-centered experiences at FSDB are designed to foster intellectual curiosity, nurture personal growth, encourage creative exploration and inspire a lifelong love of learning.

As students progress through FSDB K-12 schools, they learn to read actively, to write clearly, to think critically, to engage in meaningful dialogue and to act responsibly in today's changing world. Students also learn from each other, grow together, and are a part of a dynamic and vibrant educational community.

What makes us different from other educational

Continued on Page 18



FSDB Front Gate with students.

Continued from Page 17

programs is full access to world-class knowledge through language acquisition, development and mastery. Students who are deaf or hard of hearing benefit from American Sign Language (ASL) and English instruction.

Through small class sizes, individualized instruction, specialized professional services, and advanced technologies, we strive to develop confidence, acquire new skills, and strengthen students' ability to achieve success both within and outside the classroom. Teachers, specialists, coaches, and mentors motivate FSDB students to stretch beyond their comfort zones. They continuously encourage students to become proactive, independent, and thriving learners who take responsibility for their academic, athletic, and on-the-job experiences and accomplishments. Students are consistently encouraged to push their boundaries and "reach for the stars" by participating in academic and career competitions at the local, regional, state, and national levels.

FSDB prepares students for success in careers by integrating academic and career coursework and on-the-job training activities. Career development at FSDB begins early; elementary students explore and gain exposure to the world of work. Middle and high school students have the opportunity to take Career and Technical Education (CTE) skills development courses in specific career paths. FSDB works closely with campus departments and local business partners to provide students with real-world learning experiences through on- and off-campus employment opportunities.

Students unleash their creativity and self-expression through a variety of visual and performing arts including dance, drama, film, fine arts, graphic design, photography, poetry, theatre, and video.

Students engaged in athletics acquire teamwork, sportsmanship, and leadership skills while increasing pride in achievement and passion for success as they compete in team sports with local public and private schools and across the state and nation. Athletes compete on the field, in the gym, on the court, around the track, or in the pool as they participate on football, volleyball, cross country, swimming, basketball, cheerleading,

weightlifting, wrestling, flag football, track & field, and goalball teams.

FSDB is a home away from home for our students in the boarding program. Boarding services begin with the youngest students at age five and continue to adult students up to the age of 21. Boarding personnel are teachers, mentors, advisors, and surrogate family members. Boarding students learn the life skills essential for a successful transition to the adult world of independent living, employment, postsecondary education, and community involvement. Students also engage in recreational and leisure activities after school and during evening hours.

Students who graduate from FSDB will join the growing ranks of alumni who are successful in their careers and in life. The caring and dedicated staff at FSDB support students to enable their dreams to come to fruition and provide opportunities that are not offered elsewhere.

We believe that the learning and educational experiences our students receive are unlike any other school in Florida and the nation. We value our commitment and dedication to our mission and vision to continue to provide high-quality academic programs and services to the students entrusted to our care and whose families have chosen FSDB for their child's educational journey.



A Bridge to Multiple Pathways



By: Summer Crider, Former FSDB Student

NAVIGATING AS A DEAF PERSON WITH SEVERAL IDENTITIES:

Being born and growing up in two worlds, I have always considered myself being a bridge. This concept arose from being raised in two different cultures- from my participation in the Deaf and Hearing worlds. Rather than belonging in one world, I sort of felt as a “bridge” or someone “in between.”

The feeling of “in-between” also surfaced when I became a Forest and Nature Therapy guide, understanding both the human and the more-than-human world. My identity now has, however, transformed from “bilingual” into a multilingual human being. This story explains how this all came to be.

I share with you these stories from a language & cultural perspective, also because my academic background and training has me focused on this phenomenon of being bilingual and bicultural.

I used to think in black and white but this new realization has allowed me to visualize my surroundings differently.

People ask me, how do you do all this? How do you handle all these modalities, technologies, and languages? Won't you get confused? I didn't have an answer for all this- it was just something I morphed into growing up. Something to do with survival instinct, being on the margins... not quite understanding the verbal language, I observed from different viewpoints and met others who were on a similar path.

Dr. Tom Zavelson, my pediatrician who helped my family navigate choices for dealing with my deafness, recently asked me to write an article for a medical journal. He was aware of my life story but wanted to better understand my recent journey from being hearing, to becoming deaf, then getting the cochlear implant (CI), then navigating in between two worlds.

I was resistant at first because this is a highly politicized discussion and I was unsure of getting myself into it. But the more I reflect on my journey and make connections with the Natural world... The more I became open to sharing.

WORLDS OF SOUND AND SILENCE

At the age of 3, my world became silent when I became deaf as a result of spinal meningitis. My family and I started learning sign language together, but they also explored ways that could help me regain my hearing.

This medicalization of deafness is very common, under the guidance of doctors and parents who want the best for their child. Naturally, parents want their child to be like them, to speak their language and to navigate the world together as a family. Sign language is something that wasn't as accessible in my hometown where I grew up, but my mother learned anyway. My father, however, was resistant- still clinging to the idea that perhaps I would regain my hearing. In 1990, the FDA approved cochlear implantation in young children.

At the age of 6, I got the cochlear implant and got some of my hearing back. I could participate in spoken conversations, hear music, laughter, birds, etc. But I also needed the visual language in which I had learned and relied on during my formative years. My mother, who felt that sign language was too special to give up, tried to abide with the doctor's advice that I should rely solely on the implant in order to learn to speak. She watched me suffer as specialists tried to communicate with me without the benefit of Sign. Even though I could hear some words and sounds, I was not given any visuals; the therapist would even completely cover her own mouth. I became agitated as my mother tried to get the audiologist to understand that I was not misbehaving; I was lacking the visual support that I obviously needed. Needless to say, she then allowed me to communicate using whatever modality that I felt helpful. I never stopped signing nor did I stop wearing my implant. I obviously needed and wanted both.

These early years in the educational system were not without struggle; I had a love and hate relationship with my cochlear implant. During early teens, I took it off to “look normal” and not a cyborg with a string attached to my brain. But I put it on when I wanted to listen to music with my best friends. When the processor became smaller and closer to looking like a “hearing aid”- there was no bulky box and string anymore - it was just behind the ear so I wore it more. I was also entering a time of my life where I wanted to be around those “like me”- meaning deaf kids. Transferring to The Florida School for the Deaf and the Blind in the 10th grade, I wore it all the time because I blended in well with other deaf kids who had hearing aids and cochlear implants.

Fast forward to age 20, when PBS interviewed me in the documentary, *History Through Deaf Eyes*, explaining my experience with both worlds. This was during my college years at Gallaudet University, where I was becoming more and more enculturated in Deaf culture and my Deaf identity flourished. I got married into a mixed Deaf/CODA family, I worked as a teacher for Deaf children, and got a Master's degree in Deaf Cultural Studies which focused on how the

Continued on Page 20 - HOUSE CALLS 19

Continued from Page 19

Deaf can navigate through the deaf and the hearing worlds. In recent years, however, there are a lot of cultural and linguistic identity politics happening within the field of Deaf Studies. For a long time, they rejected deafness as a disability and cochlear implants were a reminder that we were not embracing our "deafhood." Thus there was resistance - the Deaf community for a long time considered cochlear implants as "cultural genocide".

Twenty years later, my life changed again. Even though I spent a large amount of my teenage and adult life immersed in the Deaf world, I wasn't satisfied. I became inquisitive and restless being in the "bubble"- I wanted to learn about the rest of the world, I wanted to build tiny houses, travel to intentional communities, and explore multiple worlds that exist outside the institutionalized and medicalized system. I ventured outside and became drawn to other worlds.

TWO WORLDS: IS THERE SUCH A THING?

Disability is a social construction and should not have any negative connotations associated with it. Just like the wild natural world is not a negative thing. It is our disconnection from Nature that makes it seem that way, with most humans having "nature deficit disorder".

Most of my life, I did not view myself as unable (disabled), but I knew I was different - how? Because the medical system said I "needed to be fixed". Cochlear implants became a part of my life because of that. The desire to fit in, to belong, was natural. The device itself was not as invasive as the pressure from society that it would help me hear.

Sign language, on the other hand, was 100% accessible to me. My whole body relaxes when I see sign language. Similarly, out in Nature- there is absolutely no pressure to fit in. I can take a walk in Nature without feeling I need to hear. I can totally relax.

When I walk into the city, or in a house full of hearing people; I instantly scramble for my CI hearing device. Why? Because society expects me to hear. So I can accommodate them. Now, on the road, traveling as I do, I find perks in both silence and sound. Most of the time, I drive with my CI turned off but I turn my processor on to listen to music to keep me awake, and yes, I start singing along.

Realizing I feel free and comfortable in the silent natural world prompted me to change directions from education to starting my own business as a Certified Nature and Forest Therapy guide. When I take hearing people in the forest with a group of Deaf people, most of the time I see they are nervous. But after a while, the nervousness goes away when they realize there is a tremendous benefit of being guided in silence. For example, we were earth-

walking - being mindful of walking with the least impact on the earth. Normally our footprints make sounds, even for Deaf people who usually walk without realizing their footfalls made sounds. So because we slowly walked in the forest for a good 10 minutes, we stopped and started conversing in sign language. We spotted a whitetail deer. Somebody gasped! Immediately a bunny hopped in the clearing... and birds flew away. A hearing participant who was local was in awe. "I've been to this park so many times, I've walked this exact trail so many times and I'm in awe because I never saw so many animals being this close." Then I asked them why they thought this was the case. What was different then and now? I could tell it was a light bulb moment! There was a benefit of silence.

So if you ask me, which "pill" would I take? Would I choose to speak or to sign? Would I choose to wear the cochlear implant or not? Which world is better? The Deaf or the hearing? Two worlds? The two worlds - much like Nature and human - don't exist. The concept of separateness is a misnomer. I think that I have finally unraveled that misconception.

Yes, I use my cochlear implant. But I don't use it all the time, and it's not my only tool. It's one of my many tools. Maybe it has more value to me depending on the context and my environment. Sure, my cochlear implant and my speaking voice have helped me go far. But without my ambition, and my multiple ways of navigating the world, I wouldn't be this far.

So, my suggestion for those who are trying to decide whether or not to get a CI. Consider this - what would you use it for? Do you rely on speech to understand your family, friends, co-workers, and other communities you belong to? Does your job rely on it? Take all these into account.

For me, my answer is yes- it has worked for me. But, I also say yes to sign language. Yes to deaf culture. Yes to learning Spanish. Yes to traveling. Yes to a full life. Being bilingual (or multilingual) actually gives you more access to the world.

Do I have to choose? I say: I choose both- because I am both - hearing and deaf.

You ask me if I chose the civilized world or the Wild world, I say... why do I have to choose? I AM both- I am human and I am Nature. We all are related. The world isn't binary. Not in my perspective or experience. We should not have to choose whether to sign or talk?

"A man who speaks one language sees the world out of one eye"

"Speak to me in your language, it goes to my brain. When you speak to a man in his language, it goes to his heart."

Nelson Mandela

The Importance of American Sign Language (ASL) for Individuals Who are Deaf and Hard of Hearing



By: David Snow, FSDB Media Specialist

Access to American Sign Language (ASL) by individuals who are Deaf and Hard of Hearing is essential for complete engagement and inclusion in all aspects of life. Whether it is used to communicate with family members, learn content in school, chat socially with friends, be productive in the workforce, or be understood by the business and medical community, the ability to communicate one with another in ASL gives the Deaf person a sense of 'naturalness' with expression and listening with like individuals, equivalent of what a hearing counterpart would experience when using spoken English.

Before we go further into what American Sign Language (ASL) is, let's start with the basic definitions of what 'language' and 'communication' mean.

'Language' from Merriam-Webster

- the words, their pronunciation, and the methods of combining them used and understood by a community.
- audible, articulate, meaningful sound as produced by the action of the vocal organs
- a systematic means of communicating ideas or feelings by the use of conventionalized signs, sounds, gestures, or marks having understood meanings

'Communication'

- a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.

'Language' from Cambridge:

- a system of communication consisting of sounds, words, and grammar
- a system of communication used by people living in a particular country

'Communication'

- the process by which messages or information is sent from one place or person to another, or the message itself

Let's compare the definition of 'American Sign

Language' to the definitions of language and communication as given by the National Institute on Deafness and Communication Disorders (NIDCD), a reputable federal agency:

American Sign Language (ASL) is a complete, natural language that has the same linguistic properties as spoken languages, with grammar that differs from English. ASL is expressed by movements of the hands and face. It is the primary language of many North Americans who are deaf and hard of hearing and is used by some hearing people as well.

It is recognized that 'sounds' mentioned in the definitions above do not match the description given of ASL. However, it bears noting that the 'language' definition represents the universal usage of language. Currently there are over 7,000 languages being used in the world, of which 33 large-population languages are primarily used in spoken form. In contrast, there are approximately 300 sign languages used with 74 recognized by the legislation of their countries.

To develop definitions of words in the dictionaries, it is my perception that the editors are representing the 'general population' of word usage. Since many languages include sounds, they need to mention that in the language's definition. It is worth acknowledging that 'sound' is not mentioned as a requirement to be considered as a language!

Historically, there has been a commonly held misconception both here in the United States, as well in other countries, if a language is not able to be verbally spoken, it cannot be considered a language. Often, people have assumed that if one does not speak, one cannot be successful in life. This is not true.

A significant and well-researched question of concern among educators of the deaf is wondering "does learning sign language affect one's spoken or written English in any way?" Unfortunately, for generations of students who are deaf or hard of hearing, many educators already decided on the answer before the research was conducted.

Professionals in the field banned sign language

Continued on Page 22

Continued from Page 21



FSDB Elementary Student and Teacher communicating with American Sign Language.

from places of learning including schools for the deaf, starting in 1880. It was not until the late 1950's, when William C. Stokoe, a hearing professor at Gallaudet University (then College) revolutionized the view of sign language. He was an English professor and not fluent in signing, however, his inquisitive fascination with the signing of students around him led him to spend the rest of his career in determination to understand what 'Sign Language' (before it was renamed "American Sign Language") is. Ultimately, he concluded that ASL did contain all the components of what makes a language a language except for the aspect of sound. However, like English or any other well-known languages, ASL, through the movement and position of hands and facial expressions, still delivers communication as effectively as languages utilizing sounds and spoken words.

In doing so, Stokoe along with his colleagues in linguistics studies dispelled American educators' over-50-year-old concern: does learning sign language affect one's spoken or written English in any way? The researchers reported: "teaching a deaf child the language of signs will help him learn English later." Furthermore, among the findings, the colleagues stated that:

- 1) Deaf children taught the language of signs from infancy tend to read, write and lip-read better than other deaf children.
- 2) The very young deaf child needs a method of communication and can learn signs much faster

than speech.

3) Parents may communicate via the language of signs with preschool deaf children without fear they are jeopardizing the later learning of English.

4) The early use of the language of signs teaches a child the value of communication and gives him an advantage over a child with no means of expressing himself.

The benefits of using ASL was not limited to the Deaf/Hard of Hearing's natural easiness of communication expression. Dr. Herbert R. Kohl, a renowned educator and advocate for progressive alternative education, stated:

"...the sign language appears to be a 'natural language' to Deaf children, and that the deaf child should be permitted to use this natural mode of communication from the very beginning of schooling...

...this suppression of the sign language by schools for the deaf has blocked the emotional development of the deaf child and contributed to his present lag of four to seven years and that the social, emotional, linguistic, conceptual and intellectual problems of the deaf are inextricably bound together." (Baker, 1980)

Despite the research strides supporting American Sign Language as beneficial for deaf children (at that time, oralism, a method of speaking and reading lips and other spoken English approaches was prevalent in education), it took many years before it finally took hold with the rest of the nation. The reason for such resistance was because of the long-held belief that a language (spoken English) is expected to be used because of the sound component, and that children will not succeed in life if they do not learn how to speak.

Fortunately, with time and continued research regarding methods, practice and applications, American Sign Language has increased in recognition as an important means of communication for Deaf and Hard of Hearing people. Today, in the United States, almost all the states formally recognize American Sign Language as a language and have it noted in state law. ASL is offered as a foreign language course in both K-12 schools as well as at the college and university level. These course offerings have grown in popularity over the year with ASL being ranked the third most popular foreign language course for college and university students

Continued on Page 23

in which to enroll.

The conception of giving attention to the “disabilities” of deaf people has also transformed the focus to be on deaf people’s abilities. The deaf person’s right to having an ASL interpreter is now part of the Americans with Disabilities Act (ADA). The ADA requires many public and private businesses to provide reasonable accommodations to individuals who are Deaf or hard of hearing in order to ensure effective communication. Because every person is different, determining what a reasonable accommodation would be varies based on the person, situation, need, setting, and length and complexity of the communication.

There are some situations in which writing a note might be an appropriate accommodation. This option of communication would need to be thoughtfully considered by taking into account the amount of information being shared, the content of the communication, and the length of time required. For brief interactions, like at a restaurant or shopping in a

store, writing notes may be appropriate. However, if you were to have a 20 minute spoken conversation, would you still accurately capture the same quality and quantity of information writing back and forth on paper? What about back-and-forth conversations with more than two people? Additionally, people whose primary language is ASL may have some difficulty with written English language, since it is a second language. Therefore, the method of writing back and forth may become ineffective and exclude the person from having complete engagement and understanding.

This right to have the same level of equal access and effective communication can be achieved through the use of qualified ASL interpreters. For many situations, a live ASL interpreter is preferred as an effective and appropriate accommodation for an individual who is deaf or hard of hearing who uses ASL to communicate. Another strategy being utilized more recently is the Video Relay Interpreter (VRI) system. This is a way to provide a professional interpreter through a video connection instead of in-person. One note to mention regarding the use of a VRI, is that at times it may not provide effective communication if technological glitches happen such as the screen freezing, individuals do not know how to use it, or if it is not suitable for the situation.

In closing, American Sign Language is a recognized language, essential for many individuals who are Deaf and Hard of Hearing in order for them to have access, engagement, and to be included. Deaf people are truly fortunate to be living in a time where ASL use is flourishing due to the support of research and application, ASL advocacy groups, and an increase of options for ASL accessibility through technological means. This growth and recognition has greatly and positively impacted the lives of Deaf people: Families are using ASL with their deaf and hard of hearing babies; instruction is being provided through ASL in schools; ASL is recognized as a foreign language at the college and university level; and interpreters are being provided as a reasonable accommodation in the work place as well as in the community. Even though there is always some room for improvement, persons who are Deaf are truly blessed to be living in this age. As a community, we look forward to increased recognition, research, access, and inclusion.

References available upon request.



FSDB Students communicating while on campus.

Deaf Culture



By: June Ann LeFors, ASL Director, Flagler College, FSDB Instructor



In 1834, Ferdinand Berthier, a Deaf man from Paris, France, organized the first "silent banquet," an event aimed to bring together "all the deaf spread across the globe... to put speaking and deaf men of intelligence and heart in rapport with each other, no matter the distance, no matter the difference in language, culture and laws" (Quartararo, 2002, pg.192). The banquet eventually was known as Société Centrale des Sourds-Muets (Societe Centrale for the French Deaf Community). It was part of a larger government-supported social movement in the 1830's (Quartararo, 2002). The Société Centrale became so well known that even King Louis-Philippe embraced and supported it. It was there that the patrons recognized that Deaf people are the world's first "Global Community" even though they do not belong to any specific country. The commonality that is shared across Deaf people from all over the world is "home." Wherever Deaf people congregate, this fosters a fierce loyalty to each other, perhaps even greater than allegiance to citizenship of one's own country. The experiences Deaf people face are similar all over the world no matter the geographical location. When a Deaf person travels internationally and meets another Deaf person, the stories and

experiences they share with each other will be nearly identical. Indeed, Deaf people are truly part of a global community.

Deaf culture and Deaf community are often used synonymously resulting in confusion regarding the differences between the two terms (Holcomb, 2012, p. 20). Deaf community is not pinpointed to a specific country because its members come from all over the world. This community is composed of individuals who choose to use a visual language and are naturally connected to a "community" by a shared culture.

In the book titled Introduction to American Deaf Culture, Holcomb (2012) elaborates the five hallmarks of Deaf culture:

1. **Language** - there is a shared type of language, by way of the hands, a visual language.
2. **Heritage** - there is a sense of belonging and has a historical view.
3. **Customs** - there are certain customs and rules that have been mutual among the Deaf
4. **Arts** - there are specific arts that are descriptive towards the hands, eyes, and ears and of the experiences by the Deaf.
5. **Family** - there is a special connection- a family feel - once one Deaf person is connected to another Deaf person, no matter the location.

In layman terms, **Deaf culture is simply the Deaf people's way of life.** They are a "people of the Eye" (Lane, 2010). The use of a visual language, American Sign Language (ASL), as used in the United States, is very important to the Deaf. It serves as the core of having a culturally Deaf identity. Being that ASL is a visual language, eye contact is extremely important. It is considered rude to not have eye contact with a Deaf person while talking with them. Eye contact is an act of reassurance that you are acknowledging the conversation that is happening. This also includes the choice to sit across from one another rather than side-by-side. Deaf people will carefully choose where to sit and how they can see others, often resulting in them sitting or standing in a circle.



FSDB Ski Club Members.

In Deaf culture, it is acceptable to touch another person to gain their attention. Tapping lightly on the shoulder, or a brief rub on the arm are common ways to get the attention of a Deaf person. It is also not odd to give hugs or a side hug after the end of a conversation between two Deaf people even if they are strangers. The visual communication between two Deaf strangers often creates a connection immediately and it can be normal to depart with a hug. Other ways of getting the attention of a Deaf person are hand waves, where you simply wave your hand or flicker the lights.

Conversations among Deaf people are usually filled with details. This most likely stems from life at residential schools. Residential schools are often the first opportunity for Deaf people to congregate with others and share information with each other. For example, a retelling of a car accident would include the reason they ended up in the area, why they needed to drive on that specific road, and their destination. There is a need to share detailed information with others due to the lack of incidental learning in their personal lives as they grew up. The idea of gathering information is important to them. This leads to the Deaf not feeling offended when asked for personal information such as how that member of the family died, the mortgage of their house, their yearly salary, or even how much they paid for their car. Deaf people are also known to spend a long time saying goodbye. In many instances, the final goodbye is the fifth "goodbye" said in a span of forty-five minutes. Parting is often difficult for Deaf people because to part ways into the hearing world often means a return to a world of isolation and disconnection.

Once a Deaf person becomes part of the Deaf community, they are given a "name sign" from a member of the Deaf community. It is common to introduce yourself using only the sign name without having to finger-spell your given birth name. Deaf children who are born to Deaf parents are given a name sign by their parents, but Deaf children or adults who do not have Deaf parents often receive a name sign from a member of the Deaf community. The name sign given, in almost all cases, stays with the person for the rest of their lives.

Technology in the 21st century has genuinely enhanced the lives of Deaf people. The use of new technology has given Deaf people the opportunity to utilize equipment that helps them navigate into the world that they live in. Doorbells in homes of the Deaf are usually connected to lamps that flicker. The same can be said for a baby-cry monitor. The monitor

detects a baby cry sound and sends signals to a specific lamp and the lights start flickering. Not too long ago, mothers would tie one end of a string on the leg of their infant and the other to the wrist of the mother during the night. When the baby woke up in the middle of the night and started moving, the string started tugging the mother's wrist. Deaf people have certainly been known for making innovative solutions to life's demands.

Events created by and of the Deaf around the world help to preserve the Deaf culture. One of the many international Deaf organizations is the Deaflympics. It is an event that is greatly enjoyed and supported by many Deaf people from all over the world. It is a time and place to showcase athletic abilities and, at the end of the day, everyone, no matter which country you hail from, will feel as if it was a family reunion; having the opportunity to meet new "cousins". The World Federation for the Deaf hosts conventions bi-annually. Its mission is to promote the human rights of Deaf people and equal access to all spheres of life, through self-determination, sign language, education, employment, and community life. Even after 150 years, the Deaf still aim to live up to the ideas created by Ferdinand Berthier by seeing the togetherness of "all the deaf spread across the globe... to put speaking and deaf men of intelligence and heart in rapport with each other, no matter the distance, no matter the difference in language, culture and laws," (Quartararo, 2002, p. 192).

References available upon request.



FSDB President, Tracie Snow, with Elementary students.

HAPPENINGS

ACMS

ACMS Fall Social & Vendor Show UF Professional Park -- October 19, 2022



Carl Dragstedt, DO, ACMS President with Guest Speaker:
William Hollifield, MD with UF Health Psychiatry



Mike Lukowski, MD and Byron Flagg, JD of
Gray-Robinson Attorneys.



L to R: Nickie Doria, Sales & Marketing Director with Oak
Hammock; speaking with Steven Reid, MD and Casey Jones, MD.



Judith Lightsey, MD and Lloyd Alford.



L to R: Scott Medley, MD; Norman Levy, MD;
Evelyn Jones, MD; and Judy Lukowski.



L to R: Community Hospice & Palliative Care
Representatives Wendy Crews; Audrey Williams;
and Charlene Stefanelli; with Patricia Hess, MD.

HAPPENINGS

ACMS

ACMS Fall Social & Vendor Show UF Professional Park -- October 19, 2022

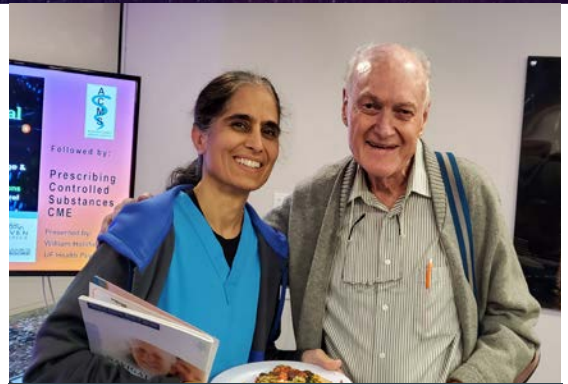


L to R: Kim Clawson; Karina Quinn; Karen Humphreys; Chris Drum; Jose Gibert; Tammy Lindsay; and Phoebe Howard (seated) all with our Host: UF Health.



L to R: Brittany Bruggeman, MD, ACMS Secretary/Treasurer; Carl Dragstedt, DO, ACMS President; Mary Aplin, MD; and Cynthia Cromer, MD.

Celebrating & Remembering Colleagues Haven Hospice - October 20, 2022



Jyoti Budania, MD and Forrest Clore, MD



Shirley Codada, MD, Chief Medical Officer and Pauline Taylor, RN, President; both of Haven Hospice.



L to R: Rudy Gertner, MD and Norman Levy, MD, PhD.

HAPPENINGS

ACMS

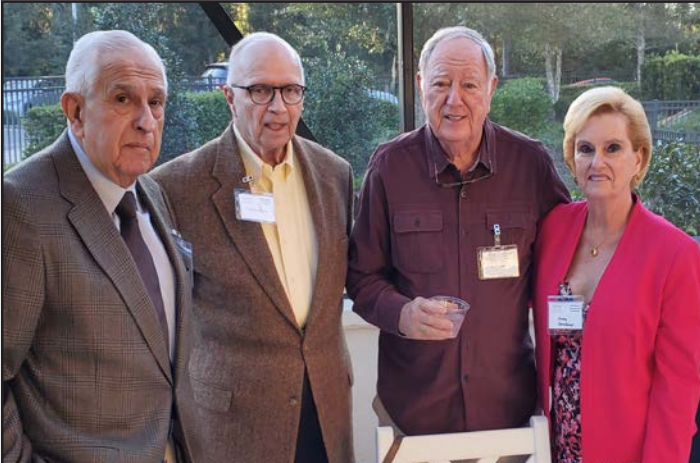


L to R: Scott Medley, MD; Joanne Young; and Tom Young, MD.

Celebrating & Remembering Colleagues Haven Hospice - October 20, 2022



Caroline Rains, MD and Doug Rains.



L to R: Jack Londono, MD; Perry Foote, MD; Mark Barrow, MD; and Nohra Londono.



Rogers Bartley, MD and Cherise Bartley.



Mike Lukowski, MD and Tom Zavelson, MD.



Norman Levy, MD, PhD, ACMS Past President; and Roslyn Levy, Alliance President.

HAPPENINGS

ACMS

**Celebrating 40 Years of the Robb House Museum
Honoring: W.C. Thomas, Sr., MD; and Florence Van Arnam
Robb House, Gainesville, Florida - November 5, 2022**



**Clark Thomas (Grandson of W.C. Thomas, Sr.) and
Brenda Thomas (daughter-in-law of W.C. Thomas, Sr.).**



L to R: Dow Van Arnam; Florence Van Arnam; Roger Van Arnam; Thi Nguyen; and Carla Van Arnam (back row).



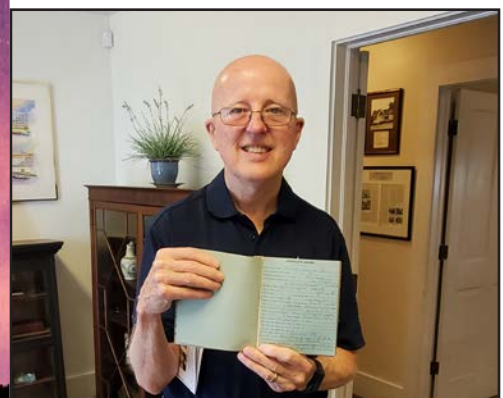
Mark Barrow, MD; and Scott Medley, MD.



**L to R: Judy Lukowski, Blanca Millsaps; and
Ellen Gershow, JD.**



**L to R: Marihelen Wheeler, Chair, Alachua County Commission;
Andrea Briscoe; Florence Van Arnam; and Dow Van Arnam on a
tour of the Robb House Medical Museum.**



**Robert Mounts, President of the Board of
the Matheson History Museum, finding
his original birth entry in the Alachua
General Hospital Birth Records.**

**Celebrating 40 Years of the Robb House Medical Museum
Honoring: W.C. Thomas, Sr., MD; and Florence Van Arnam
Robb House, Gainesville, Florida - November 5, 2022**



Marihelen Wheeler, Chair, Alachua County Commission; presenting Florence Van Arnam with a Lifetime Achievement Award for her contributions to the Community, the Robb House and the medical profession.



Portrait of W. C. Thomas, Sr., (1891 - 1972) displayed at the Robb House Medical Museum on loan from Mrs. Brenda Thomas and the Thomas Family.

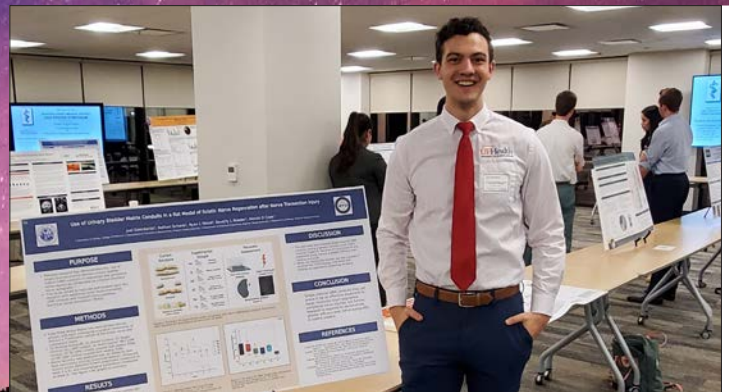
**ACMS 2022 Poster Symposium
UF Professional Park - December 1, 2022**



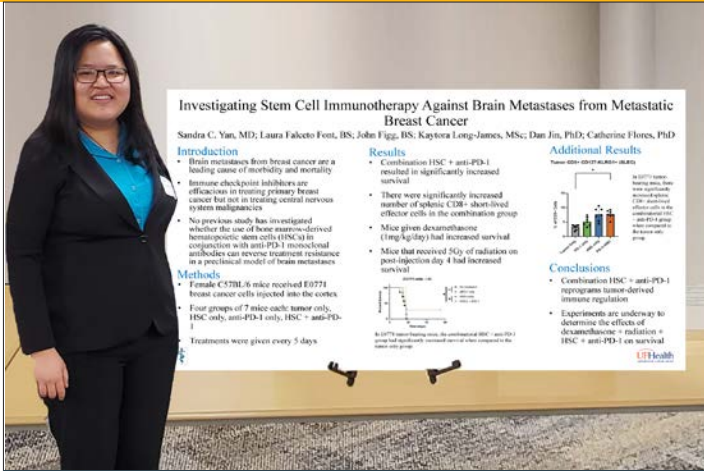
Participants, Judges and Hosts of the ACMS 2022 Poster Symposium. Thanks to all for making this a great event!



L to R: Joel Goeckeritz (1st Place); Brittany Bruggeman, MD, ACMS Secretary/Treasurer and Judge; Savanna Gorisiewicz (5th Place); Frederick Ashby (4th Place); Phoebe Jin (3rd Place); and Sandra Yan, MD (2nd Place). Congratulations to all!



1st Place Poster: Joel Goeckeritz, UF Medical Student. Poster title: "Use of Urinary Bladder Matrix Conduits in a Rat Model of Sciatic Nerve Regeneration After Nerve Transection Injury."



2nd Place Poster: Sandra Yan, MD, UF Neurosurgery Resident
Poster title: "Investigating Stem Cell Immunotherapy Against Brain Metastases from Metastatic Breast Cancer."



3rd Place Poster: Phoebe Jin, UF Medical Student
Poster title: "Fatal Venous Air Embolism in the Setting of Hemodialysis and Pulmonary Hypertension: A Point of Care Ultrasound Diagnosis."

Tap Room Thursday -
Daft Cow Brewery - December 1, 2022



L to R: Jay Peacock; Jyoti Budania, MD; and Carolyn Carter, MD.



Carl Dragstedt, DO, ACMS President; and Charles Riggs, MD, with his dog Josee.



L to R: Roslyn Levy; Norman Levy, MD; a UF Pediatric Resident; Charles Riggs, MD; Donna Boucher, MD; Carl Dragstedt, DO, ACMS President; , Maritza Rivera Montalvo, MD; Carolyn Carter, MD (in back); William Warrick, MD; Jackie Owens, ACMS EVP; and Consuela Pico-Soldevilla, MD.

HAPPENINGS

ACMS

Groundbreaking of the HCA Florida Gainesville Emergency and HCA Florida Gainesville Hospital and HCA Florida North Florida Hospital's 50th Anniversary Kick-off Celebration
Gainesville, Florida - February 23, 2023



Board Members, Administrators, Physicians and others at the HCA North Florida Groundbreaking.



Tammy Clark celebrating the 50th Anniversary of HCA North Florida Hospital.



Eric Lawson, CEO, HCA Florida North Florida Hospital and Scott Medley, MD.

Groundbreaking of the HCA Florida Gainesville Emergency and HCA Florida Gainesville Hospital and HCA Florida North Florida Hospital's 50th Anniversary Kick-off Celebration
Gainesville, Florida - February 23, 2023



L to R: Tom Young, MD; Rudy Gertner, MD; and Eric Godet, President and CEO, Greater Gainesville Area Chamber of Commerce.



Eric Lawson, CEO HCA Florida North Florida Hospital, addressing the group.



Steve Roark, MD, Chair of Board of Trustees at HCA Florida North Florida Hospital.



Christopher Bray, MD, GME Program Director, Internal Medicine and Sean Benoit, MD, Chief Medical Officer, HCA Florida North Florida Hospital.



Ann Weber, MD; and Scott Medley, MD; the first two Chief Medical Officers (CMO's) at HCA North Florida.



John Andrews, MD, one of the founders of HCA North Florida Hospital.

In Memoriam

Thomas J. Lau, MD

(1935 - 2023)

Thomas Joseph Lau, MD, died January 8, 2023 in Gainesville, Florida, following a long illness. Dr. Lau received his medical degree from Yale Medical School. Following graduation, he began a long career with the United States Department of Public Health, working with the Peace Corps. He had duty stations in Monrovia, Liberia, and Dar Es Salaam, Tanzania. He returned to Gainesville to serve a Residency in Pathology at the University of Florida, before going to Kuala Lumpur, Malaysia and then serving in Natal, Brazil aboard the hospital ship the USS Hope. He served as a professor of Pathology at the University of Connecticut and as a Pathologist at North Florida Regional Medical Center. Dr. Lau was on staff at Tacachale and the University of Florida Department of Student Health, retiring in 2021 at the age of 86.



Dr. Lau was a docent at the Harn Museum of Art, a member of the University Park Neighborhood Association and a member of the Yale Club of Gainesville. He served as a volunteer pianist in the Arts In Medicine Program at Shands Hospital and was an avid sailor.

He is survived by his wife of 61 years, Ellen Corey Lau; by two sons, David Matthew (Heidi) Lau, and Eric Corey (Jennifer) Lau, and by three grandchildren, Brett, Madeleine and Katherine. In lieu of flowers, donations may be sent to: Helping Hands Clinic in Gainesville, 2603 NW 13th Street # 306, Gainesville, FL 32609. His memorial page may be found at: www.williamsthomasfuneralhome.com.

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ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, September 6, 2022

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, September 6, 2022, virtually on Zoom.com.

We Care Report: Mr. Campo requested ACMS Board consideration of a pilot program for healthcare for women in the Alachua County area. An informal poll was taken showing Board approval of the program as presented.

Secretary's Report: Dr. Bruggeman welcomed New Members Angelina Bernier, MD; Martin Back, MD; Don Henry Esprit, MD; Mariam Hanna, MD; Eric Jeng, MD; Stefanie Lord, MD; and Carlos Sanchez, MD.

Treasurer's Report: At Dr. Bruggeman's request, Ms. Owens presented the financial report:

Alachua County Medical Society, Inc. – a 501(c)6: Membership dues, Publication Income and Activities Income have improved resulting in total income of \$108K in 2022 compared to \$58.5K in 2021. Total Expenses declined from the previous year, resulting in Net Income for the eight month period in 2022 of \$36.2K.

Alachua County Medical Society Foundation, Inc. - a 501(c)3: The Foundation disbursed \$49K in grants during

the eight months under review – going to an updated Patient Information System for the We Care Clinic and Salaries for We Care Clinic support staff. Grant Income was \$52.3K. Total Assets are \$96.4K, with \$0 liabilities.

President's Report: Dr. Dragstedt gave a summary of the FMA Meeting and requested that the EVP circulate the Final House of Delegates report on the 2022 Resolutions once it is completed. A request from Dr. Stechmiller to issue a letter addressing the deplorable treatment of Dr. Fauci was reviewed. The Board agreed that the EVP should circulate the letter to ACMS Members giving them the opportunity to sign the letter individually, if they so choose.

EVP Report: Ms. Owens discussed upcoming meetings and an in-person Vendor Show to be held on October 19th at the UF Professional Park, the November Meeting and the 2022 Poster Symposium to be held on December 1st. Proceeds from the Vendor Show will fund scholarships for the Poster Symposium.

Alachua County Medical Society - Board of Directors Meeting Minutes, October 4, 2022

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, October 4, 2022, virtually on Zoom.com.

Secretary's Report: Dr. Bruggeman discussed a meeting in Washington, D.C. as a representative for the American Diabetes Association. She met with several Senators and Representatives to discuss the costs of pharmaceutical drugs facing diabetic patients today and recommendations for the future.

Treasurer's Report: At Dr. Bruggeman's request, Ms. Owens presented the financial report:

Alachua County Medical Society, Inc. – a 501(c)6: Membership Dues Income has returned to pre-COVID levels totalling \$83.6K. Publication Income of \$22.4K, Activities Income of \$7.7K and Grant Administration Income of \$2.4K resulted in a Gross Profit \$116K for the 9 months reviewed. Event Expense of \$3K reflects the return of the Vendor Show in 2022 – the first since we suspended in-person activities in March of 2020. Publication, Payroll and Insurance Expenses declines somewhat, while Operations Expense increased due to Professional Fees and Utility Expense. Net Income for the 9 months was \$39K.

Alachua County Medical Society Foundation, Inc. - a 501(c)3: The ACMS Foundation received Grant Income of \$70.3K in 2022 with Grant Disbursements totalling \$53.3K, resulting in Net

Income of \$17K. Assets totaled \$156.6K, with zero Liabilities.

President's Report: Dr. Dragstedt discussed that the position of Gator Caucus Chair at the annual FMA meeting is available and inquired as to interest in pursuing the Chair. Dr. Bruggeman expressed interest and agreed to provide a letter and CV to be distributed to the members of the Gator Caucus to present her campaign. The EVP agreed to circulate the information to the County Execs for voting upon by the Gator Caucus members. Dr. Dragstedt has requested a summary of the FMA meeting outcomes and will present that information to the Board once it is compiled.

EVP Report: Ms. Owens announced that the 2022-23 Physicians Directory is now available in print and online at acms.net. Also coming up is the October Vendor Show on October 19th, featuring a presentation on "Prescribing Controlled Substances" and the ACMS Poster Symposium on December 1st. A 40th Year Celebration of the Robb House will be on November 5th to dedicate the portrait of W. C. Thomas, Sr., MD; to recognize Florence Van Arnam for 40 years of service as Docent and Curator of the medical museum; and to thank the contributors to the Robb House Raise the Roof fund. All members are invited to attend.



ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, November 8, 2022

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, November 8, 2022, virtually on Zoom.com.

Secretary's Report: Dr. Bruggeman presented the New Members for consideration: Ryan Chauffe, DO; Alexandra Otto, MD; and Erich Wyckoff, MD. Membership was motioned by Dr. Stechmiller, seconded by Dr. Riggs, and approved by the Board.

Treasurer's Report: At Dr. Bruggeman's request, Ms. Owens presented the financial report:

Alachua County Medical Society, Inc. – a 501(c)6:

2022 Membership Dues Income total \$84.4K. Dues and Publication Income of \$27K, Activities Income of \$9.7K and Grant Administration Income of \$2.4K resulted in a Gross Profit \$123.5K for the 10 months reviewed. Event Expense, Publication, Payroll and Insurance Expenses declined slightly, resulting in Net Income for the 10 months of \$35.9K.

Alachua County Medical Society Foundation, Inc. - a 501(c)3:

The ACMS Foundation received Grant Income of \$77.2K in 2022, with Grant Disbursements totaling \$54.6K, resulting in Net Income of \$21.4K. Assets totaled \$181.3K, with zero Liabilities.

President's Report: Dr. Dragstedt discussed the annual review of the EVP, conducted with Board Members prior to tonight's meeting. The EVP was commended for returning the ACMS to a profitable position again and restructuring activities to reflect the current needs of the membership.

Dr. Dragstedt inquired about the status of the Council of Deans and UF involvement. The Board recommended contacting Melissa Carter and Matt Crowley with the FMA to gather information on the Council of Deans contact person. The EVP agreed.

EVP Report: Ms. Owens reported on the Robb House 40 Year Celebration that took place on November 5th and the upcoming ACMS 5th Annual Poster Symposium, soliciting Judges for the event. Also noted was that the Fall issue of House Calls magazine is now available online for download. The Board recommended meeting topics for 2023 including the status of Covid and RSV this flu season, and an update on HIV and Covid outcomes.

Alachua County Medical Society - Board of Directors Meeting Minutes, January 10, 2023

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, January 10, 2023, virtually on Zoom.com.

Secretary's Report: Dr. Bruggeman presented a New Member for consideration: Youssef Wassef, MD. Membership was motioned by Dr. Stechmiller, seconded by Dr. Levy, and approved by the Board. A vacant Board Position was announced as Dr. Rizwana Fareeduddin has taken a position in Orlando, FL. Board members were asked to submit names of colleagues who might qualify for the position.

Treasurer's Report: At Dr. Bruggeman's request, Ms. Owens presented the financial report:

Alachua County Medical Society, Inc. – a 501(c)6:

2022 Membership Dues Income total \$84.4K. Dues and Publication Income of \$28.4K, and Activities Income of \$9.7K resulted in a Gross Profit \$122.5K for the 2022 fiscal year. Publication Expense increased slightly due to the 2023 Physicians Directory. After Payroll, Insurance and Operations Expenses, overall Net Income for 2022 was \$12.4K.

Alachua County Medical Society Foundation, Inc. - a 501(c)3:

The ACMS Foundation received total Grant Income of \$81.6K in 2022, with Grant Disbursements totaling \$58.3K, resulting in Net Income of \$22K. Assets totaled \$181.3K, with zero Liabilities.

President's Report: Dr. Dragstedt –

Old Business: 1) We Care does receive referrals from Equal Access Clinic, 2) Dr. Ryan is going to pursue the request for a meeting with UF for approval of 2024 Dues Reimbursement; 3) The ACMS plans to recommend a liaison to inquire about participation with the Council of Deans.

The Board discussed the upcoming meeting of the Florida Board of Medicine and the Florida Board of Osteopathic Medicine regarding proposed Rule 64B8-9.019 Standards of Practice for the Treatment of Gender Dysphoria in Minors. The Board consensus was to defend the existing ability of physicians to exercise professional judgment within the confines of national standard practice, while maintaining a science-based doctor-patient relationship. A letter of opposition will be submitted through the public comment portal by February 7th. Dr. Riggs mentioned that the District H Representative to the FMA Board of Governors is soon coming up for a vote. Those interested in the position were asked to contact the Executive Committee and/or Dr. Riggs to discuss further.

EVP Report: Ms. Owens discussed the 2023 Membership Drive and possible ACMS events.

Are you caring for someone with dementia?

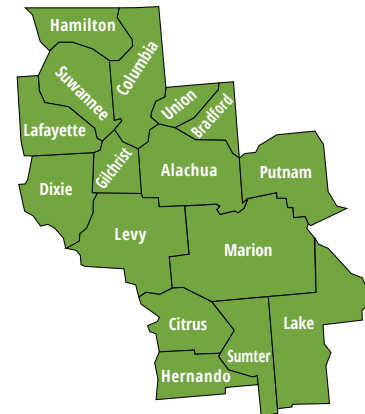


Savvy Caregiver Training is an educational program designed for caregivers who assist family members with Alzheimer's or any other form of dementia

Course Objectives

Participants will learn:

- Signs of dementia
- To recognize a person's losses and abilities
- Self-care strategies
- Effective ways to manage common behaviors
- How to connect with local resources



Classes offered throughout the year **online** and in various **locations** throughout our service area

For more information or to view our current class schedule, contact us or visit our website

agingresources.org/savvy-caregiver-training | savvy@agingresources.org

Elder Options hotline: 800-262-2243



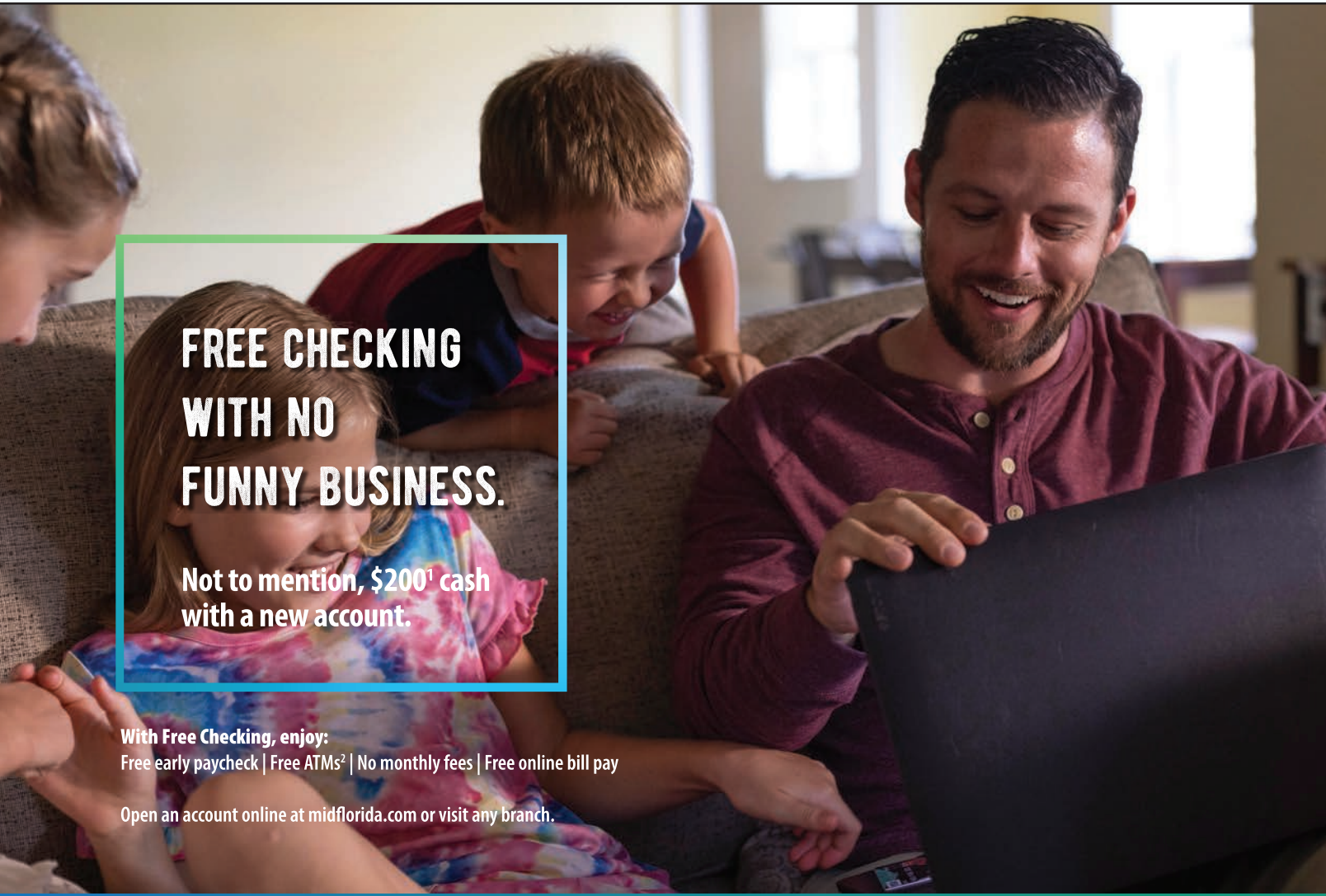
Savvy Caregiver is offered by Elder Options with support from the Florida Department of Elder Affairs

Alachua County Medical Society

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1. Offer valid as of August 30, 2021, and may be canceled at any time without notice. Eligibility requirements apply. See associate for details regarding fees and terms. To qualify for the \$200 incentive, you must open a new Free Checking account with direct deposit (\$500 cumulative which must post within 45 days of account opening), as well as accept and open online banking, online bill payment, eStatement, eNotice, and a debit card. No dividends are paid on Free Checking. Annual Percentage Yield is 0.00%. Anyone who has held a checking account with MIDFLORIDA in the past year will not qualify for the incentive. The incentive will be deposited to new Free Checking account after the qualifications have been met and will be reported to the IRS. Minimum to open Free Checking is \$50. 2. ATM transactions are free at any MIDFLORIDA proprietary ATM or when using a Publix Presto! ATM.