TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
Volume LX, No. 1
January 2003

The 78th Texas Legislative Session Convenes

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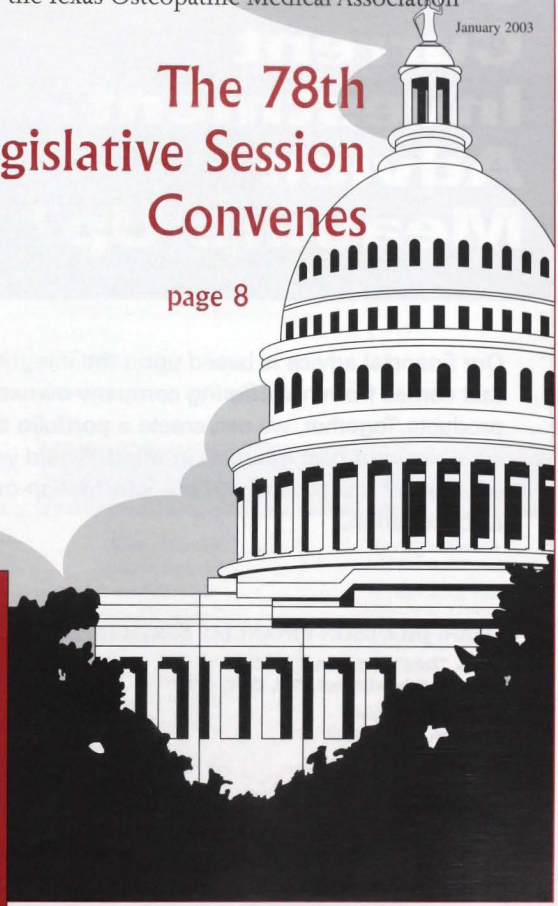

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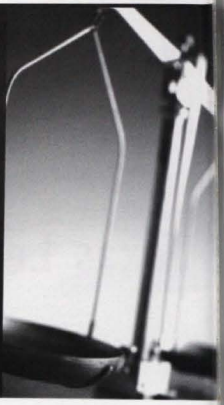
Does Your Current Investment Advice Measure Up?



Our financial advice is based upon the integrity and objectivity that comes from not offering company-owned investment products. Together, we can create a portfolio that you can be sure has your best interests in mind. Would you have it any other way? Call today for more information or to schedule a consultation.

DEAN, JACOBSON FINANCIAL SERVICES, LLC

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TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association

JANUARY 2003

Texas D.O. is the official publication of the Texas Osteopathic Medical Association.

Published eleven times a year, monthly except for July. Subscription price is $50 per year.

Texas D.O. does not hold itself responsible for statements made by any contributor. The advertising contained in this magazine is not necessarily endorsed by the Texas Osteopathic Medical Association.

Published by the Texas Osteopathic Medical Association, Volume LX, No. 1, January, ISSN 0275-1453.

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Copy and Advertising deadline is the 10th of the month preceding publication.

INSIDE THIS ISSUE

Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising" according to Texas Gov't Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the ***Texas D.O.*** is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

CALENDAR OF EVENTS

JANUARY 10

"A Day of Pain: Pain Management Update"

Sponsored by the University of North Texas Health Science Center/Fort Worth

Location: UNTHSC/Fort Worth
3500 Camp Bowie Blvd., Fort Worth, TX
CME: 8 hours category 1-A credits anticipated
Contact: UNTHSC/Fort Worth Office of Professional & Continuing Education
817-735-2539
www.hsc.unt.edu

FEBRUARY 7 – 9

"TOMA's 47th MidWinter Conference & Legislative Symposium"

Sponsored by the Texas Osteopathic Medical Association

Location: Omni Mandalay Hotel at Las Colinas
Irving, Texas
CME: 16.75 hours category 1-A credits anticipated
Contact: Sherry Dalton
800-444-8662
512-708-8662

FEBRUARY 21 – 23

"13th Annual Update in Clinical Medicine for Primary Care Clinicians"

Sponsored by the University of North Texas Health Science Center/Fort Worth

Location: Steamboat Grand Hotel, Steamboat Springs, CO
CME: 20+ hours category 1-A credits anticipated
Contact: UNTHSC/Fort Worth Office of Professional & Continuing Education
817-735-2539
www.hsc.unt.edu

MARCH 19 – 23

"ACOFP 40th annual Convention & Exhibition"

Sponsored by the American College of Osteopathic Family Physicians

Location: The Gaylord Opryland Resort & Convention Center, Nashville, TN
Contact: ACOFP
www.acofp.org

APRIL 11-12

"15th Annual Spring Update for Family Practitioners"

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Dallas Southwest Medical Center, Dallas, TX
CME: 13 hours category 1-A credits anticipated
Contact: UNTHSC Office of Professional & Continuing Education
817-735-2539 or 800-987-2CME
www.hsc.unt.edu

MAY 2

"TOMA Board of Trustees Meeting"

Location: Austin Renaissance Hotel
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662

MAY 3

"58th Annual Meeting of the TOMA House of Delegates"

Location: Austin Renaissance Hotel
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662

Wednesday, January 29, 2003
D.O.M.E. Day in the Texas Legislature
Visits Your Texas Representative and Senator Offices

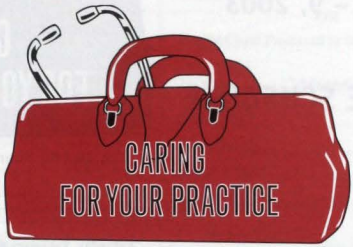
Organized by the ***Texas Osteopathic Medical Association***
to gain visibility for osteopathic medicine among Texas lawmakers and their staffs.

A unique opportunity for Texas osteopathic physicians to discuss ***Professional Liability Insurance*** reform and to see, first-hand, ***how the legislative process works***.

For Information about D.O.M.E. Day,
contact TOMA at 800-444-8662 • 512-708-8662

Don't Miss TOMA's

47th MidWinter Conference & Legislative Symposium



February 7 – 9

Omni Mandalay Hotel at Las Colinas
Irving, Texas

Patterned after the exotic charm of a tropically lush Burmese city, the Omni Mandalay Hotel at Las Colinas invites you to experience the elegance of a luxurious hotel with an Asian touch of distinction. Located in the prestigious Las Colinas Urban Center on the beautiful Mandalay Canal, this AAA, Four-Diamond hotel looks and feels like a luxury resort, yet provides the perfect environment and all the contemporary amenities for TOMA's MidWinter Conference activities.

Visit the hotel web site at <www.omnihotels.com>

See pages 6 and 7 for Conference Schedule and Early Registration Form.

TOMA's 47th MidWinter Conference & Legislative Symposium

February 7 – 9, 2003

CONFERENCE SCHEDULE

16.75 CME Hours Category 1-A Anticipated

Friday, February 7

5:00p.m. – 6:00p.m.	Welcome Reception with Exhibitors
6:00p.m. – 7:00p.m.	Daniel R. Rouch, D.O. "More Money-Less Work" Sponsored by Meditalk
7:00p.m. – 8:00p.m.	Rod Elliott-Mullens, D.O. "Sleep Apnea 2003"
8:00p.m. – 9:00p.m.	Conrad Speece, D.O. "OMT Workshop"

Saturday, February 8

7:30a.m. – 8:30a.m.	Breakfast with Exhibitors
8:30a.m. – 9:30a.m.	Jack Cohen, D.O. "Dermatitis/Eczema" Sponsored by Novartis
9:30a.m. – 10:30a.m.	Mark Olmstead, D.O. "One Airway: Coexistence of Allergic Rhinitis/Asthma & Implication for Treatment" Sponsored by GlaxoSmithKline
10:30a.m. – 11:00a.m.	Pharmaceutical Update Break in Exhibit Hall
11:00a.m. – Noon	Monte E. Troutman, D.O. "TAPA Update" Sponsored by AstraZeneca

Saturday, February 8 continued

Noon –1:30p.m.	Legislative Update Luncheon Invited Guest Speaker – Senator Kyle Janek, M.D. Sponsored by Texas Medical Liability Trust and GlaxoSmithKline
1:30p.m. – 3:30p.m.	Joe Gagen, J.D. – Legislative Grassroots Trainer – "Affective Communication with Legislators or *Why You Can't See What is Entirely Clear to Me*" Sponsored by Pfizer
3:30p.m. – 4:00p.m.	Pharmaceutical Update Break in Exhibit Hall
4:00p.m. – 5:00p.m.	Irvine Prather, D.O. "Pressures Ulcers and Common Lower Extremities Ulcers"
5:00p.m. – 6:00p.m.	Jeffrey Stone, D.O. "Hyperbaric Treatment of a Diabetic Foot"

Sunday, February 9

7:00a.m. – 8:30a.m.	Continental Breakfast
8:00a.m. – 12:15p.m.	Risk Management Program Sponsored by Dean, Jacobson Financial Services, LLC and Texas Medical Liability Trust

This course is designated by the Texas Osteopathic Medical Association for one (1) hour of education in medical ethics and/or professional responsibility.

47th MidWinter Conference & Legislative Symposium
EARLY REGISTRATION FORM

PLEASE PRINT CLEARLY or TYPE

Name:_____

Name for Badge (if different from above):_____

Address:_____

City:_____ State:_____ Zip:_____

Business Phone: (____) _____

Home Phone: (____) _____

FAX: (____) _____

Email:_____

Spouse/Guest Name (if requesting badge):_____

D.O. College:_____

Graduation Year:_____ AOA#:_____

Specialty:_____ TOMA District:_____

REGISTRATION FEES

	Postmarked by Jan. 17, 2003	Postmarked after Jan. 17, 2003
TOMA Member	$250 (includes one luncheon ticket)	$325 (includes one luncheon ticket)
Non-Member	$325 (includes one luncheon ticket)	$400 (includes one luncheon ticket)
Retired TOMA Member	$125 (includes one luncheon ticket)	

Please include _____ additional tickets for the Legislative Luncheon on Saturday, February 8, 2003 at $30 each.

REGISTRATION TOTALS

Registration Fee(s) $_____

Additional Luncheon Ticket(s) $_____

TOTAL $_____

REGISTRATION PAYMENT

Check enclosed in the amount of $_____

OR

Credit Card Payment in the amount of $_____

Check One:

☐ VISA ☐ MasterCard ☐ AmericanExpress

Credit Card#_____

Expiration Date_____

Name on Card:_____

Signature:_____

REFUND POLICY

- **Refund requests postmarked on or before January 17, 2003 will receive a refund less 25% administration fee.**
- **All refund requests MUST be made in writing.**
- **NO REFUND WILL BE GIVEN AFTER JANUARY 17, 2003.**

Return completed form, *with payment in full*, to:
TOMA
Attention: MidWinter 2003 Registration
1415 Lavaca Street
Austin, Texas 78701-1634

Fax *ONLY* if paying by credit card
512-708-1415

Hotel Information

TOMA's 47th MidWinter Conference & Legislative Symposium will be held at the Omni Mandalay Hotel at Las Colinas, 221 East Las Colinas Blvd, Irving, Texas (see page 5 for hotel description).

Please call the hotel directly to make reservations at 972-556-0800. **Reservations must be made no later than JANUARY 10, 2003** to receive the discounted group rate of $119 per night– single/double.

Be sure to ask for the "Texas Osteopathic Medical Association Conference Room Rate" to receive the discounted rate.

The 78th Texas Legislative Session Convenes

Texas legislators prepare for the opening session of the 78th Texas Legislature; something they have been working on since November 12, 2002, the first day to pre-file bills for the session. The legislature convenes on Tuesday, January 14.

Legislative Dates of Interest

January 14
78th Legislature convenes.

March 14
Deadline for filing bills and joint resolutions which are not local or have not been declared an emergency by the governor.

June 2
Final day of 78th Regular Session.

June 22
Last day governor can sign or veto bills.

September 1
Date that bills without specific effective dates become law.

What's on the Legislative Agenda?

Professional liability reform is expected to be one of the hottest issues this session. TOMA is actively working with the Texas Alliance for Patient Access, a broad-based coalition of health care providers, consumer groups, individual physicians and insurance carriers to support the following reforms: limitation on non-economic damages; collateral source rule; periodic payments on future damages; limitations on attorney contingency fees; procedural issues that address frequency of claims, costs of litigation; pre-judgment interest; charitable immunity; limitation on liability for prescribing of drug or device; and managed care liability.

In view of the above, physicians will have an excellent opportunity to discuss their concerns regarding the professional liability crisis with Texas lawmakers on January 29 during D.O.M.E. Day (D.O.s working for Medical Excellence) in the Texas Legislature. Organized by TOMA, this event is intended to gain visibility for osteopathic medicine among Texas legislators and their staffs. For more information, call TOMA at 512-708-8662 or 800-444-8662.

Other high priority issues for physicians in the upcoming Legislature will most likely be Medicaid, which faces rising enrollment, a projected budget shortfall, and all the problems this combination will create for both patients and physicians; the expansion of scope of practice by nonphysicians; and prompt pay and managed care. Physicians should recall that H. B. 1862, the much-heralded prompt pay bill, was vetoed in 2001 by Govornor Rick Perry.

As an added note of interest, on November 15, 2002, the Senate Committee on Health and Human Services submitted a report on assigned and considered interim studies entitled, "Report to the 78th Legislature." It is currently available at <www.senate.state.tx.us/75r/senate/commit/c610/Downloads/HHS_Report2002.pdf> and lists recommendations for consideration by the 78th Texas Legislature. The recommended issues are mental health, Supplemental Security Income, prescription painkillers, public health preparedness, organ donation and allocation, increasing childhood immunization rates, and restraint and seclusion. TOMA will be monitoring legislation of interest to the profession and will keep the membership informed of any action that may need to be taken on specific bills.

The following are various pre-filed bills of interest. For more detailed information, click on <www.capitol.state.tx.us>

HB 85 – Rep. Ruth J. McClendon - An undergraduate medical academy would be established at Prairie View A&M University to be under the control of The Texas A&M University System.

HB 126 – Rep. Lon Burnam - Relating to parity in certain disability insurance benefits. This bill would require parity in benefits for mental and physical disabilities.

HB 145 – Rep. Burt Solomons – Relating to workers' compensation dispute resolution. This legislation sets forth violations of TWCC decisions by individuals or insurance carriers.

HB 150 – Rep. Norma Chavez – Relating to the establishment of a geriatrics research academy at the Texas Tech University campus in El Paso. The Board of Regents of the Texas Tech University System would be authorized to establish the Texas Tech Geriatrics Education and Care Research Academy for purposes of researching issues related to: long term care; geriatrics; gerontology; and providing resources for training and research for professionals in medicine, nursing, pharmacy and allied health schools as well as training and research for persons in the care giver, advocacy and regulatory areas.

HB 224 – Rep. Todd Smith – Relating to deposition fees charged by certain physicians. A physician who is or previously has been the treating physician for a party in a civil action would be prohibited from charging a fee for each hour of that physician's deposition testimony related to the party's condition or treatment that exceeds 125 percent of the physician's usual hourly fee for a patient office visit. This would not apply to a physician providing expert testimony not relating to the condition or treatment of a current or former patient of the physician.

SB 12 – Sen. Jane Nelson – Relating to health care liability claims. This legislation would limit past and future pain and suffering awards to $250,000, while reducing the amount that attorneys can collect in contingency fees related to malpractice suits.

SB 38 – Sen. Judith Zaffirini - Relating to certain immunization programs. The Texas Department of Health (TDH) would be required to develop informational materials and physician education programs relating to immunizations and vaccines for chil-

"SB 42...The comptroller of public accounts would be directed to study the feasibility of implementing a universal vaccine purchase plan and other vaccine delivery alternatives in Texas."

dren's programs with the assistance of a work group, to include physicians and nurses. Such materials would address the administrative requirements of the program, including the requirements for vaccine storage, paperwork, and physician evaluation. Also addressed is enrollment simplification, whereby providers would be able to enroll in the TDH Vaccines for Children program on the same form used to apply as 1) a Medicaid health care provider; and (2) a children's health insurance program health care provider.

SB 39 – Sen. Judith Zaffirini – Relating to the immunization registry. This legislation would basically provide for a change in the state's immunization registry whereby a child's immunization information would automatically be included in the registry. Currently, parents make the decision whether to allow their child's information to be included. The bill also stipulates that a child's parent may opt out by way of written notification to the TDH.

SB 40 – Sen. Judith Zaffirini – Relating to an immunization education program established by the Texas Department of Health. A statewide coalition would be established to educate the public about the importance of children's immunizations.

SB 41 – Sen. Judith Zaffirini - Relating to health benefit plan coverage for immunizations. Health benefit plans would be required to provide coverage for immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

SB 42 – Sen. Judith Zaffirini - Relating to the study of the feasibility of a universal vaccine purchase plan. The comptroller of public accounts would be directed to study the feasibility of implementing a universal vaccine purchase plan and other vaccine delivery alternatives in Texas. Not later than October 1, 2004, the comptroller of public accounts would be required to submit a report detailing the study's findings to the lieutenant governor and the speaker of the house of representatives.

SB 43 – Sen. Judith Zaffirini - Relating to certain immunization programs. The Texas Department of Health would be directed to report to the legislature, no later than October 1, 2005, the results of the educating physicians in your community pilot program operated by the Texas Pediatric Society. The report would include: (1) an analysis of the program's effect on immunization rates; (2) a statement regarding the cost-effectiveness of the program; (3) recommendations for expanding the program; and (4) a list of possible sources to fund the program.

SB 56 – Sen. Judith Zaffirini – Relating to the creation of rural health centers. Regional health centers would be established in rural counties by the Office of Rural Health Affairs (ORCA), with the cooperation of the Texas Department of Health, Health and Human Services Commission, the statewide rural health care system and public health departments in rural counties. These agencies would then contract with health care professionals to provide health services to these rural health centers. ORCA is instructed to report to the legislature as to the efficacy of rural health centers and, not later than January 1, 2004, to choose three or four sites to serve as rural health centers.

SB 104 – Sen. Jane Nelson – Relating to the regulation and enforcement of the practice of medicine by the Texas State Board of Medical Examiners. The TSBME would be required to establish a physician education and assistance program, not later than January 1, 2004, to ensure that physicians have sufficient knowledge regarding current medical technology and other developments in the practice of medicine. The TSBME would also be charged with establishing a procedure to identify and provide assistance to physicians who may be at risk of committing medical errors or other acts of malpractice.

SB 116 – Sen. Leticia Van de Putte - Relating to health benefit plan coverage for certain mental disorders in children. Health benefit plans would be required to provide coverage for mental disorders under the same terms and conditions as coverage for physical illnesses.

SB 118 – Sen. Judith Zaffirini - Relating to establishing child fatality review teams. This legislation authorizes the commissioners' court of each county to appoint a child fatality review team for that county.

SB 144 – Sen. Kip Averitt - Relating to the requirement that certain information be provided to health care practitioners regarding the use and abuse of certain drugs. This legislation would amend the Occupations Code to require that at least once each biennium, the board would provide each license holder information on: (1) prescribing and dispensing pain medications, with particular emphasis on Schedule II and Schedule III controlled substances; (2) abusive and addictive behavior of certain persons who use prescription pain medications; and (3) common diversion strategies employed by certain persons who use prescription pain medications, including fraudulent prescription patterns. In addition, each license holder would be provided with information regarding the services provided by poison control centers.

Practice Management Vendor Directory to Assist with HIPAA Compliance

The AOA, in collaboration with more than a dozen medical specialty organizations, has created a web site designed exclusively to ascertain the HIPAA-readiness level of their practice management software (PMS) vendors.

A new resource is now available through the American Osteopathic Association (AOA) DO-Online members-only web site to assist practices develop a strategy to comply with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, better known as HIPAA. HIPAA mandated a set of electronic transactions and code sets standards to be used in the health care system. These include important business transactions commonly utilized in medical practices such as health care claims, remittance, patient eligibility verification, treatment and referral authorizations and certifications, claim status, and others. Although originally scheduled to go into effect October 16, 2002, President Bush signed a law extending that deadline one year. This resource offers contact names and numbers, transaction-specific information, and opportunities for vendors to list several products. Located at www.hipaa.org/pmsdirectory, this site allows vendors to self-report the HIPAA-readiness level of their products and if a third party has certified the product. Physicians and practice administrators can access this site free of charge to establish the readiness level of their own vendors or review the compliance status of potential new software.

Typically, many medical practices have been anticipating that their PMS vendors will be providing a "HIPAA-compliant" solution for them. In many cases this will be true. However, concern has been raised in the industry that many PMS vendors will be unable to offer medical practices the necessary solution for the following reasons:

- Some software vendors will be offering appropriate modifications, but not in time to meet the deadline;
- Some vendors have made a corporate decision not to offer a HIPAA compliant solution, but rather will be requiring their customers to go through a particular clearinghouse that they own, and incur per transaction fees; or
- Some vendors will not be offering any HIPAA-ready solution.

Medical practices are "covered entities" under HIPAA and must adopt these new standards if they fall into either of the following categories:

- Those practices that electronically exchange information related to any of the HIPAA transactions (i.e., you submit health care claims electronically, use a web site to check a patient's health plan eligibility); or
- Those practices that pay a third party (clearinghouse or billing service) to submit any of the HIPAA transactions electronically on their behalf.

The repercussions of any of these scenarios could have detrimental impact on the cash flow of a medical practice. Therefore it is important that physicians and their practice administrators act proactively to ensure that their organization will be in full compliance by October, 2003 and incur no disruption in cash flow or patient services. It is recommended that a contingency plan be developed that includes setting aside cash reserves, instituting a line of credit at a local bank, and establishing a relationship with a HIPAA-compliant clearinghouse permitting you to send paper or non-compliant electronic claims, at least for the short term, therefore ensuring continual cash flow.

It is also recommended that you adopt a proactive policy with your practice management software vendors and contact them as soon as possible in writing. The following are a series of questions that you should consider asking of your vendor:

- Will the version of your software product that I currently use be able to send to all payers a claim/encounter form in the HIPAA standard X12837 content and data format?
- Have your transactions been tested and certified by a third party as offering a "HIPAA-compliant" software modification?
- When will you be ready to upgrade my system (ask for a specific date)?
- Will the modifications require a new version of my PMS software?
- Will I require new hardware to support these modifications?
- When will you be sending me a schedule of testing that includes:
  - Internal testing
  - Testing with a clearinghouse (if applicable)
  - Testing with Medicare
  - Testing with commercial payers?

continued on next page

- Can I upgrade to the various standards incrementally (i.e., can my system generate HIPAA-compliant X12837 claims immediately, and then move to the other transactions standards at a later time)?
- Will my modified system accept the National Provider Identifier (NPI) number (expected to be a ten-digit numeric number)?
- Do you offer a product or service that will assist me in completing my "gap analysis" (moving my practice from the paper 1500 form to the 837 electronic will require additional data elements)?
- Will you be providing training for this modification?
- What are the expected costs?

It is recommended that you get all answers in writing. If your vendor is NOT offering an appropriate HIPAA solution, you should identify alternative products as quickly as possible in order to meet the October 16, 2003 deadline.

Information on State Preemption of HIPAA Privacy Rules

The federal HIPAA privacy regulation contains a provision requiring a state privacy regulation to preempt or override the federal regulation if the state requirement is stricter. As each state has its own very complicated privacy regulations, determining what is the state requirement has been very complicated.

The Georgetown University Health Privacy Project web site, www.healthprivacy.org, has summaries of all the state privacy regulations. These summaries focus on use and disclosure of health information gathered and shared while providing and paying for health care.

Additional information on the HIPAA Transaction Standards and Codes Sets requirements can be obtained through a manual offered free to AOA members in the HIPAA resource center on the DO-Online web site. You can also contact Janet Horan, JD, Director, AOA Division of Socioeconomic Affairs at 800-621-1773, ext. 8187, or by e-mail at jhoran@aoa-net.org.

TOMA Welcomes New Members

The Board of Trustees of the Texas Osteopathic Medical Association is pleased to introduce the following new members who were formally accepted at the December 7, 2002 Board meeting.

Eduardo Aguirre, D.O.
2701 S. Hampton Dr. #201
Dallas, Texas 75224
Dr. Aguirre is a first year member and a member of District 5. He graduated from the Texas College of Osteopathic Medicine in 1999, and is Board Certified in Family Practice.

John D. Capobianco, D.O., FAAO
6 Circle Way
Sea Cliff, New York 11579
Dr. Capobianco is a Non-Resident Associate Member. He graduated from the University of New England College of Osteopathic Medicine in 1989, and is Board Certified in Family Practice and Osteopathic Manipulative Medicine.

Earl R. Chase, D.O.
3101 Garrett Dr.
Perryton, Texas 79070
Dr. Chase is a member of District 1. He graduated from the College of Osteopathic Medicine of the Pacific in Pomona, California; and specializes in Emergency Medicine.

Joseph A. Cocco, D.O.
7100 Oakmont Blvd. #105
Fort Worth, Texas 76132
Dr. Cocco is a first year member and a member of District 2. He graduated from Michigan State University College of Osteopathic Medicine in 1997, and is Board Certified in General Surgery.

Daniel O. Cuscela, D.O.
1450 8th Ave.
Fort Worth, Texas 76104
Dr. Cuscela is a member of District 2. He graduated from the Philadelphia College of Osteopathic Medicine in 1988, and is Board Certified in Radiation Oncology.

Jennifer L. Devoke, D.O.
Mid Coast Medical Clinic
El Campo, Texas 77437
Dr. Devoke is a first year member and a member of District 9. She graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Family Practice.

Laurie G. Harris, D.O.
Crandall Family Clinic
P.O. Box 887
Crandall, Texas 75114
Dr. Harris is a member of District 3. She graduated from the Texas College of Osteopathic Medicine in 1984, and specializes in Family Practice.

Carlton J. Lewis, D.O.
10 Medical Center Blvd. #I
Lufkin, Texas 75904
Dr. Lewis is a member of District 3. He graduated from the Texas College of Osteopathic Medicine in 1994, and is Board Certified in Family Practice.

continued on next page

Kurt A. Moehring, D.O.
10 Riverside Dr.
Bay City, Texas 77414
Dr. Moehring is a member of District 9. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa; and is Board Certified in Family Practice.

Daniel K. Morris, D.O.
1627 N. Grand St.
Gainesville, Texas 76241
Dr. Morris is a first year member and a member of District 15. He graduated from Nova Southeastern University of Health Sciences-College of Osteopathic Medicine, Fort Lauderdale, Florida, in 1986; and is Board Certified in General, Vascular and Thoracic Surgery.

Patrick P. Nguyen, D.O.
143 Pleasant Dr.
Warren, PA 16365
Dr. Nguyen is a Non-Resident Associate Member. He graduated from the Texas College of Osteopathic Medicine in 1995, and specializes in Family Practice.

Johnny R. Paine, D.O.
513 Porter St.
Helena, AR 72342
Dr. Paine is a Non-Resident Associate Member. He graduated from The University of Health Sciences College of Osteopathic Medicine, St. Louis, MO; and is Board Certified in Family Practice.

Charles K. Roberts, D.O.
149 Hart St.
Sheppard AFB
Wichita Falls, Texas 76311
Dr. Roberts is an Associate Military Member. He graduated from the Texas College of Osteopathic Medicine in 1998, and specializes in Aerospace Medicine.

David W. Thetford, D.O.
206 East 16th St.
Dalhart, Texas 79022
Dr. Thetford is a first year member and a member of District 1. H graduated from Oklahoma State University/College of Osteopath Medicine in 1993, and is Board Certified in Family Practice.

New Intern & Resident Members

Joel R. Dow, D.O. graduated from the Texas College of Oste pathic Medicine in 1998, and is serving a Residency in Fami Medicine at Dallas Southwest Medical Center.

Raymond G. Duggan, D.O. graduated from the Texas Colleg of Osteopathic Medicine in 2002 and is serving an Internshi followed by a Residency in Internal Medicine at Scott & Whit Hospital in Temple.

Matthew J. Furman, D.O. graduated from The University o Health Sciences College of Osteopathic Medicine, Kansas City MO.; and is serving a Residency in Anesthesiology at th University of Texas Health Sciences Center in San Antonio.

Lien B. Lam, D.O. graduated from the Texas College of Osteo pathic Medicine in 2002, and is serving an Internship at th University of Arizona Health Science Center in Tucson.

Frank L. Loyd, D.O. graduated from the Texas College o Osteopathic Medicine in 2002, and is serving an Internship a Plaza Medical Center in Fort Worth.

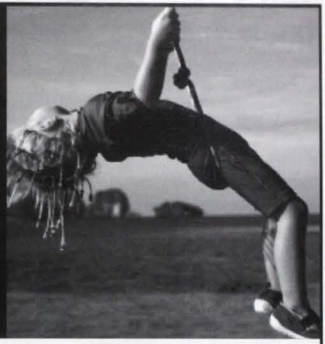
Andrew S. McAdoo, D.O. graduated from the Texas College o Osteopathic Medicine in 2002, and is serving an Internship followe by a Residency in Radiology at Tulsa Regional Medical Center.

Fang Wang, D.O. graduated from the Texas College of Osteo pathic Medicine in 2001 and is serving a Residency in Interna Medicine at Plaza Medical Center in Fort Worth.

CMS Publishes Final Rule On Outpatient Prospective Payment System

On November 1, 2002, the Centers for Medicare & Medicaid Services (CMS) published its final rule regarding Medicare's outpatient hospital prospective payment system. The rule, effective January 1, 2003, increases payment rates to hospital outpatient departments by 3.7 percent in 2003. Payments to rural hospitals will increase 6.2 percent in 2003, while payments to urban hospitals will increase 3.1 percent. The final rule did not include a pro-rata reduction in pass-through payments for new technologies such as drugs and medical devices, as CMS does not project that pass-through spending in 2003 will exceed the established payment cap. Other aspects of the final rule include a reduction in payment for many medical devices and device-related services, a lowering of both the outlier threshold and the outlier reimbursement rate, and an amendment to Medicare regulations that would permit partial and not complete suspension for failure of a hospital to comply with cost report filing requirements. The complete rule is available at <http://www.cms.hhs.gov>.
(Vinson & Elkins Health Headlines, 11-11-02)

I remember when she was just a baby



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Self's Tips & Tidings

By Don Sel

When to Send Patient Statements

In the fee and code analysis we do for practices, we see a wide variation on when practices collect from the patient to when they send out statements to when they turn an account to collection. There is not one "correct" way to do it for all offices, as every office is different. There are some basic recommendations we make and there are also a lot of myths about billing as well. Here are a few myths about billing rules or regulations:

"You can't collect a co-pay from a Medicare patient at the time of service." This is untrue and incorrect. You should collect the patient's co-pay and/or deductible at the time of service.

"You have to wait until the patient is leaving to get their insurance co-pay." Again, untrue. I recommend that in the case of managed care or private insurance plans, where you know the standard co-pay ($15 or $25 or whatever), you collect it PRIOR to the patient being seen by the provider. If the patient doesn't have it, explain that the doc is running a little late, which gives them time to run down the street to an ATM while you hold their time slot for them.

"You can't turn an account to a collection service if they are paying anything on the bill." Another myth. You can turn an account to a collection service if they are paying any amount. On top of that, you can even take them to small claims court and you'll win a judgment on the case, even if they're paying you monthly payments. The base fact is that they owe you money they haven't paid you yet. It's no more complicated than that.

"You can't turn an account to collection until you've given them a written notice of your intent to do so." Where do people come up with these things? If a patient walks out your door and says they don't intend to pay you, we recommend you have that account turned to your collection service before the patient has a chance to drive all the way home. There is no law or regulation that says you have to send a past due reminder.

Remember, you're running a business. Yes, it is a medical business, but still a business. It's necessary that you and your employees treat it like a business.

HIPAA Privacy Policy

I was recently in an office where the staff has been telling the physicians how important it is for them to get started on HIPAA privacy issues, yet the staff felt the physicians were not taking it seriously. I understood why the staff felt that way. When I was pointing out a few things that would definitely cause major problems from the practice, I felt like my information was going in one ear and out the other.

HIPAA is real. HIPAA is NOT going away. There will be examples made and those examples may be fines exceeding $100,000 for an office or possibly even jail time for the providers. You would find it ludicrous for a patient to ignore chest pains, radiating pain in the arm or jaw and dismiss it as nothing. I find it equally ridiculous for practices to ignore HIPAA. Let's discuss "Privacy and Policy" and how to set up a policy in your office, which you need to get started on immediately.

When to Start the Privacy Policy

You need to start working on your privacy policy today. If you wait until February or March, you will not have time to have it done along with the actual implementation of the policy and the other steps that will have to be taken prior to April 14, 2003. Remember, the one year extension you applied for on the electronic transactions has nothing to do with the Privacy Provisions that must be in place by April.

Protected Health Information (PHI) (Consists of 19 main elements)

- Name
- Address
- Telephone Number
- Social Security Number
- E-mail address
- URL (Web site information)
- IP Address (special number assigned to personal computer)
- Dates
- Medical Record Number
- Health Insurance Information including policy number
- Internal account number
- Certificate Number
- License Number
- Vehicle Identifiers
- Facial Photos
- Device Identifiers
- Biometric Identifiers
- Geographic Units
- Any other unique identifier or codes

HIPAA requires that all PHI be accessible to patients and inaccessible to non-covered entities. The doctor's office must keep a log of when, why, and to whom this PHI was disclosed. The patient has a right to receive an accounting of all disclosures made during the six years prior to the date of his/her request.

HIPAA also requires the doctor's office to post a statement detailing the practice's policies and procedures regarding PHI. When any changes are made to the existing policies and procedures, the changes must be promptly documented and implemented. This statement MUST include:

- Fee for obtaining records
- Fee for obtaining disclosure log (if requested more than once during a 12 month period, otherwise the first copy of the log is free)
- A clause to allow changes to policies and procedures that can affect PHI previously created or obtained

- A statement reserving the right to make such changes in privacy practices that are deemed necessary (this decision is made by the primary care giver and Privacy Officer)
- Instructions on how a patient can access his or her records (e.g., must receive request in writing, must allow 14 days, etc.)

Privacy Officer

HIPAA mandates that each doctor's office designate a Privacy Officer for development and implementation of policies and procedures. A Contact Person must also be designated for receiving complaints and providing additional information about matters covered in the privacy notice. These designations MUST be documented along with sanctions for those who fail to comply with the policies and procedures implemented.

So, who will be the Privacy Officer in your business? It could be the office manager, the physician, a nurse or any other staff member that you choose. This does carry certain obligations and responsibilities, so this needs to be a job that someone volunteers for, rather than just being assigned the function and title.

HIPAA obligates all practices to train their existing workforce on policies and procedures regarding PHI by the implementation date as well as provide training to any new hires that occur after the implementation date. All training MUST be documented. That training and documentation is the responsibility of the Privacy Officer.

HIPAA regulations state that safeguards to protect PHI from intentional or unintentional use or disclosure must be documented. This is a very time consuming process to develop the disclosure policy which must be accessible to auditors should your office be audited. In most offices, plan on taking at least 3 to 4 weeks in the determination and formulation of necessary documents – prior to April 14. Remember, this must be completed by then, not started by April 14th.

Complaint Process

The Complaint Process deals with complaints filed by patients in your practice, not your physician complaining about HIPAA and it's burden on the practice. The Complaint Process MUST be documented and include the following elements:

- All complaints received must be documented including date, time, complaint and disposition of complaint
- Sanctions applied
- Any harmful effects that are known to have occurred as a result of the failure to comply must be mitigated

Anyone associated with the complaint process must refrain from intimidating or retaliatory acts against individuals who file a complaint, testify, assist, or participate in an investigation, or oppose any unlawful act.

Patient Consent

All patients MUST sign a consent that contains:

- A description of the information to be disclosed and the purpose for each disclosure (in specific and meaningful language)
- Name or specific identification of persons or class of persons authorized to make requested use or disclosure
- Name or specific identification of persons or class of persons to whom the covered entity may make the requested use or disclosure
- Expiration date or expiration event that relates to the individual or the purpose of the use or disclosure
- Statement of the individual's right to revoke the authorization in writing and exceptions to the right to revoke, together with a description of how the individual may revoke the authorization
- Statement of the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule
- Signature and date
- Description of representative's authority to act for an individual

The ONLY time you do not have to obtain consent is:

- Indirect treatment relationships
- Patient is an inmate
- Emergency situation (but you must obtain consent as soon as possible thereafter)
- Communication barrier (but consent must be inferred)

If consent is not obtained for one of the above reasons, you must document why consent was not obtained. This consent may be included with other authorizations (such as assignment of benefits) but it MUST be organizationally separate from any other authorizations and separately signed and dated. The patient MUST get a copy of this consent.

So get started today on assigning a Privacy Officer and developing a Privacy Program to safeguard PHI in your practice. More information about HIPAA will be coming to you in upcoming issues of the *Texas D.O.*

New Associate Joins Don Self & Associates

I am proud to say that Nick, our oldest son, has joined us in the business as an associate and may be calling on you in the near future. Please do not hesitate to call on Nick Self if he may be of any assistance. We have also added on another 14 consultants around the nation to help service physicians and we will be introducing them in the near future.

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Call for Award Nominations

The TOMA Board of Trustees is currently accepting nominations for four awards.

Distinguished Service Award

Meritorious Service Award

Outstanding Community Service Award

Public Service Award

These awards represent the highest honor that TOMA can bestow in recognition of outstanding service and contributions to the osteopathic profession in Texas.

The Nomination Process

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available by contacting Lucy Gibbs at the TOMA office, 800-444-8662. Include pertinent biographical data about the individual as well as information about the person's accomplishments that makes his or her deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. **The nomination form should then be sent to Terry Boucher, TOMA Executive Director, no later than March 15, 2003**, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

Upon receipt of the nomination form, the TOMA Awards and Scholarship Committee will conduct a discreet but thorough investigation as to the accuracy of the information. After careful review, the committee chairman may nominate a candidate, if recommended by the committee, presenting necessary information to the Board of Trustees. An affirmative vote by three-fourths of the members of the Board of Trustees will be required to grant any award.

Award recipients will be notified by the Board of Trustees and will be requested to attend TOMA's annual convention, at which time the award will be presented by the TOMA President or Master of Ceremonies during the President's Banquet on Saturday night, June 21st.

Please note that not more than one of each award will be granted in any one year, except for the Public Service Award. Additionally, these awards are not necessarily annual awards.

The Distinguished Service Award is presented to an osteopathic physician in recognition of outstanding accomplishments in scientific, professional, osteopathic education, or service to the osteopathic profession in Texas or at the national level. The candidate must be a member of the Texas Osteopathic Medical Association; a longtime member of their district society and a member of the American Osteopathic Association. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Meritorious Service Award is presented to an individual in recognition of outstanding accomplishments in scientific, philanthropic, or other fields of public service to the osteopathic profession in Texas. The candidate does not have to be an osteopathic physician.

The Outstanding Community Service Award is presented to an osteopathic physician in recognition of outstanding service to his or her community through the promotion of and dedication to osteopathic medicine in his or her practice. The candidate must be a member in good standing of the Texas Osteopathic Medical Association, have provided excellent service to their local, regional, or state community, exceptional care to his or her patients, and demonstrated a commitment to the principles and philosophy of osteopathic medicine. The candidate should exemplify what the profession perceives to be the "typical" osteopathic physician who cares for patients and is an unsung, local hero. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Public Service Award, TOMA's newest award, may be presented to a maximum of two governmental officials whose works and accomplishments are outstanding in promoting the health care needs of the state of Texas, while recognizing the unique value of the osteopathic philosophy.

The SHEL Model: Applying Aviation Human Factors to Medical Error

by Bascom K. Bradshaw, D.O.

"In human factors, the SHEL model provides a blueprint for individuals or organizations to discover where errors or potential for errors might enter into a system."

Medical error and patient safety have become a major public concern since the publication of the Institute of Medicine (IOM) report "To Err Is Human."[1] An estimated 44,000 to 98,000 deaths due to medical error occur each year, according to studies quoted by the IOM report. Although some feel the report overestimates the mortality due to medical error,[2] few will deny that the medical profession has lagged behind other major industries in addressing error prevention. As a result of the IOM report on error, the Center for Patient Safety has been developed within the Agency for Health Care Policy and Research (AHCPR) to direct initiatives for safety improvements throughout the industry. As part of its research agenda, the task force on investigating methods to reduce medical errors is analyzing safety methods and education programs currently used in non-healthcare fields, such as aviation.

Lessons from Aviation Safety

The field of aviation is recognized as an industry that has made tremendous gains in reducing accidents while its systems have grown increasingly complex. Between 1967 and 1976, the risk of dying in a domestic jet flight was 1 in 2 million departures. This rate improved to 1 in 8 million by the 1990s.[3] In 1998, US airline carrier and commuters flew 615 million passengers without a single fatality. Research done by the National Aeronautics and Space Administration estimates that 70-80% of all aviation accidents are due to human error.[4] With the remarkable decline in aircraft accidents secondary to mechanical failures, human error has become a primary target for reducing aviation mishaps. The aviation industry employs many rigorous safety programs and incident reporting systems to facilitate their goal of "zero" accidents. Although the safety system of the aviation industry is not perfect, it has adapted over time to place greater attention on evaluating its approaches for reducing errors and their consequences.

One area of a typical aviation safety program that is beginning to receive more attention in medicine is "human factors." Human factors can be defined as the technology concerned with optimizing the relationships between people and their activities by the systematic application of the human sciences, integrated within the framework of system engineering.[5] Although there are still many complex cultural and conceptual frameworks that must be understood before applying aviation safety concepts to the medical environment, these concepts can still be applied on a basic level to one's everyday clinical situations. The purpose of this article is to outline the clinical application of a model commonly used in aviation called the SHEL model.[5]

The SHEL Model

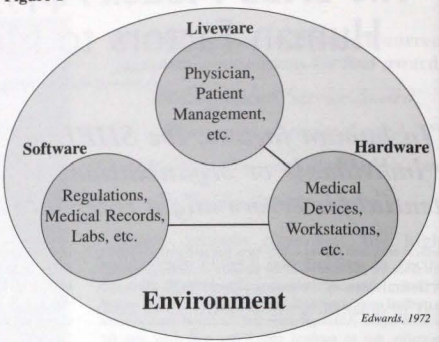
We often ask, "Why does every action, or lack of action, I take in patient care seem to have a 'domino effect' in the patient's overall health?" Why can we often trace the events that lead up to a poor patient outcome to something we did, or did not do? Often, these events do not involve direct patient contact. These are the questions that we often deal with in "morbidity and mortality" conferences. In human factors, the SHEL model provides a blueprint for individuals or organizations to discover where errors or potential for errors might enter into a system. This model will be used to help determine where potential for error exists throughout a patient's hospital stay or during an outpatient visit.

The SHEL model illustrates the interrelationship of three types of resources and their environment (E). These three resources include: software (S), hardware (H), and liveware (L). All of these resources are continuously interacting within the context of their environment. Software includes all of the regulations, standard operating procedures (SOPs), and policies that we follow. Clinical pathways, "standard of care" treatments, and lab readouts are also elements that can be thought of as software. Hardware is the medical device, instrument, diagnostic equipment, or computer system that is used to deliver healthcare. Liveware consists of the physician, the patient, and staff that interact throughout the patient care process. Lastly, all of these elements interact within the context of the medical environment, which may be the hospital or clinic setting. Physical/physiological, economic, political, and social factors are all part of one's working environment.[5]

No arrangement of these resources exists by itself. All factors that are out of our control are often regarded as being environmental for the simplicity of distinguishing what can be influenced by organizational efforts.[5] Current policies directed at reducing medical error are directed at some aspect of the following interrelationships seen in the SHEL model. If there is a

breakdown in one of the elements in a particular resource, a negative impact can often be seen in other areas affecting patient care. The following provides a few examples of these interrelationships in the context of the medical environment as illustrated in Figure 1. Lines joining the system resources can be thought of as interfaces in which energy and information interchange.[5] The boundary of these interfaces is where many of the problems that we see in our clinical environment occur. It is certainly true that mismatches at the interfaces of the system, rather than single catastrophic events, typify the circumstances leading to an adverse event.

Figure 1 The SHEL Model



The liveware-hardware (L-H) interface is one of the key targets in reducing medical error. Medical devices are expected to perform with high reliability in a wide range of operational settings. This can involve the monotonous setting of a third shift, or the high-pace of performing a code. In either case, devices are expected to provide data that can direct medical decisions or facilitate communication between various specialists. The Food and Drug Administration's Center for Devices and Radiological Health has instituted measures to ensure that human factors analysis and testing is included early in the development of new medical devices.[6] The result of this process will be development of medical devices that have intuitive operation and low reliance on manuals; easy-to-read displays; easy-to-use controls; positive and safe connections; effective alarms; and easy repair and maintenance. On the human side, initial and recurrent training are performed to ensure that individuals understand how to use equipment. The FDA focus group addresses the issue of the narrow limits in which humans can be re-trained to satisfy the limits of machinery. Initial acceptance of human limitations in the design process will prove to be the most fruitful for anticipating preventable errors that may occur during medical device operation. From the patient's perspective, medical devices are being developed to provide more effective therapy by improving patient compliance and ease of use in the in-patient and outpatient settings.

The liveware-software (L-S) interface is probably the most controversial and best known of the system interfaces currently being analyzed. In order to achieve safe and efficient patient care, software must not be in conflict with human, or, liveware, characteristics. It is unwise for regulatory agencies to develop rules with which conformity cannot be attained or which impose undue difficulty. Despite this, the medical profession is beginning to understand the evidence from peer-reviewed studies on the physiological/psychological effects of sleep deprivation and the potential economic and personnel implications that will result from new policies.[7] This interface is an area of concern for adopting new policies on patient safety education and incident reporting. Further detail is beyond the scope of this article but much cultural (medical) and organizational resistance is expected before the benefits of these countermeasures are to be seen.[8] Other aspects of L-S interface occur with the generation and reading of patient data. Do we currently have methods in place that provide swift, error-free retrieval of data? Is patient medical information optimally indexed in records using well-designed physician or nursing notes? With regards to the patient, liveware-software interface can be thought of as the instructions that we give our patients. Are our explanations and instructions clearly conveyed to the patient? For instance, size and shape of printed characters on patient handouts or instructions have to be considered when caring for geriatric patients. Literacy is often an issue with indigent care. Much more improvement can be made in the L-S interface by employing the use of checklists, hand-held devices, or by using electronic medical records. All of these advances will have significant economic impact on healthcare institutions but information design and regulatory reform will continue to play a crucial role in effective functioning of the L-S interface.

The environment (E) encompasses all factors that are outside of an organization's and individual's control.[5] Within the liveware-environment (L-E) interface, healthcare providers must consider a wide range of variables that have an impact on patients. Healthcare providers also must consider how the environment influences their ability to provide quality care. The environment of the healthcare setting can be thought of as the physical/physiological, economic, political, and social factors that are present. The L-E interface can be broadly thought of as a matter of how the provider or patient can be protected from discomfort or harm. Countermeasures for these environmental threats are adequate amounts of sleep, nutrition, and outlets for addressing social and psychological concerns. Although the patient is of obvious concern, many are starting to

address the well-being of physicians and residents and the impact of occupational stresses outside of work.[9] Many additional aspects of the environment will interact with the system resources S, H, and L because of the political, economic and cultural constraints that exist within medicine. As healthcare institutions becoming more concerned with "cost containment," physicians are continuously juggling resources to provide quality care while ensuring that the organization remains competitive in providing its services. This is evident by the rise in hospital staff shortages and increased patient volume seen in many hospitals. Increased utilization of "prn" personnel adds additional disturbances to the L-E interface that have to be accommodated. Other factors included in the environment are cultural and organizational attitudes that exist in the medical profession. Many healthcare providers and institutions are still unwilling to accept that humans have limitations and errors in patient care are inevitable.

Liveware-liveware interface will not be discussed but is currently an area of research that is being pursued by experts from many fields. Patient simulator centers are quickly sprouting at many academic institutions to understand how medical personnel communicate and perform within their environment.[10] For further reading in this particular area, the University of Texas Human Factors Research Project is a good source of literature.[WWW-1] One key issue that should be kept in mind when addressing the human factors issue of a system is differentiating between "cause" and "blame." Cause is part of an error chain, or sequence of events, that lead to an adverse event or accident if the chain is not interrupted. Blame is a litigation issue and basically establishes, "Who is responsible and going to pay for this!" In order to learn from our mistakes, these two concepts should be put in perspective.

Conclusion

The goal of this article is to examine the dynamics of human interaction, performance, and functions by applying a human factors model as a template. A hospital or institution must strive to identify errors, minimize those errors and make them reversible, or at least reduce the consequence. These objectives can be accomplished by understanding the interrelationships that exist within the clinical environment and by understanding the multiple factors that are involved with reducing preventable error. The evolution of providing safe, quality patient care will take much effort and much research before we can understand how to effectively apply methods from other industries. Finally, we will have to overcome our own cultural barriers and well-rooted beliefs as medical professionals before we can move forward.

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Dr. Bradshaw is a PGY-2 U.S. Army Aerospace Medicine resident, and is currently in his Master's of Public Health year at UTMB-Galveston. He is also working on a Master's of Aeronautical Science/Human Factors in Aviation Systems through Embry-Riddle Aeronautical University.

High-Income Americans Going Without Health Insurance

Premiums Rise at Their Fastest Rate in 10 Years

While the working poor make up the biggest chunk of the 41.2 million Americans who lack insurance, 811,000 people with household incomes above $75,000 joined the ranks of the uninsured in 2001, bringing that group's total to 6.6 million. Hardest hit in higher income groups are those who run their own businesses, early retirees or consultants, who must buy coverage in the individual market where policies are more expensive and harder to get.
(USA Today, 11-22-02)

Bulimia Nervosa
Can You Diagnose It?

by
S/D Nancy Kragt, S/D Jeanette Valdivieso,
K. L. Rainville, D.O., and Charles Mathis, M.D.

S/D Nancy Kragt

S/D Jeanette Valdivieso

Bulimia nervosa is a serious psychological illness with physical, social and psychological consequences for sufferers and their families. The diagnosis and treatment of bulimia nervosa is often done by psychiatrists. However, the roles of primary care physicians and gynecologists are crucial to the early detection and treatment of the disorder. Bulimia nervosa is difficult to recognize and diagnose because it is often not as obvious to the primary care physicians as some of the other eating disorders, such as anorexia nervosa. Therefore, it is imperative that physicians recognize the prevalence of bulimia nervosa and its consequences. Equally important are the signs and symptoms of the disorder and the treatment options available.

Bulimia nervosa is characterized by recurrent binge eating accompanied by the use of an inappropriate mechanism to counteract the effect of the calories that are consumed during a binge. As classified by the DSM-IV, the cycle of binging and counteracting usually occurs at least twice weekly for a minimum of three months. There are two types of bulimia nervosa: purging and non-purging types. Individuals who engage in purging behavior counter binge eating with self-induced vomiting, laxatives, or diuretics. Individuals who engage in non-purging type behavior counter binge eating with fasting or over-exercise.[7] Further characteristics of this disorder include the individual experiencing a lack of control over eating massive quantities of food while oftentimes maintaining a normal to above normal body weight.

Statistics indicate that 90% of bulimia nervosa patients are female, greater than 95% are Caucasian, and greater than 75% are adolescents when they first develop the disorder.[6] The peak age of onset is between the ages of 13 and 20 years. Approximately 3% to 10% of adolescent and college age women in the United States currently have bulimia nervosa, yet only 5% of women who see family physicians are diagnosed with bulimia nervosa.[5,7,10] Clearly this implies a significant percentage of untreated young women slipping through the cracks.

Most patients with bulimia nervosa are from middle class to upper middle class socioeconomic status; however, the disorder has no boundaries and patients can be of any sex, race, age, or socioeconomic status. Studies indicate that female athletes are at an increased risk of developing eating disorders than the general population. More specifically, the sports associated with this increased risk include gymnastics, long distance running, and figure skating.[7,9]

Medical complications of the disorder usually are not as severe as other eating disorders, but can be life threatening nonetheless. The frequency and severity of the consequence depend on many factors such as the nature of the purging. Those who purge by laxatives and self induced vomiting are more likely to suffer a serious medical complication when compared to those who purge through excessive exercise and fasting.[1,7] Laxative abuse may lead to a metabolic acidosis secondary to the loss of bicarbonate in the stool. The most severe consequence of bulimia nervosa is potassium depletion caused by recurrent purging. Hypokalemia adversely affects cardiovascular function, especially if combined with a low weight individual. Consequences of bulimia nervosa seen in those who purge via self-induced vomiting include: metabolic alkalosis, erosion of enamel, caries, and periodontal disease.[1] Bulimia has also been associated with impaired satiety, decreased resting metabolic rate, and abnormal neuroendocrine regulation. Recent studies suggest that the decreased serum Leptin seen in bulimia nervosa patients may contribute to diminished satiety responses and therefore increasingly larger binge meals.[4]

Clinical research also indicates a number of co-morbid associations seen in conjunction with bulimia nervosa, further strengthening the importance of recognizing and diagnosing the disorder promptly. Among the co-morbid conditions associated with the disorder, major depressive disorder and substance abuse are most prevalent.[1] Clearly the consequences of bulimia nervosa affect the patient physically, mentally, and emotionally which is why it is crucial for primary care physicians to be able to recognize and treat the disorder. Walsh, Wheat, and Freund report "two questions which have been shown to be very sensitive when used in the primary care setting for the detection of bulimia nervosa are 'Do you ever eat in secret?' and 'How satisfied are you with your eating habits?'."[10] These questions could easily be included in a general history during a routine office visit.

The most common physical exam signs to look for in the evaluation of a patient suspected of bulimia nervosa are as follows: [3,6,9,10]

- Bilateral parotid gland hypertrophy.
- Erosion of teeth enamel, periodontal disease, and extensive dental caries due to self-induced vomiting.
- Russell's sign: callosities, scarring, and abrasions on the knuckles and dorsum of the hand secondary to repeated self-induced vomiting.
- Hoarseness, sore throat, or heartburn due to repeated contact of the esophagus and pharynx by gastric acids.

A complete physical exam should include vital signs, evaluation of height and weight relative to age, and assessment of hair loss, lanugo, abdominal tenderness, acrocyanosis, jaundice, edema, parotid gland tenderness or enlargement, and scars on the dorsum of the hand. Routine laboratory tests in patients suspected of bulimia nervosa include a complete blood count with differential, serum chemistry and thyroid profiles, and urine chemistry microscopy testing. A chest radiograph and an electrocardiogram may also be indicated depending on the results of the physical exam.[6] All patients suspected of self-induced vomiting should also be referred for a complete dental examination.

Treatment should begin with the assessment of weight loss or control thus giving the physician an opportunity to emphasize the importance of maintaining a healthy weight. Setting a goal weight early in treatment along with a limit on weight loss is of utmost importance. A patient who is unable or unwilling to identify a target weight or who chooses an excessively low weight should receive close follow up.[3]

Psychiatric evaluation and therapy is an essential component in the treatment of a patient diagnosed with bulimia nervosa. In fact, few other disorders require the extent of interplay between psychiatry and medicine. Current research indicates that cognitive behavioral therapy CBT is the most effective psychiatric approach in treating bulimia nervosa. CBT not only addresses eating habits and weight control behaviors, but it also confronts underlying deficits in self-esteem thought to contribute to an over-evaluation of weight and body shape and a preoccupation with becoming thin. Treatment typically lasts from weeks to several months. CBT has been shown to reduce the frequency of binge eating and purging by approximately 75%. Complete cessation of binging and purging, however, occurs in less than 50% of patients.[3,7]

A variety of pharmacologic interventions have been studied for the treatment of bulimia nervosa. To date, fluoxetine is the only medication approved by the Food and Drug Administration for the treatment of bulimia nervosa. In a recent multicenter study comparing 20mg and 60mg dosages of fluoxetine with placebo, the 20mg dose resulted in a 45% reduction in binge eating compared with a 33% reduction with placebo. The 60mg per day dose demonstrated a 67% reduction in binge eating. The reasons for the effectiveness of SSRI's are unknown. Various placebo-controlled studies have also been conducted looking at the effectiveness of tricyclic antidepressants, monoamine oxidase inhibitors, bupropion, naltrexone, odansetron, and lithium. Several studies found that the tricyclic antidepressants, desipramine and imipramine, reduced binge eating by 47% to 91% and vomiting by 45% to 78%. Desipramine therapy has also been shown to produce lasting improvement even after the medication was withdrawn. The other agents were either found to have no improvement in binge eating over placebo or the side effect profiles discourage their use.[6,11]

In comparing the various treatment regimens, CBT has been found to be superior to medication alone. It remains unclear as to whether combination CBT and medication is more effective than either CBT or medication alone. Hospitalization may be required for the patient with severe electrolyte imbalances or cardiac dysrhythmias such as T wave inversion and prominent U waves due to hypokalemia. Even with early treatment, the clinician should expect treatment to last from 6 months up to two years or more.

In summary, the primary care physician is in a unique position to both identify and manage treatment for patients with bulimia nervosa. Although identification of these patients can be difficult, the prevalence of the disorder among adolescent and young adult women warrants a high index of suspicion on the part of the clinician. Open and consistent communication with these patients with a focus on health rather than dysfunction will help facilitate the multidisciplinary approach needed for treatment.

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Texas ACOFP Update

by Joseph Montgomery-Davis, D.O.

D.O.M.E. Day in Austin

On November 5, 2002, a ray of sunshine finally appeared at the end of the liability tunnel. State and national election results presented the Texas osteopathic medical profession with a welcome opportunity to move forward on medical liability reform. We must "strike while the iron is hot" and not waste this golden opportunity to assure that patient access to quality health-care in Texas is maintained.

As you may know, Osteopathic Medicine Day with the Texas Legislature (D.O.M.E. Day) is scheduled for Wednesday, January 29th. It is designed to gain visibility for osteopathic medicine by having Texas osteopathic physicians discuss professional liability insurance reform with Texas lawmakers and their staffs.

TxACOFP is 100% supportive of D.O.M.E. Day in the Texas Legislature and asks their members to call the TOMA executive office at 800-444-TOMA or 512-708-8662 for more information about this unique event in our state's capitol.

And speaking of the upcoming legislative session, the TxACOFP Board of governors met at the TOMA building in Austin on October 26, 2002. One action of interest was the decision to have a lobbyist to assist the TOMA Executive Director, Terry Boucher, in the upcoming Texas legislative session starting in January 2003. It will be a joint legislative effort on the part of TOMA and the Texas ACOFP to promote and protect the professional interests of Texas osteopathic physicians.

National ACOFP Delegates from Texas

The current list of TxACOFP members signed up as delegates to the National ACOFP House of Delegates, to be held March 19-23 in conjunction with the ACOFP 40th Annual Convention & Exhibition at the Opryland Hotel in Nashville, Tennessee, are as follows:

Ronda Beene, D.O.
Tony Hedges, D.O.
Robert S. Stark, D.O.
Harold Lewis, D.O.
Richard C. Erickson, D.O.
Jamie D. Inman, D.O.
Bruce Maniet, D.O.
David Hill, D.O.
David Garza, D.O.
Donald Peterson, D.O.
Neil Berry, D.O.
Patrick Hanford, D.O.
Nelda Cunniff-Isenberg, D.O.
James E. Froelich, III, D.O.
Robert L. Peters, Jr., D.O.
Wayne Rogers, D.O.
John Bowling, D.O.
Robert C. DeLuca, D.O.
Steve L. Yount, D.O.

We need 5 more TxACOFP delegates for 2003. TxACOFP members who are also National ACOFP members in good standing and would like to serve as a delegate to the National ACOFP House of Delegates, should contact Jerry Smola, President of the TxACOFP, at 915-235-1727 or FAX 915-235-3525.

The ACOFP Congress of Delegates meets in Nashville, Tennessee, on Thursday, March 20, 2003, from 3:30 to 5:30 p.m. and on Saturday, March 22, from 2:00 to 4:00 p.m.

Dr. Smola's appointments for TxACOFP committees for 2002-2003 are listed below:

Awards: Ronda Beene, D.O., chair; Rodney Wiseman, D.O.; Robert DeLuca, D.O.; T. R. Sharp, D.O.

Government Relations: David Garza, D.O., chair; Pat Hanford, D.O.; Robert DeLuca, D.O.; Robert Stark, D.O.; Tony Hedges, D.O.; Harold Lewis, D.O.; Steve Yount, D.O.

Long Range Planning: Robert DeLuca, D.O., chair; Harold Lewis, D.O., Richard Erickson, D.O.; Donald Peterson, D.O.; Rodney Wiseman, D.O.; Robert Stark, D.O.; John Bowling, D.O.; Pat Hanford, D.O.; T. R. Sharp, D.O.

Membership: Robert Stark, D.O., chair; R. Greg Maul, D.O.; Royce Keilers, D.O.; Robert DeLuca, D.O.; Jamie Inman, D.O.; Donald Peterson, D.O.; David Hill, D.O.; Sara Apsley-Ambriz, D.O.

Nominations: Jerry Smola, D.O., chair; Ronda Beene, D.O.; Harold Lewis, D.O.

Program: Tony Hedges, D.O., chair; Ronda Beene, D.O.; Jamie Inman, D.O.; Rodney Wiseman, D.O.; Robert DeLuca, D.O.

Student Relations and Intern and Resident Committee: Tony Hedges, D.O., chair; Richard Erickson, D.O.; Jamie Inman, D.O., Bruce Maniet, D.O., Samuel Coleridge, D.O.

Bylaws: Joe Montgomery-Davis, D.O., chair; Rodney Wiseman, D.O.; David Garza, D.O.; T. R. Sharp, D.O.; Robert DeLuca, D.O.

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Congratulations

Congratulations are in order for T. R. Sharp, D.O., the President Emeritus of the TxACOFP, who was awarded the highest honor that can be given by the AOA, the Distinguished Service Award, on October 8, 2002, at the AOA Convention in Las Vegas, Nevada. He is a mentor to so many of us and a class act.

FYI

Dues for the year 2003 will be handled through the National ACOFP. We pride ourselves on representing Texas osteopathic family physicians and welcome your continued support and comments at anytime.

Remember, we must hold our elected officials' feet to the fire and make sure their pre-election promises become post-election deeds. Texas osteopathic physicians must always remember that we are our patients' health care advocate, and that we need their support to bring about lasting medical liability reform that will result in patient access to affordable and quality health care.

Wishing all a healthy and happy 2003.

HHS Announces Medicare Premium and Deductible Rates for 2003

On October 18, 2002, the Department of Health and Human Services (HHS) announced the Medicare premium, deductible and coinsurance amounts to be paid by Medicare beneficiaries in 2003.

For Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the deductible paid by the beneficiary will be $840 in 2003, up 3.5 percent from 2002's $812 deductible. The monthly premium paid by beneficiaries enrolled in Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items, will be $58.70, an increase of 8.7 percent over the $54.00 premium for 2002.

Medicare law requires that the deductibles and premiums be updated annually in accordance with statutory formulas. The law sets the premium at the amount needed to cover 25 percent of estimated program costs for aged enrollees. General revenue tax dollars cover the other 75 percent of the costs. All Medicare beneficiaries enrolled in Part B pay the monthly premium. The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. Those who enroll in private Medicare+Choice plans may not be affected by the Part A increase, and may receive additional benefits with different cost-sharing arrangements.

Most of Medicare's 40.4 million beneficiaries are enrolled in the optional Part B, which helps pay for physician services, hospital outpatient care, durable medical equipment and other services, including some home health care. Nearly 90 percent also have some form of supplemental coverage to help reduce out-of-pocket medical costs.

The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care. However, for extended Medicare-covered hospital stays, beneficiaries must pay an additional $210 per day for days 61 through 90 in 2003, and $420 per day for hospital stays beyond the 90th day in a benefit period. For 2002, per day payment for days 61 through 90 was $203, and $406 for beyond 90 days. For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 will be $105 in 2003, compared to $101.50 in 2002.

Most Medicare beneficiaries do not pay a premium for Part A service. Seniors and persons under age 65 with disabilities may obtain Part A coverage even though they have fewer than 30 quarters of Medicare-covered employment, by paying a monthly premium set according to a formula in the Medicare statute at $316 for 2003, a reduction of $3 from 2002. To be eligible for voluntary enrollment in Part A based on disability, the person must have lost disability benefits solely because earnings exceeded a certain amount.

Information concerning the Social Security cost of living increase for 2003 has also been released and can be found at <www.SSA.gov>.

Who's in the News?

NOM Week Proclamation

Laura Miller, mayor of the city of Dallas, proclaimed October 6 - 12, 2002, National Osteopathic Medicine (NOM) Week. Kenneth Bayles, D.O., a TOMA board member whose orthopedic practice is in Dallas, accepted the proclamation on behalf of TOMA and the AOA.

William R. Jenkins, D.O., FACOS – Recipient of 2002 Distinguished Osteopathic Surgeon Award

Dr. William R. Jenkins of Fort Worth was honored during the 2002 Ceremonial Conclave of the American College of Osteopathic Surgeons as recipient of its Distinguished Osteopathic Surgeon Award.

A 1951 graduate of the Kirksville College of Osteopathic Medicine, Dr. Jenkins began a surgical practice in Fort Worth in 1964, recently retiring from active practice. He was instrumental in the growth and development of the University of North Texas Health Science Center, and is currently professor emeritus of its department of surgery.

Dr. Jenkins served at the Osteopathic Medical Center of Texas as director of medical education, chair of the surgery department, chief of medical staff, and as general surgery residency program director. He is also active in the Texas Osteopathic Medical Association, and served as TOMA president from 1982-83. Special honors include the TCOM Founder's Medical, OMCT Medical Staff Award, and the TOMA Distinguished Service Award.

Robert DeLuca, D.O., and Daniel Saylak, D.O., Receive Fellow Designations

The American College of Osteopathic Family Physicians announced that on October 10, 2002, Robert C. DeLuca, D.O., FACOFP, and Daniel W. Saylak, D.O., FACOFP, received Fellow designations. The awards were announced during the ACOFP's Annual Conclave of Fellows Award Banquet at the American Osteopathic Association Convention and Scientific Seminar in Las Vegas, Nevada.

The honorary designation of Fellow is bestowed upon those candidates who have contributed outstanding national and local service through teaching, authorship, research, or professional leadership. They have also contributed outstanding service in their professional career and family practice duties in their community and civic activities.

A 1984 graduate of the Texas College of Osteopathic Medicine, Dr. DeLuca operates his own practice in Eastland and is an Associate Professor of Family Medicine at the University of North Texas Health Science Center at Fort Worth.

Dr. Saylak is a 1983 graduate of the Texas College of Osteopathic Medicine. Currently, he serves as medical director of the Department of Emergency Medicine at College Station Medical Center.

Benjamin L. Cohen, D.O., Receives Alumnus of the Year Award from the University of Health Science Alumni Association

Dr. Benjamin L. Cohen was honored with the Alumnus of the Year Award from the University of Health Science Alumni Association at its annual Homecoming Banquet on September 13, 2002, in Kansas City, Missouri.

The award is presented to a graduate who has attained exemplary achievements in his or her chosen field, and who has distinguished himself or herself in contributing to the osteopathic medical profession.

A 1960 graduate of the UHS-COM, Dr. Cohen pursued training in pediatrics and practiced in Columbus, Ohio. He later accepted a clinical faculty position at Ohio State University while continuing to serve as senior attending physician at Columbus Children's Hospital.

Dr. Cohen is the founding dean of the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine. In 1990, he became vice president for academic affairs and dean of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine, where he was instrumental in transforming the campus into a health sciences center with a graduate school of biomedical science to train scientists working toward their doctoral degrees. In 2002, Dr. Cohen retired to Boynton Beach, Florida.

T.R. Sharp, D.O., Receives American Osteopathic Association's Highest Honor

Dr. T.R. Sharp of Mesquite was awarded the American Osteopathic Association's highest honor, the Distinguished Service

Certificate, during its 107th Annual Convention & Scientific Seminar held in October in Las Vegas.

Whether on the local, state or national level, Dr. Sharp is known as a tireless advocate for the osteopathic profession. A family physician throughout his career of 58 years, Dr. Sharp has practiced in Mesquite since 1960.

On the state level, he has been active in the Texas ACOFP, as a past president, secretary-treasurer and program chair. A longtime member of TOMA, he served as program chair and TOMA representative to the Family Practice Residency Advisory Committee to the Coordinating Board of Texas Colleges and Universities. He was also active in the fledgling Texas College of Osteopathic Medicine and served as chair and clinical professor of the Department of General and Family Practice.

Nationally, Dr. Sharp has served as president of the American College of Osteopathic Family Physicians, and is a founding member of the American Osteopathic Board of Family Physicians.

In 2002, Dr. Sharp was the recipient of the TOMA Distinguished Service Award, the highest honor that TOMA can bestow upon an osteopathic physician in recognition of outstanding service and contributions to the osteopathic profession in Texas.

Pamela Adams Elected Secretary of the Auxiliary to the American Osteopathic Association

Mrs. Pamela Adams of Fort Worth was installed as secretary of the Auxiliary to the American Osteopathic Association (AAOA) on October 9, 2002, at the Las Vegas Hilton. Her first meeting as the new secretary will take place in February, 2003, in Fort Lauderdale, Florida.

A registered nurse, Mrs. Adams currently works at the Osteopathic Medical Center of Texas in Fort Worth as a Marketing Coordinator. She is also the current president of the Auxiliary to the Texas Osteopathic Medical Association (ATOMA) and the Student Associate Auxiliary Advisor (SAA) for ATOMA.

Partnership Declares Health Improvement Priority Goals for Texas

The Texas State Strategic Health Partnership, a group of public and private organizations convened by the Texas Board of Health and Texas Commissioner of Health Eduardo Sanchez, has identified a series of priority goals to improve the health of Texans and issued a "Declaration of Health" committing partnership agencies to "share responsibility and accountability for creating a healthier Texas."

Priority health improvement goals announced by the group include addressing healthy eating and physical activity, tobacco use, risky sexual behavior, substance abuse and violence, mental health, high school graduation rates, adult literacy, environmental and consumer hazards, and timely immunizations for children and adults.

The partnership also called for making essential public health improvement and protective services available for all Texans, building public-private partnerships, ensuring a capable public health system workforce, establishing a flexible funding system to support state and local public health structure, and improving data collection and disease reporting.

Representatives of the 17 member organizations on the partnership's steering committee signed the declaration in a ceremony in Austin in early December, 2002. The goal setting is the latest in a series of steps to produce and implement a strategic health improvement plan for the state. The plan will be published in late January, 2003.

In August, 2002, the Texas Department of Health (TDH) released "The Health of Texans" report, which presented illness rates and trends in Texas and statistics about illness-related behavioral risks.

In September, 2002, TDH issued a second report, a "Public Health Improvement Plan," which describes the public health system in Texas.

In October, 2002, the partnership was convened to identify priority goals to improve the health of Texans and to improve the state's public health system.

More information, including the text of the declaration and goals, the health status and public health system reports and how to participate in the partnership, is available online at <www.tdh.state.tx.us/dpa/sshp.htm>.

In Memoriam

Nancy Charlene Woodruff

Mrs. Nancy Charlene Woodruff of Port Arthur passed away October 20, 2002. She was 58. Services were held at Presbyterian Church of the Covenant in Port Arthur.

Mrs. Woodruff was a native of Glendale, California, and had lived in Port Arthur since 1991. She was the office manager for her husband, Dr. James J. Woodruff, in Port Arthur. Other survivors include two sons, James J. Woodruff, II, of Houston, and Robert Arnold Woodruff, III, of Oak Harbor, Washington.

Memorial contributions may be made to Kirksville College of Osteopathic Medicine, Alumni General Fund, Kirksville, Missouri, 63501-1497.

Howard Harris Krantman

Howard Harris Krantman of San Antonio passed away November 2, 2002. He was 55. Services were held at Porter Loring Chapel, San Antonio, with interment in Agudas Achim Memorial Gardens on Austin Highway.

Mr. Krantman continues to hold State Track and Field records at Deering High School in Portland, Maine. He was an avid golfer and an active member of Congregation Agudas Achim, especially the Men's club. He was also a member of the Barshop Jewish Community Center.

Survivors include his wife, Teresa Boyd Krantman, D.O.; daughter, Kayla Fay Krantman of San Antonio; sister, Joni Cohen and husband, David. Memorial contributions may be made to a charity of choice.

You are invited to leave a message or memory in the guest book at www.porterloring.com by selecting the Sign and View Family Guestbook icon.

William Harley Clark, Jr., D.O.

William Harley Clark, Jr., D.O., of Fort Worth passed away on November 21, 2002. He was 77. Services were held November 25 at Greenwood Chapel in Fort Worth.

Dr. Clark served in the 97th Infantry Division, Army Artillery, during World War II and was involved in combat in the European Theater of Operations and in the occupation of Japa at Nagano and Matsumoto.

Dr. Clark graduated from Baylor University in Waco in 195 and worked for the U. S. Department of Labor and the Civ Service Commission before entering medical school. He earne his D.O. degree in 1958 from Kansas City College of Osteopath Medicine and interned at Fort Worth Osteopathic Hospital.

He entered into the private practice of family medicine i Whitehouse from 1959 to 1981. Dr. Clark relocated to Fo Worth in 1981, and joined the faculty in the Family Practic Department at Texas college of Osteopathic Medicine. He was professor and director of affiliated family practice clinics fro 1981 until his retirement in January of 1996.

Dr. Clark was one of four physicians responsible for the co struction of Doctors Memorial Hospital in Tyler in 1963. H chartered the First National Bank of Whitehouse in 1965.

He was a member of the American Osteopathic Associatio the American Medical Association and a life member of th Texas Osteopathic Medical Association. Other membership included the American Legion, member of the Masonic Lodg since 1962, member of the York Rite Masonic Bodies since 195 and a member of Green Acres Baptist Church in Tyler.

Survivors include two daughters, Helen Clark of Scottsdal Arizona, and Elizabeth McCurdy; son-in-law, Dr. Mat McCurdy; granddaughter, Catherine McCurdy.

Randall Allen Cary, D.O.

Dr. Randall A. Cary of Spring passed away September 2002. He was 50. Services were held September 7 at Klei Funeral Home-Champion Forest, with interment at Klei Memorial Park, Klein, Texas.

A 1978 graduate of the Texas College of Osteopath Medicine, Dr. Cary was certified in Family Practice. He was o staff at Houston NW Medical Center, and practiced at the Oak Medical Center in Spring. He was active in local, state an national medical associations.

Survivors include his wife, Christine; father, James Cary an his wife, Linda; mother, Anita Cary; sister, Susan Cary; niece Christina and Aubry Cary; and nephew James Cary.

Study Underway on Anthrax Shots and Side Effects

by Karen Fleming-Michael
Special to the American Forces Press Service

A study to decrease the required number of anthrax shots and its accompanied side effects is being conducted at the Walter Reed Army Institute of Research (WRAIR) in Maryland.

"We want to use our stores of vaccine wisely and we want to immunize people effectively and minimize side effects," said Col. Janine Babcock, principal investigator for the study. The study's goals are twofold.

The first is proving the anthrax vaccine, manufactured by BioPort Corp in Lansing, Mich., is still effective when subjects are given fewer doses than the normal regimen of six shots delivered at one, two and four weeks and then at six, 12 and 18 months, with annual boosters.

"The (current vaccination) schedule is extremely cumbersome," Babcock said. "It is expensive to implement, and it is very difficult to support from a vaccine production and logistical point of view."

Decreasing the number of doses will also increase patient acceptance, she said. "If you have your choice between six shots and three, we'd all pick three."

The second goal is to change the way the shots are given, which should reduce the side effects of redness, tenderness, swelling and discomfort sometimes associated with the vaccine. Currently, the shot is given subcutaneously.

Serious reactions remain statistically rare. However, of the 2,120,594 doses given to 528,015 service members, 11 people reacted severely enough to result in hospitalizations that were "certainly or probably caused" by the vaccine, according to a May, 2002, Anthrax Vaccine Expert Committee report.

By the mid-1970s, most vaccines were given by intramuscular injections because they produce fewer side effects and they are easier to administer. The anthrax vaccine, which was developed in the 1950s and 1960s and licensed in 1970, remained a subcutaneous injection because only a few hundred people, mostly veterinarians, received it each year, and no one approached the Food and Drug Administration about changing it.

"When we now vaccinate hundreds of thousands of people, we want to use it as well as we can," said Col. Alan Magill, deputy division director for Communicable Diseases and Immunology and also a study associate investigator.

The study hopes to show that intramuscular shots are the best way to deliver the vaccine, which will make it more tolerable for service members who must receive it.

The clinical study is based on preliminary results Dr. Phil Pittman found in a study conducted at the U.S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, Md., from 1996 to 1998.

"In his study (of 173 subjects), the people who got the fewer doses intramuscularly had levels of antibodies that were not inferior (to the subcutaneous injections) and the reactions were much fewer," Babcock said.

The study, funded by Congress, has three parts: Part A is a human study, Part B is a primate study and Part C is a basic science study.

TRICARE News and Related Military Information

WRAIR is participating in Part A, which involves testing the change from subcutaneous to intramuscular injection and decreasing the number of doses. Part B will test the changed regimens against an aerosol challenge in primates to show whether they are protected from getting anthrax.

Part C will go a long way in helping develop new generations of the anthrax vaccine. Researchers will examine blood samples from people and primates taken at the same times, such as before a dose and after a dose, to find the key things in the immune system that predict protection.

The study will last for 43 months. Of the five centers in the United States hosting the trials—Baylor College of Medicine in Houston, Texas; Emory University in Atlanta, Ga.; University of Alabama at Birmingham; and the Mayo Clinic in Minnesota — WRAIR is the only military site.

Three hundred of the study's 1,560 subjects will participate at WRAIR. None will be active-duty military because service members need to receive the shots under the current FDA license.

U.S. Postal Service to Give Workers Potassium Iodide Pills

The U.S. Postal Service is purchasing nearly 1.6 million potassium iodide pills for distribution to all 750,000 postal workers nationwide as a proactive measure. The pills will help protect against thyroid cancer in the event of a radiological emergency. Two tablets will be given to any employee who wants to have the pills in case of an emergency, much like free flu shots that were offered in the wake of anthrax scares after the Sept. 11 attacks.
(Associated Press, 12-2-02)

HEALTH NOTES

Doctors Not Following Guidelines Recommending Flu and Pneumonia Vaccinations for Hospitalized Adults

According to an analysis of medical records for 107,311 Medicare patients nationwide who were hospitalized during 1998 and 1999, more than 95 percent of patients aged 65 and older who were not already vaccinated were not immunized against either disease during their hospital stays. Only about 50 percent of adults 65 and older have received the pneumococcal vaccine and only 65 percent get annual flu shots, while the government's Advisory Committee on Immunization Practices recommends that both vaccines be administered to adults during hospitalizations in order to boost vaccination rates.
(Archives of Internal Medicine, 11-11-02; Associated Press, 11-10-02)

Government Issues Updated Guidelines On High Blood Pressure

Exercise and Diet Often Enough to Prevent Hypertension

The guidelines also say recent research has cast doubt on the benefit of some products promoted as blood-pressure reducers, such as calcium supplements and fish-oil supplements, which the guidelines say show only modest effects. The guidelines are geared toward the general population, especially people with high normal blood pressure, measuring from 130 over 85, up to 139 over 89.
(Associated Press, 11-16-02)

FDA Approves Childbirth Infection Test

Hospitals will soon be able to offer a IDI-Strep B test to women in premature labor or who missed prenatal care and get results in just one hour to detect Group B streptococcus, an infection that can be fatal or brain-damaging if passed to infants inside the birth canal once labor has begun. Obstetricians already test women for Group B strep two to four weeks before their due date, but that test needs up to 48 hours for results and does not work once women are in labor, leaving premature babies or those whose mothers lacked prenatal care at risk.
(Associated Press, 11-18-02)

Terminally Ill Patients Spending Fewer Last Days In Hospice Care

A report by Last Acts, a coalition of health and aging groups, found that enrollment in hospice care jumped from about 1,000 a year in 1975 to 700,000 in 2000, but patients are entering hospice care ever closer to the time of death. Patients spent an average of 70 days in hospice care in 1983, but that dropped to 36 days by the late 1990s, while 28 percent of hospice patients in 1998 were enrolled for one week or less before they died.
(Associated Press, 11-18-02)

Rates for Some Cancers Rising, According to a New Analysis by NCI Scientists

Previous indications of a decline in some cancers reflected significant delays in reporting the cases rather than an actual decline. Revised estimates show that breast cancer rates have been rising 0.6 percent a year since 1987, lung cancer in women has been rising 1.2 percent a year since 1996, melanoma rates in white males has been soaring 4.1 percent a year since 1981, prostate cancer rates in white males have been rising 2.2 percent a year and colorectal cancer cases for both genders and all races are three percent higher than first reported.
(Wall Street Journal, 11-16-02)

FDA Approves the First At-Home Defibrillator

Government approval of the first defibrillator specifically for home use is heating up debate over whether broader sale of the devices, already common in airports and shopping malls, will save many more lives or waste precious minutes if distraught relatives attempt using the machine before dialing 911. The first version designed specifically for a home use, Philips Electronics' HeartSt... Home Defibrillator, requires a doctor prescription, comes with advice f... potential users to get some training and... not meant as a substitute for paramedi...
(Associated Press, 11-12-02)

New Recommendations to Prevent High Blood Pressure Issued

Additional Lifestyle Approaches Advised

The National High Blood Pressu... Education Program (NHBPEP) h... updated its recommendations to preve... hypertension. New recommendati... include adequate intake of potassium a... an eating pattern rich in fruits, vegetable... and low-fat dairy products and reduced... saturated and total fat. The advisory al... reinforces earlier recommendations ... limit consumption of sodium and alcoh... reduce excess body weight, and increa... levels of physical activity.

Published in the October 16, 20... issue of *The Journal of the Americ... Medical Association*, the report al... cautions that some widely publicize... approaches have less proven or uncert... efficacy. Fish oil (omega-3 polyunsatu... rated fatty acids) and calcium supplemen... lower blood pressure only slightly in ind... viduals with hypertension. In addition, t... ability of herbal and botanical supplement... to safely lower blood pressure is unprove... and these unregulated products can interf... adversely with medications.

Developed by a distinguished panel o... experts convened by the NHBPEP Coo... dinating Committee, the advisory reflec... the latest scientific evidence and upda... the first recommendations on preventi... high blood pressure released nearly a... decade ago. Like the 1993 advisory, th... new report emphasizes two overall strat... gies to keep blood pressure from rising: ... population-based strategy and an inte... sive strategy for high-risk individuals.

Fifty million adults in the United Stat... — including more than one of every tw... adults over the age of 60 — have hi... blood pressure, according to the Nationa... Center for Health Statistics. Furthermor... data from NHLBI's landmark Fra...

ingham Heart Study suggest that middle-ged and elderly individuals face a 90 ercent risk of developing hypertension luring their remaining years.

Framingham research has also shown hat the risk of cardiovascular disease ssociated with high blood pressure ncreases gradually — even before hyper-ension occurs. The approximately 23 nillion adults in the U.S. with high-ormal blood pressure levels (systolic ressure of 130-139 mmHg and/or a dias-olic pressure of 85-89 mmHg) are 1.5 to .5 times more likely to have a cardiovas-ular event or to die within 10 years, ompared to those with optimal blood ressure (systolic pressure of less than 20 mmHg and diastolic pressure of less han 80 mmHg). Normal blood pressure evels are 120-129 mmHg systolic and 80-84 mmHg diastolic.

Proven behavioral changes can lower one's blood pressure and reduce the risk of a cardiovascular event. The report cites one study, for example, that found that people with normal blood pressure levels who increased the amount of regular physical activity lowered their systolic blood pressure by more than 4 mmHg. In another study, overweight participants with normal blood pressure levels signifi-cantly lowered their systolic blood pres-sure by losing weight (fewer than 8 lbs); in addition, the percentage of participants in this group who had high blood pressure seven years later was less than half of the percentage of the control group which remained overweight.

The clinical trial known as Dietary Approaches to Stop Hypertension, or DASH, has demonstrated the critical role of nutrition in controlling blood pressure. Based on the results of DASH, the NHBPEP now recommends an eating plan that is rich in fruits, vegetables, and low-fat dairy products and that has limited saturated and total fat.

Furthermore, limiting daily dietary sodium intake to less than 2,400 mg of sodium (about 1 teaspoon of salt) per day helps lower or control blood pressure. In one study, older patients with hyperten-sion significantly lowered their systolic blood pressure and decreased their need for medications by moderately reducing how much sodium they consumed. The advisory highlights that although limiting the amount of salt added during cooking and at the table is important, three-fourths of the average individual's total intake of salt and sodium comes from sodium added during processing and manufac-turing. Therefore, NHBPEP urges food manufacturers to lower the amount of sodium in the food supply — and to offer these products at equitable prices.

Other behavioral changes for people with blood pressure above optimal levels include consuming more than 3,500 mg of dietary potassium per day — an approach especially important for individuals with high sodium intake — and limiting alcohol consumption to 1 ounce of ethanol (e.g., 24 oz beer, 10 oz wine, or 2 oz 100-proof whiskey) per day in most men and to no more than 0.5 ounce per day in women.

To learn more, visit the NHLBI Web site at <www.nhlbi.nih.gov>. Click on Special Web Pages and Interactive Applications, then High Blood Pressure for interactive quizzes and tools, such as a body mass index calculator; tips, recipes and real-life examples to help control blood pressure; and other educational materials for consumers and clinicians.

Task Force Finds Evidence Lacking on Whether Routine Screening for Prostate Cancer Improves Health Outcomes

Although screening for prostate cancer is a common part of a routine checkup for American men, a new finding issued December 2, 2002, from the U.S. Preventive Services Task Force concludes there is insufficient scientific evidence to promote routine screening for all men and inconclusive evidence that early detection improves health outcomes. The finding is published in the December 3 issue of the *Annals of Internal Medicine*.

The Task Force, an independent panel of experts sponsored by the Agency for Healthcare Research and Quality, reviewed studies on the effect of screening for prostate cancer using prostate-specific antigen (PSA) tests and digital rectal exams to prevent death in men over the age of 40. The Task Force found that while the tests are effective for detecting disease, there is insufficient evidence that they improve long-term health outcomes.

Over their lifetime, 15 percent of U.S. men eventually will be diagnosed with prostate cancer, three-fourths of whom will be diagnosed after age 65. A man in the United States has a 3 percent chance of dying from prostate cancer. Because many prostate cancers grow slowly, many men diagnosed with prostate cancer will die of other causes, especially men older than 65.

If clinicians opt to perform prostate cancer screening for individual patients, the Task Force recommends that they first discuss the uncertain benefits and possible harms. Benefits of the tests may include early detection of cancer, but harms may include false-positive results and unnecessary anxiety, biopsies, and potential complications of treating some early cancers that may never have affected a patient's health or well being. Potential side effects of surgery and radiation treatment include erectile dysfunction, urinary incontinence and bowel dysfunction.

One part of a National Cancer Institute randomzied clinical trial of over 150,000 people called the Prostate, Colorectal, Lung and Ovarian Screening Trial is looking at whether, in men, screening with digital rectal examinations plus a PSA test can reduce deaths from prostate cancer. Results from this large trial, which should be available later this decade, could help clarify the benefits of prostate cancer screening.

The Task Force grades the strength of the evidence from "A" (strongly recommends) to "D" (recommends against) or "I" (insufficient evidence). The Task Force found insufficient evidence that clinicians should routinely provide prostate cancer screening to those men not at high risk for the disease. In 1996, the Task Force recommended against routine prostate cancer screening for men.

The prostate cancer screening recommendation and materials are available at <www.ahrq.gov/clinic/3rduspstf/prostate-scr/>.

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