TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
Volume LVIII, No. 10
November 2001

National Osteopathic Medicine Week

November 11-18, 2001

End-of-Life Care

Because everyone dies, end-of-life care is among the most prevalent issues in healthcare today. Both healthcare professionals and patients are seeing a great need for improvement.

plus

TOMA's 46th MidWinter Conference & Legislative Symposium

Program Information & Early Registration Form

pages 24 – 26

On September 11, 2001, there came a heartache from which there seems no relief.

Our thoughts and prayers go out to all whose lives were lost, and to all whose hearts were broken. Our despair is tempered only by the acts of courage, kindness, and resolve we have seen in the hours and days since that terrible morning.

If the perpetrators of these atrocities sought to expose a weakness in America, they have only revealed our strength. This great nation will endure.

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

NOVEMBER 2001

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CALENDAR OF EVENTS

NOVEMBER 16 - 18

"18th Annual Family Practice Update"

Sponsored by the Oklahoma State University College of Osteopathic Medicine

Location: Downtown Doubletree Hotel, Tulsa, OK
CME: 25 hours category 1-A credits anticipated
Contact: Janice L. Giacomo, CME coordinator
800-274-1972
gjanice@osu-com.okstate.edu or
www.osu.com.okstate.edu

DECEMBER 1

TOMA Board of Trustees Meeting

Location: TOMA State Office, Austin, TX
Contact: Paula Yeamans
800-444-8662 or 512-708-8662

DECEMBER 7 - 9

"20th Annual Winter Update"

Sponsored by the Indiana Osteopathic Association

Location: The Westin Hotel Downtown, Indianapolis, IN
CME: 20 hours category 1-A anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

2002

JANUARY 16 - 20

"Ninth Winter Medical Symposium"

Sponsored by the Nevada Osteopathic Medical Association

Location: Harveys, South Lake Tahoe, Nevada
Contact: NOMA
702-434-7112
nvoma@aol.com

FEBRUARY 8 - 10

"TOMA 46th MidWinter Conference & Legislative Symposium"

Sponsored by the Texas Osteopathic Medical Association

Location: Renaissance Dallas North Hotel, Dallas, TX
Contact: Jill Weir, CAE
800-444-8662 or 512-708-8662

APRIL 18

"D.O. Day on Capitol Hill"

Sponsored by the American Osteopathic Association

Contact: AOA, 800-621-1773

APRIL 20

"57th Meeting of the TOMA House of Delegates"

Location: Austin, Texas
Contact: Paula Yeamans
800-444-8662 or 512-708-8662

MAY 2 - 5

"105th Annual Convention"

Sponsored by the Indiana Osteopathic Association

Location: Adam's Mark Hotel Downtown, Indianapolis, IN
CME: 30 hours category 1-A credits anticipated
Contact: IOA
800-942-0501 or 317-926-3009

CME CORRESPONDENCE COURSE

"Medical Ethics: Applying Theories and Principles to the Patient Encounter"

Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services

CME: 60 category 2-B hours
Course Tuition: $1,200
Contact: 800-480-5542

www.txosteo.org

ON THE WEB in November

ON THE WEB is a monthly feature of the *Texas D.O.* announcing headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website <www.txosteo.org>.

- **Health Notes**
- **News from the Department of Health and Human Services**
- **TRICARE News and Related Military Issues**
- **In Brief**
- **10 Years Ago in the *Texas D.O.***

Follow These Guidelines for Documenting E&M Services

Evaluation and management (E&M) services account for 40 percent of billed physician charges, or $18 billion annually. An appropriately documented medical record can reduce many of the hassles associated with processing claims for E&M and other services.

Following is a list of principles to guide you in the documentation of evaluation and management services:

- ✓ Current procedural terminology and ICD-9 codes reported on the insurance claim or billing statement must correspond with the documentation in the medical record.
- ✓ For each visit, the physician must document the chief complaint or reason for the visit, relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date of visit, and the name of the health care professional who provided the service.
- ✓ The physician must document the rationale for ordering diagnostic or other ancillary services; if not, the rationale should be easily inferred.
- ✓ The medical record should be complete and legible.
- ✓ An addendum to the medical record should be dated the day the information is added to the medical record, not the day the service was provided.
- ✓ To maintain accurate medical records, many practices are asking physicians to document the visit as it is happening.

Still confused about correct coding and documentation? TOMA Physician Services can help by conducting a coding and documentation review of your practice. TOMA's experienced consultants will analyze a representative sample of your practice's patient charts and corresponding explanations of benefits, claims, and fee tickets; identify problem areas; make recommendations for improvement; and provide on-site training in correct procedures. An annual coding and documentation review will help assure your practice is receiving proper reimbursement for your services. Contact Physician Services today for more information at 800-523-8776 or <physician.services@texmed.org>.

National Osteopathic Medicine Week
November 11 – 18, 2001
A Focus on End-of-Life Care

There are 35 million people age 65 or older in the United States who currently account for almost 13% of the total population. By 2030, that number is expected to double to 70 million people, or 20% of our country's total population.

Care at the end of life has become a national concern. During the past several decades, biomedical advances have extended the life span as well as the management of chronic diseases. Such advances have also changed the way people die, often resulting in a more extended dying process. In a primarily cure-oriented healthcare system, futility is sometimes hard to recognize.

The message that the medical needs of the dying are fundamentally different is beginning to be heard, thanks in large part to America's 76 million baby boomers. The taboo against talking about death is breaking. And, in response to widespread dissatisfaction regarding such care, a movement to improve and redefine end-of-life care is mounting across the U.S.

End-of-life care encompasses a wide range of topics, from complementary and conventional acute pain management, to addressing social, cultural, and religious differences and sensitivities. It also involves counseling and other forms of support for patients and their caregivers, discussions about the costs related to end-of-life care, insurance coverage, advance directives for final stages of life care and treatment, and more.

The Institute of Medicine, in its report "Approaching Death – Improving Care at the End of Life," defined a good death as "one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards."

As the world continues to mourn the tragedy of September 11, the specter of death has suddenly become more visible and personal to Americans. To those left behind, it has pushed death to the forefront as never before.

NOM Week Focus

"...Advance care medical directives speak for patients when they cannot speak for themselves, either because of a dire health emergency or as they are entering the final stages of life".

This year's NOM Week centers on educating and informing Americans about end-of-life care and related topics, such as advances in pain management, cultural sensitivities toward final stages of life, organ donation, advance directives, and end-of-life care options and financing.

As a matter of related interest, a 15-week newspaper series, called "Finding Our Way: Living with Dying in America" is a national initiative in the end-of-life movement. The articles, which run from September 9 through December 16, carry forward the public education efforts of "On Our Own Terms: Moyers on Dying." The articles can be accessed at <www.findingourway.net>.

The nation's 47,154 osteopathic physicians are dedicated to helping maintain health through a whole-person, patient-centered approach to healthcare. And, within that principle, they recognize death as the legitimate endpoint to the human life cycle and respect the dignity and special needs of both patients and their caregivers.

The following end-of-life care core principles, adopted at the July 2000 AOA House of Delegates meeting, call on D.O.s to:

- Recognize death as the legitimate endpoint to the human life cycle.
- Understand that dying patients warrant the clinical competence and attention afforded all others.
- Respect the dignity of both patient and caregivers.
- Be sensitive and respectful to the patient's and family's wishes.
- Use the most appropriate measures that are consistent with patient choices.
- Encompass alleviation of pain and physical symptoms.
- Assess and manage psychological, social, and spiritual/religious problems.
- Offer continuity. (The patient should be able to continue to be cared for, if so desired, by his/her primary care and specialist provider.)
- Provide access to any therapy which may realistically be expected to improve the patient's quality of life, including osteopathic manipulative techniques (OMT) and alternative or non-traditional treatments.
- Provide access to palliative care and hospice care.
- Respect the right to refuse treatment, and understand appropriate application of advance directives.
- Respect the physician's professional responsibility to discontinue some treatments when appropriate, with consideration for both family and patient preferences.
- Promote clinical and evidence-based research on providing care at the end of life.

(These core principles incorporate the Milbank Memorial Fund consensus report, "Principles for Care of Patients at End of Life" by Drs. Christine K. Cassel and Kathleen M. Foley, with the osteopathic philosophy of care.)

Effective Pain Management– Assuring Quality of Life at the End of Life

Effectively managing the physical pain associated with terminal illness can enhance the quality of life at the end of life. A lessening of pain can give people the opportunity to put their affairs in order or discuss the future with loved ones. Tragically, however, a 1995 survey revealed that 50% of hospitalized, terminally ill patients had moderate to severe pain during more than half of the time they were conscious before they died.

A focus on pain was given a major boost last year when the 106th U.S. Congress passed H.R.3244, providing for the "Decade of Pain Control and Research." This Congressionally declared medical decade began January 1, 2001, and is a step in stimulating further progress into research, education and management of pain.

Currently pending in the 107th Congress is S.1024, the "Conquering Pain Act of 2001," which addresses the public health crisis of pain. Among other issues, the legislation calls for development/maintenance of a Web site on evidence-based practice guidelines for pain treatment; grants to health care provider training entities to establish six National Family Support Networks in Pain and Symptom Management; establishes the Advisory Committee on Pain and Symptom Management; mandates an Institute of Medicine report on controlled substance regulation and the use of pain medications; instructs the Surgeon General to prepare a report concerning the state of pain and symptom management in the U.S.; and mandates grants for demonstration projects on end-of-life care and effective methods to measure improvement in the skills and knowledge of health care personnel in pain and symptom management.

Findings of S.1024 include:

- Pain is often left untreated or under-treated especially among older patients, African Americans, Hispanics and other minorities, and children.
- Chronic pain is a public health problem affecting at least 50,000,000 Americans through some form of persisting or recurring symptom.
- 70 to 80 percent of cancer patients experience significant pain during their illness.

continued on next page

- One in 7 nursing home residents experience persistent pain that may diminish their quality of life.
- Despite the best intentions of physicians, nurses, pharmacists, and other health care professionals, pain is often undertreated because of the inadequate training of clinicians in pain management.
- Despite the best intentions of physicians, nurses, pharmacists, mental health professionals, and other health care professionals, pain and symptom management is often suboptimal because the healthcare system has focused on cure of disease rather than the management of a patient's pain and other symptoms.
- The technology and scientific basis to adequately manage most pain is known.
- Coordination of federal efforts is needed to improve access to high quality effective pain and symptom management in order to assure the needs of chronic pain patients and those who are terminally ill are met.

The legislation also terms "palliative care" to include: the control of pain and of other symptoms, including psychological social and spiritual problems; affirms life and regards dying as a normal process; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; and offers a support system to help the family cope during the patient's illness and in their own bereavement.

Pain is now considered the fifth vital sign and is entered into a patient's medical chart along with blood pressure, temperature, pulse, and respiratory status. Three main types of physical pain a person can experience during the final stage of life include somatic pain (localized in the skin, soft tissue, muscles, and bones); visceral pain (general aching or throbbing in the abdomen, internal organs); and neuropathic pain (tingling, burning sensation in extremities).

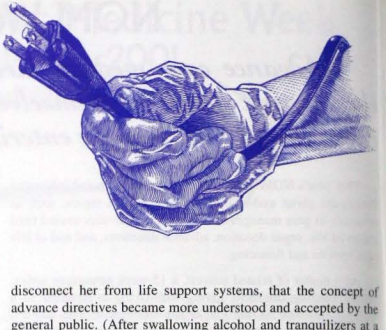
Osteopathic physicians can provide additional end-of-life management through the use of OMT. In fact, a recent study published in the *New England Journal of Medicine* noted that OMT is not only an effective and low-cost form of treatment for low back pain, but also helps decrease the need for medications and surgery.

A critical factor in effectively treating pain is adequate assessment of the pain. One of the tools that can assist both patients and physicians in opening dialogs to better quantify pain and discuss treatment options is the new pamphlet, *Cancer Pain Treatment Guidelines for Patients*, published by the National Comprehensive Cancer Network (NCCN) and the American Cancer Society (ACS).

(Sources: National Institutes for Health; New England Journal of Medicine*; National Comprehensive Network; American Cancer Society; The Public Broadcasting System "Before I Die" series; <thomas.loc.gov>)*

The Importance of Advance Medical Directives

The first advance directive was written in 1967 by an organization now known as the Partnership for Caring: America's Voices for the Dying. But it wasn't until nearly a decade later and after the legal battle fought by Karen Ann Quinlan's parents to



disconnect her from life support systems, that the concept of advance directives became more understood and accepted by the general public. (After swallowing alcohol and tranquilizers at a party, 21-year-old Quinlan had suffered brain damage and lapsed into a persistent vegetative state for many years.)

Today, 75% of Americans favor advance directives, but according to *Modern Maturity*, only about a third of them have actually taken the time to put their end-of-life care instructions in writing.

Older or seriously ill patients write most advance directives. But medical and legal experts also counsel younger adults in good health to put their wishes in writing to deal with sudden or unexpected accidents or serious illness. Advance directives speak for patients when they cannot speak for themselves, either because of a dire health emergency or as they are entering the final stages of life.

According to a recent article in the *Journal of the American Medical Association*, 61% of terminally ill patients surveyed wanted to avoid a drawn out death and many were afraid of being kept alive. Yet, without an advance directive, hospital staffs are legally bound to keep a patient alive as long as possible through artificial feeding, mechanical ventilators, defibrillation, antibiotics, dialysis, resuscitation, and other invasive procedures.

A Variety of Directives

The term "advance directive" actually encompasses several different legal written documents that instruct your doctor in the type of medical treatment and care you do or do not want if you reach the point where you can no longer speak for yourself. These documents include the "living will," "durable power of attorney for healthcare," or a combination of both, called an "advance care medical directive."

Living Will: A document in which a person, while mentally competent, directs end-of-life medical care. Every American has the constitutional right, established by a Supreme Court decision, to request that medical treatments be withheld or withdrawn. A living will typically becomes effective when you can no longer express your wishes and have been diagnosed as terminally ill, irreversibly unconscious, or in a persistent vegetative state. A living will does not let you name someone else to make decisions for you.

Durable Power of Attorney (POA) for Healthcare (also called a medical power of attorney or healthcare proxy): This document names a proxy to make medical decisions for another person. POAs direct a proxy to make a wider range of decisions than allowed in a living will, such as accepting or refusing specific treatment or care, being hospitalized or staying home, donating organs, etc. A proxy is usually a relative or close friend whom you know and trust to act as your legal decision-maker and spokesperson.

Advance Care Medical Directive (ACMD): A combination of the living will and POA. An ACMD can be much more specific than a living will or POA, because it is generally made in consultation with a physician who then knows of its existence.

Other end-of-life care and treatment instructions include: Do-Not-Resuscitate (DNR) Order, which instructs a doctor or emergency personnel to not use cardiopulmonary resuscitation (CPR). Doctors and hospitals in all states accept DNR orders; and Preferred Intensity of Care Document, which outlines for physicians patients' preferences for care under special circumstances.

There are a number of community, state and online sources that provide information and assistance in developing advance directives.

Experts generally recommend:

- ✓ Use a form provided by your physician or state representative and have it notarized, if possible.
- ✓ Be specific and precise about what kinds of treatment and care you do and do not want.
- ✓ Be informed as to advance directive laws in your state, even though living wills and POAs are legal in most states.
- ✓ Discuss your wishes with your proxy, in advance, to make sure they understand and are willing and able to carry out those wishes.
- ✓ Review your advance directive with your physician, family members, or friends.
- ✓ Make sure your proxy, physicians, family members, and hospital all have copies of your completed advance directive.
- ✓ Store the completed advance directive where it can be easily found. An estimated 35% of advance directives cannot be found when they are needed.
- ✓ Review your advance directive documents periodically and keep them current.

Points to Consider

- ➢ A recent nationwide survey by *Modern Maturity* found that 71% of people responding believe there's a point at which costly health treatments should be stopped.
- ➢ The Patient Self-Determination Act (PSDA), a federal law passed by Congress in 1990, requires healthcare providers to inform all adult patients about their rights to accept or refuse medical or surgical treatment and the right to execute an "advance directive."
- ➢ In research commissioned by the National Hospice Foundation in 1999, shows that fewer than 25% of Americans have thought about how they would like to be cared for at the end of life and put it in writing. While 36% say they have told someone about how they would like to be cared for, focus groups show that people often view a passing comment about how they would like to die as informing their loved one of their wishes.
- ➢ Stress levels have been measured as extremely high for family members who must decide whether or not life support should be withdrawn from relatives too incapacitated to decide for themselves, according to a recent study funded by the National Institute of Nursing Research. Reported levels of stress are twice as high as those due to other serious crises, such as ferry or construction disasters, or losing a home to fire. Stress was least severe when patients' written advance directives were available and most severe in the absence of written or verbal directives.

(Sources: American Medical Association, American Association of Retired Persons, American Bar Association, NHF Public Opinion Research news release, National Institutes of Health)

Caring for Children and Adolescents at the End of Life

Advances in medicine and preventative healthcare, along with several other factors, have helped to substantially lower the child mortality rate in the U.S. over the past several decades.

Yet, in 1998, an estimated 55,010 children and adolescents (from infancy to 19 years of age) died in the U.S. and approximately 64% of those deaths were not preventable. About a third of those deaths were from cancer and neurological progressive disorders and another third from prematurity and congenital anomalies.

According to Jimmie P. Leleszi, D.O., director of consultation to pediatric psychiatry and hospice at Children's Hospital of Michigan in Detroit, "Caring for young people who are at the end of life does not mean curing them, but instead providing them with the compassionate support and understanding that will help make their final journeys as comfortable, functional, and dignified as medically possible."

Dr. Leleszi, who is the only certified child psychiatrist in the country to specialize and be certified in the area of pediatric hospice, also notes, "Helping young patients who are nearing the end of their life's journey to keep their dignity and quality of life is one of the most important things that family members and physicians can do."

Children typically have certain views toward death, both their own and that of others, at different ages.

- Up to age 2: children have no concept of death.
- Age 2 to 7: death is viewed as something that is not permanent; it happens, but it can be reversed.
- Age 7 to 12: It is understood that death is permanent; however, it is still seen as unpredictable and something that happens to someone else.
- Age 12 and older: it is understood that death is permanent and it happens to everyone; however, it is still viewed as something that will occur in the distant future.

For the very young child who has no concept of death, parents and family members should give the maximum physical care and comfort. Children in the 2-7 age group need reassurance that their illness is not a punishment for having done something "bad."

A major part of helping dying children maintain dignity and quality of life is acknowledging that they very likely realize they

are dying and, therefore, need help in expressing their wishes and planning for their death. This is particularly important for terminally ill children in the two older age groups, notes Dr. Leleszi. "From age 7 to 12, children should be included in open and honest discussions about the seriousness of their illness and be given a sense of control. And, adolescents in the fourth age group must have privacy to help them maintain a comfortable body image, have access to their peers, and be allowed to maintain a sense of self-esteem."

"The adults involved in these children's lives – the parents and physicians – must be the children's advocates and they need to listen to and hear what terminally ill children say and don't say."

Factors that parents and physicians should consider when discussing death with a child include the child's developmental level, previous experience with and understanding of death, and how the child usually deals with pain and sadness. The family's religious and cultural belief about death should also be considered.

The child's physician should play a major role in assisting and supporting the parents and siblings of the ill child, all of whom are affected by the child's condition and eventual death.

"The worse thing that can happen to terminally ill children is to die alone and not be able to share their feelings and celebrate their lives with those who love and care for them," states Dr. Leleszi.

Points to Consider

- There is considerable delay among parents in recognizing when children with advanced cancer have no realistic chance of cure, according to a Dana-Farber Cancer Institute and the Children's Hospital-Boston study published in the November 15, 2000 issue of *The Journal of the American Medical Association*. Researchers concluded that earlier recognition of this prognosis by both parents and physicians could lead to stronger emphasis on treatment directed at lessening suffering and greater integration of palliative care.
- Helping young patients who are nearing the end of life to keep their dignity and quality of life is one of the most important things a physician and the family can do.
- Factors that parents and physicians should consider when discussing death with a child include the child's developmental level, previous experience with and understanding of death, and how the child usually deals with pain and sadness.

(Sources: Pediatrics Magazine, *American Academy of Child and Adolescent Psychiatry, <kid-z-tuff.com>, The Compassionate Friends, Inc., Dana-Farber Cancer Institute)*

Bringing Cultural and Spiritual Sensitivity to End-of-Life Care

The ethnic, cultural, and religious diversity of America adds another dimension to the special needs that physicians must address when providing end-of-life care to these different communities.

Along with the more than 200 living languages spoken in the U.S. – from Aleut to Zuni – comes a multitude of cultural attitudes and rituals regarding death, dying, and end-of-life healthcare that physicians must consider. For example:

- Many West African cultures believe that telling a person they are very sick or dying is predicting the future – if you say something bad will happen, it will.
- In many cultures, it's believed that if the body is opened up for surgery there is a chance for evil spirits to enter the person.
- Latinos typically do not believe in nursing homes or hospice care and tend to make their own care arrangements for terminally ill family members.
- European- and African-Americans generally believe a patient should be told the diagnosis of a terminal illness, while Korean- and Hispanic-Americans do not.

In addition to its cultural diversity, America has more religions and faith groups than can be calculated. And each of these groups has specific rituals and approaches to dealing with death and dying, such as:

- The Buddhist faith teaches that a person's state of mind while dying is of great importance. To help achieve a peaceful state of mind, the dying person is surrounded by family, friends, and monks who recite Buddhist scripture and mantras.
- Practicing Catholics who are dying let their relatives and friends know they wish to receive the "last rites," which is usually accompanied by the sacrament of reconciliation and receiving Holy Community as "viaticum," or food for the journey.
- Islamic practices surrounding death vary, but generally the dying are positioned on their backs with their heads facing Mecca. The room is perfumed and Islamic scriptures are read by the dying person or a relative.
- In the Hindu religion, at the time of death, holy ash must be applied to the forehead while holy mantras are chanted.
- Judaism mandates that the body be treated with awe and reverence and embalming or viewing of the body is usually not permitted because this tends to turn the person into an "object."

Religious or spiritual beliefs can have a powerful impact on end-of-life care and the outcome for a dying patient. In fact, the importance of addressing patients' spirituality is considered so important that eight college of osteopathic medicine offer course work on the topic of spirituality as it relates to end of life, and the University of Chicago has created a course called "Spirituality in Medicine."

In order to develop an approach to end-of life care that respects patients' and their families' requirements, there must be open dialog between everyone involved. The following points should be addressed and/or considered:

- If appropriate, physicians should ask patients if they wish to receive information and make decisions for their own care, or if they prefer that their families handle such matters.
- If religion is an important part of the person's life, clergy members should be included in the discussions.
- The physician must be straightforward with patients. Let

them know that you will tell them what they want to know and ask if you should talk to their family members or not.

- If there is a language barrier, the family and doctor should request that an independent, outside translator be brought in, particularly if the burden of translating would otherwise fall on the shoulders of a young or adolescent family member.
- In terms of determining spirituality, a physician may ask open-ended questions, such as "What gives you your strength" or "What is the most meaningful thing in your life?"

Points to Consider

- ➢ Because members of different groups make medical decisions differently, cultural and religious needs must always be taken into account and those borders must not be violated when discussing terminal illness and end-of-life care.
- ➢ As already noted, America has more religions and faith groups than can be calculated and each group has specific rituals and approaches to dealing with death and dying.
- ➢ "Advance directives" are particularly important in helping assure that the requests, wishes, and cultural and spiritual beliefs of the terminally ill patient are not violated.

(Sources: American Osteopathic Association, <lastacts.org>, <breadforthejourney.org>, <religioustolerance.org>, University of Southern California Pacific Center for Health Policy and Ethics, SIL International)

Selecting and Financing End-of-Life Care Programs

In 1999, approximately 50 percent of nearly 2.4 million Americans died in a hospital; 25 percent in their homes or elsewhere; and another 25 percent in nursing homes. Three major categories related to end-of-life care should be examined and understood by patients and their families, as follows:

- The type of and approach to end-of-life care patients wish to receive.
- The physical setting in which they spend their final days.
- The costs of care, what is covered by insurance, and other financial support options that may be available.

Palliative care services can be provided to the terminally ill patient in a number of settings, including a hospital, the patient's home, a nursing home, an extended care facility, or other specialized units. Because medical needs vary depending on the disease from which a terminally ill person is suffering, palliative care programs may vary slightly between more common conditions, such as cancer and AIDS, and diseases that may change brain function and lead to coma or dementia.

One of the primary contexts within which palliative care is administered is the hospice, a word that derives from the Latin "hospitium" and means guesthouse. The first hospice in the United States was established in New Haven, Connecticut, in 1974. Today, there are more than 3,100 hospice programs in the U.S. and in 1998, hospice cared for nearly 540,000 Americans.

Hospice care can be administered in a number of physical settings, including patients' homes, units within a hospital, stand-alone hospice organizations, extended care centers, as well as nursing homes.

Financing

Typically, hospice care at the end of life is covered by Medicare, Medicaid, most private insurance companies, HMOs, and other managed care organizations. Community contributions, memorial donations, and other gifts often make free care possible for patients without sufficient funds, and some programs charge patients according to their ability to pay.

If the end-of-life care period is expected to be longer than the maximum six months of hospice care covered by Medicare, families should also seek professional advice about their eligibility for long-term care insurance. Medicare provides limited coverage for long-term care, while Medicaid covers more long-term care.

Other potential sources of income which may be needed by the family during the end-of-life care period and after, can also include: life insurance policies, which can be used as collateral for loans, sold for a percentage of their face value, or from which accelerated benefits can be taken; or real estate, which can also be used as loan collateral or for which a reverse mortgage may be arranged.

Points to Consider

- ➢ Palliative care takes a comprehensive, team approach that involves the patient, family members, loved ones, the primary care physician, the clergy, support counselors, and others.
- ➢ The patient and family should be made aware of and discuss end-of-life care costs and coverage, as well as other sources of income that may be necessary to cover the family's living expenses.
- ➢ Early on in the end-of-life situation, families should consult with their primary care physician, insurance carrier, lawyer, financial planner, accountant, appropriate governmental agencies, and other experts.

(Sources: National Hospital and Palliative Care Organization, Hospice Foundation of America, National Center for Health Statistics)

Organ Donation Giving the Gift of Life at the End of Life

In March of this year, the United Network of Organ Sharing (UNOS) reported that an unprecedented number of Americans – more than 75,000 men, women, and children – were on the national organ transplantation waiting list. Because of the severe shortage of donated organs, many on that list will die. On average, 15 people die every day, or some 5,500 every year.

In 1999, UNOS reported that doctors performed 27,715 transplants in the U.S., nearly double the number performed in 1990. During that same time, the number of organ donors rose 59%, but the need for transplantable organs grew fivefold.

"...stress, extra responsibility, fatigue, potential depression, strain on finances, and other emotions...involved can overwhelm caregivers to the point where their own health suffers."

In answer to why the demand for organs outpaces the supply, Alan Langnas, D.O., professor of surgery and chief of the Section of Transplantation at the University of Nebraska Medical Center in Omaha, believes there are two factors at work.

"On one hand, medical advances have increased the success rate of using organ transplantation to treat a number of life-threatening disease," noted Dr. Langnas. "Yet, there hasn't been a corresponding increase in the efforts by doctors and their patients to become more informed about the need for donated organs, or to openly address the issues and concerns patients may have about donating. In light of this, the demand is obviously far outstripping the supply of donated organs."

When considering donation, many people think only about the major organs, such as the heart, liver, or kidneys. However, there are more than 25 different transplantable organs and tissues, which means each donor can potentially save and enhance up to 50 lives and take eight people off the national organ donor waiting list. In addition to the heart, kidneys, liver, pancreas, lungs, and intestines, donations can include; corneas; bone marrow; skin grafts; bone; heart valves; and tendons, ligaments and cartilage.

"Americans' attitudes about organ and tissue donation are changing, but we still have a long way to go," says Wayne J. Reynolds, D.O., of the Hayes Medical Center in Hayes, Virginia.

He acknowledges that organ donation is a topic that is very difficult for patients, their families, and physicians to discuss. "But organ donation can be a comforting experience, one that helps a family heal after losing a loved one," he says. "Whether it's the unexpected, devastating loss of a child or young adult, or it's the expected death of a terminally ill older adult, organ donation is an act of charity that can help patients and their families make something 'good' come out of a death."

There is another relatively new development in the area of organ donation that may ultimately have a major impact on the number of future donors. "We are now starting to bring organ donor and organ recipient families together," says Dr. Langnas. "Often, this is an incredibly warm experience and a bond develops between the two families."

These meetings, Dr. Langnas says, let the donor's family members know that the death of their loved one had a positive impact on someone else, which helps in creating closure.

Additionally, he notes, such meetings give the organ recipient and his or her family the opportunity to "illustrate the importance of what the organ donor has done by giving the gift of life to another person."

Points to Consider

- The number of organ donors rose 59% between 1990 and 1999, but the need grew fivefold.
- Each organ donor can potentially save and enhance up to 50 lives and take eight people off the national organ donor waiting list.
- Most organ donations come from people who have died, but in 1999, there were 4,712 living organ donors.
- Most living organ donors donate one of their two kidneys, though donations of a piece of liver are becoming more common, with 218 in 1999.
- Most living donors are family members, usually siblings.

(Source: United Network for Organ Sharing)

Support and Care for End-of-Life Caregivers

Caring for a terminally ill spouse, child, sibling, friend, or parent can be one of the most selfless acts of love and kindness one human being is capable of showing another. However, regardless of the intent, the stress, responsibility, fatigue, potential depression, strain on finances, and other emotions and considerations involved can overwhelm caregivers to the point where their own health suffers.

Caregiving by family members and others of the chronically and terminally ill in American is much more common than may be expected. According to a 2000 survey by the National Family Caregivers Association (NFCA), nearly 27% of those surveyed were currently, or had been for the past year, caring for a family member or friend. That translates to more than 54 million American caregivers during the past year. And, those numbers can be expected to rise as more and more baby boomers grow older.

According to the NFCA survey, the majority of caregivers were between the ages of 35 and 65, and more than half of them provided physical care for daily living activities, such as feeding, dressing, and helping the ill person move about. Another 46% performed some type of nursing care, such as giving medications or monitoring vital signs.

The U.S. Government has recently recognized the prevalence and importance of caregivers as evidenced by Congress authorizing the National Family Caregiver Support Program, the first

piece of federal legislation to specifically address the needs of family caregivers. As part of the reauthorization of the Older Americans Act, the legislation allows funding over five years for Area Agencies on Aging to provide services, such as caregiver counseling and respite, along with traditional information and referral services.

In order to lessen stress, caregiver organizations recommend the following:

- Prior to entering a caregiving situation, a family should discuss which members will be responsible for certain tasks.
- The family should educate themselves about the illness and discuss with the physician what types of care will be required.
- The situation should be openly discussed with involved children, who should be encouraged to help care for the ill family member, if they are of an appropriate age.

Important Sources of Caregiver Support from Respite or Hospice Care

Respite care is given to a terminally ill person's family or caregivers, and takes into account their physical, emotional, and spiritual needs. This approach to caring for caregivers typically involves several team members, such as clergy, social workers, family counselors, volunteers and others. Respite care also gives primary caregivers time away from their duties.

Hospice emphasizes comfort care, rather than curative treatment, that addresses the patient's physical, emotional, and spiritual well being. Hospice also regards the family as a whole and provides family members with spiritual, psychological, and anticipatory supports, such as counseling and bereavement services.

Family caregiver support is also available from a variety of local organizations, including hospitals or clinics, adult daycare centers, social service agencies, and the county or state Department of Health and Human Services.

Points to Consider

- According to the NFCA study, 61% of "intense" family caregivers – those providing at least 21 hours of care a week – have suffered from depression.
- Congress recently authorized the National Family Caregiver Support Program, the first piece of federal legislation to specifically address the needs of family caregivers.

(Sources: American Association of Retired Persons, National Family Caregivers Association, Center for Gerontology and Health Services Research, U.S. Department of Health and Human Services)

Suggested Reading

JAMA 2000 November 15; 284 (19): 2476 – 2482

JAMA 2000 November 15; 284 (19): 2483 – 2488

JAMA 2000 November 15; 284 (19): 2502 – 2507

JAMA 2000 January 13; 281 (2): 163 – 168

George Smith, D.O. 2002 Olympic Torchbearer

Dr. George Smith, a family practitioner in West, Texas, has been chosen as an Olympic Torchbearer for the Salt Lake 2002 Olympic Torch Relay. He will carry the official Olympic Torch on December 11 for approximately two-tenths of a mile through the Greater Austin area before handing it to another torchbearer. The Olympic Flame will be carried on a 65-day, 13,500-mile journey from Atlanta, Georgia, to Salt Lake City. The relay is in conjunction with the 2002 Winter Olympics in Salt Lake City.

In a call for nominations issued by the Salt Lake Organization Committee (SLOC), Coca-Cola Company and Chevrolet Motor Division, Americans were given the opportunity to recognize people who have been an inspiration in their lives by nominating them to carry the Olympic Flame. The selection process required that nominated candidates meet one or more of the following criteria: inspires others to greater achievement; has been a source of inspiration for his/her community; embodies the inspirational spirit of the Olympic Movement; and motivates others by encountering and overcoming adversity. Out of more than 210,000 inspirational nominees, 7,200 torchbearers were selected.

This year's torch relay will prove to be especially poignant. Commemorative events are scheduled to take place when the Relay goes through New York City, Washington, D.C., and Pennsylvania. "We believe the Olympic Torch Relay has a deeper sense of meaning after the events of September 11," stated Mitt Romney, SLOC president and CEO. "Now more than ever, the Relay will be a celebration of humanity and civilization and all torchbearers will represent the best of our nation."

"Inspiration" is the theme of the Olympic Torch Relay, and Dr. Smith's notable activities surely embody the spirit of Olympic achievement. He has volunteered at all the local sports programs for his community for over 26 years, serving, among other capacities, as volunteer team physician for West ISD and as volunteer announcer for West baseball and softball tournaments. Also, Dr. Smith, who has been in practice in West since 1975, is on the board of directors of West Hospital Authority, West EMS and the Texas Medical Directors Association. He also serves as volunteer medical director for West EMS and as medical director of West Rest Haven.

A certified medical director for nursing homes, Dr. Smith was honored October 25 as one of 19 physicians to receive the Fellow Award from the American College of Osteopathic Family Physicians.

Dr. Smith's says his philosophy towards life is, "Work with the tools the good Lord has given you, share your experiences and knowledge with others, and always have a sense of humor; after all, laughter is the best medicine."

Independent Investor

A monthly update on money and markets from **Dean, Jacobson** Financial Services, LLC

October, 2001

New Legislation Means More Advantage to 529 Plans

Perhaps you've heard about the 529 savings plan, an investment vehicle that allows families to invest for future college tuition and other higher education expenses.

What you might not know is that changes brought through the recently passed Tax Relief Reconciliation Act, to begin in 2002, will make 529 plans even more attractive to those saving for college.

A 529 plan, named for the section of the Internal Revenue Code that created it, is an investment plan that can be used for virtually any accredited college or university in the U.S. Each state is now committed to offering some variation of a 529 plan, but most do not require residency to invest in that state's plan. This allows the potential to shop around for the plan that works best for you.

Two basic versions of the 529 plan are available. The first option, a pre-paid tuition plan that can be offered by states and certain eligible educational institutions, offers a fixed return on contributions based on the level of inflation for in-state college expenses. This more conservative option is nonetheless attractive to some investors, since it hedges against inflation by locking in current tuition prices for future use.

The other option, which can only be offered by the states, is the higher education savings account, in which the plan's performance is based on that of its underlying investments. Depending upon the state's plan, investment options such as equities and fixed income can be available, providing the opportunity to outperform the inflation of college costs.

There are plenty of significant benefits of a 529 plan. Here are just a few:

- The owner retains control of the account, not the beneficiary.
- Earnings grow federally tax-deferred, and can be used for qualified higher education expenses including tuition, fees, books, equipment and supplies, and qualified room and board expenses for students taking a half-time or greater course load.
- If the beneficiary receives a scholarship, funds in the plan up to the amount of the scholarship can be withdrawn without penalty, passed on to a beneficiary's family member or left intact for graduate school. Should the beneficiary pass away or become disabled, withdrawn funds are not penalized but are taxed to the owner.
- Owners of 529 plans may withdraw assets for their own personal use. However, these non-qualified withdrawals will be treated as a pro-rata share of principal (i.e., contributions) and earnings on the account, and the earnings portion will be taxed as ordinary income and be subject to a 10 percent penalty. In other words, even if funds are taken out and used for non-educational purposes, the original contribution to the plan plus 90 percent of the gains (pre-tax) is available to the owner on a tax deferred basis.

This year's Tax Relief Act further improves upon the 529 plan to bring even more advantages to investors:

- Funds drawn from a 529 plan for qualified expenses will no longer be taxed as income at the federal level. This means investments not only grow tax-deferred, but earnings will be federally tax-exempt once they are put to use for college.
- Investors will be able to transfer funds tax-free from one 529 plan to a different plan, provided the beneficiary remains the same and the rollover occurs within 60 days. This action can occur no more than once in a 12-month period.
- The definition of "family member," for purposes of rolling over a 529 plan to a new beneficiary tax-free, will be expanded to include first cousins of the original beneficiary. Through a quirk in the original law, cousins had been inadvertently excluded from the definition of "family member."

The changes to 529 plans, along with the rest of the Tax Relief Reconciliation Act, are scheduled to end December 31, 2010 unless further Congressional action is taken.

As with any financial plan, the 529 plan may not be right for everyone. But for families saving for the rapidly increasing costs of a higher education, the potential benefits are difficult, if not impossible, to ignore.

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Texas Medical Association, Texas Osteopathic Medical Association, and Texas Academy of Family Physicians are pleased to announce that the Texas Department of Health has approved regulations authorizing TMA/TOMA/TAFP to offer physicians an on-the-job training program for *non-certified* radiologic technicians.

Physicians can now train staff to become *x-ray equipment operators* with this convenient educational tool. The OTJ program allows physicians to effectively train individuals to perform routine diagnostic X-Ray procedures in their office. The two-binder program includes a physician's training guide and a student workbook. All tests, answer keys, certificates and forms are included.

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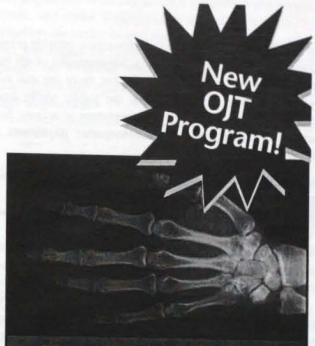

The Physician's Guide & Training Program for

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OSTEOSURV: A NEW TOOL FOR OSTEOPATHIC HEALTH SERVICES AND POLICY RESEARCH

by John Licciardone, D.O.

It is well known that osteopathic physicians provide primary health care for millions of patients in communities of all types and sizes throughout the United States. Yet, there are still many unanswered questions regarding what the public really knows about osteopathic medicine. It is also important to acquire better information concerning who visits osteopathic physicians and how they rate their medical care.

What little we know about such questions generally comes from studies based on administrative databases that are not designed to provide insight into the public's knowledge of osteopathic medicine or osteopathic physician practice patterns. For example, a study based on data from the National Ambulatory Medical Care Survey in 1977-1978 reported that back symptoms were the most common reason for visits to osteopathic physicians.[1] A more recent publication, based on the updated database, reported that osteopathic physicians account for more than 58 million ambulatory patient visits annually in the United States.[2] Such isolated statistics do not provide insight into osteopathic health services.

The Osteopathic Survey of Health Care in America (OSTEOSURV)

The Osteopathic Survey of Health Care in America (OSTEOSURV) was developed in 1998 to serve as a longitudinal research instrument to facilitate uniquely osteopathic research. OSTEOSURV is a questionnaire designed to be administered every two years in the general adult population of the United States. It focuses on the health care needs of ambulatory patients. The main objectives of OSTEOSURV are to monitor changes over time in such measures as awareness of osteopathic physicians, public perceptions of osteopathic medicine, utilization of osteopathic physicians, and satisfaction with health care provided by osteopathic physicians. OSTEOSURV-I was conducted in 1998 as a random national telephone survey. A total of 1,106 respondents participated in the survey. Another 499 participated in OSTEOSURV-II during 2000. A series of publications providing more technical details on OSTEOSURV and early findings are available[3-11] or forthcoming.

Early OSTEOSURV Findings

The geographic distribution of respondents in OSTEOSURV-I and II is presented in Figure 1. This demonstrates that a representative sample of respondents nationwide participated in both OSTEOSURVs. The Table (on page 18) shows that OSTEOSURV respondents are generally similar to the United States adult population, based on data reported by the Census Bureau. The only significant discrepancy is that women were oversampled in OSTEOSURV. This is not an uncommon situation in many surveys, but OSTEOSURV-III will take special steps to ensure a more balanced gender distribution in 2002.

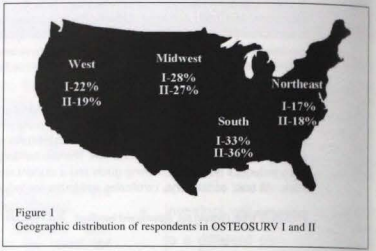

Figure 1
Geographic distribution of respondents in OSTEOSURV I and II

The results of OSTEOSURV-I and II are remarkably consistent in many areas. About one-half of American adults are not aware of osteopathic physicians. About 16-22% have visited osteopathic physicians for health care at some time during their lives, and 5-7% currently have an osteopathic physician as their main health care provider.

When comparing osteopathic physicians and other health care providers such as allopathic physicians and nonphysician clinicians, women are much more likely than men to have visited osteopathic physicians for their health care (Figure 2). Although women generally visit physicians more often than men, it is unclear why they visit osteopathic physicians disproportionately more often than men, even after statistically controlling for such factors as age, race or ethnicity, educational level, residence (urban, suburban, or rural), and geographic location. One possible explanation is that osteopathic physicians may provide more of the preventive medical services often sought by women. Another theory, supported by our research, is that women experience greater improvement in pain or discomfort than men following osteopathic manipulative treatment.

Conversely, members of racial and ethnic minority groups are less likely to visit osteopathic physicians (Figure 3). In fact, visits to osteopathic physicians are about 70% lower than expected among minority groups. Again, the reasons for this finding are unclear, but it suggests the need to improve access to osteopathic medical education among underrepresented minorities and to continue to strive for osteopathic training that meets the needs of our increasingly diverse population.

Respondents generally support the use of osteopathic manipulative treatment as an effective modality for musculoskeletal disorders (Figure 4). Although support for this position is greatest among current patients of osteopathic physicians, even persons who never visited an osteopathic physician tend to agree that osteopathic manipulative treatment is beneficial for musculoskeletal problems. Even greater agreement is noted regarding

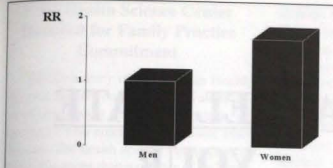

Figure 2
Gender of patients who ever visited an osteopathic physician (vs. other types of providers). Relatives rates (RR) adjusted for age, race/ethicity, education, residence, and geographic location.

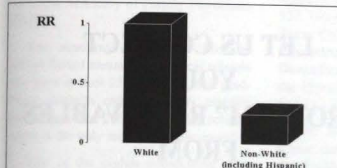

Figure 3
Race/ethnicity of patients who ever visited an osteopathic physician (vs. other types of providers). Relatives rates (RR) adjusted for age, race/ethnicity, education, residence, and geographic location.

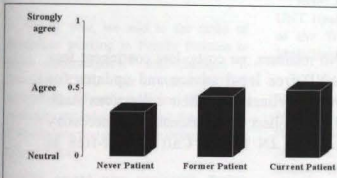

Figure 4
Mean standardized perception scores in response to the item "OMT" is beneficial for musculoskeletal disorder", according to osteopathic patient status, OMT denotes osteopathic manipulative treatment.

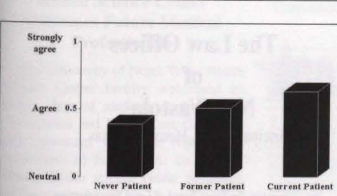

Figure 5
Mean standardized perception scores in response to the item "The cost OMT" should be covered by health insurance", according to osteopathic patient status, OMT denotes osteopathic manipulative treatment.

the desire for health insurance to cover the costs of osteopathic manipulative treatment (Figure 5).

Current patients of osteopathic physicians express high levels of satisfaction with their health care (Figure 6). In fact, osteopathic physicians score higher than allopathic physicians, chiropractors, and other nonphysician clinicians in 8 of 11 patient satisfaction elements, including travel time to their office, availability for urgent or emergency care, reasonableness of fees, emphasis on wellness, distribution of educational materials, respectfulness and courteousness, time spent with patients, and overall satisfaction.

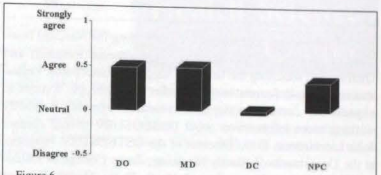

Figure 6
Mean standardized perception scores in response to the item "Overall, I am satisfied with my healthcare provider", according to type of provider (DO denotes osteopathic physician; MD, allopathic physician, DC, chiropractor; NPC, other non-physician clinician).

Future Direction of OSTEOSURV

OSTEOSURV is also designed to collect information about health care issues that are not specifically "osteopathic" in nature, but that may be emerging health-related topics of interest to osteopathic physicians or the public at large. The previous OSTEOSURVs have addressed such issues as sources of health information (e.g. magazines, radio, television, Internet) and areas of biomedical research to receive priority in federal funding. OSTEOSURV-III includes plans to collect data on access to osteopathic health care among racial and ethnic minority groups, health issues for Americans traveling abroad, and preparedness for bioterrorism. In addition to addressing emerging health care issues, OSTEOSURV-III will seek to acquire a much larger sample of respondents and a higher response rate than previous OSTEOSURVs.

Implications for Osteopathic Health Services and Policy Research

The real usefulness of OSTEOSURV is that, for the first time ever, a valid and reliable tool is available to foster research efforts uniquely aimed at addressing ambulatory health care issues relevant to osteopathic physicians and their patients. OSTEOSURV will enhance the ability of the osteopathic profession to conduct research in the realm of health services and policy research. In fact, several osteopathic researchers have already expressed interest in using data from OSTEOSURV to extend their own research.

The OSTEOSURV Program, housed within the Department of Family Medicine at the Texas College of Osteopathic Medicine, is seeking to evolve into a Center for Osteopathic Health Services and Policy Research. To that end, it is requesting grant

Table
Comparison of respondents in OSTEOSURV-I and II with referents from the United States general adult population (data from Census Bureau).

Characteristic	I	II	Referents
Age, yr (mean)	44.8	46.3	47.6
Gender, % women	62	66	51
Race, % White	86	86	83
Household income, $ (mean)	43,300	44,500	43,500
Have health insurance, %	89	90	83

funds from various federal agencies, including the National Institutes of Health and the Agency for Healthcare Research and Quality, and soliciting the financial support of osteopathic organizations, private foundations, and other philanthropic sources to expand its current osteopathic research agenda. Anybody wishing more information about OSTEOSURV should contact John Licciardone, D.O., Director of the OSTEOSURV Program, at the Department of Family Medicine, Texas College of Osteopathic Medicine, University of North Texas Health Science Center, 3500 Camp Bowie Boulevard, Fort Worth, TX 76107, or calling 817-735-2405, or e-mailing to <jlicciar@hsc.unt.edu>.

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NEWS from the University of North Texas Health Science Center

UNT Health Science Center Honored for Family Practice Commitment

The University of North Texas Health Science Center continues to lead all Texas medical schools in the percentage of graduates who enter family practice residencies. The health science center consistently has more than a quarter of its Texas College of Osteopathic Medicine graduates enter family practice.

This commitment has again earned the health science center recognition from the Texas Academy of Family Physicians (TAFP).

The academy presents a Medical School Award annually to medical schools who have at least 25 percent of their graduating students entering family practice residencies. For 2001, the health science center is the only recipient of the award.

This is the eighth consecutive year that the UNT Health Science Center has received the award and the third time that it has been the sole recipient. For the class of 2001, the health science center had 33 percent of its graduates enter family practice residencies.

"Every year, we add to the ranks of physicians working in Family Practice in Texas communities," said Samuel T. Coleridge, D.O., chair of the UNTHSC department of family medicine. "UNTHSC graduates are helping alleviate the shortage of family practice physicians throughout the state of Texas."

The award was presented during TAFP's 52nd Annual Session August 3-5, 2001, in Houston.

Health Science Center Welcomes Future Medical Professionals

The University of North Texas Health Science Center faculty welcomed its newest class of students at the annual Convocation and White Coat Ceremony held September 14 at the Will Rogers Auditorium in Fort Worth. Dr. Ronald Blanck, health science center president, led the ceremony.

The White Coat ceremony is a rite of passage for students entering the academic health community. During the ceremony, students receive gifts signifying entry into their respective health professions. The incoming students are literally "coated" for the first time with a white coat to symbolize humanism and professional ethics in medicine.

For the third year, TOMA purchased the white coats provided to the incoming medical students. Jim Czewski, D.O., TOMA vice president, also presented each first year student with a TOMA lapel pin to wear on his or her new white coat.

This year, the UNT Health Science Center's White Coat ceremony included 122 incoming medical students of the Texas College of Osteopathic Medicine, 62 students of the Graduate School of Biomedical Sciences, 26 new students in the Physician Assistant Studies Program and 112 in the School of Public Health

Dr. Benjamin Cohen, provost and senior vice president for health affairs at the health science center, presented the keynote address during the ceremony.

UNT Health Science Center Names New TCOM Dean

Marc B. Hahn, D.O., has joined the UNT Health Science Center as the dean of the Texas College of Osteopathic Medicine (TCOM).

Dr. Hahn was previously a professor anesthesiology and director of the Pain Medicine Fellowship Program at the Pennsylvania State University College of Medicine. He was also a 1998-1999 Robert Wood Johnson Health Policy Fellow at the Institute of Medicine of the National Academy of Sciences in Washington, D.C. In that capacity, he served as a Health Advisor to the U.S. Senate Committee on Finance.

"Dr. Hahn is an excellent physician, teacher, and administrator," said Ronald Blanch, D.O., health science center president. "These skills will serve him well as he guides the medical school."

Dr. Hahn, 49, served for 12 years in the U.S. Army prior to an honorable discharge at the rank of Major. While in the Army, he served as an anesthesiologist for two U.S. Presidents.

Currently, he is active in clinical research, having published multiple abstracts, book chapters, book reviews, editorials, and scientific papers. He textbook, *Regional Anesthesia: An Atlas of Anatomy and Technique*, was recognized as the Best New Textbook in Clinical Medicine by the Association of American Publishers. The second edition of this textbook is in progress.

The TCOM dean's position became vacant last year when Benjamin Cohen, D.O., was promoted to provost and senior vice president for health affairs. Deborah Blackwell, D.O., associate dean for clinical and health affairs, served as acting dean during the search process.

Donald M. Peterson, D.O.

Recipient of the AOA Distinguished Service Certificate

Donald M. Peterson, D.O., FACOFP, of Mesquite, was awarded the American Osteopathic Association's highest honor during its 106th Annual Convention & Scientific Seminar, held October 21-25 in San Diego, California.

Dr. Peterson's accomplishments are impressive and demonstrate a legendary advocacy of the profession and the people it serves. On the national level, he has served the AOA since 1960 as a member of the Ad Hoc, Bylaws and Resolutions Committees, as well as an AOA delegate. He has also held numerous offices and/or committee appointments in the American College of Osteopathic Family Physicians, the American College of Osteopathic Obstetrics and Gynecologists, the American Board of Quality Assurance and Utilization Review Physicians, the American College of Utilization Review Physicians, and Sigma Sigma Phi. He has the distinction of being the first osteopathic physician elected to the Board of Trustees of the American Medical Peer Review Association, in which he has held numerous positions during the years.

On the state level, Dr. Peterson was a representative to the Texas Medical Foundation (TMF) for 21 years; member of the Texas Board of Health from 1989-1993; and is a past president of the Texas Society of the American College of Osteopathic Family Physicians.

His continuous service to the Texas Osteopathic Medical Association include president; Executive Committee; Board of Trustees; program chair; and House of Delegates. He has also held all positions in his divisional society, TOMA District 5.

Dr. Peterson has been honored with numerous awards, including the Phil Overton Award for Outstanding Leadership in Futherance of Quality Medical Review in Texas, from the TMF; General Practitioner of the Year in 1986 from the Texas Society of the American College of Osteopathic General Practitioners in Osteopathic Medicine and Surgery; and the Sigma Sigma Phi Award of Distinction in 1983.

In nominating Dr. Peterson for the AOA Distinguished Service Certificate, the Texas Osteopathic Medical Association noted, "Throughout a lifetime of devotion to the profession and to his patients, Dr. Peterson serves as a distinctive example to others. His knowledge and futherance of the principles of osteopathic medicine are truly an asset to the entire profession."

TSBME Board Names New Executive Director

The TSBME Board has named Donald W. Patrick, M.D., J.D., as Executive Director of the Texas State Board of Medical Examiners.

Dr. Patrick, 63, graduated from Baylor College of Medicine in 1962 and trained in neurosurgery at Baylor and at the University of Washington. He has been the Chief of Staff at both Brackenridge Hospital and Health South. He served as an on-call neurosurgeon at the Brackenridge Hospital Emergency Department for 23 years. Dr. Patrick was elected President of the Texas Association of Neurological Surgeons in 1988-89.

He graduated from the University of Texas law school in 1996 and received his law license in 1997, practicing with the firm of Chin and Patrick. Prior to accepting his position at the Board, Dr. Patrick was Chief of Surgery at Round Rock Medical Center.

(TSBME news release, 9-17-01)

Three-Quarters of Texas Hospitals' Emergency Departments Divert Patients to Other Facilities Due to Lack of Medical Specialty Coverage

According to a survey by The Schumacher Group, an emergency medicine management firm, patient volume increased at 83 percent of Texas' emergency departments last year, representing a large factor in the increase in the number of patients being diverted. More than half diverted because their departments were overcrowded, while 58 percent of managers in Texas' emergency departments reported that caregivers at their facilities spend less time with patients than they did last year. Of the 30 Texas hospitals surveyed, 40 percent reported seeing more uninsured or indigent patients in the last year.

(Dallas Business Journal, 9-17-01)

Health Care Management Firm Closing Down Operations

The management firm that operates one of San Antonio's largest primary care physician networks, and whose owners include Methodist Healthcare System and five IPAs that represent a combined 130 primary care physicians, has begun to wind down operations and said it has no plans to seek bankruptcy protection. Health care industry officials attribute much of QualityCare's impending demise on full-risk contracting, under which increasing medical expenses far outpaced flat-lined revenues.

(San Antonio Business Journal, 9-10-01)

Donations of Skin Sent to Burn Victims of September 11 Attack

Seventy square feet of skin from Dallas was delivered by two technicians who volunteered to drive the tissue 1,300 miles to Washington after the University of Texas Southwestern Medical Center could not guarantee when they could fly out the skin on a medical or military flight. This according to Ellen Heck, director of the medical center's Tissue Transplant Services Center. The center had 90 square feet of skin on hand instead of the usual 20 square feet, which is used to help burn victims retain fluid, ward off infection and pain, and increase mobility.

(Dallas Morning News, 9-12-01)

Texas House and Senate Name Joint Interim Committee to Monitor the Impact on State Budget Serving Poor and Working-Class Texans

The committee will be chaired by Democrat Sen. Judith Zaffirini of Laredo and Rep. Patty Gray of Galveston, and is charged with reviewing the expense associated with 12-month, continuous eligibility for Medicaid and the Children's Health Insurance Program (CHIP) and making recommendations to the next Legislature; monitoring a new law that allows state agencies to share in bulk purchases of pharmaceutical drugs; monitoring the impact of a bill passed last spring to simplify access to the Medicaid health insurance program for poor children; and overseeing a major reorganization of indigent health insurance programs, acute health reimbursement rates, caseload and cost projections. Medicaid and CHIP currently cost Texas $26.7 billion, or about a fifth of the state's $113.8 billion budget.

(Houston Chronicle, 9-8-01)

One of the Last Medicare HMOs in the Metroplex Plans to Shut Down, Forcing 14,000 North Texas Seniors to Find New Coverage

Citing inadequate funding from the federal government, Texas Health Choice, owned by Sierra Health Services of Las Vegas, said that it is dropping its Golden Choice Medicare HMO as of January 1, 2002. Texas Health's exit will leave Tarrant County with just two Medicare HMOs: Secure Horizons, which is run by PacifiCare Health Systems, and AmCare Health Plans, a Houston-based health plan that entered the local market this year. Texas Health will continue to offer its commercial HMO and point-of-service plans in Fort Worth and Dallas.

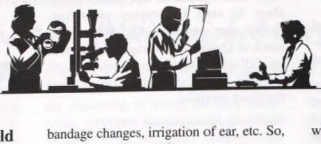
(Star-Telegram, 9-19-01)

Over Half-Million Dollars Unaccounted For in the Bankruptcy Case of Tarrant County's Largest Physician Association

At a September 24 hearing in U.S. Bankruptcy Court, Medical Select attorney Bruce Howell called the missing $503,000 a "mystery account." He said Dan McAfee, Medical Select's sole employee, has been trying to find out what happened to the money. Judge Barbara Houser ruled that a Chapter 11 trustee would be appointed to oversee the company. The ruling squelched a motion that had been filed by some doctors groups to convert the case into a Chapter 7 bankruptcy, which physicians hoped would have forced a resolution more quickly.

(Star-Telegram, 9-25-01)

Self's Tips & Tidings



By Don Self

Medicare Reform Put on Hold

Due to the fact that America has been attacked and we are now in a semi-state of war with the activation of our reservists, tightening down of security and increased vigilance, it is highly unlikely we'll see any kind of large-scale Medicare reform package. It seems the government will not have time to push through any new prescription drug packages for Medicare while they are trying to organize relief for those already injured in the September 11 attacks. Many believe the HHS appropriations bills calling for the increased Medicare spending will speed through Congress, since lobbying efforts seem to be nil right now.

Body Fat Composition

There is no separate CPT code for body fat composition testing. This service would be included in the examination component of the Evaluation and Management code. So, evaluating a patient's body fat composition is simply one of the exam elements of the Physical Examination, which contributes to assigning which level of the E/M to the visit.

Where is the Physician?

There are still many, many offices in this country that are not clear on the Incident-to rules that Medicare carriers (and some private carriers) use. Medicare says that a physician's employees can do certain services that are within their scope of practice, as long as the physician supervises the service. That supervision does not require that the physician actually be in the same room as the employee providing the service, but the physician does have to be present in the same office or suite of offices when the service is being done. These services are considered to be "professional services" such as injections, blood draws, blood pressure checks, bandage changes, irrigation of ear, etc. So, if you're having patients come to your office in the morning for venipuncture or allergy shots while you are at the hospital making rounds, you may wish to change your internal policies.

New ICD-9 Codes for 2002

Even though there are some people telling you to spend money on classes and books on ICD-10, we will still be using ICD-9 books in 2002. Here are just a few of the new codes:

256.31	Premature Menopause
464.0	Acute Laryngitis, No mention of obstruction
464.01	Acute Laryngitis, obstruction
530.12	Acute Esophagitis
564.00	Unspecified Constipation
602.3	Dysplasia of prostate
692.76	Sunburn of 2nd degree
692.77	Sunburn of 3rd degree

Handling Bounced Checks

We recently saw the following letter sent to a patient on their alleged first check to be returned by the bank:

"We recently received a returned check issued to us by you on January 17, 2001. The amount of the check was for $40. We will be unable to refill any prescriptions or see you in follow-up until this check amount and the bank fee of $25 is paid in full, by cash. Payment must be made in full in 10 days or else we will be turning you in to the state attorney's office for writing a check for insufficient funds. We will no longer accept anything but cash for our services to you as a patient."

While we recommend you notify patients of bounced checks, the above is NOT a letter we would recommend. I recommend a phone call to the patient letting them know they need to come in within two days to pick up the check, with cash. I also suggest that your staff let the patient know that this happens to all of us from time to time, and they understand. Remember, the patient is probably embarrassed and it actually might not be the patient's own fault. To permanently lose a patient because of what might be a mistake at their bank or by their spouse could be a tragedy. If the phone call cannot be made, due to no answer by the patient, a simple and courteous letter is recommended.

Follow-Up Consults

I don't think 99% of the doctors in the country should ever use a follow-up inpatient consult code as 99% of them do not do a "follow-up" consult. If the doctor assumed responsibility for ANY PART of the patient's care, then it's not a follow-up consult. It will be a daily care hospital charge instead. Now, how many doctors do you know that will go back to the requesting doctor and tell them step-by-step of what to do for the patient and NOT change the diet, prescription, treatment, advise the patient on counseling, medications, etc.? The moment they do any of these things, they've assumed concurrent care for some portion of the patient and voila, no follow-up consult.

Nutritionists

Nutritionists are not treated like a NP or PA. They can only bill incident to a physician, cannot bill without direct supervision of a doctor, and cannot be paid third party reimbursement (at least not Medicare) without the doctor. However, they can collect cash outside of insurance reimbursement from individuals needing their services. They can negotiate and get allowances for third party non-Medicare payers to pay for their services without a doctor on a payer-

by-payer basis. But Medicare does not pay for their services beyond what is defined in the diabetes program.

Monitors Are Saving Lives

If you have patients with intermittent syncope, dizziness, vertigo, shortness of breath, or other symptoms and you put them on a 24 hour holter, you have a good chance of not capturing that event in the first 24 hours. Instead of waiting until the event returns more frequently, by putting a 30 day event monitor on the patient, you might be able to capture the arrhythmia and save the patient's life. I am hearing from doctors every couple of weeks stating how this has helped their patients. I'm hearing from the doctor's staff as to how this is making the doctor money, too. The best part is that it doesn't cost the doctor one penny. Call me at 800-256-7045 and let me explain how this can help your patients and your practice. I now have hundreds of physicians using this service from us and it doesn't cost them anything.

Don Self & Associates, Inc.
305 Senter Avenue
Whitehouse, TX 75791
908-839-7045; FAX 903-839-7069
E-mail: donself@donself.com
www.donself.com

Coming Soon to Your VCR: Diabetes Experts

Diabetes in Texas: Making a Difference, a new continuing education videotape from the Texas Diabetes Council and Program, Texas Department of Health, will be available beginning Fall 2001.

The tape offers a convenient way for primary care physicians and other healthcare professionals to learn about standards of care and medical management of patients with Type 2 diabetes. For more information call the Diabetes Program office at 512-458-7490.

Montemayor Approves Clean Claim Improvements

Texas Department of Insurance Commissioner Jose Montemayor has adopted new rules aimed at making health insurers and HMOs pay doctors more quickly.

"Texas' doctors and providers have a legal right to payment within 45 days of sending in their clean claims. These rules remove some of the ambiguities and loopholes that stood in the way of prompt payment," said Montemayor.

The new rules apply to claims filed by physicians and providers for services rendered on and after September 12, 2001. The rules govern claim payments by HMOs and insurance company preferred provider plans.

Montemayor also said that he intends to appoint a Clean Claims Working Group, which will include physician, provider and health insurance representatives, to study remaining obstacles to prompt payment of clean claims.

Key provisions of the new rules approved by Montemayor include:

- Proof of receipt. Physician and provider contracts may include procedures for proving that HMOs and preferred provider carriers have received claims. When contracts don't specify a procedure, the rules lay out ways that physicians and providers may establish a "rebuttable presumption" that their claims were received. These include faxing or electronically transmitting a mail log listing all claims mailed to a carrier and retaining the carrier's fax or electronic transmission acknowledgment.

- Contracts. Physician and provider contracts may not include language extending the time for paying a claim or waiving the physician or provider's right to recover reasonable attorney's fees in lawsuits to obtain payments for services rendered.

- Clean Claim Elements/Attachments. Carriers may only require as attachments or additional clean claim elements information from patients' medical or billing records maintained by the physician or provider. The rule addresses complaints that carriers have requested such information as police reports, health plan members' tax statements, and documents from college and university registrars' offices.

- Audits. A carrier has 180 days from the date of receipt to audit a claim it has questioned. The old rules had no such time limit. When a claim is audited, Texas law requires the carrier to pay a minimum of 85 percent within the first 45 days. At the end of the 180-day audit period, a carrier must notify the physician or provider in writing of the audit results and either pay the additional 15 percent or other amounts due to the physician or provider or seek a refund of amounts paid that are not covered.

- Disclosure. When an HMO or insurer requires attachments or clean claim elements beyond those mandated by TDI rules, it must disclose that requirement more prominently than in the past. Physicians and providers must receive at least 60 days' notice of such a requirement. HMOs and insurers must conspicuously and prominently notify physicians and providers of the name, address and telephone number of the place where claims must be sent for processing.

Schedule II Prescriptions – New Design

Prescriptions for Schedule II controlled substances will have an entirely new look in the near future. You will recall that in 1999, the 76th Legislature amended the Texas Controlled Substance Act and replaced "triplicate prescriptions" with "official prescriptions." This was the year that electronic submissions of Schedule II prescriptions to the Texas Department of Public Safety became a requirement, making the need for triplicate prescriptions obsolete.

As a result of these changes, the Texas Department of Public Safety has been working with a contract vendor to develop and produce a single-copy prescription form for use in prescribing Schedule II controlled substances. The new prescription will be used in addition to the traditional triplicate prescription, and either prescription will be valid if the practitioner's preprinted DPS controlled substances registration number is valid. It is anticipated the new single-copy prescription will become available for use in late fall.

The new, single-copy official prescription will look considerably different than the triplicate prescription. The official prescription will also contain the following security features, which can help to confirm the validity and legitimacy of the prescription.

- Prescription control number – Preprinted by DPS or contractor and unique to individual prescriptions.
- VOID pantograph – If the prescription is copied, the word "VOID" appears.
- Heat sensitive "RX" symbol – Disappears when rubbed or heated.
- Microlines – The practitioner signature lines are actually the phrase "txdps" printed over and over, which when copied, appears as a straight line.

Additional information is available at the DPS Web site <www.txdps.state.tx.us/criminal_law_enforcement/narcotics/Triplcate>.

(Texas State Board of Pharmacy Newsletter, Vol. XXV, No. 3)

Only Six Percent of Gynecologists Offer the "Early-Abortion" Option

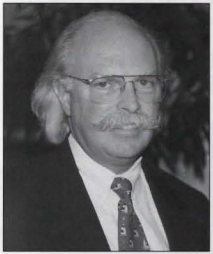
According to a New Survey Released September 24, forty percent of the 595 gynecologists surveyed by the nonprofit Kaiser Family Foundation said they didn't offer the government approved abortion pill, RU-486, also called mifepristone or Mifeprex, because they personally oppose abortion. Of those who don't offer Mifeprex for other reasons, 62% said their patients simply hadn't asked for it and half also cited concerns about protest or violence. Another Kaiser survey of 1,000 women found that 42% confused the abortion pill with the so-called morning-after pill.

(Associated Press, 9-25-01)

Texas Osteopathic Medical Association 46th MidWinter Conference & Legislative Symposium

February 8 – 10, 2002
Renaissance Dallas North Hotel • Dallas, Texas

"A Change of Heart"



Joseph M. Perks, D.O., a family practitioner in Greenville, Texas, is Program Chair for the 46th MidWinter Conference & Legislative Symposium. He has planned and is coordinating an outstanding program to reflect the theme "A Change of Heart...Practicing Preventive Healthcare." Conference attendees will be updated on procedures, products and techniques designed to keep the art of preventive healthcare strong in all physicians' practices. In addition, the conference will feature timely information on OMT, cardiovascular disease, ethics and risk management. Recent legislation and its impact on healthcare will also be presented.

See page 25 for the Conference Program Schedule and page 26 for the Early Registration Form which includes the discounted "early" registration fee.

A CHANGE OF HEART
Practicing Preventive Healthcare

Texas Osteopathic Medical Association
46th MidWinter Conference & Legislative Symposium
PROGRAM SCHEDULE

Joseph M. Perks, D.O., Program Chair

17.75 Catagory 1-A CME Hours Available

Friday, February 8

8:00am – 5:00pm	Committee Meetings
3:30pm – 7:00pm	Registration Open
3:30pm – 7:00pm	Exhibit Hall Open
5:00pm – 6:00pm	Reception with Exhibitors
6:00pm – 7:00pm	Risk Reduction for Patients with Coronary and Vascular Disease *A. H. O-Yurvati, D.O.*
7:00pm – 9:00pm	OMT for the Cardiovascular System *Russ Gamber, D.O.* *Eric Gish, D.O.*

Saturday, February 9

7:30am – 4:30pm	Registration Open
7:30am – 4:00pm	Exhibit Hall Open
7:30am – 8:30am	Breakfast with Exhibitors
8:30am – 9:30am	Challenge of Treating Tobacco Dependence: Translating Research into Practice *Tres Dunmore, M.D.*
Sponsored by:	M.D. Anderson Cancer Center Tobacco Outreach Education Program
9:30am – 10:30am	Management of Migraine Headaches in the Primary Care Practice *Frederick G. Freitag, D.O.*
Sponsored by:	Pharmacia

Saturday continued

10:30am – 11:00am	Break with Exhibitors
11:00am – 12:00pm	Treating Diabetes – New Insulin Medications *Royce Keilers, D.O.*
Sponsored by:	Aventis Pharmaceuticals
12:00pm – 1:30pm	Legislative Luncheon
1:30pm – 2:30pm	Primary Prevention – National Cholesterol Education Program *Michael Clearfield, D.O.*
Sponsored by:	Pfizer
2:30pm – 3:30pm	Ace Inhibitor Risk Reduction – The HOPE Study *Charles A. Reasner, II, M.D.*
Sponsored by:	Wyeth-Ayerst
3:30pm – 4:00pm	Break with Exhibitors
4:00pm – 5:00pm	Medical Ethics *Monte Mitchell, D.O.*

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

5:00pm – 6:00pm	Obesity and Nutrition Speaker – TBA
Sponsored by:	Roche Pharmaceuticals

Sunday, February 10

8:00am – 1:00pm	Risk Management Program
Sponsored by:	Dean, Jacobson Financial Services

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

??? QUESTIONS??? Contact Jill Weir, CAE, TOMA Projects Coordinator
512-708-8662 or 800-444-8662

46th MidWinter Conference & Legislative Symposium
EARLY REGISTRATION FORM

PLEASE PRINT or TYPE

Name:_____

Name for Badge (if different from above):_____

Address:_____

City:_____ State:_____ Zip:_____

Business Phone: (____) _____

Home Phone: (____) _____

FAX: (____) _____

Spouse/Guest Name:_____

D.O. College:_____

Graduation Year:_____ AOA#:_____

Specialty:_____ TOMA District:_____

REGISTRATION FEES

	Postmarked by Jan. 25, 2002	Postmarked after Jan. 25, 2002
TOMA Member	$250 (includes one luncheon ticket)	$325 (includes one luncheon ticket)
Non-Member	$325 (includes one luncheon ticket)	$400 (includes one luncheon ticket)

Please include _____ additional tickets for the Legislative Luncheon on Saturday, February 9, 2002 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 ☐ AmExpress

Credit Card #_____

Expiration Date_____

Name on Card:_____

Signature:_____

REFUND POLICY

- **Refund requests postmarked on or before January 25, 2002 will receive a refund less 25% administration fee.**
- **All refund requests MUST be made in writing.**
- **No refund will be given after January 25, 2002.**

Return completed form, *with payment in full,* to:
TOMA
Attention: MidWinter 2002 Registration
1415 Lavaca Street
Austin, Texas 78701-1634

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

Hotel Information

TOMA's 46th MidWinter Conference & Legislative Symposium will be held at the Renaissance Dallas North Hotel in Dallas, Texas, 4099 Valley View Lane (LBJ Freeway & Midway Road).

Please call the hotel directly to make reservations at 972-385-9000. **Reservations must be made no later than JANUARY 17, 2002** to receive the discounted group rate of $109 per night– single/double/triple.

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

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 September 22, 2001 Board meeting

Donald J. Brown, D.O.
818 Parkland Dr.
Clovis, NM 88101
Dr. Brown is a Non-Resident Associate Member. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri in 1993; and is Certified in Family Practice.

Ronald L. Cook, D.O.
TTUHSC – Department of Family Medicine
3601 4th Street
Lubbock, TX 79430
Dr. Cook is a member of District 10. He graduated from the Texas College of Osteopathic Medicine in 1993, and is Certified in Family Practice

Christopher J. Imperial, D.O.
1512 Holleman
College Station, TX 77840
Dr. Imperial is a first year member and a member of District 18. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Certified in Family Practice.

Peter T. Kropf, D.O.
9805 Anderson Mill Rd.
Austin, TX 78750
Dr. Kropf is a member of District 7. He graduated from the Texas College of Osteopathic Medicine in 1981, and is Certified in Obstetrics and Gynecology.

Charlie Kuo Wei Lan, D.O.
1213 Hermann Dr. #570
Houston, TX 77004
Dr. Lan is a member of District 6. He graduated from the Texas College of Osteopathic Medicine in 1997, and specializes in Internal Medicine.

Steven C. Mays, D.O.
2318 Pat Booker Rd.
Universal City, TX 78248
Dr. Mays is a member of District 17. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri in 1975. Dr. Mays is Certified in Emergency Medicine, but currently has a full-time office practice.

Clayton S. McGuire, D.O.
3603 W. 7th Street
Fort Worth, TX 76107
Dr. McGuire is a member of District 2. He graduated from Oklahoma State University College of Osteopathic Medicine in 1989, and is Certified in Radiology.

Maya M. Namboodiri, D.O.
3433 Riveroad Court #1915
Fort Worth, TX 76116
Dr. Namboodiri is a member of District 2. She graduated from the Texas College of Osteopathic Medicine in 1995, and specializes in Family Practice.

Clayton L. Pickering, D.O.
202 E. Jefferson
Whitney, TX 76692
Dr. Pickering is a member of District 18. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Certified in Family Practice.

H. Bart Robbins, D.O.
750 E. Anderson
Weatherford, TX 76086
Dr. Robbins is a first year member and a member of District 15. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Certified in Pediatrics.

Anthony R. Wright, D.O.
3740 Colony Dr. #208
San Antonio, TX 78230
Dr. Wright is a member of District 17. He graduated from the University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1993; and specializes in Urgent Care and Osteopathic Manipulative Medicine.

Matthew W. Waack, D.O.
12406 Stable Forest
San Antonio, TX 78249
Dr. Waack is an Associate Military Member and a member of District 17. He graduated from Oklahoma State University College of Osteopathic Medicine in 1979, and is Certified in Aerospace Medicine.

Michael G. Clark, P.A.-C, Ph.D.
UNTHSC Physician Assistant Program
3500 Camp Bowie Blvd.
Ft. Worth, TX 76107
Dr. Clark is Assistant Professor in the Physician Assistant Program at UNTHSC. He joins as an Associate Member.

New Intern/Resident Members

Bryce I. Benbow, D.O. graduated from the Texas College of Osteopathic Medicine in 1997; and is serving a Residency in Orthopedics at Osteopathic Medical Center of Texas.

Nicolle R.M. Benz, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Internal Medicine at Maine Medical Center, Portland, Maine.

Lance H. Borup, D.O. graduated from the Kirksville College of Osteopathic Medicine in 2001; and is serving an Internship at Osteopathic Medical Center of Texas.

Bascom K. Bradshaw, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving an Internship at Dwight D. Eisenhower Army Medical Center, Fort Gordon, Georgia.

Steve R. Buck, D.O. graduated from Chicago College of Osteopathic Medicine of Midwestern University in 2001; and is serving a Residency in Physical Medicine and Rehabilitation at University of Texas Southwestern Medical Center in Dallas.

Aaron L. Cernero, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving an Internship at Plaza Medical Center in Fort Worth.

Brent K. Combs, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Pediatrics at Tulane Medical Center, New Orleans, Louisiana.

Yen K. Dao, D.O. graduated from the Texas College of Osteopathic Medicine in

2001; and is serving an Internship at Brackenridge Hospital in Austin.

Elisa D. DePani-Sparkes, D.O. graduated from Nova Southeastern University of Health Sciences College of Osteopathic Medicine in 2001; and is serving a Residency in Internal Medicine at Osteopathic Medical Center of Texas.

William K. Denton, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving an Internship at Plaza Medical Center in Fort Worth.

Robert F. Denyer, D.O. graduated from the Texas College of Osteopathic Medicine in 1997; and is serving a Fellowship in Cardiology at Scott & White Medical Center in Temple.

Timothy J. Doyle, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Family Practice at Osteopathic Medical Center of Texas.

Rosemary A. Dubiel, D.O. graduated from Oklahoma State University College of Osteopathic Medicine in 2000; and is serving a Residency in Physical Medicine and Rehabilitation at Baylor University Medical Center in Dallas.

Danielle A. Eigner, D.O. graduated from Western University of Health Sciences in Pomona, California in 1999; and is serving a Residency in Family Practice at Brackenridge Hospital in Austin.

Jeffrey F. Erdner, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Emergency Medicine at Thomasson Hospital in El Paso.

Theresa Nguyen Garza, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Family Practice at Charlton Methodist Hospital in Dallas.

Daniel P. Gilday, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Emergency/Internal Medicine at Christiana Care Health System, Newark, Delaware.

Grider G. Gordon, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving an Internship at Plaza Medical Center in Fort Worth.

Terry A. Grover, D.O. graduated from Midwestern University Arizona College of Osteopathic Medicine in 2001; and is serving an Internship at University of Texas Health Science Center, San Antonio.

Rachna Gupta, D.O. graduated from the Texas College of Osteopathic Medicine in 2000; and is serving a Residency in Internal Medicine at Sinai Hospital, Baltimore, Maryland.

Sharon M. Gustowski, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Alex T. Hewlett, D.O. graduated from Ohio University College of Osteopathic Medicine in 2000, and is serving a Residency in Internal Medicine at University of Texas Medical Branch in Galveston.

Daniel Anh-Dung Hua, D.O. graduated from Kirksville College of Osteopathic Medicine in 1998; and is serving a Residency in Pediatrics at Texas Tech University Health Science Center in Amarillo.

David M. Hufnagel, D.O. graduated from Chicago College of Osteopathic Medicine of Midwestern University in 1999; and is serving a Residency in Internal Medicine at Brooke Army Medical Center, Fort Sam Houston, Texas.

John Jason James, D.O. graduated from Pikeville College School of Osteopathic Medicine in Pikeville, Kentucky in 2001; and is serving an Internship at Osteopathic Medical Center of Texas.

Van L. Jones, D.O. graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri in 2001; and is serving a Residency in Internal Medicine at Scott & White Memorial Hospital in Temple.

Jeremiah N. Keng, D.O. graduated from the Texas College of Osteopathic Medicine in 2001; and is serving a Residency in Family Practice at Brackenridge Hospital in Austin.

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