

# TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LVIII, No. 9

October 2001



plus

AOA  
House of  
Delegates  
Report

page 17

## *Sports Medicine*

*Every sport puts stress on the body in different ways.  
However, all sports share a common thread – you can't play  
your best if you're injured.*

*pages 6 – 16*

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# CALENDAR OF EVENTS

## OCTOBER 21 - 25

### "106th AOA Annual Convention"

*Sponsored by the American Osteopathic Association*

Location: San Diego Convention Center, San Diego, CA

Contact: Ann Wittner, 800-621-1773

E-mail: mthompson@aoa-net.org

## 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

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## DECEMBER 1

### TOMA Board of Trustees Meeting

Location: TOMA State Office, Austin, TX

Contact: Paula Yeamans

800-444-8662 or 512-708-8662

## 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; or 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

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## 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

## Correction Effects of Lamisil® Tablets

Physicians are urged to read the following clarification in reference to the article, "FYI on Fungus Treatment," which appeared in the July/August 2001 issue of the *Texas D.O.*

The above referenced article contained misinformation about the possible association of Lamisil® Tablets (indicated for the treatment of fungal nail infections or onychomycosis) with serious cardiac adverse events. This is inaccurate.

The FDA public health advisory brought attention to possible adverse reactions among two oral antifungal agents, Lamisil® Tablets and Sporanox® Tablets. However, physicians are advised that the advisory actually addressed cardiac problems of congestive heart failure associated with Sporanox only, not Lamisil® Tablets.

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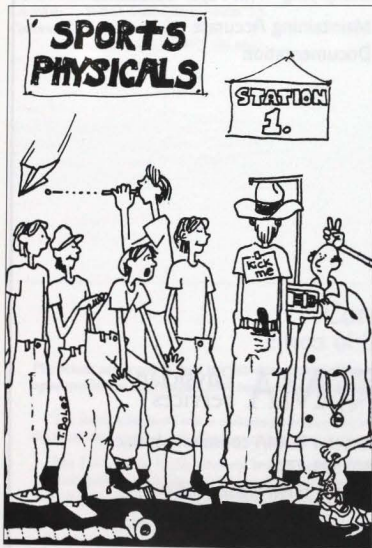
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# GETTING (A) PHYSICAL

by Alan R. Stockard, D.O., Fellow, American Osteopathic Academy of Sports Medicine

*"There is a necessary evil called the Preparticipation Physical Evaluation (PPE) for junior and senior high school athletes. The schools and coaches find it necessary for liability reasons. Parents feel it is necessary to make sure their son or daughter can safely play sports. Physicians and trainers say the PPE is necessary to uncover conditions that might prohibit or limit certain physical activities."*



In order for this goal to be accomplished, an accurate sports medical history should be completed by the parents (who know their child's history better than the child does), and a thorough physical exam should be performed in a quiet, comfortable setting such as a physician's office.

The history is now a simple matter. There is a standard form now recommended in a monograph published in 1997 jointly by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine. This form asks all the pertinent questions that can lead the physician to suspect potential exercise-induced conditions such as asthma, cardiovascular problems, heat injury, neurological problems, or musculoskeletal deficiencies. Without asking all pertinent questions, a potential life-threatening condition can be easily overlooked, especially if the physician is hurried or not particularly familiar with athletes.

The physical exam itself is the typical thorough, complete physical with special emphasis on the neurologic, cardiovascular, respiratory and musculoskeletal exams, including range of motion and manual muscle testing of all joints. Once the medical status of the athlete is determined, he/she is then cleared to play unconditionally, after completing evaluation/rehabilitation of specific conditions, or with restriction to contact or non-contact sports.

In order to achieve the best PPE, the exam should be performed either in a physician's office (preferably by the athlete's personal physician) or in a quiet private setting elsewhere. Mass physicals in a locker room are not conducive to good outcomes due to the noise, hurried atmosphere and lack of equipment/personnel. Also, PPEs performed en masse for schools (even at no charge) leave physicians open to liability since they are not protected by either the Good Samaritan Law or the Charitable Liability Act of 1987<sup>1</sup> (which does not hold physicians liable for free physicals done for documented charitable organizations such as the Boy Scouts, Special Olympics, etc.).

Physicians performing athlete PPEs are providing a valuable service, especially if they use this opportunity to counsel young people about sexual issues, drugs, alcohol and tobacco since many young people unfortunately rarely see physicians for the biannual physical recommended by the AAP<sup>2</sup>. Physicians can obtain a copy of the recommended history and physical form by contacting the University Interscholastic League, Box 8028, University Station, Austin, Texas 78713-8028 or calling 512-477-5883.

#### References

1. Thompson, Helene Alt: "Volunteer Liability," Texas Medicine, Vol. 87, No. 7, July 1989, p.58.
2. American Academy of Pediatrics: "Guidelines for Health Supervision," Evanston, IL, AAP, 1985.

Alan R. Stockard, D.O., FAOASM, serves as Division Chief of Primary Care Sports Medicine, Department of Family Medicine, at the University of North Texas Health Science Center at Fort Worth.

# Geriatric Sports Medicine

by Richard J. Perry, D.O.

*"...newly retired people who, now having more free time, wish to become more active."*



Sports medicine evokes images of young, strong, healthy athletes seeking medical care for injuries sustained in competition. With Americans living longer, there is a growing population of older athletes. The Senior PGA Tour, Senior Olympics and other masters level competitions allow athletes to remain competitive longer, thus creating a need for geriatric sports medicine specialists. The exercise boom of the 70's and 80's has transpired into a geriatric population, which is more active and inclined to need sports medicine care. No longer are we retiring and wasting away in nursing homes.

There are several groups of "geriatric athletes," as follows: Those who were competitive athletes, either retired or still competing, that now need on going care for old injuries; recreational athletes, who have exercised and participated in sports for health and entertainment during their adult lives; and, newly retired people who, now having more free time, wish to become more active.

Each of these groups has the same needs as younger athletes in caring for their injuries and health concerns. However, they also

present a challenge in managing multiple coexisting diseases and medications. Geriatric athletes may be suffering from hypertension, diabetes, arthritis, or Parkinson's as well as other disabilities from injuries sustained over the years. They may require guidance in maintaining their desired level of activity and may need to find new sports that are better suited for their abilities and limitations. Recreational athletes may present with the same problems and concerns as retired professional athletes. Newly retired people wishing to become more active need medical guidance and clearance, stress testing if indicated, and advice on starting and maintaining an exercise program.

Geriatric sports medicine is an expanding field offering opportunities for physicians to care for a "new breed of athlete." We need to encourage all of our geriatric patients to be athletes and be prepared to meet their specific needs.

*Richard J. Perry, D.O., is board certified in Family Practice, Sports Medicine and Geriatrics by the AOBFP. He is a 1990 graduate of the University of North Texas Health Science Center at Fort Worth, Texas College of Osteopathic Medicine, and has been in private practice in Sanger, Texas, since 1991.*

# An Unusual Discovery in an Injured Baseball Player

by Richard J. Perry, D.O.



This is a case presentation of a 12-year-old baseball player. He originally presented in October 1993, after being hit in the eye by a foul tipped ball while batting. Past medical history was significant for exercise induced asthma, well controlled with albuterol MDI. He had no other medical problems. The patient was seen in an ER where a CT scan was performed to rule out fracture of the orbit. No fracture was present; however, a large mass of the clivus and base of the skull was seen. Further study with an MRI showed the tumor to be in the clivus and posterior pharynx. He had no neurologic symptoms prior to discovery.

He underwent excision of the tumor in November 1993; subsequent pathology was read as a chordoma, a benign tumor. Post operative MRI revealed residual tumor and a chiari malformation, necessitating radiation treatment, which was completed in May 1994. Two years later, the patient developed a subarachnoid hemorrhage. Arteriogram showed no A-V malformation, aneurysm and no vasospasm. Follow up MRI have shown no evidence of tumor.

Presently, the patient is 19 years old and doing well. He does have bilateral CN VIII deficits secondary to the radiation treatments. He functions well with hearing aids. Additionally, he has a left CN XII deficit and decreased right arm swing. He has successfully returned to playing baseball and received a scholarship to college, where he is the starting shortstop.

*Richard J. Perry, D.O., is board certified in Family Practice, Sports Medicine and Geriatrics by the AOBFP. He is a 1990 graduate of the University of North Texas Health Science Center at Fort Worth, Texas College of Osteopathic Medicine, and has been in private practice in Sanger, Texas, since 1991.*



# Stress Fractures

## Case Review of a 13 Year-Old Female Figure Skater

by Martha A. Dodson, D.O., M.P.H.

A 13 year-old female competitive ice-skater presented to an outpatient family medicine clinic for evaluation of right-sided low back pain. The pain was insidious in nature over the prior two to three weeks without an inciting incident. It was dull in nature and did not radiate. It occurred only while skating, specifically when landing on her flexed right leg after a jump and proceeding into full knee and hip extension. The pain was alleviated by rest.

The patient had been skating daily for approximately seven years for a minimum of two hours a day. She stated she had fallen numerous times onto her hips and back during the course of her training and that she had a similar pain, though of much more limited duration, approximately three months prior. The intensity of her training had recently increased in preparation for an upcoming competition.

Physical examination of her back revealed full range of motion in the cervical, thoracic and lumbar segments with an increased lumbar lordosis and mild rotoscoliosis. There was no point tenderness along the spinous processes; however, there was mild point tenderness to palpation of the L2-5 paravertebral musculature and subjective right-sided lumbar pain with lumbar hyperextension. The motor and sensory examination to the lower extremities was within normal limits as were the patellar and achilles deep tendon reflexes. The straight leg raise was negative as was the Flamingo balance test.

Radiographs of the lumbosacral spine were unremarkable. Single photon emission computed tomographic (SPECT) bone scintigraphy revealed abnormal tracer uptake activity in the right side of the posterior elements of L-4 (figure 1).

A computed tomography (CT) scan (figure 2) showed an incomplete stress fracture of the right pedicle of L-4 with increased sclerosis at the site. This was

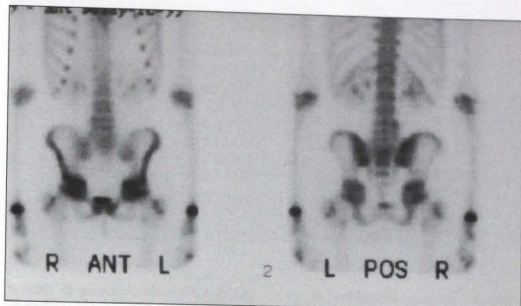


Figure 1

felt to be consistent with repetitive trauma and an incomplete healing stress fracture.

The treatment plan for this patient's lumbar stress fracture consisted of three, four-week phases. The initial phase consisted of a period of relative rest during which time she was not to participate in any athletic activity that elicited pain; jumps, hyperextension. Additionally, she was fitted with a lumbosacral corset to be worn 24 hours a day. The second phase consisted of abdominal stabilization exercises and removal of the corset to sleep. The final phase consisted of progressive abdominal and lumbosacral stabilization exercises as well as a slow progression into her sport-specific activities. Progression to each new phase in treatment was dependent upon pain-free activity. At this time her treatment is ongoing.

## Discussion

### Overview of Stress Fractures

The medical literature does not agree upon the etiology of stress fractures, nor does it have an exact definition of stress fractures and consequently, there are not precise values for the incidence of stress

fractures. Hulkko et al site stress fractures in 3-5% of chronic sport injuries.<sup>1</sup>

A variety of theories have been proposed to explain the cause of stress fractures. The traditional explanation, supported by Wolff's Law of Transformation<sup>2</sup>, is that osteoblastic activity is unable to keep up with the osteoclastic activity of remodeling which is an adaptive response to increased, repetitive stress placed upon bone. This dysequilibrium weakens the cortex and a stress fracture can result. Stress may be either in the form of an increase in exercise volume, intensity or frequency. Another theory is that physical exercise leads to muscle fatigue thereby altering movement patterns and distributions of stress, with resultant excessive concentration of force being transmitted to focal sites on the underlying bone.<sup>3</sup> Stanitski proposed that the reverse is in fact the case. He proposed that highly concentrated muscle forces acting across a specific bone from particular, repetitive tasks enhance the loading that occurs. The rhythmic, repetitive muscle action causes sub threshold, mechanical insults that exceed the stress-bearing capacity of the bone, resulting in a stress fracture.<sup>4</sup> The



Figure 2

common offense, regardless of the supporting pathophysiology, appears to be excessive, repetitive motion.

The medical history usually reveals an increase in training frequency, duration or intensity prior to the onset of insidious pain in the area of the fracture. The change may be over a period of time or it may be a single event. The pain may have been present for several weeks to several months. Initially the pain may be experienced only towards the end of the inciting, repetitious activity and resolves with rest. If the diagnosis of a stress fracture is delayed, and the repetitious training continues, the pain may progress to being experienced earlier in the training session and requiring prolonged rest for resolution. Ultimately, the athlete may experience pain with non-training activities including ambulation and may result in a limp if the fracture involves a lower extremity.

Clinical impression suggests that stress fractures are more common in weight bearing activities, particularly those involving a running or jumping component.<sup>5</sup> There are sport-specific patterns of stress fractures as noted in a literature review by McBryde (Table 1).<sup>6</sup>

The relative incidence of stress fractures appears to increase with age. Orava et al found that 9% of stress fractures

occurred in children less than 15 years of age, 32% in 16–19 year olds and 59% in patients older than 20 years.<sup>7</sup> Yngve<sup>8</sup> reviewed 23 published reports of stress fractures in children less than 14 years old and noted a difference in the distribution of stress fractures between adult and pediatric athletes. The tibia was the predominant site of stress fractures in the pediatric athletes with an incidence of 51%. Other sites, in descending order, were the fibula 20%, pars interarticularis 15%, femur 3%, metatarsal 2%, and the tarsal navicular 2%. In adults, tibial stress fractures are likewise most commonly reported with 50% incidence, followed by metatarsal at 14%. Spinal involvement was less than 1% in adults.

Prepubescent girls who initiate serious training and competition before menarche may have delayed menarche and be at increased subsequent risk for secondary amenorrhea, and therefore fractures.<sup>9</sup> A menstrual history should be obtained including questions which might elicit concern for an eating disorder, often seen among lean body mass competitive female athletes, which can result in bone demineralization and an increased risk for stress fractures.<sup>10</sup>

The physical examination is crucial to correctly diagnose an injury. Pain on palpation is the hallmark of the physical exam. Deformity at the fracture site is not usually

present and edema and erythema may or may not be present. Pain often is felt at the fracture site with percussion to the bone at a point distant to the suspected fracture.

Abnormal biomechanics have been implicated as causative factors in stress fractures. Therefore, intrinsic anatomic variations such as pes planus / cavus, excessive pronation, leg-length discrepancy, and limited ankle dorsiflexion must also be identified. The differential diagnosis must include insufficiency-type stress fractures, metabolic bone disease, tumors (i.e., osteoid osteoma), chronic compartment syndrome, medial tibial stress syndrome, infection, avulsion fractures, muscle strain and other overuse injuries such as bursitis, tendonitis or fascitis.

Multifaceted variables in the development of the stress response account for the variation in radiographic findings. Because this is an injury continuum the point in the course of the response will determine the radiological findings as well. Radiological changes may not be present for two to three weeks following the onset of symptoms with maximum periosteal new bone formation at six weeks.<sup>11</sup> In actual practice only 50% of stress fractures will be seen on plain films.<sup>3</sup> The gold standard is the technetium-99 diphosphate three-phase or single-phase bone scan, which incorporates the isotope into the osteoblasts of new bone formation rendering the area of new bone formation detectable in as little as 48–72 hours following the onset of clinical symptoms.<sup>10</sup> More recently, SPECT scanning has been found to be more specific and sensitive than planar scintigraphy for detecting lesions,<sup>12</sup> especially those of the pars interarticularis.<sup>13</sup> Computed tomography (CT) may be used to identify a fracture and/or to further define the anatomy of the fracture.

Approximately 10% of all athletic injuries involve the spine<sup>14</sup> and as much as 25%–39% of sports-related low-back pain arises from interarticular injuries; either spondylolysis or spondylolisthesis.<sup>15</sup> A high incidence of low back pain has been reported in young athletes; specifically those involved in sports requiring repetitive flexion/extension (football linemen, tennis, volleyball, gymnastics, diving, figure-skating), rotation (racquetball, tennis, baseball, softball, golf) and weight

loading (weight/power lifting) of the spine as part of training.

Morita et al studied 185 adolescents with spondylolysis and classified their pars defects into one of three stages; early, progressive or terminal. Of the 346 pars defects in 185 patients, 39.6% were early, 29.5% were progressive, and 30.9% were in the terminal stages. All subjects were treated conservatively with a lumbar corset and discontinuation of sporting activity for three to six months. Union was achieved in 73% of the early stage defects, 39% of the progressive stage defects and none of the terminal stage defects.<sup>16</sup> Early intervention and treatment can result in complete healing of the pars interarticularis defect while delayed treatment can result in delayed, or non-union of the defect with resulting spondylolysis and persistence of pain and limited future strenuous activity.

Pediatric athletes presenting with low back pain associated with repetitive hyperextension training and a physical examination that demonstrates pain on provocative testing should be evaluated for a vertebral stress fracture. The initial studies should include anteroposterior, lateral and oblique radiographs of the lumbar spine. If these are negative but the index of suspicion for a stress fracture remains high, SPECT scanning should be performed.

## Conclusion

Consider a stress fracture in your differential diagnosis any time you have an athletic patient with localized, insidious pain. Failure to diagnose stress fractures can cause a significant amount of lost time from participation in athletic activities as well as the risks of progression to a frank fracture, non-union of the fractured segments, chronic pain and/or instability, and ultimately early retirement from offending activities.

Table 1.

Sport/Activity	Bone Commonly Involved
Running	Tibia, Fibula
Hiking	Metatarsal, Pelvis
Jumping	Pelvis, Femur
Tennis	Ulna, Metacarpal
Baseball	
Pitching	Humerus, Scapula
Batting	Rib
Catching	Patella
Basketball	Patella, Tibia, Os Calcis
Soccer	Tibia
Swimming	Tibia, Metatarsal
Skating	Fibula
Ballet	Tibia
Fencing	Pubis
Water Skiing	Pars

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Martha A. Dodson, D.O., M.P.H., is board certified in Family Medicine and board eligible in Sports Medicine. She completed a Family Medicine residency in June 2000 at the University of North Texas Health Science Center at Fort Worth, and a Sports Medicine fellowship at the Sports Medicine and Rehabilitation of Texas/UNTHSC in August 2001. She is currently practicing in Arlington, Texas.



# Decompression Illness in North Texas

by Irvine D. Prather, D.O.  
Fellow, American Osteopathic Academy  
of Sports Medicine

## *"The most common scenario of divers with DCI symptoms in the Dallas-Fort Worth area occurs among persons taking short trips to the Mexican Caribbean."*

Decompression illness (DCI), more commonly called the Bends, is broadly categorized in two types. Type I, or pain-only bends, includes any array of arthralgias and/or myalgias. Type II is characterized by neurologic symptoms from mild paresthesias to paralysis. Type II will most likely manifest at the dive site and diagnostic dilemmas will not present to physicians in the Dallas/Fort Worth area. While the overall incidence of DCI is quite low relative to the number of dives completed, twenty to twenty five SCUBA divers are treated in the Dallas/Fort Worth area annually.

Decompression illness is most often described as bubbles of nitrogen interrupting blood flow or joint fluids or nervous tissue. A gas dissolves in a liquid dependent upon the innate properties of that particular gas and liquid, and the pressure under which the gas exists. A common experience is carbon dioxide dissolved in soft drinks. When in the can or bottle, the carbon dioxide is under some pressure and remains in solution. When the container is opened, pressure is released and bubbles form. This is the problem the diver faces.

Nitrogen is an inert gas existing in air at approximately 71%. Under normal atmospheric conditions, our tissues hold as much nitrogen as can be dissolved in them at that pressure. When SCUBA diving, air is breathed under greater pressure, thus more nitrogen will dissolve in the tissues. All tissues take up nitrogen including blood, muscle, nervous, fat, etc. This added nitrogen load poses no problem as long as the diver remains at depth. When the diver ascends, the pressure decreases, the tissues cannot contain as much nitrogen in solution, and it evolves. Like the soft drink analogy, if the top is opened slowly, the pressure decreases slowly and the carbon dioxide seeps out of solution. If the top is removed quickly (i.e., the diver ascends too rapidly) bubbles form.

When divers descend beneath the surface, their tissues begin to take on more nitrogen. The amount of nitrogen depends upon the pressure (i.e., the depth) and the length of time exposed. Therefore, divers must remain at the surface for a specific interval in order for the excess nitrogen to seep out of their system. This

equates to slowly opening the soft drink container. If the diver wishes to fly on a commercial aircraft, he or she must wait an additional length of time. Commercial aircraft cabins are usually pressurized to the equivalent of an altitude of 8 - 10 thousand feet. This further reduces the pressure on the gas and allows for rapid evolution of nitrogen (i.e., opening the drink container quickly).

If a person should suffer decompression illness, their symptoms will depend upon which tissues are disrupted by bubble formation. If a blood vessel in a fat pad is occluded, there could be few symptoms and few sequelae. On the other hand, if bubbles form in the joint fluid, arthralgic pain develops, and if the spinal cord is disrupted, paralysis may develop.

Most sport divers today use dive computers as part of their underwater equipment. These calculate the consumption of nitrogen based on algorithms using time of exposure and depth of exposure. These computers signal when it is safe to return to diving and when it is safe to fly. Divers seem to believe that if they adhere strictly to the rules, they cannot develop DCI. This is not the case at all. In fact, most cases of mild DCI occur to divers who have stayed well within the recommended parameters. Dive computers can very accurately record time and depth, but

they do not record the diver's level of conditioning, percent body fat, level of hydration, and other factors which affect the risk of DCI.

The most common scenario of divers with DCI symptoms in the Dallas/Fort Worth area occurs among persons taking short trips to the Mexican Caribbean. Usually there is limited time to dive and they push their computers to the limit. Evening parties may involve alcohol and dehydrate the diver. People remain asymptomatic until they reach altitude in an aircraft. At that time they develop muscle aches similar in quality to overuse injuries. Often divers attribute these pains to the added strain of unaccustomed exercise associated with diving and deny DCI since they obeyed the rules.

With the following history and the persistence of symptoms, a diagnosis of DCI can be easily made. In a more difficult scenario, the onset of symptoms does not occur until after the plane lands or the next day. This pattern of symptom evolution is difficult to fit into the classic bubble model, but is nonetheless well recognized in the diving medical community. The delay in the onset of symptoms further tends to divert the diver's attention to other diagnoses. For the physician, the challenge is to distinguish between delayed onset muscle soreness and DCI.

In order to assist in making this distinction, the physician needs to do a thorough history and physical and review the patient's dive log. This will only enable the physician to categorize approximately 30% of the patients, and leaves a large number with a diagnosis unestablished. In order to further subdivide this group a trial of pressure is required. The current recommendations are to place the patient in a decompression chamber pressurized to the equivalent of 60 feet of sea water (FSW). The patient breathes 100% oxygen in 20-minute segments while the chamber remains at 60 FSW. The pressure is then gradually reduced over a 30-minute period to bring it to 30 FSW. It remains there for 25 minutes and gradually (30 minutes) ascends to surface. This is the U.S. Navy treatment table 5 for pain only bends. Should the patient experience resolution of symptoms after 10 minutes at depth, the diagnosis of Type I bends is established and the completion of table 5



is the only treatment required. If the patient does not respond to the initial pressurization, the diagnosis remains in question and the treatment is extended in time as is the duration of oxygen breathing (U.S. Navy table 6), with repetitive treatments likely.

A difficulty for divers is that these treatments can be quite expensive. The recommendation from our Hyperbaric unit is that divers purchase DAN (Divers Alert Network) insurance. DAN is a worldwide organization which promotes diving research and diver safety. They are based at Duke University in North Carolina, and can be contacted at 1-800-446-2671 or visited online at <www.diversalertnetwork.org>. An individual dive insurance package currently costs \$29.00 per year and will cover any and all treatment required for a diving injury, even if it is a stubbed toe on board ship. Some dive sites are quite remote and devoid of medical facilities. In these instances specialized air evacuation must be arranged at astronomical cost.

In summary then, while the incidence of DCI is low, it remains a concern for divers. For physicians geographically remote from dive sites, the diagnosis can be difficult to establish. The Hyperbaric treatment facility can double as a diagnostic center. Dive insurance is a worthwhile investment.

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Irvine D. Prather, D.O., is an associate professor and vice chair for Postdoctoral Studies at UNTHSC/COM, program director of the Family Practice Residency Program and medical director of the Wound Healing and Hyperbaric Medicine Center. Board certified in Family Medicine, Dr. Irvine has been on the faculty at UNTHSC/COM since 1991. He is a 1984 graduate of the West Virginia College of Osteopathic Medicine.

## A Call for an Evidence-Based Approach to Boxing Injuries

by Thomas Edwards, MPAS, PA-C, MS-2

Boxing is unquestionably a violent sport. The innately violent nature of the sport leads many to believe that it is also an inherently dangerous sport. This is clearly the intuitive response. As we move into the era of evidence-based medicine, it is important to ask whether this intuitive view is supported by science. In order to evaluate the relative dangers of boxing, it is imperative that we first separate ourselves from the emotional responses that rapidly become evident whenever boxing is discussed. I offer two incidents to illustrate how, even among experienced medical personnel, emotions often interfere with scientific attitude.

The first incident occurred at a Sports Medicine conference I attended several years ago. One highly renowned national expert in Sports Medicine presented a study that, while not the emphasis of his presentation, revealed boxing to be considerably less dangerous than such "safe" sports as cheerleading. At the end of his talk, when questions were fielded from the audience, I tried to ask the speaker about how he felt his data reflected on boxing safety. His abrupt response was that "I don't talk about boxing....It's too dangerous." Clearly, he allowed his emotional response to the sport to cloud his scientific thinking to the extent that he could not see that his own data contradicted his view of the sport.

The second incident occurred while I was working with a prominent emergency medicine group in the Pacific Northwest. Because of my interest in martial arts and kickboxing, I had been asked by a promoter to help recruit additional personnel to provide ringside medical care for an upcoming boxing event. When I approached the CEO of the Emergency Medicine group I worked with to see if any of the physicians were interested in assisting with the event, I was merely told "I expect that no one from this group will be involved with this, or any other, boxing event." The implication was clear that should anyone from our group try to be involved in such an event, the group in some fashion would likely penalize them.

When I began searching the medical literature to evaluate the relative dangers of the sport I discovered there was, compared to other sports, very little data available on boxing related injuries. What I did find was somewhat surprising. Based on published studies, other sports seemed to have a higher incidence of injuries than boxing. For example, during the years from 1970-1992 there were 378 fatal or catastrophic injuries associated with football among high school and collegiate players alone.<sup>1</sup> I found numerous studies comparing the injury rates of various sports, yet seldom were the injury rates in these sports compared to those for boxing.

In one comparative study in Glasgow, boxing ranked 7th in percentage of head injuries admitted to the neurosurgical unit (4%) behind rugby, football, and horseback riding. Perhaps surprisingly, golf had the highest incidence of head injury in this study (27%).<sup>2</sup> A



report published in 1998 reviewed boxing fatalities from January 1918 and January 1997.<sup>3</sup> The study reported 659 fatalities associated with boxing during that time period. This is an average of less than nine per year. Compare this to the previous report of 378 fatal or catastrophic injuries associated with football during a 22-year period. Actual incidence rates may vary as both studies reported only the number of injuries but failed to report the total number of athletes involved or number of contests from which the data was recorded.

The failure to report incidence rates in these studies further illustrates the concern I have raised. Particularly given the inherently violent nature of boxing, it is imperative that we find ways to accurately report and measure the true incidence of morbidity and mortality associated with the sport. Once we have obtained accurate data we need to compare the relative risks of this sport to other popular sports in order to determine if its inherent violent nature does, in fact, translate into an increased incidence of significant morbidity or mortality.

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Thomas Edwards is currently a medical student at the UNTHSC/TCOM as well as a physician assistant.

## Sports Medicine Career Pathways

by Alan R. Stockard, D.O., Fellow, American Osteopathic Academy of Sports Medicine

As the head of the Sports Medicine Division of the Department of Family Medicine and Sports Medicine Student Club Advisor at the University of North Texas Health Science Center at Fort Worth, the most common question I am asked is: "How can I get involved in Sports Medicine"? The answer to this question is somewhat easier than it used to be.

The practice of Sports Medicine has not always been considered a sub-specialty of medicine. The term "Sports Medicine" currently does not even apply strictly to physicians. Sports Medicine is "practiced" by certified and licensed athletic trainers, physical therapists, chiropractors, massage therapists, podiatrists, and personal trainers as well as physicians. In short, any treatment rendered to an athlete by anyone could be called Sports Medicine treatment according to today's current definition. While some would argue that "medicine" should only be practiced by physicians, it is clear that "Sports Medicine" is practiced more often by non-physicians.

For many years (and to some extent the notion still exists), when the term Sports Medicine Physician was used, most people automatically thought of an orthopedic surgeon. Even today, orthopedic surgeons seem to get most of the headlines in the media because they surgically repair a famous athlete's serious traumatic injury. We who practice primary care Sports Medicine know that approximately 98% of Sports Medicine is non-surgical. As osteopathic physicians (well schooled in the structure and function of the musculoskeletal system), we are ideally suited to practice Sports Medicine at high level in any area of primary care. I personally feel that the ideal primary care physician in Sports Medicine is the family physician because he/she can evaluate and treat the entire gamut of health problems that might impair an athlete's performance.

There was a time when a family physician could become a Sports Medicine Practitioner simply by having an interest in athletes and sports. He or she could volunteer as the local high school physician, attending games and performing physicals and indeed practice Sports Medicine. However, through the years as

medicine has become more specialized and attorneys have realized that no physician can possibly know everything about every aspect of medicine, physicians have retreated to a comfort level in which they practice only the type of medicine in which they feel very competent. Sports Medicine is not a conservative, wait and see type of practice. It is an aggressive approach to diagnosis, treatment and rehabilitation as well as preventive measures. It requires that the physician be on the cutting edge of technology in all of those areas.

Today's Sports Medicine physician must know exactly when an athlete (or injured worker) can return to limited physical activity or moderate and strenuous activity with a high degree of assurance that the patient will not re-injure themselves. Americans place a high level of importance on sports. Doctors who deal with athletes comfortably and have good results will be highly sought by athletes, coaches and athletic trainers as well as the schools and organizations for which these athletes participate. An excellent track record of returning athletes and workers to their previous level of intense activity will assure the Sports Medicine physician of wide notoriety and praise.

Until the last two or three years, Sports Medicine education was more or less self-taught through attendance at Sports Medicine meetings and by reading a number of Sports Medicine journals. In the late seventies, the American College of Sports Medicine was formed by a group of physicians and researchers who were interested in learning more about athletic injury and performance. Much collaborative research was done and continues today. Unfortunately, many practicing physicians felt that the ACSM did not give them enough information they could "take home" and use in daily practice but rather produced research-oriented articles.

In the early eighties, the American Osteopathic Academy of Sports Medicine (AOASM) was formed by a group of D.O.s who felt that Sports Medicine was indeed a sub-specialty and began to promote clinical conferences dealing strictly with Sports Medicine issues in daily practice. These physicians were mainly family

*"...orthopedic surgeons, who wish to attract many athletes in today's market, must also complete a one-year Sports Medicine orthopedic fellowship in order to be competitive."*

physicians with a few orthopedic surgeons and physical medicine specialists as well. In 1989, this group produced the first Certificate of Competence in Sports Medicine, which involved a 250-question board type exam as well as an oral/practical portion. Since its inception, the AOASM has desired to produce the first board certification in Sports Medicine. Approximately three years ago, the American Medical Society for Sports Medicine was formed by a group of primary care M.D.s and D.O.s (no orthopedists) to promote primary care Sports Medicine.

In the allopathic profession, the American Academy of Family Practice currently has a Certificate of Added Qualification in Sports Medicine that can be taken only if you complete an AAFP approved residency. Allopathic pediatricians and orthopedic surgeons also have their version of a Certificate of Competence in Sports Medicine.

In the summer of 1995, the American Osteopathic Association agreed to approve the concept of board certification in Sports Medicine in the osteopathic profession by forming the conjoint board of Sports Medicine. This board was made up of representatives from the specialties of family medicine, physical medicine and rehabilitation, pediatrics, internal medicine, manipulative medicine, emergency medicine, preventive medicine and the American Osteopathic Academy of Sports Medicine. This board was allowed to produce and administer a board exam for the purpose of awarding a secondary board certification in Sports Medicine. (The applicant must hold a primary certification by one of the participating boards.) The applicant must also possess at least four years of practice experience with a minimum of twenty percent in Sports Medicine as well as 400 continuing medical education credits with a minimum of 100 in Sports Medicine. The practice experience requirement can be waived if the applicant has completed a one or two year AOA approved Sports Medicine fellowship in addition to a residency in their primary specialty. Although this was to be a Board Certification in Sports Medicine, when the certificates were mailed out to the initial awardees, it unfortunately read "Certificate of Competence in Sports Medicine" awarded by the Conjoint Committee of Specialty Board Representatives and certified by the American Osteopathic Association. The AOASM will continue to pursue the goal of having this certification named a Board Certification in Sports Medicine.

Both the osteopathic and allopathic professions currently offer one to two year primary care fellowship programs

throughout the country. This concept was pioneered by members of the AOASM in the mid-eighties. Currently there are approximately 50 of these fellowships (both M.D. and D.O.) available nationwide. The AOASM has standard guidelines for these fellowships and certifies them with regular inspections.

These primary care Sports Medicine fellowships are intended to give at least one year of intensive primary care Sports Medicine exposure. Most of the fellowships have physician program directors who are involved with college or professional teams. The idea is to round out the Sports Medicine knowledge of the primary care physician who already has completed a residency in family medicine, internal medicine, emergency medicine, manipulative medicine, pediatrics, preventive medicine or rehabilitative medicine. I recently performed a study involving the division one NCAA universities in the United States with the finding that most universities would prefer their team physician to be a board certified family physician with a Sports Medicine fellowship who also has a Certificate of Added Qualification in Sports Medicine. This is not surprising, as these positions have become highly competitive and widely sought.

Of course, a physician can be involved in Sports Medicine by becoming an orthopedic surgeon, which by training alone would qualify one to practice orthopedic Sports Medicine in a general sense. However, orthopedic surgeons who wish to attract many athletes in today's market must also complete a one-year Sports Medicine orthopedic fellowship in order to be competitive.

In summary, the chief prerequisite for a career in Sports Medicine is an interest in athletics and sports in general, as well as a competitive desire to be a part of a team in which the physician plays an integral role in the success of that team. A physician who can keep the athletes healthy and participating is highly revered and indeed honored by that team through public recognition and awards. However, the personal satisfaction gained by the physician who observes his or her patient succeeding in athletics far out weighs any honor or award that can be bestowed. I would urge any physician in primary care to consider a career in Sports Medicine or at least incorporate some of the principles into your practice.

Please address any questions or comments to: Alan R. Stockard, D.O., FAOASM, Division Chief, Primary Care Sports Medicine, Department of Family Medicine, UNT Health Science Center at Fort Worth, 3500 Camp Bowie Boulevard, Fort Worth, TX 76107, 817-377-3422; astockar@hsc.unt.edu.



# Athletic Physicals – Practical Pearls

by Nick S. Pomonis, D.O.  
American Academy of Family Physicians

As a busy osteopathic family physician, I find myself once again filling out various sports physical forms for Little League and junior/senior high school sports. The following are some observations I have made over the years.

First and foremost, the American Osteopathic Association needs to work toward having athletic physical forms standardized.

I still charge way below a normal office visit. The time-honored \$10 sports physical has been replaced recently by the \$20 visit due to mounting managed-care induced overhead. I still agree with my older and wiser professors that this is a loss leader that serves both as a community service as well as a practice builder. I have learned that the best advantage, in terms of both time and dollars, is to bring my trusty nurse with me on a Saturday morning to the field house the last few days of the school year (in May), after the school has sent home announcements. With the coach's help (heights/weights), we finally get through; but I am still surprised how parents (waiting out in the parking lot) expect their child to be out of the exam in 10 minutes when it is clearly visible that 200-300 kids have arrived for exams. Warning with this method! Fully expect the coaches to see you immediately afterwards to go over their entire personal medical history and medical concerns/refills.

I often wonder (as do many of my colleagues, judging from all the recent comments lately in journals), why we even bother with these exams. The theory is we are trying to prevent a catastrophe (i.e., sudden cardiac death). The facts would argue otherwise. Some countries in Europe do not even require them. Annually, 12.3 million adolescents and college kids participate in sports. About 13 out of 2.7 million high school athletes die suddenly, ten of cardiac death and half of these are from cardiomyopathy. Studies suggest that only 3% of cardiac abnormalities would be found on a routine exam. Thus, one would have examined 630,000 kids before a severe cardiac disease would be discovered during the physical.

The obvious things I look for are atlanto-axial instability in Down Syndrome; asthma; kids that resemble Marfans (the tallest kid in line whose knuckles drag); poor dental hygiene; the female athletic triad of eating disorder, osteoporosis and amenorrhea; hypertension; severe obesity; potential face-disfiguring acne; obvious growth curve abnormalities; and old, unstable joint injuries. The most important question to lead off with is "Have you ever had any chest pain/shortness of breath or a near collapse while exercising?"

One of my oldest concerns, however, is that I have seen some school districts that have allowed these types of exams to be done by chiropractors. The potential medical/legal liability is mind boggling from where I'm standing, but the state boards actually allow this. UIL rules require the exam to be done by a physician, physician's assistant, or nurse practitioner, but then allow local school districts to include other health providers.

I think the best thing I like about these physicals, which is probably the one really redeeming value, is that this will be the only physician visit that year for half of the kids, and it gives me a fast 1-2 minute overview to bring up timely issues. During this quick one-sided chat, I discuss tobacco, sex, grades, STDs, birth control, vaccinations, seat belts, bad diets, anabolic steroids, car speed, alcohol, college plans, drugs, and domestic abuse/dysfunction.

I am sure the kids walk away giggling at that "old-timer, nerd-geek doctor with that two-second, rapid-fire memorized morality/health warning discussion." However, I really hope that I have opened a window of opportunity for them to see me or their own doctor about these subjects, or to at least seriously consider them since they have been validated by a hopefully respected health care professional.

After all, I know I really am a geek; just ask my kids.

Nick S. Pomonis, D.O., is a board certified family practitioner in solo practice in Orange, Texas, and a past team doctor at various area schools. Certified in Disability Impairment Ratings, his special interests are Medical Ethics, Sports/Physical Medicine, Geriatrics, Pharmacology and Correction Medicine. He is a 1983 graduate of University of North Texas Health Science Center at Fort Worth, Texas College of Osteopathic Medicine.



Your dedicated colleagues who served as delegates to the American Osteopathic Association's House of Delegates contributed a lot to make this year's House a valuable experience for Texas osteopathic physicians. Accomplishments at the AOA House of Delegates don't happen in a year; they are achieved across time. Our delegation has worked hard to build a level of trust and understanding among the other osteopathic organizations. Some of our delegation's efforts were realized this summer when Mark A. Baker, D.O. was re-elected to serve as Speaker of the House for the American Osteopathic Association. I would like to personally thank the Texas physicians who attended the AOA House of Delegates. It was a sacrifice of time and finances, but it shows your dedication to the osteopathic profession.

The Texas delegation to the American Osteopathic Association's House of Delegates, led by Chair Rodney M. Wiseman, D.O. and Vice Chair, James E. Froelich, III, D.O., met in Chicago on July 12 through July 15, 2001 for the AOA Annual House of Delegates. Sixteen delegates, eleven alternate delegates and two student delegates from the Texas College of Osteopathic Medicine traveled to the meeting. The Texas Delegation included: Drs. Kenneth S. Bayles of Dallas; George M. Cole of Amarillo; Troy L. Creamean of Corpus Christi; James W. Czewski of Fort Worth; James E. Froelich, III of Bonham; Russell G. Gamber of Fort Worth; Patrick J. Hanford of Lubbock; Royce K. Keilers of La Grange; Hector Lopez of El Paso; James R. Marshall of Abilene; Robert G. Maul of Lubbock; R. Greg Maul of Rowlett; Jack McCarty of Lubbock; Ray L. Morrison of Crockett; Elizabeth A. Palmarozi of Fort Worth; Robert L. Peters, Jr. of Round Rock; Donald M. Peterson of Dallas; Jeffrey D. Rettig of Groesbeck; Daniel W. Saylak of College Station; George N. Smith of West; Arthur J. Speece, III of Burleson; Laura S. Stiles of Mesquite; Monte E. Troutman of Fort Worth; Rodney M. Wiseman of Whitehouse; P. Steve Worrell of Dallas; John L. Wright, Jr. of Plano; and T. Eugene Zachary of Colleyville. Scott Young, MS III was the student doctor delegate and Shelly R. Van Scoyk, MS IV was the student doctor alternate.

The TOMA delegation met for over three hours on Thursday evening to receive their assignments to reference committees and to review and discuss the resolutions that were available at that time. The delegation met again on Friday and Saturday mornings to discuss other resolutions and to report on the reference committee each delegate attended. The TOMA delegation is to be commended for their participation and input on the resolutions.

Many of the reference committees heard testimony and reviewed over thirty resolutions submitted by various committees, specialty colleges and state divisional societies. TOMA was well represented as several members of our delegation served on AOA Reference Committees in various capacities:

**Monte E. Troutman, D.O.**, chaired the Committee on Constitution and Bylaws;

**George M. Cole, D.O.** served as a member of the Ad Hoc Committee;

**R. Greg Maul, D.O.**, served as a member of the Joint Board/House Budget Review Committee;

**James E. Froelich, III, D.O.**, served as a member of the Committee on Public Affairs;

**Rodney M. Wiseman, D.O.**, served as a member of the Committee on Professional Affairs;

# Texas Delegates Achieve Results at the AOA House of Delegates

by Terry R. Boucher, M.P.H.  
TOMA Executive Director



Top R to L: Texas AOA Delegates, Rodney Wiseman, D.O., Steve Worrell, D.O. and James Froelich, D.O.

Above: AOA Board Member, Eugene Zachary, D.O., (L) and TOMA President, Mark Baker, D.O.

Below R to L: AOA board member, Robert Peters, D.O., with Mark Baker, D.O., and Eugene Zachary, D.O.



continued on next page

**Elizabeth A. Palmarozi, D.O.** served as a member of the Committee on Resolutions;  
**Daniel W. Saylak, D.O.**, served as a member of the Committee on Rules and Order

**James E. Zini, D.O.** from Mountain View, Arkansas assumed the presidency of the American Osteopathic Association. Other officers elected were: **Anthony A. Minissale, D.O.** (Pennsylvania) President Elect; **Ray E. Stowers, D.O.** (Oklahoma) 1st Vice President; **Martin S. Levine, D.O.** (New Jersey) 2nd Vice President; and **John W. Becher, D.O.** (Pennsylvania) 3rd Vice President. Those elected to 3-year terms on the AOA Board of Trustees are: **Phillip L. Accardo, D.O.** (Missouri); **Peter B. Ajluni, D.O.** (Michigan); **Joel B. Cooperman, D.O.** (Colorado); **Carlo J. DiMarco, D.O.** (Pennsylvania); **Philip L. Shettle, D.O.** (Florida); **John A. Strohsider, D.O.** (Kentucky). Elected to serve an unexpired one-year term on the AOA Board of Trustees was **Amelia G. Tunanidas, D.O.** (Ohio). Osteopathic student representative to serve on the Board, elected by the Student Osteopathic Medical Association (SOMA), is **Student Doctor W. Ashley Hood** (Missouri). Due to a proposed bylaw change, the House voted to have a resident physician serve as an observer until the House amends the bylaws next year. Elected to serve as the Resident Observer is **Raul J. Garcia, D.O.** (New York).

### Texans Named to AOA Committees

During the AOA Board of Trustees meeting, immediately following the adjournment of the House of Delegates, Dr. Zini named the following Texans to serve on various AOA bureaus, councils, and committees:

**Mark A. Baker, D.O.** – Advisor, Committee on Health Related Policies and Advisor, Committee on Basic Documents and Operations of Affiliated Organizations

**Elmer C. Baum, D.O.** – Advisor, Council on Federal Health Programs

**Ronald R. Blanck, D.O.** – Council on International Osteopathic Medical Education and Affairs

**Mr. Terry R. Boucher** – Bureau of State Government Affairs

**Michael A. Cawthon, D.O.** – American Osteopathic Information Association, Technical Advisory Committee

**George M. Cole, D.O.** – Bureau of Research

**Wayne R. English, Jr., D.O.** – Bureau of Osteopathic Clinical Effectiveness

**Ms. Adela Gonzalez** – Minority Health Initiative Advisory Committee

**Elizabeth A. Palmarozi, D.O.** – Council on Predoctoral Education

**Robert L. Peters, Jr., D.O.** – Chair, Committee on Strategic Planning; Bureau of Osteopathic Clinical Effectiveness; Committee on AOA Organizational Structure; and, Committee on Basic Documents and Operations of Affiliated Organizations

**Bernard R. Rubin, D.O.** – Chair, Bureau of Research

**Frederick A. Schaller, D.O.** – Council on Postdoctoral Training and COPT Subcommittee on OPTI Evaluation

**Mr. Frederick R. Stephen** – Committee on Socioeconomic Affairs

**Scott T. Stoll, D.O.** – Bureau of Research and Council on Research Grants

**R. Russell Thomas, D.O.** – Bureau of State Government Affairs

**Rodney M. Wiseman, D.O.** – Bureau of Osteopathic Clinical Effectiveness

**T. Eugene Zachary, D.O.** – Chair, Task Force on Complementary & Alternative Medicine; Chair, Matching Grants Committee; Chair, Dale Dodson Foundation; Advisor, Bureau of Professional Education; and, Advisor, Council on Predoctoral Education

Re-elected to his 2nd term as AOA Speaker of the House was **Mark A. Baker, D.O.** (Texas). Others elected were **Robert S. Seiple, D.O.** (Ohio) vice speaker; **Ethan R. Allen, D.O.** (California) Osteopathic Progress Fund and **Eugene L. Sikorski, D.O.** (Michigan) to a 3-year term on the Bureau of Insurance.

The 2001 TOMA House of Delegates referred four resolutions to the AOA House of Delegates for consideration and action. The actions on those resolutions are as follows:

TOMA #	AOA #	TITLE	ACTION
01-14	239	Medication for Needy Elderly Patients	Approved as Amended
01-16	240	Insurance Coverage for Chronic Gingivitis	Approved as Amended
01-23	241	Medicare Coverage for Diabetes and Lipid Screening	Approved as Amended
01-27	242	Streamlining Dual Accreditation of Osteopathic and ACGME Residencies	Referred to the Council on Postdoctoral Education

### Joint Board/House Budget Review Committee

This committee met on July 13th to review the proposed budget for the American Osteopathic Association for fiscal year 2002. The committee reported that the AOA has exceeded its goal of having one year's operating funds in reserve. The basic figures listed below reflect the proposed budget for the fiscal year 2002.

Total Operating Revenues	\$17,933,009
Total Operating Expenditures	\$17,604,124
Excess of Operating Revenue over Expenses	\$328,885
Non-operating Revenues (AOA Building and Investments)	\$1,235,582
Increase AOA Net Assets in FY '02	\$1,475,258
TOTAL ASSETS	\$48,043,398
TOTAL LIABILITIES	\$14,882,785
TOTAL NET ASSETS	\$33,160,613

This budget was recommended to the House and was approved as of July 15, 2001. A copy of the complete AOA budget is on file in the TOMA office for examination by the membership.

## Committee on Constitution and Bylaws

The following proposed amendments to the AOA Constitution and Bylaws were approved:

### Proposed Amendments to the Constitution

**Article VI – House of Delegates, Section 1 – Composition.** Representation of Interns and Residents in the House of Delegates. It was determined that this amendment would allow intern and resident delegates to be seated in the 2002 House, but they cannot vote or make motions until the House acts on the proposed amendments to the Constitution (2 years). This proposed amendment would be placed before the House in July, 2002, for final action.

**Section 1.** The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the association and of such other members as may be provided for in the Bylaws, but only delegates of divisional societies and specialty colleges shall have a vote, or privilege of motion.

**Explanatory Statement:** The interests and concerns of the osteopathic physicians in postdoctoral training are often different from the concerns of students and practicing physicians. Providing for postdoctoral physician delegates at the AOA House of Delegates will provide for representation of their special concerns and will strengthen the AOA's efforts to recruit and hold new members, and as such, promote the growth of the Association and the profession.

### Committee on Professional Affairs

- 201 Autonomy of Osteopathic Schools – *Approved as Amended*
- 216 Minority Health & GME – *Referred to Committee on Health Related Policies*
- 217 Occupational Safety & Health Act – *Approved as Amended*
- 218 Patient – Physician Relations – *Approved as Amended*
- 224 Teaching Osteopathic Philosophy & Manual Techniques to Non-Licensed Practitioners – *Referred for Legal Evaluation and Guidance*
- 227 Soft Drinks in Schools – *Disapproved*
- 228 Logo – Use By Affiliates – *Disapproved*
- 233 Medical Errors – Reducing & Improving Patient Health – *Approved*
- 235 Student Loan Interest Deductions – *Approved (adopted to delete)*
- 240 Chronic Gingivitis – Insurance Coverage for Surgery – *Approved as Amended*
- 242 Dual Accreditation of Internships & Residencies – *Referred to Council on Postdoctoral Training*
- 243 Voting System for AOA House of Delegates – *Approved as Amended*
- 244 ACGME Training for Internship Year – *Withdrawn*
- 245 COMLEX - PE – *Withdrawn*
- 246 Creation & Publication of Dual Accredited Postdoctoral Programs – *Approved as Amended*
- 247 Enhancement of the AOA Opportunities Website – *Approved as Amended*

- 248 Osteopathic Education in Rural and Underserved Areas – *Approved*
- 249 Multi-Media Facilitation in AOA House of Delegates – *Approved*
- 250 Office Based Surgery – *Referred to Bureau of State Government Affairs*
- 252 AOA Strategic Plan – *Approved*
- 253 Carbonated Soft Drinks in Schools – *Approved*
- 254 Medical Malpractice Crisis – *Approved*
- 257 Lack of Response to Waiver Requests – *Approved*
- 258 Code of Responsibility – *Disapproved*
- 259 AOA Policy on International Osteopathic Medicine – *Approved*
- 260 Transportation for Disabled/Elderly Attendees at AOA Conventions – *Approved as Amended*
- 261 CME Deficiency List – *Approved*
- 262 Osteopathic Postgraduate Training – *Referred to Council on Predoctoral Education*
- 264 Inclusion of OMT in the Patient Protection Act – *Withdrawn*

### Committee on Public Affairs

- 203 Drug Samples – *Approved as Amended*
- 205 ERISA Act – *Approved*
- 206 Experimental & Research for Drugs, Devices & Procedures – *Deleted*
- 209 Insurance Coverage for Immunizations – *Approved as Amended*
- 211 Mandatory Participation in Medicare – *Approved*
- 212 Medicaid Pharmaceutical Benefits – *Approved as Amended*
- 213 Medicare – Claims – *Deleted*
- 214 Medicare Current Beneficiary Survey – *Deleted*
- 215 Medicare – Reimbursement for OMT – *Approved as Amended*
- 219 Physical Fitness and Sports – *Approved as Amended*
- 220 Postpartum/Postnatal Care – *Deleted*
- 222 Standard Policies for Certifying Indigent Patients for Free Pharmaceuticals – *Approved*
- 225 Medicare Reimbursement for Transportation – *Referred to the Council on Federal Health Programs*
- 226 On Site Lab Work – *Approved as Amended*
- 232 Medicaid Prior Authorization Programs – *Approved as Amended*
- 234 Physician Negotiation Rights – *Approved as Amended*
- 239 Elderly Patients – Medication for Needy – *Approved as Amended*
- 241 Diabetes & Lipid Screening – *Approved as Amended*
- 255 Obesity in Children – *Approved*
- 256 Framework Convention on Tobacco Control – *Approved*
- 263 Commitment to Organ Donation & Transplant Initiatives – *Approved as Amended*
- 265 Vaccine Dilemma – *Approved as Amended*
- 266 Direct Consumer Advertising of Prescription Drugs – *Approved as Amended*
- 268 Managed Care Referrals – *Approved as Amended*
- 269 Timely Access to Ancillary Facilities – *Approved as Amended*

*continued on next page*



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- 270 Prior Authorizations for Medications – *Approved as Amended*
- 271 Emergency Room Reimbursements for On-Call Physicians – *Approved*

## **Ad Hoc Committees**

- 200 AOA Supports Early Voting Day Policy – *Approved*
- 202 Driver Intoxication – *Approved as Amended*
- 204 Small States – *Approved*
- 207 Firearms Federal Legislation – *Approved as Amended*
- 208 Human Immunodeficiency Virus – AOA Position – *Approved as Amended*
- 210 Development of Programs to Reduce Violence – *Approved as Amended*
- 221 Teenage Sexuality, Contraception, and the Media – *Approved as Amended*
- 223 Team Physician – AOA Position – *Approved as Amended*
- 229 Educate Legislators & Federal Agencies on Osteopathic Philosophy – *Disapproved*
- 230 On-Line Prescribing – *Disapproved*
- 231 Domestic and Family Violence Education – *Approved as Amended*
- 236 Aircraft Crew Members – Hypoxia Recognition Training – *Disapproved*
- 237 Good Samaritans (Hold Harmless Agreement) – *Approved as Amended*
- 238 Patient Interpreters – *Approved as Amended*
- 267 Commendation for Dr. Satcher – *Approved as Amended*

## **Committee on Constitution and Bylaws**

The Committee reviewed A-800ff and made the following recommendations:

Article II – Memberships, Section 1 – Classifications; Paragraph G. International Physician Members – *Approved*

Article II – Memberships, Section 1 – Classifications; Paragraph H. Allied Members – *Approved*

Article III – Dues and Assessments, Section 2 – Dues Rates – *Approved*

If a particular resolution is of interest, the TOMA office has a complete transcript of all the resolutions and will mail or fax it to any TOMA member.

## **Texas ACOFP Update**

*by Janet Dunkle, Executive Director*

### **Bruce Maniet, D.O. Joins TxACOF Board**

Dr. Bruce Maniet from Sherman, Texas was elected as a Governor of the Texas ACOFP. Dr. Maniet received his medical degree from the Philadelphia College of Osteopathic Medicine and completed his internship at Memorial Hospital in York, PA. He is a preceptor in the Family Medicine Department of the Texas College of Osteopathic Medicine and has been a member of Texas ACOFP since 1992.

*continued on next page*



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Arlington, Texas 76014  
1508 Sante Fe Drive, Suite 102  
Weatherford, Texas 76086

## **TxACOFP Primary Care Update Postponed Until November 30**

Due to the recent tragedy and the uncertainty regarding airline travel, the Austin Primary Care Update has been moved to November 30 – December 2, 2001. This update will be enhanced by the opportunity to also participate in intensive OMM of the Pelvis workshop, allowing you to mix and match segments with the regularly scheduled program. Registration forms will be mailed the week of October 1, 2001. November 9, 2001 is the deadline for reserving a room at the Renaissance Austin Hotel. For more information, contact the CME Department of the UNTHSC at 817-735-2539.

## **TMF, TSBME and TxACOFP collaborate on Medical Practice Act Presentation**

The Texas Medical Foundation will begin producing a 30 minute presentation of the rules and regulations of the Texas Medical Practice Act. Material provided by the Texas State Board of Medical Examiners will be available on the Internet, CD and VHS and will be distributed to all physicians holding licenses in Texas as well as all 4th year medical students in Texas.

This project is the effort David Garza, D.O., board member of TxACOFP and TSBME, and Patrick Hanford, D.O., past president of TxACOFP and current member of the TMF executive board. Its goal is to inform Texas physicians of the importance of following the regulations of the Practice Act and the serious consequences of an informal settlement conference.

## **TCOM Alumni Reunion Honors Class of '76 and '91**

The recent TxACOFP Annual Clinical Seminar was held in conjunction with the TCOM Alumni Weekend. A 25th Jubilee Dinner was held for the class of '76 at the Colonial Country Club and Family Fun Night was a Country Western Party in the atrium at TCOM.



*Members of the Class of '76 attend the Country Western Party at TCOM.*



*Dr. Robert Paul and his family enjoy the TCOM Reunion Party.*



*Dr. Mike Franz and his family relax during the TCOM Alumni Party.*

*Attending members of the Class of 1976.*



# Texas Osteopathic Medical Association

## 2001 – 2002 Committee Appointments

### Board Consultant for Health

#### Affairs

Joseph Montgomery-Davis

### Department of Professional Affairs

Irvin E. Zeitler, Chair

### Constitution, Bylaws & Documents (2002)

A. Duane Selman, Chair  
Ray L. Morrison, Vice Chair  
S/D Katherine Andrews  
Jobey Claborn  
Gregory A. Dott  
Joseph Montgomery-Davis  
Randall W. Rodgers  
Monte E. Troutman  
Stephen F. Urban  
John L. Wright, Jr.

### Ethics (2003)

Patrick Hanford, Chair  
David R. Armbruster  
Frank J. Bradley  
Nelda N. Cunniff-Isenberg  
George L. DeLoach  
David E. Garza  
Monte M. Mitchell  
David J. Randall  
Irvin E. Zeitler

### Osteopathic Principles & Practice (2005)

George M. Cole, Chair  
Teresa D. Boyd  
Daniel J. Boyle  
Nelda N. Cunniff-Isenberg  
Gregory A. Dott  
Wayne R. English, Jr.  
Russell G. Gamber  
Eric A. Hegybeli  
William D. Hospers  
Ray L. Morrison  
Donald M. Peterson  
Daniel L. Rader  
S/D Turner Slichio  
Arthur J. Speece  
Conrad A. Speece

### Convention Program (2005)

Bobby D. Howard, Chair  
Joseph M. Perks, Vice Chair  
Mrs. Rita Baker, Ex Officio  
Joseph A. Del Principe

Charles R. Hall  
Patrick J. Hanford  
Pam McFadden  
Nick S. Pomonis  
A. Duane Selman  
George N. Smith, Past Chair  
Jill Weir, Ex Officio  
P. Steve Worrell

### Physicians Health & Rehabilitation (2005)

John R. Marshall, Chair  
Dan W. Saylak, III, Vice Chair  
Edward L. Baker, III  
Mr. Terry R. Boucher  
Daniel J. Boyle  
Ronald W. Brenz  
John J. Cegelski, Jr.  
Jerry T. Davis  
Richard A. Friedman  
Doyle F. Gallman, Jr.  
Samuel B. Ganz  
Gunda L. Kirk  
Neal S. Levy  
Jeffrey C. Thompson  
Stephen B. Trammell  
Robert S. Wilson  
Ms. Paula S. Yeamans

### Professional Liability Insurance (2006)

Bobby D. Howard, Chair  
Jack McCarty, Vice Chair  
Kenneth S. Bayles  
Mr. Terry R. Boucher  
Richard A. Friedman  
James E. Froelich, III  
Elizabeth A. Palmarozzi  
George N. Smith

### Socioeconomics (2004)

Kenneth S. Bayles, Chair  
Ted C. Alexander, Jr.  
Mr. Terry R. Boucher  
S/D Dave Brabham  
George M. Cole  
Al E. Faigin  
Richard A. Friedman  
D. Dean Gafford  
Bobby D. Howard  
Joseph Montgomery-Davis

### Department of Public Affairs

Hector Lopez, Chair

### Environmental Health & Preventive Medicine (2006)

John J. Cegelski, Jr., Chair  
James R. Marshall, Vice Chair  
Merritt G. Davis  
Alfred R. Johnson  
Hector Lopez  
Paul K. McGaha  
John G. Mills  
S/D Reina Patel  
Laura S. Stiles  
Paul S. Worrell

### Awards & Scholarship (2003)

Jerry E. Smola, Chair  
Nelda N. Cunniff-Isenberg  
James W. Czewski  
R. Greg Maul  
Arthur J. Speece, III  
Rodney M. Wiseman

### Military Affairs (2003)

Ronald W. Brenz, Chair  
Ronald R. Blanck  
S/D Happy Castro  
William D. Hospers  
S/D Bruce Weaver  
Arthur S. Wiley  
S/D Christy Zalucki

### Department of Development & Liaison

Daniel W. Saylak, Chair

### Governmental Relations (2002)

Jim W. Czewski, Chair  
George M. Cole, Vice Chair  
S/D Lisa Allen  
Elmer C. Baum  
David M. Beyer  
Mr. Terry R. Boucher  
James E. Froelich, III  
S/D Mark Gamber  
Russell G. Gamber  
Patrick J. Hanford  
Lewis Isenberg, Ex Officio  
Hector Lopez  
Elizabeth A. Palmarozzi

Robert L. Peters, Jr.  
Donald M. Peterson  
Daniel W. Saylak  
A. Duane Selman  
Jerry E. Smola  
S/D Lou Taylor  
Monte E. Troutman  
John L. Wright, Jr.

### Liaison to American Osteopathic Association (2006)

Mark A. Baker  
Robert L. Peters, Jr.  
T. Eugene Zachary

### Liaison to the Texas College of Osteopathic Medicine (2002)

Mark A. Baker  
Mr. Terry R. Boucher  
James E. Froelich, III

### Membership Services & Professional Development (2004)

Daniel W. Saylak, Chair  
Jack McCarty, Vice Chair  
Jamison Albracht  
Samuel T. Coleridge  
Jim W. Czewski  
Joseph A. Del Principe  
Patrick J. Hanford  
Hector Lopez  
S/D Jonathan Matthews  
Joseph Montgomery-Davis  
S/D Christian Niedzwecki  
Elizabeth A. Palmarozzi  
Loraine N. Yeoham

### Strategic Planning (2003)

James E. Froelich, III, Chair  
Joseph Del Principe, Vice Chair  
Ted C. Alexander, Jr.  
Kenneth S. Bayles  
George M. Cole  
Samuel T. Coleridge  
Nelda N. Cunniff-Isenberg  
Gregory A. Dott  
Patrick J. Hanford  
Hector Lopez  
Jack McCarty  
S/D Ryan Morris  
Robert L. Peters, Jr.  
S/D Paula Rossi

Adam B. Smith  
Jerry E. Smola  
Arthur J. Speece, III  
Rodney M. Wiseman

#### **Student/Post Doctoral Affairs (2006)**

Monte E. Troutman, Chair  
John R. Bowling, Vice Chair  
S/D Michael Baldovsky  
Robert C. DeLuca  
Al E. Faigin  
S/D Mark Kuper  
S/D Brandon Lewis  
Hector Lopez  
John C. McDonald  
Elizabeth A. Palmrozzi  
Robert Parrot

Rita Schindeler-Trachta  
A. Duane Selman  
Adam B. Smith  
Laura S. Stiles  
Ronald D. Tanner

#### **Executive Committee**

Mark A. Baker, Chair  
Jim W. Czowski  
James E. Froelich, III  
Hector Lopez  
Daniel W. Saylak  
Bill V. Way  
Rodney M. Wiseman  
Irvin E. Zeitler

#### **Past Presidents' Advisory Council (2005)**

Rodney M. Wiseman, Chair  
All TOMA Past Presidents

#### **AD HOC COMMITTEES**

##### **Archivers/History**

James E. Froelich, III, Chair  
Mr. Terry R. Boucher  
Sam B. Ganz  
Charles D. Ogilvie  
Donald M. Peterson  
Daniel L. Rader  
Mr. C. Ray Stokes

##### **Executive Director Annual Assessment**

Monte E. Troutman, Chair  
Jack McCarty  
Bill V. Way  
Rodney M. Wiseman  
Irvin E. Zeitler

##### **Information**

##### **Technology/Website**

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Rick J. Lin  
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## **Learn to Recognize These Symptoms of an Ailing Practice — Part 3**

One way to stay on top of the business side of your practice is to keep a sharp eye out for signals that something is amiss. TOMA Physician Services has identified financial, operational, and personnel symptoms that may indicate an ailing practice. This article, the third of three in a series, looks at personnel indicators.

- High turnover rate can be costly for a practice. Employees leave for a variety of reasons. More often, they leave because of poor working relationships, lack of respect for management, lack of challenge in the work, lack of growth opportunities, or a culture with which they do not feel comfortable. To find out more information about why your employees leave, you might consider exit interviews or an employee survey.
- Low employee morale and internal power struggles often indicate poor communication among staff members and management. Regular staff meetings can provide an effective avenue for working out misunderstandings and improving communication.
- Increased patient complaints and dissatisfaction may be a by-product of personnel problems. Monitor the way that staff interacts with patients, and then provide them with tools and goals to increase patient satisfaction.

If you need help gauging your practice's health or analyzing symptoms, turn to your organization — the Texas Osteopathic Medical Association. TOMA Physician Services consultants can conduct an operations assessment of your practice, offering customized, practical solutions for your unique operational challenges. The consultants also can help with hiring, staff training, or policy and procedures manual development. Contact Physician Services today for more information at 800-523-8776 or <physician.services@texmed.org>.



# In Memoriam

## John H. Boyd, D.O.

John H. Boyd, D.O., of Eden, passed away September 3, 2001. He was 76. Services were held September 5 at First Baptist Church of Eden.

A 1955 graduate of Kirksville College of Osteopathic Medicine, Dr. Boyd practiced in the towns of Louis and Silvertown before relocating to Eden in 1974, where he had a family practice.

Dr. Boyd was certified by the American Board of Quality Assurance and Utilization Review Physicians, and was an Aviation Medical Examiner.

He was the recipient of numerous awards and honors over the years. He had been a TOMA member since 1955, serving as president from 1973-74. He was a former member of the House of Delegates and was vice speaker of the House from 1966-72. In 1994, Dr. Boyd was awarded the TOMA Distinguished Service Award for outstanding service and contributions to the osteopathic profession.

Locally, he had held many offices including Wharton County health officer, Briscoe County health officer, Southern Pacific Lines local surgeon, Eden City health authority, Concho County Hospital Board of Trustees, Eden Detention Center medical director, and Menard Manor medical director.

Dr. Boyd had also served as president and vice president of the Civil Aviation Medical Association; president and chairman of the review committee of the Texas Institute for Medical Assessment; secretary/treasurer of the Texas State Board of Medical Examiners; and as a professor at Texas College of Osteopathic Medicine.

Other memberships included the State Rural Medical Education Board; Quality Assurance Committee; American Osteopathic Association; Aerospace Medical Association; Mensa; and the Texas Medical Foundation.

Survivors include his wife, Myrtle Boyd of Eden; seven children, John Hamilton Boyd, III, of Nuevo, California; James Robin Boyd of Bryan; Dr. Teresa Diane Krantman and Robert Boyd, both of San Antonio; Ann Maxwell of San Angelo; Deborah Carol Carrigan of Lubbock and Melody Sue Medders of Eden; one special niece, Janet Franklin of Abilene; one sister, Bess Hamlett of Sweeney; three

brothers, Joe Boyd of Port Lavaca, Bob Boyd of Schulenburg and Bill Boyd of Kingsville; 15 grandchildren, Philip, Chris and Scott Boyd, Steven and Amy Jasper, Lance, Zeb and Jeremy Holt, Ashley and Terrence Medders, Kayla Krantman, Megan Boyd, Darrel and Danny Poore and Melanie Oaks; and three great-grandchildren, Brandon and Lance Boyd and Blake Jasper.

## David B. Greene, D.O.

Dr. David B. Greene of Heath, passed away on July 5, 2001. He was 71. Services were held July 7 at Holy Trinity by the Lake Episcopal Church in Heath.

Dr. Greene was a 1957 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri.

Certified in Family Practice, he had been in private practice in the Oak Cliff area from 1962 to 1995. He served as assistant director of Columbia Dallas Southwest Family Practice Residency Clinic. Dr. Greene was also a longtime TOMA member.

An avid sailor, he and his wife were early members of the Rush Creek Yacht Club, in which he had served as club commodore. He was also a member and had served as a senior judge of the U. S. Sailing Association, and had been secretary and treasurer of the Texas Sailing Association.

Dr. Greene was also a member of Holy Trinity by the Lake Episcopal Church. Survivors include his wife, Betsy Greene of Heath; brother, Lowell Greene and wife, Ann, of New Smyrna Beach, Florida; mother-in-law Marietta Bork; niece, Suzanne McLean; and nephew, Michael Greene.

## Grover Stuckey, D.O.

Dr. Grover Stuckey of Brownsville, passed away on April 23, 2001. Born in 1918, he was a 1940 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri.


A certified surgeon, Dr. Stuckey was retired at the time of his death. He was a long-time member of TOMA, and had been honored with Life Membership.

## Applications to U.S. Medical Schools Fell 3.7 Percent in 2000 — Fourth Straight Year of Decline

Reasons for the drop, according to the American Medical Association's medical education council, could include attractive jobs in dot-coms and information technology; the prospect of large medical school debts; and increased paperwork, regulations and concerns brought on by managed care. The applicant pool last year totaled 37,092 and included 17,274 women, a 9.9 percent drop from 1999, while the number of minority applicants climbed two percent to 4,266.

(*Journal of the American Medical Association*, 9-5-01; *Associated Press*, 9-5-01)

# Claim management at its best.

A woman with short blonde hair, wearing a dark blue blazer over a black top, is smiling and holding a dark folder. The folder has a small gold-colored plaque that reads "Teresa Canant-Finch, M.D., M.P.L., TMLT". In the background, there is a framed picture on the wall and a stack of papers on a table.

Teresa Canant-Finch is a fighter. An experienced fighter. As a senior litigation supervisor for TMLT, Teresa has managed malpractice claims for physicians for sixteen years. She is good at what she does, but is the first to say she doesn't achieve her success alone.

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# Independent Investor

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

October 2001

## "Caveat Emptor" For Those Who Rely on Analysts' Recommendations

Thanks to the explosion of the Internet and the proliferation of financial cable television channels, investors looking for information or advice on stocks have access to a wealth of data.

Analysts, whose ratings are widely quoted in the financial press and featured prominently on television programs that report on the stock market, often provide the most visible evaluation. However, for investors who rely solely on the advice of analysts they believe to be objective sources of information, the Latin phrase "*caveat emptor*," or buyer beware, best applies.

Confusing classifications, a lack of accountability for their evaluations and inherent conflicts of interest mean analysts' recommendations should at best be examined closely.

To begin with, the classifications used by investment firms when evaluating a stock's prospects vary widely. An online search for investment banks' ratings systems reveals that many employ a unique system of ratings, making it difficult to com-

pare a stock's standing with analysts from one firm to the next. Dozens of different ratings are used, often employing vague classifications such as "accumulate," "hold" and "outperform." One firm's recommendation to "buy" may represent its highest rating, while for another firm the same term ranks below "strong buy" and may even hold a negative connotation. Unless one is familiar with each firm's ratings system, these labels are rendered nearly meaningless.

Another troubling aspect of analysts' ratings is a general lack of accountability. Much time and effort is spent tracking the performance of a particular stock and ranking this data relative to its peers, yet little attention seems to be paid to the accuracy of the analysts who follow these stocks. Websites that champion the cause of individual investors, such as Motley Fool ([www.fool.com](http://www.fool.com)), are rife with examples of how analysts sometimes not only miss the boat on rising or falling stocks, but also often provide recommendations that are effectively the opposite of sound investment advice. One such example tracks an analyst's appearance on television to announce a sell rating for a popular stock. Nine months and a 40 per cent gain later, the analyst finally changed his rating to "buy."

The conflict of interest inherent when brokerage firms issue analyst ratings and perform underwriting business also raises questions. Underwriting

public offerings for companies is lucrative business, and the recommendations from analysts are an effective publicity tool. An analyst that issues a negative rating risks scaring off profits for his or her company, while a positive rating on a stock for which the analyst's firm has an underwriting relationship can mean bigger profits for the investment bank.

One certainty is that following analysts' recommendations should not be the sole basis of a stock investment strategy. Picking a stock on the basis of its short-term potential to rise or fall is a risky practice. A buy-and-hold investment strategy, in which profits are reinvested and allowed to compound over time, eliminates the headache and heartache of guessing where a stock is headed in the short term. This approach allows the benefits of compounding interest to work to the advantage of a portfolio over a long period of time, and perhaps equally important, frees up investors to concern themselves with matters other than deciphering the real meaning of the word "outperform."

Country Dean, CFP  
Jake Jacobson, CLU, ChFC  
Jeff Schmeltekopf, ChFC, CFP

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# Disability Income Insurance Policies Aren't All Alike

*"Protecting your livelihood could be the most valuable financial move you'll ever make. Asking the right person the right questions will ensure that it is."*

Your single most important asset is your ability to earn a living. That's why disability income insurance – coverage that will pay you while you are unable to work due to long-term illness or injury – is essential for financial security.

Since physicians tend to be more aware of the need for disability coverage than the general public, you're already likely to have coverage. But, whether you bought a policy before or are planning to buy one now, you should be asking yourself if it's the best one for your needs.

The fact is, not all DI policies are alike. Policies that are adequate for typical wage earners may not cover your special needs as a high-earning professional. These are the provisions physicians should look for in a disability income policy:

## Your Occupation Coverage

A "your occupation" rider provides the most comprehensive protection for the income you can command by virtue of your highly specialized skills. A good policy already covers you for a disability in your own occupation for the duration of the benefit period. This rider removes the language "and not gainfully employed" from the policy definition of total disability. The full benefit would be payable if you are unable to perform the material and substantial duties of your regular occupation i.e. medical specialty, even if gainfully employed in another occupation.

## Non-cancelable Coverage

A non-cancelable, guaranteed continuous policy will keep you covered even if your health deteriorates in future years, as long as premiums are paid on time, the company cannot change the policy or it's premium rates until the first premium due date on or after the your 65th birthday.

## Choice of Waiting Periods

Only you can determine how long you can maintain your finances on your own before disability payments begin. A choice of waiting periods, ranging from

60 to 730 days, gives you the flexibility to get the coverage you need without paying for unnecessary benefits.

## Recurrent Disability Provision

Some disabilities come back, thwarting your best efforts to stay at work. Choose a policy that acknowledges this reality with a generous recurrent disability provision. The provision enables you to waive another waiting period if your disability returns after you're back at work.

## Residual Benefits

These benefits cover the likelihood that you won't be able to generate adequate income if you return to work on a reduced schedule or in a reduced capacity after a disability. The residual provision will continue to pay a partial benefit, proportionate to your income loss, if you are able to return to work while you are still recovering from a disability. The best residual clauses will pay benefits even if you experience as little as a 20% loss of income.

## Cost of Living Benefit

You want to know that benefits will increase while you are disabled to keep pace with inflation. Look for a policy provision that will automatically give you coverage an annual "raise" while you are receiving benefits.

## Indexing of Pre-Disability Earnings

Likewise, to ensure your residual income will keep pace with inflation, your pre-disability earnings should be increased each year you continue to receive benefits. The increase should be pegged to a guaranteed minimum or the increase in the Consumer Price Index, whichever is higher. Indexing of pre-disability earnings will increase your benefits.

## Psychiatric and Substance Abuse Limitations

The policy should treat mental, nervous, alcohol and drug addiction claims as any other sickness and pay benefits for the duration of the policy. If the policy

provides an option to allow a choice of benefit periods on psychiatric and substance abuse claims, it would be ideal to provide the most liberal coverage period to protect your ability to earn a living.

These benefits form the core of adequate coverage for physicians. Policies that don't provide every one should be eliminated from the running. Once you've narrowed the field, you can consider additional benefits to customize your policy. For example, waiver of premium will continue paying your premiums while you're collecting disability benefits. Guaranteed insurability options let you increase coverage as your income goes up without proving medical insurability. The lifetime monthly benefit rider provides a lifetime total disability benefit, paid during continuous total disability. A premium refund benefit will return money to you when you remain healthy and don't file claims.

Of course, price is also a consideration – but it should be the final one. Compare prices only after you've identified policies that offer the provisions you need.

Now that you know what to look for, what's the best way to evaluate the policy you already have or are thinking of buying? Just as patients consult you because you know more about medicine than they do, it's to your advantage to consult a disability income specialist: Someone who specializes in disability income instead of dabbling in it will have in-depth knowledge about the many policies and provisions on the market. Ask them to perform a policy comparison – and explain the differences in plain English – to help you make an informed decision.

*David Lutz, RHU began his insurance career with Paul Revere Life Insurance Company in 1994 as an Individual Disability Income Specialist and joined Ackley Financial Group in 1997. He works with physicians, business owners and other professionals.*

*Neil H. Resnik, LUTCF, founded Creative Financial Professionals in 1981. CD200106101, EXP 7/31/2002*

# LOOKING BACK

## "CELEBRATING 100 YEARS OF OSTEOPATHIC MEDICINE IN TEXAS"

*The following provides a sense of the many obstacles faced by early osteopathic physicians in their fight for equal recognition of the profession, in both private and government settings. The text is taken from "The First Decade of Osteopathy in Texas 1900-1919," by James Holloway, D.O., published in Dallas in 1944.*

### Congressional Recognition of Osteopathy (Pages 103-107)

Favorable legislative recognition of Osteopathy by Congress is due in the main to three factors, viz.: Its legal standing in all the States; its phenomenal record in the treatment of the scourge of pandemic Influenza and Pneumonia during World War I; and to the activity of the American Osteopathic Association through its department of Public Relations headed by Dr. Chester D. Swope of Washington, D.C. Dr. Swope stands in the same relation to national legislation as did the late Dr. Arthur G. Hildreth to State legislation, and both deserve the grateful thanks of the entire profession for their efficient labors.

When in 1918 our service men were dying by the thousands, the Osteopathic profession, which had demonstrated its success in handling the influenza scourge, offered its service to the medical heads of our Army and Navy, which offer was rejected. The Surgeon General of the day made the following report: "To admit Osteopathic physicians as such without the degree of Doctor of Medicine would have the practically unanimous opposition of this and all Allied countries, and justly so, as lowering the standards, educational and professional, of our Medical Corps, and would have a discouraging and detrimental effect upon the general morale of the Corps."

Notwithstanding the fact that in many states the tests for admission to practice were identical (as they are today), and the courses given in the schools cover the same number of hours of instruction, Osteopathic physicians were refused to serve their country professionally because their degrees were D.O.s and not M.D.s. Since that date much progress has been made in both Medical and Osteopathic education and practice.

Coming to the present Global War, the same unyielding attitude is shown by the heads of our medical service system, in spite of Congressional action favoring the admission of Osteopathic physicians into the professional service of both Army and Navy. The following clipping taken from the Dallas Morning News of January 10, 1944, quoting from a copyrighted article by United Feature Syndicate, entitled "No Naval Osteopaths", shows the unmistakable determination of the medical hierarchy to maintain its exclusive control of this service, "The flu has been epidemic partly because there aren't enough doctors to care for the civilian population. This shortage of doctors could be somewhat relieved, however, if the services would commission osteopathic physicians instead of making them orderlies, whose duties range from dumping bedpans to cleaning floors."

"Actually, Congress has already ruled for commissioning osteopaths in the Navy, but the American Medical Association has put such pressure on Navy Surgeon Gen. Ross T. McIntire that the will of Congress has been thwarted and osteopaths are still being used frequently as orderlies."

"More than a year ago Congress authorized the Navy to commission osteopathic graduates. Last June, Congress specified in the Navy appropriation bill that funds were available for the "pay of commissioned medical officers who are graduates of reputable schools of osteopathy." Still no action from the Navy."

"Admiral McIntire contends that osteopaths are not qualified for general practice. The osteopaths contend that they are. Meantime Admiral McIntire continues to use, with his No. 1 patient, F.D.R., a mild form of osteopathy which he calls physiotherapy. At the end of every day, McIntire's assistant, George Fox, stimulates the President's circulation with a therapeutic massage."

As to the question of fitness of Osteopathic physicians for the service, it is the understanding of the writer that quite a number have made application, proffering to undergo any tests required of medical applicants. As yet, to our knowledge, not a single applicant from our ranks has received appointment. Apparently it would seem that Navy regulations take "priority" over congressional action, the supposed voice of the people of the United States.

It is a matter of record in the files of the Judge Advocate General of the Army, that in World War I about twenty-five osteopathic physicians took the regular Army medical examination for commissions in the medical corps, answered the same questions, met the same tests, passed with good grades, received the hearty recommendation of the medical board for commissions, and were turned down by the office of the Surgeon General.

ExPresident Theodore Roosevelt, writing to Dr. Green of New York, Dec. 17, 1917, thus expressed himself, "I am sorry that licensed osteopathic physician who have passed the medical examining board, examinations for commissions in the medical corps and have been recommended, have not received them. I earnestly hope Congress will pass legislation enabling osteopathic physicians to serve their country in the capacity for which they are best fitted."

Senator Warren G. Harding wrote in February 1918: "I have a very high opinion of the value of osteopathic treatment...but have long since come to a realization of the hostility of the regular school of physicians toward the recognition of anything new in the medical service."

A resume of some of the laws enacted by Congress of interest to the osteopathic profession, is here given:

1. In 1929 a measure governing the licensing of physicians in the District of Columbia, had this specific clause in it, "The degree of doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations."

*continued on next page*

**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>.

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## Managed Care Premiums Are Projected to Rise 15 Percent in 2002

That finding of an annual survey of more than 75 major employers, coalitions, health plans and benefit consultants in 28 states shows the increase to be higher than the 11 percent to 12 percent hike pushed through in 2001, and notes that next year's increases will hit Texas, Florida, New Jersey, Ohio, Iowa and Alabama particularly hard. Prescription drug cost increases of 15 percent to 20 percent continue to be a key driver, along with increased utilization brought on as HMOs loosen the reins on medical management, as well as higher provider reimbursements resulting from tough negotiating stances taken by hospitals and physicians over the past 18 months. Government mandates, including patients' rights legislation giving consumers the right to sue their HMO, will only drive rates up further.

(*Managed Healthcare Market Report*, 8-15-01)

*Continued from previous page*

2. An amendment to the Act relating to United States Employee Compensation provides: "The term "physician" includes surgeons and osteopathic practitioners within the scope of their practice as defined by state law. The term "medical, surgical, and hospital services and supplies" includes services and supplies by osteopathic practitioners and hospitals within the scope of their practice as defined by state law". This law became effective May 31, 1938.
3. In the law cited as the Military Appropriation Act, passed May 31, 1941, the following language is found: "For the pay of interns who are graduates of or have successfully completed at least four years of professional training in reputable schools of medicine or osteopathy at not to exceed \$720.00 per annum each". Similar appropriations have been made since.
4. The Naval Appropriation Act, 1944, carried the same language, ad id previous Acts, viz.: "For pay of commissioned medical officers who are graduates of reputable schools of osteopathy".
5. Under a law cited as "Labor-Federal Security Appropriation Act", approved July 12, 1943, in providing obstetrical care for wives of service men, this clause is found: "Provided that no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order, or regulation relating to the care of obstetrical cases which discriminate between persons licensed under state laws to practice obstetrics". Another clause states: "Provided further, that the foregoing proviso shall not be construed as to prevent any patient from having the services of her own choice, paid out of this fund, so long as state laws are complied with". On October 1, 1943, \$18,600,000 additional was made available for the care of service men's wives, and the House Appropriation Committee stated that these funds are to be used in the same way.
6. In a law entitled "Public Health Service Act of 1943", in section 4, this language is incorporated: "For the duration of the present war and for six months thereafter, graduates of reputable schools of Osteopathy shall be eligible for appointment as reserve officers of the Public Health Service".



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