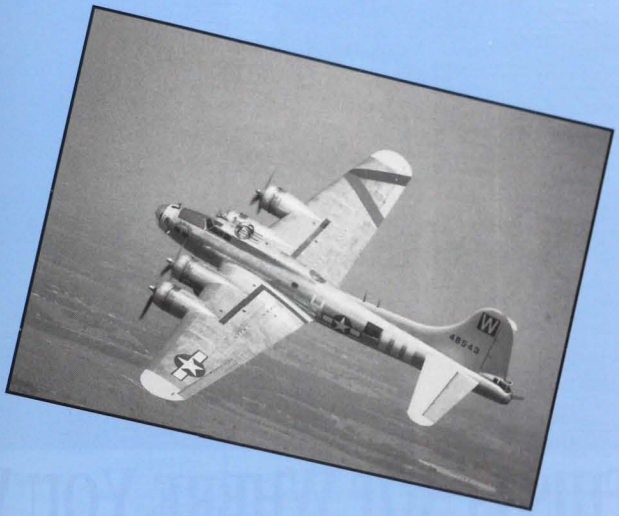
TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
May, 1997
LIV, No. 5

SOAR WITH THE SUSTAINERS



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TEXAS D.O.

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS D.O.
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

May 1997

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Calendar of Events

MAY 14-17

98th Annual Convention and Scientific Seminar
Sponsored by the Michigan Association of Osteopathic Physicians & Surgeons
Location: Hyatt Regency Dearborn, Dearborn, MI
Hours: 34 1-A Hours
Contact: 800-657-1556

27

"Medical Futility: When is Enough Enough?"
Sponsored by Osteopathic Health System of Texas, Osteopathic Medical Center of Texas, UNTHSC Department of Medicine and UNTHSC Department of Medical Humanities
Location: Osteopathic Medical Center of Texas V.L. Jennings Outpatient Pavilion, Conference Center 1001 Haskell Street, Fort Worth
Time: 2:00 p.m.
Hours: 2 AOA/AMA Category 1
Contact: Robin Rienstra, OHST Corporate Communications, 817-735-4466

JUNE 1-5

Hawaii '97: A State-of-the-Art Pediatric Update
Sponsored by the American College of Osteopathic Pediatricians
Location: The Ritz-Carlton, Kapalua in Maui, Hawaii
Hours: Over 20 AOA Hours
Contact: ACOP, 301-968-4180; FAX 301-968-4199

11-15

17th Annual Primary Care Update
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Sheraton Fiesta Padre Island Resort South Padre Island, TX
Hours: 24 AOA Hours
Contact: UNT Health Science Center, Office of Continuing Medical Education 800-987-2CME (2263)

12-15

D.O. Brand of Medicine
98th Annual TOMA Convention and Scientific Seminar
Sponsored by the Texas Osteopathic Medical Association
Location: Radisson Plaza Hotel and Tarrant County Convention Center Fort Worth, TX
Hours: 27.5 AOA Hours
Contact: TOMA 512-708-8662; 800-444-8662; FAX 512-708-1415

JULY 16-19

3rd Annual Primary Care Update
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Sheraton Uptown Albuquerque, Albuquerque, NM
CME: 24 AOA Hours
Contact: UNT Health Science Center, Office of Continuing Medical Education 800-987-2CME (2263)

25-27

Annual Meeting of the Colorado Society of Osteopathic Medicine
Location: Manor Vail Lodge, Vail, CO
CME: 18 AOA Hours and Physician Assistants credits
Contact: Patricia Ellis, 303-322-1752 or 303-322-1956
E-mail: csom@capcon.com
http:\\www.capcon.com/csom

JULY 31 - AUGUST 3

40th Annual Clinical Seminar
Sponsored by the Texas ACOFP
Location: The Adams-Mark Hotel, Dallas, TX
CME: 29.5 Category 1-A credits
Contact: Janet Dunkle, Texas ACOFP Executive Director, 888-892-2637 or 512-708-9959

AUGUST 9-10

Sutherland's Methods for Treating the Rest of the Body
Sponsored by Dallas Osteopathic Study Group
Location: Dallas, TX
CME: 16 Category 1-A Credits
Contact: Conrad Speece, D.O., 10622 Garland Road, Dallas, TX 75218 214-321-2673

Articles in the "TEXAS D.O." that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the "TEXAS D.O." is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

Legislative Update

Editor's note: The following legislative updates were faxed to TOMA members in March. Due to time constraints in the final rules, they are being printed here for your information.

Texas Board of Health Amends Final Rules on Non-Certified Radiologic Technicians

Under pressure from TOMA and other health provider groups, the Texas Board of Health amended and approved the final rules, including the addition of four new hardship exemptions, for non-certified radiologic technicians (NCT). The new rules delete pediatric radiology from the list of hazardous procedures and authorize R.N.s and P.A.s to perform fluoroscope, shoulder girdle and sternum radiographs and radiographs using contrast media. However, on or after January 1, 1998, the R.N. or P.A. must have completed the training prescribed by Texas Department of Health rules in order to perform these procedures.

Although 10 hardship exemptions are available, the one that will probably be most applicable to TOMA members is Section 143.19 (I); *"Financial hardship to the physician due to the training requirements. Employment of a person performing radiologic procedures who is registered with the Texas State Board of Medical Examiners (TSBME) on or before 1-1-98 and the physician attests on a sworn affidavit that the person is adequately supervised and trained for the procedures being performed."*

In order to obtain an exemption by January 1, 1998, physicians are urged to apply now, but no later than November 1, 1997, to allow sufficient processing time. Applications postmarked after November 1 may not be approved until after the January 1, 1998, deadline for completing the training requirements. Approval of a hardship exemption is for one (1) year. Hardship exemption application forms are available from the TDH. TOMA members may apply for a hardship exemption application packet by calling 512-834-6617. For a complete copy of the adopted rules, contact the TOMA office at 800-444-8662.

TOMA Introduces Legislation to Place NCT Registration Under the Texas State Board of Medical Examiners

TOMA and other health provider organizations have introduced legislation in the 75th Legislature that will transfer registration of NCTs from the Health Department to the Texas State Board of Medical Examiners. The TSBME would then develop rules that would establish the appropriate amount of training for a NCT in a physician's office. Senate Bill 943 by Senator Jane Nelson (R-Flower Mound) and House Bill 1644 by Representative Tom Uher (D-Bay City) creates a Radiologic Advisory Committee composed of a variety of health providers including an osteopathic physician. Another provision changes the "grandfather" deadline from January 1, 1998, to September 1, 1998; while another provision exempts a person who performed radiologic procedures, under the direction of a physician on or before September 1, 1996, from complying with the requirements. Please contact your State Senator and Representative immediately and ask them to support these two bills. To find the names and numbers of your elected officials, contact the TOMA Office or the Texas Legislature Online (www.capitol.state.tx.us). Thank you for your help. ■

AAOA President to be Special Guest During TOMA Convention

Mrs. Carolyn H. Carr, president of the Auxiliary to the American Osteopathic Association (AAOA), will be addressing the TOMA House of Delegates as well as the ATOMA House of Delegates during TOMA's convention in Fort Worth.

Mrs. Carr is serving her ninth year on the AAOA Board of Directors. As president, she presides over the AAOA House of Delegates, the AAOA Board of Directors and Executive Committee meetings. During the past eight years on the AAOA Board, Mrs. Carr served on and chaired numerous committees. She has served two years as AAOA secretary, three years as director, as first and second vice president, and as president-elect. In addition, she has chaired the National Osteopathic Student Scholarship Commission, Allied Organizations, Educational Endowment and Legislative Committees.

Born in Washington, Pennsylvania, Mrs. Carr has actively supported and promoted the osteopathic profession for the past 40 years. A past president of the Auxiliary to the Florida Osteopathic Medical Association, she held all state offices and chaired both the AFOMA and APCOMS (district) Scholarship and Student Loan Programs; and assisted deserving osteopathic medical students by obtaining thousands of dollars in scholarships and student loans. She is the recipient of the first annual "Distinguished Service Award," presented by the Pinellas County Osteopathic Medical Society, and the "Special Recognition" award from her local auxiliary for her work with scholarships and student loans. Mrs. Carr is an active member and former chairman of the board of trustees at Sun Coast Hospital Foundation and is a member of the Administrative Board and Music Ministry of Ahona United Methodist Church.

Mrs. Carr is office manager for her husband Charles L. Carr, Sr., D.O., who has surgical practices in Largo and Dunedin, Florida. Her hobbies include music, art, golf, travel and enjoying her 10 grandchildren.

Combining music and medical changes, Mrs. Carr chose "In Tune with the Times, Like Music in Motion" for her theme, expressing the hope that in the near future, patients, physicians and medical personnel alike will experience peace of mind in dealing with the constant changes in medicine. With four osteopathic physicians in her immediate family, supporting the osteopathic profession and trying to keep abreast of the constant changes in medicine have been a priority and life's work for Mrs. Carr. ■

Managed Care: A Look from the Inside Out

By Lois Weixler, D.O., FAADEP

I am a family practitioner who has worked in the managed care setting for the last three years. I have worked with Humana Health Care Plans in Louisville, Lexington and Frankfort markets.

We, as primary care physicians (PCPs), are in control of our futures in this changing medical environment. We can learn to play the game, and become involved in the initiation and growth of the managed care in our area, or we can let it run us out of business as we know it by not being willing to adapt and influence change.

The Managed Care Companies want to develop an efficient, well oiled network of PCPs and specialties to serve their enrollees. They will not tolerate overuse and inefficiency. Their reprimand for unwanted practice behavior is to remove that physician from the network of providers.

I have developed a list of "Covenants of Managed Care" to outline some of the changes that must occur internally in your practice to fit into the managed care mold. Because these Managed Care Companies see themselves as "divine powers," I have used language that the Managed Care Companies would use if they were a little more bold.

Covenants of Managed Care

1. Thou shall retrain the patients to understand their policies.

2. Thou shall begin charting dates and results of maintenance and preventive medicine visits. For example, PAP smears, PSA tests, rectal exams and flexible sigmoidoscopy.

3. Thou shall not order tests that do not match the diagnosis.

4. Thou shall not order tests that maintenance visits will not pay for. For example, Medicare visits only allow a certain number of screening blood tests per year.

5. Thou shall track appointment availability for physical exams, maintenance follow-up visits and acute appointments.

6. Thou shall track appointment no show rates.

7. Thou shall track appointment cancellation rates.

8. Thou shall not see the patient without collecting a copay in full.

9. Thou shall not bill a patient for a copay, if not paid at the time of the visit.

10. Thou shall inform the patients that a referral takes five business days to complete.

11. Thou shall inform patients that appointments they make as a self referral will not be honored unless the primary care provider approves of the need for the referral and the referral process can be completed before the appointment date.

12. Thou shall inform the patients that the referral network for your practice is not always the same as the list in the book that your patient got from the Managed Care Company.

13. Thou shall create a patient grievance procedure to handle patient complaints and problems.

14. Thou shall complete phone call messages within two hours of receiving the call. (From the phone ringing to when the definitive action is taken.)

15. Thou shall develop treatment plan flow sheets to monitor progress of patients with chronic diseases like diabetes mellitus or asthma (in addition to health maintenance sheets).

16. Thou shall receive reports from a specialist in a timely manner.

17. Thou shall not approve continued care by said specialist until reports are received.

18. Thou shall not approve referrals made by one specialist to another specialist, or any other service, for example, to PT or Home Health.

19. Thou shall monitor over usage of lab tests, referrals and formulary compliance. Your bonus will be based on it!

20. Thou shall create a mechanism for same day appointments for acute problems.

Some other helpful hints I have gathered in my experience are as follows:

1) Educate your patients as to how their care will become a joint venture and explain how they will have to accept some responsibility for their care. (At least, form a policy point of view.)

2) Read your contracts and be aware what normal routine types of care may be excluded from your patients' coverage.

3) Keep an updatable reference book on all plans you belong to. Include in the book:

- phone and fax numbers of all the contact people at the managed care company
- phone numbers to submit referral information
- requirements for information needed on referral
- what procedure or test require referrals
- network participants that you are familiar with in your area
- formal referral requirements
- services excluded from coverage
- special circumstances unique to each company
- mechanisms that have worked for you to get particularly difficult circumstances approved

Initially, the Managed Care Company will want all physicians in the market area to become providers to begin to track your efficiency. After one to two years they will attempt to narrow their network by choosing the most efficient providers. By this, I mean they will determine which of the providers can provide the most service for the least money. If, in their opinion, you are one of the most wasteful, you will be dropped from their provider network.

You may be discouraged by this process but the concept can be workable. We have to develop a plan of attack. We need to be at the forefront of the changes needed. We need to consider development of an Independent Practice Association (IPA) in our areas to help us gain some bargaining power with these giant companies.

We can be successful in these new times if we work with it, influence it, anticipate the changes and remain willing to adapt. ■

Reprinted with permission from The West Virginia D.O., January-February, 1997.

Does Insurance Status Influence Physicians' Decisions?

Lack of insurance is widely recognized as a bar to full access to the nation's health care system. It's well documented that uninsured individuals generally receive fewer medical services and suffer poorer health outcomes than those who have insurance.

But do doctors treat uninsured patients differently from those who are insured? A new study suggests this is true.

Researchers suspect that insurance-related disparities in the utilization of health care services stem from a variety of causes. These include differing health needs and treatment preferences among insured and uninsured populations.

A new study provides initial evidence that physicians' clinical decisions, particularly those made by providers of primary care, also may be influenced independently by the insurance status of their patients, potentially contributing in a large way to the gap in services received by the two groups.

The researchers' conclusion is based on physicians' responses to a series of 8 clinical scenarios describing problems commonly encountered by providers of ambulatory pediatric and adult primary care. Survey participants were randomly assigned to receive scenarios in which patients were either insured or uninsured and asked to indicate the percentage of patients for whom they would recommend a given service.

"In all cases where differences in treatment recommendations were demonstrated, physicians were more likely to recommend the service to insured patients than to the uninsured," the researchers found.

Overall, services were recommended for 72 percent of the insured patients and 67 percent of those who were uninsured. In situations involving discretionary services - implying clinical uncertainty as to the best course of action - treatment was recommended for 50 percent of the insured patients and 42 percent of the uninsured. For nondiscretionary cases - where a general consensus exists as to the best course of action - treatment was recommended for 93 percent of insured patients and 91 percent of those uninsured.

"Even these minor differences may have important consequences for the uninsured," the study's authors report. "Given the millions of uninsured in the United States, even small differences in recommendation rates may have a clinically important impact on the care received by this group as a whole."

But the researchers also caution that the "high rates of use among the insured may not always reflect higher quality of care." On the contrary, they note that when it comes to discretionary medical procedures, "the insured may be at risk for receiving too much care from physicians."

Data for the study were collected as part of the American Medical Association's 1992 Socioeconomic Monitoring System Survey. The treatment scenarios were presented to a nationally representative sample of nearly 1,200 primary care physicians.

Researchers acknowledge two important limitations to the study: Did the self-reported responses of the participating physicians accurately predict decisions they would make in actual practice, and did the specific inclusion of the patients' insurance status in the scenarios heighten the participants' awareness of that variable and thereby affect their responses?

The study's authors argue, however, that their findings raise sufficient concerns to warrant further research. "Individuals concerned about excessive use of services in the ambulatory setting may want to focus their efforts on modifying physicians' use of discretionary services" for insured patients. And those "concerned about the lower rates of important health care services among individuals without health insurance should engage in further study of the ways in which patients' insurance status influences physicians' judgment." ■

Mort EA, Edwards JN, Emmons DW et al. Physician Response to Patient Insurance Status in Ambulatory Care Clinical Decision-Making: Implications for Quality of Care. Medical Care 34 (August): 783-793, 1996.

(Reprinted from Advances, the national newsletter of The Robert Wood Johnson Foundation.)

Membership *On-The-Move*

This is your last chance to receive $50.00 off your registration fee for TOMA's 98th Annual Convention and Scientific Seminar. Each new member you recruit is a $50.00 savings. For more details or membership applications, call Stephanie, TOMA Membership Coordinator, at 800-444-8662.

Federal Issues

• Rural healthcare bills have been introduced in both the House and Senate. Legislation by Senator Max Baucus (D-MT) and Senator Charles E. Grassley (R-IA) would allow small rural hospitals across the country to apply for a "critical access" designation. The legislation builds on several existing demonstration programs - the Essential Access Community Hospital (EACH) and the Rural Primary Care Hospital (RPCH) programs, as well as the Montana Medical Assistance Facility (MAF) program. Critical access hospitals must have 15 or fewer beds, generally be no closer than 35 miles from another hospital and have an average length of stay of not more than 96 hours. They would be paid on a reasonable cost basis and would receive relief from regulatory requirements designed for full-scale hospitals.

In the House, Representative Jim Nussle (R-IA) has introduced legislation supported by the House Rural Health Care Coalition that would equalize Medicare reimbursement rates for rural HMOs, provide technical assistance to developing rural health networks, and offer incentives for health professionals to practice in rural areas.

• Representative Maurice Hinchey (D-NY) has reintroduced a bill that would require hospitals to release to the public detailed information about their nurse-to-patient staffing ratios and patient outcome and mortality data. Hospital employees would be protected against adverse action by their employers for reporting potentially dangerous conditions. The bill would also require review of the impact on public health and safety of proposed mergers and acquisitions of Medicare providers. The American Nurses Association is pushing for adoption of this legislation.

• Representative Benjamin L. Cardin (D-MD) has introduced the "Access to Emergency Medical Services Act of 1997." It is intended to avoid denial of health plan coverage for emergency care when, for example, chest pains turn out to be indigestion rather than a heart attack. The bill was developed with, and has the support of, the American College of Emergency Physicians and Kaiser Permanente. Under the bill, health plans that offer coverage for emergency services, including the Medicare and Medicaid programs, would be required to cover and pay for emergency care based upon the patient's presenting symptoms, rather than the final diagnosis. The definition of emergency would require coverage of an emergency room visit if the patient presents with symptoms that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect to result in serious impairment to the patient's health.

• Recently released Congressional Budget Office (CBO) estimates show that President Clinton's budget proposal for Medicare saves $82 billion over five years, not the $100 billion that the administration had estimated, and that the administration's overall budget would fail to show the claimed surplus of $17 billion by 2002. Congress will use the CBO, not administration, estimates. This means larger budget cuts are likely, if a balanced budget by 2002 continues to be the goal.

Source: AOHA Washington Update

THANK YOU!

TOMA would like to thank the following "Texas Stars" who have contributed above the $1,000 donation level

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Aeromedical Certification of the Insulin Treated Diabetic

By H. Stacy Vereen, M.D.

Recent history of aviation medicine reveals a trend toward the liberalization of the medical standards and certification. We should not view this trend as laxity on the part of the Federal Aviation Administration (FAA), but rather an attempt to conform the FAA standards to fit the needs and safety requirements of the real world cockpit environment. There is no doubt that cockpits have gotten friendlier (quieter, better climate controlled, better sound systems, more ergonomically designed and certainly more comfortable) but medical technology has made great advances also. The development of modern medicines that are efficacious without the side effect profile of the earlier versions make it possible for many otherwise grounded pilots to be considered for aeromedical certification. Blood pressure medications are a good example of this. In the past, diabetes was considered to be the end of the road for a pilot career. Once hung with the diagnosis of diabetes mellitus, pilots were left with few alternatives. Several years ago, the FAA began considering limited pilot certification for pilots who are under adequate control with diet or oral medications. Not all NIDDM pilots could gain recertification and the rules are fairly strict. But many of these pilots could and did qualify.

Now the Office of Aviation Medicine has announced that it will begin considering for the first time ever, insulin treated diabetics for third class medical certification. This consideration will be strictly on a case by case basis under the Special Issuance Provision of Part 67.401 of the FARs. Since Special Issuance is alive and well within the Civil Aeromedical Institute in Oklahoma City, there is no regulatory change necessary. This only represents a policy change within the agency. Many view this as one of the most significant (not to mention controversial) policy changes to come out of the FAA for quite a while.

This question of the insulin treated diabetic airman taking to the skies has been a hot issue among the various organizations that represent pilots, as well as among many AME's and other doctors who have concerns and misgivings about such a venture. Most sport, private pilot and general aviation organizations are understandably elated. The insulin treated diabetic represents a tiny but vocal segment of their constituency. But, since only third class medical certification will be considered, it is predictable that professional pilot organizations are less enthralled. The Aerospace Medical Association had concerns, as did many members of the Civil Aviation Medical Association. Reactions have run from exuberance to caution, from surprise to dismay. However, the emotional highs and lows alike were dampened when the restrictions and safeguards inherent in this new protocol were understood. Notable is the term insulin treated diabetic, rather than the much more familiar insulin dependent diabetic (IDDM) and the non-insulin dependent diabetic (NIDDM). The term "insulin treated diabetic" would put all applicants taking insulin under this policy change, whereas a pilot taking insulin might claim to be non-dependent on insulin for his disease but merely taking it because he chose to. It's clear that if an applicant takes insulin, he should be under this rule. The inherent increased risk for sudden incapacitation through hypoglycemia is very real and should be considered. Less important, but perhaps still significant, is the fact that treatment with insulin implies a more severe disease - less control for whatever reason - including the sub-group of late onset diabetics who are non-compliant with diet and/or medications, hence wind up on insulin as a last ditch effort to control the disease. That these same individuals might be less than compliant with the rather strict FAA protocol is of some concern. There will be less concern, perhaps, after reading the protocol and the discovery therein that the FAA has covered its hypoglycemic bases very well.

The second problem with insulin treated diabetic airmen is the late complications of diabetes. These can be further subdivided into the macrovascular problems of cardiovascular disease and the major microvascular problems of retinal, renal and neurological pathology. Because these sorts of complications are insidious, frequent monitoring will be required. Incapacitation from an M.I. can be just as deadly as hypoglycemia.

The rationale for any restrictive policy in certification must be based on flight safety. The insulin treated diabetic presents us with the two basic problems alluded to above: Hypoglycemia & Chronic Complications. The most common problem, as well as the most acute (and potentially the most deadly) is, of course, unrecognized and thereby untreated hypoglycemia. Flying is a thinking man's game and, as you know, our thinking apparatus doesn't store glucose or glycogen, so low blood sugar is fraught with all sorts of mental aberrations of which we are all familiar. This begins with little lapses in judgment and ends in coma. This whole spectrum is inconsistent with safe flight. The saving grace for most diabetics is the recognition of these impending hypoglycemic episodes and the correction with the ingestion of glucose or something that quickly becomes glucose in the body. The protocol itself is presented below with some practical hints on what it means and how to implement it.

I. Miscellaneous limitations
II. The initial certification requirements
III. The inflight requirements for monitoring and managing glucose levels
IV. The ongoing recertification requirements

I. Miscellaneous Limitation and Requirements

1. Class of Certificate: Third Class Medical Certification Only.

2. Privileges: Student, recreational or private pilots only.

3. Flight Restriction: In United States airspace only.

4. Special Requirements: Be in compliance with the monitoring requirements (explained later) while exercising the privileges of the Third Class Medical Certificate.

II. Initial Certification Requirements

1. Applicant must show no other disqualifying

conditions, including diabetic related complications, such as atherosclerotic coronary or cerebrovascular disease, retinal disease or chronic renal failure.

2. History of no more than one hypoglycemic episode.

3. The applicant must submit copies of all medical records, diabetic diagnosis and disease history, hospital records (if admitted for any diabetes related cause including accidents and injuries).

4. Complete medical evaluation by an endocrinologist or other diabetic specialist, acceptable to the Federal Air Surgeon.

5. Complete medical history, current medical condition, general physical examination, which at a minimum shall include:

A. Two measurements of glycolated (A1C, A1, glucated) hemoglobin and the laboratory reference normal range. The first such measurement at least 90 days prior to the second.

B. A detailed report of the insulin dosage, including types, amounts and any diet used for glucose control.

C. Maximal stress EKG for applicants age 40 or older.

D. An examination and if indicated, diagnostic tests to detect any peripheral neuropathy.

E. Confirmation by an ophthalmologist of the absence of any clinically significant eye disease. This ophthalmology report can be submitted on FAA Form 8500-7: Report of Eye Evaluation.

F. The verification by the specialist of the monitoring and management procedures, the education given to the applicant, the applicant's understanding of hypoglycemia and any presence or absence of hypoglycemia awareness.

G. The applicant must also, of course, allow his/her physician to provide information to the FAA if requested/required.

H. The applicant will also be required to have been stable on his/her insulin treatment for at least six months prior to the request of special issuance.

I. Under Part 67.401 the Federal Air Surgeon can require a special flight test to determine that the applicant can adequately perform an inflight blood glucose test while safely controlling the aircraft.

J. Also under Part 67.401 the applicant agrees to immediately report any adverse changes in his condition to the FAA. This is true for all special issuance situations.

Hypoglycemia: Definitions and Policy

The FAA is pretty clear that if an applicant has had two episodes of hypoglycemia that have resulted in loss of consciousness, seizure, impaired cognitive function or has required the intervention by a third party, then this will preclude consideration for certification. If the applicant has had only one episode of any of the foregoing, then a period of one year of demonstrated stability is required to be considered for special issuance of a third class medical. Last, but not least, on the issue of unrecognized hypoglycemia, a specialist must verify that the applicant has been educated in diabetes and its control and thoroughly understands the monitoring and management procedures and how to handle impending hypoglycemia. The specialist must also comment as to whether he/she thinks the individual has the ability and willingness to handle his/her diabetes. Any specter of hypoglycemia unawareness should certainly be noted.

III. Inflight Requirements for Glucose Monitoring and Management

1. The individual shall maintain medical supplies for the purpose of monitoring and management of her/her disease while piloting and/or acting as a crew member in an airplane.

2. The disposable supplies must be within the expiration date. The critical supplies here are the strips and the batteries in the glucose monitoring device. An extra set of batteries for this glucose monitor, readily accessible in the cockpit, would be a good idea.

3. The airman must establish a blood glucose greater than 100mg/dL but not greater than 300mg/dL within a half hour prior to take off. "Prior to take off" can be considered engine start. Minor delays for clearances or landing traffic, etc., will not be critical. This glucose determination will be recorded on the Glucometer and if the blood glucose measures less than 100mg/dL, the individual should ingest a 10 gram glucose snack. In 30 minutes, a check and documentation of the blood glucose level should be accomplished. If the glucose concentration measures greater than 300mg/dL, then the individual must follow his/her regimen of glucose control until the measurement of glucose is between 100mg/dL and 300mg/dL. Only then can the individual consider flight.

4. During the flight, the airman shall measure and record his/her glucose, every hour, beginning with the end of the first hour of flight. If the glucose is less than 100mg/dL, the individual shall then ingest a 20 gram glucose snack and recheck and document the concentration again after an hour. If it is between 100mg/dL to 300mg/dL, the individual may continue the flight as planned, but there again, check the blood glucose level in an hour. If the blood glucose level is greater than 300md/dL the individual shall land as soon as practical at the nearest suitable airport.

5. The FAA recognizes that there will be times when the individual cannot adhere to these requirements. (Increased workload due to adverse weather, equipment failure are examples of this.) If the glucose measurements cannot be done, then the individual shall instead ingest a 10 gram glucose snack and one hour after this ingestion, the individual shall then measure his glucose again. If he is still unable to perform the measurement safely, he should have a 20 gram glucose snack and land as soon as practicable at the nearest suitable airport.

6. The individual is also expected to perform and record a glucose measurement thirty minutes prior to landing. Of course if the individual is operating under the above guidelines that cover adverse conditions precluding glucose testing, then this half hour prior to landing test is also waived.

IV. The Ongoing Recertification Requirements

A. Annual Requirements:

1. Special Report to include his 4 quarterly reports.

2. Ophthalmologist Report.

3. Flight Physical (with AME comments, if appropriate).

4. At age 40 and at 5 year intervals thereafter, a maximal stress EKG.

B. Immediate Requirements:

1. Report to FAA immediately any episode of hypoglycemia resulting in cognitive impairment, cease flying until cleared by the FAA.

2. Report to the FAA immediately any accident or adverse event - including those involving motor vehicles, aircraft, etc.

3. Report to the FAA immediately any determination by any physician of loss of diabetes control, significant complications or inability to manage diabetes. The airman must cease flying until cleared by the FAA.

What is Needed to Monitor and Manage

If a pilot is to monitor and manage his/her glucose level in the flight environment, he/she will need a whole blood digital glucose monitor, and since he/she is going to have to present this monitor during the recertification process, it will need to have memory. The FAA's intent is presently to accept all FDA approved Glucose Monitoring Systems that have a memory sufficient to store the necessary data for three months. Most all insulin treated diabetics are now in possession of one of these monitors and have been educated on their proper use. The other supplies, of course, would include the Reagent Strips, alcohol swabs and lancets. To manage the blood sugar fluctuations in the cockpit, the pilot should have enough rapidly absorbable glucose appropriate to the potential duration of the flight. Since glucose is cheap and easily storable, to be on the safe side, one could certainly take what he/she needs for the duration of any particular flight and double or triple it. There should be less excuse for running low on glucose in the cockpit than for running low on fuel (and there are not many excuses for that). A good 5 gram portion of rapidly absorbable glucose comes in a tablet made by Bectin Dickinson and is carried by virtually all pharmacies. The FAA will, however, accept any rapidly absorbable form of glucose that can be reasonably measured so that 10 or 20 grams can be ingested rapidly.

Between 100gm/dL and 300mg/dL - NO INSULIN

The FAA Guidelines are roughly based on keeping the blood glucose level between 100mg/dL and 300mg/dL. If the level falls below 100mg/dL then the airman must ingest an appropriate glucose snack. If the level rises above 300mg/dL, contrary to the initial proposal, the FAA requires the airman to land as soon as practicable rather than try to self administer insulin in flight.

Annual Reports Expanded

The recertification process is also geared to follow the late complications of diabetes (as well as to check on the presence or absence of hypoglycemic episodes). The applicant will be required to go to his/her specialist every three months and undergo a general physical examination and undergo testing of the total A1 or A1C hemoglobin concentration and any other tests deemed necessary by the specialist or that are clinically indicated. This encounter with the specialist will also contain an assessment of the individual's continued ability and willingness to monitor and manage his diabetes and whether this specialist thinks the individual can reasonably be expected to safely control an aircraft. This quarterly report will not be required by the FAA until the application for annual renewal of the original certificate becomes due, so although the applicant undergoes these examinations by the specialist quarterly, these reports are then furnished to the FAA annually.

The FAA also welcomes the comment of the AME relative to the applicant's diabetes and his control thereof. The airman should understand that any negative quarterly report precludes flying until the situation is resolved or stabilized and approved by the FAA. The AME is, in all cases, to defer certification to the Civil Aeromedical Institute. So a report from the specialist including the results of the quarterly examinations must be submitted along with an annual evaluation by an ophthalmologist (as in the initial evaluation, the FAA form 8500-7 -Report of Eye Evaluation - may be used). The FAA intends at this time to issue third class medical certificates with a duration of one year. Each year the airman will be responsible for submitting the required documentation in a timely manner (that means at least 30 days prior to the expiration date of the certificate). At the present time the FAA will not require an annual flight physical. On years that the flight physical is due (every third year for applicants under age 40 and every other year for applicants 40 and older), the assessment by the specialist, the ophthalmology report and the form 8500-8 should be sent to the Civil Aeromedical Institute in Oklahoma City. In years that the flight physical is not due, it is only necessary to send the quarterly specialist reports, the annual specialist exam, and the ophthalmology report to the FAA. The FAA will review the data and if "all is well" then Oklahoma City will mail the airman a medical certificate that is valid for another year.

In any case, the information should be submitted as one package to the FAA. There is no requirement for this, but trying to merge various reports, received separately at different times by an organization that processes thousands of pieces of paper every day is not easy and is fraught with all sorts of delays. The airman and the FAA are better served by the "one package" method.

So, the requirements are formidable. Will any diabetic meet these strict standards? You bet they will. There are many very conscientious diabetics out there who have been stable on insulin for a long time and have demonstrated their conscientiousness with meticulous blood sugar control and willingness to participate actively in the management of their disease. Some of these, unfortunately, have had several hypoglycemic episodes and will be excluded from consideration, but many are very sensitive to hypoglycemia and keep it under control very well.

The first influx of insulin treated diabetic applicants will indeed probably be older pilots who have developed late diabetes that has progressed to insulin treatment. "There is no person that loves flying half so passionately as the grounded pilot." This small group of pilots will conform to the strictest protocol to be able to regain and retain certification. The insulin treated diabetic who wants to learn to fly will probably come along somewhat later. Most of these individuals have been told for years that there is no possibility that they will ever be able to be certified, so their mindset may have moved them to other avocations. But news travels fast and undoubtedly there will be many whose dream to fly will awaken. ■

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THE INDEPENDENT
INVESTOR

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The Case for Strategic Asset Allocation

Although you may believe your best investment strategy is to buy low and sell high, studies of some of America's major pension funds have shown that an asset allocation policy is the major determinant of portfolio performance.

Asset allocation is the decision of what percentage of your assets are invested in various asset classes, such as small company U.S. growth stocks, small company foreign stocks, or short term, high yield bonds. Strategic asset allocation involves establishing different weightings for various asset classes and making few changes in those weightings over the short run, unless there are changes in your investment objectives.

Strategic asset allocation can attribute its positive results to the fact that performance of different asset classes is not always closely related; some do quite well at the same time others are declining.

Stock prices, for example, fell precipitously in October and November 1987 (down 28%), but foreign bonds rose 16 percent at the very same time. 1967 was the worst year in the last six decades for government bonds (down 9.2%) but strangely enough was the best year since World War II for small company stocks (up 83%).

Asset allocation strategies take advantage of this lack of correlation to build portfolios that are unlikely to have assets that all do well or poorly at the same time. As a result, although no investment strategy can guarantee success, a properly allocated portfolio is more likely to participate in positive investment trends while at the same time reducing volatility when the investment climate changes.

Personalization

The asset weighting in your portfolio will depend on your individual needs and financial objectives. As your lifestyle changes and your time horizon shortens, you can, with the help of your investment representative, change the weightings in your portfolio to reflect your changing goals.

For example, in your earlier investment years, you will probably want a larger portion of your assets invested in equities, for long-term growth. Although past performance cannot guarantee future results, equities have historically outperformed other investment vehicles. Because equities also tend to fluctuate more over the short term than bonds or money market instruments, the more time you have to reach your investment goals, the more of your assets you'll want to invest in equities.

As you get older and need to start investing more conservatively, you will probably start to shift more of your assets into less volatile investment vehicles, such as fixed income investments. You will still need some growth so that your investment income can keep pace with inflation, but stocks might represent a smaller portion of your retirement portfolio than they did decades earlier. Fixed income instruments would now make up larger portions of your asset mix, offering the income and stability you require.

As investment representatives, it is our job to help you establish asset weightings tailored to your long-term investment objectives. To accommodate your changing needs, we will periodically change your asset mix. If you would like to learn more about asset allocation and how it might benefit you, contact us today. Together we can explore how asset allocation can help you reach your long-term goals.

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District Stars
News from TOMA/ATOMA District VI

By Mrs. Jerry W. Smith (Joy)

Members of TOMA and ATOMA District VI met at the Maxim Restaurant on March 18, 1997.

Dr. Carl Mitten, TOMA District VI president, introduced Dr. Morton Rubin and asked that he take over his duties for the evening. It was noted that Dr. Mitten had recently had a roller skating accident with his grandchildren, resulting in a broken right leg. Dr. Mitten is in a full leg cast and wheel chair.

Dr. Rubin introduced Carl Giesler, M.D., who presented a slide lecture entitled, "Women and Heart Disease."

The program and dinner were sponsored by Merck Co. The host was Russell Buckner of Merck.

Joy Smith, ATOMA District VI president, reported that three delegates are needed for the TOMA convention on June 12, 1997, in Fort Worth. She also noted that $300 will be sent to the ATOMA Scholarship Fund.

The district voted to send $500 to Dr. Larry Pepper, who is serving as a medical missionary in Africa.

The next meeting is scheduled for May 20, at which time new district officers will be installed. ■

Guidelines for Electronic Messengers

E-mail may be the quickest way to communicate, but it's not necessarily always the best way. In the interest of fostering trust in the workplace and preventing misunderstanding, chief executives and staff need to consider several factors before they hit the "send" key.

George A. Orr, III, co-author of *The Courageous Messenger* and a principal with Cultures for Quality, Inc., in the Seattle, Washington, area, offers some helpful "rules of thumb" for effective communication, beginning with two absolute e-mail "don'ts":

1. Don't use e-mail to communicate a sensitive message. "E-mail is one-way communication that is devoid of context, so the possibilities of being misunderstood are significantly greater," observes Orr, adding that the best way to deliver a tough message is always face-to-face. If that's not possible, consider other interactive forms of communication, such as a phone call (which provides context in the form of inflections and tone of voice), televideo, or computer conferencing that allows you to see the other person you're talking to on the computer screen.

2. Don't use e-mail if confidentiality and security are key concerns. You can never be sure that someone won't intercept and read your message or forward it to others unknown to you or that you won't make a mistake and send a confidential message to the wrong e-mail address.

Orr lists these additional tips:

• **Consider the message recipient's communication preferences.** Many young professionals grew up with computers and don't think twice about communicating via e-mail. Older professionals, on the other hand, are used to discussing issues with colleagues in person or on the phone. To be able to communicate effectively with one another, both parties need to understand each other's communication preferences and find some common ground.

• **Think twice before hitting the send button.** Forethought is especially important in an emotional moment if you want to avoid "sender's regret." "E-mail is so instantaneous that there's no time to reflect" on whether the message is appropriate, notes Orr.

• **Know the local rules of the road.** Many organizations have established guidelines for electronic communications. Find out what they are and abide by them.

• **Plan carefully what you want to say.** Think through an e-mail just as you would if sending a traditional business letter. Be as descriptive as possible so that the recipient will know where you're coming from. Don't assume that the recipient is familiar with the various e-mail methods used to suggest feeling: for example, all caps to suggest strength of feeling, or :-) to suggest happiness, or :-(to suggest unhappiness. It's better to just state, "This is how I feel..." ■

Reprinted from Association Management, April 1997

Consensus Statement on Physician Workforce Issues

The American Osteopathic Association was one of six groups to develop and endorse the following statement on Physician Workforce Issues. The five month long process confirmed the AOA's "seat at the table" in identifying potential reforms of the nation's graduate medical education system. The consensus statement was officially released on February 28 and positions in the statement will be used by Congress and other policy making bodies as a basis for proposed legislation to reform the current GME system.

Consensus Statement on the Physician Workforce

American Association of Colleges of Osteopathic Medicine
American Medical Association
American Osteopathic Association
Association of Academic Health Centers
Association of American Medical Colleges
National Medical Association

During the past few years, studies of the physician workforce have produced compelling evidence that the United States is on the verge of a serious oversupply of physicians. The attendant consequences of physician oversupply - the underemployment and unemployment of physicians - are highly undesirable from the perspective of both the society at large and the individual physicians who are affected. Given this, the current rate of physician supply (the number of physicians entering the workforce each year) is clearly excessive.

The rate of physician supply is determined primarily by the number of both U.S. and non-U.S. medical school graduates who enter the country's graduate medical education (GME) system each year. In recent years, the number of non-U.S. medical school graduates (international medical graduates /IMGs) entering GME in the United States has approximated 40 percent of the number of U.S. medical school graduates. To decrease the rate of physician supply, limits must be placed on the number of medical school graduates entering GME. Since the federal government currently plays a major role in financing GME and is responsible for establishing immigration laws that affect IMG participation in GME in this country, it is imperative that the federal government partner with the medical education community to achieve this goal.

Limiting the number of medical school graduates entering GME each year has important implications for the medical students and medical school graduates who may wish to pursue GME in this country, for hospitals that sponsor GME and are dependent on resident physicians to provide patient care services, and for patients who receive those services. Given these considerations, the associations that are party to this consensus statement offer the following recommendations to guide the administration and members of Congress in their deliberations of potential policy solutions to the problem of physician oversupply.

Recommendations

- The number of entry level positions in the country's GME system should be aligned more closely with the number of graduates of accredited U.S. medical schools. This realignment should be achieved primarily by limiting federal funding of GME positions. Since in the United States all physicians must complete a period of GME before being licensed to practice medicine, the number of funded positions should be sufficient to allow all M.D. and D.O. graduates of accredited U.S. medical schools an opportunity to enroll in an accredited GME program.

- The United States should continue to provide GME opportunities for foreign born physicians who have graduated from non-U.S. medical schools. These physicians should participate in GME under the J-1 Exchange Visitor Program. Their training should not be financed from Medicare funds currently dedicated for the support of GME, or from any national all payer GME fund that might be established in the future. It is important that these physicians return to their country of origin after completing GME in this country. To ensure this, the government should eliminate all waiver programs that allow these physicians to remain in the United States if they agree to accept a practice position in a state or federally designated medically underserved area. As noted below, the government should attempt to meet the needs of these communities by expanding existing (for example, the National Health Services Corps) or establishing new programs designed to recruit U.S. graduates to these practice positions.

- It is likely that many traditionally underserved communities will continue to have an inadequate number of physicians, particularly generalist physicians, to meet the needs of the population. Given the existence of physician oversupply, it is clear that this problem will not be solved by increasing the supply of physicians. At present, there is no federal program that provides funds explicitly for the purpose of establishing new medical schools or expanding the enrollment of existing schools and no federal program should be established for this purpose. The communities that are traditionally underserved are characterized by location - rural or inner city - or by the race and ethnicity of the population. To increase the likelihood that U.S. medical school graduates will establish practices in these communities, federal funds should be provided to encourage and support medical school efforts to expand the opportunities students have to gain experience in rural and inner city communities so that they will have an appreciation of the needs and challenges of practice in these communities. Historically, minority physicians have been more likely than non-minority physicians to establish practices in communities with minority populations. Given this, medical schools should be supported and encouraged in their efforts to increase the diversity of their student bodies so that they will be able to graduate an increasing number of minority physicians. To complement medical school efforts to increase the number of their graduates who might establish practices in traditionally underserved communities, federal incentives should be provided to encourage students to pursue careers as generalist physicians and to establish practices in these communities.

- Changes occurring in the financing of medical care are

eroding the individual revenue streams that have supported GME for the past three decades. A national all payer fund should be established to provide a stable source of funding for the direct costs of GME (resident stipends and benefits, faculty supervision and program administration, and allowable institutional costs). Payments should be made from this fund to entities that incur the costs of GME, whether they be hospital-based or not, or to other entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring the costs. In the meantime, the formula used currently by the Medicare program to determine capitated payments to managed care organizations should be revised to ensure that the funds intended for the support of GME are used for that purpose.

- Teaching hospitals that lose resident physicians as a direct result of the reduction in the number of entry level positions in the GME system should receive transitional funds to assist them in establishing alternative methods of delivering services that formerly involved resident physicians. This is particularly critical for those institutions that have traditionally used resident physicians to provide services to the poor.

- There are a number of reasons why teaching hospitals incur higher costs than non-teaching hospitals in providing patient care - the complex nature of the patients cared for in these institutions, the participation of health professions students in the delivery of care, the development and deployment of new diagnostic and therapeutic technologies, and the conduct of concurrent clinical research activities. Historically, these costs have been funded through special types of reimbursement (most notably, the Medicare Indirect Medical Education Adjustment) and higher payment levels for patient care services. Given changes occurring in the financing of health care services, a stable source of funding for these activities must be established.

- A national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by non-physician health professionals. This body should be legislatively mandated but staffed independently of existing government agencies. In order to meet its responsibilities, the body should have a budget that is adequate to support an appropriate staff and to allow the staff to conduct necessary analytic work. The government should continue to provide funds to support research on workforce issues. ■

Networks May Help Physicians Receive Adequate Reimbursement Rates

By Dean L. Peyton, D.O.

"I don't know what I'll do," said my doctor buddy as we ate lunch in the Physicians' Lounge. "Aetna sent us a letter cutting the office reimbursement by one-third and I can't do a good job at that rate." He didn't know how he could see more patients and do anything approximating a good job. He knew that some doctors were simply trying to increase the volume of patients seen, but this didn't fit his personality. He'd heard enough comments to know that he did not want to be known in the community as a hurry-up, non-caring doctor.

"Medicare to Pay for Office Visits."

I remember seeing this headline in 1965. I was not a doctor, but I was a pharmacy student and I was working in a pharmacy. Medicare was a big topic. In 1964, the average family practitioner in the United States saw 13 patients per day. By 1967, that number had increased to 40 patients per day. The over-65 group, with almost no cost to themselves for medical care, flocked into offices. Although it was only 30 years ago, it should be remembered that there was no preventive medicine and many of the "problems" that we treat routinely today were not treated at all (like elevated cholesterol, hormone replacement and hypertension).

At current fee-for-service rates, many practices are willing to see unlimited patients. When these fee-for-service rates fall to levels that cannot sustain an office, there will be a lot less capacity there and it will be very hard for patients to get medical office services on their insurance plans. Some, as the patients who were uninsured for office visit costs in 1964 found, will be able to be seen at clinics when they pay the bill. This has recently occurred with Medicaid patients, some of whom found that they could "trade a chicken" or pay some nominal fee rather than go to emergency rooms with their long waits if they happened to live in areas (like Arlington) where Medicaid patients were not welcome in private offices due to the inadequate reimbursement.

Some observers of the modern scene think this is part of the agenda of managed care. On paper, it covers people for medical services, but makes it impossible for them to get it except when they pay for it out of their own pockets.

In the long run, the answer to my friend's dilemma is that physicians put themselves into networks (hopefully operated by the doctors) that function either as public utilities or for-profit businesses. These businesses are tied together with a comprehensive computer network and organized to provide an appropriate level of medical care in a community. They would be large enough, powerful enough, and efficient enough to negotiate even with powerful giants like Aetna for an adequate reimbursement rate to get the job done. The national consulting firm, Hamilton.KSA of Atlanta, has recently put together an impressive consulting report that lays out how this can occur. If you would like a summary, it appeared on pages 28-29 of the February 20, 1997, issue of *Hospitals and Health Networks*. You can order a copy of the full report, "Demand for Value in Health Care," by faxing a request with name and mailing address to 404-873-5493. ■

ATOMA News

S.A.A.: Celebrating a Successful Year

By Marvella McElya
S.A.A. Advisor

Embracing their slogan, "The Hearts Behind the Hands that Heal," the Student Associate Auxiliary of the University of North Texas Health Science Center at Fort Worth has had an incredibly successful 1996-97 academic year. Under the leadership of president Nicky Knighton, 1st vice president Missie Way, 2nd vice president Heather Marlow, treasurer Lynn Finley, recording secretary Gina Brookshire and corresponding secretary Claudine Doyle, S.A.A. boosts a membership of 60 and a calendar filled with activities supporting the UNTHSC community, the Fort Worth community and the medical student family.

In August, they organized the Lab/Clinic Coat Fund Raiser and distributed over 500 coats, provided over 300 welcome brochures to the incoming freshman class and new graduate students, and conducted Orientation Night, complete with guest speakers and a slide show for over 100 attendees.

September was the setting for the Freshman Brunch held at Kathy and Vernon Hayes' beautiful lake house, the Family Pizza Party and the 25th Anniversary Gala of UNTHSC, of which S.A.A. served on the planning and decorations committees.

In October, S.A.A. supported a Couples Bunko Night and Dinner (you have to have some fun in medical school), and a hospital tour and dinner. Two S.A.A. representatives, Heather Marlow and Shari Blary, attended the American Osteopathic Association's convention in Las Vegas. While there, they presented the S.A.A. National Osteopathic Medicine week proposal, and the AAOA approved the creation of a high school essay contest for Fort Worth Independent School District students.

The essay contest was conducted in November and two student essays were chosen as the best submissions. These students will receive a cash award and the opportunity to shadow a medical student. The essay contest was created to increase awareness of osteopathic medicine in the Fort Worth community. The contest will be conducted again next year and the awards will be increased. Also in November, the S.A.A. conducted their canned food drive and presented the proceeds to the Tarrant County Food Bank, organized a pot luck dinner, held crafts night and sent representatives to the ATOMA board meeting in Austin.

Busy, busy December didn't stop the S.A.A. from providing tray favors for patients hospitalized during the holidays at the Osteopathic Medical Center of Texas, or from celebrating a little themselves by having the annual S.A.A Christmas party at the lovely home of Rita and Mark Baker, complete with dinner and a Chinese gift exchange.

In January and February, S.A.A. hosted another bunko night, a Speakers Night and Dinner and the very informative Clinical Rotations Lottery Panel, which serves the second year class in gaining information about clinical rotations during their third and fourth years. Representatives also attended the ATOMA board meeting in Dallas.

A spouses night out at Good Eats in March and S.A.A. elections for the 1997-98 year, as well as a day at the farm of Dodie and Arthur Speece in April, made for a busy spring.

On May 3, the Senior Luncheon/New Officer Installation at the Colonial Country Club will be held. This is always a wonderful time as the entire S.A.A. community celebrates with the graduating seniors and their spouses/significant others. Also in May, the NOM Week essay awards will be presented to the winning high school students by S.A.A. members at their annual high school awards ceremonies. (Watch the newspapers for some press.)

In addition to all these events, they published a monthly newsletter, held monthly planning meetings and served over 35 dinners to the families of students who have had new babies or suffered sickness. And, once again they will be represented at the TOMA Annual Convention in Fort Worth in June by manning booths for ATOMA and raffling a gift basket.

Certainly a word of praise or a gesture of support is due to the entire S.A.A. membership for once again excelling in their every effort.

It is has been my pleasure and honor to have served as their advisor this past year.

Spotlight

By Merilyn Richards
Auxiliary News Chairman

Joseph A. DelPrincipe, D.O., and family are "in the spotlight" for this issue. Joe is a 1983 graduate of the Texas College of Osteopathic Medicine and is board certified in Emergency Medicine. Joe is married to Mary Eileen and their children are: Lorenzo, who is 18 years old and has been accepted as a freshman at Columbia State University in Missouri for the fall; Joey, seven years old; Vince, six years old; Dominic, three years old; and twins Ricky and Victor, eight months. Mary Eileen is a graduate nurse, having received her B.S.N. from the University of Texas in Arlington, as well as a B.S. in Education from Texas Tech University.

Both Joe and Mary Eileen are actively involved, both at the district and state levels, in supporting the profession through TOMA and ATOMA. They are also busy with their commitments to their church and in keeping up with their boys' varied activities. The DelPrincipes recently moved into their newly completed home, located on "almost" an acre of land, so, they are further occupied with gardening and creating new flower beds while trying to keep the poison ivy and poison oak out of the back yard.

Although they have had to put their "fun activities," sailboating, camping and fishing - on the back burner for now, they expect to return to them when the babies get older. The babies are mobile now, crawling all through the house and are happy and healthy boys, so keeping up with them and the rest of the family keeps Mary Eileen "up to her ears" and with little time for her volunteer work. In fact, Mary Eileen reports that "just keeping all the kids clean and fed keeps us busy."!

Destination: Fort Worth

By B. J. Czewski
ATOMA Convention Chairman

When it comes to cowboys and longhorns, this city epitomizes the vitality of the "Old West." But, don't be fooled when you hear the word "Cowtown" over and over during your visit - it is definitely more. Come to the TOMA convention early or plan on staying a few days longer so you

can attend all the convention activities as well as enjoy exploring exciting "Old Fort Worth."

The following list will give you a brief idea of activities that will be going on during the month of June.

Cultural District

Kimbell Art Museum – Fort Worth's Kimbell Art Museum has been described as America's best small museum, housing such masterpieces by Matisse, El Greco, Cezanne, Rembrandt and Picasso. "Monet and The Mediterranean Exhibition" runs June 8 through September 7; 3333 Camp Bowie Boulevard; open Tuesday, Wednesday, Saturday and Sunday, 10:00 - 6:00; Thursday and Friday, 10:00 to 8:00.

John Tesh Concert – June 8; Will Rogers Auditorium; prices range from $29.95 to $48.75 at Ticketmaster.

Van Cliburn International Piano Competition Finals – June 8; Landreth Auditorium, Tarrant County Convention Center; 817-738-6536.

Shakespeare in the Park – June 11 to July 6; Trinity Park; $6 lawn seat, $12 per person for table and chairs; dinner available; 817-923-6698.

"El Grande Coca Cola" – June 28; Fort Worth Theatre Orchestra Hall, 4401 Trail Lake.

"Forever Plaid" – June 29; Casa Manana's Theatre, the longest running show in Metroplex history; Thursday, 8:00 p.m., Friday and Saturday, 5:00 and 9:00 p.m., and 2:00 p.m. on Sunday; Casa's Theatre on the Square.

Family Fun

Tarantula Train Trips – Short trips on this steam engine train depart from the 8th Avenue Station to the Fort Worth Stockyards, a total of nine miles. Or, depart from the Stockyard Station and journey to historical Main Street in downtown Grapevine (one hour, 15 minutes). This small town has a lot to offer: 75 restored sites, 20 historical markers and La Buena Vista Vineyards Winery and Tasting Room, owned by TOMA member Bobby Smith, D.O. For additional information, call 817-625-4147.

Fort Worth Zoo – 1989 Colonial Parkway; features new penguin and crocodile exhibits; open from 10:00 a.m. to 5:00 p.m., Monday through Friday, and 10: a.m. to 6 p.m., Saturday and Sunday; $7; 817-871-7050.

Six Flags Over Texas – Interstate 30 in Arlington; 10:00 a.m. - 11:00 p.m., seven days a week; $35 for one-day pass for adults, $25.99 for seniors and children 48" and shorter; 817-530-6000.

Texas Rangers Home Games – Arlington; June 12 and 13, San Francisco, June 14 and 15, San Diego; 800-654-9545.

N.A.S.C.A.R./I.R.L. Racing – June 6; Texas Motor Speedway; Craftsman Truck Series, Longhorn 500, Indy Racing League; 888-215-8506.

International Arabian Horse Association, Region IX Championship Show – June 18-22; Will Rogers Memorial Center; 817-871-8150.

Cowboys Stockyards and Country Texas Longhorn Breeders Association Exposition World Show – June 12-14; Will Rogers Memorial Center; 817-871-8150.

Country Fest '97 – June 14; features Hank Williams, Jr., Wynonna, Travis Tritt, Vince Gill, Randy Travis, Bryan White, Charlie Daniels Band and more; Texas Motor Speedway; $16 at Ticketmaster.

Cattleman's Museum – 1401 West 7th Street; 8:30 - 4:30, Monday through Friday; free admission; 817-332-7064.

Chisholm Trail Round-Up and Chief Quanah Parker **Comanche Indian Pow Wow –** Cowtown Coliseum; 817-625-7005.

For more information, call for a free visitor's guide at 800-433-5747.

ATOMA Schedule of Events

Wednesday, June 11
1:00 p.m. - 6:00 p.m.
ATOMA Pre-convention Board Meeting
Continental Room, Radisson Hotel

Thursday, June 12
9:00 a.m. - 12 noon
ATOMA House of Delegates
Continental Room, Radisson Hotel

12:15 p.m. - 1:30 p.m.
Keynote Luncheon

5:30 p.m. - 6:30 p.m.
M.O.P.P.S. Reception
Metropolitan Room, Radisson Hotel

Friday, June 13
10:00 a.m. - 12:00 noon
ATOMA President's Luncheon and Installation
Continental Room, Radisson Hotel

2:00 p.m. - 8:00 p.m.
Family Day at Texas Lil's Diamond "A" Ranch

2:00 p.m. - 8:00 p.m.
Golf Tournament
Rivercrest Country Club

Saturday, June 14
9:00 a.m.
ATOMA Post-convention Board meeting
Metropolitan Room, Radisson Hotel

12:00 - 1:15 p.m.
AOA Luncheon with AOA-President-elect
Crystal Room A, Radisson Hotel

6:30 p.m. - 7:00 p.m.
President's Reception

7:00 p.m. - 12:00 p.m.
President's Banquet

"Long-Term Care"

SOME SURPRISING STATISTICS:

- According to The New England Journal of Medicine (1991), **43%** of people who turned age 65 in 1990 can expect to spend some time in a nursing home during their lifetime. Of that number, **21%** can expect a nursing home stay of five years or more.

- According to the Health Care Financing Administration, 1993, **$70 million** was spent on nursing home care in 1993. Only **9%** was Medicare's share of that $70 million. **33%** was paid directly out-of-pocket by patients.

- According to the Health Insurance Association of America's, "*Guide to Long-Term Care Insurance*," 1994, the average annual cost of nursing home care is **$36,000**. Assuming an inflation rate of 5%, the projected annual nursing home cost in 10 years will be near **$60,000.**

Clearly, paying for long-term care can be a serious problem if you haven't planned for it. Even so, long-term care insurance is not for everyone. The most important thing to remember is this: the longer you wait to purchase a long-term insurance policy, the more expensive it will be. Don't wait until you need long-term care to talk to us because then it will probably be too late.

TO DISCUSS LONG-TERM CARE INSURANCE AND ITS APPROPRIATENESS FOR YOUR FINANCIAL FUTURE, CALL US TODAY.

DEAN, JACOBSON FINANCIAL SERVICES, LLC

Fort Worth	Dallas	Toll Free
817-335-3214	972-445-5533	800-321-0246

Texas Osteopathic Medical Association
98th Annual Convention and Scientific Seminar
June 12 - 15, 1997

Join TOMA as we explore the "D.O. Brand of Medicine" at our 98th Annual Convention and Scientific Seminar in Fort Worth. The D.O. Brand of Medicine is unique and will be emphasized throughout the program. A variety of primary care topics will be provided in a fast paced environment. Fourteen workshops will provide for individualized learning.

Educational Objectives

1. To provide attendees with a renewed perspective of Osteopathic Medicine and its unique role in applying preventive concepts in the practice of medicine within a changing healthcare environment.
2. To provide current knowledge in key selected topic areas of clinical medicine.
3. To provide this learning in small, interactive environments as well as in plenary sessions.

Accreditation

The TOMA 98th Annual Convention and Scientific Seminar has been approved for 27.5 hours of Category 1-A AOA Credit.

AAPA accepts Category 1 CME Credit from the AOA Council on Continuing Medical Education.

Register Early and Save

If you send in your registration before May 22, you will save $100!

Registration Fee Includes

The registration fee includes exhibit hall and general session admission, lecture handouts, CME credits, refreshment breaks, and tickets to the Opening Breakfast, Keynote Luncheon, the AOA Luncheon and the President's Banquet. Spouse registration includes exhibit hall admission and tickets to the Opening Breakfast, Keynote Luncheon, the ATOMA President's Installation Luncheon, the AOA luncheon, and the President's Banquet. Individual tickets may also be purchased for the ATOMA President's Installation luncheon and the TOMA President's Banquet. The computer workshop, the golf tournament, and the Family Day program at Texas Lil's Diamond A Ranch are priced seperately as noted and attendance is limited.

Convention Program Committee

A special thank you to all of the members of the Annual Convention Committee for their hard work and dedication in designing this year's convention educational program.

Gregory A. Dott, D.O.
Annual Convention Chair
Joseph A. DelPrincipe, D.O.
Al E. Faigin, D.O.
Donna Hand, D.O.
Bobby D. Howard, D.O.
Lisa R. Nash, D.O.
George N. Smith, D.O.
Craig D. Whiting, D.O.

Preliminary Schedule of Events

Wednesday, June 11, 1997

8:00 am - 1:00 pm **TOMA House of Delegates Registration**
9:00 am - 5:00 pm **TOMA House of Delegates**
12:00 pm - 1:00 pm **TOMA House of Delegates Luncheon** *Sponsored by UNTHSC-FW/TCOM Educational Foundation*
2:30 pm - 5:30 pm **TOMA Convention Registration Desk Open**
5:30 pm - 7:30 pm **Discover Medicine on the Net Workshop** at UNTHSC/FW-TCOM Gibson D. Lewis Library Computer Lab - Suzanne Gravois and Mark Wilson
5:30 pm - 8:30 pm **Preceptor and Rural Rotation Supervisor Workshop** - Cindy Passmore, M.A., William K. Mygdal, Ed.D., and Marty Kinard, Ed.D.

Thursday, June 12, 1997

7:00 am - 5:00 pm **Registration Desk Open**
7:30 am - 8:45 am **Opening Breakfast - Common Eye Problems: Diagnosis & Management** - H. Dwight Cavanagh, M.D., Ph.D.
8:45 am - 4:00 pm **Exhibit Hall Open**
8:45 am - 9:30 am **Immunization Update** - James R. Marshall, D.O.
9:00 am - 12:00 pm **ATOMA House of Delegates**
9:30 am - 10:15 am **Exhibit Hall Break**
10:15 am - 10:45 am **Common Pitfalls in Steroid Use** - Jack B. Cohen, D.O.
10:45 am - 11:15 am **Therapeutic Update on Dermatology** - David A. Amato, D.O.
11:15 am - 11:45 am **Osteopathic Evaluation of Pelvic Pain in Gynecology** - Melicien Tettambel, D.O.
11:45 am - 12:15 pm **Dysmenorrhea and Premenstrual Syndrome in Adolescents** - Robert Adams, D.O., FACOOG
12:15 pm - 1:30 pm **Keynote Luncheon**
1:30 pm - 2:15 pm **Sexual Issues in Medicine** - Marian E. Dunn, Ph.D. *Sponsored by Pfizer Pharmaceutical*
2:15 pm - 3:00 pm **Exhibit Hall Break**
3:00 pm - 5:00 pm **Concurrent Workshops**
- **Dermatology Workshops: Common Uses of Radiosurgery for Family Practitioners** - David A. Amato, D.O. *Sponsored by Ellman International, Inc.* and **Practical Uses of Cryosurgery** - David Grice, D.O.
- **OMT for Common Female Complaints** - Melicien Tettambel, D.O.
- **Medical Spanish I** - Miriam Perez and Craig Whiting, D.O.
- **Estate Planning** - William H. "Country" Dean *Sponsored by Dean, Jacobson Financial Services*

5:30 pm - 6:30 pm **MOPP's Reception**
5:30 pm - 6:30 pm **Alumni Receptions**
6:00 pm - 7:00 pm **POPP's Reception**
7:00 pm - 11:00 pm **Sustainer's Party** - Vintage Flying Museum

Friday, June 13, 1997

7:00 am - 1:15 pm **Registration Desk Open**
7:30 am - 8:00 am **Breakfast with the Exhibitors**
7:30 am - 1:15 pm **Exhibit Hall Open**
8:00 am - 8:30 am **Exercise and Health** - Allen W. Jacobs, D.O., Ph.D. *Sponsored by Searle Pharmaceuticals*
8:30 am - 9:00 am **Hip Problems in Children: Diagnosis and Treatment** - Christine Quatro, D.O.

9:00 am -	9:30 am	**Nutrition and Supplements for the Athlete: What's New?** - David S. Ross, M.D.
9:30 am -	10:15 am	**Exhibit Hall Break**
10:00 am -	12:00 pm	**ATOMA President's Luncheon and Installation**
10:15 am -	12:15 pm	**Concurrent Workshops**
		• **Practical Approach to Sports Medicine Injuries** - Allen W. Jacobs, D.O., Ph.D. *Sponsored by Searle Pharmaceuticals*
		• **Imaging of the Extremities** - R. Gene Moult, D.O.
		• **Medical Spanish II** - Miriam Perez and Craig Whiting, D.O.
		• **Valuation of a Medical Practice** - Mark T. Bower, CPA
12:15 pm -	1:15 pm	**Lunch in the Exhibit Hall**
2:00 pm -	8:00 pm	**Family Day at Texas Lil's Diamond A Ranch**
2:00 pm -	8:00 pm	**Golf Tournament at Riverside Golf Course,** *Sponsored by Dean, Jacobson Financial Services*

Saturday, June 14, 1997

7:00 am -	4:00 pm	**Registration Desk Open**
7:00 am -	8:00 am	**TXACOFP Breakfast** - *TXACOFP members only*
7:30 am -	8:00 am	**Continental Breakfast**
8:00 am -	8:45 am	**The Lessons We Should Have Learned from Osteopathic Medicine** - J.L. Dickey, D.O.
8:45 am -	9:30 am	**Recognition, Diagnosis and Treatment of Thyroid Disease** - Craig Spellman, D.O. *Sponsored by Knoll Pharmaceuticals*
9:00 am -	11:00 am	**Texas Academy of Osteopathy Treatment Service**
9:30 am -	10:00 am	**Attention Deficit Disorder** - Stanley E. Grogg, D.O., *Sponsored by Richwood Pharmaceutical*
10:00 am -	10:15 am	**Refreshment Break**
10:15 am -	10:45 am	**Update on the Pathogenesis and Management of GERD** - Bashar M. Attar, M.D. *Sponsored by Janssen Pharmaceutica*
10:45 am -	11:15 am	**Latest Recommendation Regarding PSA Test and Treatment** - Wayne A. Hey, D.O. *Sponsored by Merck & Co., Inc.*
11:15 am -	12:15 pm	**Screening Guidelines - Prevention 1997 - What is the Controversy?** - Muriel Marshall, D.O., DrPH, FACPM
12:15 pm -	1:30 pm	**AOA Luncheon** - Howard M. Levine, D.O., AOA President-Elect
1:30 pm -	2:30 pm	**Behavioral Management of Alzheimer's Disease - Hugs, Not Drugs** - Kevin Gray, M.D., *Sponsored by Pfizer, Inc.*
2:30 pm -	4:30 pm	**Concurrent Workshops**
		• **How Do "You" Treat Headaches?** - David Vick, D.O. and Richard W. Koss, D.O.
		• **Flexible Proctosigmoidoscopy** - Monte Troutman, D.O. *Sigmoidoscopy Models and Scopes provided by Olympus America*
		• **Pitfalls in Managed Care Contracts** - Rocky Wilcox, J.D.
		• **Medicare Changes for 1997** - Don Self
4:30 pm -	5:15 pm	**Texas Academy of Osteopathy Meeting**
6:30 pm -	7:00 pm	**President's Reception**
7:00 pm -	12:00 am	**President's Banquet** *Sponsored by Glaxo Wellcome, Inc.*

Sunday, June 15, 1997

7:30 am -	1:00 pm	**Registration Desk Open for Risk Management Program**
7:30 am -	8:00 am	**Continental Breakfast**
8:00 am -	9:00 am	**Triggers to Investigation: How to Avoid the Hot Seat** - R. Russell Thomas, Jr., D.O.
9:00 am -	10:00 am	**An Irreverant Look at Wrongful Credentialing** - Rodney M. Patterson, J.D. *Sponsored by Dean, Jacobson Financial Services*
10:00 am -	10:15 am	**Refreshment Break**
10:15 am -	11:15 am	**Medical Liability - What a Physician Needs to Know** - Harold Freeman, J.D.
11:15 am -	1:15 pm	**Who's in the Middle?** - Monte Mitchell, D.O., J.D. and Kay Elkins-Elliott

Special Events

Family Day at Texas Lil's Diamond A Ranch A full day of fun for all ages is planned at Texas Lil's Diamond A Ranch. Among the varied activities are horseback riding, fishing, swimming, golf driving range, organized field events, petting zoo, volleyball, and softball (bring your glove). This perfect day at a dude ranch will end with a delicious barbeque dinner. The cost for this event is $15 per person and includes all activities, unlimited soft drinks all day, dinner, and round-trip transportation from the Radisson Plaza Hotel.

Sustainer's Party at the Vintage Flying Museum Join us for a fabulous evening with a 1940s theme - the era of Big Bands and B-17s. The party will be held in an airplane hanger filled with vintage aircraft and memorabilia. After dinner we will dance the evening away to the varied sounds of the Wayland Smajstrla Band. The Sustainer's Party is open to each Sustaining Member and one guest as a special "thank you" for their support. If you would like to attend the Sustainer's Party, it's not too late to join. Just call Stephanie Boley at 800/444-8662 and she will sign you up!

Arthur J. Speece, III, D.O.

Golf Tournament at Riverside Golf Club Spend a day out on the links with your friends and fellow physicians. The challenging course at the Riverside Golf Club is sure to provide ample opportunity to test your skills. Awards will be given out this evening at a barbeque dinner at the course. The cost for this event is $50 and includes greens fees, a cart, range balls, dinner, and round-trip transportation from the Radisson Plaza Hotel.

President's Reception and Banquet The Annual President's Banquet (black tie optional) will be held on Saturday evening in honor of TOMA's president, Arthur J. Speece, III, D.O. The gavel will be passed to President-Elect R. Greg Maul, D.O. Many prestigious awards will be presented including the Distinguished Service Award and the Meritorious Service Award. HOTCAKES - America's Band will make an encore performance following the presentations, so plan for an evening full of excitement.

For Your Information

CME Sign-In In your registration packet, you will recieve a two-part form with each educational session and its CME hours listed. It will be your responsibility to indicate the sessions you attended, total the number of CME hours, and sign the form certifiying your attendance. Once you have completed the form, you will keep the bottom copy for your records and turn the top copy into the registration desk for reporting to the AOA.

Computer Workshop "Discover Medicine on the Net," an interactive workshop at the UNTHSC/FW- TCOM Gibson D. Lewis Library Computer Lab, will be held on Wednesday, June 11. This workshop will introduce physicians to the internet and the wide variety of medical information available on this excellent resource. The workshop fee of $25 includes round-trip bus transportation from the Radisson Plaza Hotel.

Preceptor and Rural Rotation Supervisor Workshop The Faculty Development Center will present this workshop on Wednesday evening for all active and prospective preceptors. There is no charge for this workshop.

Convention Center Thursday and Friday's educational sessions and exhibits will be held at the Fort Worth/Tarrant County Convention Center, located across the street from the Radisson Plaza Hotel.

Hotel The Radisson Plaza Hotel is located adjacent to Fort Worth's Sundance Square district, which is filled with interesting shops and restaurants. A block of rooms has been reserved at the special rate of $88 per night plus tax, single, double, triple or quad occupancy. *This special rate is available for reservations made before the deadline of May 25, 1997.* To make a reservation, send the form on the next page to the hotel at 815 Main Street, Fort Worth, TX 76102 or call Radisson's toll free number, 800-333-3333 or dial the hotel directly at 817/870-2100. Be sure to mention that you are with TOMA to receive our rate.

Airline Discounts Southwest Airlines is offering a discount on most of its already low fares, for travel to and from the TOMA Annual Convention. Call (or have your professional travel agent call) the Southwest Airlines Group and Meeting Desk at 1-800-433-5368, Monday - Friday, 8:00 a.m. - 5:00 p.m. and refer to I.D. code P9827. Call no later than June 4, 1997, to take advantage of this offer. Call right away as fares are subject to terms and availability.

Disability Statement Individuals needing special accomodations during TOMA's 98th Annual Convention and Scientific Seminar should contact either Robyn Shapiro or Vanessa Kemper prior to May 15, 1997. They can be reached at the Texas Osteopathic Medical Association, 1415 Lavaca Street, Austin, TX 78701, or call 800/444-8662.

Ticket Refund and Cancellation Policies All cancellation requests must be received in writing and will be charged a 25% handling charge. Cancellations will receive a full refund minus the 25% handling charge. No refunds will be given to those cancellation requests postmarked after May 22.

Workshops, Special Events, and Meals Space in all workshops, special events, and meals is limited and tickets are needed for all of these events. Tickets will not be available in the 24 hours before each event so that we may plan appropriately.

Attire Dress comfortably for the educational sessions. As meeting rooms are often cold, a light sweater or jacket would be wise to bring. You are invited to dress in 1940s attire for Thursday's Sustainer's Party. Saturday evening's President's Banquet is black-tie optional.

Hotel Reservation Form

Please send this form to the Radisson Plaza Hotel at 815 Main Street, Fort Worth, TX 76102 *or call Radisson's toll free number, 800-333-3333 or dial the hotel directly at 817/870-2100.*

Texas Osteopathic Medical Association Annual Convention and Scientific Seminar
June 9 - 14, 1997

We look forward to welcoming you on your upcoming visit. The Radisson Plaza Fort Worth is located in the heart of downtown Fort Worth adjacent to the Fort Worth/Tarrant County Convention Center on Main Street, 15 minutes from the Museum District, the Historic Stock Yards, D/FW airport and Six Flags Amusement Park.

To guarantee your reservation, we will require either:
(A) An enclosed check or money order covering the first night's stay OR
(B) Major credit card number, expiration date, and signature.
The Radisson Plaza Fort Worth regrets that we cannot guarantee your reservation without one of the above.
Deposits will be refunded only if cancellation notification is received at least 72 hours prior to arrival.
Bed type on a request basis only. Check-in time: 3:00 p.m. Check-out time: Noon

Date of Arrival _____

Time of Arrival _____

Date of Departure _____

Check-in time: 3:00 p.m. Check-out: Noon

Name _____

Address _____

Telephone Number _____

Sharing Room with _____

Type of Room	# of Rooms	Rate
Single		$88
Double		$88
Triple		$88
Quad		$88

The above rates are subject to 13% state and local taxes.

Guarantee to one of the following: (Circle)

American Express
Carte Blanche
Master Card
Check or money order
Visa
Diner's Card
Discover

Card Number _____

Expiration Date _____

Signature _____

Reservations requested after May 25 or after the room block has been filled are subject to availability and may not be available at the convention rate.

Texas Osteopathic Medical Association

98th Annual Convention and Scientific Seminar

June 12 - 15, 1997

To register, mail this form along with payment to: Texas Osteopathic Medical Association, 1415 Lavaca Street, Austin, TX 78701. **Meal and event tickets (including those included with registration fee) will not be provided unless you request them on this form.** Tickets will not be available in the 24 hours before each event so that we plan appropriately.

Please print or type this form.

Name _____

Name for name badge (if different) _____

Address _____

City _____ State _____ Zip _____

Phone number _____ Fax number _____

D.O. College _____ Year Graduated _____ AOA # _____

Specialty _____ TOMA District _____

Spouse or Guest Name (if attending) _____

Registration Fees

(Please circle one)

	Early Registration **(postmarked by 5/22)**	Regular Registration **(postmarked after 5/22)**	Total
TOMA Member	$350	$450	$_____
1st and 2nd Year in Practice	$200	$300	$_____
Spouse, Military, Retired, Associate	$150	$250	$_____
Physician Assistants	$350	$450	$_____
Interns and Residents*	$0	$0	$_____
Non-Members	$600	$700	$_____

Please order meal, special event, and workshop tickets on the reverse side of this form.

Workshops

Wednesday Evening (Pre-Convention):

Please check only one.

Discover Medicine on the Net _____ $35
Preceptor and Rural Rotation Supervisor _____ -0-

Thursday Afternoon

Please check only one.

Dermatology Workshops _____ -0-
OMT for Common Female Complaints _____ -0-
Medical Spanish I _____ -0-
Estate Planning _____ -0-

Friday Afternoon

Please check only one.

Practical Approaches to Sports Medicine Injuries _____ -0-
Imaging of the Extremities _____ -0-
Medical Spanish II _____ -0-
Valuation of a Medical Practice _____ -0-

Saturday Afternoon

Please check only one.

How Do "You" Treat Headaches? _____ -0-
Flexible Proctosigmoidoscopy _____ -0-
Pitfalls in Managed Care Contracts _____ -0-
Medicare Changes for 1997 _____ -0-

Special Events and Meals

Tickets will not be provided unless requested on this form. Additional tickets will not be available within 24 hours of the function.

THURSDAY, JUNE 12

Opening Breakfast # _____ -0-
Keynote Luncheon # _____ -0-
Alumni Reception # _____ -0-
Sustainer's Party # _____ -0-
(open to Sustaining members and one guest only)

FRIDAY, JUNE 13

ATOMA President's Luncheon and Installation # _____ $20
(No charge if registered as a spouse)
Family Day at Texas Lil's # _____ $15
I/we will ride the bus Yes No
Golf Tournament # _____ $50
I/we will ride the bus Yes No
My handicap is_____

Saturday, June 14

TXACOFP Breakfast # _____ -0-
TXACOFP members only
AOA Luncheon # _____ -0-
President's Banquet # _____ $50
(One banquet ticket is included in each physician or spouse registration fee)

Summary of Registration Fees:

Total Registration: $ _____
Total Workshop Fees: $ _____
Total Special Events $ _____

Total Fees: $ _____

Please mail completed form and payment in full (checks or money orders only, made out to TOMA) to: Texas Osteopathic Medical Association, 1415 Lavaca Street, Austin, TX 78701-1634. No registrations will be taken over the phone.

Questions? Please call the TOMA office at 800-444-8662.

All cancellation requests must be received in writing and will be charged a 25% handling charge. Cancellations will receive a full refund minus the 25% handling charge. No refunds will be given to those cancellation requests postmarked after May 22.

News from Osteopathic Health System of Texas

Experimental Stroke Drug May Help Prevent Brain Damage

A landmark study being conducted at Osteopathic Medical Center of Texas with researchers at the University of North Texas Health Science Center may mean preventing brain damage for stroke victims in the near future.

Patients at OMCT who agree to participate in the study and meet certain criteria are involved in a national study involving a new drug called fosphenytoin (Cerebyx). Stroke victims who meet certain requirements are allowed to participate in the study if they take the drug or a placebo within four hours.

The drug may prevent brain damage if patients take it within four hours of having a stroke. Some participants take a placebo, and no one, including the physicians participating in the study, knows which the patient is receiving. This is a standard part of the process for approval through the Food and Drug Administration. Cerebyx has already been approved for use in patients who suffer from seizures.

Seventy percent of stroke victims have ischemic strokes, or strokes that stop blood flow to the brain. The only effective therapy currently in use is to give the patient a medicine that dissolves blood clots. This medicine has to be given within three hours of the stroke - an even shorter time window. Many patients do not qualify to take that medicine for medical reasons or because they could not receive treatment within three hours, according to William McIntosh, D.O., a co-investigator in the project. Ed Kramer, D.O., is the other co-investigator, and is also on the OMCT medical staff.

OMCT is one of 50 sites in the United States and Canada participating in the project. OMCT has six participants so far; the goal is 10 to 20. The total national goal for participation is 600; about 300 have participated in the study to date.

"We won't know for a year after the study is completed who received the drug and who received the placebo," said Dr. McIntosh, an associate professor of neurology at UNTHSC and a practicing neurologist at OMCT.

And like many stroke therapies available, time is of the essence in preventing or stopping stroke damage. Citicoline is another drug being tested for FDA approval that can protect cells that have been threatened or damaged by stroke from undergoing further injury. It can be effective if taken within 24 hours of the onset of stroke symptoms.

"We want to emphasize that people should not wait until the next day (after a stroke) to get to the hospital," said Madelon Petersen, R.N., clinical project manager for the university. "The therapies we have in place are very time-sensitive."

OMCT boasts one of the newest, best CT scanners in Fort Worth. CT technician Julia Baker, standing, gives the new General Electric spiral CT scanner a test drive with the help of radiology technician Tim Stevens.

OMCT Home to First G.E. Spiral CT Scanner in Fort Worth

OMCT's radiology department is the first in Fort Worth to own a new General Electric spiral CT scanner.

CT, or computed tomography, is a specialized type of X-ray used to record images of body tissues such as the brain, chest, abdomen and spine.

The scanner works by continuously X-raying a patient's body in a spiraling pattern from many different angles. Because the scan is continuous, patients spend much less time being X-rayed by the new spiral scanner than they would with an older-model scanner.

"One advantage of this is the speed," said Wayne Johnson, D.O., member of OMCT's radiology team. "We don't have to go slice by slice anymore. We can do a continuous scan as long as the patient can hold their breath."

Older axial CT technology required patients to lie on a table that slowly advanced them through the scanner's path. The table stopped to allow X-rays to be taken from different angles. A regular abdominal scan could take up to 45 minutes using the old stop-and-go process.

Although spiral CT patients still lie on a table that advances them through the scanner's path, they are continuously moving. A complete abdominal scan can be obtained in about 10 minutes.

Improved picture resolution is another spiral CT plus. Because whole sections of the body are continuously scanned, technicians can use even thinner scan sections to reconstruct clearer images. Additional reconstructed images can also be saved and analyzed by doctors later. This holds down costs by preventing patients from having to return for extra CT tests.

Continuous scanning also allows images to be reconstructed three dimensionally. Complex software can isolate just a section of the spine, for example, and allow a physician to turn and view the body part from many different angles.

"It's a real pleasure to work with this scanner," Dr. Johnson said. "The images are improved and the patient finishes the test much faster."

Other automated features in the spiral CT scanner help cut down total scanning time. Scans can also be customized to fit specific patient needs.

"The difference between this machine and the old axial scanners is like night and day," Dr. Johnson said. "It's exciting for me and the technicians to work with such a state-of-the-art piece of equipment." ■

Self's Tips & Tidings

Don Self & Associates

Is it Time to Divorce CHAMPUS Patients?

As we noted in last month's issue, CHAMPUS is going to make you "play" by their rules, whether or not you participate with them. If you do not enroll as participating with them, you have Limiting Charges; if you do participate with them, you may end up making a simple mistake and land in a Federal Prison for the next seven years (see last month's issue). For this reason, and due to the hassle factor, we are now recommending that all of our clients divorce their CHAMPUS patients. Patients will be able to find another physician who wants to take the CHAMPUS reductions, accept the litigious risks and spend hours on claims/appeals.

Along those same lines, we are looking closely at MetraHealth, due to the number of complaints, problems, and denied claims submitted to us by a number of our retainer clients. It is very probable that we may recommend not only to our retainer clients, but also to several specialty societies in regional areas, to divorce themselves from the MetraHealth Managed Care Plans.

Doctor: you can either continue to be in charge of your own practice or you can hand your autonomy and freedom over to managed care. It's your business and your choice, but in order to best make that choice, we highly recommend you have every managed care contract reviewed by an attorney you trust before you sign.

The Lighter Side of Lost Claims

We recently met with a large insurance company with a 90 day filing deadline and discussed the case of a physician who claimed he had filed within the deadline. Of course, the insurance company held that the claim had never been received.

Why, we then asked, did the insurance company send a letter to the physician within the 90 day limit asking for more information about the claim it never received?

The claim was then paid.

Sent to us by Lawrence E. Epstein

Coding Current or Past Diagnoses

After reviewing the "items of interest" (fraud watches) in the latest Office of Inspector General bulletins, we want to caution physicians on their diagnosis coding. Since we know many physicians are "adding" diagnosis to their "menus" when reporting their nursing home visits to their billing staff, we felt you should be aware of fraud-watch areas:

"Inspectors are advised to examine coding conditions presently existing, conditions no longer existing, residuals (late effects) of conditions no longer existing and certain postoperative status conditions that require consideration in the management of patient care. Some physicians will add to the list of conditions currently being treated any previous surgery or conditions that no longer exist to provide easy reference to the patient's history for recapitulation in the ongoing care of the patient. These should not be coded unless they require or affect patient case treatment or management."

S.T.A.T. Now on Subscription Basis

For eight years, Don Self has published portions of his monthly newsletter in this magazine. If you would like information on receiving the 10-to 12-page monthly newsletter on a subscription basis, please contact his office at 1-800-256-7045.

A Short History of Medicine

[Author unknown]

I have an earache...

2000 B.C. - Here, eat this root.
1000 A.D. - That root is heathen. Here, say this prayer.
1850 A.D. - That prayer is superstition. Here, drink this potion.
1940 A.D. - That potion is snake oil. Here, swallow this pill.
1985 A.D. - That pill is ineffective. Here, take this antibiotic.
2000 A.D. - That antibiotic is artificial. Here, eat this root.

Charging for No-Shows

On several occasions, we've been asked about charging patients for not keeping their appointments. While we believe this would be very difficult to collect from new patients, we do recommend you establish a policy in your office about no-shows. Once you've established the policy, we recommend you advise patients in advance, in writing. For instance, you can publish the policy in your newsletter to your patients; have flyers in treatment rooms; put up a sign in your reception area; or optimally, have the policy included in your practice brochure. While we do not recommend charging a no-show charge for the first missed appointment, we do advise making a charge on the second and subsequent missed appointments.

You are allowed to charge Medicare and Medicaid patients (good luck collecting from them) if your policy is to collect from non Medicare and non Medicaid patients also. Since these services are never paid by Medicare or Medicaid, you do not have to have the patient sign a waiver. Naturally, we do not recommend assigning an office visit code (99201-99215) to this charge; if you are forced to have a "code" for your computer, let your imagination run wild and create one (i.e.,99998, 00005 or alpha code NOSHO).

Does Medicare "Split" Your Claims?

Do you find that Medicare sometimes splits the claim and sends part of the money to you and part of the money to the patient? If this is happening to you, the problem may not be at Medicare, but in the way that you complete the claim. On HCFA-1500 claim forms (and on electronic claim formats also), there is a box to indicate how much the patient paid at the time of service (box 29). Invariably, when Medicare sends part of the money to the patient, we find the provider has completed this box. Our recommendation is that this box should be blank on every claim you file, whether it be Medicare, Medicaid, Blue Cross or any commercial carrier. The carrier does not need to know how much the patient paid you, and this should not affect

how much they pay you. We file hundreds of claims per day in our claims filing business, and every claim we file has box 29 blank.

Bill Only for What You, Not Others, Do

No, I'm not referring to billing for your own employees under incident-to-rules, but I am referring to "coverage" billing. In other words, when you are covering for another physician over the weekend and see their patients, we suggest that you bill for those hospital visits and not the "covered" physician. Along the same lines, if someone covers for you next Sunday, we do not recommend you bill for the daily hospital care for that day, but allow the other provider or physician to bill for their own services, while you bill only for yours. Yes, this means you will have to obtain the billing information on your colleague's patient, but then your bill will be dependent upon your own documentation and not theirs. Yes, it is legal to do reciprocal billing for coverage, but we don't recommend you adopt a reciprocal policy, due to the liabilities involved. ■

Medical Review Educational Seminars

The Medical Review Division of the Texas Workers' Compensation Division announces its 1997 seminars covering selected medical benefit topics for workers' compensation. The seminars target health care provider billing staff and insurance staff who audit and pay medical bills, but are open to the public. Medical Review staff will present information and answer questions. Seminars last a half day; morning and afternoon seminars are available in most locations. For questions and/or further information, call 512-440-3815.

Seminar Dates & Locations

El Paso
Friday, May 16: 8:15-12:15 or 1:00-5:00
Airport Hilton, 2027 Airway Blvd., 915-778-4241

Dallas
Wednesday, May 21: 8:15-12:15 or 1:00-5:00
Thursday, May 22: 8:15-12:15 or 1:00-5:00
Clarion Hotel, 1981 N. Central Expressway, 972-644-4000

Houston
Thursday, May 29: 8:15-12:15 or 1:00-5:00
Friday, May 30: 8:15-12:15
Renaissance Houston, 6 Greenway Plaza East, 713-629-1200

Austin
Tuesday, June 3: 8:15-12:15 or 1:00-5:00
Wednesday, June 4: 8:15-12:15
Austin North Hilton, 6000 Middle Fiskville Road, 512-451-5757

Lubbock
Wednesday, June 11: 8-:15-12:15
Holiday Inn Plaza, 3201 South Loop 289, 806-797-3241

Harlingen
Friday, June 20: 8:00-12:00
Best Western, 6779 West Expressway 83, 210-425-7070
(Due to limited space, the Harlingen seminar will be presented from 8:00 to 12:00, without breakout sessions. All participants will attend all topics in an expanded format. ■

10 Years Ago in the *Texas D.O.*

• T. Eugene Zachary, D.O., was named vice president for academic affairs and dean at the Texas College of Osteopathic Medicine.

•The United States Department of Defense initiated a new policy recognizing the AOA specialty certification process. The essence of the policy, which was circulated throughout the military chain of command, read: "Those osteopathic physicians who do not desire allopathic board certification, shall be afforded the opportunity to compete on an equal basis for military graduate medical education programs, provided they will thereby be eligible for board certification by the American Osteopathic Association."

• Jay G. Beckwith, D.O., was elected to the American College of Osteopathic Internists Board of Directors. The 12-member board is the governing body of the ACOI, whose members specialize in the practice of internal medicine.

• David Teitelbaum, D.O., was elected president of the Texas Academy of Osteopathy.

• Ted C. Alexander, Jr., D.O., was appointed General Chairman of the Shrine Oil Bowl Football Classic.

• A compromise on the issue of drug sampling was reached. An agreement between drug manufacturers and Congressman John Dingell was a modified version of the "Prescription Drug Marketing Act of 1987," the legislation which included restrictions on the distribution of pharmaceutical samples to physicians. The compromise included the provision that drug salesmen could continue to distribute samples to physicians' offices but must acquire a signed receipt. The original legislation would have prohibited salesmen from distributing samples altogether. ■

Texas ACOFP Update

By Joseph Montgomery-Davis, D.O., Texas ACOFP Editor

At the time of this update, S.B. 386, which deals with HMO liability, passed the Texas Senate by one vote and is scheduled for its second reading in the full House. Governor Bush is currently undecided as to whether he will or will not support S.B.386.

The people of Texas need S.B. 386. There is no reason why managed care organizations should be the only health care entities in Texas to enjoy complete immunity from liability in medical negligence cases. There needs to be a level playing field for all players. If no man is above the law, it follows that no health care entity should be above the law. It is not a question of money; it is a question of justice.

On March 18, 1997, it was my pleasure to serve as the "Doctor of the Day" at the Capitol in Austin, Texas. This was part of the Osteopathic Family Physician Week. During each Texas Legislative session, on a daily basis, a volunteer physician and a full-time R.N. are available in the First Aid Office of the Capitol to treat legislators, their staff and visitors.

Tim Flynn, R.N., did a superb job of relieving my initial anxiety by ushering me to the Senate and House chambers on time to meet with my personal legislators prior to the beginning of the legislative sessions. Senator Carlos Truan introduced me in the Senate and Representative Irma Rangel introduced me in the House. Photos were taken with my personal legislators prior to getting back to my primary duty of patient care. The rest of my day was spent treating patients. A portable OMT table was available for treating musculoskeletal problems, and the required patient care paperwork was kept to a bare minimum. I would highly recommend participation in the "Doctor of the Day" program to all Texas physicians.

One indirect result of the Osteopathic Family Physician Week at the Capitol is that osteopathic physicians who participate in the future will be expected to provide OMT services to legislators and their staff. There is a need for OMT services at the Capitol.

On behalf of the following physicians who participated in the 1997 Osteopathic Family Physician Week (Wesley Wilson, D.O., Forney; Joe Montgomery-Davis, D.O., Raymondville; Jeffery Butts, D.O., Austin; and T. Robert Sharp, D.O., Mesquite), I would like to thank Terry Boucher, TOMA Executive Director; Janet Dunkle, Texas ACOFP Executive Director; and Tim Flynn, R.N., for their assistance in making our day at the Capitol so successful, rewarding and enjoyable.

Federal Labor law now requires employers to display labor law information in their place of business. Failure to comply may result in penalties of up to $10,000. The United States Code of Federal Regulations stipulates that all employers must permanently display information about the following labor laws:

- Family and Medical Leave Act 29 [CFR 828.300 (a)]
- Employee Protection Act 29 [CFR 801.6]
- The Williams-Steiger Occupational Safety and Health Act 29 [CFR 1903.2 (a) (1)]
- Americans with Disabilities Act & Civil Rights Act 29 [CFR 1601.30 (a)]
- E.E.O.C. provisions
- Minimum Wage information

You may comply with these regulations by posting a single 5-in-1 poster which is laminated and available for purchase from Remarkable Products, 382 Rte. 59, #310, Monsey, NY 10952. The telephone number is 800-600-0142 and the FAX is 914-369-0136. The total cost is less than $20.00. Don't overlook this federal requirement!

Recently, the topic of depositions came up during a TOMA committee meeting chaired by Dean Peyton, D.O. The members, all of whom were osteopathic physicians, were polled by the committee chairman as to their policy on the taking of depositions. What was discovered was that there was a lack of knowledge regarding depositions. Perhaps anti-trust considerations have prevented physicians from discussing fees for depositions?

Dean Peyton, D.O., was kind enough to provide a sample deposition request form which has been slightly modified and reproduced below:

Deposition Request

Patient: _____ Treatment Date: _____
Physician: _____ Diagnosis:_____
Attorney scheduling _____ Phone_____
Representing _____

How to Schedule: Submit the minimum fee. You may suggest days and time; we will accommodate if possible. We will call you to schedule the deposition.

Ground Rules

1. Fees must be received one week before the deposition. They are:
   Minimum Deposition $_____ including the first hour of testimony and up to one hour of records review
   $_____ for each additional quarter hour
   Pre-deposition exam $_____ if needed
2. We reserve the right to read and sign the final transcript.
3. The lawyer is expected to provide an authorization from the patient.
4. Questions will be confined to our findings, treatment, and medical opinion. We will not give an opinion of another physician's treatment, diagnosis, or interpret tests we did not do unless these documents are submitted in advance for us to review.
5. No badgering over probable cause. Based upon reasonable medical probability the relationship of the patient's condition to the allegedly causative event is:
   _____
   _____
   _____
   _____
6. We expect you to be brief. If you anticipate that this will take longer than 1-2 hours, you must warn us to avoid running the risk of having to schedule a continuation.
7. Unlike many physicians, we feel that depositions are a needed service for some of our patients. However, please cooperate by doing what you can to make the process more convenient and less stressful for all involved parties.

As you can see, there are no money amounts listed. However, by the time you receive this issue, there should be a range of fees for the services listed above, which will be supplied by lawyers, not physicians.

Texas osteopathic physicians will have to determine their own fees for services rendered. This information will be kept on file for reference and will be available upon request by calling TOMA or the Texas ACOFP office.

I recently received a letter from Ann Brooks, Associate Director, Gibson D. Lewis Health Sciences Library, in regards to library services to Texas ACOFP members. The Texas ACOFP has a contract with the Lewis Library to provide its members with information access and training. Members interested in having a password to directly access the library's data base should contact Mrs. Brooks at 800-687-5302 or e-mail: apbrooks@jove.acs.unt.edu. The databases presently available include MEDLINE (1966 to date), CINAHL (nursing and allied health), and HealthSTAR (health services, technology, administration and research). The library plans to make a training class available at the annual Texas ACOFP meeting, which is tentatively set for July 31, 1997, from 2 - 4 p.m.

Be sure to mark your calendars and attend the TOMA and Texas ACOFP seminars this summer:

June 12-15
98th TOMA Annual Convention & Scientific Seminar
Location: Radisson Plaza Hotel and Fort Worth/Tarrant County Convention Center
Contact: TOMA at 800-444-8662

July 31-August 3
40th Texas ACOFP Annual Clinical Seminar
Location: Adam's Mark Hotel, Dallas
Contact: Texas ACOFP at 888-892-2637 ■

TSBME Adopts Position on Bariatric Medicine Issues

The following position statement was adopted by the Texas State Board of Medical Examiners on March 1, 1997, to help physicians in the state understand proper prescribing for obesity.

Quality medical practice dictates that obese and overweight citizens of Texas should be adequately treated for these conditions, not only to address serious medical problems associated with these conditions, but also to improve quality of life. A misconception appears to have arisen that the TSBME will indiscriminately discipline physicians for prescribing anorectic medications in conjunction with weight control programs. To the contrary, the TSBME does not intend to inhibit the proper prescribing of anorectic medications for weight control.

In fact, the TSBME recognizes that obesity is a disease which affects millions of people and causes a variety of medical conditions, which exacerbate or contribute to a great deal of suffering. As a complex multi-factorial disease, the appropriate treatment of obesity can involve many disciplines including genetics, physiology, metabolism, exercise and nutritional counseling, and other environmental, psychological and cultural factors. Therefore, obesity may require treatment by a physician. The treatment, including the use of anorectics, of overweight individuals, who do not meet a clinical definition of obesity, may be indicated as well. Such treatment and care may be appropriate not only for an individual's psychological well-being, but also because studies have shown that a relatively small amount of weight loss (i.e., five to 10 percent of body weight) can significantly reduce health risks such as coronary artery disease.

In determining the standard of practice for bariatric medicine, especially in the area of prescribing, the TSBME will continue to focus on the same concerns it has in other areas of medical practice. The TSBME's primary concern is the provision of quality medical care, including performance of an appropriate physical and psychological evaluation, appropriate laboratory testing, discussion of treatment risk factors with the patient, follow-up care, monitored prescribing practices, and maintenance of proper medical records. The physician must ultimately evaluate the risks involved in the treatment of patient in light of the benefits received by the patient, particularly regarding the prescribing of medication; and the analysis of risk versus benefit should be fully disclosed to the patient.

Controlled substances are subject to abuse by individuals who seek them for other than their legitimate medical uses. The TSBME continues to be concerned about the inappropriate prescribing of controlled substances in the practice of Bariatric medicine, just as in other practice areas. A physician may be able to appropriately prescribe Schedule III, IV or V drugs for treatmen of obesity and overweight conditions, as long as the standards of quality medical care described above are met; but the prescribing of Schedule II drugs would likely be assumed to be inappropriate without proper medical indications documented by the physician. ■

Public Health Notes

"Rules and Regulations Pertaining to Duties and Responsibilities of Physicians with Regard to Deceased Persons and Death Records"

By Alecia Anne Hathaway, M.D., M.P.H., F.A.C.P.M.

We receive on a regular basis, reports and concerns from the health community administrators and medical personnel regarding issues centered around the handling of bodies of deceased individuals and procedures related to the filing of death records. I have researched the statutes for the benefit of the health community and request the assistance of all physicians, medical personnel and health administrators to ensure that the following State Administrative and Health and Safety Codes are adhered.

The first issue relates to clearly identifying a deceased person known to have had certain communicable diseases.

Deceased persons who were known to have had certain communicable diseases are not consistently being identified, thus unintentionally exposing persons involved with the internment and preparation of the deceased to potential increased risk of contagion. This problem has been experienced on occasion in nearly all of the community's larger health care facilities and in nursing home facilities. Texas law (Title 25, Texas Administrative Code [TAC] § 97.12) requires that if a physician has knowledge that a person had a communicable disease (as listed below) at the time a death, then the physician shall affix or cause to be affixed a tag on the body, preferably on a great toe.

The tag shall be on card stock paper and shall be no smaller than five centimeters. The tag shall include the words "COMMUNICABLE DISEASE-BLOOD/BODY SUBSTANCE PRECAUTIONS REQUIRED" in letters no smaller than six millimeters in height. The name of the deceased person shall be written on the tag. The tag shall remain affixed to the body until the preparation of the body for burial has been completed. All persons should routinely practice standard infection control procedures when performing postmortem care on a deceased person who is known or suspected of having a communicable disease.

Diseases that shall require tagging are acquired immune deficiency syndrome (AIDS); anthrax; brucellosis; cholera; Creutzfeldt-Jakob disease; hepatitis, viral; human immunodeficiency virus (HIV) infection; plague; Q fever; rabies; relapsing fever; Rocky Mountain spotted fever; syphilis; tuberculosis; and viral hemorrhagic fevers.

The most frequently noted reason doctors have given for not complying with the above law stems from a concern of possible violation of confidentiality. The warning on the tag is broad and does not disclose specific information about the deceased, but properly warns persons necessarily involved with preparations of the body. Such personnel are part of the chain of the medical community and are compelled to observe strict confidentiality.

On the other hand, physicians who are responsible for determinations of the deceased and who fail to ensure that a body known to have had a communicable disease is properly tagged, can be held accountable by the State Board of Medical Examiners and/or in civil court by any parties who might suffer as a result.

This is a traditional and important health standard and I would enlist all our colleagues' support to increase compliance.

The second issue pertains to timely filing of Certificates of Death.

Texas Health and Safety Code § 193.003 "Time and Place for Filing Death Certificate," stipulates that:

A. Not later than the 10th day after the date of a death that occurs in this State, a death certificate shall be filed with the local register of the registration district in which:

1. the death occurs; or
2. the body is found, if the place of death is unknown.

B. Subject to Board rules, this shall also pertain to a fetal death.

Normally, funeral directors are responsible in Tarrant County for filing the death certificate. Physicians are normally responsible for certifying the death and are asked to do so in a timely manner so that funeral directors may file the certificate within the 10 day required time frame.

The registrar cites that the majority of delays for certificate filing is a result of physician noncompliance.

We would encourage doctors' cooperation in fulfilling their part of the death certification process. Should there be difficulties in doing so, please contact your county health authority for assistance. ■

OSHA Increasing Safety Investigations

According to the U.S. Department of Labor, The Occupational Safety and Health Administration (OSHA) has not only increased the number of workplace safety investigations it is making, it is also issuing more of the most serious citations. OSHA statistics indicate that in comparison to 1995, the number of citations given for very serious safety violations jumped by 30 percent in 1996. This type of citation carries proposed penalties of a minimum of $100,000, and frequently involves a number of "willful" violations of the law.

Assistant Secretary of Labor for OSHA Joseph Dear asserts that this trend sends "a clear warning to those employers who may be tempted to neglect the safety and health of their workers that OSHA will continue to strongly enforce its requirements for protection, with stiff penalties for violations." ■

TEXAS STARS

The following people have made pledges or have contributed to TOMA's Building Fund Campaign. These people are now known as "Texas Stars" because of their commitment to the osteopathic profession.

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Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
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If you would like to contribute to the Building Fund and become a "Texas Star," call Paula Yeamans at 800-444-8662. Please note that contributions received three weeks prior to each issue may not appear until the following issue.

Opportunities Unlimited

PHYSICIANS WANTED

FORT WORTH AREA FP-GP CLINIC needs an additional GP for full or part time. No OB, no hospital required. 817-924-7978. (02)

SEMI-RETIRED PART-TIME GP — Accident and Injury Clinics - Dallas/Fort Worth area. Call 972-647-4591; FAX 817-424-1059. (05)

NEEDED IMMEDIATELY - DALLAS/FORT WORTH/MIDCITIES AREA — Family Practice needs Primary Care Physician, BC/BE. No OB, competitive salary, and full benefits. Call DeAnne Jolly at 817-281-0402 or FAX CV to 817-281-6364. (07)

HIGH VOLUME CLINIC - Patient Mix, Medicaid and Fee for Service. Spanish with a touch of reality a plus. Compensation dependent upon production. Call 817-574-2777 or 800-767-1007. (09)

BOARD CERTIFIED FAMILY PRACTITIONER to join 2 Family Practitioners in established Grand Prairie metroplex practice. Light hospital (Baylor-Irving), no OB. Flexible work schedule (currently rotating work 2 days with 3rd day off). No weekend office. Share calls. Managed Care experience a plus. Call Jeff Thompson at 972-262-1425 or 817-429-4711. (10)

RADIOLOGIST: BC/BE Interventional radiologist needed to join growing practice of 8 radiologists in Texas. Would prefer fellowship training in Interventional or Neurointerventional. Primary responsibility would be in Special Procedures with some general diagnostic radiology. Full benefit package with liberal CME and vacation time. Salary commensurate with experience. Direct CV and inquiries to Richard Schellin, D.O., Department of Radiology, OMCT, 1000 Montgomery St., Fort Worth, TX 76107; 817-735-3220. (15)

PHYSICIAN-OWNED EMERGENCY GROUP — is seeking Full or Part-Time D.O. or M.D. emergency physicians who practice quality emergency medicine. BC/BE encouraged, but not required. Flexible schedules, competitive salary with malpractice provided. Send CV to Glenn Calabrese, D.O., FACEP, OPEM Associates, P.A., 4916 Camp Bowie Blvd., Suite 208, Fort Worth, 76107. 817-731-8776. FAX 817-731-9590. (16)

HILL COUNTRY — Established and flourishing Women's Health & Fitness Center in Boerne, Texas, searching for dynamic, motivated D.O., GYN or Cosmetic Surgeon. Opportunity as working partner or straight office lease available. Need is immediate...patients are waiting. Call Phyllis today - 210-816-2946 or 210-249-9063. (18)

DOCTOR NEEDED in various parts of Texas to work small hospital emergency rooms on weekends. Also, full-time/part-time primary care opportunities available. For more information, call Jerry at the Lewis Group at 800-460-8159. (20)

FAST TRACK CLINIC OPENED JANUARY, 1996 — Primary Care Physician needed. Flexible schedule with malpractice provided and competitive salary. Send CV to: OPEM Associates, P.A., 4916 Camp Bowie Blvd., #208, Fort Worth, TX 76107; 817-731-8776; FAX 817-731-9590. (24)

DALLAS/FORT WORTH — Physician Opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call, no weekends, and no emergencies. Please call Lisa Abell at 800-254-6425 or FAX CV to 972-256-1882. (25)

WANTED — Physician interested in Bariatrics to work part-time in Dallas area clinic. Contact Pat at 214-638-4923. (33)

AMBULATORY FAMILY PRACTICE has opportunities for FT/PT BC/BE FP. Full benefits package for FT including malpractice, paid time off, expenses for CME/Lic. fees. Flexible schedule, no night call, no hospital work, no administrative hassles. Enjoy the lifestyle afforded by the Metroplex. Please FAX CV to 817-283-1059 or call Shannan at 817-283-1050. (36)

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FOR SALE — Late model MA X-ray and processor with view box and accessories; hydraulic stretcher; transport stretchers; Coulter counter and diluter; storage cabinets; office desk; assorted other items - very good condition. Contact Dr. Glen Dow or Office Manager, 915-485-4711. (48)

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