TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
Volume LVII, No. 1 January 2000

Obesity in America

A National Epidemic

The Tale of the Scale

pages 6 - 16

plus

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Calendar of Events - page 4

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JANAURY 2000

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Inside This Issue

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CALENDAR OF EVENTS

JANUARY

28-30

"TOMA's 44th MidWinter Conference & Legislative Symposium –What's New for the New Millennium"

Sponsored by the Texas Osteopathic Medical Association

Location: Renaissance Dallas North Hotel
LBJ Freeway at Midway Road, Dallas, TX
CME: 17.5 hours category 1-A credits
Contact: Sherry Dalton, Conventions Coordinator
800-444-TOMA or 512-708-TOMA
FAX: 512-708-1415; E-mail: sherry@txosteo.org

FEBRUARY

23-27

"Osteopathic Medicine: A Universal Approach"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Sheraton Universal Hotel, Universal City, CA
CME: 40 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

FEBRUARY 27 – MARCH 3

"Ski & CME Midwinter Conference"

Sponsored by the Colorado Society of Osteopathic Medicine

Location: Keystone Lodge & Resort, Keystone Colorado
800-258-0437, Code CA2CCSO
CME: 40 hours category 1-A credits
Contact: Brooke Chynoweth
650 Cherry St., #440, Denver, CO 80246
303-322-1752 or 800-527-4578
FAX: 303-322-1956
E-mail: info@ColoradoDO.org
Web site: www.ColoradoDO.org

MARCH

3-7

"10th Annual Clinical Medicine Update for Primary Care Physicians"

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

Location: Harvey's Hotel & Casino
South Lake Tahoe, Nevada
CME: 20 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

APRIL

7-8

"Texas Osteopathic Medical Association House of Delegates Meeting"

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

APRIL

15-16

"14th Annual Spring Update for Family Physicians"

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

Location: Dallas Southwest Medical Center
Dallas, TX
CME: 12 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

MAY

3-6

"92nd Annual Clinical Assembly & Scientific Seminar"

Sponsored by the Pennsylvania Osteopathic Medical Association

Location: Adam's Mark Hotel, Philadelphia, PA
CME: Over 40 hours category 1-A credits anticipated
Contact: Mario Lanni, POMA Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX: 717-939-7225, E-mail: poma@poma.org

4-7

"103rd Annual Convention"

Sponsored by the Indiana Osteopathic Association

Location: Sheraton Hotel/Westin Suites, Indianapolis, IN
CME: 30 hours category 1-A credit anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

JUNE

8-11

"OMT With a View: Pain Management by the Sea"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Marriott Laguna Cliffs Resort, Dana Point, CA
CME: 2040 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

15-18

"TOMA's 101st Annual Convention & Scientific Seminar –The Century of Tomorrow Touching Our Communities Today"

Sponsored by the Texas Osteopathic Medical Association

Location: Bayfront Plaza Convention Center and
Bayfront Omni Hotel, Corpus Christi, TX
Contact: Sherry Dalton, TOMA Conventions Coordinator
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On the Web in January

Starting with this first issue of the new millennium, "On the Web" will be a monthly feature of the magazine. This page will share headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website:<www.txosteo.org>.

Obesity and Overweight in America

A National Epidemic?

Overweight and physical inactivity account for more than 300,000 premature deaths each in the U.S., second only to tobacco-related deaths.

Federal Obesity Clinical Guidelines

Clinical Practice Guidelines to Help Physicians.

In 1998, the first federal guidelines on the identification, evaluation, and treatment of overweight and obesity in adults were released by the National Heart, Lung, and Blood Institute, in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases.

AOA Eye on Federal Agencies

How to Handle Professional Courtesy.

According to the OIC, a routine practice by a physician of waiving the entire fee for service provided to other physicians, without regard to the potential for referrals, is not a problem.

FYI

- **Osteopathic Physician Day**
- **HCFA Announces 2000 Medicare Physician Fee Schedule**
- **Two Texas Locations Selected for NHANES Program**

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

- **Fort Worth Osteopathic Medical Center changes its name**
- **TCOM is honored as "Employer of the Year"**
- **T. Eugene Zachery announced his resignation as dean of TCOM**
- **Charles D. Ogilvie, D.O. was awarded rank of professor emeritus by the TCOM Board of Regents**

News You Can Use

- **TWCC Converts to New Phone Number**
- **New Compass 21 implementation Schedule**

Texas Stars

A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" due to their commitment to the osteopathic profession.

Thank You

A Listing.

Thank you to "Texas Stars" who have contributed above the $1,000 donation level to TOMA's Building Fund Campaign.

For Your Information

A Listing.

Phone numbers of Federal agencies, osteopathic agencies and state agencies useful to the osteopathic healthcare community.

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The Alarming OBESITY Epidemic

By Amber Patrick, MS, and Amy Simpson, MS

Thirty-four percent of the United States population is overweight or obese, according to the National Health and Nutrition Examination Survey III (NHANES III), conducted from 1988 to 1991 (Gutherie, 1995). Alarming? This trend has continued to increase in recent years. As a result of this ever-fattening nation, the U.S. Department of Health & Human Services released the Healthy People 2000 objectives. This document, published to instill a new sense of purpose for public health and preventative medicine, met only one of the thirteen objectives (Francis, 1999).

Obesity increases and exacerbates the development of heart disease, diabetes, COPD, hypertension, psychological conditions, some cancers, and more (Winslow, 1996). This trend is due to an increase in sedentary habits, such as TV watching, computer use, smoking, and lack of physical activity. Increasing physical activity remains a key to maintaining and/or losing weight (Coakley, 1998). Physicians, exercise physiologists, and health providers are extremely concerned about the future health of the nation as society continues to become more sedentary with the ever-increasing advancement of technology. As Echoboomers age, and technology continues to create a sedentary culture, obesity trends may escalate beyond the current epidemic proportions. There is an inverse relationship between physical activity and obesity (Raitakare, 1997 & Fujii, 1998). The same study by Raitakare and colleagues, 1997, concluded by stating, "The promotion of physical activity is important in childhood in preventing obesity and premature cardiovascular disease." Participating in a regular exercise program will decrease weight in obese patients, and will reduce the risk factors for such diseases related to obesity (McMurray, 1998 & Stafford, 1998).

As awareness to the growing epidemic of obesity continues to alert more public health officials, education, suitable programs and a new approach for obese individuals will become more important. (Vansant, 1999). Programs must utilize different methods to assist with lifestyle change, have personnel trained to deal with special needs, and address concerns such as strain on joints, existing heart or hormonal abnormalities (Engelhart, 1996 & Lyons, 1999). Engaging obese individuals in an exercise program combined with diet therapy is successful. Practitioners must "first, help the patient understand the value of the therapy; second, discuss the way in which treatment will evolve and set goals; and third, follow-up by monitoring and encouraging the patient's progress and identifying any barriers or adverse effects" (Winslow et al., 1996). When aiding an obese person in this process, Lyons, 1999, concludes by stating, "Address the special needs of large people by outlining an approach sensitive to their needs."

Many fitness or health and wellness facilities have developed programs with well-trained staff, sensitive to the physical and emotional needs of this population. Some facilities are utilizing the Social Learning Theory to classify individuals with a high risk of non-compliance. Once the individuals are identified, strategies can be implemented to increase the likelihood of success. Facilities affiliated with hospitals, physical therapy clinics, and dietitians, have resources that can be tapped for the use of developing programs specifically designed for obese patients.

Health care providers committed to decreasing obesity and physical inactivity must consistently ask about patients' physical activity levels and hold them accountable for exercise compliance. Health care providers may find assistance from fitness facilities willing to aid in follow-up reports on usage and progress.

Amber Patrick, MS, is the General Manager of The Health & Fitness Connection's Camp Bowie (Fort Worth) location. She earned her BS in Dietetics from Baylor University and continued her education by earning a MS in Exercise Physiology as well. Currently, she develops exercise and nutrition programs for members of both HFC locations.

Amy Simpson, MS, is the Assistant General Manager for The Health & Fitness Connection. She earned her BS from Baylor University and continued her education at Texas Christian University, earning an MS in Exercise Physiology. Recently, Simpson was named the 1999 IHRSA/CYBEX Fitness Director of the Year, selected from over 4600 fitness facilities world wide.

References

Coakley, E. H., E. B. Rimm, G. Colditz, J. Kawachi, & W. Willett. 1998. Predictors of weight change in men: results from the health professionals follow-up study. International Journal of Obesity and Related Metabolic Disorders. 22 (2). 89-96.

Engelhart, M. J. Kondrup, L. H. Hoie, V. Andersen, J. H. Kristensen, & B. L. Heitmann. 1996. Weight reduction in obese patients with rheumatoid arthritis, with preservation of body cell mass and improvement of physical fitness. Clinical and Experimental Rheumatology. 14 (3). 289-293.

Francis, K. T. 1999. Status of the year 2000 health goals for physical activity and fitness. Physical Therapy. 79 (4). 405-14.

Fujii, T., J. Ohsawa, A. Nozawa, K. More, M. Kagaya, T. Kaijoka, Y Oshida, & Y. Sato. 1998. The association of physical activity level characteristics and other lifestyles with obesity in Nagoya University alumni, Japan. Scandinavian Journal of Medicine & Science in Sports. 8 (1). 57-62.

Guthrie, H. A., & M . F. Picciano. 1995. Human Nutrition. Mosby – Year Book Inc: Von Hoffmann Press, St. Louis, MO. 224.

Lyons, P. & W. C. Miller. 1999. Effective health promotion and clinical care for large people. Medicine and Science in Sports and Exercise. 31 (8). 1141-6.

McMurray, R. G., B. E. Ainsworth, J. S. Harrell, T. R. Griggs, & O. D. Williams. 1998. Is physical activity or aerobic power more influential on reducing cardiovascular disease risk factors? Medicine and Science in Sports and Exercise. 30 (10). 1521-9.

Raitakari, O. T., S. Taimela, K. V. Porkka, R. Telama, I. Valimaki, H. K. Akerblom, & J. S. Viikari. 1997.

Vansant, G. & E. Muls. 1999. New directions in public health approach to obesity management. Acta Clinica Belgica. 54 (3). 151-3.

Winslow, E., N. Bohannon, S. A. Brunton, & H. E. Mayhew. 1996. Lifestyle modification: Weight control, exercise, and smoking cessation. American Journal of Medicine. 101 (4A). 4A25S-31S.

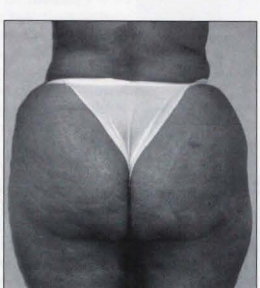
Liposuction for the Control of Obesity

By Richard C. Grossman, D.O., F.O.C.O.O.

This issue of the *Texas D.O.* is highlighting obesity. The question posed to me by the magazine's journalist was, "Can liposuction be used to treat obesity?" The simple answer is "no." Liposuction was never designed as a substitute for weight loss. Fat has a low density so that even if a large volume of fat were to be removed, the change in body weight would be minimal. But if the question were about whether or not liposuction can be used to treat obese or overweight patients, the answer would be "yes."

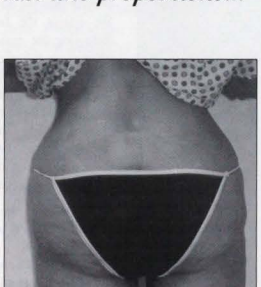
Obesity has many medical ramifications, including diabetes, high blood pressure, hypertension, heart disease, and orthopedic problems. But one of the overweight or obese patients' unseen problems is psychological, affecting the person's self image. A patient may come to your office obese, overweight, or even at ideal weight and say she dislikes her body shape due to localized bulges or deposits of fat. This is the patient that I can help. While in the early years of liposuction, physicians said the patient must be at his or her ideal weight prior to liposuction. Today, however, we understand that even obese patients can receive very satisfying results if their expectations are realistic.

I have performed an average of three or four liposuction cases a week for fourteen years. One of my most satisfied liposuction patients was a woman who weighed 350 pounds and had massively large, disproportionate hips. Her fat deposits lay so that they actually formed a "shelf" on her sides below her waist. (Some Southern patients call these "pones.") I was able to reduce these by tumescent liposuction under local anesthesia. This surgery gave her a more proportional body shape and she could then buy clothes to fit the rest of her body. I told her clearly what she could expect from the surgery and she was delighted with the results.

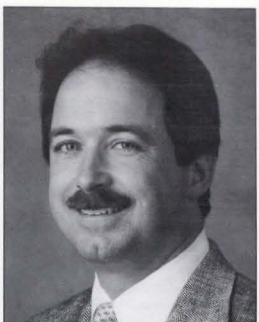


Before liposuction

"...our patients often want to lose weight to alter their body shape, size and proportions..."



After liposuction



In the medical control of obesity, our patients often want to lose weight to alter their body shape, size and proportions. We, as physicians, want them to lose weight to lessen the medical risks of obesity. Both goals are admirable, but the patient whose goal is to get rid of those hip, thigh, or abdominal bulges by weight loss and exercise is generally doomed to failure. Photographs of patients before and after weight loss show that these bulges are still present after weight loss although the patient is smaller and lighter. These patients, while losing weight and reducing medical risks, have not achieved their goal of having a more proportionate shape. They are often so frustrated that they give up their good eating and exercise habits.

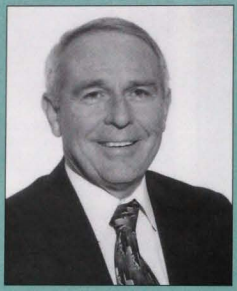
The patient who is overweight, has liposuction and then loses weight, is often more motivated because the weight loss enhances the results of liposuction. This dramatic change motivates the patient to keep the weight off and continue his good habits.

Modern tumescent liposuction under local anesthesia has proven itself to be safe for the removal of two to six liters of fat. Patients recover quickly and blood loss is minimal. While liposuction cannot cure obesity, it can change the shape of your obese patients and improve their self-image.

Dr. Grossman is in private practice at Metropolitan Surgical Specialties in Colleyville. He is certified in otorhinolaryngology and facial plastic surgery, and is a Fellow of the Osteopathic College of Ophthalmology and Otorhinolaryngology.

The SKINNY on Diet Pills

By Otto F. Puempel, D.O.



When fenfluramine (Pondimin and Redux) was removed from the market, all anorectic medication took a public relations hit. Most of the media reports placed the blame for heart valve abnormalities and primary pulmonary hypertension on the combination of phentermine and fenfluramine. At the time of withdrawal of fenfluramine, phentermine remained on the market. The National Institutes of Health took it upon themselves to re-evaluate all the remaining diet pills. In a report given at the annual symposium of the American Society of Bariatric Physicians in December 1998, Susan Yanovski, M.D., representing the NIH, stated that there was no evidence of any connection between phentermine and heart disease (including heart valve lesions and primary pulmonary hypertension). In a question and answer session Dr. Yanovski stated, "If you are not willing to use diet pills long term, don't use them."

In a letter addressed to our office and dated October 5, 1999, Velerie Cullen R.Ph.M.M., Medical Affairs Associate from Gate Pharmaceuticals, stated, "A review of our product complaint files has revealed no reports of primary pulmonary hypertension (PPH) when Adipex-P is used as the sole anorectic agent. We have recently been advised by the FDA of the existence of two case reports, both from Europe from more than 25 years ago, each of which allegedly describe one case of PPH in persons exposed to phentermine as a sole anorectic agent. Based upon their age and anecdotal nature of these case reports, and the fact that they stand in isolation as the only reports in almost forty years of the use of phentermine as an anorectic agent, we do not believe that they constitute evidence for an authoritative association of PPH with phentermine use. Our review of the literature did reveal studies purporting to demonstrate serious health consequences, including PPH associated with long term use of fenfluramine."

What, then, are the barriers to prescribing phentermine (and other diet pills) as an adjunct in the treatment of obesity? The American Society of Bariatric Physicians has outlined these barriers in their Prologue to the Anorectic Usage Guidelines:

(1) Barrier: The public and professionals perceive that obesity is caused by lack of willpower.

Comment: As noted by Weintraub and Bray (1): "Obesity is stigmatized, and the obese are perceived as lazy, lacking in willpower, and being less motivated than others. In a survey on society views of obesity, students at Michigan State University indicated that they would prefer marrying a cocaine user, a shoplifter, or a communist over marrying an obese person. The non-obese majority, having no difficulty curtailing their weight, find evidence for the character weakness of the obese in everyday life."

Accusations of gluttony have not been borne out in a number of studies. In particular, the Human and Natural Evaluation Survey I (HANES I) which surveyed, among other things, the eating habits of 20,749 individuals across the United States, found that the obese actually ate less than their normal weight counterparts. To lose weight and to maintain a reduced weight by means of caloric restriction, these individuals must reduce their food intake even further in relation to energy expenditure. In order to reach and maintain a normal weight, many are forced to live with chronic hunger. Enduring this level of discomfort on a long-term basis is often more than the patient can bear and the weight is regained.

(2) Barrier: The anorectics are held to a higher standard in defining desired outcome than are other medications.

Comment: Again, Weintraub and Bray (1) note: "The view that obese people need only to close their mouths has caused us to demand a higher standard for medication use in treating obesity than we do for treatments of any other chronic condition. We accept the fact that serum cholesterol values will rise following the cessation of therapy. We accept that ulcers will often recur following cessation of H2 blocking medications. We understand that rising intraocular pressure when pilocarpine treatment is stopped means that glaucoma has been controlled but not cured. Even in the absence of cure, patients and physicians still view ocular medications, hypotensive agents, cholesterol-lowering medication, and H2-blockers as valuable. All of these failures to cure a problem of mal regulation in human organisms are acceptable.

"Obesity is the only analogous clinical setting where failure of medications to achieve a cure is unacceptable."

(3) Barrier: There is an inappropriate fear of the "dangers" of the anorectics and their potential for abuse by patients.

Comment: Richard and Lasagna (2) cite the Griffiths, et. al.,(3): "Review of the literature in five schedule III and IV anorectic drugs which concluded that they were all associated with

relatively low or zero anorectic reinforcement ratios. Clinically, all of the latter five compounds have anorectic properties... there are, however, relatively few case reports involving abuse of these drugs."

Conn's Current Therapy (1996) states, "Much of the concern regarding drug therapy for obesity grew from use, abuse, and the addictive potential of the amphetamine family of drugs (schedule II), which are no longer suggested for obesity. Other centrally acting adrenergic agents bind to beta receptors, reduce hunger and food intake, and have low abuse potential. Further research and more flexibility in prescribing available drugs are needed."

The 1996 National Institutes of Health position paper on long term pharmacotherapy for the management of obesity, states, "Although amphetamines frequently result in abuse or dependence, abuse is less frequent with schedule III medications, and uncommon with schedule IV medications such as phentermine, mazindol, diethylpropion, et. al."

(4) Barrier: Outdated information and rigid adherence to PDR labeling prevent appropriate "off label" use of anorectics.

Comment: Albert Stunkard, Professor of Psychiatry at the University of Pennsylvania Medical School, stated in 'The Salman Lecture - Some Perspectives on Human Obesity,' the following: "For many years it has been established practice to prescribe appetite suppressant medication for only limited periods of time. The evidence for this belief is obscure, and a set point interpretation of tolerance make clear its limitation. In terms of body weight, tolerance to appetite suppressants does not develop, which means that old argument against their use (a loss of efficacy) is no longer valid. These agents retain their efficacy. Paradoxically, it is precisely this maintenance of efficacy that argues against their short term use."

"If any benefits of appetite suppressants are lost when the medication is discontinued, then such medication should not be used on a short-term basis. Current policy appears to be diametrically opposed to rational use of appetite suppressant medication, and current practice appears wholly unwarranted. Furthermore, the myth of tolerance seems to have prevented use of appetite suppressants in precisely those situations in which they are indicated, that is over the long term."

"There are strong positive indications for the long-term use of appetite suppressants. Many obese hypertensive and diabetic patients can control their conditions by weight loss. Unfortunately, however, many of them cannot lose weight by diet alone. As a result, they are forced to rely on long-term use of medication to control their hypertension, diabetes, and other conditions. If these patients must receive long-term medication, they may well be better off on appetite suppressants than on the usual remedies. At the very least, weight loss will control their complications in a more physiologic manner. Over the long term, the risks of treatment with appetite suppressant medication may be less than those of the medications they are now taking. Long term studies of the safety of appetite suppressant medications are needed. If they can be shown to be safe, major changes in the treatment of obesity-related disorders could result."

Douglas and Munro summarize some of the long-term studies with mean duration's running from 10 to 16 months (4). They conclude: "A number of studies have suggested that diethylpropion, phentermine, fenfluramine, and mazindol can be given for periods of up to several years with reasonable safety and without weight regain occurring. As the risk increases with the degree of obesity, long-term therapy could be most readily justified in the most overweight." Comparative safety and efficacy of concurrent anorexiants prescribed for up to three and one half years was demonstrated in the Weintraub Study(5).

(5) Barrier: Many physicians, because of a lack of guidelines, fear regulatory retaliation.

Comment: The guidelines are available to us from two sources: (1) Anorectic Usage Guidelines from the American Society of Bariatric Physicians. These guidelines include a protocol for long term use of appetite suppressants; and (2) The Texas State Board of Medical Examiners has issued a policy statement on the use of anorectics and it is available upon request.

Finally, in a survey of 1,651 Americans done for Shape Up America, reported in the November 8, 1999 issue of Health and Science, we read, "Although communication is lacking on both sides of the doctor-patient equation, the survey found that it is doctors who most often fail to broach the subject of weight loss, and even when they do, doctors often don't recommend comprehensive treatment programs involving diet, exercise, behavior modifications and medication, where necessary."

How can we, as osteopathic physicians, deny access to a mode of therapy that may be of benefit to our obese patients? We are trained to treat the "body as a whole." Can we treat diabetes, hypertension, arthritis, hyperlipidemia, reflux esophagitis, sleep apnea, depression, back pain, etc., in our obese patients and not treat the obesity which may be causative? You, as the physician, can have great influence on the outcome of these obesity related conditions. Your patients are looking to you for answers.

Dr. Puempel is a board certified family practitioner who has limited his practice to the treatment of obesity and associated conditions. Dr. Puempel has office locations in Arlington, Dallas and Waco.

References

1. Weintraub, Michael & Bray, George A.: Drug Treatment of Obesity, Medical Clinics of North America, 73:237-249, 1989

2. Richard, Barbara W. & Lasagna, Louis: Anorectic Drugs: Drug Policy Making at the State Level, J. Clinical Pharm., 28:395-400, 1988

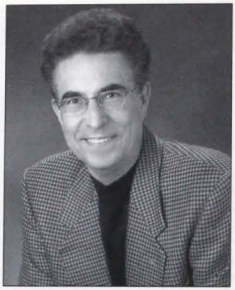
3. Griffiths, et.al. Advances in Behavioral Pharmacology, Vol. 2, New York: Academic Press: 163-208, 1979

4. Douglas, J.G. & Munro, J.F.: Drug Treatment and Obesity, Pharmac Ther: 181351-373, 1982

5. Weintraub M., et al.: Long Term Weight Control, The National Heart, Lung and Blood Institute Funded Multimodal Intervention, Clinical Pharmacal Ther, 51(5): 581-646, 1992

Modern Liposuction

A Logical Alternative Therapy for Obesity and Lipodystrophy



By Walter A. Dobson, D.O., F.A.C.O.S.

Over one-third of the adult population in this country (in excess of 58 million) are either overweight or obese, leaving the medical community searching for answers. While obesity is a growing epidemic, under a skilled surgeon's care, liposuction may provide a logical alternative where other therapies have failed or as an adjunct to those which have been successful.

The Problem with Obesity

Obesity is a national epidemic that creates serious health risks in many Americans and results in burgeoning financial costs to society. National health statistics calculate direct and indirect costs to society for treating obesity to be $99.12 billion annually. Further, obesity is a contributing risk factor in four of the seven leading causes of death in the United States. The bottom line is that obesity can be a deadly disease for a large percentage of the population.

Studies today clearly demonstrate that obesity and associated disorders continue as a multi-billion dollar drain on the U.S. economy and the health of a growing number of Americans, making prevention and treatment for the obese a nationwide health priority. Such alarming statistics justify the search within the scientific community for new therapeutic methods to treat this growing epidemic, particularly when conventional treatments have failed.

Liposuction has proven an effective alternative treatment for a large number of patients suffering from obesity and/or lipodystrophy. Obesity and lipodystrophy occur when a person gains weight causing an increase in the size of fat cells. When that individual begins to lose weight, each fat cell decreases in size, while the overall number of fat cells remains somewhat constant. Liposuction is the only surgical procedure that actually reduces the number of fat cells.

Today, improved equipment and innovative surgical techniques such as tumescent and ultrasonic lipoplasty have revolutionized liposuction and provide dramatic results for the obese patients, as well as those with concentrated areas of fat. Historically, liposuction was unavailable to most obese patients, as only those patients who were slightly overweight were considered good surgical candidates for liposuction. Today, increasing numbers of patients with varying degrees of obesity are able to enjoy what modern liposuction technology can offer them.

Scores of men and women, including professionals competing for jobs and others dissatisfied with disproportionate areas of their body, have joined the obese in the search for effective treatment options for surplus fat. Most men and women who come to my office for solutions for obesity or lipodystrophy have already tried a multitude of diets, prescribed medications, and exercise programs. Many have investigated or undergone other surgical techniques, such as vertical banded gastroplasty, gastric bypass, or the adjustable gastric band. Ultimately, many of these patients have turned to antidepressants to treat their troubled emotional state in response to failed therapies, persistent obesity, and lipodystrophy.

Liposuction as an Alternative Therapy for Treating Obesity and Lipodystrophy

Improved techniques in liposuction and modern equipment make liposuction a safe and effective treatment for obesity and lipodystrophy. Liposuction is a surgical technique that removes unwanted deposits of fat located between the skin and muscle. Developed in the late 1970's in Europe, liposuction landed on American shores in 1982, and is now the most commonly performed cosmetic procedure in this country. Liposuction has undergone a continuous evolution and refinement that have included changes in cannulae design and various infiltration techniques, with improved and more sophisticated high tech equipment. Patient demand may explain the dramatic advances in surgical procedures, as surgeons search for newer and better methods to meet the growing number of patients choosing this form of therapy.

Modern liposuction involves a combination of techniques. The tumescent and ultrasonic techniques allow surgeons to treat multiple areas, removing larger amounts of fat without significant blood loss, together with less edema and bruising than they would have experienced only a short time ago.

The tumescent technique, used in conjunction with ultrasonic liposuction, offers an attractive solution for the obese and those suffering from lipodystrophy. This technique is considered by many as the safest form of liposuction, as it reduces fluid and electrolyte shifts, while allowing for removal of large volumes of fat during one procedure. The use of the tumescent technique utilizing smaller diameter cannulae permits local sedation and effective vasoconstriction permitting significant success in large body contouring with safety and efficiency.

The obese and patients suffering from lipodystrophy should be considered satisfactory candidates for liposuction. The skilled surgeon can thus achieve impressive, circumferential reduction, improved body contours, along with grateful, satisfied patients. The tumescent technique in combination with internal ultrasound is also beneficial in male patients by distending the more fibrous fat found in and around the flanks and back as it magnifies the deformity, and allows for an easier and more all-inclusive removal with small diameter cannulae.

Ultrasonic assisted lipoplasty effectively emulsifies fat by cellular fragmentation with the use of ultrasonic energy. The liquefied fat, along with the infused tumescent fluid, forms a stable fatty emulsion that can be either simultaneously or subsequently extracted from the subcutaneous space by means of vacuum suction and small suction cannulas.

My personal patient experience and an exhaustive research of experiences related by cosmetic surgeons all over the world have revealed that tumescent and ultrasonic liposuction in combination offer the patient a logical alternative in the treatment of obesity and lipodystrophy. I have carefully recorded pre-operative, post-operative and intraoperative data on my patient population. My studies have revealed extremely high patient satisfaction, and further confirm that large volumes of fat can be safely and effectively removed with minimal blood loss, little or no bruising, and an extraordinary control of contour. Modern liposuction techniques for the removal of adipose tissue have proven to provide vastly improved advantages over traditional liposuction.

An unexpected advantage emerged from my experience. Because the results of liposuction are so dramatic and immediate, the patient instantly achieves increased self-esteem and determination that many patients failed to realize with alternative therapies. Thus, the patients are more receptive to diet and exercise to maintain their new look. Not only does the patient look and feel like a new person, he or she achieves better overall health and fitness, with increased energy, determination, and emotional well-being.

The Physician Patient Relationship for an Effective Surgical Experience

Patients suffering from obesity or lipodystrophy come to my office where I conduct an evaluation of their psychological well-being, body type, and skin elasticity. Some patients have poor skin quality that might not contract well after surgery. These patients may be candidates for skin reductions either performed during the initial surgical procedure, or at some point within a year post-surgery. Therefore, during this stage of the pre-surgical evaluation process, I consult with the patient if it appears skin resection and/or muscle tightening may be necessary to achieve optimum results.

After a complete evaluation the patient's commissions are accepted and surgical planning begins. Individually tailored surgical alternatives are reviewed, as I help the patient understand that one of the goals of liposuction is to reduce body fat and mass. So that I can offer the patient predictable results to ultimately improve both body appearance and self-esteem, I carefully review the safest methods for corporal contouring and reshaping of that patient's individual needs.

The patient's physical stature and lipodystrophy are carefully analyzed to determine the number of procedures that may be required to achieve the patient's desired results. Body contouring for some patients is not a single-stage procedure. More than one procedure is often necessary to ensure the desired endpoint.

Next, I discuss the risks inherent in any type of surgical procedure, and those peculiar to liposuction. Though rare, liposuction, like any surgical procedure, involves risks and complications. The most common complications in liposuction are related to the skin. A skin necrosis occurs in approximately 3% of liposuction patients nationwide. In my surgical experience, skin necrosis occurs most often among smokers, diabetics, patients with a very large abdominal region, or areas where the patient has undergone a prior surgical procedure.

The patient returns for a pre-op surgical appointment that involves a complete patient medical history, pre-op surgical labs, EKG, chest x-rays, pre-op markings, and photographs of the surgical areas. All pre-op and post-op paperwork is carefully reviewed with the patient, along with the surgical consent. The patient has two to three weeks prior to their procedure to review all of the educational material and consent forms that are provided. Patients are urged to read all printed material and are required to verify by their signature that they have read and understand all of the material in full prior to surgery. Further, they are encouraged to call my office with any questions or concerns.

Tumescent volume and total fat volume are calculated. Finally, the patients begin pre-op vitamin therapy, including vitamin K to decrease bruising, vitamin C and iron. The patients receive counseling about lifestyle modifications, such as diet and exercise regimens, together with explanations about the need to eliminate alcohol and tobacco use.

At the Dallas Fort Worth Institute of Body Sculpturing, I regularly perform liposuction on an outpatient basis, utilizing either twilight or general anesthesia, with an anesthetist present at all times during any procedure. A warming blanket is placed under the patient throughout the procedure, and during recovery for maintenance of constant body temperature and for patient comfort.

At the conclusion of the surgery, the patient is placed in a compression garment that must be worn twenty-four hours per day for three weeks. Following liposuction, patients continue to decrease in size for several months with marked skin contraction. Proper compression is paramount during the entire recovery process. Patients commonly experience a two to three size reduction from their pre-surgical appearance. Most patients return to work and normal activities within three to seven days. Final surgical results occur over the next three to six months, depending on the size of the patient and the amount of fat removed.

The results of liposuction are dramatic and immediate. Patients who have elected to have liposuction are happy with their decision, excited about their overall appearance, and their ability to look and

feel better in smaller sized clothing. Often they are surprised by the added benefits that include increased mobility and energy. Many willingly incorporate a well-balanced diet and new exercise regimen into their lifestyle to maintain their new body contour.

At one time, studies suggested that if one day we could eliminate cancer from this planet, life expectancy would be increased by one year. Today, research shows if there were no more obesity, life expectancy would be increased by five years. Liposuction may not eliminate obesity or provide an answer for everyone, but everyone suffering from obesity or lipodystrophy should consider liposuction among his or her treatment options.

Physicians and surgeons with questions or comments concerning this article, their surgical experiences in this field, or patient problems are encouraged to contact Dr. Dobson at the Dallas-Fort Worth Institute of Body Sculpturing through his website at www.dfwibodysculpture.com or at his office telephone of 972-660-3188.

A native of New York, Walter Dobson, D.O., graduated from Des Moines College of Osteopathic Medicine and Surgery. He completed his residency in general surgery and received his board certification from the American Osteopathic Board of Surgery in 1982. Having practiced both general and cosmetic surgery for twenty years, his practice is now limited to body contouring techniques and research at the Dallas-Fort Worth Institute of Body Sculpturing of which he founded. Dr. Dobson has received the honorary title of "Fellow" from the following organizations: American College of Osteopathic Surgeons, American Academy of Cosmetic Surgery, American Society of Cosmetic Breast Surgeons, Cosmetic Surgical Society of Texas, and the American Society for Laser Medicine and Surgery. He was honored this year in the National Register's *Who's Who 2000 Edition*.

Case Study

A 38-year-old female with marked lipodystrophy, 5'7", 212 lbs, dress size 22, G3P3003, good skin tone with no serious prior medical illness. This patient is a good candidate for modern liposuction. Two-stage procedure was planned. First stage procedure areas treated included abdomen, anterior thighs, inner thighs and knees. Second stage procedure areas treated included posterior axilla, flanks, waist, hips, buttocks, lateral thighs and posterior thighs. Post-operative views show the patient 12 weeks from the first stage and 5 weeks post second stage. As demonstrated she showed remarkable change in body contour. The patient's weight dropped to 176 lbs. and her dress size from size 22 to a size 12. Patient experienced good skin retraction without the need of a skin reduction

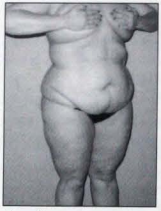


Figure 1

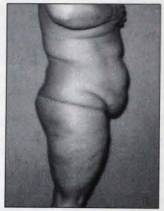
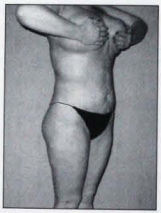


Figure 2

Figure 1
Preoperative view-anterior oblique

Figure 2
Preoperative view-lateral



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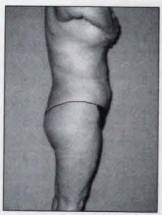

Figure 4

Figure 3
Postoperative view-anterior oblique

Figure 4
Postoperative view-lateral

References

Hunstad JP: Liposuction for obesity, operative techniques in plastic and reconstructive surgery, May 1996.

Zocchi ML: Ultrasonic assisted lipoplasty, technical refinements and clinical evaluations, Clinics in Plastic Surgery, Volume 23, Number 4, October 1996.

Hughes CE: Patient selection, planning, and marking in ultrasound-assisted lipoplasty, Clinics in Plastic Surgery, Volume 26, Number 2, April 1999

Hunstad JP: Body contouring in the obese patient, Clinics in Plastic Surgery, Volume 23, Number 4, October 1996.

Zocchi M: Clinical aspects of ultrasonic liposculpture, Perspectives in Plastic Surgery, Vol. 7, No. 2, 1993. Kenkel Robinson, Beran, Tan, Howard, Zocchi,

Rohrich: The tissue effects of ultrasound-assisted lipoplasty, Department of Plastic and Reconstructive Surgery at the University of Texas Southwestern Medical Center, and Aesthetic Plastic and Reconstructive Surgery in Torino, November 1997.

Maxwell GP & Gingrass MK: Ultrasound-assisted lipoplasty: A clinical study of 250 consecutive patients, Institute for Aesthetic and Reconstructive Surgery, Baptist Hospital, October 1996.

Peren, Gomez, & Guerrero-Santos: Total corporal contouring with megaliposuction (120 Consecutive Cases), Presented at the 15th Annual Scientific Program (ISNA Meeting, San Francisco, 1997, Aesthetic Plastic Surgery, 1999 Springer-Verlag New York Inc.

Fournier PF: Therapeutic megalipoextraction or megaliposculpture: Indications, technique, complications, and results, The American Journal of Cosmetic Surgery, Vol. 14, No. 3, 1997

Lieberman C & Cohen J: Why abdominoplasty when you have liposuction, The American Journal of Cosmetic Surgery, Vol 14, No. 3, 1997

Colditz GA & Wolf, AM: Current estimates of the economic cost of obesity in the United States, Obesity Research, March 16, 1998

Klein JA: Tumescent technique for local anesthesia, Improves safety in large volume liposuction, Plastic Reconstructive Surgery 92(6): 1085, 1993

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College Planning - the Key is Starting Early

The time of the year is once again upon us when newly graduated high school students turn their attention toward starting college in the fall. It's an exciting time, as new friends, intellectual challenge and independence lie ahead. But for parents who pay the bills for higher education, it can also be an anxious time.

According to a recent study by Sallie Mae, the nation's largest source of funds for higher education, parents saving for their children's college had saved less than half of what will be needed to cover the expected expenses. One in five hadn't saved anything at all.

Fortunately, you can go a long way in avoiding this headache by getting an early start in saving for college. It's simply a matter of doing some planning, estimating costs and investing diligently.

Understand that it's going to be somewhat difficult to plan with a large degree of certainty, due to variables such as tax laws, interest rates and spikes in college tuition that are bound to change over time. The key is to do your best with what you know, and try not to worry about the rest. There are, however, some points you should consider before getting started.

Consider ownership. Do you want to create an account that will give your child ownership of any money, or would you rather retain control? There are tradeoffs to this decision. If you create a guardian account, you own the money, but any distributions or dividends are taxed at your rate. You can also create a custodial account, which you control only until the child's age of majority, which can be either 18 or 21, depending on state laws. The account is taxed at the child's rate, which is generally lower than yours.

Decide on your risk tolerance. As financial planners, we can help you develop a portfolio that reflects both your tolerance to risk and the time remaining until you need the money. By and large, most planners believe that earlier in the portfolio's life you can be more aggressive with the investments you choose, with a majority of money in equities. The closer the child gets to college age, money is usually shifted into an investment that is less exposed to market risk.

Decide what college will cost. This will be a tough decision, since the cost of college depends on so many variables. In-state versus out-of-state and public versus private are just a few of the choices that will be made. Costs of living can also vary from school to school.

Once you sort these choices out, you're ready to start saving. And the earlier, the better! For example, suppose that you've determined you'll need $50,000 for your child's college expenses at age 18. Starting at your child's birth, you decide to invest monthly in an account that you expect will pay 10 percent interest. You'll need to contribute $84 per month, and when you reach the $50,000 mark, you will have put in only $18,144 yourself. The rest, of course, will have come from the power of compounding interest.

On the other hand, let's look at what happens if you wait until age 10. You'll need to save $343 per month to reach $50,000, and you'll have put in $32,928 of the total. As you can see, just by starting eight years earlier, you'll keep an extra $14,784.

College is a wonderful time, a bridge of self-discovery between adolescence and young adulthood. By saving early, you can guarantee that you'll be just as excited about college as your child is.

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The Facts About Obesity and Our Kids

Diabetes, hypertension and other obesity-related chronic diseases that are prevalent among adults are becoming more common in youngsters as well. The percentage of children and adolescents who are overweight and obese is now at its highest. Poor dietary habits and inactivity are reported to contribute to the increase of obesity in youth. As the most inactive generation ever in history, today's youth are at a disadvantage of having less physical education programs in schools as well as recreational facilities that are unsafe. This fact sheet outlines many factors related to obesity in youth that make it a major health care challenge for the 21st century.

Prevalence and Trends

- 1 in 5 children in the U.S. are overweight.
- Approximately 25% of children and adolescents are considered overweight, a figure which has doubled in 30 years.
- Excess weight in childhood and adolescence has been found to predict overweight for adults. Children with obesity, age 10 to 13, are reported to have a 70% likelihood of obesity persisting into adult years.

Overweight and Obesity Defined

- Overweight for children and adolescents is defined as the 85th percentile of Body Mass Index (BMI), which corresponds to the overweight cut off point for adults – BMI of 25.
- Obesity for children and adolescents is defined as the 95th percentile of BMI, which corresponds to the cutoff point for obesity in adults - BMI of 30.
- For boys, ages 6 to 11, the prevalence of obesity tripled in nearly 25 years, and increased more than two and a half times for girls.
- Obesity prevalence for male adolescents, ages 12 to 17, more than doubled in nearly 25 years and increased one and a half times for females.

Race

- Blacks (non-Hispanic) have the highest overweight prevalence among female children and adolescents. Hispanic have the highest prevalence among male children and adolescents.
- Overweight prevalence for Native American children and adolescents is 39% for males and 38% for females.
- Asian American and Hispanic adolescents born in the U.S. to immigrant parents are more than twice as likely to be overweight as foreign born adolescents who move to the U. S.

Health Effects

Many adverse health effects associated with overweight are observed in children and adolescents. Overweight during childhood and particularly adolescence is related to increased morbidity and mortality in later life.

Asthma

- Prevalence of overweight is reported to be significantly higher in children and adolescents with moderate to severe asthma compared to a peer group.

Diabetes (Type 2)

- Type 2 diabetes in children and adolescents has increased dramatically in a short period. The parallel increase of obesity in children and adolescents is reported to be the most significant factor for the rise in diabetes.
- Type 2 diabetes accounted for 2% to 4% of all childhood diabetes before 1992, but skyrocketed to 16% by 1994.
- Obese children and adolescents are reported to be 12.6 times more likely than non-obese to have high fasting blood insulin levels, a risk factor for type 2 diabetes.
- Type 2 diabetes is predominant among African American and Hispanic youngsters, with a particularly high rate among those of Mexican descent.

Hypertension

- Persistently elevated blood pressure levels have been found to occur about 9 times more frequently among obese children and adolescents than in non-obese.
- Obese children and adolescents are reported to be 2.4 times more likely to have high diastolic blood pressure and 4.5 times more likely to have high systolic blood pressure than their non-obese peers.

Orthopedic Complications

- Among growing youth, bone and cartilage in the process of development are not strong enough to bear excess weight. As a result, a variety of orthopedic complications occur in

–OBESITY– *Not* a Medical Deduction

The Internal Revenue Service (IRS) has declared that treatments for obesity are not eligible for a tax deduction. A tax code authorized by Congress ruled that medical care costs are deductible. "Medical care," as defined by Congress, includes costs for the "diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body." The deduction is available for persons whose medical expenses exceed 7.5% of adjusted gross income.

Deductibility is already allowed for preventable causes of death, such as alcoholism treatment and drug addiction treatment. In addition, a recent IRS ruling now allows individuals to deduct costs of smoking cessation programs.

Obesity is a complex, multi-factorial chronic disease involving genetic, metabolic, psychological, behavioral and environmental factors. The behavioral and environmental components, involving poor diet and inactivity, have made obesity the second leading cause of preventable death.

Obesity and the IRS

In 1979, the IRS issued a revenue ruling stating that the cost of a physician-prescribed weight loss program was not tax deductible.

Most recently, the IRS ruled that the cost of a weight loss program for general health, even if prescribed by a doctor, could not be included as a deduction for 1998 tax returns.

Non-deductibility of obesity treatment on individual tax returns also affects the coverage of a medical savings account (MSA). MSAs, authorized by Congress in 1996, allow employees to reduce their taxable income by setting aside an amount, through their employer, to be used for unreimbursed medical services.

Source: American Obesity Association.

children and adolescents with obesity. In young children, excess weight can lead to bowing and overgrowth of leg bones.

- Increased weight on the growth plate of the hip can cause pain and limit range of motion. Between 30% to 50% of children with this condition are overweight.

Psychosocial Effects and Stigma

- Overweight children are often taller than the non-overweight.
- White girls who develop a negative body image are at a greater risk for the subsequent development of eating disorders.
- Adolescent females who are overweight have reported experiences with stigmatization such as direct and intentional weight-related teasing, jokes and derogatory name calling, as well as less intentional, potentially hurtful comments by peers, family members, employers and strangers.
- Overweight children and adolescents report negative assumptions made about them by others, including being inactive or lazy, being strong and tougher than others, not having feelings, and being unclean.

Source: American Obesity Association. (Readers should note that researchers have not always used the same criteria to identify overweight and obesity. In this fact sheet, the American Obesity Association has attempted to use the generally accepted definitions of overweight as a BMI of 25-29.9 and obesity as a BMI of 30 or above.)

Physical Activity Among Adolescents and Young Adults

- Nearly half of American youths aged 12-21 years are not vigorously active on a regular basis.
- About 14 percent of young people report no recent physical activity. Inactivity is more common among females (14%) than males (7%) and among black females (21%) than white females (12%).
- Participation in all types of physical activity declines strikingly as age or grade in school increases.
- Only 19 percent of all high school students are physically active for 20 minutes or more, five days a week, in physical education classes.
- Daily enrollment in physical education classes dropped from 42 percent to 25 percent among high school students between 1991 and 1995.
- Well designed school-based interventions directed at increasing physical activity in physical education classes have been shown to be effective.

Source: Centers for Disease Control and Prevention, "Physical Activity and Health – A Report of the Surgeon General."

OBESITY and the ADA

Is Obesity a covered condition?

By Suzanna Currier, ADA Coordinator
Texas Department of Health, Office of Equal Opportunity

"...a person covered under the ADA for obesity will largely depend on the underlying factors as to why the individual is obese, and how significantly limited the individual is restricted to perform many of their daily activities as compared to the average person..."

As with other civil rights laws prohibiting discrimination on the basis of race, color, gender, national origin, religion or age, the Americans with Disabilities Act of 1990 (ADA) prohibits discrimination on the basis of disability. Like ADA's precursor, Section 504 of the Rehabilitation Act of 1973 (Section 504), prohibits federally funded recipients to discriminate based on handicap. Section 504 and ADA guarantees the same civil rights protections. The only distinction is that Section 504 applies to public entities that receive federal funding. The ADA expands those provisions to a larger segment of American society. It protects individuals with disabilities from employment discrimination or non-participation to programs, activities and services provided by a local or state government and a private business that employs more than 15 or more employees. Either way, a medical provider must provide services and accommodations in an equitable manner.

Can a person discriminated for their size or weight be considered protected under the ADA?

There are many conditions that are specifically not covered under ADA. Some physical characteristics would not be covered, such as a person with blue eyes or black hair, or someone who is left-handed. Further, a characteristic predisposition to illness or disease is not an impairment. A person may be predisposed to developing an illness or a disease because of factors such as environmental, economic, cultural, or social conditions. This predisposition does not amount to an impairment. Other conditions that are not considered impairments are pregnancy, common personality traits, normal deviations in height, strength or being overweight. Being overweight, in and of itself, generally is not an impairment. For example, a flight attendant whose body fat and a high percentage of muscle exceeds the airline's weight guidelines would not be considered to have an impairment.

On the other hand, severe obesity, which has been defined as body weight more than 100% over the norm, is clearly an impairment. In addition, a person with obesity may have an underlying or resultant physiological disorder, such as hypertension, diabetes or a thyroid disorder. A physiological disorder is an impairment. However, the mere presence of an impairment does not automatically mean that an individual has a disability. Whether severe obesity rises to the level of a disability will depend on whether the obesity substantially limits, has substantially limited, or is regarded as substantially limiting a major life activity. The ADA has described a major life activity as any of the basic activities that the average person in the general population can perform with little or no difficulty. Major life activities include caring for one's self, performing manual tasks, seeing, hearing, breathing, walking, speaking, learning and working. This list is not exhaustive. Other major life activities include, but are not limited to, sitting, standing, lifting and reaching. Except in rare circumstances, obesity is not considered a disabling impairment.

Another factor to consider is whether exclusion to a program, activity or service, is solely based on the fact that the person is obese. Common attitudinal barriers frequently result in the exclusion of individuals for whatever the regarded disability, including obesity. If an individual can show that an employer or service provider denied services because of a perception of disability based on "myth, fear or stereotype" the individual will satisfy the "regarded as" part of the definition of disability.

Therefore, a person covered under the ADA for obesity will largely depend on the underlying factors as to why the individual is obese, and how significantly limited the individual is restricted to perform many of their daily activities as compared to the average person. Clearly, a person who weighs over 600 pounds and is unable to stand, sit, walk or perform any other physical activity as the average person, would be considered an individual with a disability. But keep in mind, even though the individual does not have the significant restrictions from the obesity, nevertheless, they can meet the definition if a decision to deny services, is strictly made based on the fact that the person is obese.

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Call for Awards Nominations

The TOMA Awards and Scholaship Committee is currently accepting nominations for four awards:

- **Distinguished Service Award**
- **Meritorious Service Award**
- **Outstanding Community Service Award**
- **Public Service Award**

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

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

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

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

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

The Nomination Process

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available from Paula Yeamans at the TOMA State Office, and include pertinent biographical data about the individual as well as information about the person's accomplishments that make them deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. **The nomination form should then be sent to the TOMA Executive Director, no later than March 1, 2000**, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

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

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

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

Attention TOMA Members

This serves as a reminder that any member or district planning to present resolutions to the TOMA House of Delegates' meeting, April 7-8, 2000, in Austin, must submit such resolution(s) to the TOMA office prior to February 15, 2000.

No resolutions will be voted on in the House of Delegates' meeting unless they have been received in the TOMA office prior to the above date.

If you have any questions regarding resolutions, please call Paula Yeamans at the TOMA office at 800-444-8662.

☛ *See related article "Proposed Revision to the TOMA Bylaws" on page 27.*

Texas ACOFP Update

by Janet Dunkle, Executive Director

– Certification – Time Is Running Out

Why Become Board Certified?

Certification can be the key to a successful practice. It can increase your reimbursement rates and increase participation in many third party programs. A more knowledgeable public now uses certification as a factor in choosing a health care provider and certification reinforces the professional standing of osteopathic physicians in the health care community.

What is Expected on the Exam?

The exam is in two parts: Written examination and performance evaluation. The written consists of approximately 400 multiple-choice questions in a variety of areas, which include general medicine, surgery, behavioral sciences, pediatrics, Ob/Gyn and sports medicine. The other half day session is a "hands on" performance evaluation. The candidate is given a questionnaire to complete and is assigned a random case history. He or she is then asked to diagnose the case and demonstrate the osteopathic manipulative treatment.

When are Exams Administered?

Exams are given twice a year: In the spring before the ACOFP Annual Convention and in the fall before the AOA/ACOFP Convention. Each has its own application cut off date. For the upcoming exam, applications must be made by July 14, 2000 for the fall 2000 exam, which will be given October 28-29, 2000 at the AOA Convention in Orlando. The next exam will be given on March 26 and 27, 2001 during the ACOFP Convention in Philadelphia and the application deadline is December 1, 2000.

Who is Eligible?

You are eligible to sit for the certification exam if you completed an osteopathic family medicine residency program or if you are within four months of completing your family medicine program.

If you did not complete a residency program, you have until the year 2001 to sit for the exam through the clinical pathway. After the year 2001, you must complete a residency program to be board eligible.

Those who have completed an ACGME Family Medicine residency program may still be able to become certified in osteopathic family medicine. Call the Education Department of the AOA at (800) 621-1733 to apply to have your ACGME program and training approved. There is no fee to apply for this approval.

Those completing an AOA approved internship but not a residency program may apply if they have practiced for a minimum of six years and have documented, per the AOA Individual Activity Report, at least 600 applicable CME hours of AOA approved postgraduate work prior to application for the exam. All applicants must be a member in good standing of the AOA.

Questions?

Additional information may be obtained by contacting the American Osteopathic Board of Family Physicians at 847-640-8477.

Delegates Needed to Represent Texas

The Texas ACOFP is looking for members to represent Texas at the ACOFP Annual Convention and Scientific Seminar. This year's Congress of Delegates will meet Wednesday, March 29 and Thursday March 30, 2000 at Bally's in Las Vegas.

If you are planning to attend this convention and are willing to give a few hours to represent Texas, please call Janet Dunkle at 888-892-2637.

TxACOFP Director Registers as Lobbyist

To assist TOMA and TAFP in efforts to support the rights of the osteopathic physician, TxACOFP Director Janet Dunkle has registered as a lobbyist for the year 2000. As issues are already being debated for the upcoming 77th Legislative Session, her registration permits an additional voice on issues that can protect your practice rights.

2000 Dues Statements

If you have not yet renewed your 2000 membership, there's no time like the present. Membership dues are the most important source of revenue to our society. They enable us to provide you with CME and to represent you at a state and national level. If you did not receive a dues statement or are interested in becoming a member, please contact the state headquarters at 888-892-2637.

UnitedHealth Group Gives Physicians the Say Over Treatment

UnitedHealth Group has set national precedent by stating it will give physicians final approval over patients' treatment. The nation's second largest health plan, with 14.5 million people nationwide, noted that reviewing doctors' decisions was not profitable and did not improve patient care.

"We feel that we do not belong in the exam room, nor the operating room," said Dick Migliori, senior vice president of health operations.

The company will still closely monitor its physicians and will still require doctors to alert the health plan when they order expensive tests or admit patients to the hospital. But in disagreements on treatment, the doctors will have the final authority.

The decision by United won high praise from President Clinton, who supports federal legislation allowing patients to sue their HMOs.

News

from the University of North Texas Health Science Center at Fort Worth

Dr. Benjamin L. Cohen Named Interim President of UNT Health Science Center

The University of North Texas System Regents have named Benjamin L. Cohen, D.O., 64, to the post of interim president of the UNT Health Science Center at Fort Worth.

Cohen will serve in the presidency from December 10, 1999 – following the retirement of president David M. Richards, D.O. – to mid August – when the new president Army Lt. Gen. Ronald R. Blanck reports for duty.

UNT System Chancellor Alfred F. Hurley nominated Cohen after consulting with Blanck and Richards and reviewing records of potential candidates for the interim post.

"Dr. Cohen has the training and experience to administer the UNT Health Science Center until Gen. Blanck can assume full-time responsibility," said Hurley.

Cohen has served as vice president for health affairs for the UNT Health Science Center at Fort Worth and executive dean of the Center's Texas College of Osteopathic Medicine since 1993. Prior to that, he was vice president for academic affairs and dean of TCOM.

Cohen's past positions include serving as chairman and chief executive officer of both 21st Century Health Corporation and Ameriwell International; and serving as dean at the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine.

He is former president of the American Association of Colleges of Osteopathic Medicine and currently is chair of the Dean's Council of the association. He also is a former president of the American College of Osteopathic Pediatricians. He currently serves as chair of the North Texas Medical Education Consortium. He earned his doctor of osteopathic medicine degree from the University of Health Sciences in Kansas City.

Concluding a nationwide search in October, the UNT System Regents selected Blanck, who currently is the Surgeon General of the United States Army and commander of the U.S. Army Medical Command, for the UNT Health Science Center presidency. However, Blanck will not begin his new duties at the UNT Health Science Center until August 15 – shortly after he retires from the Army on July 31.

UNT launched the search early last year after Dr. Richards announced plans in December 1998 to serve one final year and then retire.

UNT Health Science Center Awarded $5.3 Million Grant From Centers for Disease Control

The Centers for Disease Control and Prevention awarded a $5.3 million, 10-year grant to fund a site of the Tuberculosis Trials Consortium at the University of North Texas Health Science Center at Fort Worth. The research site will be under the direction of principal investigator Stephen Weis, D.O. Award announcements were made October 18 at the Centers for Disease Control and Prevention Tuberculosis Trials Consortium meeting in Atlanta. The grant will be a joint collaboration of the UNT Health Science Center, Tarrant County Public Health Department and the Texas Department of Health.

Dr. Weis' team will work to expand the number of patients in tuberculosis (TB) clinical trials. Currently trials are ongoing in persons with tuberculosis who have drug resistance and co-infection with HIV. Trials are also exploring new methods of TB treatment where medications are taken only once weekly. With more patients, the study can explore new therapeutic approaches to managing drug resistant TB patients and enable the team to complete studies. In the future, the consortium plans to conduct trials in the search for a more effective TB vaccine.

Dr. Weis has been conducting TB research for 15 years in the Tarrant County Health Department. He also works as an internist in the department of internal medicine at the UNT Health Science Center, and as the director of tuberculosis services for the Tarrant County Health Department.

"With direct access to a large patient population, we expect to be able to enroll 100 patients with active tuberculosis and 100 patients with latent tuberculosis yearly," said Dr. Weis. "Our cooperation with hospitals, private physicians, services and drug treatment programs allows us to screen and identify individuals with active TB and latent TB. Patients will receive services at the Tarrant County Health Department."

"The World Health Organization estimated that 2.5 to 3 million people died in 1998 from TB," said Dr. Weis. "This grant benefits Tarrant County tuberculosis control as it adds significantly to the amount of funds available for the control and prevention of TB."

Andrew Vernon, co-chair of the Tuberculosis Trials Consortium Steering Committee, said, "In the initial major study undertaken by the Tuberculosis Trials Consortium, Dr. Weis and his team enrolled more patients than other sites, an aspect that distinguishes Dr. Weis in his TB research efforts."

For 15 years, Dr. Weis and his team have been using universal directly observed therapy (DOT). With DOT, a health care worker goes to the patient's home or place of work and gives every dose of medication under direct observation. This has resulted in reductions in drug resistance and relapse of TB in Tarrant County. DOT is now recommended for all patients with TB.

More Members in the News

Dr. William Jordan Elected to American Cancer Society's Board of Directors

William Jordan, D.O., president of Texas Cancer Care, has been elected to the Fort Worth Unit of the American Cancer Society's Board of Directors.

During the past 20 years, Dr. Jordan has served as chairman of the service and rehabilitation committee and participated in many workshops and programs.

Dr. Jordan has served as president of Texas Cancer Care since its inception in 1994. In addition to being responsible for the practice's overall operation, Dr. Jordan is also a practicing physician who is board certified in medical oncology and internal medicine. He is licensed to practice by state boards in Texas, Hawaii, Michigan and Tennessee. A widely known lecturer and researcher, Dr. Jordan received his doctor of osteopathic medicine degree from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri. He was a fellow of medical oncology and faculty member at the University of Texas M.D. Anderson Hospital and Cancer Center in Houston, prior to returning to Fort Worth.

Texas Cancer Care is the regional affiliate of the M.D. Anderson Physicians Network and is a regional physicians group providing medically advanced patient-centered care for the treatment of cancer. More information about Texas Cancer Care is available at <www.txcc.com>.

Dr. Randall Perkins New President-Elect of American Society of Bariatric Physicians

Randall C. Perkins, D.O., whose medical offices are at 2612 Harwood Road, Suite B, Bedford, has been elected president-elect of the American Society of Bariatric Physicians (ASBP). He will assume the office of president in the Fall of 2001.

ASBP is a national medical society of physicians and allied health personnel who offer comprehensive medical weight loss programs in treating overweight, obesity and associated conditions. For the past two years, Dr. Perkins has been vice president of the society.

A 1974 graduate of the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, Dr. Perkins interned at Osteopathic Medical Center of Texas in Fort Worth. He has been a member of the ASBP since 1988 and is a Diplomate of the American Board of Bariatric Medicine. He is a member of the Texas Osteopathic Medical Association and the American Osteopathic Association.

ASBP's Bariatric Practice Guidelines call for treating overweight and obesity through a comprehensive program of proper diet and nutrition, appropriate exercise, behavior modification and, when indicated, the use of prescription anti-obesity medications and other pharmaceuticals.

ASBP was formed in Denver in 1950 by a group of primarily osteopathic physicians. The society has a mission to establish and maintain bariatric practice guidelines and to provide accredited continuing medical education to physicians and allied health personnel. Through an extensive program of CME, ASBP exposes its members to the most recent developments in treating obesity to ensure that the physicians remain on the cutting edge of the new technology used in treating the overweight patient.

From National Heritage Insurance Company
Texas Medicaid Re-Enrollment

Attention Medicaid Provider

Your future Medicaid reimbursement is contingent upon your re-enrollment in the Medicaid Program. Texas law requires that those providers who have not re-enrolled, according to NHIC's records, may be disenrolled from the Texas Medicaid Program effective September 1, 2000; therefore, Medicaid claims with dates of service on or after September 1, 2000, may be denied and ineligible for appeal. It is very important for all providers to complete re-enrollment prior to September 1, 2000.

Re-enrollment is *mandatory* to ensure continued participation in the Texas Medicaid Program.

If this is a number for which you do not intend to use for billing beyond 9/1/2000, and have opted not to re-enroll, then please disregard this notice and any future notices.

Return the completed re-enrollment packet to:
National Heritage Insurance Company
Attn: Provider Re-enrollment
12545 Riata Vista Circle
Austin, Texas 78727-6404

Please contact the Customer Service Department at 1-800-925-9126, Option 1#, if NHIC may be of assistance, or if you have any questions regarding the re-enrollment process. Remember, it takes 6-8 weeks for processing of your re-enrollment packets; so don't delay, re-enroll today. You may also inquire about your re-enrollment status by calling the Customer Service Department or by e-mailing us from our web site: <www.eds-nhic.com>.

Important Note for Managed Care (STAR) Providers

If you are a Medicaid Managed Care (STAR) provider, you will receive additional notifications from the Managed Care Organizations in which you are currently enrolled as a provider. If you are a Primary Care Physician (PCP) and are not re-enrolled, we strongly encourage you to complete your application packet and return it as soon as possible. Incomplete applications will be returned for resubmission.

Self's
Tips & Tidings

By Don Self

Wow! You're the first one to see my magazine column in 2000. Since you're the first, let me fill you in on a little secret but don't tell anyone. "We survived the Y2K transition." It wasn't as bad as many believed it was going to be. Heck, some folks were expecting all kinds of trouble, but luckily it didn't happen. I know I was kind of concerned about my computer actinggggg up in 2000 but I was wrong, so here we are. If you are having trouble with your computer and Y2K, give us a call at 800 256-7045 as we have some ideas that may help. We expect to see some minor problems cropping up with computers and Y2K throughout the first half of this year.

Okay, 2000 is bringing about some changes. By the time you receive this issue of the *Texas D.O.*, you're probably aware that Medicare held the claims from January 1st through January 16th, so the first checks don't get issued until the 17th. Hopefully, that didn't cause you too much cash flow trouble, but if it did cause you to lighten up on eating at the Golden Corral, you needed to lose the weight anyway.

So, what is Medicare looking for in 2000, other than ways to make themselves look good? Let's see - they're still doing E&M documentation audits randomly so make sure you cross all of your T's, document the chief complaint (no, the word "follow-up" is not a chief complaint), ensure you are adding the ROS to your progress note and, when billing for counseling visits, include the start-stop times.

This year, Medicare is also intensifying their audits on ABN (Advance Beneficiary Notice) waivers that HCFA mandated last century, so make sure you are using the waivers correctly. Don't forget, a couple of months ago I told you that HCFA now requires you to file a HCFA-1500 claim on those services for which you had the patient sign the waiver. Be sure to include the GA modifier when you do so that Medicare won't send you a nastygram ordering you to refund the patient.

Other news for this century includes the fact that more and more patients, employers and physicians are starting to doubt the wisdom of signing up on all of those managed care plans and many will be leaving those plans this year. (Who was that wise and sage person who said that we would start seeing a decline in managed care in the first few years of 2000?) Also, hopefully you've gotten wise to some of the garbage being put in the contracts by some of the managed care companies, and you're now reviewing them with scrutiny and even having a qualified healthcare attorney read them before you sign.

On the Light Side: A woman went to her doctor's office and was seen by one of the new doctors. After about four minutes in the examination room, she burst out, screaming as she ran down the hall. An older doctor stopped and asked her what the problem was, and she explained. He had her sit down and relax in another room. The older doctor marched back to the first and demanded, "What's the matter with you? Mrs. Berry is 63 years old, she has four grown children and seven grandchildren, and you told her she was pregnant?" The new doctor smiled smugly as he continued to write on his clipboard. "Cured her hiccups though, didn't it?"

You can expect to see some third party carriers still hoping you'll be foolish enough to send them a check just because they ask for it this year, just like last. They'll send you a letter stating they reviewed the claim that was paid to you a year ago and discovered they paid it in error and expect you to send them a check for $121.12. We recommend that you not write a check to them yet. We have on our website (which has been visited about a quarter of a million times) a great letter for you to download (for free) and copy onto your letterhead telling the carrier that you're not required to refund them. It also gives legal examples where the courts have said "tough luck" to the carriers that paid claims in error. Hey, if they tell you that you only have 180 days to appeal a claim, then they should have to abide by the same rules.

Also new for this year is an idea that TOMA, TxACOFP and yours truly have been discussing. We're thinking about offering some classes or workshops for your staff at the annual and mid-year medical conferences. Think about it. You're already closed since your highness will be away from the office for a couple of days. So why not take the same opportunity to offer some collection, coding, insurance or Medicare courses for your staff at the same hotel where you're having your conference? If you like the idea, let your association and moi know.

Also available this year is a brand new website for medical business learning that I've had the pleasure of helping create. The site is: www.med2learn.com and has interactive, self-paced, Internet courses on all kinds of medical business issues. In fact, this year we'll even be adding some courses geared towards the clinical side of the practice.

Pull out your day timer and circle September 20-23 as a reminder to send your staff to the 12th annual conference of the Professional Association of Health Care Office Managers. This year, it will be at the Beau Rivage Hotel/Casino in Biloxi, Mississippi. Of course, you'll need to sign your office manager up as a member of PAHCOM and, next to hiring us as a consultant or subscribing to our eight-page monthly newsletter, it's the best thing you could do for your practice. And, it's only $125 a year. Call PAHCOM at 1-800-451-9311 and you'll soon discover your ROI is at least 500% on that small investment.

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HEALTH NOTES

Non-Smoking Women and Lung Cancer

Women without a gene called GSTM1, which is known to inactivate carcinogens found in tobacco smoke, were 2.6 to 6 times more likely to develop lung cancer if they lived with smokers, reported the Associated Press. Researchers said that the gene is missing in 50 percent of Caucasians.

(Associated Press, December 1, 1999)

New Epilepsy Drug Approved

The Food and Drug Administration has approved Keppra (levetiracetam), a new epilepsy drug that controls partial onset seizures in adults when used with other epilepsy medications.

Keppra, chemically unrelated to most currently marketed antiepileptics, provides a new treatment option for patients. Unlike most epilepsy drugs, Keppra as well as Neurontin (gabapentin), another approved epilepsy drug, do not interfere with the body's metabolism of other epilepsy drugs. Studies have indicated that because the drug is not metabolized through the liver, it is unlikely to cause interactions with other epilepsy drugs or commonly used drugs such as oral contraceptives. In addition, no serious blood or liver related toxicities were seen in clinical trials of more than 1300 patients with epilepsy. Three multicenter clinical studies in about 900 patients demonstrated Keppra's effectiveness as adjunctive therapy for adults who experience partial onset seizures.

The new drug will be manufactured and distributed by UCB Pharma, Inc., of Smyrna, Georgia.

(FDA Talk paper, December 1, 1999)

FDA Notifications to Health Professionals

- The Food and Drug Administration is notifying health professionals of adverse events related to the use of vascular hemostasis devices. These devices provide an alternative to manual compression in achieving hemostasis following percutaneous femoral arterial punctures in patients undergoing diagnosis and treatment for cardiovascular disease. Reported complications related to these devices include hematoma, retroperitoneal bleed, pseudoaneurysm, late bleeding, and infrequently death. The letter may be found at: <www.fda.gov/cdrh/safety/vashemo.html> and the PDF format at: <www.fda.gov/cdrh/safety/vashemo.pdf>.

- Boehringer Ingelheim notifies health professionals about the potential effect that Viramune (nevirapine) may have in patients taking chronic methadone maintenance therapy. Viramune may decrease plasma concentrations of methadone by increasing its hepatic metabolism. A copy of the letter may be found at: <www.fda.gov/medwatch/safety/1999/viramu.html> and in PDF format at: <www.fda.gov/medwatch/safety/1999/viramu.pdf>.

- Health professionals are notified of a voluntary recall of Vanceril 84 mcg DOUBLE STRENGTH (beclomethasone dipropionate) Inhalation Aerosol Convenience Pack because a number of canisters in five (5) lots may not contain active drug. The company press release may be found at: <www.fda.gov/medwatch/safety/1999/vancer.pdf>.

Local Oncologists Research New Supportive Treatment for Cancer Patients

Texas Cancer Care is participating in a clinical research trial which investigates the effectiveness of a new long-acting form of Neupogen, a drug that helps stimulate the production of white blood cells in cancer patients receiving chemotherapy.

Current standard therapy involves administering Neupogen daily for 10 to 14 days after the patient has received chemotherapy. This study measures the effectiveness of administering the long-acting version of the drug once during a cycle of chemotherapy to high-risk breast cancer patients. The long-acting version of Neupogen may allow for less frequent dosing, a benefit to cancer patients. Currently, phase II clinical studies are investigating the once-per-cycle dose versus daily injections.

Several hundred cancer patients in the U. S. and Canada will be enrolled in the study designed by Amgen, Inc. Locally, Texas Cancer Care will recruit eight to 12 women and men for the trial. Ray Page, D.O., principal investigator, will conduct the study for Texas Cancer Care.

This new therapy is very promising. We are very excited to participate in this study. We are always looking for new and innovative therapies to enhance the treatment options for our patients," said Dr. Page.

Texas Cancer Care is the regional affiliate of the M.D. Anderson Physicians Network and is a regional physicians group providing medically advanced patient-centered care for the treatment of cancer. More information about Texas Cancer Care is available at: <www.txcc.com>.

In Memoriam

Robert R. Crawford, D.O.

Robert R. Crawford, D.O., of Keller, passed away on October 16, 1999. He was 67. Services were held October 22 at Lucas Funeral Home Chapel in Hurst.

Dr. Crawford was a 1959 graduate of the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri. He was a surgeon at Northeast Community Hospital for many years. He had recently retired from surgery and was doing emergency room medicine.

Dr. Crawford was a longtime, active member of TOMA and was a Fellow of the American College of Osteopathic Surgeons.

Survivors include his wife, Penny Crawford; brother, David Crawford; daughters, Lisa and Denise; sons, Doug, Matt and John; and grandchildren, Brian and Jimmy Crawford and Lesha and Chance Smith.

TRICARE Active-Duty Family Member Inpatient Rate Increases

"DRG" Rate and Non-Active-Duty Inpatient Mental Health Cost-Shares Also Go Up

Inpatient rate increase - Effective October 1, 1999, the daily amount active-duty family members pay for inpatient care in civilian hospitals under TRICARE Standard and TRICARE Extra increased from $10.45 to $10.85.

The rate increase means that an active-duty family member who's admitted to a civilian hospital for care (except mental health care) under TRICARE Standard or TRICARE Extra will pay the $10.85 daily rate, multiplied by the number of days spent in the hospital—or a flat fee of $25, whichever total is greater. The flat $25 cost-sharing rate also applies to ambulatory (same-day) surgery.

The $10.85 inpatient rate doesn't apply to any other category of TRICARE-eligible patients, only to active-duty family members. Inpatient care for other categories of TRICARE beneficiaries will, in most cases, be cost-shared under the diagnosis-related group (DRG) payment system for TRICARE Standard and TRICARE Extra.

The inpatient rate for active-duty family members who are enrolled in TRICARE Prime, and who are admitted to a civilian hospital, remains at $11 per day, with a minimum co-payment of $25 total.

Inpatient mental health care at civilian facilities costs $20 per day for active-duty family members under TRICARE Standard, TRICARE Extra or TRICARE Prime. This rate applies to admissions to:

* Any hospital for mental health services;
* Any residential treatment facility or substance use disorder rehabilitation facility;
* Any psychiatric and substance use disorder rehabilitation partial hospitalization services.

The daily inpatient mental health rate for other (non-active-duty family member) patients is $40 per day under TRICARE Prime. The TRICARE Extra cost-share is 20 percent of institutional and professional charges.

Inpatient mental health rate - Under TRICARE Standard, for lower-volume hospitals and units, the mental health care/substance use disorder treatment cost-share for other-than-active-duty families will be the lesser of a specific daily rate ($144 in Fiscal Year 2000, up from $140 in FY 1999) or 25 percent of institutional billed charges. For high-volume hospitals and units, the cost-share is 25 percent of the hospital's specific per diem amounts and separately billed professional charges.

"DRG" rate increase - The TRICARE Standard diagnosis-related group (DRG) daily rate for most civilian non-mental health hospital admissions increased on October 1, 1999, to $390. The rate had been set at $376 for the past year.

The inpatient daily rate will be $390 for TRICARE Standard-eligible persons other than active-duty family members. They'll pay either the fixed inpatient daily rate of $390, or 25 percent of the hospital's billed charges, whichever is less.

The inpatient daily rate for non-active-duty family members at a TRICARE network facility is cost-shared using TRICARE Extra. The cost-share for TRICARE Extra users is the lesser of $250 per day, or 25 percent of the institution's billed charges, plus 20 percent of the charges by individual professional providers who treat the patient during the hospital stay.

Active-duty family members' cost-shares aren't affected by the DRG rates. As noted earlier, they'll pay a small daily fee of $10.85 for each day in a civilian hospital ($20 per day for inpatient mental health care) or a total of $25 for each hospital stay, whichever is greater.

When non-active-duty family members are admitted to hospitals that are exempted from the DRG payment system, their cost-share will be 25 percent of the TRICARE-determined allowable charges. DRG-exempt hospitals include psychiatric, cancer, long-term care, rehabilitation, and sole community hospitals exempt from Medicare's prospective payment program. Hospitals in the state of Maryland are also exempt from the DRG payment system because of Maryland's stricter state law.

For more information about DRG payments, contact the health benefits adviser at the nearest uniformed services medical facility, or talk to a staff member at your nearest TRICARE service center.

Reserve Health Care Benefits, Entitlements Study Report Sent to Congress

Secretary of Defense William S. Cohen sent a report to Congress on November 8, 1999 that recommends sweeping changes in the statutes and policies covering health care benefits and entitlements for members of the National Guard and Reserve.

The study contains 14 recommendations to ensure that medical treatment, entitlements and force health protection measures for Reserve component personnel are sufficient at a time in history when reservists are increasingly being called upon, and when they are increasingly going in harm's way. Some of these recommendations have already been adopted by the Congress and included in the Fiscal Year 2000 National Defense Authorization Act (NDAA).

"The findings of this report are compelling and important because the changed nature of today's Total Force requires a new approach to providing medical care to our reservists," Cohen

said. "At the core of this new approach is the notion that performance of duty, not length of duty, establishes risk and exposure to harm. In other words, we will treat injury or illness, sustained in the line of duty, regardless of the duty status in which the individual is serving."

The study, formally titled, "Means of Improving the Provision of Uniform and Consistent Medical and Dental Care to Members of the Reserve Component," is part of a three-year effort to reassess Reserve component health care issues. Known as the 746 Study after the numbered section in the 1997 NDAA, it was undertaken by the Offices of the Assistant Secretaries of Defense for Reserve Affairs and Health Affairs.

The complete text of the report is available on line at : <www.defenselink.mil/pubs/Sec746_111099.html>.

Military Considering Use of New Dog Tag Containing Medical Info

By Linda D. Kozaryn
American Forces Press Service

WASHINGTON — In the future, service members may wear two kinds of dog tags instead of one - the traditional metal ID tags and a new plastic tag bearing digitized medical information. Defense officials are considering using Personal Information Carriers, known as PICs. Similar to the plastic memory cards used to store pictures taken with digital cameras, the PIC holds a service member's shot record and data on allergies and surgical history. While the metal tags would continue to serve as the primary means of identification on the battlefield, the PIC would give field medical personnel access to service members' medical records. It could be read by laptop computers at battalion aid stations.

The military first issued each service member an aluminum dog tag in 1906. During World War I, mindful of the realities of war deaths, the military began issuing two tags, one to be interred with the body, the second to turned over to personnel to record the death.

DoD recently awarded Informatec, Inc., a contract to produce an initial order of 5,000 to 20,000 digital tags, which will be demonstrated in simulated operational environments in the next few months. The contract includes options for a total of 2.5 million tags over the next five years, according to Lt. Col. Bradley Dawkins, an Air Force physician and DoD's PIC project manager. DoD has not yet decided to employ the high capacity PIC, however. Dawkins said the department is also developing digital Smart Cards to carry an individual's security key and other information. Officials are studying whether the cards could also carry medical information, Dawkins said.

If the department fields the PIC, the initial versions will hold only text-based data, Dawkins noted. Eventually, as data capacity increases and costs per device decreases, they also may hold X-rays, EKG and MRI results and other multimedia data, he said.

The PIC is part of the Composite Health Care System II (CHCS II), a computerized system designed to allow providers to track health care services delivered to members of the military's health care beneficiary community.

The PIC would be an electronic theater medical record in settings where computer network connectivity is unavailable. Thus, the PICs would give in-theater health care providers immediate access to accurate clinical information and would allow them to update service members' permanent records in the field. The PICs are a result of lessons learned following the Gulf War, Dawkins explained. Defense officials found medical services performed in the field did not always reach service members' permanent paper medical records. A 1998 presidential report on Gulf War illness directed the department to develop a force health protection program and maintain consistent, continuous records, he said.

Researching Gulf War illness using paper-based medical records proved difficult, Dawkins added. Digital information, he said, lends itself more readily to statistical analysis.

Washington Update

- On November 3, the Department of Health and Human Services (HHS) published proposed regulations to safeguard medical privacy. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress was given until August 21, 1999, to pass legislation to protect individually identifiable medical data. With Congress' failure to act, the spotlight shifted to HHS to put a confidentiality rule into place by February 2000. Under the agency's proposal, health care providers would be required to get written patient consent to release individual health information for any purpose other than treatment, payment or public health. Those misusing confidential information would be subject to civil and criminal penalties. Also required: the development of specific procedures for handling confidential records; patient notification of those procedures; and appointment of an officer responsible for assuring their enforcement. In accordance with HIPAA's mandate, the propose rule covers electronically transmitted and maintained data only, establishing a federal floor of protections for individual health information. Providers would be required to comply with state standards that are more stringent than those in the rule, as well as state requirements applicable to paper records.

- HCFA has issued proposed regulations establishing a new prospective payment system (PPS) for home health agencies (HHAs). Under the proposal, the basic unit of payment is a 60-day episode of care, regardless of the number of days of care actually provided during the 60-day period. Adjustments would be made based on severity of illness, patient functional status, intensity of services, and local wage rates. Payment for care requiring four or fewer visits would be based on the number of visits, rather than the episode rate. The new system is scheduled to go into effect October 1, 2000.

Source: AOHA Washington Update

Who's in the News?

L - R: Speaker of the TOMA House of Delegates, Dr. Mark Baker, Senator Jane Nelson, Texas Lt. Gov. Rick Perry and Rita Baker, AAOA president.

Ron Kirk (L), Dallas Mayor, presents a proclamation to TOMA board member, Dr. Kenneth Bayles.

Shirley Bayles and former governor of Texas, Ann Richard at the AOA Convention in San Francisco.

PHYSICIAN ASSISTANTS
"PA"rtners for Healthy Communities

Changes in the delivery of health care in the United States have placed new burdens on patients. Today, consumers may find themselves confused by the variety of health care providers in a clinic. One profession that has become a recognized member of the medical team is the physician assistant.

Physicians Assistants, or PAs, are licensed medical professionals who provide medical care under the supervision of physicians, providing patient care services, which would otherwise be performed by physicians. As part of their comprehensive services, PAs take medical histories, perform physical examinations and interpret lab tests, diagnose and treat illnesses, suture lacerations, assist in surgery and, in more than 40 states, Texas included, they can write prescriptions when authorized to do so by their written protocols.

On October 6, PAs around the United States, including the members of the Texas Academy of Physician Assistants, celebrated National Physician Assistant Day. It was on that day in 1967 that the first class of PAs graduated from Duke University in North Carolina.

Physician assistants build healthy communities by working with physicians to increase access to medical care. "Physician assistants have a record of more than 30 years of providing quality, cost-effective health care to patients," said Ron Nelson, PA-C, President of the American Academy of Physician Assistants (AAPA).

PAs are employed by solo physicians, HMO group practices, nursing homes, and hospitals. The largest segment of physician assistants – more than 47 percent – practice family and internal medicine. PAs also serve as commissioned officers in all branches of the military and practice as members of the White House medical team, caring for the president and vice president.

The relationship between a physician and a physician assistant is one of mutual trust and reliance. It is common in rural areas for the supervising physician to live in another community and to make routine visits as required or necessary, while the PA provides day-to-day medical care to the local residents. There must always be a means for consultation between the physician and the PA, but not necessarily the physical presence of the supervising physician when the PA is treating patients.

Because physicians and PAs usually train together during their education and work as teams during clinical rotations, physicians have become increasingly supportive of the physician/PA team. Patients also report satisfaction with care provided by physician assistants.

The Texas Academy of Physician Assistants (TAPA) is embarking on a campaign to educate the public regarding the dangers of tobacco use. This includes cigarette, cigar, pipe, chewing tobacco and snuff use as well as the hazard of second hand smoke on non-smokers. Texas PAs are being trained to educate civic groups on the hazards of tobacco abuse.

TAPA would like to thank the Texas Osteopathic Medical Association for their support of the physician/PA team. We look forward to working together to make quality health care a reality for all Texans.

TAPA asks any physician who currently employs a PA to nominate that PA for the Texas Academy of Physician Assistants' "PA of the Year" award. Include the PA's name, address and phone number. Deadline is January 31, 2000. Send nominations to: TAPA, 401 West 15th St., Austin, TX 78701, 800-280-7655.

Proposed Revision to the TOMA Bylaws

As required by *Article XIV* of the TOMA Bylaws, the following change will be presented to the TOMA House of Delegates for their consideration on April 7-8, 2000.

Mark A. Baker, D.O., Chair of the TOMA Constitution, Bylaws & Documents Committee, would like to present the following change to the TOMA Bylaws.

Due to the action of the 1999 TOMA House of Delegates, the following section of the TOMA Bylaws needs to be revised. Below is the Committee's proposed revision to *Article IX – House of Delegates, Section 6.*

(new language is **underlined**, deleted language is in [ ])

ARTICLE IX - House of Delegates

SECTION 6 - The House of Delegates shall meet annually **[, coincident with each annual convention of the Association, except that the House may and shall convene earlier for such annual session upon call of the President]**. A special meeting of the House of Delegates may be called by the President, by the petition of two-fifths of the accredited delegates, or by petition of a simple numerical majority of the District societies themselves. In such calls the delegates shall be given at least two weeks notice, and the object or objects shall be stated in the call. The Speaker shall be the presiding officer in the House of Delegates. If the Speaker is absent, or wishes not to preside, the Vice Speaker shall preside.

IN BRIEF

Ten New "Safe Harbors" Added to Medicare, Medicaid Anti-Kickback Regulations

The new rules will allow hospitals to form joint ventures with physicians in underserved areas and offer them financial perks such as recruitment bonuses and subsidies for malpractice insurance premiums, reported Modern Healthcare. Hospitals may also own surgery centers with physicians, under the new safe harbors, but must not be in a position to make or influence referrals to and from the center.

(Modern Healthcare, November 22, 1999)

Baylor to Build Dallas Heart Hospital

Baylor Health Care System plans to partner with doctors and build a $48 million heart hospital attached to its downtown Dallas campus. Groundbreaking for the Baylor Heart and Vascular Center took place in December, with completion scheduled for the spring of 2002. The acute-care hospital will house 59 beds and will focus on vascular surgical procedures such as pacemaker implantation and balloon angioplasty.

Medicare Part B Premium Unchanged for 2000

The Part B premium paid by Medicare beneficiaries, which covers physician services, hospital outpatient care, durable medical equipment and other services outside hospitals, remains unchanged for the second time in three years. The Part B premium stays at the 1999 rate of $45.50. In 1998, it rose by $1.70.

The Medicare Part A deductible for inpatient hospital care has risen by $8, about 1 percent, to $776. The small increase largely reflects savings from reductions in Medicare hospital payments and other program changes signed into law in the Balanced Budget Act to help protect and preserve the Medicare Hospital Insurance Trust Fund. In 1998, the deductible rose by $4.

The Part A deductible is a beneficiary's only cost for up to 60 days of inpatient care. The cost to beneficiaries for hospital stays longer than 60 days has risen by $2, to $194 per day, and by $4, to $388 per day, for stays longer than 90 days. The skilled nursing facility deductible, which must be paid after the first 20 days of such care has risen by $1, to $97 per day.

Texas Children's Insurance Expansion Approved

Federal regulators have approved a proposal by Texas to expand its Children's Health Insurance Program (CHIP) in order to cover thousands of children who would otherwise not be covered. The second phase of the CHIP program will enroll an estimated 423,000 children by September 2001. Adding to the 57,000 children that Texas estimated would be covered under the original plan, which was approved in July 1998, the number of children to receive coverage under CHIP is expected to total more than 480,000. Texas is eligible to receive as much as $558 million in new funds for fiscal year 1999 as the second phase expands coverage under the CHIP program.

Texas HMOs Lost $185 Million in the Third Quarter – $414 Million this Year to Date

HMOs have attributed the losses to higher prescription drug costs, new medical technologies and tougher negotiating stances by hospitals and large physician groups, reported the Dallas Morning News. Analysts expect greater increases in premiums and more consolidations in response to the losses.

(Dallas Morning News, December 1, 1999.)

Medical Mistakes Responsible for Thousands of Deaths

A report by the National Academy o Sciences' Institute of Medicine says tha as many as 98,000 Americans die every year from medical mistakes made by physicians, pharmacists and other health care professionals.

The report calls for the establishment of a federal agency, a Center for Patient Safety, to set detailed national goals for reducing medical errors. It also calls for mandatory federal reporting requirements for serious medical accidents, and suggests that minor medical errors that have not resulted in serious injuries or death be collected in a confidential database, not available to the public.

Most errors are not the result of flagrant recklessness, says the report, but occur because of the cumulative opportunities for human error that arise in today's complex medical system. "To err is human, but errors can be prevented," the report concludes.

BC/BS of Texas Inappropriately Billed Medicare for $1.6 Million

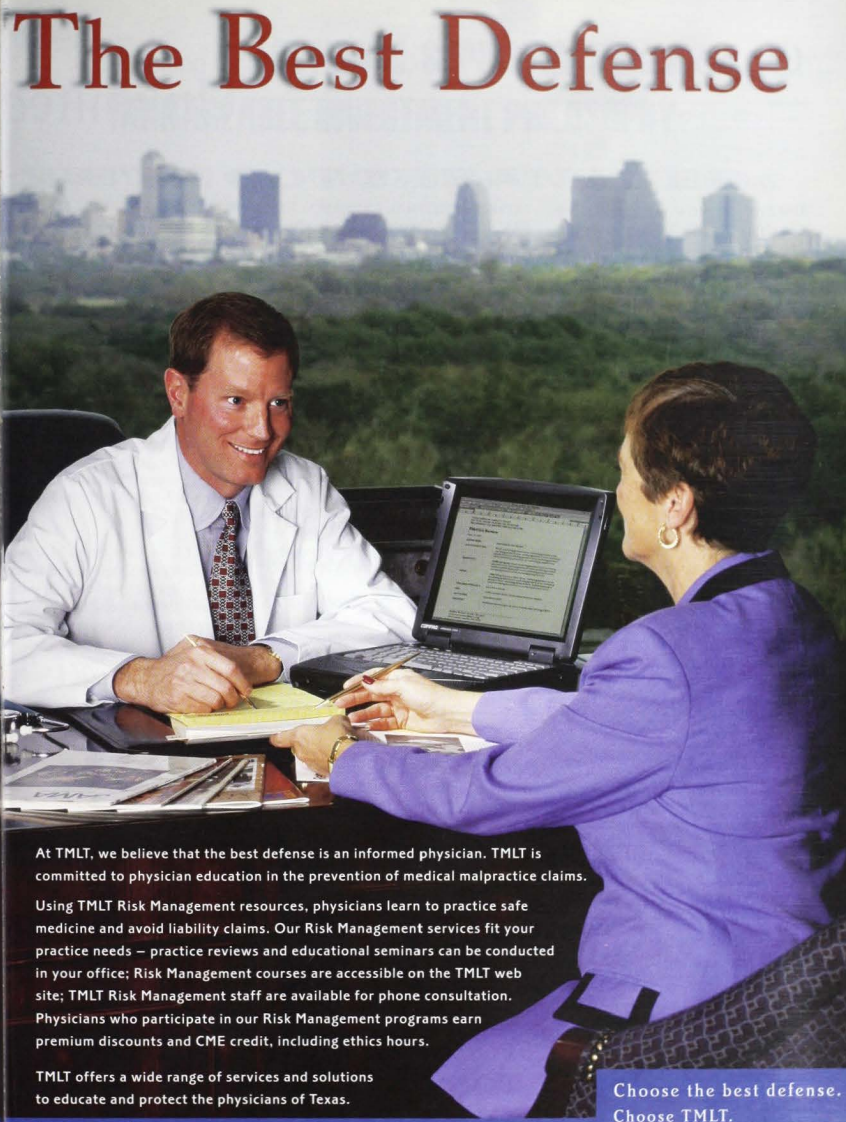
Among the billings were costs related to Blue Cross executives, lobbying costs, duplicate charges and charges that should have been billed to other insurance companies, reported the Dallas Morning News. HCFA is reviewing Blue Cross Blue Shield of Texas' position that it should not have to repay the money because it sold its Medicare claims processing subsidiary to Blue Cross Blue Shield of South Carolina in September.

(Dallas Morning News, December 4, 1999)

Study on OMT Generates National Media Attention

A study entitled, "A Comparison of Osteopathic Spinal Manipulation with Standard Care for Patients with Low Back Pain," was published in the November 4th issue of the New England Journal of Medicine. The study found that patients with subchronic low back pain can be treated effectively and more cost-efficiently with OMT. Media coverage on the study includes FOX, NBC, CBS and ABC. Other coverage includes the Washington Post and ABC Online.

The Best Defense



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