TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LVIII, No. 6

June 2001

Emotional Wellness

Where does it come from?

"The greatest discovery of my generation is that a human being can alter his life by altering his attitude."

— William James

"Being kind is much more important than being right."

— Phil McGraw

"When just one person says to me, 'You've made my day', it makes my day."

— Andy Rooney

"Laughter is about the only thing that can bring trouble down to where you can talk to it."

— Dan Jenkins

"Love, not time, heals all wounds."

— Anonymous

"There is a gold mine within you from which you can extract everything you need to live life gloriously, joyously and abundantly"

— Joseph Murphy

pages 6 – 15

plus

56th Annual Meeting of the TOMA House of Delegates

pages 24 – 28

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

JUNE 2001

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Clinical Focus – Emotional Wellness

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CALENDAR OF EVENTS

JUNE 6 – 10
"102nd Annual Convention and Scientific Seminar"
Sponsored by the Texas Osteopathic Medical Association
Location: Arlington Convention Center, Arlington, TX
CME: 26 hours Category 1-A credits
Contact: Jill Weir, CAE, Projects Coordinator
800-444-8662 or 512-708-8662
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JUNE 16 – 20
"Basic Course: Osteopathy in the Cranial Field"
Sponsored by The Cranial Academy
Location: The Westin Mission Hills Resort
Rancho Mirage, CA
CME: 40 hours Category1-A credits anticipated
Tuition: Program Director: Judith L. Lewis, D.O., FCA
(for scholarship information)
$1,150 (nonmembers)
Scholarship: $575 (nonmembers)
Contact: The Cranial Academy
317-594-0411
FAX: 317-594-9299
E-mail: CranAcad@aol.com

JUNE 21 – 24
"99th Annual Convention & Scientific Exhibition"
Sponsored by the Georgia Osteopathic Medical Association
Location: Amelia Island Plantation, Amelia Island, FL
Contact: GOMA, 2160 Idlewood Road, Tucker, GA 30084
770-493-9278
E-mail: GOMA@mindspring.com
Web: www.goma.org

JUNE 21 – 24
"Annual Conference"
Sponsored by The Cranial Academy
Location: Rancho Mirage – Palm Springs, CA
CME: 21 hours Category1-A credits anticipated
Contact: The Cranial Academy, 317-594-0411
FAX: 317-594-9299
E-mail: CranAcad@aol.com

JUNE 21-24
"88th Annual Northwest Osteopathic Convention"
Sponsored by the Washington Osteopathic Medical Association
Location: Resort Semiahmoo, Blaine, Washington
CME: 27 hours Category1-A credits
Contact: Washington Osteopathic Medical Association
206-937-5358

JUNE 27 – JULY 1
"21st Annual Primary Care Update"
Sponsored by the University of North Texas Health Science Center Office of CME
Location: Radisson Resort, South Padre Island, Texas
CME: 24 hours Category1-A credits anticipated
Contact: UNTHSC Office of Continuing Medical Education
800-987-2CME

JULY 13 – 15
"AOA House of Delegates Meeting"
Sponsored by the American Osteopathic Association
Location: Fairmont Hotel, Chicago, IL
Contact: Ann M. Wittner, AOA Director of Administration
800-621-1773
E-mail: awittner@aoa-net.org

OCTOBER 21 – 15
"106th Annual Convention and Scientific Seminar"
Sponsored by the American Osteopathic Association
Location: San Diego Convention Center, San Diego, CA
Contact: Ann Wittner, 800-621-1773
E-mail: mthompson@aoa-net.org

CME CORRESPONDENCE COURSE
"Medical Ethics: Applying Theories and Principles to the Patient Encounter"
Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services
CME: 60 hours Category 2-B credits
Course Tuition: $1,200
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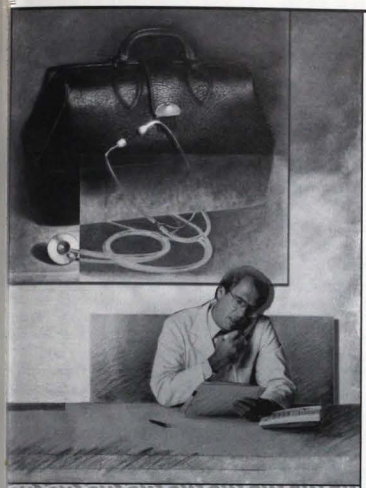

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Emotional Wellness

"Understand that happiness is not based on possessions, power or prestige, but on relationships with those you love and respect, including yourself."

– H. Jackson Brown, Jr.

Physical Activity: A Mood Booster

Regular physical activity that is performed on most days of the week reduces the risk of developing or dying from some of the leading causes of illness and death in the U. S. Regular physical activity also improves health in other ways:

- Physical activity appears to relieve symptoms of depression and anxiety and improve mood.
- Physical activity appears to improve health-related quality of life by enhancing psychological well-being and by improving physical functioning in persons compromised by poor health.
- Exercise is a potential pathway to reducing both depression and risk of heart disease. A recent study found that participation in an exercise training program was comparable to treatment with an antidepressant medication (a selective serotonin reuptake inhibitor) for improving depressive symptoms in older adults diagnosed with major depression. Exercise, of course, is a major protective factor against heart disease as well.

(Depression Can Break Your Heart — NIH Publication 01-4592; and Physical Activity and Health: A Report on the Surgeon General Executive Summary)

The Power of a Positive Attitude

Women Blame Stress for Their Breast Cancer and Attribute Positive Attitude for Remission

Ask women what caused their breast cancer, and the most common answer will be stress, an unfounded belief that can affect how these women approach their treatment and survival.

Published in the March 2001 issue of *Psycho-Oncology* a study of nearly 400 breast cancer survivors who had been disease-free for an average of nine years, 42 percent cited stress as one of the main causes of their breast cancer. This was many more than the 27 percent of the women who felt genetics was involved, the 26 percent who attributed a role to environmental factors, 24 percent who blamed hormones and 16 percent who

thought diet was a contributing factor; the scientific evidence supporting these factors as potential causes of breast cancer is far stronger than that for stress.

Sixty percent of the women also felt that a positive attitude helped them keep the breast cancer from returning, followed by diet (50 percent), healthy lifestyle (40 percent), exercise (40 percent), stress reduction (28 percent), prayer (26 percent), complementary therapies (11 percent), luck (4 percent), and tamoxifen (4 percent).

The conviction that stress caused cancer or that a positive attitude has kept their breast cancer from recurring may give women a sense of control over the disease, noted Donna E. Steward, M. D., and her associates at University Health Network and the University of Toronto. This belief can be beneficial when it helps women switch to a low-fat diet or exercise more, but can backfire in a feeling of "personal failure" if the disease returns.

The study noted that when asked what advice the women would give another woman who was recently diagnosed with breast cancer, more than half (52 percent) said they would tell the woman to have hope, have courage and be positive. And 58 percent said they would take more control of their treatment if they had to relive their experience.

("Women Blame Stress for Their Breast Cancer, Attribute Positive Attitude for Remission." News release. 3-7-2001. Center for the Advancement of Health, <www.cfah.org>)

Emotional Well-Being May Lower Risk of Stroke

Feeling happy and hopeful seems to offer powerful protection against the risk of stroke, outstripping the increased stroke risk linked to depression, according to a new study published in the March/April 2001 issue of *Psychosomatic Medicine*.

The association between depression and an increased risk for stroke has been established in several studies on the impact of psychological factors on stroke incidence.

Glenn V. Ostir and associates at the University of Texas Medical Branch decided to assess signs of depression – termed negative affect – separately from signs of emotional well-being – termed positive affect.

"Our results suggest that increasing levels of positive affect are strongly associated with a reduced risk of stroke. This inverse relationship between positive affect and stroke held for the entire sample, by gender and by race, after controlling for known risk factors of stroke and for negative affect score," he stated in the paper.

The study followed 2,478 subjects 65 years and older for six years. Using a 20-item questionnaire, with 16 questions on negative affect and four questions on positive affect, the investigators found that subjects scoring high in terms of emotional well-being had significant reductions in their stroke risk while risk increased for depressed subjects.

The investigators then looked at the positive and negative affect components separately. Subjects who scored highly for emotional well-being had a stroke incidence that was one-third that of subjects who scored zero. In contrast, subjects scoring highly for depressive symptoms experienced only fractional increases in stroke incidence above those with little or no signs of negative affect. The reductions in stroke associated with positive affect was more pronounced in men than women and in whites than African Americans.

"Positive affect is related to a number of characteristics known to improve health or to protect against chronic disease. Individuals who report high levels of positive affect may be more likely to exercise, to maintain a healthy lifestyle and to adhere to medical therapy," Ostir said.

He noted that although the study controlled for known risk factors for stroke, there is still the possibility that the observed association between emotional well-being and stroke may have been the product of a moderating factor that they did not take into account.

Loneliness and Health

Loneliness undermines health by altering people's cardiac function and disrupting their sleep, according to research at the University of Chicago.

Doctors have known for some time that lonely people do not live as long and have more medical problems than non-lonely people, but the reasons for this connection have not been clear. This research demonstrates that lonely people may have more health problems because they perceive the world to be threatening and their orientation to others reduces positive feedback and emotional support. These perspectives can ultimately lead to higher blood pressure and sleep disruptions. These factors, in turn, have been shown to have an impact on the body's resilience in dealing with disease.

"The strength of social isolation as a risk factor is comparable to obesity, sedentary lifestyles, and possibly even smoking," said John Cacioppo, Professor of Psychology at the University of Chicago and director of an interdisciplinary team of investigators studying loneliness as part of the Mind-Body Network of the John D. and Catherine T. MacArthur Foundation.

Cacioppo reported his findings in a paper, "Biological Costs of Social Stress in the Elderly," in 2000 at a meeting of the American Psychological Association.

The findings about loneliness are significant because life style changes have altered the structure of the family, the traditional source of emotional support. By 2010, 31 million Americans are projected to be living alone, a 40 percent increase from 1980, according to U.S. Census projections.

Being alone is not the only cause of loneliness, however, Cacioppo noted. Loneliness is characterized by three conditions: isolation (such as absence or distance from a romantic partner); feelings of being disconnected (not having close friends); and feelings of not belonging (not identifying with or not being accepted by valued social groups).

For the study, Cacioppo and his colleagues tested 89 students (45 men and 44 women) aged 18 through 24 at Ohio State University and 25 older people in Chicago, a group in a pilot study that provided evidence for the long-term impact of loneliness.

Researchers found that in response to stressors, the lonely students, who felt

"...older adults who participate in private religious activity before the onset of ADL (activities of daily living) impairment appear to have survival advantages over those who do not."

threatened, showed increases in blood pressure fueled by increases in the resistance to blood flow through the body. While the blood pressure of non-lonely students also increased, that change was due to more blood being pumped through their bodies in response to their feeling challenged by the stressors. They also found that lonely and non-lonely students spent approximately equal amounts of time in bed, but lonely individuals slept 5.8 hours on average while non-lonely students slept 6.4 hours. The lonely students also had a more restless sleep, awakening, for instance, more often during the night.

As with the young participants, the team found no differences in health habits or cortisol levels among the lonely and non-lonely older people. The differences among older people in sleep patterns and cardiac responses were similar to the differences between lonely and non-lonely students. The blood pressure of lonely participants in the 65 to 78 year range was 16 points higher than the non-lonely participants. Cacioppo said that among older people, a lifetime of loneliness leads to diminished health as they experience continued high blood pressure and chronic sleep deprivation.

People can improve their health by learning to overcome loneliness, Cacioppo said. For instance, by becoming a contributing member to school, neighborhood, church or community groups. "A good time to start that people often overlook is when a person is in a new social situation, such as when they've moved to a new community. Our research shows that people aren't lonely simply because of a personality trait, such as being shy. By reaching out to make friends and helping others, people can increase their connections with others."

("University of Chicago Research Shows Link Between Loneliness and Health." News release. 8-7-2000. University of Chicago, <www-news.uchicago.edu>)

Religion and Health Behaviors

Frequent Religious Attendance May Encourage Better Health Behaviors

Individuals who attend weekly religious services may be more likely than less-frequent attenders to improve their health behaviors and to maintain already established good health habits, according to a three-decade-long study published in the February 2001 issue of the *Annals of Behavioral Medicine.*

The study was supported by grants from the National Institute on Aging and the Centers for Disease Control and Prevention.

"Our analyses indicate that attenders did not all start off with such good behaviors," said lead author William J. Strawbridge, Ph.D., of the Human Population Laboratory in Berkeley, California. "To some extent, their good health behaviors occurred in conjunction with their attendance."

Several studies have found religious attendance improves one's chance of survival. Those who regularly attend services are known to smoke and drink less, and in general to exhibit better health behaviors. However, the question remaining has been whether religious organizations attract people who already have good health behaviors or if attendance helps create these behaviors.

Nearly 30 years of health data on more than 2,600 individuals were analyzed. "We examined the extent to which religious attendance is associated with both improving poor health behaviors and maintaining good ones already established," said Strawbridge.

"Individuals who regularly attended religious services were more likely to become more physically active, quit smoking, become less depressed, increase social relationships and initiate and maintain stable marriages," said Strawbridge.

Certain results were stronger for women than for men. The researchers noted that female frequent attenders tended to be more likely than male frequent attenders to improve poor health behaviors and mental health.

More research is need on exactly how religious attendance may increase survival, according to the researchers. It may benefit health by offering attendees a sense of coherence or perceived control of their lives or by exposing them to organizational rules that discourage smoking and to philosophical principles that stress respect for the body. The support offered by the religious community may also be a boon to health, according to the study.

("Frequent Religious Attendance May Encourage Better Health Behaviors." News release. 2-24-2001. Center for the Advancement of Health, <www.cfah.org>)

Survival of the Religious

Researchers found that older adults who participate in private religious activity before the onset of ADL (activities of daily living) impairment appear to have survival advantages over those who do not. This was the finding of a companion study by a group of Duke University researchers published in the July 2000 issue of the *Journal of Gerontology: Medical Sciences.* The other study looked at religious attendance and survival while this study looked at the relationship between survival and private religious activity.

In this study, researchers "found that private religious activities provided a protective effect against mortality for an elderly population free of functional impairment; no such effect persisted in the ADS impaired group."

This, according to the researchers, is probably the first study to document a

possible protective effect for private religious activity on mortality in a large community-dwelling population.

ADL impairments have long been recognized as a strong predictor of mortality in older adults. The purpose of this study was to determine if private religious activity had an impact on survival.

The study found that private devotional not only positively affected health, but that the benefits extended nearly equally from those who participated daily to those who participated in religious activity a few times a month. In other words, the researchers noted, "the benefit extends to all" regardless of frequency.

("Survival of the Religious." News release. 6-28-2000. The Gerontological Society of America, <www.geron.org>)

The Dangers of Anger and Hostility

A new study published in the March/April issue of *Psychosomatic Medicine* shows that depression and anger are associated with hardening of the arteries in women, in part, through physical and behavioral risk factors such as bad cholesterol levels, obesity and smoking.

"There is evidence that psychosocial distress is prospectively associated with increased risk of disease and premature mortality from cardiovascular events," noted Thomas Rutledge, Ph.D., of the University of Pittsburgh and his associates.

The study showed that subjects with the most depression symptoms were 2.5 times more likely to smoke than subjects with the least depression symptoms. Depressed subjects were also less likely to exercise or be physically fit than non-depressed women.

Subjects who scored highest for outwardly displaying their anger were the most likely to have low levels of high-density lipoproteins and high levels of low-density lipoproteins. These women were also more likely to be overweight or obese.

Cynical hostility, defined as a consistent lack of trust and bitterness toward others, was also associated with atherosclerosis risk factors such as smoking, poor physical fitness and lower HDL levels.

The investigators initially detected an association between cynical hostility and high blood pressure, which disappeared once they controlled for socioeconomic status. This suggests that low socioeconomic status may increase the risk for both cynical hostility and hypertension.

("Anger and Depression Predict Artery-Hardening Risks, Behavior." News release. 3-22-2001. Center for the Advancement of Health, <www.cfah.org>.)

Ponder This

"For every minute you are angry, you lose sixty seconds of happiness."
– Ralph Waldo Emerson

"A smile is an inexpensive way to improve your looks."
– Jim Begg

"Never let defeat have the last word."
– Tibetan Proverb

"It is neither wealth nor splendor, but tranquility with life which gives happiness."
– Thomas Jefferson

"Choose a job that you love and you will never work a day in your life."
– Confucius

"Trouble is only opportunity in work clothes."
– Henry J. Kaiser

"You may do foolish things, but do them with enthusiasm."
– Colette

"Smile, it is the key that fits the lock to everybody's heart."
– Anthony J. D'Angelo

"Take time to laugh out loud. It is the music of the soul."
– Michel De Montaigne

"We cannot do great things on this earth. We can only do small things with great love."
– Mother Teresa

"The most wasted day of all days is one without laughter."
– e.e. cummings

"Nothing is more important than your own sense of happiness and inner peace and that of your loved ones."
– Richard Carlson

The Essence of Giving

"Resolve to be tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and wrong...because sometime in your life you will have been all of these."

How Good is a Good Night's Sleep?

Diagnosis and Treatment of Insomnia by the Primary Care Doctor

by S/D Chris Hummel , Karen Rainville, D.O., and Charles Mathis, M.D.

Most of us take a good night's sleep for granted. We shouldn't. Research reveals that almost one third of the adults in this country suffer from episodic periods of insomnia.[1,2,3,4,6,10,11,12] What makes this of particular importance to address is that most patients do not even realize that they are suffering from a sleep disorder until they are actually questioned about it. For one reason or another, almost all of the patients that we see will suffer from some form of insomnia – be it secondary to a major medical condition, adverse reaction to medications, as a symptom of a psychological disorder or caused by poor sleep hygiene. Unfortunately, the diagnosis of insomnia is often overlooked or minimized by physicians. Although treatment options are broad for this disorder, evidence suggests that good sleep hygiene and behavioral modification can alleviate much of the suffering. Along with a brief overview of sleep and common causes of insomnia, this article will discuss general approaches to evaluating and establishing good sleep hygiene.

"...studies suggest that patients suffering from sleep disorders typically miss twice as many days of work per month when compared to those without sleep disorders."

The costs associated with untreated insomnia are difficult to estimate. What is known is that patients suffering from acute or chronic sleep difficulties are at increased risk for daytime fatigue and drowsiness, decreased ability to concentrate and work and typically suffer from reduced enjoyment of interpersonal relationships.[5,9] A recent study found that nearly half of all accidents involving commercial trucking each year are directly attributable to poor sleep and fatigue.[8] Other studies suggest that patients suffering from sleep disorders typically miss twice as many days of work per month when compared to those without sleep disorders. Insomniacs also typically cost 60% more per month in direct healthcare costs.[4]

What constitutes a good night's rest? Most sleep researchers agree that the average person needs between six and eight hours of undisturbed sleep nightly. But it is not only the total number of hours required that is important – it is also experiencing the proper sleep cycle that leads to refreshing sleep. Sleep can be broken down into four stages, based on brainwave activity, plus a fifth stage, referred to as Rapid Eye Movement sleep, or REM sleep. As a person progresses from wakefulness to sleep, he or she first enters Stage 1 sleep, with characteristic Alpha waves seen on EEG. This stage is sometimes referred to as "relaxed wakefulness". As the sleep cycle continues, the patient enters Stage 2, a deeper sleep associated with K Complexes and Sleep Spindles on EEG. Approximately one half of a normal sleep cycle will be spent in Stage 2. This stage is thought to act as a transition zone from light sleep into the deeper sleep stages where Delta waves predominate. These Delta wave periods, occurring in Stages 3 and 4, produce the most restful sleep.[6,8]

REM sleep, the lightest phase of sleep, is also referred to as paradoxical sleep because the brain wave activity seen during this phase is very similar to that seen during normal waking periods. During this phase, skeletal muscle response is greatly diminished, and most of the dream activity that we remember upon awakening occurs during this period. Although the mix of the various stages of sleep changes throughout a patient's life, all must be present to one degree or another in order to avoid the ill effects of chronic sleep disruption.[6,8]

If sleep disorders are so common and the burden is potentially so high, then it is incumbent upon all primary care physicians (PCP) to effectively screen for them as part of the routine History and Physical.[8] Issues that must be addressed during this routine screening include the following: total number of hours spent asleep, subjective assessment of sleep quality, ease of falling asleep, occurrence of nighttime awakenings, self perception of morning refreshness, incidence of daytime naps and daytime fatigue. Other screening questions should ascertain whether or not the patient has an established bed and wake-up time, regular sleeping quarters and an established sleep ritual. This information is easily obtained during the initial nurse/patient contact along with obtaining the chief complaint. Responses that warrant concern can then be followed up on during the doctor/patient visit.[1,7,8]

Although an in-depth discussion of disorders that can lead to sleep disturbances is beyond the scope of this article, a partial list of the most common causes of insomnia would include the following:

- Restless leg syndrome
- Sleep apnea
- Nocturnal myoclonus
- CHF
- Asthma
- COPD
- GERD
- Hypertension
- Hyperthyroidism
- Peptic ulcer disease
- Depression
- Anxiety
- Alcohol/substance abuse [6]

If, after reviewing and evaluating a patient, a physician determines that the

patient is indeed suffering from a non-medical sleep disorder, there are two treatment pathways available. In the first case, the physician can attempt treatment himself/herself, or secondly, the patient can be immediately referred to a sleep specialist. With a few notable exceptions, this referral should be delayed pending the results of treatment therapy initiated by the primary physician.[8] Immediate referral should be reserved for those few patients who report excessive daytime drowsiness to the point of not being able to function at all and for those patients whom you suspect of having a breathing related sleep disorder. In all cases where the patient has failed initial therapy instituted by the primary care physician, a referral should be made to a sleep specialist.[6,7,8]

Assuming that treatment is going to be initiated by the PCP, research indicates that the most effective and least invasive approach generally should focus on establishing and encouraging good sleep hygiene and some behavioral modification.[6,8,9] Studies have shown that such modifications are at least as effective as the short-term use of hypnotics. In addition, such behavioral modification is usually well tolerated, and has few, if any, negative side effects.[12] The following guidelines are useful in establishing good sleep hygiene:

- Use the bedroom for sleep and sex only
- Avoid daytime naps
- Establish a routine bed time and wakeup time
- Limit total sleep per day to eight hours
- Discontinue the use of nicotine
- Do not consume alcohol or caffeine within six hours of scheduled sleep
- Establish a regular aerobic exercise program
- Keep the bedroom quiet, cool and dark[1,2,6,8,12]

Two other forms of behavioral modification that tend to be very effective are stimulus control therapy and sleep restriction therapy. In stimulus control, patients are instructed to get into bed only when sleepy, and to immediately get out of bed and go to a different part of the house if unable to fall asleep within ten to fifteen minutes. Patients are also told to set a standard wake-up time – regardless of what time they finally fell asleep the night before and regardless of whether or not it is a weekend. The purpose of sleep restriction therapy is to match the patient's perceived sleep time with the total time actually spent in bed. This means that if the patient thinks he or she is sleeping only five hours a night, then that patient is instructed to spend no more than five hours in bed. Gradually, the total time in bed can be increased by fifteen to twenty minutes per night every week until the optimum sleep time is reached.[2,8,9,12]

Recommended Screening Questions for Sleep Disorders

1. Does the patient take frequent daytime naps?
2. Is the patient a shift worker?
3. Does the patient snore, gasp or awake with feelings of choking?
4. Is the patient on any medications?
5. Is the patient, or a bed partner, aware of any sudden arm or leg jerk motions during the night?
6. Does the patient complain of chronic daytime fatigue?
7. How many hours of sleep does the patient get every night?
8. Are there established sleep and wake times? [2,7]

Research shows that these non-pharmacological approaches to insomnia consistently produce reliable and, importantly, durable, clinical benefits.[1,2,9,12] In addition, these approaches to treatment have shown to be effective for months following cessation of active therapy.[9,12] This long-term stability associated with behavior therapy may be one of its greatest strengths when compared to more traditional, pharmacological therapies. Since these behavioral therapies are aimed at correcting the underlying dysfunctions leading to sleep problems, their efficacy tends to be greater than that observed when using sleep-inducing agents.

Cost of therapy must always be considered. While the initial cost of behavior therapy approaches tends to be slightly higher than traditional pharmacological treatments, the long-term costs and benefits of behavior therapy tend to be lower. This is due mainly to the fact that once learned, appropriate sleep practices do not need continued intervention by the PCP.[2,9,12]

Compliance also becomes an issue. Few, if any, patients will remain compliant with a long-term pharmacological approach to this problem. On the other hand, proper sleep practices tend to be self-reinforcing, and have few negative side effects.

With acute and chronic insomnia so common in the general population, it is incumbent upon physicians to develop effective screening tools for its early detection. Once detected, the majority of sleep related disorders could be addressed at the primary care level. For those few patients that appear to be suffering from breathing-related insomnia or excessive daytime drowsiness, immediate referral to a sleep specialist is appropriate.[6,10,12] For all of the other patients, behavioral modification should be considered as first line therapy. These tend to be well tolerated, effective, and, in the long run, cost effective.

S/D Chris Hummel is a third year student at Texas College of Osteopathic Medicine.

Karen L. Rainville, D.O., is an attending psychiatrist on the chronic unit at Terrell State Hospital, Terrell, Texas, where she also serves as Director of Clinical Clerkship.

Charles Mathis, M.D., is a geriatric-trained psychiatrist from Southwestern Medical School. He is currently the Medical Director of Admissions at Terrell State Hospital, and has been involved with teaching medical students from UNT and psychiatric residents from Southwestern Medical School.

Bibliography

1. Attarian HP. Helping patients who say they cannot sleep: practical ways to evaluate and treat insomnia. Postgrad Med. 2000;107:127-142.

2. NCSDR Working Group. Insomnia: assessment and management in primary care. Sleep. 1999;22(suppl 2):S402-S408.

3. Ancoli-Israel S, Roth T. Characteristics of insomnia in the United States: results of the 1991 National Sleep Foundation survey. I. Sleep. 1999;22(suppl 2):S347-S353.

4. Simon GE, VonKorff M. Prevalence, burden and treatment of insomnia in primary care patients. Am J Psychiatry. 1997;154:1417-1423.

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5. Zammitt GK, Weiner J, Damato N, Sillup GP, McMillan CA. Quality of life in people with insomnia. Sleep. 1999;22(suppl 2):S379-S385.

6. Rajput V, Bromley S. Chronic insomnia: a practical review. Am Fam Physician. 1999;60:1431-1442.

7. Chesson A, Hartse K, Anderson WM, et al. Practice parameters for the evaluation of chronic insomnia. Sleep. 2000;23:237-241.

8. Rakel RE. Insomnia: concerns of the family physician. J Fam Pract. 1993;36:551-558.

9. Morin CCM, Culbert JP, Schwartz, SM. Nonpharmacological interventions for insomnia: a meta-analysis of treatment efficacy. Am J Psychiatry. 1994;11:1172-1180.

10. Murtagh DDR, Greenwood KM. Identifying effective psychological treatments for insomnia: a meta-analysis. J Consult Clin Psychol. 1995;63:79-89.

11. Verbeek I, Schreuder K, Decleck G. Evaluation of short-term nonpharmacological treatment of insomnia in a clinical setting. J Psychosom Res. 1999;47:369-383.Southwestern Medical School.

You Know You Care About Your Geriatric Patients... But Do They?

by Christopher Dalton, Ph.D.

As healthcare providers, regardless of discipline, we all work to improve the quality of life for our patients. Whether this means a return to a previously high level of functioning or maximizing their current potential, their complete "wellness" is our goal. As a clinical psychologist, my focus, more often than not, is on improving my patients' emotional wellness potential as much as their overall health. One easy way I do this is to show interest in them as people who need emotional attention, as well as clinical and medical attention.

During my career, I have been fortunate to work with an extremely diverse group of clients and patients in a great variety of settings. For example, during my graduate school training and clinical internship at the Austin State Hospital in Austin, Texas, I worked with patients in Acute Care, Extended Care, Geriatrics, and Mentally Retarded and Mentally Ill Units. Despite the diversity of the patient populations, I came to recognize that physical illness appeared to exacerbate their psychiatric symptoms, although an argument could be made that the actual physical illness did not cause the worsening symptoms, but rather it was their attitude or outlook that stimulated those symptoms. However, there were numerous aspects of their care and relationships with their treating physicians which I believe are germane today to the influence of emotional wellness and our patients' response to treatment, regardless of type. Without fail, when I took time to express kindness, sympathy or compassion, beyond what was expected of me professionally, it helped them cope with the realities of their lives. Even if it was only for the moment, they felt better about themselves, making their physical conditions a little more bearable.

Currently, I work primarily in nursing homes where many times a patient's physical illness or condition is a major obstacle to my goals. In this environment, I have become acutely aware of the circular nature of the relationship between physical and emotional wellness. Though this relationship is hardly difficult to notice, I would like to offer some observations and suggestions as to how healthcare givers can improve their patients' overall health by remembering to attend to this phenomenon.

Emotional wellness is typically considered the lack of some of the problems I cite. I find the most common and pervasive emotional problems presented in the nursing home geriatric patients in my caseload are anxiety, depression and sometimes paranoid delusions about caregivers and their motives. These

emanate from internal stimuli, but also external stimuli over which we as providers have some control and influence. Therefore, the following are brief descriptions of several typical scenarios to which I will suggest simple, straightforward strategies that we can all implement in our treatment of these patients. I make the presumption that addressing these "symptoms" will reduce the incumbent distress, and thereby reduce the negative impact on their health.

1. The fear of the unknown, whether it's a psychological or medical problem, greatly affects the elderly. We all deal with patients everyday who tend to believe that whatever changes they experience in their body are "symptoms" of a new disease.

2. False expectations that go unfulfilled, such as immediate response to treatment, rapid medication benefits, relief from pain after a few physical therapy sessions, or even that the problem will quickly pass after a brief time are common. These false expectations set up all healthcare givers for "failure" in the eyes of patients. Adding to the problem are involved family members who, for reasons unique to them, tend to expect the same.

3. Many elderly patients, particularly those in nursing homes, have an excess of time to ponder their lives and may tend to obsess about their illnesses (real or imaged), develop suspicions about the need for "more pills", or question all aspects of their healthcare in general. Much of this is not necessarily their fault, as the milieu in many nursing homes does not provide the frequent distractions of varied activities available to patients in the community.

Primary care physicians will recognize that these scenarios coincide with their experiences with geriatric patients in nursing homes, but may also ask the logical question of what to do about these endemic problems. I would like to offer some simple suggestions, based on my relationship with some of the physicians with whom I collaborate.

First, start or increase informal visits with the patients in your caseload. I know that time is always short, and stopping in to "just say hello" to a patient can be a trap. However, this can be managed through a process of consistently setting limits and boundaries with patients, particularly for these brief contacts. Many nursing home residents tell me that they would just like to "see" their doctor more frequently, if only for a few minutes. They do not expect the equivalent of a formal medical visit, but would accept simply their doctor sticking his or her head into their room, assuring them that their needs are being considered, even if there is not time for discussion. This extra bit of kindness sends a strong message that the patient matters as a real human being. Just "seeing" their doctor in the facility would do wonders for many of my nursing home patients.

Second, provide basic, simple information, and be willing to reinforce it with cognitively challenged patients. Take the time to talk with them using words they can understand and they can easily remember when you leave, providing them with conversations they can share with visiting family members and other caregivers.

Third, consider establishing a system where your patients have a place to leave written questions, concerns or requests that you could collect and review before you see them on your next visit. This lessens the burden on staff, is very empowering of your patients, and further provides an avenue for the involved family members. It also reinforces the feeling that someone "out there" is listening to their concerns.

Emotional wellness and its relationship to physical health is still a relatively new area in the health sciences. There is existing research suggesting the direct relationship between stress and illness, but much less on the relationship between "emotional wellness" and physical health. Using this as a focus of my comments, my hope is that physicians will recognize that there are straightforward, effective ways to address some of the common emotions surrounding treatment of the numerous medical issues of the elderly.

I believe we can all agree that even if emotional wellness does not directly contribute a response to clinical treatment, addressing some of the common reactions of our patients in the ways suggested above will improve our therapeutic relationships with patients, as well as with their families. To that end, helping to reduce the anxiety, stress, and, at times, depression of these patients by showing them that they matter as people, as well as patients, would surely add to their complete wellness and quality of life.

Christopher Dalton, Ph.D., is a licensed clinical psychologist with Senior Connections, Inc., a company that specializes in providing psychological services to geriatric residents in nursing homes throughout Texas. He practices in Austin, Texas.

Don't Sweat the Small Stuff

Often we allow ourselves to get all worked up about things that, upon closer examination, aren't really that big a deal. We focus on little problems and concerns and blow them way out of proportion. A stranger, for example, might cut in front of us in traffic. Rather than let it go, and go on with our day, we convince ourselves that we are justified in our anger. We may play out an imaginary confrontation in our mind. Many of us even tell someone else about the incident later on rather than simply let it go. Why not instead simply allow the driver to have his accident somewhere else? This way, we can maintain our own sense of well-being and avoid taking other people's problems personally.

There are many similar examples that occur every day in our lives. Whether we had to wait in line, tolerate unfair criticism, shoulder the blame for someone else's mistake, or do the lion's share of the work, it pays enormous dividends if we learn not to worry about such "small stuff". So many people spend so much of their life energy "sweating the small stuff" that they completely lose touch with the magic and beauty of life and often create unnecessary physical stress for themselves in the process.

("Chapter 1 – Don't Sweat the Small Stuff", reprinted with permission, Don't Sweat the Small Stuff...and it's all small stuff, *Richard Carlson, Ph.D., 1997)*

Postpartum Major Depression: A Review

by S. Minhas, M.D., K.L. Rainville, D.O. and K. Vogtsberger, M.D.

Postpartum Major Depression (PMD) is a clinical term referring to a major depressive episode that is temporally associated with childbirth. PMD is not recognized by DSM-IV as being diagnostically distinct from MDD, although it does allow the addition of a postpartum onset specifier for women who have onset within four weeks of delivery.[1]

Prevalence [2]

Postpartum blues	30 - 85%
Postpartum depression	10 - 15%
Puerperal psychosis	0.1 - 0.2%

Risk of puerperal relapse at future pregnancies [2]

Postpartum psychosis	70%
Postpartum major depression	50%
Major depressive disorder	30%

Many women experience mild depressive symptoms after a child is born. Symptoms known as "postpartum blues" or "baby blues" typically peak on the fourth or fifth day after delivery and terminate by the tenth postpartum day. Postpartum blues are relatively benign; symptoms are dysphoria, mood lability, irritability, tearfulness, anxiety, and insomnia. Although postpartum blues do not necessarily reflect psychopathology in women, they have an increased risk of postpartum depression later in the postpartum period.[1,2]

Postpartum depression, minor depression, and major depression occur in 10 to 15% of child bearing women. Depression may have an acute onset after delivery, however more commonly develops insidiously over the first six postpartum months. A significant number of women actually experience symptoms during pregnancy. Signs and symptoms including dysphoria, weight loss, irritability, anhedonia, insomnia, fatigue and somatic complaints are common. Postpartum depression increases the risk of alcohol and illicit drug use in teen-age mothers.[1,2]

Co-Morbid Factors

Co-morbid factors associated with postpartum depression include young age, single marital status, poor social support, primiparity, low education level and socioeconomic status. Various obstetric complications, e.g. prolonged labor, cesarean section, and stillbirths, may increase the likelihood of postpartum depression.

Hormonal Factors

In the first 48-hour postpartum period, rapid downward shift of certain hormones including estrogen, progesterone and cortisol occur. There is evidence that depression is associated when the hypothalamic-pituitary-gonadal axis in postpartum depression, is disturbed, however cortisol and thyroxin concentrations also fall during the postpartum period. A small study by Ahokas, Kaukoranta, and Aito of Helsinki demonstrated that estrogen relieves depressive symptoms.[1,2,3]

Diagnosis

Diagnosis of postpartum depression is often missed. It is overlooked or ignored, both by patients and their caregivers. Studies report that less than one third of affected women seek professional help. The first time mothers do not differentiate norms from symptoms of depression. Societal pressure to be a "good mother" thoughts of "going crazy" or being "locked up" and fears of the baby being taken away will prevent access to professional help. Another factor is that women who had no perinatal care do not know whom to turn to. A physician may also contribute to delay in detection of postpartum depression. Another important factor is pressure from managed care to evaluate more patients in a limited time.[1,2]

Screening

The Edinburg postpartum depression scale (EPD) is a ten item, self rated screening instrument. It is a useful test because a threshold score higher than 12 has been 100% sensitive and 95.5% specific in detecting major depression. Providing educational material on postpartum depression to patients will help the patients cope and understand their overwhelming response to postpartum period. Support groups such as Depression after Delivery (800-944-4PPD) and Postpartum Support International (805-967-7636) can either supply or suggest appropriate material. Providing pamphlets, posters and information in highly visible places in offices and postnatal clinics will also educate women.[1,2]

Effects on the Child

In postpartum depression, it is common for a mother to explain concern about inability to care for her child. Ambivalent or negative feelings toward the baby are often reported. There is significant data demonstrating adverse effects on bonding attachments, cognitive, emotional, and social developments of the child. Studies have demonstrated both behavioral and cognitive deficits in three and four year old children of postnatally depressed mothers.[1,3]

Treatment

It is recommended that before starting treatments, medical causes of depression should be excluded, e.g. thyroid dysfunction, anemia, Sheehan syndrome, etc. Another very important factor is the exclusion of alcohol, illicit drugs and prescription medications that could be contributing to a presentation similar to depression.

Psychotherapy

Although studies that have assessed the use of insight oriented psychotherapy and the treatment of postpartum depression have yielded inconsistent findings, more structured types of individual psychotherapy have shown promise. Interpersonal therapy focusing primarily on interpersonal relationships has been adopted to treat postpartum depression. It may be used to address issues such as disruption of a relationship with a spouse and other social support, and the intricacies with infants. A recent study demonstrated that short-term cognitive behavioral therapy was as effective as treatment with fluoxetine in women

with postpartum depression. Six sessions, over a 12-week period, of cognitive behavioral therapy significantly reduced symptoms of depression.[2]

Pharmacological Therapy

Specific Serotonin Reuptake Inhibitors (SSRI's) are ideal first line agents and are generally not sedating. Their effect as anxiolytic is also beneficial in PMD. Several studies have demonstrated efficacy of fluoxetine, sertraline and venlafaxine in treatment of PMD. Anxiety can be treated with short-term use of a benzodiazepine, such as clonazepam or lorazepam. Tricyclic antidepressants are frequently used in PMD associated with insomnia, as they tend to be sedative. The prescribing of tricyclic antidepressants has decreased because of the high potential lethality of an attempted overdose. Counseling should be done to weigh benefits verses risk for side effects because these medications are secreted in breast milk. When the depression is severe, the use of psychopharmacological intervention, etc., is often used as the treatment of choice to hasten rapid improvement. Such cases generally require inpatient hospitalization until the patient has improved sufficiently to function on an outpatient basis. When the illness is refractory to psychopharmacological intervention, ECT is often the treatment of choice to have rapid improvement.[2,4]

In closing, the recognition, education, and treatment of postpartum depression will greatly benefit the patient and her family on multiple levels. The proverb of "An ounce of prevention is worth a pound of cure" definitely applies in postpartum depression.

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References

1 Epperson, CN, Postpartum Major Depression, Detection and Treatment, April 1999. American Family Physician, 59 (8) 2247-54-2259-60

2 Kaplan & Saddock's Comprehensive Textbook of Psychiatry 2000 (7th Edition), Postpartum Psychiatric Syndrome, 1270-1282

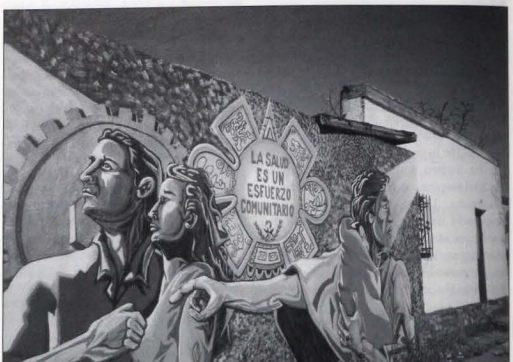
3 Ahokas, A., Kaukoranta, J., & Aito, J. (1999), Effect of Estradiol on Postpartum Depression, Psychopharmacology, 146, 108-110

4 The American Psychiatric Press Textbook of Psychiatry 1992 (3rd Edition), Psychiatric Assessment of Female Patients, 1435

A Foreword to *La Cultura y La Salud: Friends or Foes*

by Patti Pagels, MPAS, PA-C, Assistant Professor
Department of Family Medicine, University of North Texas Health Science Center at Fort Worth

During the period of 1990 – 2030, the Hispanic population is expected to increase by 250% in Texas.[1] By 2010, the border region is projected to have 2.8 million residents with 88.4% of them Hispanic.[2] With these figures in mind, medical education must rise to the challenge of producing not only skilled clinicians, but culturally competent ones as well. It is obvious that the clinician of the future will not be able to ignore diversity in her/his practice. Patients of the future will bring a variety of views on health and healing into the exam room, and future clinicians will need to be prepared to address health beliefs with confidence, knowledge, and tolerance. The challenge is how to prepare students of medicine to become culturally competent practitioners. Several options exist and the two most commonly employed are didactic and experiential. The didactic approach has much to offer in terms of helping students appreciate the role that economics, environment, education, and culture play in the health and quality of life of their patients. I believe the most valuable approach is the experiential one. What is gained by direct exposure to beliefs, customs, and other cultures can never be fully simulated or appreciated in a classroom.



A mural in the Segund Barrio bears the words, "Health is a Community Force," and depicts an ancient Mayan god next to a modern Mexican-American couple looking to the future.

Medical schools of today must provide culturally diverse experiences. Just as we arrange for clinical rotations in primary care and special settings, we must also provide for cultural rotations. Cultural rotations should, according to an article by Adams et al., expose "students to health care in rural and urban multicultural populations, and broaden the understanding and awareness" regarding unique segments of the Texas population such as those living along the U.S. – Mexico border.[3]

Clearly educators are being challenged to incorporate a comprehensive program on cultural diversity into an already full course load. One experience that UNTHSC has provided to students on a voluntary basis over the last five years is a trip to El Paso organized by the Office of Border Health at Texas Tech Health Science Center and sponsored by the Health Education Training Centers Alliance of Texas, West Texas Region. The purpose of the trip is to introduce students to border and rural health issues and to give them an opportunity to experience the border culture first-hand.

In March of this year I had the pleasure of accompanying a self-selected group of students to the border on this aforementioned trip. I was available to offer clinical correlations regarding the sites we visited and the people we met. The clinics we visited, community health workers we met, and the experts on border health issues left a lasting impression. However, I was most impressed by the depth of understanding on the part of the students regarding the role that culture and belief play in the delivery of health care. After only three days they gained respect for the difficulties that patients from other cultures encounter to reach their exam room. Before the trip students thought it was primarily a language or an economic barrier that kept patients from accessing care. Following the trip, it was clear to me, that they understood it was far more complex than language or economics alone.

I believe a third-year medical student from our institution expressed it best in a summary of his experiences in the border region entitled "La Cultura y La Salud: Friends or Foes". After reading his paper I was even more convinced that immersion into other communities is an essential tool for training culturally competent clinicians. Contact with persons and areas with differing world views will also enhance the principles of osteopathic medicine where patient care involves the patient, their family, and the community in which they reside.

The following is student Andrew McAdoo's impression of his border experience. It embodies the essence of what community encounters can offer Texas medical students and faculty alike for whom cultural competency is imperative.

References:

1. Texas Statewide Health Coordinating Council (1998). Texas State Health Plan: 1999-2004: Ensuring a quality health care workforce for Texas.
2. University of Texas System Border Health Coordination Office (Oct 1998). Texas-Mexico Border Counties 1998 Demographics and Health Statistics: TMB-HCO Series Report 98-99.
3. Adams B, Coggin C, Hastings R, Migala H, Marshall M. The borders without boundaries project: Introducing health professions students to border health concerns and practices. Texas Journal of Rural Health, *Jan 2000,18(1): 44-51.*

La Cultura y La Salud: Friends or Foes?

A Medical Student's Experience on the Texas-Mexico Border

by Andrew McAdoo, Medical Student, Year III
University of North Texas Health Science Center at Fort Worth, TCOM

When I learned of the opportunity to visit the U.S.-Mexico border, I knew I wanted to be involved. Having traveled to the border before, I had encountered a region that shares more qualities with a bus station than with a sovereign nation. The border, I knew, is an area of constant flux. The somewhat fragmented identity of the region is the result of a high-speed collision of cultures and peoples. What I did not know prior to this trip is the extent to which health care is a casualty of this collision.

Hepatitis A, shigellosis, dysentery, cholera, and tuberculosis occur at much higher rates on the border than in Texas as a whole.[1] Health care in the border region suffers for many reasons, including a relative lack of providers, poverty and the resultant lack of transportation for many, and lack of health insurance. However, I would argue that the greatest contribution to lack of adequate health care along the border stems from differing perceptions of the definition of health care. Recent immigrants to the border, it appears, have a very different view of health care than most Americans. The dilemma now is how to reconcile the attitudes of recent immigrants with the current American health care delivery system. Until fairly recently, this situation has received only passing interest by the federal government. The result of this has been a public health care nightmare in our border region.

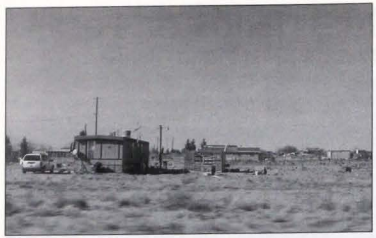
At first glance, economics may seem to be the major obstacle to providing adequate health care to the citizens of the border region. We observed first-hand the role that economics play in determining the accessibility of health care in the border region, especially those among the 280,000 who live in the colonias.[2] Colonias are neighborhoods in which there is often no running water or electricity. The plots of land are "sold" to hopeful residents, who make monthly payments on the land, but are without a title until the last payment is made. If a payment is missed, the landowners reserve the right to foreclose on the land. Houses are constructed piecemeal, as residents purchase building materials at every opportunity. The appearance of these houses attests to the conditions of their construction, as they are the architectural equivalent of a patchwork quilt, with each room often being constructed from a different material.

At Guadalupa Clinica, we saw a dramatic illustration of the water supply problem in the colonias. The Catholic Charity Clinic is located at the end of the water line, and beyond it lie many houses without running water. The clinic is one example of how many in the region have struggled to make health care available. The clinic provides health care to its patients on a sliding scale basis, and many cannot pay for their care. This represents a substantial portion of their patients, as one-third of the two million people who live in the border region are below the poverty line, have no health insurance and are not covered by Medicare or Medicaid.[2]

A culturally translated food pyramid at Centro de Salud Familial La Fe. From left to right: Jacquelin Dewbre, Santiago Gonzalez, Hoang Nguyen, Melissa Koehler, P.A., Patty Pagels, Andrew McAdoo, Barbara Adams, Cindy Wilson, Lien Lam, Patricia Meyer, Christine Widjaja, George Salazar

The substandard conditions in the region undoubtedly lead to higher rates of infectious disease and contribute to the general public health quagmire; however, I believe the main issue to be confronted is that of cultural difference. We heard from many people involved with health care in El Paso and the surrounding areas how residents of the colonias may harbor distrust of Western medicine, preferring instead to seek health care from curanderos and medicines from herberias as this is more consistent with traditional Mexican medicine, and culture. A curandero is a folk healer who deals in magical spells and herbal remedies, while an herberia sells the herbal treatments prescribed.

Promotoras are people who have assumed the role of bilingual liaisons working with communities and the health care



A colonia in Chapparal, New Mexico.

A Mexican herberia where medicinal herbs and treatments can be obtained.

providers. Their role in the improvement of health care on the border is crucial. One of the promotoras we met told us that they are not always well-liked because they are seen as radicals. Indeed, the promotoras are challenging the traditions of generations by promoting modern health care in the border region. Methods of health care integral to Mexican culture are radically different from those of modern Western medicine, and cultural differences pose a formidable barrier to adequate health care in the border region.

George Salazar, an associate director of Centro de Salud Familial La Fe in El Paso, told us how machismo is a cultural force preventing many residents of the border region from accessing health care. Many recent male immigrants on the border may hold the notion that to need health care is to show weakness and therefore is not affirmative of their masculine role in the family and in society. Some Mexican-American men, acting on this belief, may delay going to the doctor, even as their health deteriorates.

Language is a further barrier to health care in the border region, as there are a limited number of Spanish speaking doctors in the area. Lastly, lack of knowledge of the dynamics of modern health care prevents some residents of the border area from accessing health care. Many have never been to the doctor before, but have instead visited a curandero. Participating in modern, American health care, then, is a daunting experience. The typical resident of the border colonias, having no experience with modern medicine, is not familiar with the role of the patient. Things that we all take for granted, like sticking your tongue out to say, "Ahh" for the doctor, are uncharted territory to many residents of the border area.

Taking all of this into one view, it becomes quite easy to see why many residents of the colonias may not access modern health care altogether. Nevertheless, health care is more urgent in this area because of the high rates of infectious disease and serious environmental health hazards.

How can we break the chain of prejudice and misinformation? It has proven difficult largely because the acceptance of modern health care, to many of the residents of the colonias, equates to a loss of their culture. By adopting the health care delivery system of the United States, colonias residents are, in fact, rejecting the health care delivery system of their own culture, one that has persisted for generations in their families. The solution, therefore, must somehow change this equation between acceptance of modern health care and loss of culture. Education is the key. Many of the people in the El Paso border region are approaching the problem of border health from this perspective.

At Centro de Salud Familial La Fe, George Salazar and others have found a way to use educational tools to work towards improving health care in the border region. There is an educational facility on site, and they are using some creative methods of gaining an audience. In one case, guitar lessons were advertised at the clinic. Children who arrived were given lessons; however, every third lesson, they learned about health issues, such as healthy diet or avoiding drugs. These same individuals at La Fe Clinic have used dance by incorporating health issues into the dances. This serves a double purpose. First, the children can connect with cultural ideals as they are educated about health issues, thus bridging the gap between health and culture. Second, the parents are involved, so that they may have less resistance to the changes involved with transforming cultural attitudes toward health.

The people of La Fe Clinic have also developed the "Loteria de Salud," or "Health Lottery." The "Loteria de Salud" is an educational tool based on a traditional Mexican game. Many of the images in the game lend themselves conveniently to health education. One, for example, pictures a drunken man, so when this card is called, the families can learn about substance abuse. Another card is a watermelon; this presents an opportunity to learn about proper nutrition. The beauty of this concept is that it teaches modern health care within the framework of a traditional Mexican custom, so that they are not presented in opposition. This represents the essence of what must be done in the border to secure adequate health care for the residents of the colonias.

As a medical student with a year of clinical experience behind me, the lessons I learned on this trip have been applied many times in my dealings with patients. In the most telling example, an elderly Mexican-American couple, both of whom had Type II Diabetes Mellitus and hypertension, came in to the

clinic with their daughter. Their daughter, a second generation American citizen, was concerned about their general health state. They had both been prescribed multiple medications, but had not been taking them regularly. In my interaction with the couple and their daughter, it was necessary to impress upon the elderly couple the importance of taking their medications for continued health. Luckily, their daughter was present to reinforce what I told them. The daughter's attitude is a representation of the change in health care access that comes with cultural literacy. Being born in the United States, she has a familiarity and relationship with modern health care that her parents still do not possess. She was reaching out to her parents with concern for their health. As health care providers, we must also be able to reach out. We must also possess cultural literacy in order to provide health care to all who enter our doors.

Acknowledgements

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References:

1. Health Resources and Services Administration. (1992). U.S.-Mexico Health Issues. Rockville, MD.
2. Texas Statewide Health Coordinating Council. (1995). Texas State Health Plan 1995-1996.

In Memoriam

Sherman P. Sparks, D.O.

Dr. Sherman Sparks of Rockwall, passed away on May 6, 2001. He was 92. Funeral services were held May 9 at Rest Haven Funeral Home – Rockwall Chapel.

Dr. Sparks was born in 1909 in Toledo, Illinois, to Dr. Nancy Jane Sparks and Dr. Earnest Sparks. Following graduation from high school in Illinois, he completed his B.S. and M.S. at the University of Illinois. Dr. Sparks taught chemistry at Kincard, Illinois, for 10 years before entering medical school at Kirksville College of Osteopathic Medicine. He earned his D.O. degree in 1945 and interned at Sparks Hospital, Dallas. He then relocated to Rockwall, where he was a family practitioner for 50 years.

Board certified in family practice, Dr. Sparks was a member of the American Osteopathic Association and a life member of TOMA. He served as City and County Health officer, as president of the PTA and Rotary Club, and was past Chairman of the Rockwall Centennial Association in 1954. Dr. Sparks also served as a volunteer at the Rockwall Detention Center for 30 years and was the Team Physician of the Rockwall Yellow Jackets for 30 years. He was a member of the First Methodist Church in Rockwall.

He was raised a Master Mason 55 years ago in Kirksville, Missouri, and transferred his membership to the Blue Lodge in Rockwall (East Trinity 157). He was also a member of the Dallas Scottish Rite as well as the Hella Shrine in Rowlett. Dr. Sparks took great pride in pioneering the Republican Party in Rockwall with the primaries being held at his office for the eight or nine registered voters.

Dr. Sparks was an avid pilot, and along with two other pilots, E.K. Slaughter and Nick Nichols, started the Rockwall Municipal Airport, currently the Ralph M. Hall Airport.

Survivors include four sons, Dr. Robert D. Sparks and wife, Tana, Dr. Randy P. Sparks and wife, Linda, James Sparks and wife, Ginger, and David P. Sparks and wife, Shawn; grandchildren, James, Scott, Randi, Robert, Marc, Leigha, Terra, Billy, Elizabeth, Robert, Catherine, Mary Jo, Amy Lou, and Amelia Sparks; numerous great grandchildren; and a host of loving friends.

Memorial contributions may be made to the Texas Scottish Rite Hospital for Children, 2222 Welborn Street, Dallas, TX 75219.

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06/01

TOMA Welcomes New Members

The Board of Trustees of the Texas Osteopathic Medical Association is pleased to introduce the following new members who were formally accepted at the May 11, 2001 Board of Trustees meeting

David N. Barrera, D.O.
6100 Harris Pkwy, #290
Fort Worth, TX 76132
Dr. Barrera is a member of District 2. He graduated from the Texas College of Osteopathic Medicine in 1993, and is Certified in Internal Medicine. His current practice specialties are Medical Oncology, Hematology, and Internal Medicine.

Archie R. Barrett, D.O.
702 North Davis Street
Carthage, TX 75633
Dr. Barrett is a member of District 3. He graduated from the Oklahoma State University/College of Osteopathic Medicine in 1978, and is Certified in Obstetrics and Gynecology.

David A. Brickey, D.O.
855 Montgomery
Fort Worth, TX 76107
Dr. Brickey is a member of District 2. He graduated from the Texas College of Osteopathic Medicine in 1993, and is Certified in Internal Medicine. His current practice specialties are Pulmonary and Critical Care.

Peter A. Curka, D.O.
2820 University
Houston, TX 77005
Dr. Curka is a member of District 6. He graduated from the University of New England College of Osteopathic Medicine, Biddeford, Maine, in 1983, and is Certified in Emergency Medicine.

Lon A. Fry, D.O.
Brooke Army Medical Center
3851 Roger Brooke Drive
Fort Sam Houston, TX 78234-6200
Dr. Fry is a First Year Member and a member of District 17. He graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1995, and specializes in Pediatric Anesthesiology.

Timothy R. Goshen, D.O.
1800 University Blvd
Durant, OK 74702
Dr. Goshen is a Non-Resident Associate Member. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1981, and is Certified in Proctology. His current practice specialties are Proctology and Emergency Medicine.

Floyd A. Hennan, D.O.
707 South Main
Quanah, TX 79252
Dr. Hennan is a member of District 16. He graduated from the Kirksville College of Osteopathic Medicine, Kirksville, Missouri, in 1991, and specializes in Family Practice.

Cindy I. Hutson, D.O.
3201 W. Peoria Avenue, #C-500
Phoenix, AZ 85029
Dr. Hutson is a Non-Resident Associate Member. She graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1996, and specializes in Family Practice.

Deanah A. Jibril, D.O.
3212 St. Georges Drive
Plano, TX 75093
Dr. Jibril is a member of District 5. She graduated from the Chicago College of Osteopathic Medicine of Midwestern University in 1993, and is Certified in Obstetrics and Gynecology.

Donald R. Klinger, D.O.
506 Eaker
Eden, TX 76837
Dr. Klinger is a First Year Member and a member of District 4. He graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1997, and specializes in Family Practice.

Don A. Lawrence, D.O.
2320 Carswell
Lackland AFB, TX 78236
Dr. Lawrence is a Military Member and a member of District 17. He graduated from Kirksville College of Osteopathic Medicine, Kirksville, Missouri, in 1977, and is Certified in Family Practice.

Larry L. Lewellyn, D.O.
4007 James Casey, #A150
Austin, TX 78745
Dr. Lewellyn is a member of District 7. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1978, and is Certified in Pediatrics.

R. Sam Lingamfelter, D.O.
14903 El Camino Real
Houston, TX 77062
Dr. Lingamfelter is a First Year Member and a member of District 6. He graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1997, and is Certified in Family Practice.

Bruce G. Martin, D.O.
7711 Louis Pasteur, #901/905
San Antonio, TX 78229
Dr. Martin is a member of District 17. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1977, and is Certified in Allergy and Immunology.

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R. Carrington Mason, D.O.
221 West Colorado
Dallas, TX 75208
Dr. Mason is a member of District 5. He graduated from the Texas College of Osteopathic Medicine in 1970, and is Certified in Urology.

Gregory V. McIntosh, D.O.
401 East Crockett, #B
Cleveland, TX 77327
Dr. McIntosh is a member of District 12. He graduated from the Michigan State University College of Osteopathic Medicine in 1992, and is Certified in Urology.

John J. Meehan, D.O.
John Peter Smith Hospital
1500 South Main
Fort Worth, TX 76104
Dr. Meehan is a member of District 2. He graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1976, and is Certified in Diagnostic Radiology.

Chau N. Pham, D.O.
855 Montgomery
Fort Worth, TX 76109
Dr. Pham is a First Year Member and a member of District 2. He graduated from the Ohio University College of Osteopathic Medicine in 1995, and is Certified in Family Practice. His current practice specialties are Geriatrics and Osteopathic Manipulative Medicine.

Tony T. Pham, D.O.
1445 Gentry Place Road, #216
Grand Prairie, TX 75050
Dr. Pham is a First Year Member and a member of District 15. He graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1997, and specializes in Family Practice.

Thanh Ho Slavek, D.O.
1810 Worel Street
West Plains, MO 65774
Dr. Slavek is a Non-Resident Associate Member. She graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1994, and is Certified in Family Practice.

Randall L. Sloan, D.O.
229 Edgewood
San Angelo, TX 76903
Dr. Sloan is a member of District 4. He graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1981, and specializes in Family Practice and Emergency Medicine.

Alan D. Smith, D.O.
4002 South Loop 256, #H
Palestine, TX 75801
Dr. Smith is a member of District 3. He graduated from the Texas College of Osteopathic Medicine in 1982, and specializes in Family Practice.

Ronald D. Tanner, D.O.
2929 South Hampton Road
Dallas, TX 75224
Dr. Tanner is a member of District 5 where he serves as District Secretary and as a Delegate to the TOMA House of Delegates. He graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1979, and is Certified in Family Practice.

Beverly L. Waddleton, D.O.
P.O. Box 996
Quitman, TX 75783
Dr. Waddleton is a member of District 3. She graduated from the Texas College of Osteopathic Medicine in 1981, and specializes in Family Practice.

Kevin A. Weeks, D.O.
Brooke Army Medical Center
3851 Roger Brooke Drive
Fort Sam Houston, TX 78234
Dr. Weeks is an Associate Military Member and a member of District 17. He graduated from the College of Osteopathic Medicine of the Pacific, Pomona, California, in 1990, and is Certified in Internal Medicine. His current practice specialty is Hematology/Oncology.

Allen C. Williamson, Jr., D.O.
Clinical Director, Residency Program
Doctor's Hospital
5502 39th Street, #103
Groves, TX 77619
Dr. Williamson is a member of District 12 where he serves as District President and as a Delegate to the TOMA House of Delegates. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1995, and is Certified in Family Practice. His current practice specialty is Family Practice Education.

S. Alireza Zarabadi, D.O.
8811 Rodeo Drive, #116
Irving, TX 75063
Dr. Zarabadi is a First Year Member and a member of District 5. He graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1997, and is Certified in Internal Medicine.

Electronic Data Systems
National Heritage Insurance Company
Kim Laney-Gonzalez
1500-B West San Antonio Street
Lockhart, TX 78644
EDS-NHIC joins TOMA as an Affiliate Member.

Welcome New Intern and Resident TOMA Members

John Vu Anh Cao, D.O. graduated from Oklahoma State University/College of Osteopathic Medicine in 1997, and is serving a Residency in Anesthesiology at Baylor College of Medicine in Houston.

Carl G. Chakmakjian, D.O. graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 2000, and is serving an Internship/Residency in Internal Medicine at Scott & White Memorial Hospital in Temple.

Jeffrey R. Counts, D.O. graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1999, and is serving a Residency in Orthopedic Surgery at the Osteopathic Medical Center of Texas in Fort Worth.

Daniel L. Francis, D.O. graduated from the Philadelphia College of Osteopathic Medicine in 1998, and is serving a Residency in Family Medicine at Christiana Care Health System, Wilmington, Delaware.

Don R. Gladden, D.O. graduated from Kirksville College of Osteopathic Medicine, Kirksville, Missouri, in 2000, and is serving an Internship/Residency in Emergency Medicine at Darnall Army Community Hospital, Fort Hood, Texas.

Marshall T. Hayes, D.O. graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 2000, and is serving an Internship/Residency in Internal Medicine and Psychiatry at the University of Cincinnati Hospital.

Marian K. Hendricks, D.O. graduated from Kirksville College of Osteopathic Medicine, Kirksville, Missouri, in 2000, and is serving an Internship at Bay Area Medical Center in Corpus Christi.

Paul W. Krantz, D.O. graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 2000, and is serving an Internship/Residency in Emergency Medicine at Darnall Army Community Hospital, Fort Hood, Texas.

Jacqueline N. Le, D.O. graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 2000, and is serving an Internship at Osteopathic Medical Center of Texas in Fort Worth.

Mark A. Levstik, D.O. graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 2000, and is serving an Internship at Bay Area Medical Center in Corpus Christi.

Dena J. Lichfield, D.O. graduated from Midwestern University Arizona College of Osteopathic Medicine in 2000, and is serving an Internship/Residency in Family Practice at University of Texas Medical Branch, Conroe Residency Program.

Randle L. Likes, D.O. graduated from the University of New England College of Osteopathic Medicine, Biddeford, Maine, in 1999, and is serving a Residency in Emergency Medicine at Darnall Army Community Hospital, Fort Hood, Texas.

Robert S. Michaelson, D.O. graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1984, and is serving a Residency at the United States Air Force School of Aerospace Medicine, Brooks Air Force Base, Texas.

Russell M. Peckham, D.O. graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 2000, and is serving an Internship at Brooke Army Medical Center, Fort Sam Houston, Texas.

Julia A. Pewitt, D.O. graduated from Midwestern University Arizona College of Osteopathic Medicine in 2000, and is serving an Internship at Osteopathic Medical Center of Texas in Fort Worth.

Alejandro Rocha, D.O. graduated from the University of North Texas Health Science Center Texas College of Osteopathic Medicine in 1998, and is serving a Residency in Family Medicine at Thomason General Hospital in El Paso.

John A. Sanchez, D.O. graduated from the Chicago College of Osteopathic Medicine of Midwestern University in 1999, and is serving a Residency in Family Medicine at Dallas Southwest Medical Center.

Priscilla E. Sierk, D.O. graduated from Western University of Health Sciences, Pomona, California, in 1999, and is serving a Residency in Psychiatry at the Austin State Hospital.

George R. Simons, Jr., D.O. graduated from the West Virginia School of Osteopathic Medicine, Lewisburg, West Virginia, in 1997, and is serving a Residency in Emergency Medicine at Grandview Hospital, Dayton, Ohio.

Mark L. Spencer, D.O. graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1998, and is serving a Residency in Internal Medicine at Scott & White Memorial Hospital in Temple.

Scott R. Stoughton, D.O. graduated from Western University of Health Sciences, Pomona, California, in 1999, and is serving a Residency in Emergency Medicine at Scott & White Memorial Hospital in Temple.

TOMA 56th Annual House of Delegates Meeting
May 12, 2001 • Austin, Texas

Major Actions of the TOMA House of Delegates

MOTION: That life membership in TOMA be approved for Wayne R. English, Jr., D.O., of Burleson; E. Hugh Heck, D.O., of Tyler; George L. Kelso, D.O., of Arlington; Claude H. Lewis, D.O., of Ingleside; Aaron R. Mason, D.O., of Boerne; Robert L. Peters, Jr., D.O., of Round Rock; Jack W. Rice, D.O., of Lindale; and Lawrence A. Willis, D.O., of Fort Worth.
APPROVED

RESOLUTION NO. 1, PERTAINING TO TOMA DUES: The House of Delegates supports a twenty-five percent (25%) across the board increase in dues for all dues-paying TOMA members.
APPROVED

RESOLUTION NO. 2, PERTAINING TO MANAGED CARE ADMINISTRATIVE ISSUES: The House of Delegates goes on record approving the following policies: 1) seek a prohibition on "tied products;" 2) oppose the mandated use of hospitalists by managed care organizations; 3) call for increased penalties for failure to comply with prompt pay legislation; 4) support legislation that provides a statutory definition of "medical necessity;" and, 5) support legislation that states the physician determines what prescription medication is appropriate for the patient – not a formulary that is based on cost only.
APPROVED

RESOLUTION NO. 3, PERTAINING TO PATIENT PROTECTION IN MANAGED CARE PLANS: The House of Delegates supports adequate safeguards for medical and other records that contain confidential, often highly sensitive patient information that can be used to exclude patients with certain illnesses from obtaining coverage or to give health plan data that can be used to restrict drug formularies or allow direct marketing of pharmaceuticals to patients; and further resolves to work to prohibit health plans from requiring prior authorization to call 911.
APPROVED

RESOLUTION NO. 4, PERTAINING TO TOBACCO SETTLEMENT FUNDS: The House of Delegates supports the proposition that the next biennium's tobacco dollars should be placed in permanent funds allocated to health care and not be diverted to meet other state fiscal needs.
APPROVED

RESOLUTION NO. 5, PERTAINING TO SCOPE OF PRACTICE: The House of Delegates opposes expanding the scope of practice of non-physician clinicians without the benefit of an osteopathic or allopathic degree, including but not limited to: 1) Chiropractors seeking prescriptive authority, hospital privileges and ability to perform invasive diagnostic procedures; 2) Acupuncturists seeking independent practice and prescriptive authority; 3) Lay midwives seeking licensure; 4) Medical laboratory technologists seeking licensure and requesting authority to supervise pathology labs; 5) Physical therapists seeking direct access to patients without physician referral; 6) Physical therapists seeking to perform spinal manipulation; 7) Naturopathic practitioners seeking designation as physicians and separate licensure status; and 8) Psychologists seeking prescriptive authority.
APPROVED AS AMENDED

RESOLUTION NO. 6, PERTAINING TO DISEASE MANAGEMENT: The House of Delegates goes on record in support of a Medicaid pilot program, focusing on one chronic illness, to be developed in Texas; and further supports a leadership role for TOMA in the development of any disease management program for Medicaid.
APPROVED

RESOLUTION NO. 7, PERTAINING TO TAXES: The House of Delegates does not support placing a tax on health care services.
APPROVED

RESOLUTION NO. 8, PERTAINING TO CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP): The House of Delegates goes on record supporting CHIP; and further resolves to call upon the TOMA Executive Director to exercise vigilance in ensuring that appropriate medical services, including osteopathic manipulative treatment, are available to CHIP-eligible children.
APPROVED

RESOLUTION NO. 9, PERTAINNG TO UNEQUAL MEDICAID AND CHIP REIMBURSEMENT: The House of Delegates calls upon the Texas Legislature to change the current Medicaid and CHIP reimbursement policy so that all physicians will receive equal reimbursement for services rendered, regardless of their geographic location in Texas.
APPROVED

RESOLUTION NO. 10, PERTAINING TO MEDICAL MALPRACTICE LIABILITY REFORM: The House of Delegates supports tort reform by the Legislature that would include the following: 1) limiting the amount on non-economic damages that can be awarded; 2) imposing a more reasonable time limit on when a minor can bring an action; 3) greater enforcement of the cost bond and expert report requirements; 4) greater enforcement of the frivolous suits provision; 5) giving full credit for a settling defendant; and 6) imposing a sliding scale on lawyer contingency fees.
APPROVED

RESOLUTION NO. 11, PERTAINNG TO LEGISLATIVE OVERSIGHT OF THE TEXAS WORKERS' COMPENSATION SYSTEM: The House of Delegates goes on record requesting that the Texas Legislature hold well-publicized, public meetings so that the injured workers of Texas will have the opportunity to have their problems and concerns heard by the

Texas Legislature, which has the power to consider beneficial changes to the Workers' Compensation System, the TWCC oversight process, and insurance company regulations.
APPROVED

RESOLUTION NO. 12, PERTAINING TO SCREENING PROPOSED FOR ACUTE HIV INFECTION:
DISAPPROVED

RESOLUTION NO. 13, PERTAINING TO DENIAL OF OMT REIMBURSEMENT TO D.O.s IN TARRANT COUNTY UNDER TEXAS MEDICAID MANAGED CARE: The House of Delegates goes on record supporting the use of all appropriate corrective actions, including legal remedies such as "recoupment," to allow osteopathic physicians in Tarrant County to be reimbursed for OMT performed on Medicaid patients under the capitation model of managed care.
APPROVED

RESOLUTION NO. 14, PERTAINING TO MEDICATION FOR NEEDY ELDERLY PATIENTS: The House of Delegates goes on record supporting that the U.S. Congress approve a form of indemnification protection for those pharmaceutical companies that donate near-expired maintenance medication to volunteer distribution centers for distribution to elderly patients on the basis of financial need; and further resolves to forward this resolution to the AOA House of Delegates for its consideration and adoption.
APPROVED

RESOLUTION NO. 15, PERTAINING TO PROPER LABELING OF MEDICATIONS:
DISAPPROVED

RESOLUTION NO. 16, PERTAINING TO MEDICAL INSURANCE COVERAGE FOR SURGERY IN CASES OF CHRONIC GINGIVITIS: The House of Delegates supports insurance coverage that includes surgical treatment of chronic gingivitis; and further resolves to forward this resolution to the AOA House of Delegates for its consideration and adoption.
APPROVED

RESOLUTION NO. 17, PERTAINING TO ASSISTANCE FOR DOCTOR'S HOSPITAL: The House of Delegates encourages TCOM to provide assistance to Doctor's Hospital in Groves to help maintain the continued teaching of TCOM students and graduates.
APPROVED

RESOLUTION NO. 18, PERTAINING TO A PERMANENT PLAQUE FOR MEMBERS OF TOMA'S HOUSE OF DELEGATES WITH 20 YEARS OR MORE OF SERVICE:
REFERRED TO EXECUTIVE COMMITTEE TO REPORT AT HOUSE OF DELEGATES MEETING IN 2002

RESOLUTION NO. 19, PERTAINING TO ON SITE LAB WORK: The House of Delegates recommends that legislation be enacted that requires managed care companies to pay for appropriate on site testing at a rate equal to the contracted rate paid for the same service to off site providers.
APPROVED

RESOLUTION NO. 20, PERTAINING TO PROPOSED OVERHAUL OF TEXAS WORKERS' COMPENSATION PROGRAM:
DISAPPROVED

RESOLUTION NO. 21, PERTAINING TO RESTRUCTURING OF INITIAL TREATING PHYSICIAN UNDER TEXAS WORKERS' COMPENSATION PROGRAM: The House of Delegates goes on record as opposing proposed legislation, regulations, or rules which would restrict patient access to their choice of physician, when they suffer a work related injury.
APPROVED

RESOLUTION NO. 22, PERTAINING TO EMERGENCY AND AFTER HOURS CARE:
DISAPPROVED

RESOLUTION NO. 23, PERTAINING TO LACK OF MEDICARE COVERAGE FOR DIABETES AND LIPID SCREENING: The House of Delegates supports dialog with HCFA and Congress to cover screening blood sugars and lipid profiles in order to prevent complications of these diseases; and further resolves to forward this resolution to the AOA House of Delegates for its consideration and adoption.
APPROVED

RESOLUTION NO. 24, PERTAINING TO TOMA DISTRICT 15 SERVING AS THE HOST DISTRICT FOR THE 2001 TOMA CONVENTION: The House of Delegates goes on record expressing sincere appreciation to TOMA District 15 for serving as the host district for the 2001 TOMA annual convention.
APPROVED

RESOLUTION NO. 25, PERTAINING TO ESTABLISHMENT OF TCOM MSGA'S TOMA RELATIONS COMMITTEE: The House of Delegates resolves to renews its pledge to build a strong student presence within its organization by increasing the number of student related activities and member presence on campus; and TOMA recommends to the TCOM MSGA that their bylaws be re-written to provide for the election of two students from each medical school class to serve as TCOM/TOMA Relations Committee officers; and that the suggested changes to the MSGA bylaws include the provision that the MSGA TOMA Relations Committee be composed of the eight elected TCOM/TOMA Relations Committee officers; and that this committee be charged with the promotion of active membership in the TOMA and the organization of TOMA activities for the students of the TCOM; and that the MSGA's TOMA Relations Committee be co-chaired by the MSGA President and one of the eight elected representatives, to be selected by that committee; and that the suggested changes to the MSGA bylaws give the responsibility of alternate delegate to the TOMA House of Delegates and alternate student member of the TOMA Board of Trustees to the elected co-chair of the MSGA/TOMA Relations Committee.
SUBSTITUTE RESOLUTION APPROVED

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RESOLUTION NO. 26, PERTAINING TO OSTEOPATHIC PHYSICIANS WHO HAVE COMPLETED TERMS ON THE TEXAS MEDICAL FOUNDATION'S BOARD OF TRUSTEES: The House of Delegates publicly expresses appreciation to those osteopathic physicians who have served terms on the TMF's Board of Trustees, for their many years of dedicated service to the Texas osteopathic profession and TMF.
APPROVED

RESOLUTION NO. 27, PERTAINING TO STREAMLINING DUAL ACCREDITATION OF OSTEOPATHIC AND ACGME INTERNSHIPS AND RESIDENCIES: The House of Delegates supports efforts to streamline the accreditation process and the administrative and financial roadblocks to AOA approval of internship and residency programs, whether new or within existing ACGME approved programs; and further resolves to forward this resolution to the AOA House of Delegates for its consideration and adoption.
APPROVED

Other Action Taken by the House

Sunset Review of Resolutions Passed by the 1996 TOMA House of Delegates and Completed Resolutions

Number	Title	Action
	DELETE	
96-01	Gag Clause	Action Accomplished
96-05	Exclusive Contracts	Action Accomplished
96-09	AOA Approved CME at the Local Level	Action Accomplished
96-15	Osteopathic Licensure in Texas	Action Accomplished
00-11	Host District	Action Accomplished
00-02	A.T. Still, M.D.	Action Accomplished
	REAFFIRM	
96-04	Patient Directive and Durable Power of Attorney	Will be introduced in the 76th Legislature (1999)
96-06	Texas-Mexico Pharmaceutical Drug Trade	Active and Ongoing
96-08	Opposition to Independent Practice of Medicine by Physician Extenders	TOMA has worked to prevent additions to allied health providers' scope of practice laws. All PAs and ANP's must work under the written protocol and supervsion of a licensed Texas physician.
96-10	Ban on Capitation Reimbursement Systems	Active and Ongoing
96-11	Consumer Choice in Health Care	Federal and state legislation has passed to allow MSAs
96-13	Selection Process for New Osteopathic Medical Student for the University of North Texas Health Science Center, Texas College of Osteopathic Medicine	Active and Ongoing
96-14	Medicaid Managed Care	The Department of Health & Human Services Board of Directors has endorsed the policy of offering both models in all future programs
96-16	Convention Sites	TOMA is scheduling the Annual Convention in the Metoplex in odd years
99-01	American Osteopathic Association Convention Transportation	AOA House of Delegates rejected the TOMA resolution
99-08	Osteopathic Postdoctoral Training Program Information	AOA House of Delegates approved this resolution with amendments

Revised Resolutions

underlined denotes new language **[denotes deleted language]**

96-02 YELLOW PAGES LISTING

WHEREAS, Texas osteopathic physicians are very concerned about where and how they are listed in the yellow pages of telephone books, and

WHEREAS, Texas osteopathic physicians feel that inaccuracies in yellow pages listings can have a negative impact on their individual medical practices, therefore

BE IT RESOLVED, that the TOMA House of Delegates goes on record supporting the listing of D.O.'s and M.D.'s names and/or clinics in alphabetical order in Texas yellow pages under a single heading, "Physicians and Surgeons - D.O./M.D." and under the medical specialty guide listing.

[BE IT FURTHER RESOLVED, that the TOMA House of Delegates forward this resolution to the AOA House of Delegates for its consideration and adoption.]

96-03 OMT BEING GROUPED WITH NON-PHYSICIANS FOR REIMBURSEMENT

WHEREAS, Texas osteopathic physicians expected to be reimbursed for osteopathic manipulative treatments (OMT) in addition to any other physical medicine modalities provided to their patients, and

WHEREAS, Texas osteopathic physicians also expect to be reimbursed for OMT along with the office visit when a separate identifiable problem is identified, and

WHEREAS, many insurers are lumping together the office visit, OMT, and physical medicine modalities under global codes for reimbursement purposes, and

WHEREAS, under these global code fees, the sum of the whole is less than the sum of the individual components included in the global fees, and

WHEREAS, many insurers are placing OMT under the broad heading of manipulation and placing OMT administered by an osteopathic physician together with non-physician administered manipulations, therefore

BE IT RESOLVED, that the TOMA House of Delegates goes on record opposing the bundling of OMT with office visits, physical medicine modalities, or any other procedure for reimbursement purposes, and

[BE IT FURTHER RESOLVED, that the TOMA House of Delegates forward this resolution to the AOA House of Delegates for its consideration and adoption.]

96-07 MODIFICATION OF HEALTH CARE FORMS WITH PHYSICIAN SIGNATURE BLOCK ENDING WITH SUFFIX M.D./D.O.

WHEREAS, Texas osteopathic physicians are proud of their unique heritage and the fact that they are fully licensed Texas physicians, and

WHEREAS, most medical forms, including those from home health care and some state agencies, require a physician's signature, and

WHEREAS, many of these medical forms have only one preprinted signature block identifying the signer as an M.D., and

WHEREAS, the Texas Medical Practice Act and the Texas Healing Identification Act legally requires osteopathic physicians to identify themselves using the D.O. degree, and

WHEREAS, Texas D.O.'s dislike the practice of crossing out M.D. on preprinted medical forms prior to signing them, therefore

BE IT RESOLVED, that the TOMA House of Delegates directs the Executive Director of TOMA to contact the appropriate health care officials or agencies in Texas for the purpose of requesting that all health care agencies in Texas require their vendors to refrain from the use of preprinted medical forms with single signature blocks which specify M.D. only, and

BE IT FURTHER RESOLVED, that the TOMA House of Delegates goes on record supporting the modification of existing health care forms so that the physician signature block on these forms will end with the suffix, M.D./D.O., and

[BE IT FURTHER RESOLVED, that the TOMA House of Delegates forward this resolution to the AOA House of Delegates for its consideration and adoption.]

00-09 TRANSPORTATION AT SPONSORED OSTEOPATHIC MEETINGS AND CONVENTIONS

WHEREAS, some active, productive members of our state and national osteopathic associations are aging and may have difficulties including mobility, and

WHEREAS, these same members have been vital in making osteopathic medicine the extraordinary profession that it is today, and

WHEREAS, hotels at state and national conventions may be of substantial distance from the meeting areas, and

WHEREAS, the osteopathic medical associations should support the intent and purpose of the Americans with Disabilities Act, therefore

BE IT RESOLVED, that the Texas Osteopathic Medical Association House of Delegates recommends that appropriate transportation for disabled and elderly members be provided at TOMA meetings and conventions, and

[BE IT FURTHER RESOLVED, that the Texas Osteopathic Medical Association House of Delegates calls upon the American Osteopathic Association to provide similar transportation at its annual convention, and

BE IT FURTHER RESOLVED, that this resolution be presented to the American Osteopathic Association House of Delegates in order to instruct the American Osteopathic Association Bureau of Conventions to initiate mechanisms for providing appropriate transportation for the elderly and disabled physician membership.]

00-10 AOA/ACCME CME RECOGNITION

WHEREAS, a large number of graduating osteopathic physicians in the United States are doing ACGME (allopathic) residencies, and

WHEREAS, these osteopathic physicians need to obtain ACCME (allopathic) Continuing Medical Education (CME) credits to satisfy their American Board of Medical Specialties (ABMS) board certification, and

WHEREAS, the majority of AOA (osteopathic) accredited CME programs only give osteopathic credit and not ACCME (allopathic) accredited credit, and

WHEREAS, osteopathic physicians who are board certified by the ABMS have to attend CME programs that satisfy their certification requirements, therefore

BE IT RESOLVED, that the Texas Osteopathic Medical Association House of Delegates goes on record supporting the awarding of both AOA accredited and ACCME **[accredited]** joint sponsored (allopathic) CME credits at all TOMA CME programs.

The House of Delegates observed a minute of silence for the following members, family and friends who have passed on during the past year: Sheron Lynn Cunniff; Angeline K. Patrick; Joanie Spellman; Jerry M. Alexander, D.O.; Carl F. List, D.O.; Steven R. Price, D.O.; Julia Grace Mahoney Bailey; Patrick D. Kelley, D.O.; Victor H. Zima, D.O.; Marion A. Groff, III, D.O.; Gary L. Polk, D.O.; Calvin T. Vardaman, D.O.; R. LaMoyne Livingston, D.O.; Jerry R. Thompson, D.O.; William H. Van de Grift, D.O.; Steven O. Anders, D.O.; Richard L. Wascher, Jr., D.O.; Beatrice B. Stinnett, D.O.; Roy D. Mims, Sr., D.O.; and Cynthia Kibler-Schilder, D.O.

The following physicians were recognized for their service in the TOMA House of Delegates:

5 YEARS Merritt G. Davis, Jr., D.O.; Gregory A. Dott, D.O.; Jeffrey D. Rettig, D.O.; Laura S. Stiles, D.O.; Pat A. Thomas, D.O.

10 YEARS Constance I. Jenkins, D.O.; Elizabeth A. Palmarozzi, D.O.

11 YEARS George M. Cole, D.O.; Joseph A. Del Principe, D.O.; Steve E. Rowley, D.O.

12 YEARS Daniel W. Saylak, D.O.; George N. Smith, D.O.

13 YEARS D. Dean Gafford, D.O.; Linus J. Miller, D.O.; Carl V. Mitten, D.O.; Paul S. Worrell, D.O.

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14 YEARS Royce K. Keilers, D.O.; Monte E. Troutman, D.O.

15 YEARS James W. Czewski, D.O.

16 YEARS Kenneth S. Bayles, D.O., Bill V. Way, D.O.

17 YEARS David M. Beyer, D.O.; James E. Froelich, III, D.O.; Randall W. Rodgers, D.O.; Arthur J. Speece, III, D.O.; Rodney M. Wiseman, D.O.

18 YEARS Mark A. Baker, D.O.

19 YEARS Jerry E. Smola, D.O.

21 YEARS John L. Mohney, D.O.

22 YEARS Joseph Montgomery-Davis, D.O.

24 YEARS Robert G. Maul, D.O.; Robert L. Peters, Jr., D.O.

25 YEARS Donald F. Vedral, D.O.

29 YEARS Frank J. Bradley, D.O.; Bill H. Puryear, D.O.; Arthur S. Wiley, D.O.

31 YEARS John J. Cegelski, Jr., D.O.

32 YEARS Donald M. Peterson, D.O.

35 YEARS William R. Jenkins, D.O.

36 YEARS David R. Armbruster, D.O.

ATOMA News

ATOMA Events at TOMA'S 102nd Annual Convention Promise Fun, Prizes and Opportunities Galore!

New ATOMA Officers

The ATOMA Nominating Committee; Lewis Isenberg, chair, Shirley Bayles and Linda Cole, met. The following candidates have been slated for the ATOMA 2001-2001 Executive Board:

President	Susan Selman
President-Elect	Pam Adams
Vice President	Barbara Galarneau
Secretary	Linda Garza
Treasurer	Shirley Meyer

Annual Silent Auction

Once again, ATOMA will be hosting its Annual Silent Auction Fund Raiser during TOMA's Annual Convention in Arlington, Texas. The auction items will be on display and bidding will be open in the ATOMA Silent Auction area of the Convention Center Exhibit Hall during Exhibit Hall hours Thursday, June 7th, and Friday, June 8th. On Saturday, June 9th, the Silent Auction items will be at the Wyndham Arlington Hotel, 2nd Level – Champions Ballroom Foyer. Bidding will be open until the end of the President's Reception at 7:00pm. Winners will be announced during the President's Banquet in the Champions Ballroom.

President's Installation Breakfast

The ATOMA President's Installation Breakfast will be held on Friday, June 8th, at the Wyndham Arlington Hotel in the World Series I Room from 9:00am to 11:30am. The special guest speaker will be Kate Allen, Independent Sales Director for Mary Kay Cosmetics. Her presentation is titled, "Attitude!" Door prizes will be given away as well. Tickets are $30 and can be purchased at the TOMA Registration Desk.

Share with Those Who are in Need

Donations for the Arlington Women's Center will be collected during the President's Installtion Breakfast on Friday, June 8th. The shelter is in great need of the following items:

- ❖ New socks and underwear for children – all sizes
- ❖ New undergarments for women – all sizes
- ❖ New or gently used school backpacks
- ❖ New or gently used bath and hand towels
- ❖ New or gently used twin sheets and pillow cases
- ❖ New pillows
- ❖ New baby bottles and brushes
- ❖ Toilet paper and paper towels
- ❖ Packaged snacks for school lunches
- ❖ Pedialyte

Remember: Most women and their children arrive at the shelter with only the clothes on their backs, leaving behind even the most basic necessities, in order escape their violent environment.

TOMA Scrub Shirts and Commemorative Throws/Blankets Available During Convention

ATOMA will be selling white, reversible scrub shirts with the offical TOMA seal on the pockets for $20 each and TOMA Commemorative Throws, $65 each, at the ATOMA Booth in the Convention Center Exhibit Hall.

Annual Golf Tournament

ATOMA's Annual Golf Tournament will be held at Riverside Golf Club on Friday, June 8th. The bus departs from the Wyndham Arlington Hotel at 1:00pm and will return after the Awards Dinner at approximately 8:00pm. Tickets are $75 per player and can be purchased at the TOMA Registration Desk.

www.txosteo.org

ON THE WEB in June

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

- **Texas FYI**
- **Health Notes**
- **Ten Years Ago in the *TexasD.O.***
- **TRICARE News and Related Military Issues**
- **HHS News**
- **News from UNTHSC at Fort Worth**
- **Self's Tips & Tidings**
- **National Heritage Insurance Company to Unveil New Claims Processing System: COMPASS21**
- **Texas Stars and Heritage Campaign Members**
  A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" and "Heritage Campaign Members" 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.

Watch Out for These Symptoms of an Ailing Practice – Part I

Are you so absorbed in clinical work that you don't have time to keep up with the business side of your practice? **TOMA Physician Services** has identified financial, operational, and personnel indicators that you can monitor to gauge the health of your practice. This article, the first of three in a series, takes a look at financial symptoms of an ailing practice.

Instruct your staff to run monthly and year-to-date financial reports, and compare them regularly to previous months and the previous year. Get to know what is normal for your operations; then you can recognize irregularities that may be signs of trouble. Look for trends and abrupt changes, and correct problems before they become critical.

- ✓ Track your accounts receivables by provider and payer mix (for example, managed care, Medicare, and self-pay). A jump in accounts receivable may mean an increase in production — or it could indicate that billing and collections are stalled. A sharp decline could be a symptom of lower patient volume or an unfavorable change in payer mix.
- ✓ Look at monthly charges, adjustments, and receipts for each provider in your practice. You should be able to explain an abrupt change (for example, the physician has been on vacation or cut back his or her working hours).
- ✓ Track your monthly and annual rate of collections. A drop in collections might indicate a decrease in patient volume or a billing/collections problem.
- ✓ Keep an eye on late charges in your accounts payable. Late penalties could serve as a red flag that your practice suffers from cash flow problems or poor management.
- ✓ Watch overhead expenses from month to month and compare them to industry norms. If your costs for personnel, medical supplies, and other regular expenses are straying out of line, find out why.

If you need help gauging your practice's health or analyzing symptoms, turn to your organization — the Texas Osteopathic Medical Association. **TOMA Physician Services** consultants can conduct an operations assessment of your practice, offering customized, practical solutions for your unique operational challenges. The consultants will evaluate the full scope of your practice operations through personal interviews and financial analyses and provide written recommendations for improvements, along with 30 days of telephone support. Contact them today for more information at (800) 523-8776 or <physician.services@texmed.org>.

Next month: a look at Operational Symptoms.

Opportunities Unlimited

PHYSICIANS WANTED

GENERAL OPHTHALMOLOGY – Busy 22-yr.-old solo practice w/2 offices needs additional ophthalmologist. Fort Worth, Metroplex location. Opportunity for partnership/ownership. FAX CV to: 817-571-9301. (2)

PART-TIME Physician Wanted – The Davisson Clinic. Dallas, Texas. 214-546-7266. (06)

DALLAS - Physician needed at walk-in GP clinic. Flexible hours or part-time. 214-330-7777. (11)

DALLAS/FORT WORTH – Physician opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call and no emergencies. Please call Lisa Gross at 1-888-525-4642 or 972-255-5533 or FAX CV to 214-441-2813. (25)

POSITIONS WANTED

B.E. D.O., 24 years practice experience in urgent care, occupational medicine, family practice. Seeks part time (weekend) work in urgent care/occupational medicine/ family practice in Texas, DFW area preferred. Available May 1, 2001. C.V., references on request. 817-329-5453. (01)

BOARD CERTIFIED FAMILY PHYSICIAN – Physician with fourteen years experience seeking permanent position in Arlington/Mansfield or Tarrant County area. On staff at local hospitals and on numerous health plans. Contact: Doyle Gallman, D.O., at 817-473-3119. (03)

POSITION WANTED: BOARD CERTIFIED FP for outpatient full time, part time or locum tenens, prefer 60 miles radius of D/Ft. Worth area. $65.00 hour. Excellent references will be furnished. Call Eric M. Concors, D.O., at 214-365-9013. Leave message. (13)

FP, BC, D.O., desires full-time primary care position in South Texas. CV & references available on request. E-mail to <akcicora@indy.net> or call 312-257-4477 and leave message. (19)

PRACTICE FOR SALE/RENT

FOR SALE – FAMILY PRACTICE, Austin, Texas. Net $200,000/no hospital. Will finance. Will work with new associate/owner during transition period. Contact TOMA at 800-444-8662. (09)

MEDICAL PRACTICE, EQUIPMENT AND BUILDING – FOR SALE. Established 1982, no HMO, 50% cash. Good Location. Call TOMA at 800-444-8662. (18)

FOR SALE – Family Practice, Dallas, Texas. No hospital. Will work with new owner during transition period. Established practice 40 years-plus. Call TOMA (800) 444-8662. (23)

MISCELLANEOUS

FOR SALE – McManis Table, new top – Excellent condition, $700.00. James Mahoney, D.O., 817-337-8870. (50)

FOR SALE – Late model MA X-ray and processor with view box and accessories; hydraulic stretcher; transport stretchers; Coulter counter and diluter; storage cabinets; office desk; assorted other items - very good condition. Contact: Dr. Glen Dow or Office Manager, 817-485-4711. (48)

CLASSIFIED ADVERTISING RATES & INFORMATION
call Trisha at the TOMA Offices
512-708-8662 or 800-444-8662

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