TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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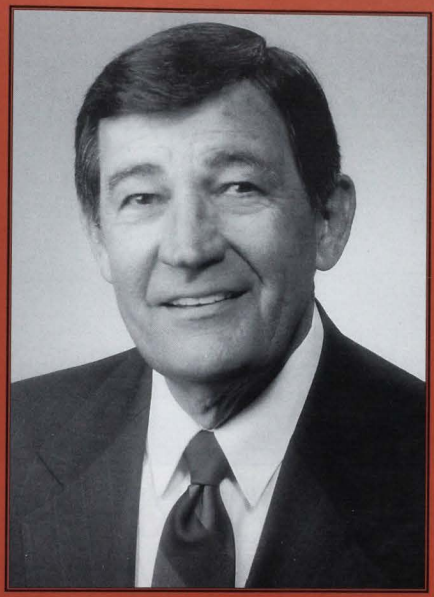

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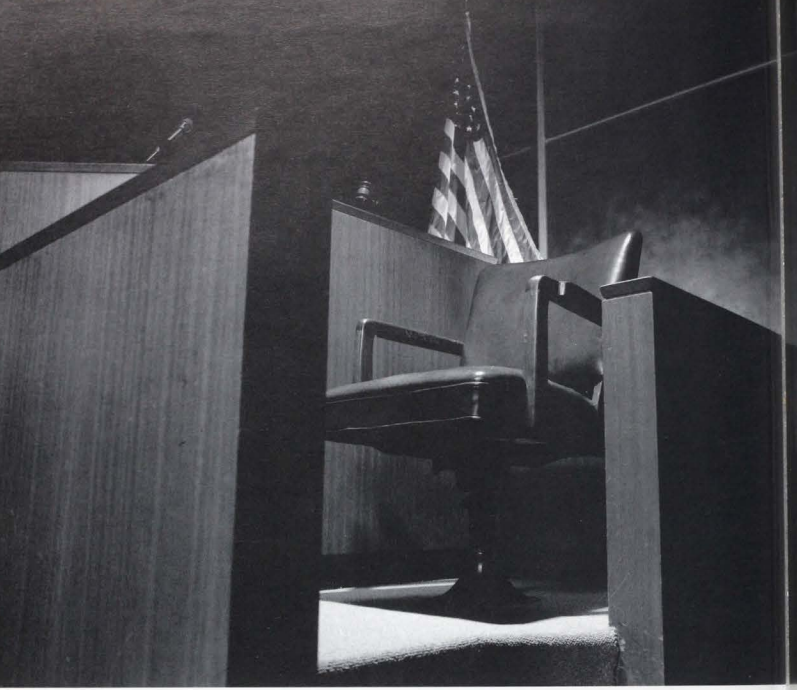
AMERICAN OSTEOPATHIC ASSOCIATION

this

This Month's Clinical Focus:

Abuse – The Hidden Pediatric Trauma

pages 6 - 14



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SEPTEMBER 2000

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Copy deadline is the 10th of the month preceding publication.

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CALENDAR OF EVENTS

SEPTEMBER 15 – 17

"2000 FOMA Mid-Year Seminar"

Sponsored by the Florida Osteopathic Medical Association

Location: Hyatt Regency Westshore, Tampa, FL
CME: Approximately 20 hours category 1-A credits
Contact: Florida Osteopathic Medical Association
The Hull Building, 2007 Apalachee Parkway
Tallahassee, FL 32301
800-226-FOMA

SEPTEMBER 22 – 24

"The Successful Osteopathic Practice: Wine Country Revelations"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Embassy Suites, Napa Valley, CA
CME: 20 hours category 1-A credits
Contact: 916-561-0224
FAX: 916-561-0728

SEPTEMBER 24 – 27

"The Third National Conference on Shaken Baby Syndrome"

Sponsored by the National Center on Shaken Baby Syndrome and by SBS Prevention Plus

Location: Salt Lake City, Utah
Contact: The Child Abuse Prevention Center
2955 Harrison Blvd., Suite 102
Ogden, UT 84403
801-393-3366
E-mail: capcente@ix.netcom.com
Download information at <www.capcenter.org>

NOVEMBER 8 – 12

"Fall CME Conference & Scientific Exhibition"

Sponsored by the Georgia Osteopathic Medical Association

Location: Atlanta Marriott Gwinnett Place, Atlanta, GA
Contact: Holly Barnwell, Executive Director
2160 Idlewood Road, Tucker, GA 33084
770-493-9278
E-mail: GOMA@mindspring.com
www.goma.org

NOVEMBER 12 – 18

"National Osteopathic Medicine Week"

Sponsored by the American Osteopathic Association

Contact: AOA – 800-621-1773, ext. 8043
312-202-8043

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
Contact: 800-480-5542

www.txosteo.org

ON THE WEB in September

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>.

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

In Brief

Health Notes

In the News

TRICARE News and Other Military Issues

Texas FYI

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

Washington Update

Texas Stars
A Listing.

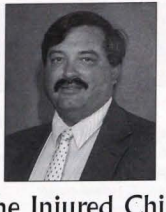
People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" due to their commitment to the osteopathic profession.

Thank You
A Listing.

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

For Your Information
A Listing.

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



The Injured Child

by Daniel W. Saylak, D.O.

Few circumstances are more stressful for a treating physician than a traumatically injured child. The call "pediatric code" may raise the anxiety level of even the most experienced emergency department veteran. Gazing into the helpless eyes of the injured child conjures many images, perhaps from our own past. The desire to alleviate pain and "do as much as we can do" can be overwhelming.

To expedite the evaluation and treatment of an injured child, the physician must develop a systematic approach. The American Academy of Pediatrics and American College of Surgeons have created advanced life support courses which present information concerning the traumatically injured child.

It is not the purpose of this article to provide a comprehensive treatise on the evaluation and management of pediatric trauma. Rather, the following will summarize a systematic and deliberate approach in the treatment of the injured child.

Advanced life support courses have broken down the evaluation of patients into surveys: the primary survey, which is an examination directed towards critically vital life functions; and the secondary survey, which is a more complete head-to-toe evaluation of the patient.

The Primary Survey

Commonly referred to as the ABC's, the primary survey involves: Airway management, Breathing, and Circulation evaluation. Establishment of a patent airway is of paramount importance. In children, the tongue occupies a greater percent area in comparison to the adult upper airway. Clearing of upper airway debris and evaluation of tongue position should be one of the highest priorities given in the initial management of the injured child. If endotracheal intubation is required for the management of ventilation in the deeply unconscious pediatric patient, an uncuffed tube should be utilized. The narrowest part of the pediatric airway is the crichoid cartilage.

Breathing evaluation can be performed quickly. Initially, this can be by observation of the thorax for symmetrical rise and fall with breathing or ventilation. Auscultation of the chest for breath sounds can be performed rapidly in assessment of pneumothorax or airway obstruction. If oxygen supplementation is required, the use of cannula and masks can be frightening to the child. If a parent is available to hold the oxygen delivery device near the child, this can alleviate some fear.

Circulation evaluation should be deliberate and rapid. Checking peripheral pulses for presence and symmetry can be done by palpation of the antecubital fossa. Capillary refill is assessed. A capillary refill time of greater than 2-3 sec. indicates a circulatory deficit. The presence of cyanosis or acrocyanosis also demonstrates a breakdown in the ventilation/circulation processes. Lastly, addressing any serious bleeding can be done at this time.

The Secondary Survey

The secondary survey is a more comprehensive head-to-toe evaluation of the injured child. One of the most important elements of the examination for osteopathic physicians is the palpation of the vertebral and paravertebral structures for signs of asymmetry and tissue texture changes consistent with osteopathic somatic dysfunction. It is important to remember that viscero-somatic reaction/responses in osteopathic somatic dysfunction can be important diagnostic tools. Osteopathic physicians can try to identify viscero-somatic components of the physical examination to reveal underlying causes of pain and discomfort. The presence of somatic dysfunction in trauma can help direct the clinician towards further evaluation via laboratory and radiological means. Primary somatic dysfunction also can be treated following the secondary survey since there may be a likelihood of musculoskeletal involvement primarily in trauma.

As the public's awareness of ch abuse rises, physicians continue to placed in the spotlight's glare screening as the principal detectors child abuse. Primary care physicians a emergency medicine physicians' roles becoming more clearly identified. In recent American Osteopathic Associat resolution from the House of Delegates July 2000, physicians were identified those most likely to initially detect ch abuse. Hidden trauma is sometimes ve difficult to identify since the patient seldom able to completely describe th symptoms. It requires an astute physici to carefully monitor and identify pediat abuse. This is usually based on histo and careful physical examinati including meticulous palpation. It shou be clear that not all pediatric trau should raise the suspicion of child abu The index of suspicion that a physici will have in suspected child abuse m rise from several sources. Observation the interaction between parent and chi is always important. Parental distance aloofness may be a trigger to further que tioning of the circumstances of injur Meticulous examination is required if t injuries appear more severe than expect from the given history. It should be cle that simple explanatory statements ma by the child can not rule out coercion the part of the abuser. Throughou training, a physician is taught to "liste with a third ear". That is, listen to what not said as much as you hear what is sai This can be an important reference tool suspected abuse.

In closing, physicians confronted wit the traumatically injured child mu deliver concise, deliberate care. A tho ough medical history and physical exam ination, including palpation f osteopathic somatic dysfunction, is one the most important tools in alleviatin pain and suffering in children. As th individuals most likely to initially identif abuse, physicians must maintain an inde of suspicion tempered with informatio garnered from the comprehensive directed history and physical examinatio to protect a child from the consequence of continued abuse.

Dr. Saylak practices osteopathic emergency med cine/family practice in College Station, Texas.

Shaken Baby Syndrome

– Silent Abuse –

by Alan Levine, D.O. and Marianne R. Levine, D.O.

Shaken Baby Syndrome (SBS) is the term used to describe a constellation of signs and symptoms resulting from the violent shaking of an infant. This is usually accomplished by holding the infant by the arms or trunk and vigorously shaking and/or striking the head against a surface. Thus the name Shaking-impact Syndrome has been alternatively applied.

"The child suffering from SBS may present with varying symptom severity, unknown or concealed history of trauma and little or no signs of external abuse."

Physical abuse is the most common cause of serious head injury in infants. In the past, abuse has been relegated to a diagnosis of exclusion. There now exists sufficient data on inflicted head trauma to make a presumptive diagnosis of child abuse when an infant presents with intracranial injury. Most cases of SBS are found in infants less than six months of age and typically occur without a believable history of how the trauma was sustained. It is generally held that falls from heights of less than five feet do not cause significant intracranial injury.

The child suffering from SBS may present with varying symptom severity, unknown or concealed history of trauma and little or no signs of external abuse. It is therefore incumbent upon physicians caring for children to have a high index of suspicion, be thoroughly familiar with the presentation and management of SBS and know their obligation to report suspected cases to the proper authorities.

Illustrative case

A young mother leaves her four-month-old male infant in the care of her boyfriend while she shops. The boyfriend is not the father of the infant. On her return she finds the infant apparently sleeping in the crib. On closer inspection, the infant is pale and limp with gasping respirations. She calls 911 and the ambulance transports the infant to the nearest emergency department. On arrival the infant seizes and becomes apneic. After intubation and stabilization, bruises are noted on the infant's torso. CT scan of the head without contrast reveals bilateral subdural hematomas. Chest radiograph reveals recent posterior rib fractures. Ophthalmology examination of the eyes reveals extensive retinal hemorrhages. Initially the boyfriend denies any violence toward the infant but later admits to briefly shaking the baby to stop him from crying.

The above scenario is a classic circumstance for shaken baby syndrome and has been documented in emergency departments throughout the country.

Mechanism of Injury

In a fit of frustration or anger the perpetrator finally grabs the infant and shakes him so violently that the infant's head moves rapidly back and forth. The chin contacts the chest anteriorly and the head moves posteriorly striking the back with the occiput. At some point, the infant's head may be struck against an object, but severe cerebral damage can occur by shaking alone. The acceleration - deceleration forces may cause rupture of bridging veins between the cortex and the dura, as well as, diffuse axonal injury. Retinal hemorrhage may occur secondary to a shearing force on the globes.

The infant's large head size proportional to body size and relatively weak neck muscles allow unmodulated whiplash movement. An infant's incompletely myelinated brain is softer than in the older child or adult and the axons are more likely to be damaged.

Rapidly developing neurologic impairment will closely follow cerebral injury. The infant demonstrates changes in level of consciousness consonant with the degree of injury. Less severe trauma may result in poor feeding, vomiting, and irritability. More severe injury may be life threatening with unconsciousness, seizures, posturing and apnea. Permanent neurological damage in survivors results from direct axonal injury in the developing brain, as well as sequelae of cerebral edema, cerebral anoxia, space-occupying effects of large intracranial hematomas and direct cerebral contusion. Retinal hemorrhages may result in markedly impaired vision, if not total blindness.

Radiographic findings

The skeletal survey should include a two-view chest, two-view skull, pelvis, AP views of upper and lower extremities and a lateral lumbar spine. A variety of fractures may be seen in shaken baby syndrome, but the most common are the following: metaphyseal-epiphyseal corner fractures at the distal long bones; rib fractures, particularly posterior rib fractures; skull fractures, especially depressed, diastatic, occipital, or fractures crossing the midline; and "bucket-handle" fractures across the distal metaphysis of long bones. Typically, metaphyseal fractures are produced by pulling or jerking the extremities. Of note, rib fractures are not produced by cardiopulmonary resuscitation.

CT scan of the head without contrast is useful for detection of skull fractures, although fractures in the plane of CT section may

be missed. CT scan is sensitive to intracranial hemorrhage such as subdural, epidural, or subarachnoid hematomas. MRI of the head is useful in dating hematoma age and can define post-injury parenchymal changes in brain tissue. Cerebral edema may occur rapidly or be delayed. Both CT scan and MRI can image cerebral edema; however, CT is more practical when life support is required for a critically ill child.

Management

The immediate management concerns are addressing the ABCs (airway, breathing and circulation), as those infants suffering from severe cranial injury usually present early in extremis or cardiopulmonary arrest as a result of axonal disruption and/or increased intracranial pressure. After stabilization of the patient, a careful history should be obtained, preferably by someone skilled in child abuse management. A thorough physical examination should be performed with special attention to other signs of physical abuse.

The head is examined for cephalohematomas and bulging of the anterior fontanel. After the neurologic system is evaluated and stabilized, the pupils should be dilated and the retinas checked for hemorrhages. Any marks, bruises or swelling of the skin are noted and photographed or documented. The extremities are palpated to discover any long bone fractures or deformities.

Appropriate imaging studies are an important method of documenting injuries. These include a non-contrast CT scan of the head and a skeletal survey. Laboratory blood tests should include all of the following: CBC, electrolytes, arterial blood gases, liver function panel, platelets, prothrombin time and partial thromboplastin time.

Suspicious cases of injury to children must be reported according to state law. Child Protective Services and the appropriate law enforcement departments are extremely helpful in assuring investigation of the case.

Outcome

SBS has an extremely poor outcome among its victims. Mortality can be as high as 40%, while up to 50% of survivors may remain vegetative or severely disabled even after long term follow up. In one study, of those infants who presented in a comatose state, 60% died or were left with profound mental retardation, spastic diplegia or quadriplegia or severe motor dysfunction. Infants who presented with seizures, irritability or lethargy without increased intracranial pressure, lacerations or infarctions, had more subtle neurological sequelae. Factors associated with poor outcome include: unresponsiveness on admission, need for intubation, age less than six months and diffuse hypodensity on CT scan.

Long-term survivors of the more severe types of injuries may be partially or totally blind or have chronic subdural fluid collections, hydrocephalus, cerebral atrophy, encephalomalacia or porencephalic cysts. In milder cases of abusive head injury, one finds seizure disorders, mental retardation, developmental delays, learning disabilities, personality changes and behavior problems. The full clinical appearance of neurological deficits may not be apparent, and no real prognosis may be rendered, before six years of age.

While the financial costs of SBS have not been well identified, the costs of one child who survived three years with severe neurological damage were estimated at more than one million dollars.

Prevention

Approximately five children die each day in the United States as a result of maltreatment, with nearly half of those never reaching their first birthday. The characteristics of children who are at greatest risk for being abused include: prematurity, neonatal separation, multiple births, congenital defects, mental retardation and difficult temperament. Those characteristics of the caretaker which place the child at risk include the following: abuse as a child, violence toward others, substance abuse, mental illness, young age, poor impulse control, unemployed, financial difficulties and lack of family support.

Research has shown that 25% to 50% of the American public is unaware of the dangers of shaking a baby. It is also known that 60% of the perpetrators of SBS are fathers, stepfathers and mothers' boyfriends. Female babysitters also comprise a significant percentage of perpetrators.

As part of anticipatory guidance during well-baby visits in the physician's office, the parents (and especially high-risk individuals) may be provided with printed and verbal information on SBS. Attempts should be made to reach adolescent and young adult males and females with public campaigns to educate them in the areas of parenting and baby-sitting skills. There are also numerous resources on SBS available to primary care providers and their patients through the Internet.

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Dr. Alan Levine serves as Associate Professor Pediatrics at the University of North Texas Healt Science Center at Fort Worth.

Dr. Marianne R. Levine serves as Assistan Professor of Pediatrics at the University of Nort Texas Health Science Center at Fort Worth.

Shaken Baby Syndrome

– One Family's Experience

by Kathryn Dittman, D.V.M.

Maggie and her mom, Dr. Kathy Dittman, in the Fall of 1997, just months before Maggie's death.

We were ushered into a room with our pediatrician, a PICU nurse, and the hospital social worker. The examination by the neurologist from earlier that morning revealed that our two-year-old daughter, Maggie, had bilateral retinal hemorrhages as well as massive cerebral edema. Maggie was lying across the hall in the pediatric ICU, comatose, on a ventilator where she had been since the afternoon before. Our doctor explained to us that her injuries were consistent with shaken baby syndrome, a term that I was familiar with only because of Mattie Eappen and Louise Woodward. As we listened to the doctor, my husband and I were stunned and speechless. There are no words to describe our shock at this unexpected news. I immediately recognized that the only one who could be at fault was Maggie's baby-sitter. I had left her alone with my smiling, waving daughter on the day before only forty minutes before receiving the phone call that all parents dread.

Let me take you back to the beginning. On January 12, 1998, our family consisted of myself, a veterinarian, my husband, an agricultural seed salesman, and our two children, Matthew, six, and Maggie, two. Matthew attended first grade and Maggie was cared for in our home by Alma Guadalupe Quintanilla. Alma had been recommended to us by her nieces, who baby-sat for us over the summer, and she had been working for us for four and one half months in January 1998. Although she had no children of her own, Alma had taken an active role while her nieces were growing up and had watched children many times in the past. She was a mature woman, about 50 years old.

Tuesday, January 13th, started out like any other day. I got up early and went to the clinic at 7 a.m. My husband, Mark, got up, got Matthew up and dressed, and waited for Alma to get there before taking Matthew to school. He then returned to the house where Maggie had awakened and Alma had her dressed. On this particular day he was helping with a barbecue lunch for approximately 80 farmers in the next county, 35 miles away. He left the house, saying goodbye to Maggie at about 9:30 a.m., not knowing that he would never see his little girl conscious again.

I came home for lunch as usual to eat and spend time with Maggie. She was acting fussy and didn't want to eat lunch, and I thought she might be teething. I read her a story and gave her a dose of Motrin. After Alma and I ate lunch, Maggie and I played together in her room for awhile. She had a shape-sorting toy, which we had played with just once before, a few days previously. On this day I was impressed by how much more quickly she matched the shapes to their holes than she had the previous time. She was mentally alert and had good vision and good hand-eye coordination. I had to return to work and as we went out the door, I glanced at the clock on the VCR to see if I was running late. The time was 1:50 p.m. Maggie always fussed when I left, so Alma took her for a ride in her wagon. As I drove out of the driveway, Maggie smiled and waved at me, saying, "Bye-bye, Mama, bye-bye."

After returning to the clinic, I checked the patients that had had surgery that morning and was just finishing up my first office visit when my receptionist pulled me out of the exam room. She said my baby-sitter was on the phone. The conversation was very short and went like this: "Maggie fainted or something and I'm not sure if she's breathing." "If you're not sure she's breathing, call 911 and I'll be right there."

I immediately sped home, making the usual twelve-minute trip in half the time. As I approached the end of our country lane, I saw the ambulance had overshot our street and was stopped up ahead. I stopped, honked my horn and flashed my lights until they saw me, and then sped down the road with them right behind. As we entered the house, Alma indicated that Maggie was back in her bedroom where I found her, lying on the floor on her back, totally non-responsive. As the paramedics came through the house I heard them ask Alma twice, "Did the child fall?" and twice she answered, "No." As they worked to establish an airway and place an IV line, I cut Maggie's dress off as instructed. They were unable to intubate her because her teeth were so tightly clenched - she was having a seizure. I told Alma to call Mark. She disappeared for a short time, and when I asked if she'd gotten in touch with him she said she'd left a message. After multiple failures at intubation, the decision was made to bag her and head for the hospital, which we did. Alma stayed at the house.

In the ER, Maggie was sedated enough to allow an anesthesiologist to intubate her, chest radiographs were done and blood was drawn. I called my in-laws and my husband, who would

"Maggie's life on this earth officially ended at 12:35 p.m., January 16, 1998, but ours continued to get worse."

have been picking up our son from school. Mark arrived a few minutes later and we went to radiology for a CT scan. The CT revealed severe, diffuse cerebral edema. After that procedure, Maggie was moved to the pediatric ICU where she was maintained on a ventilator since she could not breathe on her own.

Mark had arrived home after picking Matthew up at school at 3:30 p.m., having never received any message from Alma. When he got there, Alma told him that Maggie had fainted and was taken to the hospital by ambulance. Mark noticed four large drops of blood at the front doorstep and asked Alma, "Is this blood?" She confirmed that it was Maggie's and said that it had come from the IV. It had not. Mark rushed to the hospital, leaving six-year-old Matthew in Alma's care.

That night we wracked our brains, trying to figure out what could so rapidly turn a robust, bright, alert, normal two-year-old into a comatose patient with a nearly flat EEG. Peracute meningitis? Some previously unknown food allergy? We never entertained the possibility of trauma, even when our pediatrician asked me about our baby-sitter while taking Maggie's history in the ER. We were at our wit's end. That is, until the next morning when the retinal hemorrhages were discovered and the diagnosis was made.

What followed was truly a nightmare turned reality. For three days we kept a vigil at the hospital. My parents flew in from Florida and we watched Maggie's condition deteriorate progressively to the point where she could no longer maintain her own body temperature nor concentrate her urine. On Thursday evening I sat in as an ophthalmologist examined Maggie's retinas. I asked how long it would take for the mydriatic to wear off, as we had been monitoring her pupil size. The doctor told me that she had not needed to use any eye drops at all. Maggie's pupils were fixed and dilated already. It was at that moment that I knew that my little girl had no chance at survival. Later that evening I spoke with one of our pediatricians to ask him how I could help my six-year-old son deal with the death of his sister. He told me that including Matthew in the entire process of grieving and going through it as a family would be the best help we could offer.

The next morning an MRI and a brain scan were done to determine if there was any circulation to the brain. With the negative results of the brain scan and the lack of any response on a final neurological exam, our decision to remove our daughter from the ventilator was made. (I don't use the term "no-brainer" any more, but if I did, this decision would have been one.) There was nothing left to save.

Maggie's life on this earth officially ended at 12:35 p.m., January 16, 1998, but ours continued to get worse. Immediately after having our son come up to say a final goodbye to his little sister (if you thought the "birds and the bees" talk was hard, try this one sometime), two policemen and two caseworkers from Child Protective Services (CPS) wanted to have a talk with my husband and me. We had spoken with both of these agencies two days before, and had been fully cooperative. The police extended their sympathies and told us that once the funeral was over, we needed to come by the station to make formal statements for their investigation. We agreed. This conversation took less than 10 minutes. Then we began our ordeal with CPS. We were informed by one of the caseworkers that under no circumstances would our son be allowed to go home with us that day. We had only two choices; either name a relative with whom he could be placed, or they would put him in foster care with people we did not know, and we would not be allowed to have any contact with him or even know where he was. Once again we were totally stunned. When asked by a doctor friend of ours if Matthew could be placed with "anyone but his parents", the caseworker's answ was "Yes". When further pressed with t question, "He could even be placed w Alma Quintanilla?", again the answer w "Yes". The caseworker kept asking "Don't you want what's best for yo son?" Having learned just the night befo from an experienced doctor whom trusted what really was best for my sc we replied, "Yes, and what is best for hi is to be with us right now." Bei mentally and physically exhausted, a not in a prime decision-making frame mind, we didn't walk out or call attorney, but instead signed a "safe plan" that exiled Matthew from his hon for up to 30 days. He stayed in town wi Mark's cousin's family, whose chi attended the same school. Mark and drove home that night after about fi hours of negotiating with CPS to a hou full of relatives, but no children. Befo going to bed late that night, I told m husband that I knew what he so bad wanted to do, but he must think of t consequences of his actions and the effe they would have on his son and his wif We went to sleep, hoping to never wak up again.

After hiring legal counsel, Matthe was allowed home with us in five day but his grandfather had to move in with u and literally sleep at the foot of his bed fo almost two weeks, until we were cleare by a thorough police investigation. (CP did no further investigation after takin their four statements and removin Matthew.) Alma was indicted in March arrested, and immediately set free o bond. After many, many delays, she wa tried in November of 1998, convicted o "injury to a child", a second-degre felony, and sentenced to ten years i prison, half of the potential punishment She was released on an appellate bond o only $30,000 and remained free until Ma 16, 2000, two years and four months afte Maggie's death. She testified at a hearing that she had been and would continue t watch young children unsupervised,

direct violation of her bond. The judge revoked her bond and she finally went to jail. Her appeal is now over.

The tragedy that befell our daughter, Maggie, took our lives and totally redefined them. Life is now divided into before and after January 13, 1998. Since Maggie's murder, my husband and I have learned more than anyone should ever want to know about the criminal justice system; we've changed laws affecting the entire state of Texas; we've met the governor (and possibly the next president); we've gotten to travel to Utah, California, and Oregon to speak on or learn about shaken baby syndrome; and we've been on national television twice. I can tell you in all honesty that, given the chance, we would trade all of that and so much more to have never met Alma Quintanilla so that we could be watching a feisty little blonde four-year-old girl growing up rather than spending our time educating others in the hope of preventing future cases of shaken baby syndrome.

Kathryn Dittman is a veterinarian living in Harlingen, Texas. Since their daughter's death, Kathryn and her husband, Mark, have joined the national board of The Shaken Baby Alliance, a nonprofit organization of victim families and professionals dedicated to family support, prevention, and justice for victims of shaken baby syndrome. The alliance maintains an informative web site at www.shakenbaby.com and the author may be contacted at <kaoddvm@cs.com>.

Child Maltreatment Statistics

Research supports that very young children (age 5 and younger) are the most frequent victims of child fatalities. The National Child Abuse and Neglect Data System (NCANDS) data for 1997 from a subset of states demonstrated that children 3 or younger accounted for 77 percent of fatalities. The fatal abuse usually occurs in one of two ways: repeated abuse and/or neglect over a period of time (battered child syndrome) or in a single, impulsive incident of assault (drowning, suffocating, or shaking the baby, for example).

Characteristics of Caregivers Who Physically Abuse Children

by Karen Rainville, D.O. and Kenneth Vogtsberger, M.D.

Evaluating a child who has been physically abused stirs up strong emotions in physicians. Physicians often experience anger towards the perpetrator. Additional conflicts for physicians include reluctance to consider the diagnosis, discomfort in reporting suspected child abuse to authorities, and the feeling of being helpless regarding the abused child's situation[1].

It is important for physicians to understand that certain characteristics in adults appear to predispose them to abuse their children. There is a high incidence of the adult being a product of multigenerational abuse dynamics. Spouse abuse can concomitantly occur with child abuse (neglect, mental and sexual) as part of the whole picture of family violence[1]. Generally there is one identified child whom the abusive parent will direct their hostility toward, and this occurs generation to generation contributing to perpetrating the abuse. Characteristics of low self-esteem, self-destructive behavior, poor impulse control and alternating aggression and passivity will develop in childhood and extend into adulthood in those who have been abused and abuse others. Thus the abusing adult has a history of his or her own childhood abuse, deprivation, neglect and/or other adverse events[2].

Situational factors increase the likelihood of caregivers losing control. Acute situational stress and social isolation are the most common risk factors. Caregivers can be emotionally overwhelmed and not have the social support or models of healthy behavior to identify and integrate into their psyche[3,4]. Mental disorders are common in abusing parents. It is estimated that 34% of abusing parents in one study have received inpatient psychiatric treatment[5]. Other studies have shown significant occurrence of cognitive impairment among abusing mothers, with 30% having significant intellectual deficits [5]. Adult male perpetrators have been described as alcohol dependent with coexisting personality disorders[6].

Drs. Green and Cohn have identified important goals for working with adults who abuse their children. Crisis intervention to decrease stress and conflict is primary intervention. Addressing the abusing adults' social isolation and chronic low self-esteem can be helpful. Learning to derive pleasure from raising a child and learning new communication techniques can help decrease frustration. The abusing adults' own painful childhood memories should be addressed through therapy. Education is important and the following topics need to be covered: childhood rearing modes, nonabusive disciplinary techniques, normal child development and correction of misconceptions about children[1].

In summary, the abusing adult may have a myriad of problems that need accurate identification and intervention. Appropriate intervention, such as referral for psychiatric evaluation, substance abuse treatment, mental retardation services, social work services and parenting classes may reduce the risk of future episodes of child abuse.

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Dr. Rainville graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1990, and has returned as an assistant professor. She teaches second, third, and fourth year medical students and psychiatric residents at John Peter Smith Hospital. Her practice is devoted to inpatient treatment of psychiatric illness.

Dr. Vogtsberger is a Professor in the Department of Psychiatry and Human Behavior, University of North Texas Health Science Center at Fort Worth. He teaches Clinical Psychiatry to first, second, and third year osteopathic medical students and directs the Psychiatry Clerkship for third year students.

Referrals and Reports

Instances of possible child maltreatment are referred to local child protective services agencies. The agencies "screen out" or "screen in" referrals for investigation or assessment. Agencies also decide whether to take further actions on behalf of protecting a child.

- Of the estimated 2,806,000 referrals received, approximately one-third (34%) were screened out and two-thirds (66%) were transferred for investigation or assessment.*
- More than half of screen-in child abuse and neglect reports (53.1%) were received from professionals. The remaining 46.7 percent of reports were submitted by nonprofessionals, including family and community members.
- Slightly fewer than one-third of investigations (29.2%) resulted in a disposition of either substantiated or indicated child maltreatment. More than half (57.2%) resulted in a finding that child maltreatment was not substantiated. More than a tenth (13.6%) received another disposition.

**Findings required by the Child Abuse Prevention and Treatment Act, as amended in 1996, to be included in all annual state data reports to the Secretary of Health and Human Services. Because this is only the second year that many of these data have been required, not all states were able to provide data on every item.*

Source: U. S. Department of Health and Human Services. Child Maltreatment 1998: Reports from the States to the National Child Abuse and Neglect Data System. (Washington, D. C.: U. S. Government Printing Office, 2000)

Child Maltreatment

What is Child Maltreatment?

Child abuse and neglect are defined in both federal and state legislation. The fede legislation provides a foundation for states by identifying a minimum set of acts behaviors that characterize maltreatment. There are four major types of maltreatme physical abuse, neglect, sexual abuse, and emotional abuse. While state definitions m vary, operational definitions include the following:

Physical Abuse is characterized by the infliction of physical injury as a result punching, beating, kicking, biting, burning, shaking or otherwise harming a chil The parent or caretaker may not have intended to hurt the child, rather the injury m have resulted from over-discipline or physical punishment.

Child Neglect is characterized by failure to provide for the child's basic needs. Negle can be physical, educational, or emotional. Physical neglect includes refusal of delay in seeking health care, abandonment, expulsion from the home or refusal allow a runaway to return home, and inadequate supervision. Educational negle includes the allowance of chronic truancy, failure to enroll a child of mandato school age in school, and failure to attend to a special educational need. Emotion neglect includes such actions as marked inattention to the child's needs for affectio refusal of or failure to provide needed psychological care, spouse abuse in the child presence, and permission of drug or alcohol use by the child. The assessment of chil neglect requires consideration of cultural values and standards of care as well a recognition that the failure to provide the necessities of life may be related to povert

Sexual Abuse includes fondling a child's genitals, intercourse, incest, rape, sodom exhibitionism, and commercial exploitation through prostitution or the production c pornographic materials. Many experts believe that sexual abuse is the most unde reported form of child maltreatment because of the secrecy or "conspiracy of silence that so often characterizes these cases.

Emotional Abuse (psychological/verbal abuse/mental injury) includes acts or omission by the parents or other caregivers that have caused, or could cause, serious behaviora cognitive, emotional, or mental disorders. In some cases of emotional abuse, the acts o parents or other caregivers alone, without any harm evident in the child's behavior o condition, are sufficient to warrant child protective service (CPS) intervention. Fo example, the parents/caregivers may use extreme or bizarre forms of punishment, such as confinement of a child in a dark closet. Less severe acts, such as habitual scape goating, belittling, or rejecting treatment, are often difficult to prove and, therefore CPS may not be able to intervene without evidence of harm to the child.

Child Fatalities Due to Maltreatment are Increasing

The rate of child maltreatment fatalities, confirmed by Child Protective Services (CPS to have been the result of child maltreatment, has steadily increased over the last decade The National Child Abuse and Neglect Data System (NCANDS) reported that in 1997 there were an estimated 1,196 child fatalities, or 1.7 children per 100,000 in the genera population. (This estimate was based on reports from 41 states that reported a total of 96 fatalities). The U. S. Advisory Board on Child Abuse and Neglect in "A Nation's Shame Fatal Child Abuse and Neglect in the United States," reported that a more realistic estimate of annual child deaths as a result of abuse and neglect, both known and unknown to CPS agencies, is about 2,000 or approximately five children per day. Experts such as Ryan Rainey from the National Center for Prosecution of Child Abuse believes that the numbe of child deaths from maltreatment per year may be as high as 5,000.

The Actual Number of Child Fatalities May Be Underreported

Determining the actual numbers of children who die annually from abuse is complex Many researchers and practitioners believe that child fatalities are underreported becaus

Some deaths labeled as accidents, child homicides, and/or Sudden Infant Death Syndrome (SIDS) might be attributed to child maltreatment if more comprehensive investigations were conducted. It is difficult to distinguish a child who has been suffocated from a child who has died as a result of SIDS, or a child who was dropped, pushed, or thrown from a child who dies from a legitimate fall. Some researchers and practitioners have gone so far as to estimate that there may be twice the number of deaths as a result of abuse and/or neglect as are reported by NCANDS if cases unknown to CPS agencies are included.

The Impact of Mandatory Reporting Laws

The following is excerpted from "Current Trends in Child Maltreatment Reporting Laws," Chapter III – Impact of Mandatory Reporting Laws: "The literature also reveals that numerous professionals admit that during their careers, they have failed to report suspected maltreatment to the appropriate agencies. One possible reason is that professionals, such as elementary teachers, still lack training and knowledge about legal obligations and procedures for reporting. Some reporters may also be reluctant to report because they view social services agencies as overburdened and understaffed, which may result in more harm to the child through inadequate investigation and services. In addition, mandated reporters may believe that their professional relationship with the child will be strained if they report their suspicions of abuse."

On the flip side, research indicates that mandatory reporting laws may result in the over-reporting of suspected child maltreatment. The following is also excerpted from the above referenced text: "Commentators suggest that broad definitions of child maltreatment found in reporting laws may contribute to over-reporting. For instance, states addressing the issue of corporal punishment use terms such as 'excessive corporal punishment' and the 'reasonable exercise of discipline'. In most state statutes, there is no explanation as to what is considered 'excessive' or 'reasonable.'

"In addition, professionals may have a bias toward reporting suspected maltreatment. Such behavior may be motivated by an overall concern for child protection, the prompt identification of victimized children to protect from potentially serious consequences of delay, and possible legal consequences for failure to report as required.

"Research also indicates that the over-reporting of abuse is a contributor to the high rates of unsubstantiated reports. For example, nearly 3 million children were reported to CPS agencies as alleged victims of maltreatment in 1997, but only 984,000 children were identified as victims of substantiated abuse or neglect. High rates of reporting have made it necessary for most child protection agencies to screen and prioritize reports before conducting investigations. High rates of unsubstantiated reports may overburden agencies, which potentially interferes with adequate services to maltreated children and their families."

There is a Lack of Standard Terminology for Child Fatalities

To further complicate the issue, different terminology is used to discuss child fatalities, sometimes interchangeably. NCANDS defines "child fatality" as a child dying from abuse or neglect, because either (a) the injury from the abuse or neglect was the cause of death, or (b) the abuse and/or neglect was a contributing factor to the cause of death. Researchers such as Finkelhor and Christoffel use the term "child abuse homicide" to define a childhood death resulting from maltreatment (either assault or neglect) by a responsible caretaker. Law enforcement and criminal justice agencies also use the term "child abuse homicide" but their definition, while including the caretaker as perpetrator, also includes the "criminal act of homicide by non-caretakers" (death at the hands of another, felony child endangerment, and criminal neglect). More specifically, the term "infanticide" is increasingly used to define the murdering of children younger than 6 or 12 months by their parents.

The Response to Fatal Child Abuse or Neglect is Complex

The response to the problem is often hampered by common inconsistencies:

- The inaccurate reporting of the number of children who die each year as a result of abuse and neglect
- The lack of national standards for child autopsies or death investigations
- The different roles that CPS agencies play in the investigation process
- The use in many states of an elected coroner who is not required to have any medical or child abuse and neglect training rather than a medical examiner.

Child Fatality Review Teams

To address some of these inconsistencies, multidisciplinary/multiagency Child Fatality Review Teams have emerged in many states to provide a coordinated approach to the investigation of child deaths. These teams are comprised of prosecutors, coroners or medical examiners, law enforcement personnel, CPS workers, public health care providers, and others.

The teams review cases of child deaths and facilitate appropriate follow-up. The follow-up may include assuring that services are provided for surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems. In addition, teams can assist in determining avenues for prevention efforts and improving training for front-line workers. Well-designed, properly organized Child Fatality Review Teams appear to offer the greatest hope for determining the underlying nature and scope of fatalities due to child abuse and neglect and for offering solutions.

Sources: "FAQs About Child Fatalities;" "Current Trends in Child Maltreatment Reporting Laws, September 1999;" and "What is Child Maltreatment?" - National Clearinghouse on Child Abuse and Neglect Information, U.S. Department of Health and Human Services.

Munchausen Syndrome by Proxy

A strange and often overlooked form of child abuse

Hieronymous Karl Fredrich von Munchausen was an 18th century German baron and mercenary officer in the Russian cavalry. On his return from the Russo-Turkish wars, the baron entertained friends and neighbors with stories of his many exploits. Over time, his stories grew more and more expansive, and finally, quite outlandish. Munchausen became somewhat famous after a collection of his tales was published.

In 1794, at the age of 74, Munchausen married Bernhardine Brun, then 17 years old. It is said that on their wedding night, the baron retired early, and his bride spent the night dancing with another. In 1795, Bernhardine gave birth to a son. Following the birth of this child, it was whispered that "the life of the Munchausen child will likely be short." The boy, named Polle, died at approximately 1 year of age under suspicious circumstances.

Almost a century later, an unusual behavior pattern among young men gained recognition in the writings of Charcot. In 1877, he described adults, who through self-inflicted injuries or bogus medical documents, attempted to gain hospitalization and treatment. Charcot called this condition "mania operativa passiva."

Seventy-four years later, in 1951, Asher described a similar pattern of self-abuse, where individuals fabricated histories of illness. These fabrications invariably led to complex medical investigations, hospitalizations, and at times, needless surgery. Remembering Baron von Munchausen and his apocryphal tales, Asher named this condition Munchausen's Syndrome.

Today, Munchausen's Syndrome is a recognized psychiatric disorder. *The American Psychiatric Association's Diagnostic and Statistical Manual of Disorders* (DSM III-R) describes it as the "intentional production of physical symptoms."

What is Munchausen Syndrome by Proxy?

The term "Munchausen Syndrome by Proxy" (MSBP) was coined in a 1976 report describing four children who were so severely abused they were dwarfed. In 1977, Meadow described a somewhat less extreme form of child abuse in which mothers deliberately induced or falsely reported illnesses in their children. He also referred to this behavior as MSBP.

Over the years, alternate terms, such as "Polle's syndrome" and "Meadow's syndrome," have been suggested; however, these terms never gained popularity. In contrast to its adult namesake, the American Psychiatric Association's DSM III-R does not consider Munchausen Syndrome by Proxy a psychiatric disorder.

Tragically, MSBP victims are usually children, and the perpetrators are almost always parents or parent substitutes. If and when victims are hospitalized, they may be subjected to multiple, and often, dangerous diagnostic procedures that invariably produce negative or confounding results. When the victim and abuser are separated, however, the victim's symptoms cease. When confronted, the abuser characteristically denies any knowledge of how the child's illness occurred

What are the Symptoms?

- A child who has one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling and unexplained.
- Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.
- A parent, usually the mother, who appears to be medically knowledgeable and/or fascinated with medical details and hospital gossip, appears to enjoy the hospital environment, and expresses interest in the details of other patients' problems.
- A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.
- A parent who appears to be unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, second opinions, and transfers to other more sophisticated facilities.
- The suspected parent may work in the health care field herself or possess interest in a health-related job.
- The signs and symptoms of a child's illness do not occur in the parent's absence (hospitalization and careful monitoring may be necessary to establish this casual relationship).
- A family history of similar illness or unexplained sibling illness or death
- A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.
- A suspected parent with an emotionally distant relationship with her spouse; the spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.
- A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, that affect her child her family while her child is undergoing treatment.
- A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgement of her abilities.

Source: The AsherMeadow MSP Resource Center <www.ashermeadow.com>.

Disclaimer: The content displayed on the AsherMeadow web site is designed to educate and inform. Under no circumstances is it meant to replace the expert care and advice of a qualified physician.

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Summer's Almost Over and the Time is Right for Planning Your Retirement

Summer is now almost over, and warm weather, vacations, little league baseball games and cookouts have taken a back seat to gearing up for another school year.

Whether your summer was busier than ever or your plans proudly involved little more than relaxing in a hammock with a glass of ice tea, this halfway point of the year offers a great opportunity to evaluate your investment goals for retirement and how your portfolio is designed to meet them.

Everyone has a different idea of what his or her retirement will hold. Whether it means traveling the world, volunteering time, starting a business or visiting family, your retirement plan should allow you to reach a goal that is important to you and your loved ones.

You have several investments choices to help you seek your ideal retirement. A 401(k) or 403 (b) plans through work or an IRA are investment vehicles that can offer tax- advantaged investing, helping you keep more of what you earn while creating a long – term investment plan.

Once you have started investing for your retirement, you'll want to evaluate how much risk is acceptable to you. Certain types of investments are inherently more risky than others, but may have the potential for higher returns. Does it make you nervous to see the value of your retirement nest egg fluctuate with changes in the markets? If so, you might be more comfortable in less volatile investments. In any case you should diversify your portfolio to help safeguard against inevitable ups and downs in the markets.

A diversified collection of investments can mean much more than owning several mutual funds. If you examine the holdings in your funds and find that they hold many of the same securities, your portfolio may be vulnerable to dips in the markets.

Other factors to consider may be how close to retirement age you are. It is likely that the closer you get to the age when you will need your money, you will want to move portions of your portfolio to more conservative investments.

Once your plan is in place, you should monitor its performance at least annually to ensure that its holdings are still in line with your retirement goals. Life is a long, exciting journey, and your priorities and needs may shift from time to time.

Once your retirement plan is in place, however, you can afford to be patient and let compounding interest work to your favor. Compounding interest, in which your investment earns interest on both the original investment and the gains on that investment, is your retirement plan's best friend over time.

As the saying goes, " summertime, and the living's easy." By investing diligently in a retirement plan that meets your tolerance to risk and is designed to meet your future goals, you can go a long way toward "living easy" for many summers to come.

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Donald J. Krpan, D.O.

New President of the American Osteopathic Association

Donald J. Krpan, D.O., F.A.C.O.F.P., was installed as president of the American Osteopathi Association (AOA) at the recent AOA's House of Delegates Meeting held in Chicago. Dr. Krpan, board certified family practice physician and a fellow of the American College of Family Physician will devote the year of his presidency to osteopathic graduate medical education's challenges an opportunities.

A practicing family and emergency room physician for 20 years, Dr. Krpan currently serves as th University Provost at Western University of Health Sciences College of Osteopathic Medicine of th Pacific in Pomona, California. In addition, he serves as a member of the board of directors of Ma River Community Hospital in Arcata, California, and a member of the Joint Conference Committee o Arrowhead Regional Medical Center in San Bernardino.

Dr. Krpan has been involved with the osteopathic profession in a number of capacities befor becoming AOA president. He serves as chairman of the ethics committee of the Osteopathic Medica Board of California, and is emeritus member of the Osteopathic Physicians and Surgeons of California's board of directors after servin as its president in 1982 and 1988. Dr. Krpan has also served as a member of the AOA's Board of Trustees since 1988, as well as member of its House of Delegates

A graduate of the University of Health Sciences/College of Osteopathic Medicine in Kansas City, Missouri., Dr. Krpan complete a rotating internship at Phoenix (Arizona.) General Hospital. He has two sons and a nephew who are also osteopathic physicians.

AAOA PRESIDENT RITA BAKER ADDRESSES AOA HOUSE OF DELEGATES

The following is the speech presented by Rita Baker, current president of the Auxiliary to the American Osteopathic Association, to the AOA House of Delegates meeting on July 27.

I bring all of you greetings from the Auxiliary to the American Osteopathic Association and the great state of Texas.

One of my goals this year has been to get the information out to our membership on the Unity Campaign. I have shared with each officer that I installed the information that I received through the Ambassador training program. I have encouraged each auxiliary member to learn the tag line and include this in every piece of correspondence.

Each one of us is proud of our spouse's profession and therefore we must be willing to tell our friends, children's teachers, and anyone we come into contact with what osteopathic medicine is and how our spouses have a unique medical philosophy to offer patients. We need to promote the osteopathic difference.

As a speech pathologist I have had the opportunity to work with both D.O.s and M.D.s and I have seen first hand what the osteopathic profession has to offer. I feel we should be proud of the uniqueness of osteopathic medicine and never pass up an opportunity to let our light shine in the public eye. We cannot "blame" others for what they do not know about osteopathic medicine since it is our responsibility to create awareness and provide information.

One of the things that I learned through the ambassador training program is that we need to be involved in something that the public is interested in to be a vehicle through which we can bring out our tag line. The auxiliaries' association with the Yellow Ribbon Teen Suicide Program gives us this vehicle. Several years ago Marge Croushore, 1st vice president of the auxiliary, was in charge of long range planning. She researched how organizations in America would be changing over the next 20 years and how, if an organization were going to survive in the 21st century, it would have to change to meet the needs of its members. The author projected that in the 21st century people will no longer join an organization simply for socialization. They will join for personal growth and to fulfill the need of helping their fellow man through community involvement. It was about this time that Marge read about the Yellow Ribbon Program in one of the "Chicken Soup for the Soul" books. She had the vision to see that this was a community outreach program with which everyone would want to be involved. Teenage suicide is reaching epidemic proportions, not only affecting teenagers but children as young as 9 and 10 years of age. Each time someone sees the video that the Auxiliary developed for the yellow ribbon program they are seeing osteopathic medicine. Each time an auxiliary member gives out a yellow ribbon card, the name of the Auxiliary to the American Osteopathic Association is on the card. This is a wonderful program for the auxiliary to align themselves with.

I would like to share with you some of the ways that the auxiliary has teamed up with the AOA over the last year: Through the Auxiliary National Ad Campaign fund, we placed ads in two San Francisco newspapers at a cost of $35,000 to support the Woman's Health Symposium, held in conjunction with the AOA convention with over 600 women in attendance.

Plans are under way to support the symposium, which will take place during National Osteopathic Medicine Week in New York City, this year targeting young women ages 12-24. The auxiliaries' association with the Yellow Ribbon Teen Suicide Program fits nicely into the AOA's plan to target this age group. Plans are underway to bring the Emme family, who started the Yellow Ribbon Teen Suicide Program after their son Michael, age 17, committed suicide, to New York with Marge Croushore, AAOA 1st vice president.

Through our AAOA Scholarship Program, two osteopathic students received a $5,000 scholarship this year. Since the inception of the AAOA scholarship program, we have given over $1.5 million to osteopathic students through scholarships.

Dr. Oliveri has designated this year as "the year of the student". The auxiliary has taken this to heart and has designated $1,000 scholarship to be given to each of the 19 osteopathic schools through SOMA.

We have also given $20,000 over the last two years for public relations projects by SOMA on the campus of osteopathic colleges. In total, the auxiliary has given over $49,000 in two years to the osteopathic students. Like the AOA, the Auxiliary feels our future is our students.

The auxiliary has funded the legislative hotline in Washington, D. C., for the past 59 months. As many of you are aware, this hotline informs physicians and their families regarding federal issues affecting the profession and physicians. The calls to this hotline have increased significantly over the last year thanks to the special efforts of Heidi Ecker.

The Auxiliary gave $15,000 to develop a magazine ad to promote the AOA healthcare accreditation program to hospitals throughout the country. We have also participated in the Unity Campaign by giving over $6,500 over the last two years.

The Auxiliary will be sponsoring their 6th annual AAOA Fore You Golf Tournament in Orlando, Florida at Falcon's Fire Golf Course on Sunday, October 29th. The money raised from this tournament allows the auxiliary to continue their support of the profession. I would like to encourage you to sponsor a Tee Sign for $100 and if any of you are interested in playing, I will have brochures available or you can contact Bridget Price, our Executive Director at the AOA Office.

My theme this year has been, "We are a family, the Osteopathic Family". As I have traveled throughout the states I have experienced the true meaning of "The Osteopathic Family". This has been a year

of challenges but one that I will remember for a lifetime.

My first official visit was in California where my daughter and I were made to feel like family by the California association. Don and Gay Krpan took Carrie and I under their wing, picking us up at the airport and including both of us in all activities. I was impressed by how the family was a part of all the activities associated with the convention from the magic show through president's night.

During my visit to New Jersey the words that came to mind were "Steeped in Tradition". As I sat with Phyllis and Howard Levine, and watched their son Marty receive the physician of the year award, I witnessed a classic example of how the tradition of working for our great profession is passed on from generation to generation.

My next visit was Oklahoma. What can be said about Oklahoma! It was one extraordinary birthday party as they celebrated their 100th year. The traditions that Bob Jones created in Oklahoma live on. From the youngest to the oldest, there are activities for every member of the osteopathic family and everyone is made to feel a part of that family.

While at the Missouri Convention, Dale and Dar Emme were special guest speakers at the joint luncheon of physicians and their spouses. Many of the physicians at this luncheon were so moved by the Emme's Yellow Ribbon Teen Suicide presentation that they stood in line for an hour to find out more information on how to implement this worthwhile program into their community. I witnessed that day that the compassion of the osteopathic physician which goes far beyond their immediate family and patients, as they embraced their community by implementing this program. This is a good example of how the osteopathic physician cares about the whole person, not just their symptoms.

This was my second year as the official visitor to the Michigan Osteopathic Convention. The first year I was welcomed but this year I felt like a member of the family. It was wonderful seeing how much the Michigan auxiliary had accomplished in a year.

The auxiliary even serenaded me with the anniversary waltz when they learned that it was my 25th wedding anniversary and Mark and I were spending it apart.

Dr. Bill Mayo and Jeffery LeBeauf invited me to the Mississippi state convention in Destin, Florida in the hopes that I might be able to spark an interest in starting a state auxiliary. I was given a few minutes to give my speech about what the auxiliary was doing at the national level and then I showed two video tapes on the Yellow Ribbon Teen Suicide Program. The first video was one that was developed by the auxiliary; the second was a clipping on the Yellow Ribbon Program from the Oprah show. The story of the Yellow Ribbon program is so moving that there weren't many dry eyes in the room. Later I received an e-mail from Bill stating that the Mississippi delegation was so moved by the presentation that the association plans to have an active auxiliary in place by next year. Bill explained that several members took the yellow ribbon cards to implement this program in their hometowns.

My last official visit was in Texa Words cannot express how much I ha appreciated all the support I received fro the physicians and auxiliary membe throughout the state. They not only raise the money necessary for my installatio but they have supported me in all m endeavors this year. The TOMA District physicians gave $2,500 for the ATOM and UNTHSC/TCOM Student Auxiliar book cover project. (The Pages have give each of you one of these book covers.) Th AAOA Special Projects Fund has awarde us a matching grant to cover the remainde of the expenses of these book cover which will be distributed to over 49,00 area high school and junior high student in the Dallas/Ft. Worth area. Each boo cover contains information on the Yellow Ribbon Program and the tag line, "Doctor of Osteopathic Medicine treating peopl not just their symptoms", with other ke messages about osteopathic medicine fron the ambassador training program.

At this time, I would like to personall thank Mr. John Crosby for his article i the June issue of *The D.O.* magazin about the auxiliary. I would like to ask each of you to pay your spouse's dues a the state and national level so that th auxiliary can continue to work for th osteopathic profession.

My year is coming to a close but the hard work of the auxiliary board and its members will continue. I will always be grateful to each of you who give of your time and talents for this profession.

We still have a lot of work to do to promote the osteopathic difference, but I believe if we continue to work as a family, the Osteopathic Family, the best is yet to come.

According to Study, Medicare HMOs Provide a Poorer Quality of Treatment than Medicare Fee-for-Service

According to a University of Colorado study, published in the *Journal of the American Geriatrics Society*, involving Medicare HMO and Medicare Fee-for-Service stroke patients, statistics show that HMO patients received substantially less skilled nursing, physical therapy and occupational therapy during their rehabilitation stay in a hospital, while Fee-for-Service patients received more care from attending physicians, neurologists, physiatrists and psychologists. The Fee-for-Service patients also had longer hospital stays and a greater number of outpatient visits to doctors, while the HMO patients received more outpatient physical therapy and occupational therapy and more home health care subsequent to shorter, less-intensive rehabilitation stays.

Out of Whitesboro

One Medical Student's View of a Community-Based Rural Medicine Preceptorship

by

Ruth Ann Adell, BS, Medical Student

Barbara D. Adams, MSA, Assistant Director, Rural Family Medicine Track

and John R. Bowling, D.O., Director, Rural Family Medicine Track

Introduction

Since 1996 the Texas College of Osteopathic Medicine's Department of Family Medicine at the University of North Texas Health Science Center at Fort Worth has provided undergraduate medical students with training opportunities through the Rural Family Medicine Track. The Rural Track is a longitudinal, multi-dimensional training program in which students may elect to participate. Track experiences include immersion into a rural, often medically underserved, community through daily contact with community residents and community service resources as well as clinical training with a physician preceptor. Over the course of four years, students return to the same rural community and physician preceptor's office to experience the practice of medicine and living in a rural environment. This approach fulfills one goal of the Rural Track: to provide exposure to and experience of family medicine as it is practiced in a rural setting.

After the first year of medical school, Track participants complete their first visit to the rural community. Students are required to complete a minimum preceptorship visit of 4 days, including part of a weekend. Some students, however, elect to remain for a one month. This first "Rural Lifestyle/Practice Visit" introduces students to rural family medicine as well as the equally important lifestyle found in a rural community.

Upon completion of this initial Track component, students write a paper about their experience. The content of the resulting papers has ranged from being quite simplistic to rather sophisticated, but in all cases students have conveyed an increased understanding about their preceptor's practice and insights about rural healthcare, the community and the rural lifestyle.

What follows is one student's sharing of her first experience with her assigned preceptor. The insights and opinions expressed are deeply personal to this student. Her story, however, illustrates how direct early clinical and community involvement stimulates awareness that rural healthcare is not just about clinical practice. This increased awareness may be pivotal to later career decision. Her story provides valuable insight into the ongoing academic efforts to encourage graduates to choose the practice of rural medicine thereby addressing the physician workforce needs of Texas.

Student Experience of Ruth Ann Adell

My experience in Whitesboro, Texas was completely different, I am certain, than that of any other student in the Rural Track. Perhaps this was due to the four-week duration or the fact that I commuted each day from Denton, a distance of over 30 miles. But there were other circumstances, which contributed to creating such a unique preceptorship. Dr. John Galewaler, a family medicine practitioner, is an unusual personality. He dresses casually in blue jeans and wears support hose with his Birkenstock sandals. While he may have a tendency to be absent minded, he has a forceful way of looking after the welfare of his patients, particularly those in nursing homes, that is unlike anything I have ever witnessed before. All of my questions, bizarre or otherwise, were addressed by him with utmost honesty, and he regarded the experience as a learning opportunity for himself as well. He is no longer involved in any community activities. He runs his clinics in Whitesboro and Celina, visits his nursing home and hospital patients, and then spends any other free time he might have with his son who sustained a serious brain injury just over a year ago.

Most of Dr. Galewaler's patients are elderly. I have identified several reasons for this. Since Dr. Galewaler uses a large amount of manipulative treatment on his patients, he is uniquely suited to helping relieve the aches, pains, and stresses of advancing age. No complaint is too ridiculous not to warrant his whole attention and best efforts at treatment. Sometimes all an elderly patient can tell you is that they just do not feel well. Not many physicians are imbued with enough patience to wade through the ambiguities to arrive at the central problem. Furthermore, many of the patients that Dr. Galewaler sees he has been treating for over 25 years, ever since he first arrived in Whitesboro. When a physician gets to know a patient that well, it is easier to see when there is something seriously wrong or if it is just a case of histrionics.

Since the average age of Dr. Galewaler's patients is over 65, and because many of them lack a good income, many of his patients carry Medicare or Medicaid. The remainder pay with other insurance or out of pocket. There are a few patients who travel from as far as Arlington, Texas, 55 miles away, to visit him at his Celina clinic, but the majority actually live in or around Whitesboro and Celina. If I were asked to nail down common complaints, I really could not do that. Every day, there are different complaints and different symptoms. They are as diverse as the population. One day we saw two cases of shingles. Another day a patient came in with a severe case of jaundice not caused by hepatitis. There were complaints about arthritis and asthma and vertigo and sinus infections and so on and so on. Many husbands and wives came to be seen together at the same time, as well as mothers and kids.

The Whitesboro clinic contains an X-ray machine, CBC machine, and an osteoporosis bone density scanner. Joe Gray, PA, a physician assistant, assists with the patients, as do the two nurses. There are four front office personnel who are responsible for scheduling, filing, and insurance paperwork. The Celina office, thirty miles away, is run by Dr. Galewaler's daughter. She manages scheduling, patient chart dictation, insurance paperwork, and in office testing (strep, UA, etc.). Another of Dr.

Galewaler's daughters handles his and Joe Gray's patient chart dictation. Virginia, the office manager and general jack of all trades, oversees personnel, accounts, supply purchasing, and anything and everything else for both the Whitesboro and Celina offices. All billing is handled by an outside individual. I noticed very quickly that most all of Dr. Galewaler's employees are fiercely loyal to him, and not simply because some of them are related to him. The same holds true of his patients, who like to bring in lunch or dessert for everyone on occasion!

If serious testing is required, such as GI studies, mammograms, and stress testing, patients are referred to a hospital located in a nearby community. In fact, if hospitalization is required, this hospital is where they are sent. There is a huge amount of driving going on each day. Hospital rounds occur in the morning. From there it is off to Whitesboro or Celina for the rest of the morning, and in the afternoon, it is off to the other clinic. On Fridays, the day begins at 5:30 AM in Denison at the methadone clinic followed by rounds and clinic. Compounded with my forty-five minute commute to and from Denton, I think I have single-handedly brought down the ozone layer! Without a doubt, I did miss a considerable amount of sleep, because besides early mornings and even later evenings, I usually went home with a homework assignment of something to research, look up, or read. Not that I am complaining.

As mentioned before, Dr. Galewaler is not involved in community activities, because he feels that his time is better spent with his family, primarily his son Sean. Each morning, after visiting the hospital, we stopped at the nursing home that is caring for Sean to visit with him for a few minutes. In the evenings, Dr. Galewaler headed back to stay with Sean until he went to bed. Every weekend, he is with Sean. I could see that the time Dr. Galewaler spent with his son was deeply personal, and naturally, I hesitated to intrude beyond the week day morning visitations. For some reason, after seeing Sean each morning, I felt calmer and more alive than before. I cannot explain it. During the four weeks, I watched Sean's walking improve dramatically. By the last day I was there, I watched him demonstrate that he could actually pick up his feet and move them forward, as opposed to shuffling. Even if it was for just a brief moment before he returned to his wheelchair, it was a major triumph!

"...traits of a rural medical practice...hospitals are hours away, there is only one physician in the area and cows outnumber people."

To describe the essential features of a truly rural medical practice, I do not believe that you would be looking in North Texas. There are several things that I have always considered to be traits of a rural medical practice...hospitals are hours away, there is only one physician in the area, and cows outnumber people. For years, the Celina clinic operated as a rural clinic. I understand that Dr. Galewaler's predecessor, delivered countless babies and performed major surgeries in that office, all without hot running water. But, very few general practitioners anywhere want to mess with obstetrics nowadays, and they do not have to. No one does tonsillectomies in the office anymore.

While distances traveled are still great, and people are still primarily poor, rural practice is not much different than city or suburban practice. What separates them? The patients. There are more people in rural communities who feel that they cannot afford a trip to the dentist to remove or repair rotting teeth. Infections are treated with less aggressive antibiotics, as the bacteria themselves are not as aggressive. Complaints are more diverse. Most of these people do not run to the doctor when they start to get a scratchy throat or the sniffles. They wait until their entire ear is swollen shut and their jaw deviates from the midline before they come in. Yet, if Dr. Galewaler were to leave, there are other doctors in the area to take his patients. The care would be different, but not inadequate.

I have been asked to describe significant problems that impact on health in the Whitesboro and Celina communities. I have no answer for this other than perhaps low income. This is taken care of by our government by placing patients o Medicare or Medicaid. But, insuranc brings up a universal problem that is nc unique to the rural areas. Insuranc companies only allow certain drugs o certain types of treatment, reduce hospital stays, and less money to th physician. I spent a day with Dr Galewaler's office manager to learn abou the business side of medicine. A few year ago, a popular injection was reimburse at $15, but this has been reduced to $2.00 payback, not covering the medica tion itself, much less the syringe an personnel to deliver it. Apparently, al popular medications, treatments, and test are done this way. When insurance companies realize that a lot of money is being expended in a certain direction they respond by reducing the reimburse ment beyond the point of feasibility so doctors have no choice but to cease using it. These actions do impact the quality of care patients receive.

For several hours, I visited with the two independent pharmacists in Whitesboro. This was an amazing eye opener. The number one thing they emphasized, of course, was to make sure that throughout my career my handwriting remained legible. Too many people die and too much time is wasted because of illegible writing.

Even more interesting was the fact that both compound medications. I had no idea what this was, and actually figured it was some voodoo weirdo type of treatment. Not true. One pharmacist told me that pills, such as Viagra, come in 20mg, 40mg, and 60mg sizes, but all cost exactly the same amount of money. He simply buys a stock of the 60mg pills, grinds them up, and makes 20mg or 40mg sizes, saving his customers money. He also holds contracts with the nursing homes and hospices in the area to put pain medications into forms that can get into the blood stream of patients that are dehydrated and unable to swallow. This includes putting morphine into eye drops, creams, and suppositories.

At one pharmacy I was shown that pharmacists are making very, very little money on some prescriptions they fill, and maybe only very little money on others. No wonder it is difficult for small, independent pharmacists to remain in business! Dr. Galewaler's Whitesboro office has a direct phone line to

one pharmacist, and the two maintain a great working relationship, asking questions of each other constantly. I believe they succeed in giving patients better care. Since physicians and pharmacists really are working in conjunction with each other, perhaps all student doctors should take a similar visit to pharmacies!

I also spent time seeing patients at nursing homes in surrounding areas. The atmospheres of these nursing homes were in stark contrast to each other. One had a horrid chemical smell in its hallways that was almost overpowering, while another did not. Two homes were fairly quiet places with very little patient disruption. By far the happiest place for patients it seemed was the place with the worst reputation. It was noisy, and somewhat hot, but both the nurses and the patients did a lot of smiling. The nursing staff seemed genuinely concerned about the welfare of the people they were taking care of. This could have been due to being located in a larger city and having a larger patient community. It could also have been due to the fact that many of the patients were not dying of old age, but were rather young people placed there because of various illnesses. Because of Dr. Galewaler's deep involvement with the nursing home communities, I learned that some nurses can be uncaring and unfeeling, administrators only concerned with the bottom line and extracting revenge, and patients and families caught somewhere in the middle. After seeing some of the patients, I learned that death is sometimes a blessing and that allowing someone to die is often the best thing for them. After feeling that death should be something fought against at all costs, the realization that death is acceptable was a huge relief for me.

Being in solo practice with only his physician assistant to help, Dr. Galewaler spends a lot of time on call. All of his patients have access to his home phone number in case of emergency. While this may be considered a drawback of individual practice, he does not receive frivolous phone calls in the middle of the night. Vacations, however, are few and far between. While Dr. Galewaler has practiced with partners in the past, he does not wish to do so in the future, unless it is with a good physician assistant, like Joe. I believe that this is because of Dr. Galewaler's strong personality.

Conclusion

There is a real danger here of over analyzing rural practice and thereby making it bigger and more mysterious than it really is. The key to rural practices is that each one is as different and unique as the doctor and patients involved in it. Whether a practice is run individually, by a group, or by a university, it is a dynamic entity that is constantly changing and evolving. The Celina Clinic was basically a rural emergency room/hospital forty years ago. Currently, it is simply a family practice clinic. In the future, it will become something entirely different. Communities that rural clinics serve are constantly growing or shrinking, aging or growing younger, earning money or losing it. It is difficult to predict them and even more difficult to squeeze them into categories. Very little of what I read in the literature assigned seemed applicable to Whitesboro or Celina. Perhaps that is the whole reason for visiting and working within rural communities—to realize that a student can never accept what is said about these areas to be universal truths.

TWCC Announces Medical Review Educational Seminars

Texas Workers' Compensation Commission has announced its general education seminars for the year 2000. These one-day seminars will cover selected workers' compensation medical benefits topics, with an emphasis on the new rules governing billing and reimbursement for treatment of injured employees. Medical Review seminars are designed for health care provider billing staff, insurance carrier staff, and utilization review agents, but are open to the public.

McAllen – October 4
Four Points Sheraton
2721 South 10th Street
956-984-7900
Mail registration by September 13

Lubbock – October 18
Four Points Sheraton, 505 Avenue Q
806-747-0171
Mail registration by September 27

San Antonio – October 26
Omni San Antonio
9821 Colonnade Blvd.
210-699-5827
Mail registration by October 5

Austin – November 2
Omni Hotel Southpark
4140 Governor's Row
512-448-2222
Mail registration by October 12

Corpus Christi – November 14
Omni Marina Hotel
707 North Shoreline Blvd.
361-882-1700
Mail registration by October 24

Registration forms can be downloaded from the TWCC Web site at <www.twcc.state.tx.us>.

Any questions may be directed to 512-804-4842.

The board and members of the
Texas College of Osteopathic Medicine
Alumni Association
extend a warm welcome to
University of North Texas Health Science Center
Incoming President

RONALD R. BLANCK, D.O.

TEXAS COLLEGE OF OSTEOPATHIC MEDICINE
ALUMNI ASSOCIATION

Texas Delegates Achieve Results at the AOA House of Delegates

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

Your dedicated colleagues who served as delegates to the American Osteopathic Association's House of Delegates contributed a lot to make this year's House a valuable experience for Texas osteopathic physicians. Accomplishments at the AOA House of Delegates don't happen in a year; they are achieved over time. Our delegation worked hard to build a level of trust and understanding that is rarely found in professional organizations. Some of our delegation's efforts came to fruition this summer when Robert L. Peters, Jr., D.O. and T. Eugene Zachary, D.O. were both elected to serve terms on the AOA Board of Trustees and Mark A. Baker, D.O. was elected to serve as Speaker of the House for the American Osteopathic Association.

The Texas delegation to the American Osteopathic Association's House of Delegates, led by Chairman Mark A. Baker, D.O. and Vice Chairman Rodney M. Wiseman, D.O., met in Chicago on July 27 through July 30, 2000 for the AOA Annual House of Delegates. Thirteen delegates, seven alternate delegates and two student delegates from the Texas College of Osteopathic Medicine traveled to the meeting. The Texas Delegation included: Drs. Mark A. Baker of Fort Worth; George M. Cole of Amarillo; James W. Czewski of Fort Worth; Al E. Faigin of Fort Worth; James E. Froelich, III of Bonham; Russell G. Gamber of Fort Worth; Patrick J. Hanford of Lubbock; Royce K. Keilers of LaGrange; Harold D. Lewis of Austin; Jack McCarty of Lubbock; Ray L. Morrison of Crockett; R. Gene Moult of Dallas; Elizabeth A. Palmarozzi of Fort Worth; Robert L. Peters, Jr. of Round Rock; Daniel W. Saylak of College Station; George N. Smith of West; Arthur J. Speece, III of Burleson; Monte E. Troutman of Fort Worth; Rodney M. Wiseman of Whitehouse; and John L. Wright, Jr. of Plano. Shelly R. Van Scoyk was the student doctor delegate and Gregory D. Iverson was the student doctor alternate.

The TOMA delegation met for over three hours on Thursday evening, prior to the release of all resolutions and their assignment to reference committees, to review the resolutions that were available at that time. The delegation met again on Friday and Saturday mornings to discuss other resolutions and to decide which reference committee each delegate would attend and monitor. The TOMA delegation is to be commended for their participation and input on the resolutions. Delegates – a job well done.

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

- Mark A. Baker, D.O., chaired the Committee on Constitution and Bylaws;
- George M. Cole, D.O., Elizabeth A. Palmarozzi, D.O., and Student Doctor Shelly R. Van Scoyk served as members of the Ad Hoc Committee;
- Monte E. Troutman, D.O., served as a member of the Joint Board/House Budget Review Committee;

continued on next page

- James E. Froelich, III, D.O., served as a member of the Committee on Public Affairs;
- Rodney M. Wiseman, D.O., served as a member of the Committee on Professional Affairs;

Donald J. Krpan, D.O., of Yorba Linda, California assumed the presidency of the American Osteopathic Association. Other officers elected were: **James E. Zini, D.O.** (Arkansas) President Elect; **Amelia G. Tunanidas, D.O.** (Ohio) 1st Vice-President; **Ray E. Stowers, D.O.** (Oklahoma) 2nd Vice-President; and **Martin S. Levine, D.O.** (New Jersey) 3rd Vice-President. Those elected to 3-year terms on the AOA Board of Trustees are: **Walter B. Flesner, III, D.O.** (Florida); **E. Lee Wallace, D.O.** (Iowa); **Robert L. Peters, Jr., D.O.** (Texas); **E. Dale Brandt, D.O.** (Florida); **Darryl A. Beehler, D.O.** (Minnesota); **Karen J. Nichols, D.O.** (Arizona). Elected to serve unexpired two-year terms on the AOA Board of Trustees were **T. Eugene Zachary, D.O.** (Texas) and **Larry A. Wickless, D.O.** (Michigan). Because of the passage of an amendment to the Bylaws, for the first time in the history of the AOA, an osteopathic student will serve on the Board. **Student Doctor Jason James** will represent the Council of Student Council Presidents. Next year, the student representative on the Board will be selected by the Student Osteopathic Medical Association (SOMA). These two organizations will rotate their selections.

Elected to his 1st term as AOA Speaker of the House was **Mark A. Baker, D.O.** (Texas). Others elected were **Robert S. Seiple, D.O.** (Ohio) vice speaker; **Ethan R. Allen, D.O.** (California) Osteopathic Progress Fund; and, **William S. Mayo, D.O.** (Mississippi) to a 3-year term on the Bureau of Insurance.

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

TOMA#	AOA#	TITLE	ACTION
00-01	265	Honorary D.O. Degree	Withdrawn
00-02	266	Andrew Taylor Still, M.D.	Approved as Amended
00-05	267	Diabetics Confined to Correctional Institutions	Approved
00-06	268	Diabetic Meals for Students	Approved
00-09	269	Transportation at AOA SponsoredMeetings and Conventions	Referred to the Bureau of Conventions
00-12	270	Hyperbaric Medicine	Combined with Resolution #248

JOINT BOARD/HOUSE BUDGET REVIEW COMMITTEE

This committee met on July 28th to review the proposed budget for the American Osteopathic Association for 2000 - 2001. The Committee recommended a $100/year increase in AOA dues for all members of the AOA (other than students, interns and residents) bringing regular members' dues to $590.

The committee also reported that the AOA has achieved its go of having one year's operating funds in reserve. The basic figur listed below reflect the proposed budget for the fiscal year 200

Total Operating Revenues	$16,272,306
Total Operating Expenditures	$15,307,438
Excess of Operating Revenue over Expenses	$964,868
Non-operating Revenues (AOA Building and Investments)	$272,741
Certifying Boards Income	$279,645
Increase AOA Net Assets in FY '01	$1,574,711
TOTAL ASSETS	$47,716,994
TOTAL LIABILITIES	$14,660,063
TOTAL NET ASSETS	$33,056,931

This budget was recommended to the house and wa approved as of July 30, 2000. A copy of the complete AO budget is on file in the TOMA office for examination by th membership.

COMMITTEE ON CONSTITUTION AND BYLAWS

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

PROPOSED AMEMDMENTS TO THE CONSTITUTION

Article VI – House of Delegates, Section 1 – Composition Representation of Interns and Residents in the House o Delegates. It was determined that this amendment would allo intern and resident delegates to be seated in the 2000 House, bu they cannot vote or make motions until the House acts on the proposed amendments to the Constitution (2 years). This proposed amendment would be placed before the House in July 2001, for final action:

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

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

Article VIII – Board of Trustees and Executive Committee, Section 1 – Board of Trustees

The second sentence in Paragraph 1 was approved to be amended to read:

All Trustees, with the exception of the President, President Elect, and the Past Presidents for the preceding two years, the aggregate terms of office of Trustees shall be limited to twelve (12) years, with the exception that a Trustee may complete the term in which twelve (12) years or more of service is complete.

Explanatory Statement: This proposed amendment imposes a limitation of twelve years total not just consecutive years. Any trustee who has a total of less than twelve years (e.g., ten years)

riay be elected to a three-year term and may serve out that term, even though it may exceed twelve years. The above change shall not apply to any Trustee serving at the time of such adoption.

Article VIII – Board of Trustees and Executive Committee, Section 1 – Board of Trustees – Recommended for adoption by the Committee on Constitution and Bylaws at the July, 2000 House of Delegates meeting.

This proposed amendment would increase the number of members on the Board of Trustees to nineteen (19) by adding a student member. It was recommended for adoption by the Committee on Constitution and Bylaws/House of Delegates:

> ...and a student member elected by the House of Delegates to serve one year. Candidates for the student position shall be nominated, in alternating years, by the Council of Student Council Presidents (CSCP) and the Student Osteopathic Medical Association (SOMA).

Explanatory Statement: The student position would be an additional position on the Board of Trustees. It is suggested that the appointments be made based on the nominations in alternating years by the CSCP and SOMA, so that one year CSCP would submit the nomination and the next year the nomination would be made by SOMA. Each year the nomination should be made from the floor of the House of Delegates by the President of the nominating organization at the appropriate time in the nominating process.

COMMITTEE ON PROFESSIONAL AFFAIRS

201 Animals in Medical Research - *Approved*
207 Health Related Policies Mission Statement - *Approved*
208 Confidentiality of Patient Records - *Approved*
209 Death – Right to Die - *Approved*
210 Development and Use of Marker System - *Approved as Amended*
213 Executions in Capital Crimes - *Approved as Amended*
215 Health Care Institutional Responsibilities - *Referred to Legal Counsel*
217 Information to Legislators - *Approved (adopted to delete)*
223 Medicare Medical and Gynecological Screenings - *Approved*
228 Osteopathic Education at Rural Sites - *Approved*
233 Postgraduate Stipends - *Approved*
234 Prescription of Drugs for off Label Uses - *Approved*
237 Second Opinion – Surgical Cases - *Approved*
238 Specialty Certification – Osteopathic Membership of DOs - *Approved*
244 Tanning Devices - *Approved as Amended*
248 Hyperbaric Medicine - *Approved as Amended*
252 Prescribing and Dispensing Pharmaceuticals Over the Internet - *Approved as Amended*
253 Pharmacists Scope of Practice Expansion - *Withdrawn*
254 Osteopathic CME for Licensure - *Disapproved*
256 OPTI Training Pathway - *Withdrawn*
259 Osteopathic Unity and Identity - *Approved*
263 Expansion of AOA Approved Intern Positions - *Disapproved*
269 Transportation at AOA Sponsored Meetings and Conventions - *Referred to the Bureau of Conventions*
270 Hyperbaric Medicine - *Disapproved*
276 Osteopathic Unity and Identity - *Withdrawn*
279 Supervision of Non-physician Clinicians - *Disapproved*
280 Non-physician Clinicians - *Approved as Amended*
283 Tobacco Settlement Funds - *Approved as Amended*
284 E/M Downcoding by Managed Care Organization - *Approved*
295 Specialty Certification for Retired Physicians - *Approved*
296 OPTI Streamlining - *Approved as Amended*
299 CME Credits - *Approved*
300 Patient Privacy and Confidentiality - *Approved*
302 Fee Change – Timely Notice (Substitute) - *Approved*
309 Evaluation of the OPTI Program - *Approved as Amended*
311 Lack of Response to Waiver Requests - *Referred to the Committee on Postdoctoral Training and the Bureau of Professional Education*
313 CME and the Internet - *Approved*

COMMITTEE ON PUBLIC AFFAIRS

200 Aircraft Emergency Medical Supplies - *Approved*
211 Discrimination - *Approved*
216 Health Education – Condom Usage - *Approved*
221 Medicare Intermediary Denial Letters - *Approved as Amended*
222 Medicare Law and Rules - *Approved*
224 Medicare Medically Unnecessary Services - *Approved*
230 Medicare Fee Schedule - *Approved*
241 State Legislation to Prevent Discrimination Against Osteopathic Physicians - *Approved as Amended*
242 Support of Legislation Preventing HMO's From Banning Duel Affiliation - *Approved as Amended*
245 Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services - *Withdrawn*
246 Healthy People 2010 - *Approved as Amended*
247 Medical Error Studies - *Approved as Amended*
255 Use of Dietary Supplements and Herbal Remedies - *Approved as Amended*
258 Medicare Transportation - *Disapproved*
262 Evaluation and Management of Osteopathic Manipulative Treatment - *Disapproved*
264 Medical Errors - *Disapproved*
267 Diabetics Confined to Correctional Institutions - *Approved*
268 Diabetic Meals for Students - *Approved*
272 Discriminatory Reimbursement - *Referred to the ACOFP*
274 Withholding of Payment for Services Rendered - *Approved as Amended*
278 Health Coverage for all Children in the U.S.A. - *Referred to the Council on Federal Health Programs*
282 Silent PPO's - *Approved as Amended*
285 Home Infusion Therapy for Medicare Patients - *Referred to the Council on Federal Health Programs*
288 Non-formulary Medications – Insurance Company Authorization for Use Of - *Approved as Amended*
291 Pharmaceutical Advertising – Direct to Consumer - *Approved*
292 Genetic Manipulation of Food Products-Consumers Right to Know - *Approved*
293 Medical Forms - *Referred back to the Ohio Osteopathic Association*

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303 Ambulatory Procedure Groups - *Approved as Amended*
310 Insurance Software Vendors - *Disapproved*

AD HOC COMMITTEE

202 Cancer - *Approved*
203 CPR Training - *Approved as Amended*
205 Child Abuse - *Approved as Amended*
206 Children's Safety Seats - *Approved as Amended*
212 Environmental Responsibility-Waste Materials - *Approved as Amended*
214 Education for Users of Firearms - *Approved*
218 Long Term Care - *Approved as Amended*
219 Medical Procedure Patents - *Approved*
225 National Health Policy - *Approved*
226 Newborn Hearing Screens - *Approved*
229 Patient Access in Rural Areas - *Approved*
231 Physician Office Laboratories - *Approved as Amended*
232 Plastic Beverage and Food Container Recycling Act - *Approved*
235 Professional Association By DOs - *Approved*
236 Reimbursement Policies for OMT in a Pre-Paid Environment - *Approved as Amended*
239 International Space Station - *Approved*
240 Sudden Infant Death - Approved as *Amended*
243 Support of Literacy Programs - *Approved*
260 Uniformed Services, Divisional Society Affiliation of Reserve and Retired Members - *Approved as Amended*
261 End Of Life Care-Core Principles - *Substitute Resolution Approved*
266 Andrew Taylor Still, M.D. - *Approved as Amended*
271 Use of the Term Osteopathy - *Approved*
277 Folic Acid Endorsement - *Approved as Amended*
281 All Products Clauses - *Approved as Amended*
286 Handling Charge - *Approved as Amended*
287 End of Life Care – AOA Endorsement of White Paper - *Disapproved*
289 Use of Anorectic Drugs - *Approved as Amended*
294 Exclusive Credentialing - *Approved*
301 "Bone and Joint Decade" Endorsement - *Approved*
305 Steadman's Medical Dictionary-Revision of Definitions Regarding Osteopathic Medicine - *Approved*
306 Steadman's Medical Dictionary – Revisions of the Definition of "Doctor" - *Approved as Amended*
308 Electronic Member Surveys - *Approved*
312 Emergency Identification of Physicians - *Approved*

COMMITTEE ON RESOLUTIONS

250 Tribute to Earl A. Gabriel, D.O. - *Approved and Referred to the Bureau of Finance*
251 Tribute to Jimmie L. Hicks, D.O. - *Approved*

If a particular resolution is of interest to you, the TOMA office has complete copies of all the resolutions and would be willing to mail or fax it to any TOMA member.

Public Health Service Guideline Calls on Health Professionals to Make Treating Tobacco Dependence a Top Priority

Health care professionals have new evidence and tools t help patients quit using tobacco, according to a report issue June 27 by the U. S. Public Health Service (PHS). A private sector panel of experts convened by the federal government has challenged all clinicians, insurance plans, purchasers, and medical school officials to use the evidence in the new guideline to make treating tobacco dependence a top priority.

The PHS guideline, "Treating Tobacco Use and Dependence: A Clinical Practice Guideline," contains evidence-based information about first-line pharmacologic therapies (bupropion SR, as well as nicotine gum, patches, inhalers, and nasal sprays) and second-line therapies (clonidine and nortriptyline). It also highlights new evidence about how telephone counseling can help patients quit.

"There has never been a better time for health professionals to help their patients break free from the deadly chronic disease we know as tobacco addiction," said David A. Satcher, M.D., Assistant Secretary for Health/Surgeon General. "Starting today, every doctor, nurse, health plan, purchaser, and medical school in America should make treating tobacco dependence a top priority."

The guideline is aimed at practicing clinicians. Studies have shown that more than 25 percent of U. S. adults smoke and that 70 percent of them would like to quit. Of those smokers who try to quit, those who have the support of their physician or other health care provider are the most successful. Data show that only half of the smokers who see a doctor have ever been urged to quit.

The guideline concludes that tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. The guideline urges health care insurers and purchasers to include, as a covered benefit, the counseling and pharmacotherapeutic treatments identified as effective in the guideline and to pay clinicians for providing tobacco dependence treatment, just as they do for treating other chronic conditions.

Copies of "Treating Tobacco Use and Dependence: A Clinical Practice Guideline," and a consumer guide called "You Can Quit Smoking" are available by calling 1-800-358-9295 or writing to Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547. Or, select <www.surgeongeneral.gov/tobacco/default.htm>.

Self's Tips & Tidings

By Don Self

The last two conventions we attended (TOMA and TxACOFP), once again demonstrated to me that the osteopathic physicians in Texas have the best organizations working for them. I always look forward to these meetings as I get to see my friends in the associations. Thank you to both organizations for allowing me to be included.

Diagnostic or Therapeutic Devices - Most are Profitable, but be Careful

Something that became very obvious at these last two conventions is a subject I briefly dealt with in last month's issue - purchased or leased diagnostic or therapeutic equipment. In last month's issue, I stated that you have to be very careful when listening to sales personnel trying to get you to buy or lease this new equipment that will help your patients. No, I'm not talking about the clinical efficacy of the devices or treatment, but I'm referring to the reimbursement side. Wayne Clark, JD, in his article last month, discussed similar problems we are seeing with osteopathic physicians all over the country. Just because the salesperson says that you should use this CPT or HCPCS code with this piece of equipment doesn't make it so. In some cases, we are extremely concerned that some Texas physicians may have to pay Medicare more than $30,000 in recoupment because they believed the wrong person and billed erroneously. If it were just the recoupment, we wouldn't be too worried but we are concerned about the penalties, interest and Civil Money Penalties (CMP), which could exceed $100,000. Now, before you start thinking that I am against buying, leasing or even borrowing equipment to perform diagnostic or therapeutic services on your patients, let me assure you that I'm not. In fact, I even personally promote several programs. I especially like one that LOANS diagnostic equipment such as holters, ambulatory BP equipment and spirometry to physicians to the extent that I'm set up as a consultant to enroll qualified FP, Internal and Cardiology physicians on it. I'm setting up quite a few clients on this program, which helps their patients - and the doctor's net income (substantially) so I'm not against all of them. Another one I am doing deals with helping patients by testing the autonomic nervous system, giving the doctor valuable diagnostic information and, it too, is very profitable when medically used. Most salespeople will tell you the truth, but be careful and check out whatever they, or I, say.

Is it Part of the Global?

You performed a procedure on a patient and then the following day, the patient shows up in the ER with a violent reaction to the prescription you gave her. The question often asked is whether this is included in the 10 or 90 day global fee period, or is it separately billable. If it is the reason the patient is in the ER, then you should bill for the ER visit using codes 99281, 99285, along with a 24 modifier. The reason (diagnosis) they are there is "reaction to prescribed drug" not the surgery.

Be Careful Using Depression, Anxiety, Alzheimer's Diagnoses

When billing Medicare, we recommend caution when using the primary diagnosis as one that could be considered to be psychiatric. Instead of Medicare paying 80% and the patient having a 20% co-pay, Medicare has a 62.5% limitation. That means they pay 62.5% of the allowed amount, leaving the patient with a co-pay of 37.5% instead of 20%. The 62.5 percent limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to services furnished by physicians in the outpatient department, in the physician's office, in the patient's home, in a skilled or non-skilled nursing facility, etc. This is why we recommend that the psychiatric diagnosis not be primary on the claim, unless, of course, that is the primary reason for the visit.

Keeping Nursing Home Visit Records & Fire Proofing

Recently, in practice analyses we have been performing, we've run into a couple of practices that do not keep a copy of the SNF visit documentation in their office. They allow the nursing home to keep up with it. That may not be a problem unless the nursing home staff loses it, misplaces it, misfiles it or spills something on it making it unreadable, and you get into an audit. We highly recommend that you always keep a copy safe and tight in your own office. One more thing, and this applies to ALL PATIENT CHARTS: be careful. Last year, one of your fellow TOMA members lost ALL of his patient charts in a fire. Imagine not only the headache of having to rebuild each one, but how would you justify anything you've done in an audit without them. It may be worth it to see how much a fire resistant chart cabinet is.

Can Family Physicians Charge for Consults?

Of course they can, IF the consult is a request for the opinion of the Family Physician, by another physician. Let's say the Ophthalmologist asks the Family Physician (or Internist) to check out the patient prior to surgery, because of the patient's hypertension or diabetes. There is a reason for the consult and this is NOT screening. Consult codes 99241, 99245 should be used if it is in the office, and 99251, 99255 should be used if it is in the hospital. There seems to be some misconception going around that says that you can't charge a consult on an established

patient. Consults may be charged on new or established patients.

Austin Workshop Worth the Trip

We are having a full day workshop on October 12 in Austin, at the Holiday Inn Airport, with a guarantee you'll never see anyone else offer. The cost is $495 per person (physicians and principals only), and the guarantee is that if at the end of the seminar, you don't believe you'll increase your net income by at least $2,000 per month you get a full refund. Most doctors will see a monthly increase of at least $5,000 net income. For a flyer & details, call 800-256-7045.

Use Reason for Diagnostic Test, Not Results of Test

As you know, we review claims and progress notes for doctors all over the country on a monthly basis. Three years ago, in this column, we discussed this issue, but since we're seeing problems creeping up in this area on quite a few claims/notes, we'll cover it again. Doctor, when you perform a EKG, X-ray, Spirometry, Autotomic Test, Holter, etc., you should use a diagnosis code indicating either the known diagnosis before the test or the diagnosis code for the symptoms that prompted you to do the test. Some doctors are getting caught in audits for this, so code your claim properly. One more thing - it's okay to put 4 diagnosis codes on every claim form, but you only reference each procedure code to the "appropriate" diagnosis, in box 24E. Only one digit is entered into the carrier's computer for box 24E. If your computer puts a 1 in that box for everything (as some programs do), then you know why quite a few of your services are being denied payment.

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News
from the American Osteopathic Association

James E. Zini, D.O., is Named AOA President Elect

James E. Zini D.O., F.A.C.O.F.P., was named president-elect of th American Osteopathic Association at the AOA's recent House Delegates Meeting in Chicago. Dr. Zini is a board certified family pra tice physician and fellow of the American College of Osteopathic Fami Physicians.

Dr. Zini has been practicing medicine in Mountain View, Arkansa for 23 years. He currently serves on the Arkansas State Medical Board, where he was th first D.O. appointed to the Board, and is a member of the Arkansas Medical Society. H also serves as the medical director at the Stone County Skilled Nursing Facility and th Searcy County Nursing and Rehabilitation Center.

As a founding member of the Arkansas Osteopathic Medical Association, he went o to serve as President, Vice-President, and a member of the Board of Trustees. He is als a member of the Arkansas Osteopathic Foundation. For over a decade, Dr. Zini has bee on the AOA's Board of Trustees. During that time he chaired various committees an departments, such as the Department of Education, and was involved in several tas forces, including the Task Force on Healthcare Facilities Accreditation. Presently, Dr Zini serves the AOA as a representative to the Commission on Laboratory Accreditatio Board and to the Centers for Disease Control.

Throughout his career, Dr. Zini has garnered many awards. He receive Distinguished Citizen of the Year by the Mountain View Chamber of Commerce; Alumn of the Year from the University of Health Sciences/College of Osteopathic Medicine i Kansas City, Missouri, and Physician of the Year from the Arkansas Osteopathic Medica Association.

In addition, Dr. Zini studied at the Eden Theological Seminary in St. Louis, Missouri received his Masters of Divinity degree, and was ordained into the Christian Ministry before entering medical school. He has had the pleasure of performing the wedding ceremonies and baptisms for members of his family.

National Osteopathic Medical Week Set for November 12-18

National Osteopathic Medicine (NOM) Week will be celebrated November 12-18. NOM Week, which helps to inform the public about osteopathic medicine and encour ages individuals to practice a healthy lifestyle, has been celebrated by the AOA every year since 1979.

Young women ages 12-24 have been selected as the target group for NOM Week 2000. Topics will include the following areas:

Sexuality – teen pregnancy; contraception; STDs
Fitness – healthy eating; exercise; diabetes; eating disorders
Drugs – alcohol and other "teen available" drugs
Smoking
Depression
Tanning
My first gynecological visit and self-test breast exam

For information about NOM Week, call 800-621-1773, ext. 8043 or 312-202-8043.

Texas to Begin Physician Profiling

Texas soon will move into the ranks of states providing physician profile information to consumers as a result of action by the 76th Legislature. HB 110, sponsored by Rep. Glen Maxey of Austin, requires the Texas State Board of Medical Examiners to gather and make public certain information about physicians.

The bill became effective September 1, 1999, and requires the data to be available to the public by September 1, 2001. During that period, the Board must gather the additional data and develop the technology to make the information available via the Internet as well as on paper. Data will be gathered as part of the renewal process over the next year.

A pilot project will begin with renewal forms mailed September 1. Renewal forms will request new profile information in addition to the mandatory information now required. Provision of the additional data will be optional until September 2001 when the program becomes fully operational and compliance is mandatory. After that date, failure to return the completed form to the Board will be considered non-compliance, resulting in non-renewal of the physician's license.

Rules were adopted by the Board effective March 5, 2000 specifying the information to be provided to the public. The list includes name, date and place of birth, gender, ethnic origin, name of medical school(s) and date of graduation, a full description of graduate medical education, any specialty certification, number of years in practice, date of Texas licensure and expiration date, CME information, disciplinary history and other information designated by HB 110. Physicians may also provide brief descriptions of a maximum of five awards, honors, publications or academic appointments. A complete list of the requirements can be viewed on the Board's web site. (Go to <www.tsbme.state.tx.us> and click on the Board Rules, see Chapter 173, Physician Profiles.)

A Profile Update and Correction Form is being developed for physicians to revise and update their data. Physicians will have opportunities to correct or dispute information in their Profile before it is published.

HB 110 also allows the Board to raise licensure fees to fund the profile program by no more than $20 for each fiscal year in the 2000-2001 biennium and $10 each fiscal year in the 2002-2003 biennium. There will be a further reduction in fees within two years of full program implementation.

HB 110 also required other Texas health licensing boards to develop cost estimates to establish a profile program for their licensees. Agencies required to submit cost estimates by January 1, 2000 were the Texas Board of Chiropractic Examiners, State Board of Dental Examiners, Texas Board of Occupational Therapy Examiners, Texas Optometry Board, Texas State Board of Pharmacy, Texas Board of Physical Therapy Examiners, Texas State Board of Podiatric Medical Examiners, and Texas State Board of Examiners of Psychologists.

At least ten other states now have legislation requiring development of physician profiles, following the lead of Massachusetts which began providing physician profiles in 1996. Massachusetts has offered the information via the Internet since 1997.

(Medical Board Report, Vol. 21, Number 2)

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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)

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