TEXAS DO

February, 1995

The Journal of the Texas Osteopathic Medical Association

XXXXXII, No. 2

Dallas

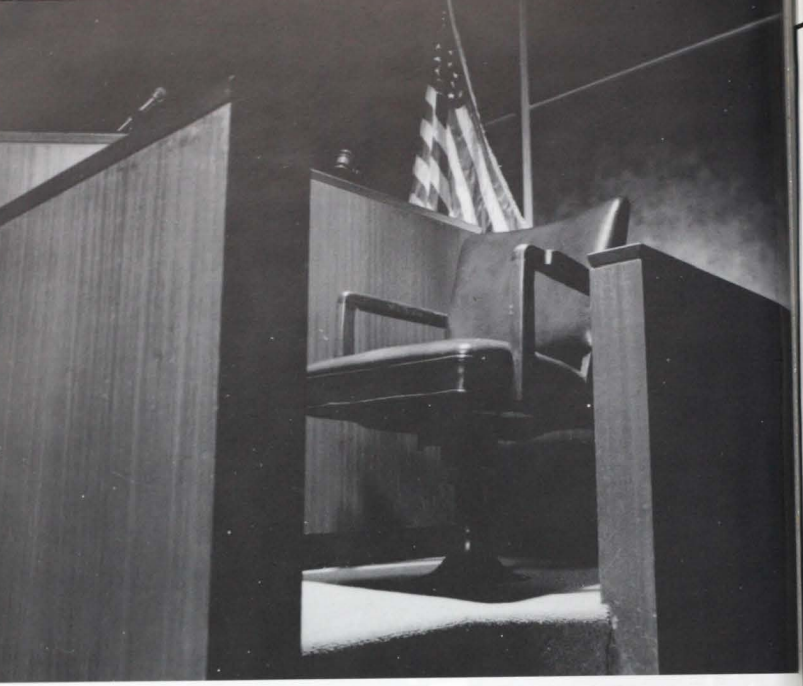
The TOMA Convention Destination For 1995

TOMA Annual Convention Committee Sketches Plans For June Convention

96th Annual Convention and Scientific Seminar

Grand Kempinski Hotel - Dallas, Texas

June 15 - 18, 1995



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All changes to existing provider number records	214/766-6158
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TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS DO
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

February, 1995

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Calendar of Events

FEBRUARY 10-12, 1995

TOMA 39th Annual Midwinter Conference and Legislative Forum
"Primary Care includes OMT"
Sponsored by Texas Osteopathic Medical Association
Location: Doubletree Lincoln Centre
Dallas, Texas
Hours: 17 Hours Category 1-A, AOA Approved
Contact: Texas Osteopathic Medical Association
512/388-9400 or 1/800-444-8662

25-26

"Advanced Cardiac Life Support Course"
Sponsored by Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort
Keystone, Colorado
Hours: 15 hours AOA Category 1-A CME credit
Contact: Patricia Ellis
50 S. Steele Street, #440
Denver, CO 80209
303/322-1752; Fax 303/322-1956

FEBRUARY 26-MARCH 3, 1995

Ski-CME Midwinter Conference
Sponsored by Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort, Keystone, CO.
Hours: 38 hours AOA Category 1A CME credits; AAFP prescribed course hours
Activities: Skiing, night skiing, cross country skiing, sleigh rides, banquet. Updates for family practitioners on orthopedics, gynecology, emergency medicine, infectious disease, physical medicine, cardiology and more.
Contact: Patricia Ellis
50 S. Steele St., #440
Denver, CO 80209
303/322-1752; Fax 303/322-1956

MARCH 9-12

Florida Osteopathic Medical Association 92nd Annual Convention
Location: Doral Ocean Beach Resort, Miami Beach, Florida
Hours: 30 Category 1-A anticipated, five hours Risk Management and three hours AIDS/HIV
Contact: Florida Osteopathic Medical Association
2007 Apalachee Parkway
Tallahassee, Florida 32301
904/878-7364

APRIL 7-8

"Ninth Annual Spring Update for the Family Practitioner"
Sponsored by University of North Texas Health Science Center at Fort Worth
Location: Dallas Family Hospital, Dallas, Texas
Hours: 10 CME hours – Category 1-A, AOA
Contact: Pam McFadden, Program Director
817/735-2539

APRIL 22-23

Sutherland's Methods for Treating the Rest of the Body
Location: Dallas/Fort Worth, Texas
Hours: 16 Category 1-A credits
Contact: Conrad A. Speece, D.O.
10622 Garland Road
Dallas, TX 75218
214/321-2673

JUNE 15-18

TOMA 96th Annual Convention & Scientific Seminar
Sponsored by Texas Osteopathic Medical Association
Location: Gand Kempinski Hotel
Dallas, TX
Hours: 30 Category 1-A anticipated
Contact: Texas Osteopathic Medical Association
512/388-9400 or 1/800-444-8662

President's Corner

By T. Eugene Zachary, D.O., President
Texas Osteopathic Medical Association

The Uniqueness of the Osteopathic Profession

I have just finished reading the editorial in the *American Academy of Osteopathy Journal*, Winter, 1994. The title really caught my eye: "The Uniqueness of Osteopathic Medicine: Do We Know What It Is?" The editor of the journal and the author of this writing is Raymond J. Hruby, D.O., F.A.A.O. and he does an excellent job of explaining his viewpoint of what that uniqueness really is. He quotes I. M. Korr, Ph.D. and mentions his prolific scientific writings on osteopathy. He quotes Norman Gevitz, Ph.D., who has made in-depth studies of the osteopathic profession over the years from the outside looking in, and he also quotes Carol Trowbridge who wrote the biography of A. T. Still.

The one thread that weaves through the three authors and is stressed by Dr. Hruby is that osteopathic manipulation is not the only unique characteristic of our profession. He challenges each of us to share our views about this issue of uniqueness. Dr. Hruby asks what our thoughts are about this uniqueness. He invites responses from readers so that the *AAO Journal* might put some of them into print.

I have been an osteopathic physician for 35 years. I have known about the profession since 1944 as I was exposed to it by my uncle, a D.O. I'd like to share some of my thoughts with you about the profession.

I have seen the profession undergo a lot of changes in those 50 years. I have seen the profession struggle to be recognized as equal to the allopathic profession. I have seen D.O.s limited to caring for their patients in strictly osteopathic hospitals because they couldn't get staff privileges on larger allopathic ones. I have seen D.O.s gain full acceptance in the military. I have seen the loss of one of our colleges and the granting of the little m.d. degree to many of our California D.O.s. I have seen the expansion of our schools from five to 16 with two to three more on the drawing board. I have seen allopathic hospitals open their staff memberships to many of our physicians.

I have seen the acceptance of our graduates into allopathic residency programs with open arms, partially because the M.D.s discovered that our undergraduate training is very good, but also partially because their programs were not being filled by their own graduates. As a result of that acceptance, some of our schools have a very high number of graduates entering M.D. programs. Therein lies a problem. I have also observed a trend developing that might decrease the number of our graduates who enter primary care fields and opt for other specialties.

As an osteopathic educator for the last 15 years, I have seen many students come and go. Some are interested in the osteopathic philosophy and some are not. I do know that our graduates are extremely well trained and well prepared for any residency program.

> ***"...osteopathic manipulation is not the only unique characteristic of our profession."***

Now that the profession has gained greater recognition and equality with the allopathic profession, we are about to find out that in doing so, we are losing some of the uniqueness that brought us to this point. If we continue to stress the need to be totally equal, we will eventually lose that unique difference which has made the profession special over the last 100 years. We will lose that which has sustained us for so long. We are already at the point in time whereby our graduates do not know what it means to fight for our survival. Those battles were fought by many of us who entered the profession many years ago.

Manipulation is a very large part of the uniqueness, but there are other things as well. As a part of becoming a D.O. we are taught to put our hands on a patient. In doing so, we develop something special – a special sense of trust and a special understanding of people. We are taught that the body has within itself the inherent ability to heal itself if all organs and tissues are in as normal a condition as possible. Therefore, we learn that prevention is a very important part of medicine. The interest we take in each of our patients and their families is another part of the uniqueness because we know that each patient's physical and emotional environment plays such an important role in their overall health.

(Continued on page 6)

President's Message, *Continued*

Norman Gevitz's idea of a profession that is both parallel and distinctive is right on target in my opinion. Parallel means that we teach everything the allopathic programs teach, and train the same specialists and generalists that they train, and basically practice medicine the same way they do. Distinctive means the use of palpation in finding structural diagnoses, treatment of those structural problems, practicing preventive medicine, and being a good listener and friend to our patients.

I believe that those are the things that make up the uniqueness of our profession. We must never lose those qualities that constitute that uniqueness and distinctiveness. We must not lose sight of the fact that our colleges train the most graduates who enter primary care fields. Our leadership in this area must not diminish. I firmly believe that we must continue to produce graduates who want to become primary care physicians, especially in family practice.

Those D.O.s who receive their training in allopathic programs must bring the best of what they have learned to both undergraduate as well as graduate osteopathic medical education and training. They must help improve those programs where needed without diluting or diminishing the osteopathicness of our programs.

I believe that we need not fear the other profession destroying us from the outside, but that our real threat is that we will destroy ourselves from within by complacency and too much "me-too-ism." We must maintain the rationale for separation as a distinctive and unique medical profession that has something special to add to the health care of the people of this nation. I firmly believe that the osteopathic profession will survive and our colleges will survive because of that special uniqueness.

I invite each of you to examine your own philosophies about osteopathic uniqueness. If you wish, I would also invite you to write your response and send it either to the *TEXAS DO* or to the *American Academy of Osteopathy Journal*. ■

David M. Richards, D.O., Appointed AHA Program Vice-Chair

The American Heart Association, Fort Worth Division, has announced the recent appointment of David M. Richards, D.O., President of the University of North Texas Health Science Center at Fort Worth, to the Program Vice-Chair position. Dr. Richards, a longtime Fort Worth resident and well respected physician and administrator, will also serve on the American Heart Association's Executive Committee and Board of Directors as part of his appointment. As Program Vice-Chair, Dr. Richards will be responsible for assisting with the educational activities of the Program Committee to include the Schoolsite, Worksite, Healthcare Site, Community Site as well as HeartFest, a grocery store campaign to educate shoppers on healthy shopping and diet.

Although Dr. Richards is a new member to the Fort Worth Division team, the University of North Texas Health Science Center (UNTHSC) has been a longtime recipient of American Heart Association funded cardiovascular research grants, receiving over $125,000 last year. "We are honored to have Dr. Richards bring his vast knowledge and wealth of experience to the Program Committee and to the Board of Directors. Our history with UNTHSC and research grant funding makes his appointment a perfect tie to our organization," said Wayne Heatherly, Chairman of the Board. "We look forward to a long relationship with Dr. Richards and the University of North Texas Health Science Center," he added.

The American Heart Association is the nation's largest voluntary health organization that is dedicated to the reduction of disability and death to cardiovascular diseases and stroke. The AHA spends over $200 million each year for cardiovascular research support, preventive education and community education programs such as CPR training. For more information, call your American Heart Association office at 817-535-7500 or 1-800-AHA-USA1. ■

In Memoriam

GORDON LEE ALLEN, JR., D.O.

Dr. Gordon L. Allen of Palestine, Texas, passed away September 18, 1994. He was 38 years of age.

Funeral services were held September 21 at St. Philips Episcopal Church, Palestine.

Dr. Allen was born October 6, 1955. He graduated from Sam Rayburn High School in Pasadena in 1974, and attended Austin College. He received his D.O. degree in 1982 from Texas College of Osteopathic Medicine, and served an internship and anesthesiology residency in Fort Worth.

He had lived in Palestine for 11 years and was serving as Chief of Anesthesiology at Trinity Valley Medical Center. He was a member of TOMA; TOMA District III; and St. Philips Church in Palestine.

Survivors include his wife, Allison C. Allen of Palestine; his parents of Pasadena; and a brother, Michael E. Allen of Pasadena.

In lieu of flowers, memorials may be made to St. Philips Episcopal Church, 106 E. Crawford, Palestine, Texas 75801.

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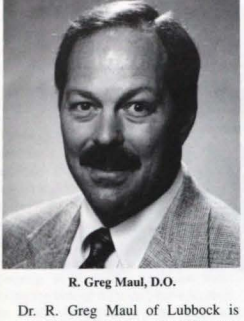
Each month TOMA spotlights a board member for his or her work and commitment to the osteopathic profession in Texas. TOMA extends a sincere thanks to every board member who has served or is serving as a member of the TOMA Board of Trustees.



R. Greg Maul, D.O.

Dr. R. Greg Maul of Lubbock is extremely optimistic regarding the profession's future. "The osteopathic profession is in the most opportune position it has been in since I can remember," he notes. "Due to managed care situations and the fact that our profession is both preventive and holistic in nature, I see an unlimited potential for osteopathic medicine to be the leader of medical care in the next century."

Certified in family practice, Dr. Maul has a private practice and also practices emergency medicine in Lubbock.

An active member of the Texas Osteopathic Medical Association, he has served as a member of the Board of Trustees since 1988, and as a member of the TOMA House of Delegates for 12 years. He has chaired and served as a member of various TOMA committees throughout the years, currently serving as chairman of the Department of Professional Affairs; member of the Finance Committee; member of the Strategic Planning Committee; and as an alternate delegate to the American Osteopathic Association House of Delegates.

Dr. Maul views his involvement in TOMA as "both a privilege and challenge. It is an honor to represent my colleagues in determining the future of osteopathic medicine in Texas. It is also a challenge," he says, "in balancing time with my family and my practice. Such involvement, however, provides a wonderful opportunity to get to know many more of my colleagues and their families. I get a feeling that the 'TOMA TEAMWORK' approach is felt by many, and I hope that spirit remains alive for years to come," he adds.

" I get a feeling that the 'TOMA TEAMWORK' approach is felt by many, and I hope that spirit remains alive for years to come,"

Dr. Maul is a 1976 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri. He interned at Dallas-Fort Worth Medical Center in Grand Prairie.

His memberships include TOMA District X, in which he currently serves as president; American Osteopathic Association; American College of Osteopathic Family Physicians; the Texas Society of the ACOFP, in which he served as president and program chairman from 1986-87; and the Texas Medical Foundation. He is a Diplomat of the National Board of Examiners for Osteopathic Physicians and Surgeons and a Fellow of the American College of Osteopathic Family Physicians.

Hospital affiliations include South Park Medical Center and Highland Medical Center, both in Lubbock.

In speaking of his practice in Lubbock, Dr. Maul says the city "has an immense medical community for the size of city it is." He notes that Lubbock "has been hit hard by managed care the past two years that I've been here. The medical profession here had been insulated for years from their arrival, and the city has now gone from essentially no managed care plans two years ago to near total saturation. Sides are already lined up and forming their own managed care plans through local hospitals."

Dr Maul believes that one of the biggest challenges D.O.s face today is "a lack of public awareness of D.O.s, not just in Texas, but across the nation. Our word of mouth and our patients' word of mouth just aren't enough anymore. I would like to see D.O.s all across the country support an advertising firm on a yearly basis. Other professions do it and it pays off."

The proud father of one son, Michael, age five, Dr. Maul says "He is one of the great joys in my life. He now resided with me permanently and really keeps me young and challenged."

When not working or involved in TOMA activities, Dr. Maul enjoys most outdoor sports. As a matter of fact, he notes "One of my New Year's resolutions is to take more time to enjoy out-of-door sports with my son and family."

TOMA extends its deepest appreciation to Dr. Maul for his continuous contributions to the osteopathic profession in Texas. ■

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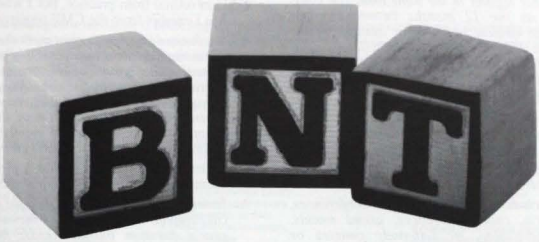

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Questions and Answers About Continuing Medical Education Requirements

Q. If the rules took effect January 1, 1994, must I obtain the required hours by January 1, 1995?

A. *No. To comply with the CME requirement, a physician must obtain the required hours during his or her "CME year" rather than during a calendar year. License expiration dates are staggered on a quarterly cycle so that all physicians do not register at the same time. The CME year is defined as the 12 months between annual registrations of the medical license. For example, if the license expires on May 31, 1995, the physicians must obtain the required hours between annual registration in 1994 and expiration of the license on May 31, 1995.*

Q. How many CME hours are required?

A. *At least 24 hours must be acquired per CME year. All 24 hours may be obtained from formal activities, but up to 12 hours are allowed in informal activities.*

Q. How does the Board of Medical Examiners define "formal" and "informal"?

A. *Formal hours include activities such as conferences, seminars, symposia, case conferences, grand rounds, educational presentations, or self-study courses or materials that are:*

1. *Designated for Category 1 credit of the Physician's Recognition Award of the American Medical Association;*
2. *Approved for prescribed credit by the American Academy of Family Physicians;*
3. *Designated for Category 1 credit of the American Osteopathic Association; or*
4. *Approved by the Council on Medical Specialty Societies.*

Informal hours can be obtained from activities such as conferences, seminars, grand rounds, case conferences, or journal clubs not designated for formal credit; self-instructional materials or courses not designated for formal credit; reading clinically relevant medical journals or articles and using literature search data bases in connection with the provision of patient care; participation in patient care review activities (peer review or hospital quality of care review committees); or research/preparation time for medical presentations delivered to practicing physicians or physicians in training. In addition, up to ten hours may be claimed for publication of a medical or medically related article, for each chapter of a medical or medically related book or other medical education materials, or preparation of an exhibit displayed at a scientific medical meeting or other CME activity. Articles must be published in a recognized medical journal that is primarily read by physicians or other health professionals. Credit may be claimed only once for a publication or exhibit, even if it is reissued in a changed format.

Q. I practice in a rural community where CME activities are not easily accessible. Does this mean I will have to close my practice and travel to obtain formal CME hours?

A. *No. Many formal CME activities are available in video, audio, and computer-based formats. Contact the Texas Medical Association or Texas Osteopathic Medical Association for information on available resources.*

Q. Should I send "proof" of my CME hours to the TSBME?

A. *No. Not unless you are requested to do so. The Board will randomly select a percentage of physicians to check for compliance. (NOTE: Physicians under Board Order requiring documentation of CME should follow the provisions outlined in their Order.)*

Q. I am retired from practice, but I want to keep my license. Am I exempt from the CME requirement?

A. *No. Retired physicians must meet the CME requirement to retain their medical licenses. Only physicians on "official retired" status with TSBME are exempt. Official retired physicians do not pay the annual registration fee, may not engage in any clinical activities, may not prescribe nor administer drugs, and may not have their licenses endorsed to any other states. Retired membership with a medical society or medical association is unrelated to this status.*

Q. Under what conditions would a physician qualify for an exemption from the CME requirements?

A. *Exemptions may be granted only for the following reasons: catastrophic illness; military service of longer than one year's duration outside Texas; medical practice and residence of longer than one year's duration outside the U.S.; or good cause shown on written application of the licensee giving satisfactory evidence why the physician is unable to comply. The TSBME plans to apply stringent criteria in granting exemptions.*

Q. The rules indicate that a physician who becomes board certified or recertified within 36 months prior to annual registration of the medical license will be in presumed compliance with the CME requirement. If I become recertified in 1995, will this satisfy my requirements until 1998?

A. *No. TSBME has determined that the activities in toto undertaken to become boarded or recertified equal the 24-hour requirement. Since 24 hours are required every 12 months, the board certification process would qualify for only 1 year.*

Q. I am a licensed physician enrolled in a residency training program. Must I obtain CME credit hours in addition to my residency training requirements?

A. *No. Physicians in residency programs satisfy the requirement through their training programs.*

Q. What are the consequences if I fail to obtain the full 24 hours within my CME year?

A. *Failure to obtain the required CME hours is a violation of the Medical Practice Act. Rules will be proposed and published over the next several months regarding the penalties for not completing the CME hours. In summary, unless exempted, a licensee who fails to obtain the required CME hours is subject to disciplinary action, which may include suspension or revocation of the license, but action not less than an administrative penalty of $100.00, in addition to the penalties for late renewal. CME hours obtained after the date for license renewal shall not be credited to meet the CME requirements for the following year even though obtained after the license expiration date. A current physician's permit will not be issued until CME hours have been obtained and reported to the Board.* ■

(Reprinted from the Texas State Board of Medical Examiners Newsletter, Fall/Winter 1994, Volume 16, Number 2.)

Osteopathic Medicine: It's Big in Texas.

So big, that osteopathic medicine is becoming the preferred choice for thousands of people who appreciate the big benefits of preventive medicine. Osteopathic Health System of Texas offers the following services and affiliates to osteopathic physicians to help provide quality health care in today's fast-changing medical environment.

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(817) 735-DOCS (3627)
Metro (817) 654-2344
1-800-299-CARE (2273)

- Physician referral service
- Information and health services referral center
- Nursing home referral service
- 24-hour regional referral center

Home Health Care/IV Infusion

4916 Camp Bowie Boulevard
(817) 377-4663

- Skilled nursing care
- Specialized services
- Available seven days a week
- 24-hour telephone assistance

The Health & Fitness Connection

6242 Hulen Bend Boulevard
(817) 346-6161

- Complete health and fitness facility
- Medical director on site
- Fitness programs and educational seminars open to members and the public
- More than 45 pieces of cardiovascular equipment
- Exercise and training programs
- Indoor pool and track
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- Childrens' playcare
- Massage and nail services

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3825 Camp Bowie Boulevard
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- Outpatient X-ray service, CT scan and ultrasound
- Mammograms
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HCT Capital Corporation

4916 Camp Bowie Boulevard
(817) 763-8706

- Small business investment (SBIC) loans to health care professionals for offices, equipment, etc.
- Equity capital for qualified small businesses

Osteopathic Health System of Texas

3715 Camp Bowie Boulevard • Fort Worth, Texas 76107 • 1-800-299-2273 • (817) 735-4466

TOMA's 1995 Convention Program Chairman Is Introduced

TOMA is pleased to announce that John R. Bowling, D.O., of Fort Worth, is once again serving as program chairman for the Texas Osteopathic Medical Association's 96th Annual Convention and Scientific Seminar, to be held June 15-18 in Dallas. Dr. Bowling served as program chairman for the 1994 convention and as such, TOMA members can expect another outstanding array of topics and speakers this year. Dr. Bowling provides the following brief rundown of what convention attendees can expect this year.

As program chairman for the 1995 TOMA Convention, I would like to invite you to come to "Big D" in June and join us in the frontiers of medicine.

This year we have formed a convention program committee which is made up of representatives from each region of the state. Our hope is that this will be an ongoing committee that can bring together many individual topics from all districts, and each year plan an excellent program.

The Committee members are: Patrick Hanford, D.O., of Lubbock; Donna Hand, D.O., of Lindale; Bobby Howard, D.O., of Corpus Christi; Gregory Dott, D.O., of Fort Worth; Frank Adams, D.O., of Austin; William D. Hospers, D.O., of Fort Worth; and Craig Whiting, D.O., of Fort Worth.

In an attempt to speak to all members of TOMA, regardless of specialty, we have tried to plan a program that is broad in scope, but specific in details. We will once again have an increased number of workshops including a computer lab. Practice management and managed care issues will be a major portion of the program and, hopefully, a symposium on violence will be included.

There will be plenty of time for education, networking, politics and, best of all, just "good old fun" with your colleagues and their families.

Keep June 15-18 open and join us in "Big D" for a "rip roarin' look at the frontiers of medicine."

Dr. Bowling is Associate Professor/Vice Chairman of the Department of Family Medicine at the University of North Texas Health Science Center at Fort Worth, and director of the Central Family Practice Clinic of the Department of Family Medicine. He is a fellow of the American College of Osteopathic Family Physicians.

Other activities include advisor to the Student Chapter of the American College of Osteopathic Family Physicians (ACOFP), chairman of the Student Health Advisory Committee and member of the Admissions Committee, all at the University of North Texas Health Science Center at Fort Worth; member of the Preventive Medicine Task Force of the Texas Medical Association; and the CATCHUM Project, an initiative for development of a cancer prevention curriculum in Texas medical schools.

Dr. Bowling makes numerous presentations at scientific/professional meetings. Several of these include "Clinical Teaching in the Ambulatory Setting" and presentation of a Flexible Sigmoidoscopy Workshop, both during the Texas Society of the ACOFP meeting in August 1994; and presentation of "A Predoctoral Program That Really Produces Family Physicians" during the 20th Annual Predoctoral Education Conference of the Society of Teachers and Family Medicine, held in January 1994.

He is listed in *Marquis Who's Who in America* and *Marquis Who's Who in American Education*, and in 1992 was named Outstanding Student Organization Advisor at Texas College of Osteopathic Medicine. Publications include "Clinical teaching in the ambulatory care setting: How to capture the teachable moment," *Journal of the American Osteopathic Association*, February 1993.

Dr. Bowling is a 1969 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri, after which he interned at Doctors Hospital, Columbus, Ohio. He is certified by the American Osteopathic Board of Family Physicians.

Professional society memberships include TOMA; TOMA District II; American Osteopathic Association; Texas Society of the ACOFP; Ohio Osteopathic Association; American Academy of Osteopathy; ACOFP; and the Society of Teachers in Family Medicine.

Dr. Bowling is on the active staff of Osteopathic Medical Center of Texas in Fort Worth, where he also serves on the Medical Records Committee. ■

Dr. Bobby Howard makes a point at the Committee meeting.

(L to R) Drs. Howard, Whiting, Dott, Hand and Bowling (standing), discuss objectives for the annual convention.

An Open Letter from the Associate Executive Director

Dear TOMA & ATOMA Members, Colleagues and Friends:

By now many of you have learned that on February 1, 1995 I became the Director of Development for the College of Education with the Oklahoma State University Foundation. My involvement as Associate Executive Director of the Texas Osteopathic Medical Association has been extremely rewarding, and I have made many good friends throughout the fields of medicine and association management across the country. I am confident improvements made in the *TEXAS DO* and the annual convention format will continue and those benefiting most will be the D.O.s of Texas!

Thanks to the competent leadership and focused guidance from the TOMA Board of Trustees, and a remarkably dynamic and motivated staff, your association will continue to bring you the class of representation the osteopathic profession deserves. I am honored to have been associated with a board so committed to the concerns and needs of the osteopathic physicians of Texas.

I would also like to express my sincere appreciation to the Auxiliary. As a unit, your efforts to promote the profession and your networking throughout the state have provided a needed balance and support. I have truly enjoyed working with each of you (or should I say y'all)!

While Gerri and I look forward to accepting this opportunity with the O.S.U. Foundation, we will dearly miss much about Texas and the wonderful hospitality which has always been afforded to us wherever we traveled. Thanks to each of you who have written or phoned to say good-bye. Your well wishes and words of encouragement mean more than you can imagine. I trust you will look us up if you pass through Stillwater, OK.

Warmest regards,

D. Scott Petty

The TOMA 96th Annual
Convention and Scientific Seminar
Grand Kempinski Hotel - Dallas, Texas

June 15 - 18, 1995

'Surviving On The Frontiers of Medicine'

Membership *On-The-Move*

We have had several calls looking for locum tenans across the state. If you would like to be on TOMA's locum tenans list for our members, call your Membership Secretary, Paula, and ask to be added to the list. Be sure to designate the area in which you will provide services. Our number is 1-800-444-TOMA.

New Year Brings New Duties for Steven J. Levy, D.O.

Steven J. Levy, D.O., of Houston, has been appointed chief-of-staff at Doctors Hospital East Loop and elected president-elect of the Houston Geriatric Society.

He began his duties as chief-of-staff at Doctors Hospital East Loop, Houston, on January 1, 1995 and his appointment runs for one year. He previously served as chief-of staff from 1990-91.

Also on January 1, 1995, Dr. Levy assumed the position of president-elect of the Houston Geriatric Society, a component of the Harris County Medical Society. He is the first D.O. to serve in this capacity.

The Houston Geriatric Society is composed of approximately 55 members involved in the various sub-specialties of geriatrics. The Society is dedicated to the pursuit of prompt scientific knowledge of geriatric medicine and to ensuring the continued delivery of excellent patient care. Dr. Levy will assume the presidency in January 1996.

Dr. Levy practices internal medicine in Houston and also serves as a clinical instructor in the Department of Community Medicine at Baylor College of Medicine.

He attended Philadelphia College of Pharmacy and Science prior to entering osteopathic medical school. A 1970 graduate of Philadelphia College of Osteopathic Medicine, he interned at Martland Medical Center of the University of Medicine and Dentistry of New Jersey. Dr. Levy served a residency at Muhlenberg Hospital in Plainfield, New Jersey, and a mini-fellowship in geriatrics at Baylor College of Medicine.

A fellow of the American College of Physicians, Dr. Levy is also a diplomate of the American Board of Internal Medicine, with added qualifications in Geriatric Medicine.

Memberships include Texas Osteopathic Medical Association; Harris County Osteopathic Medical Society, in which he served as president from 1984-85, and was named Physician of the Year for 1985-86; and the Harris County Medical Society.

Hospital affiliations include Doctors Hospital East Loop, where he was named Physician of the Year in 1981; St. Luke's Episcopal Hospital; The Methodist Hospital; Intracare Medical Pavilion Hospital, where he has served as vice president of medical staff since 1992; and Twelve Oaks Hospital, all of Houston.

TOMA congratulates Dr. Levy on his new positions. ■

FYI

TEXANS CAN KEEP UP WITH THE STATUS OF BILLS

A phone line operated by the Texas Legislative Reference Library provides details about legislation, committee activities and how to reach legislators. The toll-free number is 800-253-9693; the Austin number is 512-463-1251. Phones are operational Monday through Thursday, from 8 a.m. to 6 p.m., and from 8 a.m. through 5 p.m. on Fridays.

Additionally, a more comprehensive computer service is available through Internet. The service's Internet address is capitol.tlc.texas.gov.

Texas is one of only five states that provides entire texts of bills, debate schedules and other legislative details to computer users.

RAISE IN MINIMUM WAGE CONSIDERED

The Clinton administration is considering a proposal to raise the minimum wage, currently $4.25, to $5.25 an hour. The last time it was increased was in 1991, from $3.80, to the current $4.25.

UNINSURED REACHING 40 MILLION

Approximately 39.7 million Americans were uninsured in 1993, up 1.1 million from 1992, according to the U.S. Census Bureau. An estimated three-fourths of the uninsured had incomes above the poverty line.

HELP FOR THE NEEDLE-PHOBIC

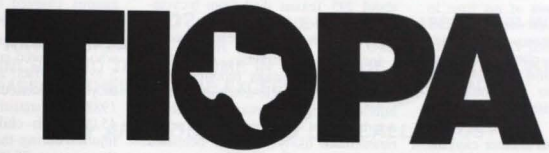
According to the publication *Nature*, researchers have developed a nasal spray that vaccinates mice against Lyme disease. They plan to work on sprays protecting humans against diseases such as pneumonia and diarrhea.

OPENING CHILD-PROOF CONTAINERS WILL SOON BE EASIER FOR ADULTS

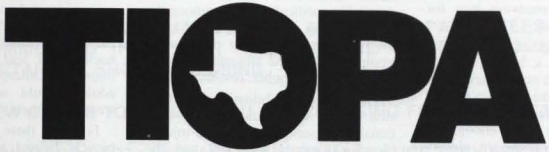
The U.S. Consumer Product Safety Commission has voted to amend the 1970 Poison Prevention Packaging Act in order to make child-proof containers "senior friendly." The amendment, which goes into effect in 1996, will require that containers be easy for adults to open, but still child-proof.

The Poison Prevention Packaging Act has been very successful. Childhood poisoning deaths declined from 450 in 1961 to 62 in 1991.

You need



TEXAS INDEPENDENT OSTEOPATHIC
PHYSICIANS ASSOCIATION



needs you.

With the arrival of managed care, physicians are searching for greater representation and a more influential voice. Texas Independent Osteopathic Physicians Association (TIOPA) is a physician-directed organization. It has recently expanded its network to help osteopathic physicians across Texas gain a competitive and organized negotiation presence. As a member, you'll benefit from:

- Joint Marketing and Promotion
- Managed Care Contract Review and Analysis
- Professional Autonomy
- Geographically Diverse Physicians Network

Join TIOPA, an organization established to promote and to support your independent practice in today's health care market.

Do it for yourself, for your practice and for other osteopathic physicians across Texas. For more information, write to TIOPA, 3715 Camp Bowie Boulevard, Fort Worth, Texas 76107, or call 817-377-8046, toll free 1-800-725-6628, or FAX 817-377-0827.

Helmets Avert Head Injury, But Only When We Use Them

By David R. Smith, M.D., Commissioner of Health

Since I spend most of my time in Austin, I welcome an occasional few days out of town when work demands it. The lifestyles I glimpse in other cities contrasted against those of Austin sometimes help to straighten my perspectives. Sometimes what I see is saddening.

On a recent trip to another city, the traffic was stopped for awhile because of an accident involving a young bicyclist who had been hit by a car. I never learned the extent of the bicyclist's injuries, but I assumed they were serious judging from the time paramedics spent readying him for transport to a hospital.

I was curious whether the bike rider had been wearing a helmet, then I spotted one strapped on the handlebars of the wrecked bike. I didn't need details about the young man's injuries since I've already seen enough in emergency rooms. They are always tragic and nearly always preventable. I considered the consequences of the boy's carrying his helmet on his bike instead of his head.

For the remainder of my trip, which included stops in several cities, I kept loose count of the bicyclists I saw who did not wear helmets and I was seriously disappointed.

I already knew from TDH's own research that fewer than 10 percent of bicyclists of all ages wear helmets, even in busy traffic or on hazardous roads. But I suppose Austin's traffic, where I see many bicyclists wearing helmets, had lulled my awareness that the majority of bike riders still refuse to wear helmets.

I couldn't help but wonder why, when common sense and fairly well-known statistics clearly show that the most serious injuries associated with bicycles are head injuries, and that helmets are the most essential safeguard against head injuries to bicyclists.

The numbers, compiled by the Injury Prevention and Control Program at the Texas Department of Health (TDH), show that between 1988 and 1992 about 295 Texans died from bicycle-related injuries. Approximately 183 of those fatalities included head injuries.

Including non-fatalities, emergency rooms and physicians reported more than 64,000 bicycle-associated head injuries during those years. Statistically non-helmeted bike riders are seven times more likely than are helmeted bike riders to suffer head injuries in an accident.

So far, the numbers I've cited reflect only part of the human toll. There also is an economic toll caused by bike riders' failure to use helmets. In these days when medical costs are among the most daunting obstacles to health care, the expense of caring for catastrophically injured patients depletes both private and public resources.

The Texas Rehabilitation Commission reports that costs for just vocational rehab services for a head-injured bicyclist exceeds $110,000 and the average lifetime cost for rehabilitation of brain-injured patients is about $4.5 million per individual. Much of that expense falls on the public, with about 16 percent of bicycle-related hospitalizations charged to public programs such as Medicaid.

Of course, many of the bicyclists who are injured are children. The age 5 to 14, in fact, are at highest risk o bicycle-associated head injuries. Th 1988-1992 statistics show that nearl 45,000 such children suffered hea injuries during that time. And amon those, some 38,000 might have bee spared their head injuries – if they ha worn helmets.

The evidence overwhelming supports the need for all bicyclists t wear helmets, both for their ow protection and to help reduce healt care costs for all of us. Similar t parents' obligation to teach children t buckle their seat belts, adults shoul insist that children use helmets – an adults should set the example b wearing helmets themselves.

For now there is no law requirin bicycle helmet use statewide, but believe there should be. Let's outla head injuries.

(Reprinted with permission of the Texa Department of Health)

Recommendations On ZDV Use

The Texas Department of Health notes that the Centers for Disease Control and Prevention (CDC) has released *Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus*. A recent AIDS Clinical Trials Group Protocol demonstrated that ZDV administered to a selected group of HIV-infected pregnant women and their infants can reduce the risk for perinatal transmission by approximately two-thirds.

ZDV is available to HIV-positive pregnant women through the Texas Department of Health's HIV/STD Medication Program. For more information, contact Sheral Skinner, LMSW-ACP, Director, HIV/STD Medication Program at 800-255-1090.

Those with client-specific clinical questions regarding recommendations of the Task Force may contact the AIDS Regional Education and Training Centers for Texas and Oklahoma/CDC through the AIDS Helpline for Health Professionals at 800-548-4659, Monday through Friday, 8 a.m. - 5 p.m. C.S.T., or 24-hour voice mail.

Texas Osteopathic Medical Association

Membership Application

One Financial Center
1717 North I.H. - 35, Suite 100
Round Rock, Texas 78664-2901
(512) 388-9400

(800) 444-TOMA
(Toll Free in Texas)

Founded in 1900
A Texas Non-Profit Organization

Join Risk Free Until March 1, 1995

Membership Classification:

Regular	$40
3rd Year in Practice	$30
2nd Year in Practice	$20
1st Year in Practice	$10
Military / Pub. Hlth. Svs.	$10

A complete refund will be provided if you are not completely satisfied with the membership services and benefits offered by TOMA.

(Please Print)

Full Name_____ Texas License #_____ AOA #_____
___ Female ___ Male Current Practice Status: __Full Time __Part Time __Active Practice __Faculty

Practice Specialty_____ Hospital Staff Privileges _____

Office Number:(___)_____ Fax Number(___)_____ Residence Number(___)_____

Please check preferred mailing site:

___Office Address_____
street city state zip county

___Residence Address_____
street city state zip county

Date of Birth __/__/__ Referred To TOMA By_____

Osteopathic College Attended_____City_____Year Grad._____

Internship Hospital_____City_____Dates_____

Residency Hospital_____City_____Dates_____

Member Specialty College _____

Date Certified _____Fellowship (if any) _____

List any additional post-graduate training_____

District Endorsement_____
District Secretary Approved - TOMA Membership Chairman

I hereby certify if elected to membership in the Texas Osteopathic Medical Association, I will uphold and abide by said Association's Constitution and Bylaws and Code of Ethics. Attached is $_____, the membership fee, which will be my dues for the current year, with the understanding that it is to be returned to me if I am not fully satisfied with the benefits and services offered by TOMA. (No application will be acted upon until the April Board of Trustees meeting.)
Request for dues refunds must be received by Friday, March 31, 1995.

_____
Signature of Applicant

Please direct any questions to Ms. Paula Yeamans, Membership Secretary at (800) 444-8662.

News From The Texas Medical Foundation

By Mark Bing, M.D., TMF Principal Clinical Coordinator

As principal clinical coordinator and the physician in charge of the cooperative projects for the Texas Medical Foundation (TMF), I would like to inform the TOMA membership of the activities of TMF's Health Care Quality Improvement Program.

In October 1993, TMF implemented its fourth Medicare contract with the Health Care Financing Administration to assess the quality of care provided to Medicare patients. Historically, this assessment was case-specific, focusing on individual providers and concerns. TMF's new contract, the Health Care Quality Improvement Program (HCQIP), dramatically shifts its focus toward looking at patterns of health care rather than individual cases. Today, TMF's efforts involve developing and sharing information with the health care community that will lead to measurable improvement in the care provided to Medicare beneficiaries.

The most important aspect of Health Care Quality Improvement Program is the development of cooperative projects. Cooperative projects are designed to help improve the quality and cost-effectiveness of health care by bringing typical care into line with best practices. Cooperative projects involve TMF working with small groups of hospitals and the health care professionals associated with those hospitals (including physicians, nursing staff, administration, radiology, lab, pharmacy, etc.) to collect and analyze clinical data to identify opportunities for improvement.

Topics for cooperative projects are found in analysis of patterns and trends from claims and review data, practice guidelines, provider/practitioner interest/consensus issues, and literature. One example of a project currently underway will measure the use of thrombolytics and aspirin in patients with acute myocardial infarction who have no contraindications to these medications.

Once clinical data is collected from a small number of facilities and analyzed, TMF shares the data with the participants and, in turn, the participants develop improvement plans to enhance the quality of care provided. TMF will then measure the effectiveness of the implemented changes.

As a physician, you have an interest in the success of cooperative projects, as well as an obligation to your patients to participate through your hospital affiliations. As you support your hospital's participation in cooperative projects, the information which will be learned can help you compare your practice patterns to best practices, assuring that you remain competitive and continue to provide the best care possible to your patients.

The Texas Medical Foundation is interested in hearing from you about your ideas for cooperative projects. For more information, please contact me at the Texas Medical Foundation, 901 Mopac Expressway South, Suite 200, Austin, Texas 78746, 1-800-725-9216. ■

IMMUNIZE YOUR LITTLE TEXAN BY TWO
SHOTS ACROSS TEXAS

Shots Across Texas Initiative Begins New Phase

In April 1994, the Texas Department of Health launched Shots Across Texas, a statewide multi-organizational coalition to boost efforts to immunize Texas children ages 0-2 against vaccine-preventable diseases. The specific goal of the initiative is to achieve a 90 percent immunization rate for two-year-olds by the year 2000.

The first phase of the statewide campaign involved a variety of strategies to reach as many infants' parents as possible. After months of immunization events attended by celebrities, accompanied by ice cream and music, and nurtured by local volunteers, the Shots Across Texas initiative faces a new challenge: zeroing in on the tough customers.

Shots Initiative Targets Hard-to-Reach Parents

The new phase, spearheaded by the Texas Department of Health in conjunction with a host of community and professional organizations, is crucial for the Shots program to make a lasting impact on the immunization rate in Texas. The key to this phase involves "different strategies to make sure targeted audiences get the information about immunization," said Lynn Denton, TDH Immunization Strategic Coordinator.

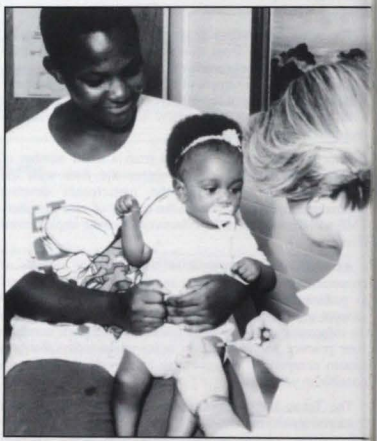
The new Shots Across Texas projects target parents least likely to know about the importance of immunizing preschoolers, physicians most likely to be in contact with these parents, and school-age children who can serve as advocates for baby brothers and sisters.

- In its project for homeless children, TDH is working with the Texas Council on Family Violence, the Texas Homeless Network, and the Texas Education Agency to provide information, immunizations, or both on a local level in homeless shelters throughout the state.
- Teenage parents are targeted in a project being developed by TDH with the Texas Association Concerned with School-Age Parenthood. A teaching module for high school teen parent organizations is being created by a team of educators, teenagers and an ad agency.
- A puppet show for elementary school children has been developed and will circulate statewide to encourage kids to remind busy or unaware parents of the need for infant immunizations.
- A series of mailings and forums will address physicians' special role in the ongoing immunization initiative.

In the meantime, the local efforts of Shots Across Texas to broadcast the news about immunization remain in full swing. "The local coalition movement is going strong," said Ms. Denton. Shots Across Texas relies on local volunteer coalitions to coordinate local immunization projects, distribute information to parents and, in some cases, administer the vaccinations.

Shots Across Texas was organized by the Texas Department of Health and is supported by the Texas Osteopathic Medical Association, the Texas Medical Association and hundreds of other businesses, agencies, associations and civic groups to educate parents about the need for infant immunization and to make immunizations available to families of all incomes.

TOMA members who would like to become involved at the local level in the new phase of the Shots Across Texas initiative should contact Lynn Denton, TDH Immunization Strategic Coordinator, at 512-458-7449 or 1-800-252-9152.



Childhood immunizations improve quality of life, save money, and are vital for all little Texans.

CLO$_2$SE BY.

A new multiplace hyperbaric chamber in Fort Worth has brought healing closer to home.

When the body needs help healing itself, oxygen can be the best medicine. So when hyperbaric oxygen therapy is your prescription, your patients can fill it nearby at Osteopathic Medical Center of Texas (OMCT).

OMCT's multiplace chamber is an advanced resource open to the entire medical community in our area. Specially trained physicians, critical care nurses, respiratory therapists and hyperbaric technicians work directly with you to plan patient therapy programs.

With the expanded hyperbaric facilities at OMCT, patients don't have to travel to Dallas for oxygen therapy. Your patients are closer than ever to being healed.

Hyperbaric Oxygen Therapy at
Osteopathic Medical Center of Texas

A joint program with the University of North Texas
Health Science Center at Fort Worth

1000 Montgomery, Fort Worth, Texas 76107 Hyperbaric Therapy Department (817) 735-3300

Tort Reform Bills Filed In 74th Texas Legislature

A package of tort reform bills has been filed by a coalition of Texas legislators, with strong backing from Governor George Bush, Lt. Gov. Bob Bullock and House Speaker Pete Laney.

Proposed measures would set limits on damage awards that go beyond actual losses; change medical malpractice laws; add restrictions for use of the Deceptive Trade Practices Act; reduce attorneys' abilities to shop for favorable trial settings; and require those filing frivolous lawsuits to pay for their defense.

Those opposed to aspects of the package include consumer groups and some members of the legal profession, who say the measures would reduce access to courts and result in inadequate compensation for injuries and death. The Texas Trial Lawyers Association will be involved in the fracas, as they were in the 1987 debate. The group opposes proposals that it feels would reduce injured parties' access to court and damage awards.

Tort laws were last revised comprehensively in 1987. Hearings on the measures are scheduled for early this month, with vigorous debate anticipated.

According to Lt. Gov. Bullock, "There is going to be a lot of tort legislation passed this session. If Texas is to grow, if we expect businesses to come to Texas to invest, if we expect businesses to stay here, I think it's imperative that these items be given a very top priority." ■

Americans Living Longer

The Centers for Disease Control and Prevention report that the average life expectancy for Americans has reached an all-time high of 75.8, the number of years those born in 1992 can expect to live. This figure is up from 75.5 years in 1991.

Death rates for 12 of the 15 leading killers dropped in 1992, however, deaths from AIDS jumped 11.5 percent making it the eighth leading cause of death in 1992. The AIDS death rate is expected to be higher for 1993, partially due to a change in the government's definition of the disease.

Overall, death rates for the six leading causes of death – heart disease, cancer, stroke, lung disease, accidents and pneumonia/influenza – dropped in 1992. The death rate for the number one killer, heart disease, fell 2.6 percent from 1991. The biggest decline, at 7.7 percent, was in the death rate from atherosclerosis.

The 10 leading causes of death in the U.S., ranked according to number of lives claimed, are: 1. Heart disease; 2. Cancer; 3. Stroke; 4. Lung disease; 5. Accidents; 6. Pneumonia, flu; 7. Diabetes; 8. AIDS; 9. Suicide; and 10. Homicide. ■

Breast Cancer Death Rate Rises for Black Women

The overall death rate from breast cancer in American women fell nearly five percent between the years 1989 through 1992, reflecting the largest short-term decline in 40 years. The largest decline was among white women in their 30s through 50s, whose death rates fell 8 to 9 percent. However, while the overall death rate among white women was falling 5.5 percent, it rose 2.6 percent for black women.

ATOMA News

By Peggy Rodgers, Auxiliary News Chairman

It's the beginning of a new year and a great time to start by coming a member of the Auxiliary to the Texas Osteopathic dical Association (ATOMA). It's a great time for sharing your sh ideas with your district and starting the new year by attending ir district meetings. Experience a new beginning with those dy to work together toward a common cause – promoting eopathic medicine.

ATOMA needs each of us to contribute our own special talents l new, fresh ideas. ATOMA needs you to lend a hand in moting osteopathic medicine, getting to know others with mmon experiences and making new friends. Make a New Year's olution to join us and make a difference by giving of your many ts to promote osteopathic medicine.

For more information on ATOMA membership, contact Mrs. rilyn Richards at 817-927-5857 or Janet at the TOMA office at 00-444-8662. Dues are a mere $20 for the state level and $20 for district level. ATOMA needs each of you in the coming year in organization that makes a big difference in public awareness, dical research and scholarships.

The ATOMA State Board met at their mid-year meeting tober 8, 1994 at the Loews Anatole Hotel, Dallas, Texas. The eting began at 11:25 and there were 11 members in attendance. e minutes were read and approved from the state convention in ne.

Business discussed during the meeting included the following:

1. Helping SAA representatives to the national convention by ying their air fare.

2. It was noted that the national convention would take place vember 11-17 in San Francisco.

3. NOM Week ideas and appreciation to Shara Lane for her icle in *The DO* magazine.

4. Having two meetings a year for the state Executive Board; at d-year and another prior to the convention. March 4, 1995 was ggested for this year.

5. Our mission statement was submitted by the Mission atement Committee, which included Dodi Speece, Chuckie spers, B. J. Czewski, Rita Baker and Merilyn Richards. The ssion statement reads as follows: To educate, inspire, and support e philosophy of the osteopathic medical profession in ourselves d others.

6. ATOMA has 245 members, and we are winning a challenge ainst Missouri. Having this many members entitles us to six legates plus our SAA delegate to the national convention.

The meeting was adjourned. ■

A New Idea for Patient Medication Compliance

Aprex Corp. of California has developed caps for medicine bottles that beep when it's time for a person to take medicine. A digital readout on the cap counts the number of times the cap is removed each day and when. Known as the SmartCap, it works by a tiny computer embedded inside the cap.

PRIVILEGES, SERVICES & BENEFITS

TOMA

- Is exclusively committed to promoting the practice of Texas osteopathic physicians.
- Is a positive force in eliminating and counteracting discrimination through education and marketing.
- Works on your behalf for successful resolution of disputes among health insurance carriers, hospitals, managed care organizations, and doctors.
- Effectively represents you, on matters of reimbursement, before health insurance carriers, Medicare, Medicaid and Texas Workers' Compensation Commission.
- Provides access to professional liability insurance, group life, disability, and major medical insurance.
- Effectively represents the osteopathic profession before legislative bodies and governmental agencies, through the constant monitoring of health care issues.
- Affords its members practice opportunities and access to current information on attractive practice locations through the physician placement service.
- Assists doctors in securing access to hospital staff privileges.
- Brings you Continuing Medical Education programs through our annual convention and medical seminars.
- Provides public information and educational programs that help you to tell a positive factual story about the osteopathic profession.
- Brings you timely information about your profession, plus articles of general interest to you in your monthly TEXAS DO magazine, legislative news bulletins, and the annual membership directory. Other materials such as the Controlled Substance Record Book and osteopathic educational materials for your patients, are available.
- Gives you an opportunity to take part in forming and approving the major policies of your Association.
- Is a vital, working state Association made up of administrative and elected officers, departmental and committee chairmen and committee members who are at work on a broad sweep of professional and public affairs.
- Provides free library reference information through Med-Search, a joint project of our Association and the UNTHSC Gibson Lewis Health Science Center medical library.
- Offers additional membership services - with the TOMA MasterCard program, the I.C. Systems collection agency, and a patient referral service.
- Supports the Physicians Assistance Program, which offers impaired physicians a peer group to monitor recovery.
- And other programs and services as they become available.

Medicaid Overhaul Proposed By Texas Senate Panel

The Senate Committee on Health and Human Services, headed by Senator Judith Zaffirini (D-Laredo), has approved 24 changes in the state Medicaid program which will be sent to the Texas Legislature for approval. The recommendations basically involve reshaping Medicaid into a managed care system to be run by HMOs and other entities.

Other changes to the Medicaid program would shift Medicaid patients in urban areas into a managed care program where they would be assigned either to a single physician or clinic; and a proposal to make local health care funds part of Medicaid in order to bring in new federal matching funds when providing indigent care.

The Medicaid program is facing an anticipated $2.2 billion shortfall during the next two-year budget period. Medicaid Director DeAnn Friedholm noted that a program cut would adversely affect health services to the elderly, disabled or poor. "The basic problem in Texas is that we have a disproportionate number of low income, uninsured people who qualify for Medicaid. This demand is coupled with medical inflation and higher reimbursement for institutions such as nursing homes and hospitals."

Although proposed recommendations involving reducing provider payments would save about $482 million and cutting services an estimated $237 million, officials felt that these types of cuts would cost more in the long run.

Additionally, the committee suggested implementing a study of privatizing Texas Department of Mental Health and Mental Retardation facilities which receive Medicaid funds. The facilities include 21 institutions, 13 state schools for the mentally retarded and eight state psychiatric hospitals. This study will be conducted by the Texas Council on Competitive Government. ■

Federal Government Implements AIDS Hot Line

The HIV-AIDS Treatment Information Service has begun taking calls in an effort to provide treatment information by phone or computer to people with AIDS, their families and health care providers. The toll-free number is 800/HIV-0440. Operational hours are 8 a.m. to 6 p.m. Central Standard Time, Monday through Friday.

MEDWATCH Update

Due to numerous inquiries, the Food and Drug Administration Medical Products Reporting Program (MEDWATCH), has provided information regarding the approval of metformin (Glucophage® – Lipha Pharmaceutical Co.), a new drug for the treatment of Non-Insulin Dependent Diabetes Mellitus (NIDDM). Sold under the trade name Glucophage, it will be distributed in the U.S. by Bristol-Myers Squibb of Princeton, N.J.

Approved by the FDA on December 29, 1994, for marketing in the U.S., metformin, as monotherapy, is indicated as an adjunct to diet to lower blood glucose in patients with NIDDM, whose hyperglycemia cannot be satisfactorily managed on diet alone. It may also be used concomitantly with a sulfonylurea when diet and metformin or a sulfonylurea alone do not result in adequate glycemic control.

The availability of metformin will provide a needed alternative to sulfonylurea therapy. The sulfonylureas (i.e., acetohexamide, chlorpropamide, glipizide, glyburide, tolazamide and tolbutamide) have been the only option available for oral drug therapy. There are variations among the sulfonylureas as to dosage ranges, duration of action and metabolism; however, they all act by stimulating insulin secretion from the pancreas. When the sulfonylureas fail to control blood sugar in a NIDDM patient, the only alternative has been to start insulin therapy.

Metformin, a biguanide-type oral hypoglycemic agent, provides another option for oral therapy. Metformin's pharmacologic mechanisms of action are different from that of sulfonylureas.

In contrast to the sulfonylureas which cause insulin to be released, metformin improves glycemic control in NIDDM patients by improving insulin sensitivity (i.e., increases peripheral glucose uptake and utilization as well as decreases hepatic glucose production) and decreasing intestinal absorption of glucose. Unlike sulfonylureas, metformin used alone does not produce severe hypoglycemia under usual circumstances of use in either diabetic or nondiabetic patients and does not cause hyperinsulinemia. With metformin therapy, insulin secretion remains unchanged while fasting insulin levels and day-long plasma insulin response may actually decrease.

Safety Issues

Two significant concerns presented by metformin are lactic acidosis and cardiovascular mortality.

Lactic acidosis: Phenformin, another biguanide oral hypoglycemic agent, was taken off the U.S. market in 1977 because of associated fatal lactic acidosis, a rare and serious metabolic condition with a mortality rate of about 50 percent. Lactic acidosis is also known to occur during metformin therapy, albeit at a much lower rate. The reported incidence of lactic acidosis in metformin patients is approximately three cases/100,000 patient-years compared to a rate of 25-400 cases/100,000 patient-years in phenformin patients.

With metformin, reported cases have occurred primarily in diabetic patients with significant renal insufficiency. The risk of lactic acidosis increases with the degree of renal dysfunction and the patient's age. Metformin's use is contraindicated in patients with renal disease or renal dysfunction. In other patients taking metformin, the risk may be significantly decreased by regular monitoring of renal function and by use of the minimum effective dose.

Cardiovascular mortality: All oral hypoglycemic agents, including metformin, carry a special warning on increased risk of cardiovascular mortality based on the study conducted by the University Group Diabetes Program (UGDP). [Diabetes, 19 (Suppl.2):747-830; Diabetes, 24(suppl.1):65-184, 1975].

The UGDP was a long-term (5 to 8 years) prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in NIDDM patients. The UGDP reported that treated patients (on diet and either tolbutamide or phenformin) had a rate of cardiovascular mortality approximately 2.5 times that of patients treated with diet alone. While controversial, the UGDP findings provide an adequate basis for warning NIDDM patients about the potential risks and benefits of all of the various modes of therapy.

A study underway in the United Kingdom, modeled after the UGDP study, includes metformin as one of the treatment groups. Upon completion in 1997, it should help answer some of the questions raised by the UGDP about the use of oral hypoglycemics and their effect on overall mortality.

How Concerns Will Be Addressed

1. An educational campaign directed to health professionals and patients about the risk and benefits of metformin therapy will be undertaken. Patient package inserts will be available for dispensing with all prescriptions, and labeling will contain a boxed warning on lactic acidosis and a special warning on increased risk of cardiovascular mortality based on UGDP findings.

2. The company will conduct a one-year postmarketing surveillance study in which 10,000 NIDDM patients will be enrolled to look at both lactic acidosis and total mortality. Study results will be presented to the FDA Endocrine and Metabolic Advisory Committee.

3. The FDA will closely evaluate the results of the United Kingdom study in regards to the incidence of lactic acidosis with metformin and overall cardiovascular mortality rates with the oral hypoglycemics studied.

Information for Patients

Patients should be informed of the potential risk and advantages of metformin and of alternative modes of therapy. The risks of lactic acidosis should be explained, and patients should be advised to discontinue metformin

mediately and to promptly notify their lth practitioner if unexplained erventilation, myalgia, malaise, sual somnolence or other nonspecific iptoms occur. After stabilization on dose level of metformin, gastro- stinal symptoms, common during apy initiation, are unlikely to be drug ted; thus, later occurrences of gas- ntestinal symptoms could be due to ic acidosis or other serious diseases.

Patients should be counselled against essive alcohol intake while receiving formin.

Metformin alone does not cause severe oglycemia under usual circumstances use, although it may occur when tformin is used in conjunction with l sulfonyureas. When initiating rapy, the risk of hypoglycemia should explained to patients.

As always, health professionals are ouraged to report any serious adverse nts to the FDA MEDWATCH program -800-FDA-1088. ■

Rural Health Factline

* Specialists practicing in group settings, in general, saw their income decline relative to primary care physicians in 1993. While cardiovascular surgeons' income dropped 10.5%, for example, internal medicine income grew 8.2% and family practice income grew 6.6%.

** Navarro Regional Hospital in Corsicana, Pinelands Hospital in Nacogdoches and Rusk State Hospital were among 32 Texas hospitals achieving "accreditation with commendation" from the Joint Commission on Accreditation of Health Organizations. This is the most distinguished accreditation award given by JCAHO. Only five percent of the hospitals surveyed have achieved this since the category was started in 1990.

*** Methodist Hospital in Plainview has developed a strategic plan that focuses on PRIDE. PRIDE stands for Positioning of the hospital; Recruitment of staff; Internal operations; Development of new programs; and Education of staff and community.

**** El Campo Memorial Hospital was scheduled to open a 10-bed geriatric mental health unit on September 1. The unit will provide mental health assessment and short-term treatment to older people who are experiencing emotional, behavioral, and psychological symptoms. Administrator John Grant notes that depression is the most common problem treated in geriatric mental health units.

**AMNews, October 3, 1994; **HealthTexas, September, 1994; ***Plainview Daily Herald, July 24, 1994; ***El Campo Leader-News, July 2, 1994.*

(Reprinted from Rural Health Reporter, Vol. 4, Issue 2.)

Medicaid Therapy Review Panel To Be Appointed

The Texas Department of Health will soon be establishing a Therapy Review Panel. The functions of the panel will be the following: to review on an annual basis those therapies currently covered under Medicaid; to review requests for new therapies/technology not covered and make recommendations regarding future coverage of those therapies; to review complaints received from providers regarding coverage of therapies and make recommendations about policy changes; to review the number of therapies paid in each area during the previous fiscal year to identify possible trends and/or problem areas.

The Therapy Review Panel will be composed of two physical therapists, two occupational therapists, two speech-language pathologists, two physicians, one consumer who received therapy(s) related to a developmental disability with onset in childhood, and one parent of a child who has received or is currently receiving therapy(s) through Medicaid or the Chronically Ill and Disabled Children (CIDC) program. All physicians and clinicians on the panel must be Medicaid and/or CIDC providers during the time they serve on the panel. The primary work setting of one of the therapists (occupational, physical, speech-language) must be in a public school. The primary caseload of one of the therapists (occupational, physical, speech-language) must be with children 0 - 3 years.

The two physicians must be licensed to practice in the State of Texas, have a practice of medicine primarily with children (physical rehabilitation medicine, pediatrician, family physician, neonatologist or developmental pediatrician), and have direct experience in longterm follow-up.

Each panel member will serve a three-year term with the exception of the initial appointees. Five of the initial appointees (one occupational therapist, one physical therapist, one speech-language pathologist, one physician, and one consumer or parent) will serve a two-year term, and the remaining five will serve a three-year term.

Persons wishing to be considered for appointment to the Review Panel should submit a letter stating why he/she wishes to be appointed, along with a current vitae. This information should be sent to Beverly L. Koops, M.D., Associate Commissioner for Health Care Delivery, Texas Department of Health, 110 West 49th Street, Austin, Texas 78756. The deadline for receipt of this information is March 31, 1995. If you have questions or would like additional information, please contact Martha McGlothlin, Texas Department of Health, 512-458-7700, 512-458-7350 fax. ■

Medicare Payments Increase While Barriers To Access Continue

In its fourth annual report to Congress since the new Medicare fee schedule was implemented in 1991, the Health Care Financing Administration has announced that average allowed charges for primary care physicians and medical specialties have increased, while allowed charges for surgical specialties have decreased. The figures cover 1991 and 1992.

Allowed charges for primary care physicians revealed a 10 percent increase, from $37,362 to $41,039; and a two percent increase for medical specialties, from $111,686 to $114,041. Allowed charges for surgical specialties fell by 3.7 percent, from $97,020 to $94,082.

Based on two HCFA surveys and six other studies of 1993 data, the report focused on the disparity over access to care between different groups of Medicare recipients. Barriers to access continue, despite financial coverage, among such groups as African Americans, the disabled, those without supplemental insurance and residents of rural areas. HCFA administrator Bruce Vladeck stated, "We are committed to seeing that our beneficiaries have access to the highest-quality care, but we see that's not happening." He added that HCFA's ability to assure equal access to care is important because the ranks of those who currently experience barriers to care are growing."

Some of the reasons for the disparity cited by HCFA are: the disabled may have problems such as lack of transportation to the physician; those lacking supplemental insurance may be unable to afford the co-payments and deductibles; and those with incomes below poverty level may be unable to afford Medicare co-payments.

Additionally, HCFA's report noted that the supply of primary care and medical specialists per 100,000 beneficiaries continues to be higher in metropolitan areas. ■

ATTENTION, TOMA Members

This serves as a reminder that any member or district planning to present resolutions to the TOMA House of Delegates' meeting on Wednesday, June 14, 1995, during the Annual Convention must submit such resolution(s) to the TOMA State Office prior to May 14, 1995.

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

If you have any questions regarding resolutions, please call TOMA at 1-800-444-8662. ■

Self's Tips & Tidings

Don Self & Associates

MEDICARE DEDUCTIBLE

At this time, you can reasonably expect that patients have NOT met their annual deductible. For Medicare, the deductible is $100. Therefore, you should collect the first $100 of APPROVED amounts from the Medicare patient. Do not include the clinical lab charges in this $100 deductible, as clinical lab services do NOT have a deductible or co-insurance. As an example, you see a patient & charge for a visit, X-ray, injection and CBC. (amounts are fictitious):

CODE	FEE	APPVD
99213	$50	$20.00
J0700	$ 5	$ 2.00
70220 WP	$60	$48.00
36415	$ 6	$ 3.00
85024	$15	$ 7.00

Collect the deductible on codes 99213, J0700 & 70220, but not on 36415 & 85024. You collect $70.00 from the patient (which Medicare will apply to the deductible) and Medicare will send you a check for $10.00 (total approved of 36415 & 85024).

If the patient has a Medigap policy, go ahead & collect the deductible from the patient as most secondary policies also require a deductible. I would much rather you collect from the patient today and eventually have to issue a refund check (thereby drawing interest in your bank account) than having to go to the expense of billing the patient each month.

If the patient also has Medicaid, there is no deductible, as Medicaid picks up the deductible.

ALLERGY INJECTIONS

Even though codes 95120, 95125 & 95130-95134 have not been deleted in the 1995 CPT manual, Medicare has classified these codes as "not valid." Therefore, you should not use these codes for Medicare, but use other codes which identify the service being rendered.

INJECTION MISTAKES – EOMBS

We have received several calls and faxes concerning the fact that Medicare is either over-paying or under-paying on injections. 90% of the time, the problem is in the number of units on the claim or the number being processed by Medicare. In one instance, Medicare was under-paying because the number of units on every claim was one (1), even when multiple units should have been used. Medicare is already paying much too low on injections anyway, so don't make it worse by improperly completing the claims. In some cases, the fault was not with the office, but with the billing service, the computer program or the computer claims processing office. In another, Medicare keypunchers (on paper claims) changed the units from 1 to 11. Instead of the EOMB reflecting 010, it indicated 110. Medicare approved the full fee, even though the client was charging much higher than Medicare should allow. If you receive ANY EOMB where Medicare approves the full amount, check it out!

CARDIOLOGY WORKSHOP

McVey & Assoc. will be hosting an all-day workshop on Cardiology coding (CPT & ICD9) in Dallas on Sat., Feb. 18 at the Harvey Hotel - DFW. You can get more information by calling 800-227-7888. Our clients receive a $25.00 discount, so make sure you mention us.

DALLAS WORKSHOP – FEB. 10

Again, we are honored to be teaching a workshop for TOMA during its Midyear Conference at the Doubletree Lincoln Centre in Dallas on Feb. 10. This Friday evening workshop will be from 7:30 - 9:00 p.m. Of course, we will be available at our booth during the convention, should you have any questions or problems. We encourage you to attend this short workshop.

SOUTH TEXAS WORKSHOP

We are currently working with the TOMA on hosting an all-day workshop in Galveston in May. This would be an excellent opportunity for you to send your staff to the beach for a couple of days. If you are interested in attending, please give us a call.

CODING FRACTURE CARE

Recently, while examining claims, we noticed several claims that did not utilize the best coding strategy. Instead of coding for fracture care, the claims were coded with strapping or casting. Reimbursement levels are much higher with the fracture care codes than they are with the strapping or casting. As an example, in one locality, code 28490 (treat fracture toe) has an approved of $73.65, while the strapping code 29550 only $28.99. We've especially notice this with hospital emergency room claim with some of the major hospitals th transmit their claims through us dail You may benefit your hospital greatly b bringing this up to your hospit administrator.

BLOOD PULLS

Another area that we have found ma physicians losing potential income on in obtaining blood coding. It surprised m to find that the large percentage o physicians in Texas are not chargin properly for this service, especially whe rendered in the hospital setting. Fou codes that you should examine closely i the CPT manual are shown next, wit their respective approved amounts fo one locality in Texas:

36000	$33.04
36600	$20.13
G0001 36415	$ 3.00
36420	$51.45
36425	$24.68

For your benefit, review the descrip tions found in the 1994 or 1995 CPT. Yo may find that you are losing hundreds i this area.

FLEX SIGMOID; CODES

Another example of PHYSICIANS no maximizing their reimbursement is in thi area. Many physicians tell their staff the did a flexible sigmoidoscopy and th claim is coded with 45330, which has a approved of $84.18 in one locality i Texas. In actuality, the physician ma have done a flex. sigmoid. with biops (45331) which has an approved o $115.01, or if it was for bleeding (45334 which has an approved of $230.74. If th staff does not KNOW the service yo rendered, they are likely to use the basi 45330, which may be costing you!

CLEANING EARS

I am not a physician, so I do not know which service you are rendering in you office, but a comparison of reim bursement levels may be helpful. Whil some offices inevitably give away irrigation of ears or ear wax removal b not charging for it, some that do so ar losing money in other codes. Some ar not charging for office visits in additio to the irrigation of ears code (69210). I the irrigation of the ear(s) is a separat

entifiable service than the visit, and you ve multiple ICD9 codes to use for the counter, by all means, go ahead and arge for both, using the 25 modifier on visit code. Along the same lines, eck out procedure code 69200 in the T manual. Code 69000 (in Medicare's tabase) says: Clean Outer Ear Canal, d has an approved of $61.09 in one ality. Code 69200 says removal reign body from external auditory canal ithout anesthesia) and has an approved $33.62. Code 69210 (Removal pacted cerumen) has an approved of 6.29. Having never performed the rvice and not being a physician, I don't ow exactly what you are doing, but you ay want to review these three codes and ake sure you give your staff the most curate code.

OUTINE EXAMS & OVERED VISITS

While this subject was discussed in *edicare Special Newsletter 127* /28/94), there are still questions in some ices. Codes 99391 through 99397 are r "Periodic preventive medicine evaluation & management...," or outine physicals." Since anything utine is not covered by Medicare, you ve to be careful how you use these des & collect from the patient. asically, we will discuss two different enarios that may occur in your office:

SCENARIO ONE: Patient requests an ppointment for a routine physical, with complaints. The Medicare patient ould be told that Medicare will not pay r the service and they will be expected pay your usual fee at the time of rvice. Code the visit as 99397 and file e claim to Medicare if either (a) The tient has a supplemental policy, in pes the secondary policy will reimburse e patient, or (b) if the patient insists that u file.

SCENARIO TWO: Patient calls for appointment for a routine physical, but mplains of a routine problem (i.e., thritis, cerumen impaction, etc.) or you e monitoring the patient's diabetes or ner condition. You may bill for both the n-covered routine physical (99397) ND the covered examination.

Let's say you did a complete, routine nual physical (including a chest X-ray EKG) on a pt. you have been treating r diabetes for a long time. Assuming u also ordered a couple of blood tests, e to the diabetes, which need to be terpreted, how would you code today's sit? Part of these services would be covered & part not covered by Medicare:

99212	Exam	Covered
82047	Lab	Covered
85024	Lab	Covered
36415	Lab	Covered
93000	EKG	Not-Covered
71020	X-Ray	Not-Covered
99397	Physical	Not-Covered

You would reference the four services that were covered to the diabetes diagnosis (i.e., 250.00 or 250.01) thereby showing they are covered services & reference the physical, EKG & X-Ray to the routine physical (ICD9 V70.2). You will need to make sure the patient signs a form in your office acknowledging they had been informed the particular services (list the procedure codes) would not be covered due to the routine nature of the circumstances. This form will need to be kept in the patient's file, so as to be available to Medicare, should they request it. The form MUST be dated for the date of service, signed and list the particular procedure codes rendered that you believe Medicare will not cover.

As far as your fees, you must ensure the total combined fees for the covered visit and the non-covered code 99397 do not exceed the amount you usually charge for the non-covered routine physical. As an example, if your standard fee for code 99397 is $150.00, your combined total charge for both procedures cannot exceed $150.00. Your fees for other services are not included in this rule. In this example, we would deduct the APPROVED amount for code 99212 ($24.00) from your usual fee for code 99397 ($150), which means we would charge:

99212	Approved	$ 24.00
99397	Usual - 99212	$126.00
35024	Usual	$ 20.00
36415	Usual	$ 6.00
82047	Usual	$ 15.00
93000	Usual	$ 65.00
71020	Usual	$ 75.00
TOTAL Covered		$ 24.00
TOTAL Non-Covered		$266.00

The patient would be expected to pay for the non-covered services in full ($126 + $65 + $75 = $), plus the co-insurance (20% of approved) on the covered office visit ($24 x 20% = $4.80. Medicare would then send you a check for the standard 80% of the approved of the visit ($19.20) and the total approved amounts of the covered lab (since lab does not have a co-insurance or deductible). Of course, if the patient had not met the annual $100 deductible yet, the pt.. would pay that also.

This is one more illustration of the importance of doctors documenting not only the progress notes, but also documenting the charge ticket or superbill, so the front office & insurance staff will be able to properly complete the claim forms. If the desk personnel are not clear on which procedures are referenced to which diagnosis, the patient cannot be properly charged and collected from.

INFO NEEDED FROM YOU

In reviewing our records, we have found that we need to receive some information from ALL retainer clients. If you have a fax machine, I need your fax number. This can be especially useful & helpful to us. As an example, on New Years day, I was faxing a partial listing of the new codes and fees to all retainers that would not receive the annual update prior to opening on January 3rd.

If I didn't have a fax number on you, I couldn't get that info to you in time.

UPDATES TO YOUR 1995 FEE & CODE BINDER

We will be sending periodic updates to all retainer clients with revised codes, revised approved amounts, injection code description changes, lab approved amounts, etc... When you receive these, please place them into the binder we recently mailed to you.

WORKSHOPS IN YOUR TOWN

We would love to come teach a workshop or seminar in your town at your hospital or at a local hotel. If you would like to help us make this possible, give us a call. Most hospitals are glad to bring a helpful and beneficial workshop to the physicians and staff. All it usually takes is knowing the right contact person at the hospital.

DON'T FORGET TO ORDER YOUR 1995 CPT CODE BOOK. WE USE SHANNON AT PMIC. HER # IS 800-633-7467, EXT. 539.

CMDS Seeks Assistance

Christian Medical & Dental Society

A Fellowship of Physicians and Dentists

Dear Doctor:

It gives me great honor and pleasure to introduce you to an encouraging and exciting organization, the **Christian Medical and Dental Society** (CMDS). Each year, the University of North Texas Health Science Center chapter of CMDS provides needed healthcare to the underserved of Mexico through a medical mission trip. This Spring Break, students and physicians will be teaming together to serve Reynosa, Mexico which is just across the border from McAllen, Texas. **In 1994, almost 30 student-doctors and three physicians served approximately 600 indigent patients during last year's mission trip to Juarez, Mexico.**

Through the teamwork of physicians, healthcare professionals, and student-doctors, last year's operation included three daily clinics at different locations, usually lasting from 9:00 AM to 4:00 PM. Once word spread that we were coming, it was not uncommon to have 50 people waiting for care when we arrived in the morning.

Although the needs of the people in Juarez were many, **needs for hygiene and personal care products were the greatest**. Our goal this year is to distribute care packages consisting of personal hygiene supplies to all patients.

Even with all this help, many more doctors and healthcare professionals are needed. For millions of people in Mexico, this is the only form of yearly healthcare they have. **Won't you please seriously consider making a commitment to aid the mission trip this year and in the years to come?**

Besides serving the healthcare needs for many Mexican residents, the CMDS mission trip provides a once-in-a-lifetime learning experience for students and physicians. Through the directorship of T. Eugene Zachary, D.O., many second-year student doctors use this valuable opportunity to fulfill the preceptorship program as required through the Department of Family Medicine at the Texas College of Osteopathic Medicine.

And lastly, our medical mission trip would be useless without supplies. We greatly need donated pharmaceuticals from clinics, physicians, and drug representatives. **If you can be of any help**, we encourage you to respond with the enclosed form. Your help is what keeps this ministry successful for the students and importantly, to those less fortunate than us.

The CMDS mission trip for 1995 will set up clinics March 13-16. If you will commit to attending or helping this year, **please take a minute to complete the reply form and make a difference in someone's life!**

With sincere thanks,

Matthew Glick
CMDS President
TCOM Class of 1997

Please send replies to: **UNTHSC-FW**
Christian Medical and Dental Society
Box 306
Attention: Matthew Glick
3500 Camp Bowie Blvd.
Fort Worth, TX 76107

Inquiries can be made by calling me at (817) 870-1836.

Name / Address _____

☐ I am interested in attending for the dates: _____

☐ I can send _____ who is my nurse/hygienist on m

behalf for the dates: _____

☐ Please send me more information regarding: _____

_____

☐ I am willing to collect pharmaceuticals/donate supplies: (Yes) (No)

Please have someone from CMDS contact me at: Office: _____

Home: _____

☐ I cannot attend, please accept this donation in the amount of

$25 $50 $100 $250 $500 other

CHAMPUS News

CHAMPUS And HMO Coverage

If you have an HMO (health maintenance organization) as ur primary civilian health insurance, CHAMPUS will cost- are covered care received from a qualified provider of the MO (including the HMO's user fees) after the HMO has id all it's going to pay for the care.

But CHAMPUS won't share the cost of services you obtain tside the HMO, if the services are available through the MO. For example, if the HMO would cover a particular rvice, but denies payment because it could have provided e service (such as a situation in which you took your child a pediatrician outside the HMO, because you didn't like the MO's pediatrician), CHAMPUS won't pay anything on the aim.

ew Group of Eligible Persons Added to CHCBP

Congress has added a new group of eligible persons to the ree original categories of eligibility for the Continued ealth Care Benefit Program (CHCBP).

The new eligibles are unmarried persons who have been aced in the legal custody of a military sponsor as a result court order, or by an adoption agency recognized by the ecretary of Defense. They must be under age 21 (or 23 if in hool full-time) or be incapable of self-support because of a ental or physical incapacity which occurred while they were onsidered a dependent of the sponsor. They must also be ependent on the sponsor for more than half of their support nd must not qualify as a dependent under any other program. hese persons will be eligible for CHCBP benefits for 36 onths.

The other three categories of eligibility are:

1. Former service members who are released from active uty (or full-time National Guard or reserve duty for a period f more than 30 consecutive days) under other than adverse onditions, and their families. Eligibility is for up to 18 onths of CHCBP benefits after enrollment.

2. Unmarried, emancipated children of service families ho no longer meet the requirements for being considered an nmarried dependent child of a military sponsor. Eligibility is or up to 36 months of benefits.

3. Unremarried former military spouses. Eligibility is for p to 36 months of CHCBP benefits, and there's no length-of- me requirement for the marriage.

CHCBP is not a CHAMPUS program, but it provides ealth care benefits like those of CHAMPUS to eligible ersons who enroll within 60 days after losing their eligibility or military health care benefits (including CHAMPUS). For ore information about CHCBP, write to the CHCBP dministrator, IM&I, Inc., P.O. Box 1608, Rockville, MD 0849-6119. Or, call IM&I at 1-800-809-6119.

HAMPUS Patients Should Use ew Forms When Filing Claims

The new CHAMPUS claim form for patients' use is in listribution now, and should be used by CHAMPUS-eligible ersons in place of the old form.

The new form is the DD Form 2642 ("Patient's Request for Medical Payment"). It replaces the yellow DD Form 2520. The "2520" won't be accepted by CHAMPUS claims processing contractors after Dec. 31, 1995, for the payment of medical care or services obtained in the U.S. or Puerto Rico.

The DD Form 2520 will continue to be used by both patients and providers of care for health care services in foreign countries. Providers who complete or file claims for CHAMPUS patients in the U.S. and Puerto Rico should bill CHAMPUS on the HCFA 1500 or the UB-92 claim form, whichever is appropriate.

Beginning Jan. 1, 1996, all providers who render care to CHAMPUS patients in the U.S. and Puerto Rico will be required to use the appropriate national claim form: the HCFA 1500 for professional services, or the UB-92 for institutional services. ■

New Benefit for TOMA Gold MasterCard Holders

MBNA Marketing Systems, Inc., has announced a new enhancement, the Transmedia Restaurant card, for TOMA members who hold a TOMA Gold MasterCard.

This new product provides the following features: 25 percent discount on meals and drinks when the card is used at participating restaurants; no limits on when or how much the card is used; over 3,000 participating restaurants in the U. S. and the United Kingdom; and the card is free for the first year, with only a $40 annual fee thereafter.

TOMA members who are currently TOMA Gold MasterCard participants will be contacted by MBNA marketing representatives regarding this new product.

We encourage those who do not have a TOMA Gold MasterCard to check out the information on page 22 in this issue. Designed especially for TOMA members, the program provides valuable benefits to both the cardholder and the association. ■

New Drug for Lung Cancer Approved by FDA

A new medication called Navelbine, shown to prolong the lives of advanced lung cancer patients by a median of two months, has received approval by the Food and Drug Administration.

Manufactured by Burroughs Wellcome Co., the drug will be used to treat nonsmall-cell lung cancer in cases too advanced to benefit from surgery or radiation. Navelbine is a semisynthetic derivative of the vinca flower family. ■

What's Happening In Washington, D.C.

• ***Middle-Class Center Stage.*** The game these days is to jump on the middle-class tax cut bandwagon. The Republicans, Democrats, Clinton Administration and various groups of individual congressmen have all jumped aboard.

• ***The Middle-Class Bill of Rights.*** That's the label for the Clinton Administration's middle-class tax cut plan. It promises a $500 tax credit for families with children under 15, a tax deduction for college tuition payments, expanded deductions for IRA contributions and liberalized rules for IRA withdrawals. All of the tax breaks are phased out at various income levels, thus preserving the benefits for only the middle class.

• ***The Cost?*** The cost of Clinton's Middle-Class Bill of Rights is estimated at $60 billion over the next five years, about one-half the cost of the Republican plan. To fund the cost, the President proposes to shrink five government agencies and shift a number of government-run operations to new corporations or private companies.

• ***The Counter Argument.*** Some advisors claim that a middle-class tax cut will spur an already rapidly growing economy, which in turn will simply motivate the Federal Reserve Board to increase interest rates to cut back inflation. They claim the results will be little or no net savings to the middle class and an increase in the government deficit due to higher interest rates.

• ***Capital Gain Details.*** The GOP has provided details on its proposed capital gains cut. The proposal includes (1) a 50 percent deduction for capital gains (2) capital loss treatment for a loss on the sale of a personal residence, and (3) indexing the tax basis of corporate stock and tangible capital assets for inflation.

• ***A $56 Billion Tab.*** That's the projected cost of the proposed capital gains tax cut over the first five years, according to the Joint Committee on Taxation. The projection does not factor in the impact of increased investments and the expected growth in economic activity.

• ***Won't Take Veto.*** House Speaker Newt Gingrich is confident that the new capital gains break will pass the House in early '95. He promises that if President Clinton vetoes the bill, he will keep sending it back to the White House to keep forcing the President's hand.

• ***Retirement Savings Way Down.*** A recent study confirmed that in 1994 each worker saved an average of $1,776 for retirement, a drop of over 34 percent from the prior two years. It's a dramatic addition to the mounting evidence that American workers are unwilling or unable to fund their own retirement and welfare needs.

• ***A Mere $1.1 Trillion Dollars.*** That's the amount that the Senate Budget Chairman says must be cut from the budget by the year 2002 in order to have a balanced budget. This number was presented to a closed House and Senate Republican leadership meeting on December 2. It assumes no tax changes. It's a scary number for those who have promised a balanced budget amendment.

• ***State Paranoia.*** The balanced budget amendment talk is making states nervous. They fear that the federal government may follow its old practice of mandating that states take over federal government programs. Senate Majority Leader Bob Dole recently noted that placing limits on these types of unfunded mandates for the states will be a top priority in the next Congressional session.

FAMILY INCOME SHIFTING STILL ALIVE

Income taxes can be saved by implementing a plan to shift income to family members who are in low tax brackets. In some cases, it's even possible to create a new taxpayer – a trust – and save taxes by shifting income to it. If the shift is carefully planned, the result is more available dollars for college expenses, retirement, the support of aging parents or just about anything else.

The key, of course, is to do it right. In recent years, Congress has complicated the Internal Revenue Code for the express purpose of making income shifting more difficult, but not impossible. The complexities includes the kiddie tax, new tax rate wrinkles, special standard deduction limitations and more. They bushwhack the uninformed, and make the challenge more interesting for those who know the rules. ■

The above information was provided by Dean, Jacobson Financial Services, Fort Worth, Texas.

Frustrated With Health Insurance? Looking for a New, Stable and Affordable Approach?

Call the Health Insurance Experts

TOMA has endorsed DEAN, JACOBSON Financial Services to handle the frustrations of health insurance for you! While volatility and increasing costs have become the norm for the health-care industry, DEAN, JACOBSON Financial Services has designed a superior group health plan specifically for TOMA members and their employees through CNA Insurance Company. CNA is one of the largest and strongest insurers in the nation. With over $10 billion of assets and a top A++ rating ("Excellent"), CNA is well-positioned to offer stability, strength and commitment for your future health care needs.

So, if you are looking for a better answer to your health insurance frustrations, call DEAN, JACOBSON Financial Services to join the TOMA program today!

For information on coverages, costs, and enrollment forms contact:

DEAN, JACOBSON FINANCIAL SERVICES

(817)335-3214
P.O. Box 470185
Fort Worth, TX 76147

(800)321-0246
(817)429-0460
Dallas/Fort Worth Metro

Texas Society of the ACOFP Update

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

The 74th Texas Legislature convened on 1-10-95, and TOMA and TACOFP were off and running! The TOMA anti-discrimination bill has been re-introduced in both houses. TOMA and TACOFP are going to exert maximum effort to pass this important legislation. It will be our number one priority during the 74th session of the Texas Legislature.

As you may remember, this anti-discrimination legislation was introduced in the 73rd session of the Texas Legislature. It passed the House but, unfortunately, time ran out before it could be voted on by the Texas Senate.

TOMA's anti-discrimination bill is being sponsored by Rep. Jack Harris in the House and Senator Carlos Truan in the Senate. During each Texas Legislative session there is a toll-free number to monitor legislation. The Legislative Update number is 800-253-9693. By calling this number you can follow this bill as it passes through committees of the Texas Senate and House.

The bill relates to hospital staff privileges for doctors of medicine (M.D.) and doctors of osteopathic medicine (D.O.). Hospital staff privileges in Texas should be based on competence. However, many D.O.s are experiencing discrimination by Texas hospitals who refuse to recognize their AOA board certification. They are also being denied hospital staff privileges because they lack ACGME residency training.

Once a physician is granted staff privileges at a hospital, he or she is placed on probational status for usually 12 months. During this period of time, the hospital medical staff has the opportunity to observe and discover any deficiencies in a physician's training, character, competence or judgement. The probational period of hospital staff privileges is the proper mechanism to weed out the "bad apples" for legitimate reasons.

D.O.s and M.D.s have unlimited licenses to practice medicine in Texas. They serve side-by-side in the Medical Corps of the military services and in the public health service. The U.S. military services and the Texas State Board of Medical Examiners (TSBME) recognize board certification by either the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA) as being equivalent for board certification purposes. To simply lock out Texas osteopathic physicians from hospital staff privileges solely because of their lack of completion of an ACGME residency program or certification by the ABMS is discriminatory and should be eliminated by law.

This anti-discrimination bill will also establish a reasonable turn-around time for processing physician applications for staff privileges including notification in writing for denial or restriction of privileges. The bill will prohibit any hospital bylaws from circumventing the nondiscriminatory provisions in the Texas Medical Practice Act. It will prohibit pre-application forms by hospitals which have been used to discriminate against physicians. Complaints will be handled by the district attorney of the county where the violation occurs or the district attorney of Travis County may bring action to enjoin the violation.

It is with great sadness that I inform the Texas Society of the ACOFP membership that with the adjournment of the 103rd Congress on 10-8-94, the "Osteopathic Medicine Awareness and Appreciation Act," H.Con.Res. 173, died in the U.S. Congress. The AOA Council on Federal Health Programs is considering what to do legislatively in the 104th Congress. However, Texas D.O.s should take no satisfaction in the fact that there were only six co-sponsors of H.Con.Res. 173 from Texas. This was an extremely poor showing – Texas is the second largest state! We have to resolve to do better in the 104th Congress. The six co-sponsors of H.Con.Res. 173 were: Ralph Hall (D), J.J. Pickle (D), Pete Geren (D), Charles Stenholm (D), Martin Frost (D), and E. Bernice Johnson (D). Note that there is not one Republican in the group!

TOMA is in the process of developing a guide to the 74th Texas Legislature which will be delineated by TOMA districts. Included in this guide will be a breakdown of members of the U.S. Congress. We must hold our Texas representatives accountable at the local, state and national levels for what they do and what they do not do! Remember, nothing has a greater impact upon politicians than a personal letter or phone call from his or her constituent. Constituents can vote their representatives in or out of public office; non-constituents can't do it!

I would like to point out some items from the *Fall/Winter 1994 TSBME Newsletter, Volume 16, Number 2.*

At least 24 hours of CME are required in Texas during a physician's "CME year" rather than a calendar year. All 24 hours may be obtained from formal activities, but up to 12 hours are allowed in informal activities. See article in this issue on page 10.

TSBME Board members and staff compliance officers have performed random checks of physician offices and find that some licensees are not in compliance with the Complaint Procedure Notification:

The 73rd Legislature enacted provisions wherein physicians, physician assistants, and acupuncturists are required to provide notification informing the public of the name, mailing address, and telephone number of the Board for the purpose of directing complaints to the Board. This can be done in one or more of the following ways:

1. Displaying in a prominent location at their place of business, signs in English and Spanish of no less than 8" x 11" inches by 11 inches in size with only the board-approved notification statement printed in black on a white background in type no smaller than standard 24-point Times Roman print.

2. Placing the board-approved

ification statement printed in English d Spanish in black type no smaller n standard 10-point, 12-pitch ewriter print on each bill for vices.

. Placing the board-approved ification statement printed in English d Spanish in black type no smaller n standard 10-point, 12-pitch ewriter print on each registration m, application, or written contract services.

f the information is put on a bill for vices or registration form, applica-n, or written contract for services, all he data contained in the notification tement must be included. The legis-ure did not provide an exemption for nsed practitioners practicing outside state or in an institutional setting.

f you have questions, please refer to two previous issues of the TSBME wsletter. To request a copy of the es related to this notification, please ll the Board office at 512-834-7728, ension 425, and leave your name and dress.

Some TACOFP members might be nning out of triplicate prescription ds and need to reorder. Contact the partment of Public Safety, Triplicate scription Section in Austin, Texas at ephone number 512-465-2189 if you not have an order card. Follow the ice mail menu. The cost is $8.00 per 100 prescriptions. If you have an order card, simply send it in with your check. The turnaround time is approximately 30 days. Remember, you need the order card to order. If you have moved and your DPS and DEA numbers remain current and the same, you can still use your old triplicate prescription pads. Simply place a line through the old address and write in your new address.

The national meeting of the ACOFP will be held in Dallas, Texas at the Loews Anatole Hotel from March 15-19, 1995. Robert G. Maul, D.O., FACOFP, of Lubbock, will be installed as national ACOFP president at this meeting. We hope all Texas Society of the ACOFP members will attend this meeting and support Dr. Maul in his new position.

Also, mark your calendars now for the Texas Society of the ACOFP's 37th Annual and 22nd Mid-Year Clinical Seminar, which will be held August 3-6 at the Arlington Marriott. This hotel is located in the midst of Six Flags, Wet N' Wild and next to the new Rangers Stadium. Watch for more information in the upcoming months or call the Texas Society of the ACOFP office at 800-825-8967.

There are a lot of activities taking place in Texas and the Texas Society of the ACOFP is committed to keeping its membership well informed. ■

Shrinking Tumors Through Blood Deprivation

According to a study in the journal *Cell*, researchers at Scripps Research Institute, La Jolla, California, may have found the means to attack cancer cells by cutting off their blood supply. The researchers have discovered a biochemical switch that triggers the growth of blood vessels in virtually all tumors in lab animals. By turning off the switch with two proteins they have developed, the blood vessels dissolved, thereby causing tumors to shrink and/or disappear due to loss of nourishment.

The treatment does not appear to damage healthy tissue. The proteins, which act as the blocking agents, are powerful enough that only one injection produces dramatic results.

David Cheresh, who led the research team, stated, "...if this theoretical approach is successful, it should have a major impact in the treatment of cancer."

Clinical trials will probably begin in 1996. ■

News from Osteopathic Health System of Texas

Mothers-To-Be Learn About Parenting One Step at a Time

Expectant mothers can learn everything they ever wanted to know about their baby before it arrives when they enroll in Baby Steps – a free childbirth/parent education program at OMCT.

Baby Steps is a move in the right direction for the mother-to-be and other members of the family – like siblings – who want to learn about the new arrival.

Open to inpatient, outpatient, adult and teen-aged women – while pregnant and up to 10 weeks after delivery – seven new classes include information about everything from giving birth to giving your baby a bath. All classes meet Monday through Thursday in 5 North, now called 5 West. Siblings enroll in a class of their own, which meets the first Saturday of each month.

Pam Walker, R.N. who teaches several classes, said classes are meant to educate mothers and families about the delivery process in order to eliminate fear and raise awareness about hospital procedures. Courses include Childbirth I, Childbirth II, Infant Care, Breast-feeding, Early Pregnancy, Exercise and a Sibling Class. These courses contain valuable information about nutrition, infant care, CPR, anesthesia, signs of labor, maternal changes and much more, Pam said. Early Pregnancy, Breast-feeding and Infant Care classes are available in Spanish.

Susie Juliano, R.N., director of pediatrics and obstetrical services, said Baby Steps courses are fun, as well as informational. As an incentive for mothers to enroll and deliver at OMCT, the department is offering attendance credits toward a new baby car seat, she said. In addition, those enrolled receive a book of baby names, a bottle bag, diaper samples and a videotape about proper baby feeding.

For more information about Baby Steps, call Care Link at 817-735-DOCS (3627) or 800-299 CARE (2273).

OHST Provides First Aid at Fort Worth's Alliance Airshow

More than 50 physicians and staff from the Osteopathic Health System of Texas were on hand last fall to provide first aid to people attending the Alliance Airshow north of Fort Worth. Despite a long and rainy week before the show, Saturday morning, October 22 turned out with clear skys and sunny weather, which added up to many people attending the show and keeping OHST volunteers extra busy.

"Our volunteers treated several people with heat-related problems," said Glen Calabrese, D.O., physician-director of the airshow. "We also set up a make-shift water station at the front entrance to give water to the crowd of thousands – some of whom walked for two hours from their cars to get to the show."

Injuries treated at the first aid tent included serious cuts and scrapes, heart problems, seizures, sunburns and ant bites. The nature of some injuries were so severe that patients were transferred to local hospitals.

"It was truly a hectic time. We treated more than 63 patients. I'm not sure about this "first aid" business…it was more like a real ER," said Barbara Suber, R.N., nurse director of OMCT's ER.

Among the patients seen in the tent, some were Airshow celebrities who needed some help from our doctors as well. The Misty Blues, a professional parachute team that performs all over the world, received OMT treatment to help them prepare and relax before their big jump.

Thanks to these OHST physicians who helped make the First Aid at the airshow run without a problem.

Charlene Alford, D.O.
Scott Barclay, D.O.
Lynn Berutti, D.O.
Glenn Calabrese, D.O.
Michael Green, D.O.
Jan House, D.O.
Michael Houck, D.O.
Sam Lee, D.O.
Tim Malone, D.O.
Randy Martin, D.O.
Trayce Orr, D.O.
Guillermo Robles, D.O.
Scott Russell, D.O.
Danny Sailsbury, D.O.
Susan Straten, D.O.
Jeanine Thomas, D.O.
David Tillees, D.O.
Steve Urban, D.O.
Jack Ward, D.O. ■

Clinical Practice Guidelines For Thyroid Disease Available

In keeping with the first national observance of Thyroid Awareness Month, observed January 1995, the American Association of Clinical Endocrinologists (AACE) have released new clinical guidelines for the diagnosis and treatment of thyroid disease.

For a copy of the *AACE Clinical Practice Guidelines for the Evaluation and Treatment of Hyperthyroidism and Hypothyroidism*, contact the Texas Osteopathic Medical Association at 1-800-444-8662. ■

Study Questions Necessity of Dilatation and Curettage

A Swedish study published in *Lancet* questions the necessity of performing D&Cs on most women who suffer miscarriages. The study's findings, based on 155 women, suggest that no action is as effective as a D&C for women who miscarry within the first 13 weeks of pregnancy and who have no infection. ■

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

ominations sought for UNT Health Science Center Awards

The University of North Texas Health ience Center at Fort Worth is cepting nominations of recipients for center's highest honors, the Texas llege of Osteopathic Medicine unders' Medal, the Mary E. Luibel stinguished Service Award presented the health science center, and the stinguished Alumni Award presented the TCOM Alumni Association. The ee awards will be presented during center's annual fall convocation in ptember, as part of the 25th niversary celebration of the center's nding as the Texas College of teopathic Medicine.

The Founders' Medal, awarded in nor of TCOM's founders George ibel, D.O., Carl E. Everett, D.O. and D. Beyer, D.O., has been presented nually since 1978. It is awarded to serving individuals in recognition of nificant contributions to health care d/or osteopathic medical education." cipients must have "demonstrated the ghest character and integrity, whose cognition will enhance the reputation the Founders' Medal."

The Distinguished Service Award, tablished in 1993, is given in honor of first recipient, Mary E. Luibel, wife Dr. Luibel. The recipient must be a rson "whose distinguished service to s/her profession, business or vocation s ensured a better world for others." ominees are to have the "highest aracter and integrity, and be a caring dividual who lives by the precept that rvice to others is life's highest lling."

The Distinguished Alumni Award cognizes a TCOM graduate for eritorious service to community and e osteopathic profession. All TCOM umns are eligible to submit ominations and receive the award.

Letters of nomination for the three wards must be received by *Friday, arch 31, 1995.* The nominations ould include:

- pertinent biographical information about the nominee, including a curriculum vitae or resume, as appropriate.
- a detailed rationale for the person's nomination, and
- the signature(s) of the person(s) making the nomination.

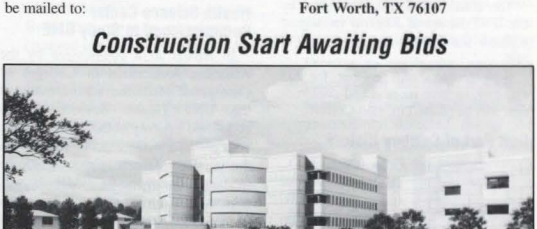
Nominations for the *Founders' Medal* and *Mary E. Luibel Award* letters should be mailed to:

Bill Hix, Public Affairs Manager
University of North Texas Health Center at Fort Worth
3500 Camp Bowie Blvd.
Fort Worth, TX 76107

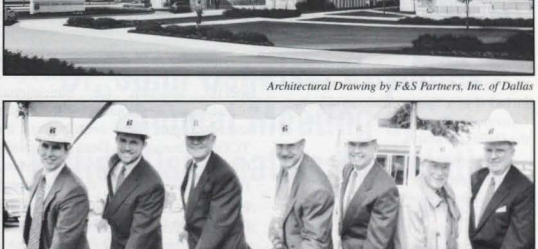
Nominations for the *Distinguished Alumni* Award should be mailed to:

Elizabeth Denton, Executive Director
TCOM Alumni Association
3500 Camp Bowie Blvd.
Fort Worth, TX 76107

Construction Start Awaiting Bids



Architectural Drawing by F&S Partners, Inc. of Dallas



Several dignitaries gathered at the UNT Health Science Center on Dec. 2 to help break ground for the new Health Science Education Building. Doing the honors are, from left, Robert Adams, D.O., chairman, Medical Services Research and Development Plan board; Grant Tarbox, Class of '97 member and Student Government Association president; Jerry Farrington, chairman, UNT Board of Regents; State Sen. Mike Moncrief; UNT Chancellor Alfred Hurley, Ph.D.; Benjamin Cohen, D.O. vice president of health affairs; and health science center President David M. Richards, D.O. Construction should take about two years.

With the new year comes new growth at the health science center. Construction bids for the new clinical education building and vivarium will be going out by late spring or early

(continued on page 40)

NTHSC News, *Continued*

summer, said Ken Coffelt. Coffelt returned to the center this month as a member of the construction project team, which includes Milton Schultz, Bob Short and Terry Brock from Construction and Renovations and others from various departments involved in the project.

The four-story, 71,500-square-foot clinical education building will front Montgomery Street on part of Parking Lot C. The vivarium construction will add 8,900 square feet to the animal care facility, on the corner of Medical Education Building 2.

The construction was authorized by the UNT Board of Regents in August with a $10 million tuition revenue bond sale.

Both projects will go out for bid together, to save money, and construction will be phased in, said Coffelt.

Dott Part of Cowboy History

Greg Dott, D.O., TCOM Class of 84 and associate professor of manipulative medicine at the University of North Texas Health Science Center, made Dallas Cowboy "history" in December when he was included in a *Sports Illustrated* feature, "America's Team: A week in the life of the Dallas Cowboys."

Dott is one of several physicians who regularly cares for the all-star football team. He has treated Emmitt Smith, Jay Novacek, Joe Fishback and others. For the story, Dott was featured treating defensive end Chad Hennings and Hennings wife, Tammy.

TCOM Students Make Who's Who Listing

The 1995 edition of *Who's Who Among Students in American Universities and Colleges* will include 22 students from the University of North Texas Health Science Center. They join an elite group of students selected from more than 1,800 institutions of higher education.

Those named are Russell Scott Bell, Christine Eady, Syed Asher Imam, James David Lowery, David Mantsch, Stephanie Prince, Reynaldo Rodriguez, Corinne Stern, James Trietsch and Kevin Van Valkenburg, all of the Class of '95. From the Class of '96 are Charles Addington, Jeffrey Bourne, Beth Cardosi, Jeffrey DeLoach, Victor Dizon, Danette Elliott, Cindy Hutson, Mario Perez, William Robertson, Brent Sanderlin, Jeffrey Swanson and Celeste Williams.

The students were chosen based on their academic achievement, service to the community, leadership in extracurricular activities and potential for continued success.

Health Science Center Commissioned to Study GME

In answer to a commission by the American Association of Colleges of Osteopathic Medicine, administrators at the UNT Health Science Center conducted a survey of the 16 osteopathic colleges' and wrote a position paper on the future of osteopathic graduate medical education, or GME. It was presented during the American Osteopathic Association's fifth annual leadership conference on osteopathic graduate medical education in September.

A summary of the position paper, authored by M. Susan Motheral, Ph.D., special assistant for educational planning and development at the health science center, with contributions by TCOM Executive Dean Benjamin Cohen, D.O., and Warren Anderson, Ed.D., associate dean for educational planning and development, was published in the December issue of *The D.O.*

From the survey of the osteopathic colleges, the trio presented recommendations for the reorganization and revitalization of osteopathic GME. The report noted current statistics that show both the lack of adequate AOA-approved and funded GME programs and the low percentage of those internship slots actually filled.

Among the recommendations made by the osteopathic colleges were:

- a call for each college to assume responsibility for osteopathic GME on a regional basis and for every GME program to be required to have a strong affiliation with a medic school to maintain AOA approval.
- a charge for the full-time medic school faculty to implement quali GME programs based on succin residency curricula that are high structured and rely on standardiz evaluation.
- a requirement for residency directo to be full-time, salaried employees the medical colleges that a responsible for ongoing site eval ation and direction.
- a call for the colleges to enhance t quality and increase the number GME programs, with standar strengthened so that stand-alo internships are eliminated a marginal programs are improved closed.
- a requirement for hospitals to have least a full residency program family practice or general inter medicine before it can serve as primary care site for an internship.
- a charge to the profession for bet monitoring of the demand for GM positions and the supply of GM positions.

The colleges also called for t profession to promote its distin tiveness by integrating osteopath manipulative medicine throughc osteopathic medical education.

For a copy of the survey results summary paper, contact Dr. Motheral 817-735-5091.

In the News

Paul F. Cook, Ph.D., of the Univers of North Texas Health Science Cente Department of Biochemistry a Molecular Biology, has been awarde grant from the National Institute General Medical Sciences.

The University of North Texas Hea Science Center at Fort Worth's Rob Dickerman, a D.O./Ph.D. student, Irv Prather, D.O., of the Department Family Medicine, and Wal McConathy, Ph.D., of the Department Biochemistry and Molecular Biolo recently published their resea findings, "Sudden Cardiac Death i 20-year-old Bodybuilder Us Anabolic Steroids" in *Cardiolo* magazine.

Blood Bank Briefs for Physicians

Autologous Blood Update

Margie B. Peschel, M.D., Medical Director
Carter Blood Center, Fort Worth, Texas

Autologous transfusion refers to the collection and storage of blood and blood components from a donor-patient for subsequent reinfusion. Carter Blood Center dictates that ologous blood is not suitable for geneic use. Autologous blood is red in a separate area from geneic units at the blood center and he hospital.

The following events will have urred before the autologous blood is dy for distribution:

All autologous units are tested for ABO group and Rh type, hepatitis B surface antigen (HBsAg), the antibody to human immunodeficiency virus 1 (anti-HIV-1), antibody to human immunodeficiency virus 2 (anti-HIV-2), antibody to hepatitis C virus (anti-HCV), antibody to hepatitis B core (anti-HBc), syphilis, antibody to human T lymphotropic virus I/II (anti-HTLV-I/II), and Alanine Amino Transferase (ALT) and,

The Medical Director of Carter Blood Center will review and approve release of any autologous units that have reactive or abnormal test results.

Autologous units reactive for anti-V, HBsAg and anti-HTLV-I will not released until confirmation tests are eived. Units that test ***CONFIRMED OSITIVE*** for HIV, HBsAg and TLV-I are destroyed and the donor-tient and the patient's physician are tified.

If the autologous units do not nfirm positive for HIV, HBsAg and TLV-I, the units will be released with itten permission from the transfusion rvice pathologist at the receiving spital. The patient's physician is formed of the abnormal results.

The 16th Edition of Standards for Blood Banks and Transfusion Services of the American Association of Blood Banks became effective in November, 1994. Additional standards are required on autologous blood and these have been implemented:

1. If the autologous unit is repeatedly reactive for HIV-2, a written request from the patient's physician is required in order to ship these units.
2. Carter Blood Center (the shipping facility) must notify the receiving transfusion service if the autologous unit tests positive for any marker of transfusion-transmitted disease.
3. Carter Blood Center, in addition, requires autologous units reactive for the antibody to hepatitis C virus on ELISA testing will not be released until there is written permission from the transfusion service pathologist at the receiving hospital.
4. The American Association of Blood Bank Standards now require the patient's physician shall be informed of any abnormal results obtained. Since the beginning of the autologous program at Carter Blood Center in 1977, the policy at Carter Blood Center is for the Medical Director to notify the autologous patient-donor and the patient's physician of any medically significant abnormality detected during the predonation evaluation or as a result of laboratory testing. ■

Reference:
Klein, HG ed. Standards for Blood Banks and Transfusion Services, 16th ed. Bethesda, MD: American Association of Blood Banks, 1994.

Dr. John Cegelski Keynotes Annual Meeting of British Osteopathic Association

John J. Cegelski, Jr., D.O., of San Antonio, was the keynote speaker at the Annual British Osteopathic Association Meeting, held December 9, 1994, in London, England. His presented topic was *"The Role of the Osteopathic Physician in Primary Care Medicine in the U.S. Today."*

Dr. Cegelski notes that BOA members were "very eager to know about all our progress in the United States and in Texas and, in particular, about health care insurance issues."

He added, "One of the topics I found at this meeting to be of interest was titled 'Adjuncts to Osteopathy' which involved presentations on epidural injections by Dr. Keith Bush, an orthopedic neurosurgeon practicing in London. Dr. Bush is well known to BOA members as a great exponent and advocate of epidurals, and gave a well illustrated and justified account of the subject."

Dr. Cegelski is a life member of the British Osteopathic Association and has presented topics in past years during their annual meetings.

An honorary life member of TOMA, Dr. Cegelski served as TOMA president from 1979-80. He is chairman of the TOMA Environmental Health and Preventive Medicine Committee, and is a fellow of the American College of Osteopathic Family Physicians. ■

New Members

TOMA would like to welcome the following new members who were approved at the December 3, 1994, Board of Trustees Meeti

REGULAR MEMBERS

Barbara A. Atkinson, D.O., *Internal Medicine*, University of North Texas Health Science Center, Texas College of Osteopathic Medicine, 3500 Camp Bowie Blvd., Fort Worth, Texas 76107. ***Medical Education***, Michigan State University, College of Osteopathic Medicine, East Lansing, Michigan, 1988. ***Internal Medicine internship and residency***, Flint Osteopathic Hospital, Flint, Michigan, 1988-1991. ***Fellowship***, Infectious Diseases, University of Texas Health Science Center, San Antonio, Texas, 1991-1994. ***DOB*** 3/22/42. Grand Rapids, Michigan.

Larry Ray Birdwell, D.O., *Family Practice and Public Health*, 401 A Broadway, San Marcos, Texas 78666. ***Medical Education***, University of North Texas Health Science Center, Texas College of Osteopathic Medicine, Fort Worth, Texas, 1980. ***Internship***, Jacksonville General Hospital, Jacksonville, Florida, 1980-1981. ***DOB*** 9/2/51. Sherman, Texas.

Bryan Edward Bledsoe, D.O., *Emergency Medicine*, 5517 Katey Lane, Arlington, Texas 76107. ***Medical Education***, University of North Texas Health Science Center, Texas College of Osteopathic Medicine, Fort Worth, Texas, 1987. ***Family Practice internship and residency,*** Texas Tech University, Odessa, Texas, 1987-1988 and Scott and White Hospital, Temple, Texas, 1988-1990. ***DOB*** 4/20/55. Fort Worth, Texas.

Richard Carlton Erickson, D.O., *Family Practice,* 1010 S. Main Street, Shamrock, Texas 79079. ***Medical Education***, University of North Texas Health Science Center, Texas College of Osteopathic Medicine, Fort Worth, Texas, 1993. ***Internship,*** Northwest Community Hospital, Bedford, Texas, 1993-1994. ***DOB*** 10/24/52. Norwalk, Connecticutt.

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Public Health Notes

Hepatitis C: (HCV) The most pernicious of the known viral hepatitides

Alecia A. Hathaway, MD, MPH, FACPM

Recently there have been news articles concerning a possible large scale exposure of individuals to Hepatitis C relating to a former employee of a midcities outpatient surgical center. Investigations are taking place to discover the circumstances surrounding this scenario. A method to definitively relate the retrovirus through polymerase chain reaction (PCR) "finger printing" of possible infected personnel to a point-source individual has been suggested. However, we have learned more about this virus in the last few years. It has been discovered that HCV mutates so effectively that even though humans mount a neutralizing antibody response upon initial exposure it becomes well established in 70 - 90% of persons.

Along these lines, chronic infection with HCV predisposes to the development of hepatocellular carcinoma. 70% of persons with hepatocellular carcinoma have been found to be anti-HCV positive.

The screening test for HCV has been improved over the last few years and PCR is now possible in a research setting. As we begin to better identify this virus more questions are raised as to its prevalence and significance in our communities.

Dr. Lynne Sehulster, Ph.D., with the Texas Department of Health (TDH) Infectious Disease Epidemiology and Surveillance section has graciously consented to a reprint of an excellent review article on HCV and the reporting requirements she prepared for the TDH Disease Prevention News.

HEPATITIS C REPORTING GUIDELINES

History

In 1975 the Food & Drug Administration (FDA) began requiring blood banks to screen all blood products for hepatitis B surface antigen (HBsAg). This screening has reduced, though not eliminated, the number of cases of transfusion-related hepatitis. The remaining cases are classified according to the duration and severity of infection. One group consists of patients whose transiently elevated liver function tests (LFTs) are a result of infection with transfusion-acquired cytomegalovirus (CMV) or Epstein-Barr virus (EBV). Because the primary site of this type of viral infection is not the liver, these infections are not true viral hepatitis and generally are not reportable.

Patients with post-transfusion hepatitis characterized by significant elevations in their LFTs comprise another group. These patients typically present with complaints of fatigue, anorexia, dark urine, malaise, and jaundice, and are found to have hepatosplenomegaly. Symptoms occur approximately seven weeks after the patients have received blood. For up to 50% of patients in this group, the infection persists and can lead to chronic liver disease including cirrhosis.

HBsAg screening provided clear evidence that a bloodborne virus other than hepatitis B (HBV) could cause transfusion-transmitted viral hepatitis. In 1984, after serologic tests for acute hepatitis A and B became widely available, TDH established non-A, non-B (NANB) hepatitis as a reporting category. The NANB category differed from "hepatitis unspecified" in that it required serologic testing to rule out the diagnoses of acute hepatitis A and B. Although the existence of a bloodborne hepatitis other than B had been postulated in the mid-to-late 1970s, a serology test for the label "hepatitis C" were not established until May 1990.

Nationwide, prior to 1990, NANB hepatitis accounted for >90% of post-transfusion hepatitis. Basic research in the 1980s revealed that NANB hepatitis also could be community-acquired and that it accounted for 20-40% of sporadic hepatitis cases during any given year.

Problems with HCV testing

When laboratory testing for antibody to hepatitis C virus (HCV) became available, epidemiologists began serologic studies to determine risk factors, incidence and prevalence rates, and the demographic characteristics of the affected populations. However, retrospective and prospective sero-epidemiologic surveys alike reveal several problem areas.

In addition to the frequent occ rence of false positive results, ea studies indicated that the current an HCV serology test does not distingui among the different stages of hepati C infection. A positive result for an HCV may indicate **acute, chronic, past hepatitis** C infection. As a gro patients with chronic hepatitis infections are more likely to seropositive for anti-HCV (70%-90 than patients with acute hepatitis (25%-70%).

False negative test results al complicate the diagnosis of acu hepatitis C. One cause of false negat results is the fact that anti-HC antibody may not reach detectal levels until six months after onset symptoms. Additionally, longitudi serosurveys have demonstrated t some patients who recover from ac hepatitis C eventually lose their an HCV. That only 25% of acute hepat C infections in adults are symptoma is also problematic for acute hepatiti diagnosis.

Ancillary information – such as L results, physical examination, clini history, specific hepatitis A and serology tests – is needed to establ accurate hepatitis C diagnosis staging. Valid surveillance informat depends on accurate diagnosis assessment of persons who test posit for anti-HCV.

HCV is an RNA virus wh physical characteristics and proper are similar to those of Yellow Fe virus, a flavivirus. HCV has not b isolated using standard virus isolat procedures, and it cannot be culture the laboratory. The current laborat test for HCV detects an antibody (a HCV) made during HCV infect Because anti-HCV is specific for a r structural viral protein, its presenc not synonymous with protec immunity. While the current anti-H test is best used only as a screening in blood banking, many laborato routinely include this test in diagno hepatitis serology panels.

Reporting Hepatitis C

Under current rules governing communicable disease reporting in Texas, cases of **acute viral hepatitis** are reportable, whereas chronic forms of hepatitis (including the hepatitis B chronic carrier state) are not. Past hepatitis infections of any type also are not reportable.

Asymptomatic infections are difficult to monitor and report, especially for hepatitis C. In hepatitis A or B testing, specific serologic markers permit accurate laboratory-based diagnosis despite the absence of symptoms. The current laboratory test for hepatitis C, however, can neither identify acute asymptomatic illness with certainty nor distinguish it from chronic asymptomatic infection.

Diagnosing and reporting acute hepatitis C infections are complex processes. The development of additional specific diagnostic laboratory tests for IgM class antibodies, viral antigens, and polymerase chain reactions (PCR) to monitor viral replication would greatly improve clinical and epidemiologic efforts. Pending development of these tests, DSHS recommends the following guidelines for acute hepatitis C reporting.

GUIDELINES FOR REPORTING HEPATITIS C

1. **Be sure that patients who are positive for anti-HCV have a discrete onset date of** symptoms suggesting an initial clinical diagnosis of **acute hepatitis**.
2. **Report asymptomatic persons as acute cases of hepatitis C, only if they have laboratory documentation of seroconversion for anti-HCV antibody from a negative to a positive status within a 12-month period.**
3. **Rule out non-infectious causes for the patient's condition** (e.g., obstructive jaundice, alcoholic hepatitis, toxic hepatitis, etc.)
4. **Rule out acute hepatitis A and/or B using specific serology.** Cautiously interpret lab results indicating hepatitis B chronic carrier status.
5. **Rule out other primary infections** (e.g., those caused by CMV or EBV).
6. **LFT results must be elevated more than 2.5 times the upper limit of normal** for a diagnosis of acute hepatitis C. In conjunction with symptoms suggestive of acute hepatitis, this benchmark can help distinguish acute from chronic hepatitis C.
7. Providing acute hepatitis A and B have been ruled out, **a symptomatic patient with acute phase illness who initially tests anti-HCV negative should be reported as an NANB case**. Retest the patient later, but within six months after onset of symptoms. If this patient then tests positive, submit an amended report of hepatitis C.
8. **Remember that a single, positive test for anti-HCV by itself may not reflect a reportable condition!** Additional clinical and laboratory evidence is required to support the diagnosis of acute hepatitis C. Asymptomatic persons with positive hepatitis C serologies obtained through routine screening programs (e.g., blood bank or plasma center screenings) do not have a reportable infection.
9. **Be aware that hospitalized patients often are tested for hepatitis virus serology if any component of the LFT profile is elevated, regardless of the admitting diagnosis**. Many patients are found to be positive for anti-HCV in spite of a clinical presentation inconsistent with viral hepatitis. Other patients present with numerous significant risk factors of long-term duration. A medical chart review is necessary to determine if the patient's condition is reportable.
10. **Remember that chronic hepatitis C infections are not reportable at this time.** Many physicians will be screening their chronic hepatitis C patients to evaluate them as condidates for alpha-interferon therapy. Patients identified via these screening results are not reportable. Patients with symptoms of chronic hepatitis who are positive for anti-HCV should be elevated with caution. Liver biopsy results are essential to determine whether the condition represents advanced liver disease.
11. **Local health department staff** should ask for at least the following information when a report of hepatitis C is received (in addition to the routine information required for all reports):

a. Does the patient have **acute viral hepatitis**?
b. What is the date of onset of symptoms?
c. What are the specific serology results for hepatitis A, B, and C? What are the dates of those results?
d. What are the LFT results, specifically **ALT** and **AST**?
e. What are the normal LFT ranges for that laboratory?
f. Was the patient hospitalized? If yes, what was the admitting diagnosis?
g. Does the patient have some form of chronic liver disease?
h. What risk factors does this patient have? ■

For clarification of these guidelines and additional information about all forms of hepatitis, contact Lynne Sehulster at (512) 458-7328.

Asthma Cases Are Soaring

The Centers for Disease Control and Prevention report that asthma cases and deaths from the disease have increased approximately 40 percent since 1982.

From 1982 through 1992, the asthma rate increased 42 percent, from 34.7 sufferers per 1,000 people to 49.4 per 1,000. Additionally, from 1982 through 1991, the death rate rose 40 percent, from 3,143 to 5,106 deaths.

Although fatalities from asthma remain rare, cases are increasing rapidly with no concrete evidence as to the increase. CDC researchers suggest such factors as air pollution and exposure to asthma-triggering substances, such as cat dander and dust mites.

The CDC estimates that five percent of the nation's population, or an approximate 10.3 million people, suffer from asthma. ■

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