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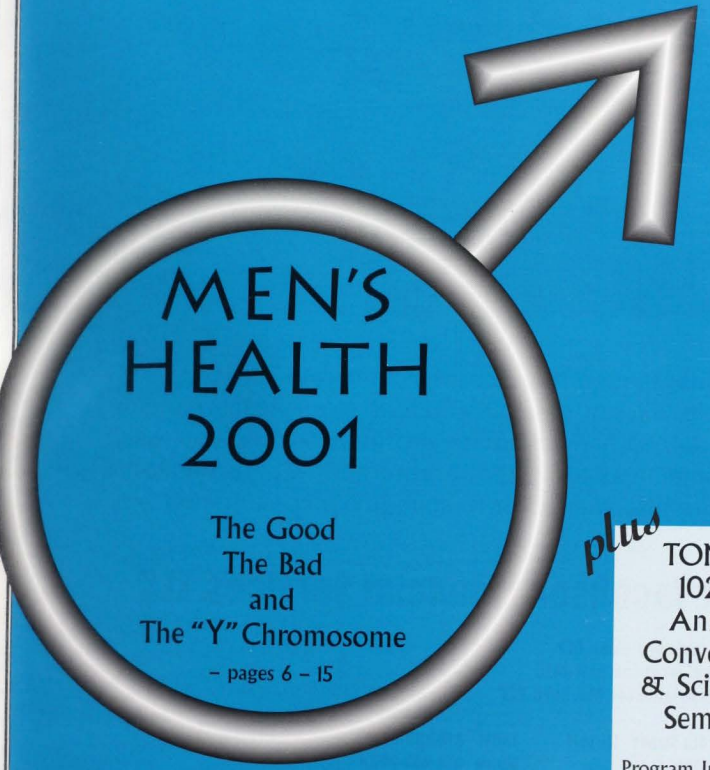

# MEN'S HEALTH 2001

The Good
The Bad
and
The "Y" Chromosome

– pages 6 – 15

*plus*

TOMA'S 102nd Annual Convention & Scientific Seminar

Program Information and Early Registration Form

– pages 25 – 29

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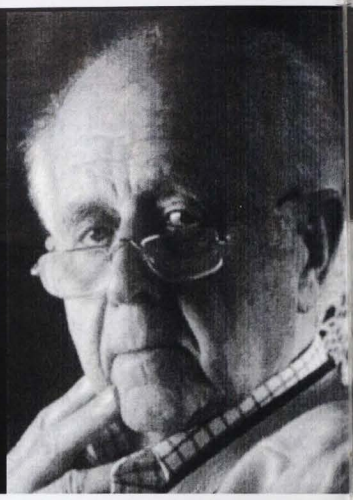

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APRIL 2001



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# INSIDE THIS ISSUE



Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising" according to Texas Gov't Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the ***Texas D.O.*** is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

# CALENDAR OF EVENTS

## APRIL 17 – 21
**"AROC 2001: NJAOPS Centennial"**
*Sponsored by the New Jersey Association of Osteopathic Physicians & Surgeons and the NJOEF*
Location: Tropicana Casino & Resort
Atlantic City, NJ
Contact: 732-940-9000
FAX: 732-940-8899

## APRIL 19
**"National D.O. Day 2001"**
*Sponsored by the American Osteopathic Association*
Contact: www.aoa-net.org

## APRIL 19 – 22
**"32nd Annual Medical-Scientific Conference"**
*Sponsored by the American Society of Addiction Medicine*
Location: Century Plaza Hotel & Spa, Los Angeles, CA
Contact: ASAM, 4601 North Park Ave., Suite 101
Chevy Chase, MD 20815
301-656-3920; FAX: 301-656-3815
E-mail: email@asam.org
Web: www.asam.org

## APRIL 26 – 29
**"Left-Brained Cranial Manipulation"**
*Sponsored by The Cranial Academy*
Location: Rosemont (Chicago), IL
CME: 32 hours Category1-A credits anticipated
Contact: The Cranial Academy, 317-594-0411
FAX: 317-594-9299
E-mail: CranAcad@aol.com

## MAY 3 – 6
**"104th Annual Convention"**
*Sponsored by the Indiana Osteopathic Association (IOA)*
Location: Marriott Hotel/Century Center, South Bend, IN
CME: 30 hours Category 1-A credits anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

## MAY 12
**"56th Annual Meeting of the TOMA House of Delegates"**
*Sponsored by the Texas Osteopathic Medical Association*
Location: DoubleTree Guest Suites, Austin, TX
Contact: Paula Yeamans, TOMA, 800-444-8662

## JUNE 6 – 10
**"102nd Annual Convention and Scientific Seminar"**
*Sponsored by the Texas Osteopathic Medical Association*
Location: Arlington Convention Center, Arlington, TX
CME: 26 hours Category 1-A credits
Contact: Jill Weir, CAE, Projects Coordinator
800-444-8662 or 512-708-8662
FAX: 512-708-1415

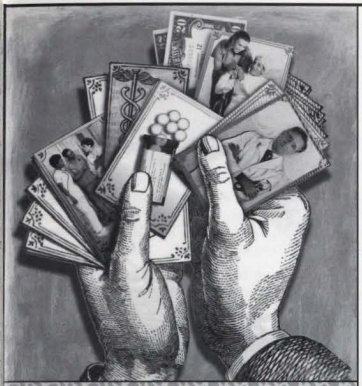
## JUNE 16 – 20
**"Basic Course: Osteopathy in the Cranial Field"**
*Sponsored by The Cranial Academy*
Location: The Westin Mission Hills Resort
Rancho Mirage, CA
CME: 40 hours Category1-A credits anticipated
Tuition: Program Director: Judith L. Lewis, D.O., FCA
(for scholarship information)
$1,150 (nonmembers)
Scholarship: $575 (nonmembers)
Contact: The Cranial Academy
317-594-0411
FAX: 317-594-9299
E-mail: CranAcad@aol.com

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

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

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

## CME CORRESPONDENCE COURSE
**"Medical Ethics: Applying Theories and Principles to the Patient Encounter"**
*Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services*
CME: 60 hours Category 2-B credits
Course Tuition: $1,200
Contact: 800-480-5542



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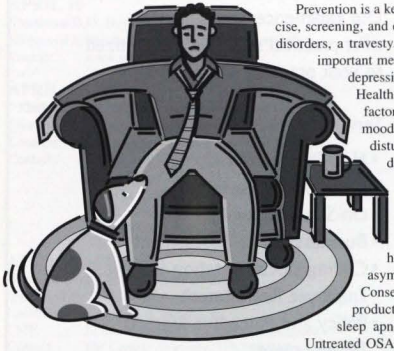
# Snoring and Sleep Apnea in Men

*by*

*David Ostransky, D.O., F.C.C.P., F.A.C.O.I.*

*Diplomate, American Board of Sleep Medicine; Fellow, American Academy of Sleep Medicine*

Men are at much greater risk of dying from heart disease, cancer, accidents, suicide, and violence because of lack of awareness, culturally-induced behavior patterns in their lives and work, and lack of education. Recently, several private and public initiatives have recognized this deadly, but silent crises. The National Men's Health Week bill which underscores the importance of these issues was introduced by Senator Bob Dole and Congressman Bill Richardson and signed into law by President Bill Clinton on May 31, 2000 (Public Law: 103-264, 103rd Congress).



Prevention is a key issue for men's health issues with emphasis on proper diet, exercise, screening, and education. Conspicuously absent is the mention of sleep and sleep disorders, a travesty. For instance, obstructive sleep apnea (OSA) leads many of the important men's health problems such as hypertension, cardiovascular diseases, depression, and impotence.[7] Recent studies from the National Institutes of Health have identified that obstructive sleep apnea is an independent risk factor for cardiovascular disease.[8] Hallmarks of depression including mood swings, irritability, memory loss, impaired work performance, and disturbed sleep may arise from OSA.[6,7] Nocturia and/or erectile dysfunction from OSA is often mistakenly attributed to prostatism.

Obstructive sleep apnea syndrome affects 5 to 9% of the adult male population of the United States.[7] In some groups such as long haul truckers, obese, or hypertensive males, the incidence of OSA approaches 30-35% ,[16,11] Most men evaluated for sleep apnea have symptoms for at least two years. In addition, 24% of men are asymptomatic, but "at risk" with physiologic hallmarks of the disease.[2] Consequences include driving and work-related accidents, decreased job productivity, and increased utilization of health care services. Obstructive sleep apnea patients are six times as likely to have a driving accident.[1] Untreated OSA patients are heavy consumers of health care services utilizing an excess of $100,000 to $200,000 per year compared to treated OSA patients.[8]

## Pathophysiology

Sleep-related breathing disorders encompass several diseases, but snoring and OSA are most common.[6] They are characterized by the recurrent and intermittent narrowing or closure of the upper airway with sleep. The mechanism for pharyngeal collapse during sleep remains uncertain. Likely pathophysiological abnormalities are anatomic obstructions and dysfunctional muscle mechanisms in the pharynx. Pharyngeal collapsibility varies along a continuum from health (low collapsibility) to snoring to disease, i.e. OSA (high collapsibility).[4] Anatomic obstructions of the naso- or oropharynx include tonsillar or adenoid enlargement, nasal polyps, retrognathia, micrognathia, macroglossia, turbinate hypertrophy, or narrowing from fatty infiltration. Dysfunctional pharyngeal muscle mechanisms are common in patients with neuromuscular diseases and abnormal respiratory control mechanisms.[2]

After sleep onset, there is a gradual progression into the deeper stages with consequent relaxation of pharyngeal muscle tone resulting in a gradual closure of the upper airway. Snoring is the audible consequence of friction from air passing through a narrowed passage. If the obstruction is complete, this leads to a respiratory event, i.e. an apnea or hypopnea which is the hallmark of obstructive sleep apnea syndrome. The respiratory event has physiological consequences (autonomic nervous system) including increases in blood pressure, heart rate alteration and hypoxemia which result in a cortical arousal or awakening and cessation of the respiratory event. This process continues repetitively while the patient sleeps.

## Diagnosis

The diagnosis of OSA is based on compatible history and physical examination and polysomnography.[6] Most patients with OSA present with snoring, excessive daytime sleepiness, unrestorative sleep, witnessed apneas, headaches, nocturia and weight gain.[6] A modest but significant number are relatively unaware or deny their symptoms and see a physician either by request of the bed partner or because of forced exile to another sleep room. A few present for evaluation because of a motor vehicle accident or they were observed to fall asleep at work. Other manifestations include impotence, mood swings, worsening depression, uncontrolled hypertension, erectile dysfunction, and dry mouth. Most patients with OSA are obese with a body mass index in excess of 29 kg/m$^2$, increased neck girth and a narrowed oropharynx.[7] They appear visibly tired and often fall asleep waiting for their physician.

Polysomnography measures various physiologic parameters including electroencephalography, eye movements, chin muscle tone, oral and nasal airflow, chest and abdominal wall movement, oximetry, snoring microphone, arm and leg movement, and electrocardiography to diagnose OSA or other sleep disorder.[7] Portable studies are not recommended.[11] Patients evaluated for snoring should undergo a polysomnogram prior to any surgical or dental intervention because of the high incidence of underlying, undetected, OSA.[11] The CPAP trial may be performed on the same night as the diagnostic study (split study) or a second night. Patients often require a second night for a titration trial because of the relative paucity of respiratory events in patients with mild to moderate OSA or in difficult to titrate severe OSA patients.

An apnea is defined as a cessation of air flow lasting at least 10 seconds and a hypopnea is typically defined as a greater than 50% reduction of airflow compared to baseline lasting at least 10 seconds. Apneas may be categorized as obstructive, central or mixed. For hypopneas, some sleep laboratories identify lower values of 30 to 50% reduction and others require a consequence such as a desaturation or cortical (EEG) arousal. There is much dispute with no universal standard. Despite the knowledge that hypopneas can be as deleterious as apneas, Medicare regulations do not consider them diagnostic of OSA. The number of apneas and hypopneas occurring per hour is the apnea/hypopnea index and utilized as a marker of severity. The lowest value associated with clinical significance has decreased significantly from 20/hour to 5/hour as identified by the Sleep Heart Health Study over the last decade.[18] Medicare requires a minimum of 30 apneas over 6 hours with an average duration of 30 seconds, in order for someone to be diagnosed with OSA.

## Management

Because confounding factors disrupting sleep and sleep disorders commonly coexist with snoring and OSA, it is important to address these issues. These include suboptimal sleep hygiene (poor sleep habits), environmental conditions, life style habits (stress, tobacco, alcohol, caffeine), shift work, chronic pain, gastroesophageal reflux, nocturnal cough, nasal drainage, pruritis, affective disorders, and bruxism.

Patients with positionally dependent snoring or OSA are easily remedied by retraining of sleep position. A simple device is readily made by sewing a tennis ball or whiffle ball into a pocket in a tee shirt or pajama top between the shoulder blades.

Obesity contributes to but rarely causes OSA.[2] Nevertheless, weight loss is beneficial for obese, sleep apnea patients with body mass index in excess of 30. Morbidly obese patients should be enrolled in a strictly supervised, weight loss program with an exercise and behavioral modification component. Current recommendations include a gradual weight loss of 10% of current body weight every 6 months. Since OSA patients are at high risk of accidents (work-related, driving, aviation or other modes of transportation), every patient should be advised of the risk of accidents.[1] In some, driving restriction may be necessary.

For snoring or OSA, it is necessary to first assess for any remediable causes of narrowing of the upper airways. This includes anatomic obstructions of the naso- or oropharynx such as tonsillar or adenoid enlargement, nasal polyps, retrognathia, micrognathia, macroglossia, turbinate hypertrophy, or masses. Edema of the upper airways secondary to inflammation from nasal drainage or gastroesophageal reflux disease may cause critical airway narrowing leading to snoring. Appropriate medical intervention for rhinitis or gastroesophageal reflux disease should considerably attenuate or relieve snoring if it is the primary cause of snoring.

Continuous positive airway pressure (CPAP) is the most common treatment modality utilized for OSA.[6,7] It is a mechanical device consisting of a mask, hose and air pressure generator. The mask fits over the nose or nose and mouth with the intent of using air pressure to maintain patency of the upper airway as a pneumatic splint. Masks are available in several formats, nasal, full face, and nasal pillows, the selection based on facial anatomy, size of nose, and patient preference. The exact amount of air pressure is defined in the sleep laboratory during a titration trial. A patient may need either CPAP or BiPAP. CPAP is positive airway pressure applied at the same level continuously during inspiration and expiration (CPAP). With BiPAP, a different level of airway pressure is applied during inspiration vs. expiration. Pressures during inspiration are identical with CPAP, but during expiration a lower level of air pressure is utilized. A significant increase in comfort and tolerance is experienced with BiPAP. If the patient is compliant with CPAP or BiPAP, it is curative and decreases mortality.[9] Proper mask fitting is key to insure use and compliance. With the large number of masks currently available, it should be uncommon not to find an acceptable mask. Adjustments to the mask to improve fit may require a knowledgeable sleep technician and persistence. This should not be delegated to the durable medical equipment vendor. Patients with pre-existing or CPAP-induced dry mouth or nasal symptoms may benefit from in-line humidification, nasal ipratropium bromide, antihistamine, or nasal saline spray. Recent advances in technology has brought many new modifications to CPAP including monitoring devices to assess compliance and automatic, breath to breath adjustment of CPAP pressures (autotitrating CPAP).[15] The role of these newer machines is not yet established for CPAP titration.

*continued on next page*

Oral appliances are small, plastic devices similar to an athletic mouth guard or orthodontic retainer usually fitted by a dentist with training and experience treating sleep disorders. A well-made, well-fitted dental appliance will effectively reduce or eliminate snoring and possibly patients with mild OSA. Dental appliances work by either bringing the lower jaw forward, holding the tongue forward, or by lifting a drooping soft palate. They are usually inexpensive, but usually not covered by insurance and may contribute to temporomandibular joint dysfunction.

Surgical intervention for snoring and OSA may be necessary for anatomic obstructions depending on the site of obstruction, including tracheostomy, tonsillectomy, uvulopalatopharyngoplasty-plasty (UPPP), glossectomy, nasal polypectomy, or turbinectomy.[14] New surgical methodologies utilized include laser and radiofrequency volumetric reduction. Tracheostomy is rarely performed, but may be appropriate when patient fails all other therapies. It is a complete cure. Uvulopalatopharyngoplasty (UPPP) may be an effective treatment for snoring.[3] For OSA, the results are less convincing and may only result in a 50% reduction in number of respiratory events.[3,12] Many sleep apnea patients with UPPP also recur requiring CPAP or BiPAP anyway. Other surgical treatments such as bimandibular advancement and hyoid advancement are sometimes helpful.[14]

## Conclusions

The first step in the recognition of the impact of sleep and sleep disorders on men's health is to identify the potential existence of a sleep disorder by simply taking a sleep history. Symptoms of snoring, unrestorative sleep, excessive daytime sleepiness, and fatigue in a obese, hypertensive male is highly predictive of OSA. Recognition of OSA as an independent risk factor for cardiovascular disease, a co-morbid factor of most of the men's health issues, increased accidents, increased health care utilization, and decreased job productivity will have profoundly positive implications for men's health. Future challenges in men's health and sleep medicine include physician and public education of the consequences of undiagnosed sleep-related breathing disorders and development of superior treatment modalities for OSA.

*David Ostransky, D.O., is a physician specialist in sleep disorders and pulmonary medicine in private practice in Fort Worth. He serves as president of the North Texas Lung and Sleep Clinic; president of Occupational Consultants, Inc.; and as medical director of Lifecare Hospital of Fort Worth. He is a 1979 graduate of the Kirksvile College of Osteopathic Medicine, Kirksville, Missouri.*

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## 10 Leading Causes of Death in Men

1. Diseases of the heart
2. Malignant neoplasms
3. Unintentional injuries
4. Cerebrovascular diseases
5. Chronic obstructive pulmonary diseases
6. Pneumonia and Influenza
7. Diabetes mellitus
8. Suicide
9. Chronic liver disease and cirrhosis
10. Homicide and legal intervention

*Source: Centers for Disease Control and Prevention<www.cdc.gov/nchs/products/pubs/pubd/hus/tables/2000/00hus032.pdf>.*

# Transurethral Microwave Therapy (TUMT) for the Prostate

*by Wayne A. Hey, D.O.*

Prostate problems remain one of the most common areas of medical intervention in men. These problems include prostate infection, also known as prostatitis, prostate cancer and benign or non-cancerous enlargement of the prostate. This article relates to treatment with a new technology for benign enlargement of the prostate, also known as benign prostatic hypertrophy or BPH.

Over the last 25 years, many treatments have been evaluated for possible application to men that are suffering from benign prostate enlargement. Symptoms of this condition are frequent urination, slow urinary stream, stopping and starting during voiding, waking up two or more times per night and a feeling of incomplete emptying of the bladder. These symptoms can sometimes progress to complete urinary retention or inability to empty the bladder at all, which is an emergency procedure that requires treatment beginning with the insertion of a Foley catheter. Traditionally the transurethral resection, affectionately known as the roto-rooter, has been the primary treatment modality since approximately 1965. In fact, over 95% of all surgeries for benign prostatic hypertrophy have been traditionally performed with this surgery. While this is an excellent procedure, it does have some complications including hemorrhage, urinary leakage or incontinence and impotence. It has also traditionally required a one to five day stay in the hospital. As more modern methods of treatment of benign prostatic hypertrophy have been evaluated, the necessity for transurethral resection with its attendant complications has come under close scrutiny.

Alternative treatments for benign prostatic hypertrophy include a host of herbal therapies, most of which include some amount of saw palmetto. Conventional medical drug therapies include medications that relax the prostate to enlarge the channel through it, as well as medications that actually shrink the prostate or make it smaller. In addition to the advent of these medical therapies, which have proven to be very effective, changes have occurred in the surgical arena. Today, in my personal medical practice which has evolved over the last 21 years, it is relatively rare for me to do a transurethral resection. Now, approximately one out of ten patients with benign prostatic hypertrophy in my practice is treated with TURP, whereas at one time, eight or nine out of ten patients received this therapy. Now the most common surgical procedure that I do for prostatic enlargement is the transurethral microwave procedure. This procedure is done on an outpatient basis. It requires approximately 30 minutes of treatment time. The patient will usually spend approximately three to four hours either at the outpatient facility or, in some cases, at the urologist's office in preoperative and postoperative care when the procedure is administered.

Some advantages of this therapy are that there is very little bleeding and I have personally never had to transfuse anyone who received this therapy. There is also no need for general anesthesia and we use local anesthetics in the form of numbing agents in the bladder and the urethra itself. This allows for relatively painless insertion of a catheter which administers the microwave treatment directly to the prostate. A computer monitors the temperature and measures it both in the urethra and in the rectum, while an ultrasound device confirms that the treatment catheter stays in the exact proper location during the treatment period. Most patients feel the sensation of heat and have the desire to urinate at the outset of the procedure, but after approximately 15 minutes these feeling tend to dissipate and most patients sleep through the majority of the procedure. Following this, the treatment catheter is removed. A very small drainage catheter is then inserted into the bladder and the patient goes home, keeping his catheter in place for three to five days connected to a bag that is attached to the patient's leg. This enables the patient to go about normal activity. The patient then either takes the catheter out at home or comes back to the office to have the catheter removed by office personnel. I recommend that the patient not do any heavy lifting or have sexual intercourse during the first month after surgery. Patients are informed that it takes one to three months after the procedure to reach maximum benefit. During this time the prostate tissue that has been heated to approximately 108 to 114 degrees begins to shrink and becomes reabsorbed. The results have been extremely favorable.

Of the patients that I have treated, no one has had problems with penile erectile impotence as a result of the procedure. Sexual function seems to be maintained and, in some instances has improved, following the procedure. Urinary flow rates have improved and patients' symptoms such as urgency and frequency as well as nocturia (getting up at night) have shown the most dramatic improvements. There have been no patients that have had urinary incontinence (leakage). This procedure is less expensive to the healthcare system than the traditional transurethral resection.

Doctors and hospitals have joined together to purchase the equipment that administers this therapy and share it among themselves. The north Texas area is the beneficiary of one or more of these shared technology devices.

If you have patients who are suffering from prostate symptoms such as I have described above, or if you know someone who is suffering from similar symptomatology, contact me at 817-731-0316 and I will give you more information regarding this new procedure.

*Dr. Hey practices in Fort Worth at the Dallas/Fort Worth Urology Consultants. Board certified in Urologic Surgery, he was the first urologist in the state to be awarded the title of Fellow by the American College of Osteopathic Surgeons.*

# Genetic Influence of Cholesterol Levels in African-American Men

*by*

*Zhihua Han, Ph.D., Jonathan D. Smith, Ph.D., Laura Colangelo, M.S. and Kiang Liu, Ph.D.*

***"Some research indicates that the gene plays an important role in directing the assembly of a particle that carries "bad" LDL cholesterol."***

A form of a gene found in some African-American men is associated with higher levels of cholesterol than other forms of the gene, a research team reported in the March *Arteriosclerosis, Thrombosis, and Vascular Biology: Journal of the American Heart Association*.

The researchers studied the effects of three common forms of a gene called MTP. Black men with the "TT" form had significantly higher levels of total cholesterol, "bad" LDL cholesterol, triglycerides, and apolipoprotein B (ApoB) -- a protein that transports certain lipids (fats) in the bloodstream -- than black men with the other two forms of the gene.

Suh-Hang Hank Juo, M.D., Ph.D., lead author of the study, says, "Understanding the role of the TT gene variation could help researchers better understand what causes elevated cholesterol in the general population and may help in dealing with its potential consequences.

"We could target individuals carrying this gene, so they could get an early start on prevention," Juo says. "A person with the 'bad' form could try to lower the risk by exercising, eating a low fat diet, not smoking and taking medication to lower cholesterol.

"Researchers studied African-Americans because their cholesterol and other blood fat levels are different from Caucasians and they have a higher incidence of cardiovascular diseases than the white population", says Juo, an associate research scientist at Columbia University Genome Center in New York City.

For their study, the team used information collected from 586 young African-American men participating in CARDIA (Coronary Artery Risk Development in Young Adults) study. This long-term study at medical centers in Birmingham, Ala., Chicago, Minneapolis, and Oakland, Calif., has collected 10 years of data on more than 4,000 black and white men and women.

As part of the study, participants received a complete evaluation of their blood cholesterol every two years. Juo and his colleagues used blood drawn from the men in their study to determine which variation of the MTP gene each carried.

A gene contains a pair of chromosomes. One chromosome is inherited from the mother and the other from the father. A person with the TT variant of the MTP gene inherited a T variant of the gene from each parent. In this study, 7 percent of the African-American men had this form, a prevalence quite similar to that found among white men in other studies. Some research indicates that the gene plays an important role in directing the assembly of a particle that carries "bad" LDL cholesterol.

The team examined the lipid data from the men's five examinations over 10 years and found significant differences between the TT and other gene forms. The men with the other variations had very similar lipid levels. However, in the five exams, total cholesterol levels for the TT group ranged from 6 percent to 11 percent higher and LDL cholesterol was 8 percent to 15 percent higher than for the other two groups. High levels of cholesterol and triglycerides are often found together.

When the team statistically controlled for factors known to influence lipid levels—such as cigarette smoking, age, body weight, alcohol intake and exercise—they found the TT group still had significantly higher lipids compared to the men with the other two MTP variations. "This means the higher lipid levels are a pure genetic result," Juo says.

This study suggests that the TT variant could increase cardiovascular risks and could be important in understanding the genetics of heart disease. While the gene can be easily measured in a laboratory, Juo says the study findings must be confirmed by other researchers before recommending testing for the gene in larger populations.

# IT'S A "GUY THING"

## Men and Hypertension

The incidence of hypertension among men in the U. S. is as follows:[1]

20-34 years: 8.6%
35-44 years: 20.9%
45-54 years: 34.1%
55-65 years: 42.9%
65-74 years: 57.3%
75 years and older: 64.2%

In 1998, there were 18,459 men's deaths attributed to high blood pressure.[2]

In 1998, 171,000 males were released from hospitals after being diagnosed with high blood pressure .[2]

*(1 "Hypertension among persons 20 years of age and over, according to sex, age, race, and Hispanic origin: United States, 1960-62, 1971-74, 1976-80, and 1988-94," CDC, National Center for Health Statistics, Division of Health Examination Statistics – unpublished data; and 2 "2001 Heart and Stroke Statistical Update," American Heart Association.)*

## Men and Cosmetic Surgery

Visiting board-certified plastic surgeons for cosmetic procedures has become more popular among men, according to statistics from the American Society of Plastic Surgeons (ASPS). In 1999, almost 11 percent of cosmetic surgery procedures were performed on men, up two percent from the previous year. Liposuction proved to be the most popular cosmetic procedure, comprising nearly 28 percent of the total number of tracked procedures performed on men in 1999.

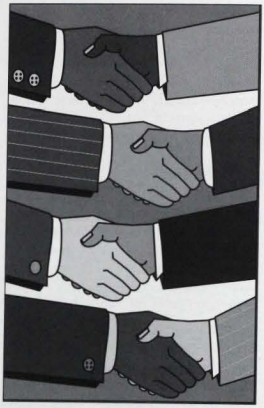
**Top Cosmetic Surgery Procedures Among Men in 1999**

Liposuction – 29,782

Eyelid Surgery – 21,859

Nose Reshaping – 11,831

*Note: ASPS statistics represent procedures performed by ASPS member plastic surgeons certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada.*



*("Men's Cosmetic Surgery Procedures on the Rise: Liposuction Number One Procedure," ASPS news release)*

## Impotence and Erectile Dysfunction

- More than 30 million men in the U.S. suffer some form of impotence.
- Impotence can be a total inability to achieve erection, an inconsistent ability to do so, or a tendency to sustain only brief erections. These variations make defining impotence and estimating its incidence difficult. In 1985, the National Ambulatory Medical Care survey counted 525,000 doctor-office visits for erectile dysfunction.
- Impotence usually has a physical cause, such as disease, injury, or drug side effects.
- Incidence rises with age: about 5 percent of men at the age of 40 and between 15 and 25 percent of men at the age of 65 experience impotence. Yet, it is not an inevitable part of aging.
- Impotence is treatable in all age groups.

The National Institutes of Health Consensus Development Conference on Impotence was convened December 7-9, 1992. Among their findings, the panel concluded that:

1) The term "erectile dysfunction" should replace the term "impotence";

2) The likelihood of erectile dysfunction increases with age but is not an inevitable consequence of aging;

3) Embarrassment of patients and reluctance of both patients and health care providers to discuss sexual matters candidly contribute to underdiagnosis of erectile dysfunction;

4) Many cases of erectile dysfunction can be successfully managed with appropriately selected therapy;

5) The diagnosis and treatment of erectile dysfunction must be specific and responsive to the individual patient's needs and that compliance as well as the desires and expectations of both the patient and partner are important considerations in selecting appropriate therapy;

6) Education of health care providers and the public on aspects of human sexuality, sexual dysfunction, and the availability of successful treatments is essential; and

7) Erectile dysfunction is an important public health problem deserving of increased support for basic science investigation and applied research.

*("Impotence", National Institutes of Health - niddk.nih.gov/health/urolog/pubs/impotnce/impotnce.htm; NIH Consensus Statement: Impotence – odp.od.nih.gov/consensus/cons/09/091_statement.htm)*

## Men and Cancer

The rate of new cancer cases and deaths for all cancers combined, as well as for most of the top 10 cancer sites declined between 1990 and 1996 in the U.S., according to a report released April 20,

1999, by the American Cancer Society, the National Cancer Institute, and the Centers for Disease Control and Prevention. However, a special section of the study focusing on lung cancer and smoking reported that, unless the increase in adolescent smoking can be reversed, declining lung cancer rates are likely to start increasing again.

By far, the greatest decline in cancer incidence rates was among men, who overall have higher rates of cancer than women. From 1990 to 1996, the decline in the cancer incidence rate was greater for men than for women. The largest decrease in men occurred among those who were 25 to 44 years old and 75 years and older.

Decreased in the death rate occurred in men of all ages except those 85 years and older. In fact, the drop in the death rate for men influenced the overall decline.

### Lung Cancer

During the 1990s, lung cancer incidence and death rates declined among males of all racial and ethnic groups except American Indians/Alaska Natives. During 1990-1996, male lung cancer incidence rates decreased on average 2.6 percent per year. Male lung cancer death rates decreased about 1.6 percent per year. These declines reflect the large decreases over the past several decades in active smoking and exposure to environmental tobacco smoke that together cause about 90 percent of lung cancer.[1]

### Prostate Cancer

After lung cancer, prostate cancer is the second leading cause of cancer death among men in the United States. It is also the most commonly diagnosed form of cancer, other than skin cancer in men. The American Cancer Society estimates that in 2001, nearly 198,100 men will be diagnosed with prostate cancer and an estimated 31,500 will die.[2]

Prostate cancer incidence rates remain significantly higher in black men than in white men. At all ages, African-American men are diagnosed with prostate cancer at later stages and die of the disease at higher rates than white men. The incidence of prostate cancer among African American men is the highest known rate in the world.[3] The cancer is most common among men aged 65 years or older. About 80 percent of all men with clinically diagnosed cases of prostate cancer are in this age group.[3]

The recommendations of the American Cancer Society and the American Urological Association are that all men over the age of 50 should have an annual digital rectal exam and PSA. African-American men and men with a family history of prostate cancer should being this screening at the age of 40.[4]

### Testicular Cancer

Cancer of the testicle is the most common cancer in men 15 to 35 years old. Men who have an undescended testicle are at higher risk of developing cancer of the testicle. This is true even if surgery has been done to place the testicle in the appropriate place in the scrotum.[5]

The American Cancer Society estimates 7,200 new cases of testicular cancer will be diagnosed this year in the U. S., and an estimated 400 men will die of it this year.[6]

### Melanoma

In 2001, 51,400 new cases of melanoma are expected to be diagnosed. Of this total, 29,000 are estimated to be men. And of that group, 5,000 deaths will be attributed to melanoma. It is the sixth most common cancer in men, excluding basal cell carcinoma and squamous cell carcinoma.[7]

*(1 "Annual Report Shows Continuing Decline in U.S. Cancer Incidence and Death Rates; Special Section Focuses on Lung Cancer and Tobacco Smoking," 4-20-99 news release; 2 CDC, Prostate Cancer Control Initiatives; 3 "Prostate Cancer: Can We Reduce Deaths and Preserve Quality of Life?", CDC Cancer Prevention and Control; 4 "Prostate Cancer Awareness," TRICARE news, 6-22-2000; 5 "Testicular Cancer," National Cancer Institute, National Institutes of Health; 6 Testicular Cancer Resource Center, American Cancer Society; and 7 American Cancer Society's 2001 Facts & Figures.)*

## Cardiovascular Disease and Men

Cardiovascular disease (CVD), principally heart disease and stroke, is the nation's leading killer for both men and women. More than 960,000 American die of CVD each year, accounting for more than 40% of all deaths.[1]

More than 59 million Americans have some form of CVD, including high blood pressure, coronary heart disease, stroke, congestive heart failure, and other conditions. Each day, more than 2,600 Americans die of CVD – that is an average of one death every 33 seconds.[2]

Heart disease is the leading cause of premature, permanent disability among working adults. Stroke alone accounts for disability among more than one million people nationwide. Almost 6 million hospitalizations each year are due to CVD. Congestive heart failure is the single most frequent cause of hospitalization for people aged 65 years or older.[1]

*(1 "Cardiovascular Disease," CDC; 2 "About Cardiovascular Disease," CDC)*

## Men's Health Act of 2001

H.R. 632, introduced in the 107th Congress by Reps. Randy Cunningham (R-CA) and James McDermott (D-WA), would create an Office of Men's Health within the Department of Health and Human Services. The bill seeks to direct research and educate the public about the importance of early detection and timely treatment for several primarily male diseases. As introduced in the U. S. House of Representatives, the bill cites the following findings:

1. A silent health crisis is affecting the health and well-being of American's men.
2. While this health crisis is of particular concern to men, it is also a concern for women regarding their fathers, husbands, sons, and brothers.
3. Men's health is a concern for employers who pay the costs of medical care, and lose productive employees.
4. Men's health is a concern to Federal and State governments which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind.
5. The life expectancy gap between men and women has increased from one year in 1920 to almost six years in 1998.
6. Prostate cancer is the most frequently diagnosed cancer in the United States

among men, accounting for 36 percent of all cancer cases.

7. An estimated 198,000 men will be newly diagnosed with prostate cancer this year alone, and 31,500 will die.

8. Prostate cancer rates increase sharply with age, and more than 75 percent of such cases are diagnosed in men age 65 and older.

9. The incidence of prostate cancer and the mortality rate in African-American men is twice that in white men.

10. An estimated 7,200 men, ages 15 to 40, will be diagnosed this year with testicular cancer, and 400 of these men will die of this disease in 2001. A common reason for delay in treatment of this disease is a delay in seeking medical attention after discovering a testicular mass.

11. Studies show that men are at least 25 percent less likely than women to visit a doctor, and are significantly less likely to have regular physician check-ups and obtain preventive screening tests for serious diseases.

12. Appropriate use of tests such as prostate specific antigen (PSA) exams and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates.

13. Educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and America's overall economic well-being.

14. Recent scientific studies have shown that regular medical exams, preventive screenings, regular exercise, and healthy eating habits can not only help save live but help ensure a higher quality of life.

15. Establishing an Office of Men's Health is needed to investigate these findings and take such further actions as may be needed to promote men's health.

# Exploring the Pros and Cons of Male Neonatal Circumcision

## Talking Points for the General Practitioner

*by Christopher Hummel, Medical Student, and A. Scott Winter, M.D.*

Routine neonatal circumcision is one of the most commonly performed surgeries in the U.S. today. Data suggests that between 50% and 90% of all males born in this country are circumcised within a few days of birth.[1,16,19] The traditional rational used to justify this procedure have focused on adherence to religious beliefs, concerns over hygiene and conformity to social norms. In more recent years, data has suggested that lack of a foreskin may lead to a decreased incidence of several diseases including urinary tract infections (UTIs), Human Immunodeficiency Virus (HIV), several sexually transmitted diseases (STDs) and penile cancer. These possible benefits have been offset by a concern over the safety of circumcisions, the procedure's effectiveness in controlling these diseases and also for the pain that the infant is exposed to during the surgery.

The intention of this article is to briefly explore these issues and to provide the medical practitioner with recent data supporting or contradicting these beliefs. The authors hope that this article will function as a starting point in the discussion between doctor and parent regarding this most common procedure.

The American Academy of Pediatrics (AAP) first commented on the procedure in 1971 with a policy statement that took a firm stand against routine circumcision.[1,2] They revisited this issue in 1975, altering their stand slightly by stating that there was "no absolute medical indication" for the procedure.[1,2] In 1983, the AAP reiterated this policy (without modification). In 1989, the AAP completed its first extensive review of the then current literature and updated their position once again.[1,2] In this review, the AAP shied away from either condemning or supporting the practice, instead suggesting that the various pros and cons be discussed with concerned parents during the informed-consent period.[3]

The AAP again reviewed the issue and released its most recent findings in 1999. In this statement, the AAP admits, for the first time, that "existing scientific evidence demonstrates potential medical benefits", but continues to avoid endorsing routine circumcision. The organization suggests that the decision be left in the hands of the parents, providing that they be informed of the possible risks and rewards.[1]

Without clear direction, the family practitioner must be able to discuss the complex issues involved with concerned parents. This in turn requires that we have a much more clear understanding of the most current literature on the subject. One of the greatest concerns for parents has been the issue of the pain associated with this surgery, and the various methods used to alleviate it. That the procedure causes pain is beyond doubt: countless studies have described increased heart rates, changes in breathing patterns, facial grimacing and increased crying.[2,8,11,14] What has not been well understood until recently is that this experience can result in increased pain sensitivity for several months in an infant.[7,8] This realization has, in turn, begun to make us aware of the necessity of establishing adequate pain control.

**Points to be Addressed with Parents in Order to help with the Circumcision Decision**

1. Religious and ethnic dictates of the parents
2. Circumcision status of the father
3. Access to doctors trained in adequate pain control methods for the procedure
4. Circumcision's potential effect on:
   - UTIs
   - STDs
   - HIV
   - Penile Cancer
5. Circumcision's potential effect on contraction rates of STDs, HIV, and Penile Cancer
6. Cost of the procedure

Currently, there are three main approaches to anesthesia during circumcision: ring block, dorsal penile block and topical EMLA cream. Many practitioners originally avoided the easy to use cream due to fears of inducing methemoglobinemia.[10] This concern appears to have been overstated, with recent research showing absolutely no evidence of this condition resulting from the use of a single application (1g to 2 g) of the cream.[8,10] Ring block anesthesia has proved to be the most effective anesthetic for the procedure, with up to a 70% reduction in pain response noted.[8,9] Unfortunately, many practitioners have not taken the time to learn this more advanced form of anesthesia and have simply ignored its benefits. The overwhelming sentiment then is that should the decision to circumcise be made, it must be carried out under the influence of some form of local anesthetic by a practitioner skilled in the various methods currently available.[6,7,8,9]

One of the most commonly stated reasons for carrying out a circumcision is the belief that the removal of the foreskin is, in some way, protective against UTIs. This hypothesis was first suggested by Ginsberg and McCracken in 1982.[3,13] Research completed since that time has firmly established this association. Indeed, in a recent meta-analysis of the subject, every research article reviewed positively stated the existence of such a relationship. Not a single research experiment disagreed.[13,15] It appears that the mucosal surface of an intact prepuce is an ideal site for the attachment and subsequent colonization by fimbrated bacteria, especially E. coli.[12,13] The consensus is that non-circumcised infants have, at a minimum, a ten-fold increase in their risk of contracting a UTI during the first five years of life.[3,11,12,13,14,15] In reality, this impressive statistic may not be quite as significant

as one would think. Based on the prevalence of UTIs in all male children under the age of five, it is estimated that about 99 circumcisions would need to be performed in order to prevent one UTI.[13] Since these infections tend to be easily treated, one can well question the cost-to-benefit ratio of performing this procedure simply to avoid the odd UTI. However, it is important to note that approximately one third of all infant UTIs lead to bacteremia and or pyleonephritis – both of which can quickly become life threatening events.[3,12,15] It is this relationship that needs to be explored with parents during any discussion regarding circumcision.

It has also been postulated that circumcision is somehow protective against STDs. Two recent studies comprised of approximately 3000 heterosexual men, agreed that removal of the prepuce does confer some protection against both syphilis and gonorrhea.[19,20] The two studies also agreed that circumcision status has no impact on infection rates for genital herpes or non-gonoccal urethritis.[19,20] The two studies disagreed on the protective role of circumcision in contracting genital warts. The authors of these studies suggest that an intact foreskin may provide pathogenic access in one of four ways: (1) traumatic tears to the foreskin during vigorous sexual intercourse may lead to microscopic lesions to the skin that allow direct access to the circulatory system; (2) the area under the foreskin may provide a protected environment for pathogens, thus extending their survival times and increasing their ability to infect; (3) the less cornified epithelium of the preputial sac of an uncircumcised male may provide less of a physical barrier to pathogenic invasion; and (4) non-specific balanitis, not uncommon in uncircumcised boys, may predispose the subject to specific STDs.[19] While it goes without saying that circumcision status is not the only factor in whether or not a male contracts an STD, these recent findings need to be discussed with parents considering whether or not to circumcise their child.

AIDs/HIV is surely one of the most feared diseases of our times. Anything, any approach at all, that can potentially reduce the risk of contracting this disease must be given serious consideration. In a recent review of articles dealing with HIV and circumcision status, 22 major studies were identified that found a positive association between an intact prepuce and increased risk of acquiring AIDs/HIV.[21,22] In fact, uncircumcised men had a greater than four fold increase in risk of contracting AIDs/HIV when compared to circumcised men.[21,22] Interestingly, while a previous history of STDs also increased the risk of infection, a history of multiple sex partners did not.[22] It appears that an intact foreskin enhances the transmission of HIV-1, possibly secondary to inflammatory cell recruitment to inflammatory sites found under the intact foreskin.[21,22] Researchers are so sure of this positive association that several groups advocate circumcision as a viable intervention strategy to control the explosive spread of AIDs/HIV.[5,21,22]

Neonatal circumcision appears to completely protect against penile cancer.[2,16,17,18] Study after study has been unable to find evidence of the development of this form of cancer in adults who were circumcised at, or shortly after, birth. Interestingly, if circumcision is delayed until late childhood or the early teen years, all of the protective benefits of neonatal circumcision are lost.[16,17] Various researchers have hypothesized that poor penile hygiene, coupled with phimosis and accumulation of smegma under the prepuce, could all lead to this form of cancer. At present this relationship remains unclear.[16] What is known is that those children circumcised during the neonatal period appear to enjoy life-long protection from this rare, but devastating, cancer.

A final issue that should be considered is the recent research that indicates that the inner aspect of the prepuce is singularly lacking in epidermal Langerhans cells (EL cells).[4] These cells are epithelial components of the immune system and function in the recognition and processing of antigens. Once processed by these EL cells, a foreign virus can be attacked by the patient's immune system. However, the relative lack of these cells under the foreskin establishes a ready portal for the entry of viruses in general and HIV-1 in particular.[4] This area of potential susceptibility is key to understanding that the "good hygiene" alternative to circumcision may not provide adequate protection. Even with proper hygiene, the potential portal still exists. To date, there are no studies that have shown that good hygiene alone is equal in protection to circumcision.[4]

In this article we have tried to touch on the highlights of the circumcision debate. We have attempted to provide a brief outline of the most recent scientific data available. No effort has been spent on exploring the various religious, ethnic or societal reasons for or against this procedure. We believe that it is not the role of the medical practitioner to interject his/her own values and beliefs into this facet of the decision process. We must remember that even as the scientific rationale for neonatal circumcision grows, it is not appropriate for us to either encourage or discourage parents in their decision regarding this most common of surgeries. Rather it is our place to provide accurate and timely information to our patients so that they can make an informed decision combining both current scientific thought and their own religious, ethnic and societal beliefs.

*Chris Hummel is a third year student at Texas College of Osteopathic Medicine. His expected graduation date is May, 2002.*

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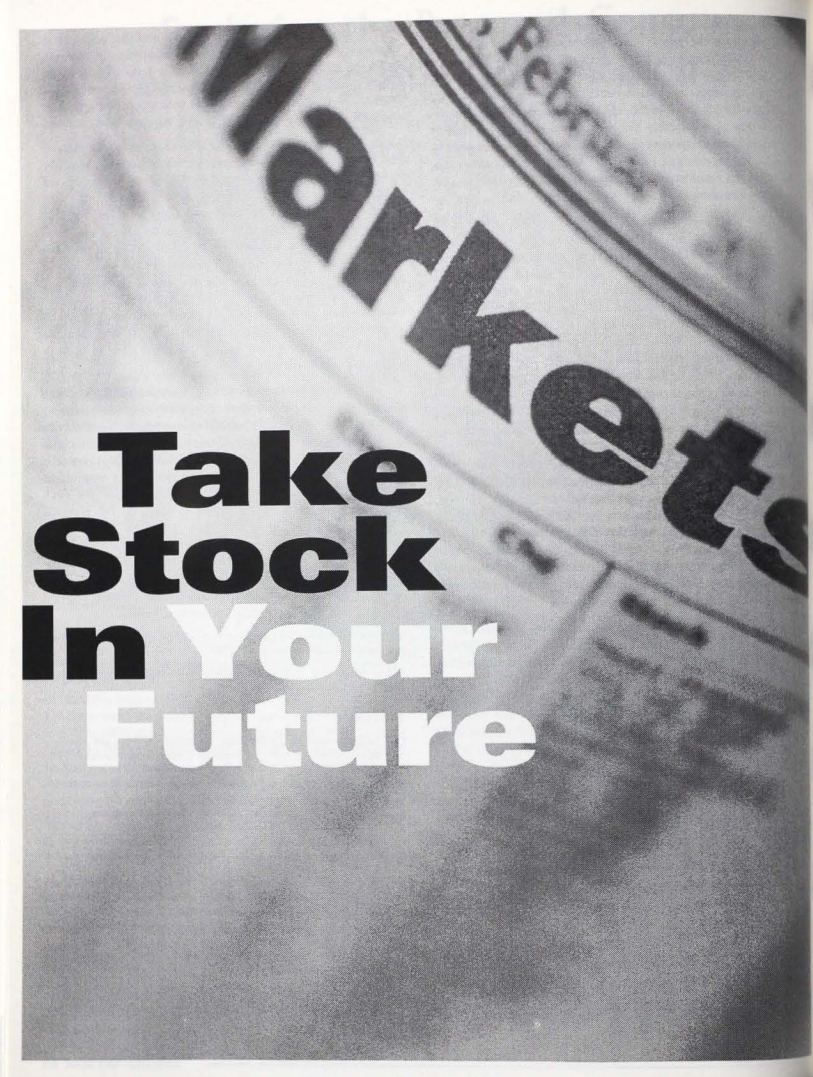
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*"Male Neonatal Circumcision"...continued from page 15*


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## MAKE PRACTICE SET-UP A SMOOTH TRANSITION

Are you leaving a residency program or group practice? When planning to make a transition to a new practice environment, you will be faced with many decisions and questions such as:

- *How many square feet of office space will you need?*
- *How much overhead can you handle?*
- *How will you manage patient records?*
- *What will your staffing needs be?*

**TOMA Physician Services** consultants can ease the challenges of setting up a new practice by helping you make informed decisions. TOMA's experienced consultants will help you answer these questions and more to assure smooth operations from the start. The consultants can handle all aspects of your set-up or just the specific areas for which you need help.

Don't let the details of setting up your new practice get you down. For help, turn to your organization — the Texas Osteopathic Medical Association. **TOMA Physician Services** offers customized, practical solutions for your unique operational challenges. Contact them today for more information at 800-523-8776 or <physician.services@texmed.org>.

# Malpractice Insurance Problems?

*Dear Colleagues:*

*Of the many things we physicians (especially those of us in private practice) have to keep up with, medical malpractice insurance is certainly among the most important. In January, my partner and I received a "Notice of Non-Renewal" from our carrier of several years. We had a zero claim history but were dropped because the purchasing group of which we were a part decided to drop this particular carrier.*

*As we began our search for new coverage we learned that the climate has changed again for the worse. Many carriers in Texas are increasing their rates, and some carriers are simply not writing new policies or are even getting out of this business altogether.*

*Ms. Linda Stacy attended our Professional Liability Insurance Committee meeting at the Mid-Winter Conference. She gave an excellent summary of the issues and some suggestions about what we can do. I strongly urge all of you to carefully read the following article, which she was kind enough to write at the committee's request.*

*Bobby Howard, D.O., Chair*
*TOMA Professional Liability Insurance Committee*

## Obtaining the Best Coverage in Today's Market

*by Linda Stacy, Director of Property & Casualty Insurance Services*
*Dean, Jacobson Financial Services, LLC*

Increased premiums? Non-renewal of coverage? Stricter guidelines? Say it isn't so! Unfortunately, the reality of today's medical malpractice market is that all of these issues are coming to pass. The "good old days" of the relatively stable – and in some cases declining – malpractice premiums are gone, at least for now. While few observers predict a malpractice crisis equal to that of the mid-1970's, most experts agree that rate increases and a closer examination of exposures is the practice of the day.

Increases can be blamed on the deteriorating claims climate, poor financial results of many carriers, as well as the consolidation of carriers that is reducing the competition. In addition, fewer and fewer carriers are looking for the same business. Insurers are moving away from their past focus on writing for volume and are concentrating on exposure and profitability. Some insured's may see a dramatic escalation in premium, while others, depending on their past loss results, may see none at all. Accounts that have been performing well are getting better renewal quotes, as opposed to other risks, but carriers want more data before issuing a renewal quote.

Here at Dean, Jacobson Financial Services, LLC, we have access to over 20 "A" rated malpractice markets. With a few exceptions, over the past 6 months, we have seen each of these markets impose higher premiums and stricter underwriting criteria. Furthermore, some carriers are withdrawing from certain types of exposures; i.e. Family Practitioners, specialties involving major surgery, part-time work, etc., while other carriers have ceased to write business altogether in certain parts of the country. Carriers are also imposing strict parameters for releasing

quotations: no open claims (new business only), must meet certain minimum limit requirements, must be board certified, etc.

So, what can you do to obtain the best coverage at the most competitive pricing?

- First, start early! Don't wait until your renewal date is just around the corner. Insured's need to plan and get the renewal specifications together early. Underwriters have become more disciplined about pricing and will require more time for a policy renewal – a minimum of 30 days, or they will not consider the account.
- Second, talk to your agent or broker. Which carriers do they recommend to meet your coverage needs? Ask questions about the carrier's financial stability and ability to meet ongoing obligations to its policyholders. How much experience does your agent/broker have in handling malpractice accounts? Are they knowledgeable about the choices in the marketplace, and can they meet your coverage needs.
- Third, market your account. While we all appreciate loyalty, there is nothing amiss in shopping your account periodically, especially in today's tough market. And remember, it is taking three to five times longer to market an account than it did last year, so plan on having your account to market no later than 60 days before your renewal date.
- Last, provide the carrier with as much information as possible. What was accepted as a submission two years ago does not pass today. The more information you can provide to the underwriter, and the better comfort level you can instill in them concerning your account, the more competitive your premium will be. A complete submission should contain the following elements:

- Current Application
  (carriers are not quoting if over 3 months old)
- Claim Information – Current Loss Runs for Past 5 Years, plus information on <u>all claims</u>
  The claim information should include:
  1) Name of Claimant
  2) Date of Incident
  3) Date Claim Reported
  4) Complete Description of Allegation
  5) Status of Claim
  6) If Claim is Open:
     a) What is Loss Reserve assigned by carrier
     b) Amount of monies paid out to date (if any)
  7) If Claim is Closed:
     a) Date claim was closed
     b) Final judgment (dismissed, claimant settlement, etc)
     c) Amount of monies paid, both Indemnity & Expenses
- Complete Description of Practice / Exposure
- Copy of Current Medical License & Curriculum Vitae
- Copy of Face Sheet from Current Malpractice Policy (for verification of Retroactive Date)

To summarize, be prepared to take a few aspirin at renewal time because the process may well cause you some headaches. Start early, be patient (expect some declines and don't take it personally) and be extremely accurate and thorough in completing new applications. In the end, you'll be rewarded for the extra time spent and for your serious focus. Also,call TOMA at 800-444-8662 or 512-708-8662 for a copy of *Malpractice Insurance: A Shoppers Guide* which may provide some additional insights and instructions.

# TEXAS CANCER CARE Establishes Foundation to Further Local Cancer Research

*Texas Cancer Care*, a premier medical resource for cancer treatment, has established a nonprofit foundation to increase local participation in cancer research programs. The Cancer Education and Research Foundation of Texas will raise funds for the advancement of cancer education and provide North Texas cancer patients local access to the latest cancer research available. All funds raised by the Foundation will directly fund cancer research programs.

Currently, most of the research into new cancer drug therapies is conducted at large academic hospitals, such as M.D. Anderson at Texas Medical Center in Houston. The establishment of the Foundation means cancer patients can take part in trials closer to home, an important choice for those who often must make the trial's required weekly trips to the doctor.

"The establishment of the Foundation allows us to participate in funded research without any conflict of interest. No clinician personally has financial gain when any patient participates in a study. This makes it perfectly clear to everyone that we are free to do what our patients decide is right for them as individuals," said Ray Page, D.O., Ph. D., the president of the Foundation Board.

Dr. Page also recognized advantages the Foundation brings to patients who will benefit from the local access to clinical trials. "If a patient can take part in a clinical trial that keeps them from having to drive long distances, then we are offering the best possible care we can – cutting edge treatment near the comfort of their own home. What makes this especially exciting for the residents of North Texas is that the money we raise here will stay here."

The Foundation currently supports research at all *Texas Cancer Care* locations, including Cleburne, Mineral Wells, Weatherford and three locations in Fort Worth. The Foundation's long-term plans include supporting other cancer research and educational endeavors throughout North Texas.

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

### Updated Physician Referral Guides Now Available

The University of North Texas Health Science Center has updated its Physicians & Surgeons Medical Group *Physician Referral Guide*.

The guide provides physicians easy access to information necessary for referring to the health science center's more than 100 faculty physicians, physician assistants and specialized clinical programs. It includes detailed information for clinics and programs and an alphabetical photograph directory of our medical staff.

One of Tarrant County's largest group practices, the Physicians & Surgeons Medical Group includes more than 100 physicians and surgeons who practice in 23 specialties and subspecialties. In addition, these physicians serve as teaching faculty for the health science center's Texas College of Osteopathic Medicine, and many engage in clinical research in their areas of expertise.

To receive a free copy of the *Physician Referral Guide*, please call 817-735-5152 or send your request via e-mail to <news@hsc.unt.edu>.

### Lubbock Physician Elected President of TCOM Alumni Association

Jack McCarty, D.O., a Lubbock family practice physician, is the new president of the Texas College of Osteopathic Medicine Alumni Association.

A 1978 graduate of TCOM, Dr. McCarty has been a member of the alumni association's board of directors for three years. As president of the board, Dr. McCarty will lead efforts to involve fellow alumni in association activities and offer programs to advance the profession and support current TCOM students.

Dr. McCarty practices at Caprock Medical Associates in Lubbock. His practice focuses on family practice and occupational medicine. He is board certified by the American Board of Osteopathic Family Physicians and a Fellow, American College of Osteopathic Family Physicians. He is also trained as a senior aviation medical examiner.

*continued on next page*

A leader in the osteopathic medical profession, Dr. McCarty has also served as president of District 10 for the Texas Osteopathic Medical Association and the Texas Society of Osteopathic Family Physicians.

A Lubbock native, Dr. McCarty is a 1959 graduate of Monterey High School and a 1965 graduate of Texas Tech University. He and his wife, Cynthia, have three children: Gregory, Jeffery, and Susan. They are also the proud grandparents of Kirstie McCarty, Steven Nicol, and Jacob Alger.

Founded in 1974, the TCOM Alumni Association provides leadership in the professional development of the medical school's graduates and seeks to advance osteopathic medicine and the medical school. The association currently boasts more than 2,100 physicians and surgeons across the country.

## TCOM Alumni Association Elects New Leadership

*Dale Chisum, D.O.*

*Elizabeth Palmarozzi, D.O.*

The Texas College of Osteopathic Medicine Alumni Association has elected its officers for 2000-2001. Jack McCarty, D.O., a Lubbock family practice physician, is now president of the board for the 2,100+ members of the association. President elect is Dale Chisum, D.O., who practices emergency medicine in Wichita, Kansas. Fort Worth physician Elizabeth Palmarozzi, D.O., is the board's vice president. Immediate past president is James Froelich, D.O., of Bonham, Texas.

Chris Pratt, D.O., joins the board this year as a new member. Returning board members are David Garza, D.O.; Tony Hedges, D.O.; David Hill, D.O.; John Jones, III, D.O.; Alvin Mathe, D.O.; Ray Morrison, D.O.; Dan Saylak, D.O.; Rodney Wiseman, D.O.; and Gary Wolf, D.O.

## Simple Memory Lapse or Serious Memory Loss?

If you or a loved one is starting to struggle with routine tasks that were previously handled with ease, the problem may be due to more than simple forgetfulness. Memory loss can be linked to a variety of causes, including certain medications, tumors, diabetes, stroke, depression, vision or hearing loss, cardiac or pulmonary complications, vitamin deficiencies, Alzheimer's disease, or simple stress, according to specialists at the University of North Texas Health Science Center at Fort Worth.

"People joke about losing their keys, but after awhile, it's not funny anymore," said Susan F. Franks, Ph.D., clinical neuropsychologist with UNT Health Science Center. "If you have a family member who has been diagnosed with dementia or if you've noticed changes in your own memory, an evaluation is in order. If you're concerned, you should do this for yourself and do it for your family."

Dr. Franks recommends that people be on the alert for signs of memory loss, including:

* Forgetting recent events, conversations, and names of friends or relatives
* Misplacing possessions
* Repeating questions or stumbling for words
* Getting lost in familiar surroundings
* Finding difficulty performing chores or using appliances and tools
* Struggling to manage money or other financial matters
* Experiencing changes in mood and/or personality

The UNT Health Science Center has opened a Memory Clinic for those concerned about their memory but who haven't been diagnosed with dementia. The clinic is the only one of its kind in North Texas for the general public.

Memory Clinic patients undergo a thorough assessment to learn if their memory problems are due to normal changes that occur with aging, treatable physical causes or chronic changes in brain function. They can choose for a report of this assessment to be sent to their doctor. The cost for the assessment may not be covered by insurance.

Patients of the Memory Clinic will be seen in the new Patient Care Center on the UNT Health Science Center campus in Fort Worth's Cultural District. For more information or to schedule an appointment, please call Barbara Harty, R.N., at 817-735-2193. No physician referral is necessary.

# Self's Tips & Tidings

By Don Self

## Refunds and Retroactive Denials

You've received a letter from a Third Party Administrator (TPA) stating they have done a review of claims dating back to 1997, and they are asking for a refund. The letter looks official enough and it references a payment made to you from CIGNA or AETNA or some other carrier back in 1998. They quote an edit that Medicare uses today from the Correct Coding Initiative (CCI) and politely, they state they made an error in processing the claim back in 1998 and respectfully request that you refund them the $212.59 that was overpaid.

Since the mistake was their fault in improperly paying the claim, they graciously decline to ask for any penalties or interest, and any interest you earned since you received their payment is yours to keep (nice folks, aren't they?). This first letter they sent you may or may not even indicate their willingness to hold the $212.59 from future checks in the event they do not receive remittance from you within 30 days.

So, what do you do? The payment records from 1998 were on a different computer, so you can't pull up the records from your computer today. Heck, you're not even sure if the paper records are still in your attic or if you've already had them transferred over to the storage facility where you rent an 8 x 10 foot storage room for old records. It's going to cost you money, time and hassles getting your staff to find the records and then find out whether you truly were overpaid 3 years ago, so perhaps it's just better to write them a check for $212.59 and be done with it. It would probably cost you that much just to research it, right? WRONG! They're counting on that very assumption you're making. They know that 80% of office managers are just going to write a check to the carrier and not mess with it. You're probably figuring they'll get their money either by check or future withholdings, so why should you fight it? It's very simple. In more than 95% of the claims we've seen, you don't owe them the money. Let's assume the edits they're using today to audit that 3 year old claim were in fact in place back in 1998 (in most instances - the edits they're using weren't developed until after that claim was paid). Let's assume they, in fact, did pay you back in 1998 or 1997 (in some instances, we cannot get proof from the carrier they even paid on the claim 3 or 4 years ago). Let's further assume that if we were able to get our hands on the records, we might find they had paid part of the patient's share of the claim. If you were to refund them - what do you think are your chances of getting the patient to pay today for a service from 3 or 4 years ago?

So, what do you do? Do you just ignore the letter? If you do, plan on seeing them withhold that money on a future check, which throws your accounting out of whack. Do you send them a nasty letter telling them that you don't owe it? Yes, but you do it in such a way as to keep yourself out of trouble. If you'll do some research, you'll find there are precedents set by the Texas courts stating you do not have to refund the money if the mistake was on the part of the carrier. We have our clients send us the letter from the carrier and we respond to the carrier with a letter where we reference specific statutes and precedents set by Texas courts and so far, we haven't lost one yet. (In one instance, we found the private carrier and Medicare had paid the doctor as primary, so we had the doctor issue a refund check for the overpaid amount) We also indicate that should the carrier withhold the $212.59 (or whatever amount) from a future check, they will definitely hear from our healthcare attorney that we have on staff (Wayne Clark, JD). So far, we always win.

The TMA is considering promoting legislation, as several other states have done, making it illegal for carriers to retroactively deny claims after payment, in Texas, but they haven't done so yet. We recommend you watch the TMA and TOMA. If they do so, let your legislators know that you're behind the bill.

## Things Change

"After preparing the patient, the physician made a 3 inch incision....."

This is part of a progress note or surgical report on a surgery done in 1980. Today, that same procedure is done through a 1 inch incision, thanks in part to the change in technology and the change in how the procedure is actually performed. You're staying on top of the changes in the clinical side of your practice, but are you doing the same for the business side? Perhaps you've gotten to the point where either you cannot see any more patients each day than you are now, or you don't want to see any more, yet your expenses keep going up, but your income isn't keeping pace with the expenses. Is it time to add a mid-level practitioner to your practice or should you buy that expensive piece of equipment that promises to pay for itself? Depending on your situation, neither may be the correct choice.

Through our association with Wayne Clark, JD, we are now taking on a limited number of new clients throughout Texas on a percentage basis of the increased collections. What does this mean? It means that we share the risk with the practice and agree to micro-manage the practice for a set period of time for a percentage of the increase of the collections. No increase means we don't make a penny. Only certain practices qualify for this, but if you want to talk to us about it, give me a call at 1-888-DONSELF. So far, our average osteopathic client has seen an increase of more than 85% in monthly collections in the first six months, over what they were doing before us. That means the average client almost doubled their monthly income.

*continued on next page*

## Lightening Takes Another Path

Ok, you've spent the money for an Uninterrupted Power Source with surge protection to protect your computer from lightening strikes and power spikes. I did, too. Last week, lightening hit my office roof. While my UPS kept the spike from getting to my computer through the power cord – it didn't slow it down as it traveled at hyper-speed through my phone line, into my modem (leaving it a charred mess of circuits) and frying my computer. So, the lesson is that if you're having a lightening storm - don't forget to unplug your phone modem or phone jack from the wall.

## Sign-in Sheets

Over the years, we have heard about offices that were sued or somehow penalized for using sign-in sheets. It's been said this is a violation of the patient's privacy. Just recently, to see if these stories about doctors being sued for using sign-in sheets were hoaxes, I asked the question on three different internet listservs. All three of these have quite a few attorneys on them, and two of them are comprised mainly of healthcare attorneys. I asked if anyone has seen any documents, listing of court cases, dockets, etc., of any case involving sign-in sheets. I had several attorneys tell me they had done word searches and found not one instance of any doctor in this country being sued, challenged or penalized for using sign-in sheets. So, if you're comfortable using them, don't worry about the hoaxes.

## Hospital Discharge

If you were at the recent workshop I did in Dallas, you heard me talking about different instances of when you can use counseling time to determine the level of service or the additional $100 to $150 you can make in addition to office visits for prolonged service. What you might not have caught was the additional income you can get for 99239 over 99238. Keep in mind that the final day discharge management includes the final examinations (note the plural), final instructions to the patient, final instructions to the patient's family, co-ordination of care with home health or durable medical suppliers, writing of prescriptions, etc.

## Mandatory Medicare Assignment

Effective February 1, 2001, HCFA requires mandatory assignment for drugs and biologicals on all Medicare claims, regardless if the physician or provider is participating or non-participating. So, doctor, you now HAVE to accept assignment on all drugs and biologicals on Medicare patients, the same way you do on clinical lab services.

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# American Osteopathic Association Seeks D.O.s as Healthcare Sources

The American Osteopathic Association's (AOA) Department of Communications is looking for D.O.s who are interested in being a healthcare resource. The theme for National Osteopathic Medicine (NOM) Week 2001 has been selected, "End of Life Care" and the AOA has begun the process of gathering osteopathic healthcare sources for the new kit.

If interested in serving as a healthcare source for one of the topics in this year's kit, physicians should contact Kelletta Blackburn, Marketing Communications Coordinator, with your name; mailing address; work phone, e-mail address; fax number; specialty area; the topic you would like to be interviewed about; and the best means of contacting you.

Once the AOA receives your intent to participate, you will be contacted regarding a day and time to schedule a telephone interview. The interview will not last longer than 30 minutes and you will be forwarded the list of questions beforehand.

## NOM Week 2001 Topics

Advanced Directives
Advances in Pain Management
Cultural Sensitivity and the Final Stages of Life
Spirituality and End of Life Care
Talking to Children Who Have a Serious Illness
Caring For Those With Serious Long-term Sports Injuries
Support for Caregivers
Organ Donation
Financing Long-Term Care
Choosing Long-Term Care Options
Talking to Children About the Serious Illness of a Parent

To sign up, please contact Kelletta Blackburn, Marketing Communications Coordinator; 312-202-8045; by fax at 312-202-8345; or by e-mail at <kblackburn@aoa-net.org>.

# Update on the 77th Texas Legislative Session

*The following are additional bills of interest that were filed in the Texas Legislature as of March 9th, the final day for filing bills. Bills of purely local interest and those with statewide impact can still be filed, however, if they win four-fifths approval in the House or two-thirds approval in the Senate.*

**HB 1577** – Rep. Dawnna Dukes – Relating to medical dispute resolution in certain workers' compensation cases. The Labor Code would be amended by adding the following subsection: "In a review of a medical service under this section, a doctor may not offer an opinion regarding whether the medical service is reasonable and necessary unless the doctor has examined the injured employee within the 12 months preceding the date of offering the opinion."

**HB 1578** – Rep. Dawnna Dukes – Relating to medical evidence introduced by a workers' compensation claimant in a contested case hearing. The Labor Code would be amended to stipulate that if a claimant introduces medical evidence from a physician that the claimant sustained an injury and the insurance carrier does not introduce medical evidence from a physician to the contrary, it is presumed that the injury exists. The presumption, however, would not affect the issue of whether the injury occurred in the course and scope of employment.

**HB 1676** – Rep. Lon Burnam – Relating to health benefit plan coverage for survivors of traumatic brain injury. This legislation would prohibit certain health benefit plans from limiting or excluding coverage for cognitive therapy, neuropsychological testing or treatment, or community reintegration activities necessary as a result of a traumatic brain injury. Training for precertification personnel of a health benefit plan would also be required.

**HB 1688** – Rep. Ruth McClendon – Relating to the possession and self-administration of prescription asthma medicine by public school students while on school property or at a school-related event or activity. This legislation would allow students to possess and self-administer prescription asthma medicine if done in compliance with the prescription or written instructions from the student's physician, a written authorization provided and signed by the parent or guardian, and a written statement from the physician. The written and signed statement from a physician or other health care provider must state that the student has asthma; is capable of self-administering the prescription asthma medicine; name and purpose of the medicine; prescribed dosage; time or circumstances under which the medicine may be administered; and the period for which the medicine is prescribed. The physician's statement would be kept on file in the office of the school nurse or, in the absence of a nurse, in the office of the principal.

**HB 1702** – Rep. Rick Green – Relating to immunization and the immunization registry. The Texas Immunization Advisory Committee would be established to assist the board and the department in the development of procedures, guidelines and policies related to immunizations in Texas. It would evaluate the existing immunization program operated by the department and identify needs not met by the program. In addition, the department would be directed to develop and provide an exemption form to a person subject to exclusion from a school or facility because the person declines a required immunization for reasons of conscience or because of a religious belief. The bill also delineates the steps to be taken for exclusion from the registry. Basically, the first time the department receives data for a child, the department must send a written notification to the child's parents disclosing that providers and insurers may be sending the child's immunization information to the department. However, the department may not keep the information if the parent or guardian chooses to exclude the child from the registry.

**HB 1704** – Rep. John Smithee – Relating to the establishment and operation of a task force to examine issues regarding expansion of the provision of health benefits to employees of small businesses. The Small Business Health Benefits Task Force would be established to make recommendations to the legislature with respect to improving the availability of group and individual health benefits coverage to employees of small businesses in the state.

**HB 1720** – Rep. Kyle Janek – Relating to liens for certain services provided by physicians. At the request of a physician, a hospital would be allowed to include in its lien the physician's charges for emergency care for the first seven days of a patient's hospitalization.

**HB 1801** – Rep. Glen Maxey – Relating to the establishment of a home telemedicine pilot program for certain recipients of medical assistance. The Home Telemedicine Pilot Program would be established whereby certain recipients of medical assistance would receive home health care services through telemedicine, in addition to other home health care services for which recipients are eligible. Program participants would have to meet certain eligibility requirements, including being diagnosed with a chronic illness; be under the care of a physician who consents to the participant's receipt of home health care services; and possess the ability to use telemedicine equipment or be assisted by a regular caregiver who is willing and able to use the equipment. No later than December 1, 2004, a report would be submitted to the legislature regarding the program, to include an analysis of the program's cost-effectiveness; the program's effect on the quality of health care received by participants; and recommendations regarding elimination, continuation or expansion of the program.

**HB 1862** – Rep. Craig Eiland – Relating to the regulation and prompt payment of health care providers under certain health benefit plans. An HMO or insurer must notify in writing a physician or provider of the need for any attachments desired in good faith for clarification of a clean claim not later than the 20th calendar day after the date the HMO or insurer received the claim. The written notice requesting the attachment must describe with specificity the information requested, provide a detailed description of the reasons why the information is requested, and pertain only to information the HMO or insurer can demonstrate is within the scope of the claim in question. Upon receiving a request, physicians would have 20 calendar days to provide the attachment without tolling the 45-day payment period as defined in this article. The 45-day payment period will be extended by the number of days by which the requested attachment is received by the health plan beyond the 20th day.

For information about additional legislative bills, log on to <www.txosteo.org> or <www.capitol.state.tx.us>.

# The New Age Health Connection

## June 6 - 10, 2001

### Texas Osteopathic Medical Association 102nd Annual Convention and Scientific Seminar

George N. Smith, D.O., Program Chair

### Arlington Convention Center and Wyndham Arlington Hotel Arlington, Texas

turn the page

– ANNUAL CONVENTION INFORMATION –
– EARLY REGISTRATION FORM –

# TOMA's 102nd Annual Convention & Scientific Seminar

Arlington Convention Center • Wyndham Arlington Hotel • Arlington, Texas
June 6 – 10, 2001

Whether you serve in osteopathic, allopathic or integrated communities as a physician, physician's assistant, nurse or other healthcare provider, you will benefit from this educational and networking opportunity. The program includes educational sessions on a wide variety of health topics, instructed by leading health care professionals, along with specialty breakout workshops. In addition to the educational value, you can visit over 75 exhibitors, enjoy great social events and network with your peers all in the thriving metroplex city of Arlington, Texas.

## Hotel Information

The host hotel for the 102nd Annual Convention is the Wyndham Arlington Hotel
1500 Convention Center Drive • Arlington, Texas

Please call the hotel directly to make your room reservations at 800-442-7275 or 817-261-8200. Be sure to say you are with "Texas Osteopathic Medical Association" to receive the group rate of $135.00 single, double or triple per night. **Reservations must be made no later than Wednesday, May 16, 2001 to receive the discounted rate.**

The Wyndham Arlington Hotel provides complimentary shuttle to the Dallas/Fort Worth Airport. The shuttle runs from 6:00am to 9:00pm, you must call the hotel directly to make reservations for the shuttle. In addition, Super Shuttle Service is available from Dallas/Fort Worth Airport. You can contact Super Shuttle directly at 817-329-2000.

## Physician Registration

The Physician's Registration Fee includes admission to all CME lecture sessions, workshops and the exhibit hall, plus 26 available hours of category 1-A credits, including two hours of ethics education and five hours of Risk Management CME. Also included are all lecture handouts, Wednesday Night Grand Opening Reception, Breakfast Thursday through Sunday and one admission ticket for each of the following: Thursday Keynote Luncheon, Saturday AOA Luncheon and Saturday Night President's Reception and Banquet. For additional tickets, please see registration form.

## Spouse Registration

The Spouse Registration Fee includes exhibit hall admission and one admission ticket for each of the following: Breakfast Thursday through Sunday, Wednesday Night Grand Opening Reception, Thursday Keynote Luncheon, Saturday AOA Luncheon, ATOMA President's Installation Breakfast and Saturday Night President's Reception and Banquet. For additional tickets, please see registration form. Contact numbers for childcare services will be available during the convention. Look for more information in your registration packet.

Tickets for individual events, *with the exception of the President's Reception and Banquet and the ATOMA President's Installation Breakfast*, can not be purchased separately. You may purchase a "meal tickets package" for individuals wanting to attend any meals. See registration form for details.

## Refund/Cancellation Policy

To receive a registration refund, less 25% for administrative handling fee, all registration and special event refund requests must be IN WRITING and postmarked no later than May 18, 2001. No refunds will be given to requests postmarked after May 18, 2001.

## Special Requests

TOMA wants your convention experience to be everything you want it to be. If you have any special requests* (such as vegetarian meals) please contact Jill Weir, CAE, TOMA Projects Coordinator, prior to May 18th at 800-444-8662 or 512-708-8662. All TOMA Annual Convention functions, including off-site activities and bus transportation, are ADA compliant.

* Contact numbers for childcare services will be available during the convention. Look for more information in your registration packet.

## Optional Activities

In addition to our planned Family Fun Day, Sustainers Party and the Annual ATOMA Golf Tournament, TOMA will provide information on other optional activities for the entire family all within close proximity to the hotel. The metroplex has an array of family activities such as Six Flags Over Texas, Hurricane Harbor Water Park, Ripley's Believe it or Not Wax Museum, extensive shopping, museums and restaurants. Look for flyers in your registration packet and a special "Arlington Information Table" near the Registration Area at the Convention Center.

## Convention Attire and Gear

Daytime convention functions are "Business Casual to Vacation Casual." Family Fun Day will be at the Ballpark at Arlington, we will be outside for both the picnic and the baseball game, please dress comfortably. The President's Banquet, Saturday night, June 9th, at the Wyndham Arlington Hotel, is black tie optional.

# PRELIMINARY PROGRAM SCHEDULE

## – 26 Category 1-A CME Hours Available –

**All events on Wednesday, Thursday and Friday are held in the Arlington Convention Center unless otherwise noted.**

**Wednesday, June 6**

4:00pm – 7:00pm Registration Open
5:00pm – 7:00pm Exhibits Open

5:30pm – 6:30pm Reception with Exhibitors in the Exhibit Hall

**Thursday, June 7**

7:00am – 5:00pm Registration Open

7:30am – 8:30am Breakfast with Exhibitors in the Exhibit Hall

8:00am – 9:00am CME Session – Topic TBD

9:00am – 10:00am Psychosis in the Elderly
George N. Smith, D.O.
*Sponsored by Eli Lilly*

10:00am – 10:45am Pharmaceutical Update

10:45am – 11:45am Functional Foods: Hip or Hype?
Shalene McNeil, Ph.D., R.D.
*Sponsored by Texas Beef Council*

Noon – 1:30pm Keynote Luncheon

1:30pm – 3:30pm HeartCare Partnership
Bob Hillert, M.D.
*Sponsored by Texas Medical Association*

3:30pm – 4:00pm Pharmaceutical Update

4:00pm – 5:00pm Temperature Controlled Radio Frequency Treatment of Snoring and Sleep Apnea
Richard C. Grossman, D.O.

**Friday, June 8**

7:00am – Noon Registration Open

7:00am – Noon Exhibit Hall Open

7:30am – 8:30am Breakfast with Exhibitors in Exhibit Hall

8:00am – 9:00am A System Approach to Improving Diabetes Care
Steven L. Yount, D.O.
Celeste A. Frangeskou, BSN, RN
*Sponsored by Texas Medical Foundation*

9:00am – 10:00am Bioterrorism
Paul McGaha, D.O.
*Sponsored by Texas Department of Health*

10:00am – 10:30am Pharmaceutical Update

10:30am – 12:30pm **Breakout Workshops**
**Wyndham Arlington Hotel**
(Workshops repeat on Saturday afternoon)

**Workshop 1**
Advanced Cardiac Life Support Protocol
Daniel Saylak, D.O.
*Sponsored by Wyeth Ayerst*

**Workshop 2**
OMT Workshop
Conrad Speece, D.O.

**Workshop 3**
Medicare Fraud and Abuse
Janet Horan, J.D.
*Sponsored by American Osteopathic Association*

2:00pm – 8:00pm ATOMA Golf Tournament
Riverside Golf Club
*Sponsored by Dean, Jacobson Financial Services, LLC*

5:00pm – 10:00pm Family Fun Day – Picnic and Texas Rangers Baseball Game

**All events on Saturday and Sunday are held in the Wyndham Arlington Hotel unless otherwise noted.**

**Saturday, June 9**

7:00am – 4:00pm Registration Open

7:30am – 8:30am Buffet Breakfast

8:00am – 9:00am Are We Vegetarians or Carnivores
Bill Roberts, M.D.
*Sponsored by Pfizer*

9:00am – 10:00am Psychological Perspective of Tattoos
Mark Bell, D.O.

10:00am – 10:15am Break

10:15am – 11:15am Sleep Disorders
Elliott Schwartz, D.O.
*Sponsored by Cephalon*

11:15am – Noon Rheumatology Update
Scott Stein, D.O.

Noon – 1:15pm AOA Luncheon

1:30pm – 2:30pm Medical Ethics
Nick S. Pomonis, D.O.
*Sponsored by Forest Pharmaceuticals*

2:30pm – 4:30pm **Breakout Workshops**
(Repeat of Friday, 10:30am - 12:30pm)

6:00pm – 7:00pm President's Reception

7:00pm – 11:00pm President's Banquet

**Sunday, June 10**

7:30am – 10:30am Registration Open

7:30am – 8:00am Buffet Breakfast for Program Attendees

8:00am – 1:15am Risk Management Program

*"TOMA has created a unique "bring the family" environment as an important part of their annual convention. Family Fun Day, door prizes, the ATOMA Golf Tournament; all these and other special activities have made this a conference not to be missed. There seems to be something for everyone plus, as always, quality CME. Will I be there in Arlington? You bet!"*

*Ray Morrison, D.O.*

## Wednesday, June 6

**5:30pm – 6:30pm**
**Convention Grand Opening Reception with Exhibitors**
***"Gear Up for The New Age Health Connection"***
**The attire is "Business Casual."**
***This a No Charge Event open to all registrants, their families (all children must be accompanied by an adult) and registered convention exhibitors.***

Join us as we gear up for the spectacular TOMA 102nd Annual Convention and Scientific Seminar in the Exhibit Hall. An hour of mixing and mingling with exhibitors and colleagues plus door prizes, food and beverages.

## Thursday, June 7

**6:30pm – 10:00pm**
**Sustainers *"Wine and Dine"* Party**
**La Buena Vida Winery**
**The dress for the evening is "Evening Casual."**
***This is a No Charge Event for sustaining members and one adult guest only.***

You will be treated to a night of elegance and fun while tasting the flavors of wine from this locally owned winery (one of TOMA's very own, Bobby G. Smith, D.O.). You will stroll through the beautiful gardens of La Buena Vida Winery, sipping wine, enjoying great company and listening to live jazz music.

Then you will be delighted by an special array of entertainment that will keep you laughing and on the edge of your seat.

Even if you are not a wine connoisseur, this evening holds something for everyone with its unique ambience, jazzy entertainment and a wonderfully lavish dinner.

## Friday, June 8

**2:00pm – 8:00pm**
**ATOMA's Annual Golf Tournament**
**Riverside Golf Club**
**3000 Riverside Parkway, Grand Prairie, Texas**
**The dress is golf attire (as comfortable as you can get in the hot Texas sun!).**
***This is a Ticketed Event open to everyone over the age of 18. $75 per person.***

Ready for a day of fun and sun out on the links? Then you won't want to miss the ATOMA Annual Golf Tournament sponsored by Dean, Jacobson Financial Services. Riverside Golf Club is the location for this year's tournament and promises to be a fun time for all golfers from novice to pro. After the tournament, relax and enjoy dinner at the club house while tournament trophies and prizes are shared.

## Friday, June 8

**5:00pm – 10:00pm**
**Family Fun Day**
***"Take Me Out to the Ball Game"***
**The dress for the ball game is casual and comfortable. Depending on the weather you will want to wear comfortable clothes and shoes. Pack an umbrella just in case.**
***This is a Ticketed Event, $20 per person.***

We will be going to the Ballpark at Arlington to watch the Texas Rangers take on the Houston Astros, a must for any baseball fan living in Texas. We will start with a picnic in a private area of the Ballpark, you can watch batting practice, tour the Ballpark, shop in the gift shops or tour the Hall of Fame museum all before the game starts. Then we have first base-line tickets to watch all the baseball action. Food, fun and something for everyone in the family.

## Saturday, June 9

**6:00pm – 7:00pm**
**President's Reception**
**7:00pm – Midnight**
**President's Banquet**
**The attire for this special occasion is "Elegant Evening" with Black Tie optional.**
***Your registration fee includes one ticket. Additional tickets are $75 per person.***

The President's Reception will take place in the Foyer of the Grand Ballroom at the Wyndham Arlington Hotel. The start of this elegant evening will be the reception where you can gather with your colleagues and friends to enjoy drinks, entertainment and lively conversation.

Following the reception is a full course extravagant dinner in the Wyndham Arlington Ballroom. Current President, Dr. Bill V. Way will pass the gavel to Dr. Mark A. Baker and TOMA award presentations will be made.

Then you will really get the party going as you enjoy great music and all your favorite tunes to dance the night away.

**? ? QUESTIONS ?? Call Jill Weir, CAE, Projects Coordinator, at 800-444-8662 or 512-708-8662**

# TOMA's 102nd Annual Convention & Scientific Seminar • June 6 – 10, 2001

**Arlington Convention Center & Wyndham Arlington Hotel • Arlington, Texas**

## REGISTRATION

**PRINT CLEARLY or TYPE**

Name_____

First Name for Name Badge (if different from above)_____

Mailing Address_____

City_____ State_____ Zip_____-_____

Phone (  )_____ FAX (  )_____ E-mail_____

D.O. College_____ Year Graduated_____ AOA#_____

Specialty_____ TOMA District_____

Spouse or Guest (if Name Badge is requested)_____

☐ Please check here if you have a disability, require a special diet or accommodations. You will be contacted to discuss your needs.

## REGISTRATION FEES

| | EARLY Registration (Postmarked by 5/9) | Registration (Postmarked after 5/9) | |
|---|---|---|---|
| TOMA Members* | $450** | $550** | $_____ |
| • 1st or 2nd Year in Practice** | $275 | $375 | $_____ |
| • Retired/Life Members** | $200 | $300 | $_____ |
| • Guests** | $200 | $300 | $_____ |
| Non-Members** | $700 | $800 | $_____ |
| Other Healthcare Professionals** (such as P.A.'s, Nurses ) | $300 | $400 | $_____ |
| Students/Interns/Residents*** | $0 | $0 | $ 0 |

* Includes members of other state osteopathic associations.
** Registration includes one ticket to all meal functions and one ticket to President's Banquet.
*** Registration does **NOT** include tickets to any meal function or special activities listed below. Meal tickets can be purchased by package only. See "Meal Ticket Package" below.

**REGISTRATION FEES SUBTOTAL** $_____

## SPECIAL EVENTS

**Family Day*** . . . . . $20 x # _____ tickets $_____
YES __I/We will ride the TOMA Shuttle. # of riders in your group____
NO __I/We will NOT ride the TOMA shuttle.
Tickets are limited to 175 people on a "First-Come First-Served" basis.

**TOMA Golf Tournament** . . . . . $75 x # _____ tickets $_____
Name: Player #1_____ Handicap_____
Player #2_____ Handicap_____
YES __I/We will ride the TOMA bus. # of riders in your group____
NO __I/We will NOT ride the TOMA bus.

**Sustainers Party** *(Open to Sustaining Members - Adults Only)*
Number of tickets (circle one) 1 2 N/C
YES __I/We will ride the TOMA bus. # of riders____
NO __I/We will NOT ride the TOMA bus.

**SPECIAL EVENTS SUBTOTAL** $_____

## ADDITIONAL TICKETS/MEAL TICKET PACKAGE

**Convention Meal Package*** . . . . . $140 per person x # _____ packages $_____
Includes Breakfast-Thurs., Fri., Sat., Sun.; Keynote Luncheon; AOA Luncheon

**TOMA President's Banquet** . . . . $75 x # _____ tickets $_____

**TOMA President's Installation Breakfast**
. . . . . $30 x #_____ tickets $_____

Convention Meal Packages can be purchased on-site. A ticket must be presented for each meal. Meal tickets **CAN NOT** be purchased separately or at the meal function.

**ADDITIONAL TICKETS/ TICKET PACKAGES SUBTOTAL** $_____

### PAYMENT SUMMARY

| | |
|---|---|
| Convention Registration Fee(s) | $_____ |
| Special Events | $_____ |
| Additional Tickets/Packages | $_____ |
| TOTAL | $_____ |

### FORM OF PAYMENT

☐ Check in the amount of $_____

**Credit Card**

☐ Visa ☐ MasterCard ☐ AmExpress

Card Number

_____

Expiration Date_____

Please **TYPE** or **PRINT** name as it appears on the card:

_____

Authorized Signature

_____

**MAIL COMPLETED FORM WITH CHECK PAYABLE TO TOMA**
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***ONLY* if paying by credit card**
**FAX: 512-708-1415**

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Date Received_____

Amount $_____

Check Number_____

# Opportunities Unlimited

## PHYSICIANS WANTED

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

**PSYCHIATRIST NEEDED – Fort Worth,** TX, Open rank for a full time academic faculty position. Responsibilities include classroom teaching and clinical supervision of medical students enrolled in the Texas College of Osteopathic Medicine, and teaching on psychiatry topics to Internal Medicine residents. Patient care responsibilities include evaluation and treatment of adults in a primarily outpatient setting with some hospital consultation and inpatient psychiatry responsibilities; and provision of psychiatric consultations at the local Federal Medical Center, Federal Bureau of Prisons. Research opportunities are available and could be developed based on the interests of the faculty member. The position includes a competitive salary and a comprehensive benefits package. Applicant qualifications include a D.O. or M.D. degree, completion of a psychiatry residency program, and board certification or eligibility. The psychiatrist should be familiar with osteopathic principles and philosophy. Prospective candidates should be energetic and capable of managing multiple responsibilities. The ability to work as a team member and to establish collegial relationships with clinical faculty within the department and other departments is a high priority. Send inquiries, a current CV, and three letters of reference to Kenneth N. Vogtsberger, M.D., Professor and Chief, Psychiatry Division, Department of Internal Medicine, University of North Texas Health Science Center (UNTHSC), 855 Montgomery Street, 3rd floor, Fort Worth, Texas 76107. Telephone: 817-735-2334; FAX: 817-735-5441. (03)

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

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

**DALLAS/FORT WORTH – Physician** opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call and no emergencies. Please call Lisa Gross at 888-525-4642 or 972-255-5533 or FAX CV to 972-256-0056. (25)

**AMBULATORY FAMILY PRACTICE** has opportunities for FT/PT BC/BE FP. Full benefits package for FT including malpractice, paid time off, expenses for CME/Lic. fees. Flexible schedule, no night call, no hospital work, no administrative hassles. Enjoy the lifestyle afforded by the Metroplex. Please FAX CV to 817-283-1944 or call Shannan at 817-283-1050. (36)

## POSITIONS WANTED

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

**BOARD CERTIFIED FAMILY PHYSI-**CIAN, 20 years practice & teaching, skilled in OMT, good surgical skills, broad knowledge of herbs, public speaking, graduate in counseling. Seeks position in consultation, administration or teaching & patient contacts in or near Metroplex. Contact TOMA at 800-444-8662. (51)

## PRACTICE FOR SALE/RENT

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

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

**FOR SALE – Moderate to large broad-**base family practice, 20 years, suburban area, no Medicaid. Available for immediate take over. Patient base OMT, Pediatric & Senior Care. Fort Worth area. Contact TOMA at 800-444-8662. (52)

**MEDICAL PRACTICE FOR SALE:** This is a positive cash flowing practice – NO DEBT!!! All the patients, receivables, files, file cabinets, copiers, computers (2), printers (2), exam tables, power table, office furniture, electrical muscle stimulators, ultrasound units, whirlpool, matrix, Arcon unit, Kin-com unit (concentric/eccentric testing and rehab), treadmill, dynathermy units, paraffin bath, exercise equipement, neurometer testing unit, ekg with interpretation, non-invasive vascular study machine with interpretation, pulmonary fuction testing, blood pressure units and all the equipment in storage. Reason for Sale: Changing careers to go into ministry full time. Total Assets Value: $700,000 Selling Price: $300,000 ***100% financing available. Call 972-709-0077 or e-mail at <slcc@airmail.net> or FAX 972-709-0240. (53)

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

## MISCELLANEOUS

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

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

www.txosteo.org

# ON THE WEB in April

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

- **In Brief**
- **Health Notes**
- **Texas FYI**
- **TRICARE News and Related Military Issues**
- **10 Years Ago in the *Texas D.O.***
- **HHS News**

- **Update on the 77th Texas Legislative Session**

- **Texas Stars and Heritage Campaign Members**
  **A Listing.**

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

- **Thank You**
  **A Listing.**

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

- **For Your Information**
  **A Listing.**

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

# LOOKING BACK

## "CELEBRATING 100 YEARS OF OSTEOPATHIC MEDICINE IN TEXAS"

The Texas Association of Osteopathic Physicians and Surgeons (TAOP&S) held its first-ever House of Delegates meeting in Tyler in 1947. Serving as TAOP&S president at the time was J. Francis Brown, D.O.

Nine of the physicians pictured served as TAOP&S president, as follows: Phil R. Russell, 1923-24; J. R. Alexander, 1935-36; Lester Vick, 1941-42; Joe Love, 1944-46; J. Francis Brown, 1947-48; H. George Grainger, 1948-49; Lige C. Edwards, 1949-50; George J. Luibel, 1950-51; and Wayne Smith, 1955-56. Dr. Love is the only physician to this day to serve two terms.

Additionally, two served as AOA president were Dr. Russell, 1941-42; and Dr. Luibel, 1976-77.

In 1949, Dr. Russell limited his practice and took over as executive secretary of TOAP&S. In the early 1950s, he built


the first state headquarters, which many physicians will recall, at 512 Bailey in Fort Worth.

Pictured are: front row, left to right – Drs. J. R. Alexander; William Badger; William Gribble; James Choate; Lige Edwards; John Donovan; Joe Love; Ray Nelson; unidentified; Robert Bruney; Merle Griffith; T.D. Crews; and Carl Stratton.

Back row, left to right – Drs. unidentified; William Roberts; J. Francis Brown; Lester Vick; unidentified; Phil Russell; Henry Spivey; Ward Hueston; George J. Luibel; Wayne Smith; John Turner; George Grainger; (first name unknown) Blackwood; and Nelson Dunn.

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